6th EDITION

THE THEORY AND PRACTICE OF GROUP PSYCHOTHERAPY

IRVIN D. YALOM

MOLYN LESZCZ

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I would like to dedicate this book to Marilyn, my beloved wife of sixty-five years, who died in 2019

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To the next generation: Sid, Pete, Lucy, and Margot

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Preface to the Sixth Edition

FIFTEEN YEARS HAVE PASSED SINCE THE FIFTH EDITION OF this textbook was published. Our task in this sixth edition is to describe the new and significant innovations in group therapy that have emerged during these years. We are pleased and grateful to continue our long collaboration, which began forty years ago at Stanford University. We have approached our work together as seasoned co-therapists and in writing this edition have sought to support and challenge one another. We write largely as "we," with an interweaving of both voices. At certain points, to identify an experience personal to one of us, we switch to first person and include a parenthetical abbreviation to indicate which of us is taking over the narration (IY or ML).

Our aim is to provide our readers with a synthesis of new knowledge and accrued wisdom in the practice of group therapy. We make extensive use of clinical illustrations to bring these concepts and principles to life and make the book both practical and instructive. Like previous editions, this one is intended for students, trainees, and frontline practitioners as well as supervisors and teachers.

Since group therapy was first introduced in the 1940s, it has continued to adapt to reflect changes in clinical practice. As new clinical syndromes, settings, and theoretical approaches have emerged, so have corresponding variants of group therapy. The multiplicity of forms is so evident today that it makes more sense to speak of "group therapies" than of "group therapy." The evidence is consistently strong, across all ages and clinical needs, that group therapy is effective, generally with outcomes equivalent to those of individual therapy, and far less costly. This is true both for mental health and for substance use disorder treatment as well as for the medically ill.

The Internet makes group therapy far more accessible today than it was in the predigital world. Geography is no longer the barrier to therapy that it once was. New technological platforms create new opportunities and challenges for group therapists: What is the same and what is different as group therapy moves from the group room to the group screen? These are questions we will address in this volume in a new chapter focused on online psychotherapy groups (see Chapter 14).

Now, as clients from diverse ethnocultural backgrounds access group therapy, whether in North America or elsewhere, it is important for therapists to develop a multicultural orientation as well as sensitivity and expertise in cultural adaptation. Therapy groups have always been settings for "difficult dialogues" and discourse; race and gender identity issues can be effectively addressed in a responsive therapy group environment (see Chapter 16). Group therapy is a powerful vehicle for working with traumatized and displaced individuals.

Paradoxically, however, professional training for group therapists has failed to keep pace with the widespread clinical application of the group therapies. Fewer and fewer training programs—whether in psychology, social work, counseling, or psychiatry—provide the depth of training and supervision that future practitioners require. All too often and in too many settings, therapists are thrust into action—and asked to lead groups of clients with complex histories and diverse needs—with little training or supervision in group therapy. Economic pressures, professional turf wars, and the current dominance of biological explanations and pharmacotherapy in mental health have all contributed to this situation. Each generation believes naively that it has discovered the true solution. Mental health is a field uniquely subject to an oscillation between zealous overvaluation and zealous devaluation, even by its own practitioners. We are therefore heartened that the American Psychological Association has recently recognized group psychotherapy as a designated specialty. This decision will encourage greater investment in education and training, and we hope it elevates group therapy to the status that its ever-widening practice warrants. We

know that training can be transformative.

Today's group therapists are influenced by the demand for greater accountability in practice. Evidence-based practice is a standard to which we must all adhere. For many years, practitioners resisted this emphasis on using research, measurement, and data as guides to effective practice as an intrusion into their work—one that impinged upon their autonomy and thwarted creativity. But it is anachronistic to think of evidence-based practice as narrowly prescriptive. We believe that a more effective approach is to embrace evidence-based practice as a set of *guidelines and principles* that enhance clinical effectiveness. Throughout the text we elaborate on the hallmarks of the evidence-based group therapist: building cohesive groups and strong relationships, effectively communicating genuine and accurate empathy, managing countertransference, and maintaining cultural awareness and sensitivity. Being reflective about our approach to our work and making our continued professional development a deliberate focus of attention are aspects of being an evidence-based group therapist. Data collection from our ongoing groups provides us with timely and relevant feedback about what is actually happening session to session, client by client (see Chapter 13).

We recognize that group therapists are now using a bewilderingly diverse set of approaches in their work. Cognitive-behavioral, psychoeducational, interpersonal, gestalt, supportive-expressive, modern analytic, psychoanalytic, dynamic-interactional, psychodrama—all of these, and many more, are used in group therapy today. Group therapists are also bringing advances in our understanding of human attachment and the neurobiology of interpersonal relationships to bear in group therapy in an effort to integrate mind, body, and brain into their work (see Chapters 2 and 3).

Although addressing *all* these group therapies in a single book presented challenges, we believe that the strategy guiding the first edition was still sound. That strategy was to separate "front" from "core" in discussions of each of the group therapies. The *front* consists of the trappings, the form, the techniques, the specialized

language, and the aura surrounding any given ideological school; the *core* means those aspects of the experience that are intrinsic to the therapeutic process—that is, the *bare-boned mechanisms of change*.

If you disregard the "front" and consider only the actual mechanisms of effecting change in a client, you will find that the change mechanisms are limited in number and remarkably similar across groups. Therapy groups with similar goals that appear to be profoundly different if judged only by their external forms may rely on identical mechanisms of change. These mechanisms continue to constitute the central organizing principle of this book. We begin with a detailed discussion of eleven therapeutic factors and then describe a group psychotherapeutic approach based on them (see Chapters 1, 2, 3, and 4).

Deciding which types of groups to discuss presented another dilemma. The array of group therapies is now so vast that it is impossible to address each type of group separately. Instead, we center our discussion on a prototypical situation—the outpatient psychotherapy group—and then offer a set of principles that will enable the therapist to modify this fundamental group model to fit any specialized clinical situation (see Chapter 15).

Our prototypical outpatient psychotherapy group meets for at least several months with the ambitious goals of both symptomatic relief and personality change. We describe this group in detail from conception to conclusion, beginning with the principles of effective selection, group composition, and preparation (see Chapters 8 and 9), and then moving on to group development, from the first sessions to the advanced stages of the group, and common clinical challenges (see Chapters 10, 11, and 12).

Why focus on this particular form of group therapy when the contemporary therapy scene, driven by economic factors, is dominated by other types of groups meeting for briefer periods with more limited goals? The answer is that longer-term group therapy has been around for many decades, and practitioners have accumulated a vast body of knowledge from both empirical research and thoughtful clinical observation. We believe that the prototypical

group we describe in this book is an intensive, ambitious form of therapy that demands much from both client and therapist. This group also affords therapists a unique lens through which to learn about group process, group dynamics, and group leadership that will serve them well in all their clinical work. The therapeutic strategies and techniques required to lead such a group are sophisticated and complex (see Chapters 5, 6, and 7). However, once students master them and understand how to modify them to fit specialized therapy situations, they will be in a position to fashion a group therapy that will be effective for a variety of clinical populations in different settings.

Trainees should aspire to be creative and compassionate therapists who understand how to put theory into practice. That requires, in turn, compassionate supervisors with similar understanding (see Chapter 16). The mounting demand for clinical care, and the effectiveness and efficiency of group therapy, make it the treatment modality of the future. Group therapists must be as prepared as possible for this opportunity. And they need to be able to care well for themselves, too, so that they can continue to treat others effectively and find meaning in their work.

Because most readers of this book will be clinicians, this text is intended to have immediate clinical relevance. We also believe, however, that it is imperative for clinicians to remain conversant with the world of research. Even if therapists do not personally engage in research, they must know how to evaluate the research of others.

One of the most important underlying assumptions in this text is that interpersonal interaction within the here-and-now is crucial to effective group therapy. The truly potent therapy group provides an arena in which clients can interact freely with others and then help members identify and understand what goes wrong in their interactions. Ultimately, it enables our clients to change those maladaptive patterns. We believe that groups based *solely* on other assumptions, such as psychoeducational or cognitive-behavioral principles, fail to reap the full therapeutic harvest. Each of these forms of group therapy can be made more effective by incorporating an awareness of interpersonal process. In this text we discuss, in

depth, the extent and nature of the interactional focus and its ability to bring about significant character and interpersonal change. *The interactional focus is the engine of group therapy*, and therapists who are able to harness it are much better equipped to do all forms of group therapy, even if the group model does not emphasize or acknowledge the centrality of interaction (see Chapter 15).

My (IY) novel *The Schopenhauer Cure* may serve as a companion volume to this text. It is set in a therapy group and illustrates many of the principles of group process and therapist technique described here. Hence, at several points in this edition, we refer the reader to sections of *The Schopenhauer Cure* that offer fictionalized portrayals of therapist techniques.

Excessively overweight volumes tend to end up on the "reference book" shelves. To avoid that fate we have resisted substantially lengthening this text. The addition of much new material has thus required us to cut older sections and citations. This was a painful task, and the deletion of many condemned passages bruised our hearts as well as our fingers. But we hope the result is a timely and up-to-date work that will serve students and practitioners well for the next fifteen years and beyond.

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MOLYN LESZCZ:

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The Therapeutic Factors

DOES GROUP THERAPY HELP CLIENTS? INDEED, IT DOES. A persuasive body of outcome research has demonstrated consistently and unequivocally that group therapy is a highly effective form of psychotherapy. Not only is it at least equal to individual psychotherapy in its power to provide benefit, it also makes more efficient use of mental health care resources.[1] Yet, paradoxically, mental health professional training programs have reduced training in group therapy. This is a matter of great concern: we need to ensure high levels of quality in group therapies if we are to achieve the impact that we desire—and that our clients require.[2] Throughout this text we will focus on the group factors and the characteristics of leaders that contribute to therapeutic effectiveness.

How does group therapy help clients? A naive question, perhaps. But if we can answer it with some measure of precision and certainty, we will have at our disposal a central organizing principle with which to approach the most vexing and controversial problems of psychotherapy. Once identified, the crucial aspects of the process of change will constitute a rational basis for the therapist's selection of tactics and strategies to shape the group experience, maximizing its potency with different clients and in different settings. Though group therapy works, there is also great variability in the effectiveness of therapists.[3] Understanding how best to implement these therapeutic processes is at the heart of effective group therapy work. Fortunately, there is much to guide us from the research evidence. Experience alone does not confer greater effectiveness.

What does? Deliberate practice, self-reflection, feedback on one's practice, and the wise use of an empathic and attuned therapeutic relationship.[4]

We suggest that therapeutic change is an enormously complex process that occurs through an intricate interplay of human experiences, which we will refer to as "therapeutic factors." There is considerable advantage in approaching the complex through the simple, the total phenomenon through its basic component processes. Accordingly, we begin by describing and discussing these elemental factors.

From our perspective, natural lines of cleavage divide the therapeutic experience into eleven primary factors:

1. Instillation of hope
2. Universality
3. Imparting information
4. Altruism
5. The corrective recapitulation of the primary family group
6. Development of socializing techniques
7. Imitative behavior
8. Interpersonal learning
9. Group cohesiveness
10. Catharsis
11. Existential factors

In the rest of this chapter, we discuss the first seven factors. Interpersonal learning and group cohesiveness are so important and complex that we address them separately in the next two chapters. Existential factors are discussed in Chapter 4, where they are best understood in the context of other material presented there. Catharsis is intricately interwoven with other therapeutic factors and will also be discussed in Chapter 4.

The distinctions among these factors can be arbitrary, and though

we discuss them singly, they are interdependent and neither occur nor function separately. Moreover, these factors may represent different parts of the change process: some factors (for example, interpersonal learning) act at the level of cognition; others (for example, the development of socializing techniques) act at the level of behavioral change; still others (for example, catharsis) act at the level of emotion. Some (for example, cohesiveness) may be more accurately described as both a therapeutic force itself and a precondition for change. Although the same therapeutic factors operate in every type of therapy group, their interplay and differential importance can vary widely from group to group. Furthermore, because of individual differences, participants in the same group benefit from different therapeutic factors.[5]

Keeping in mind that the therapeutic factors are arbitrary constructs, we can nevertheless view them as providing a cognitive map for the student-reader.[6] This grouping of the therapeutic factors is not set in concrete; other clinicians and researchers have arrived at different, and also arbitrary, clusters of factors. One team of researchers posited that there is a core therapeutic factor: clients feeling hopeful that their emotional expression and relational awareness will translate into social learning.[7] No explanatory system can encompass all of therapy. At its core, the therapy process is infinitely complex, and there is no end to the number of pathways through the experience. (We will discuss all of these issues more fully in Chapter 4.)

The inventory of therapeutic factors we propose issues from our clinical experience, from the experience of other therapists, from the views of clients successfully treated in group therapy, and from relevant systematic research. None of these sources is beyond doubt, however; neither group members nor group leaders are entirely objective, and our research methodology is often limited in its scope.

From the group therapists we obtain a variegated and internally inconsistent inventory of therapeutic factors reflecting the study of a wide range of clients and groups. Therapists, by no means

disinterested or unbiased observers, have each invested considerable time and energy into mastering a certain therapeutic approach. Their answers will be determined largely by their particular school of conviction—the allegiance effect.[8] Even among therapists who share the same ideology and speak the same language, there may be no consensus about the reasons clients improve. But that does not surprise us. The history of psychotherapy abounds in healers who were effective, but not for the reasons they supposed. Who has not had a client who made vast improvement for entirely obscure reasons?

One important source of information comes from group members' determination of the therapeutic factors they considered most and least helpful. Researchers continue to raise important questions about the study of therapeutic factors. Do the therapeutic factors impact all group members equally? What influences our clients' responses? Perhaps the relationship to the therapist, or to the group? What about session quality or depth?[9] Moreover, research has also shown that the therapeutic factors valued by group members may differ greatly from those cited by their therapists or by group observers.[10] Member responses may also be affected by a whole host of other variables: the type of group (that is, whether outpatient, inpatient, day hospital, or brief therapy);[11] the client's age and diagnosis;[12] the client's motivational stage and attachment style;[13] the ideology of the group leader;[14] and the manner in which group members experience the same event in different ways and impact one another's experiences.[15]

Despite these limitations, clients' reports are a rich and relatively untapped source of information. After all, it is *their* experience that matters, and the further we move from their experiences, the more inferential our conclusions. To be sure, there are aspects of the process of change that operate outside a client's awareness. But it does not follow that we should disregard what clients say. Paper-and-pencil or sorting questionnaires provide easy data but often miss the nuances and the richness of the client experience. There is an

art to obtaining clients' reports. The more the questioner can enter into the experiential world of the client, the more lucid and meaningful the report of the therapy experience becomes.

In addition to therapists' views and clients' reports, there is a third important method of evaluating therapeutic factors: systematic research. The most common research strategy by far is to correlate in-therapy variables with therapy outcomes. By discovering which variables are significantly related to successful outcomes, one can establish a reasonable basis from which to begin to delineate therapeutic factors. However, there are many inherent problems in this approach: the measurement of outcome is itself a methodological morass—and the selection and measurement of the in-therapy variables are equally problematic.[16]

We have drawn from all these methods to derive the therapeutic factors discussed in this book. Still, we do not consider these conclusions definitive; rather, we offer them as provisional guidelines that may be tested and deepened by others.

INSTILLATION OF HOPE

Research has consistently demonstrated that the instillation and maintenance of hope is crucial in any psychotherapy. Several studies have demonstrated that a client's high expectation of help is significantly correlated with a positive therapy outcome.[17] Consider the massive data documenting the efficacy of faith healing and placebo treatment—therapies mediated entirely through hope and conviction. In group therapy, the presence of hope deepens client engagement in the group's work.[18] A positive outcome in psychotherapy is more likely when the client and the therapist have similar and positive expectations of the treatment.[19] The power of expectations extends beyond imagination alone: brain imaging studies demonstrate that the placebo is not inactive but can have a direct physiological effect on the brain.[20]

Group therapists can capitalize on this factor by doing whatever they can to increase clients' belief and confidence in the efficacy of the group mode. This task begins before the group starts, in the pregroup orientation. Here, the therapist reinforces positive expectations, corrects negative preconceptions, and presents a lucid and powerful explanation of the group's healing properties tied specifically to an accessible and culturally resonant explanation of client difficulties (see Chapters 9 and 10 for a full discussion of pregroup procedures).

Group therapy not only draws from the general ameliorative effects of positive expectations but also benefits from a source of hope unique to the group format. Therapy groups invariably contain individuals who are at different points along a coping-collapse continuum. Each member thus has considerable contact with others—often individuals with similar problems—who have improved as a result of therapy. I have often heard clients remark at the end of their group therapy how important it was for them to have observed the improvement of others.

Group therapists should by no means be above exploiting this factor by periodically calling attention to the improvement that members have made. If we happen to receive notes from recently terminated members noting their continued improvement, we make a point of sharing them with the current group. Longer-term group members often assume this function by offering spontaneous testimonials to new, skeptical members.

A powerful example took place in a geriatric psychiatric day hospital:

> **Betty, a resistant eighty-six-year-old depressed woman, attended** her first group. Nothing the group leaders provided in the form of preparation or encouragement matched the remarkable impact of an eighty-eight-year-old member, Sarah, who greeted the newcomer in the following way. “Welcome to the group, Betty. If you are anything like me this is the last place you thought you would ever come to and you are probably here only because your daughter forced you to come. But let me tell you something. This is a special, special place. Coming here has changed my life. I am just about ready to graduate but I am taking away with me so much—I am leaving with a small bag of jewels that will help me in my life outside of this program. I have learned how bad it is to be lonely, I learned how to ask for help and reach out to people, and I learned that I deserve people’s care and attention. Trust me; this will happen for you as well if you come and participate here.” **<<**

Research has shown that it is also vitally important that therapists believe in themselves and in the efficacy of their group. It is essential to nurture and sustain a sense of one’s own therapeutic effectiveness (see Chapter 16 for more on therapist self-care).[21] In initial meetings with clients, we share our conviction with them and attempt to imbue them with our optimism.

Many of the self-help groups—for example, Compassionate Friends (for bereaved parents), Men Overcoming Violence (men who batter), Survivors of Incest, Gilda’s Club (for cancer patients and their families), the Depression and Bipolar Support Alliance, and Mended Heart (heart surgery patients)—place heavy emphasis on the instillation of hope.[22] In twelve-step recovery fellowships such as

Alcoholics Anonymous, Narcotics Anonymous, and Overeaters Anonymous, most meetings begin with a member sharing their story of “experience, strength, and hope” with other members. In AA, successful members tell their stories of downfall and subsequent recovery with the help of the program over and over again, not only to instill hope in new members, but to remind themselves that life can continue to “get better” if they stay sober. One of the great strengths of the organization is the fact that it is run by members, not professionals; the speakers, meeting leaders, and other officers are all recovering alcoholics—living inspirations to the others.

In the same way, some substance abuse treatment programs mobilize hope in participants by employing recovering drug addicts to serve as peer group leaders. Many programs have been founded by and/or are staffed by recovering addicts who have become professional counselors and therapists. Members are inspired by them: their expectations are raised by contact with those who have trod the same path and found the way back. Self-management groups for individuals with chronic medical illnesses, such as arthritis or heart disease, also use trained peers to encourage members to cope actively with their medical conditions.[23] The inspiration provided to participants by their peers is a key part of the therapy process. These groups improve medical outcomes, reduce health-care costs, promote a sense of self-efficacy in participants, and often make group interventions more impactful than individual therapies.[24]

UNIVERSALITY

Many individuals enter therapy with the disquieting thought that they are unique in their wretchedness, that they alone have certain frightening or unacceptable problems, thoughts, impulses, and fantasies. To some extent this is true for all of us, but many clients, because of their extreme social isolation, have a heightened sense of uniqueness. Their interpersonal difficulties preclude the possibility of deep intimacy. In everyday life they neither learn about others' analogous feelings and experiences nor avail themselves of the opportunity to confide in, and ultimately to be validated and accepted by, others.

In the therapy group, especially in the early stages, the disconfirmation of a client's feelings of uniqueness is a powerful source of relief. After hearing other members disclose concerns similar to their own, clients report feeling more allied with the world. They may describe the process as a "welcome to the human race" experience. Simply put, the phenomenon finds expression in the cliché "We're all in the same boat"—or, perhaps more cynically, "Misery loves company." For some clients, feeling human among other humans is the beginning of recovery and a central feature of the healing context that group therapists aim to create.[25]

There is no human deed or thought that lies fully outside the experience of other people. We have heard group members reveal such acts as incest, torture, burglary, embezzlement, murder, attempted suicide, and fantasies of an even more desperate nature. Invariably, other group members reach out and embrace these very acts as within the realm of their own possibilities, often following through the door of disclosure opened by one group member's trust or courage. Nor is this form of aid limited to group therapy: universality plays a role in individual therapy also, although in that format there is less opportunity for consensual validation, as therapists are less willing to be transparent.

During my own six hundred hours of analysis, I (IY) had a striking

personal encounter with the therapeutic factor of universality. It happened when I was in the midst of describing my extremely ambivalent feelings toward my mother. I was very much troubled by the fact that, despite my strong positive sentiments, I was also beset with death wishes for her, as I stood to inherit part of her estate. My analyst responded simply, “That seems to be the way we’re built.” That artless statement not only offered me considerable relief but enabled me to explore my ambivalence in greater depth.

Despite the complexity of human problems, certain common denominators between individuals are clearly evident, and the members of a therapy group soon perceive their similarities to one another. An example is illustrative: For many years I asked members of T-groups (training groups for professionals who are not clients—for example, medical students, psychiatric residents, nurses, psychiatric technicians, and Peace Corps volunteers) to engage in a “top-secret” task in which they were asked to write down, anonymously, the one thing they would be most disinclined to share with the group. The secrets proved to be startlingly similar, with a couple of major themes predominating. The most common secret is a deep conviction of basic inadequacy—a feeling that one is incompetent, that one bluffs one’s way through life. Next in frequency is a deep sense of interpersonal alienation—that, despite appearances, one really does not, or cannot, care for or love another person. The third most frequent category is some variety of sexual secret. These chief concerns are qualitatively the same in individuals seeking professional help. Almost invariably, our clients experience deep concern about their sense of self-worth and their ability to relate to others.[i]

When secrecy has been an especially important and isolating factor for someone, a specialized group composed of individuals with similar experiences can offset stigma and shame, particularly if universality is emphasized. For such individuals, group therapy may be more effective than individual treatment. For example, short-term structured groups for bulimic clients build this into their protocol, including a strong requirement for self-disclosure about attitudes

toward body image and detailed accounts of eating rituals and purging practices. With rare exceptions, members express great relief at discovering that they are not alone and that others share the same dilemmas and life experiences.[26]

Members of sexual abuse groups, too, profit enormously from the experience of universality.[27] For members of these groups, sharing the details of the abuse and the subsequent feeling of internal devastation, often for the first time, is an integral part of the healing process. A 2013 study comparing group and individual psychotherapy for sexually abused Congolese women who suffered from shame, stigma, and social isolation found that the group intervention produced more significant and durable positive outcomes than individual therapy.[28]

Members of homogeneous groups can speak to one another with a powerful authenticity that comes from their firsthand experience in ways that therapists may not be able to do. I (ML) recall, at the start of my group therapy work, leading a group of depressed men in their seventies and eighties. At one point, a seventy-seven-year-old man who had recently lost his wife expressed suicidal thoughts. As a much younger man, I hesitated, fearing that anything I might say would come across as naive. Then a ninety-one-year-old group member spoke up and described how he had lost his wife of sixty years, and he, too, had plunged into a suicidal despair but had ultimately recovered and returned to life. That statement resonated deeply with the members.

Since contemporary therapy groups represent our society at large, with diversity in gender, sexual orientation, and cultural composition, the group leader may need to pay particular attention to the feeling of universality in these groups. Cultural minorities in a predominantly Caucasian group may feel excluded because of different cultural attitudes toward disclosure, interaction, and affective expression. Discussion of race, gender identity, and sexual orientation is challenging and requires courage, trust, and humility; therapists must help the group appreciate the impact of culture, oppression, marginalization, and privilege on each individual's sense

of personhood.[29] We must also look at transcultural—that is, universal—responses to human situations and tragedies.[30] Only in group therapy can manifestly culturally divergent individuals find common ground—consider the strong identification of being the marginalized voice for social justice that a young, gay Palestinian man and an older heterosexual Jewish communist woman might share. Hence, it is imperative that therapists learn as much as possible about their clients' cultures and communities as well as their degree of attachment to their culture.[31] Multicultural competence is strongly associated with therapist effectiveness.[32]

Universality has no sharp borders: it merges with other therapeutic factors. As clients perceive their similarity to others and share their deepest concerns, they benefit further from the accompanying catharsis and from their acceptance by other members.

IMPARTING INFORMATION

Under the general rubric of imparting information, we include didactic instruction about mental health, mental illness, and general psychodynamics that therapists provide as well as advice, suggestions, or direct guidance from either the therapist or other group members.

Didactic Instruction

At the conclusion of successful interpersonal group therapy, most participants have learned a great deal about empathy, the meaning of symptoms, interpersonal and group dynamics, and the process of psychotherapy. Group therapy enhances emotional intelligence.[33] We often have seen student observers of group therapy marvel at the knowledge that group members demonstrate about these key concepts. Generally, the educational process is implicit: most group therapists do not offer explicit didactic instruction beyond the very early sessions, when they offer guidance about working in the here-and-now and how to provide interpersonal feedback. More recently, however, many group therapy approaches have made formal instruction, or psychoeducation, an important part of the program.

One of the more powerful historical precedents for psychoeducation can be found in the work of Maxwell Jones, who in his work with large groups in the 1940s lectured to his patients for three hours a week about the nervous system's structure, function, and relevance to psychiatric symptoms and disability.[34] L. Cody Marsh, writing in the 1930s, believed in the importance of psychoeducation and organized classes for his patients complete with lectures, homework, and grades.[35] Many other self-help groups strongly emphasize the imparting of information. Groups such as Wellspring (for cancer patients), Parents Without Partners, and Mended Hearts encourage the exchange of information among members and often invite experts to address the group.[36] The group

environment in which learning takes place is important. The atmosphere in all these groups is one of partnership and collaboration rather than prescription and subordination.

Contemporary group therapy literature abounds with descriptions of specialized groups for some specific disorder or definitive life crisis—for example, panic disorder,[37] obesity,[38] bulimia,[39] adjustment after divorce,[40] herpes,[41] coronary heart disease,[42] parents of sexually abused children,[43] male batterers,[44] bereavement,[45] HIV/AIDS,[46] sexual dysfunction,[47] rape,[48] self-image adjustment after mastectomy,[49] chronic pain,[50] organ transplant,[51] prevention of depression relapse,[52] autism spectrum disorder,[53] parents of children with autism, individuals with intellectual disabilities,[54] and genetic or familial predisposition to developing cancer.[55] And, of course, there has been an explosion of online and social media groups for a vast range of concerns.[56]

In addition to offering mutual support, these groups generally build in a psychoeducational component providing explicit instruction about the nature of a client's illness or life situation and examining clients' misconceptions and unhelpful responses to their illness. For example, the leaders of a group for clients with panic disorder may describe the physiological cause of panic attacks, explaining that heightened stress and arousal increase the flow of adrenaline, which may result in hyperventilation, shortness of breath, and dizziness. Leaders then point out that people experiencing panic attacks often misinterpret the symptoms in ways that only exacerbate them ("I'm dying" or "I'm going crazy"), thus perpetuating a vicious cycle. It's generally helpful for leaders to discuss the benign nature of panic attacks and to offer instruction on how to bring on a mild attack and then interrupt it, and then how to recognize one in its beginning stages and prevent it. In addition, leaders may teach proper breathing techniques and progressive muscular relaxation, and may ask the whole group to join in the exercise as a support to the panicked member.[57]

Groups are often the setting in which mindfulness- and

meditation-based stress reduction approaches are taught. By applying disciplined focus, members learn to become clear, accepting, and nonjudgmental observers of their own thoughts and feelings and to reduce stress, anxiety, and vulnerability to depression.[58]

Leaders of bereavement groups may provide information about the natural cycle of bereavement to help members realize that there is a sequence of pain through which they are progressing, and there will be a natural, almost inevitable, lessening of their distress as they move through the stages of this sequence. Leaders may help clients anticipate, for example, the acute anguish they will feel with each significant date (holidays, anniversaries, and birthdays) during the first year of bereavement.[59] Psychoeducational groups for women with primary breast cancer provide members with information about their illness, treatment options, and future risks as well as recommendations on cultivating a healthy lifestyle while living with cancer. Evaluation of the outcome of these groups shows that participants demonstrate significant and enduring psychosocial benefits.[60]

Most group therapists use some form of anticipatory guidance for clients about to enter the frightening situation of the psychotherapy group, such as a preparatory session intended to clarify important reasons for psychological dysfunction and to provide instruction in methods of self-exploration.[61] By predicting clients' fears and providing them with a cognitive structure, we help them cope more effectively with the culture shock they may encounter when they enter group therapy (see Chapter 10).

Didactic instruction has thus been employed in a variety of fashions in group therapy: to transfer information, to structure the group, to explain the process of illness, and to alter sabotaging thought patterns. Often such instruction functions as the initial binding force in the group until other therapeutic factors become operative. In part, however, explanation and clarification function as effective therapeutic agents in their own right. The explanation of a phenomenon is the first step toward its control. If a volcanic eruption

is caused by a displeased god, then at least there is hope of pleasing the god. Knowledge promotes mastery, which in turn promotes self-efficacy, a common pathway of all effective therapy.[62]

Over and again therapists point out that the best response to the fear and anxiety of our contemporary world is through active coping (for instance, engaging in life, speaking openly, and providing mutual support), as opposed to withdrawing in demoralized avoidance. This posture not only appeals to common sense but, as neurobiological research demonstrates, active coping activates important neural circuits in the brain that help regulate the body's stress reactions.[63]

And so it is with psychotherapy clients: fear and anxiety that stem from uncertainty about the source, meaning, and seriousness of psychiatric symptoms may so compound the dysphoria that effective exploration becomes vastly more difficult. Didactic instruction, through its provision of structure and explanation, has intrinsic value and deserves a place in our repertoire of therapeutic instruments (see Chapter 5).

Direct Advice

Unlike explicit didactic instruction from the therapist, direct advice from the members occurs without exception in every therapy group. In dynamic interactional therapy groups, it is invariably part of the early life of the group and occurs with such regularity that it can be used to estimate how long a group has been meeting. If we observe a group in which the clients with some regularity say things like, "I think you ought to…" or "What you should do is…" or "Why don't you…?" then we can be reasonably certain either that the group is young or that it is an older group facing some difficulty that has impeded its development or effected temporary regression. In other words, advice-giving may reflect a resistance to more intimate engagement in which the group members attempt to manage relationships rather than to connect. Although advice-giving is common in early interactional group therapy, it is rare that specific advice will directly benefit any client. Indirectly, however, the *process* of advice-giving, rather than the content of the advice, may be

beneficial, in that it conveys interest and caring. The father of a young son who tells the group that his intrinsic sense of badness is the cause of his child's social anxiety may receive suggestions about community resources for his child. But of greater impact is the group members' feedback about his evident decency, care, and generosity, not only to his son but also to other group members. Members internalize the group: one graduating member of a therapy group noted that he would regularly channel the group as he sought to apply what he learned inside the group to his outside life; he joked about getting a tattoo of "WWGS"—"What would group say?"

Advice-giving or advice-seeking behavior is often an important clue in understanding interpersonal pathology or group dynamics. The client who, for example, continuously solicits advice and suggestions from others, ultimately only to reject their answers and frustrate those whose help was sought, is well known to group therapists as the "help-rejecting complainer," or the "yes… but" client.[64] Some group members may bid for attention and nurturance by asking for suggestions about a problem that either is insoluble or has already been solved. Others soak up advice with an unquenchable thirst, yet never reciprocate to others who are equally needy. Some group members are so intent on preserving a high-status role in the group or a facade of cool self-sufficiency that they never ask directly for help; others are so anxious to please that they never ask for anything for themselves. Some are excessively effusive in their gratitude; others never acknowledge a gift but take it home, like a bone, to gnaw on privately. All these patterns can be helpfully addressed in the group work.

Other types of more structured groups that do not focus on member interaction make explicit and effective use of direct suggestions and guidance. For example, behavioral groups, hospital discharge planning and transition groups, life skills groups, communicational skills groups, and Alcoholics Anonymous all proffer considerable direct advice. AA makes good use of guidance and slogans: for example, its introductory literature suggests that members focus on remaining abstinent for only the next twenty-four

hours, “one day at a time,” rather than think about how they will manage not to drink for the rest of their lives. One communication skills group for chronically ill psychiatric clients reported excellent results with a structured group program that included focused feedback, videotape playback, and problem-solving projects.[65] A group for patients with schizophrenia in China reported significant positive impact when psychoeducation for patients and their families was added to the program.[66] Military veterans suffering with comorbid medical and psychiatric illnesses benefit from holistic educational groups that promote better care of their physical health and coping skills for dealing with stress.[67] Community-based group educational interventions teach emotional awareness and promote resilience to adversity.[68] Groups have been used in school systems to combat youth drinking by demonstrating to students the link between emotional vulnerability and their drinking behaviors.[69]

Are some types of advice better than others? Researchers who studied a behavioral reinforcement group for male sex offenders noted that advice was common and was useful to different members to different extents. The least effective form of advice was a direct suggestion, such as, “You need to stop looking at your cellphone,” which can easily be experienced as controlling. Most effective was a series of alternative suggestions about how to achieve a desired goal: “If you want to feel less isolated, would you consider participating more in the activities on the unit, or coming to the lounge rather than staying in your room?” Such a suggestion is more likely to be experienced as collaborative.[70] Psychoeducation about the impact of depression on family relationships is much more effective when it is made personal—as when participants are encouraged to examine how depression might be affecting their own lives and family relationships—than when the same information is presented in an intellectualized and detached manner.[71]

ALTRUISM

There is an old Hasidic story of a rabbi who had a conversation with the Lord about Heaven and Hell. “I will show you Hell,” said the Lord, and led the rabbi into a room containing a group of famished, desperate people sitting around a large, circular table. In the center of the table rested an enormous pot of stew, more than enough for everyone. The smell of the stew was delicious and made the rabbi’s mouth water. Yet no one ate. Each diner at the table held a very long-handled spoon—long enough to reach the pot and scoop up a spoonful of stew, but too long to get the food into one’s mouth. The rabbi saw that their suffering was indeed terrible and bowed his head in compassion. “Now I will show you Heaven,” said the Lord, and they entered another room, identical to the first—same large, round table, same enormous pot of stew, same long-handled spoons. Yet there was gaiety in the air; everyone appeared well nourished, plump, and exuberant. The rabbi could not understand and looked to the Lord. “It is simple,” said the Lord, “but it requires a certain skill. You see, the people in this room have learned to feed each other!”[ii]

In therapy groups, as well as in the story’s imagined Heaven, members gain through giving: there is something deeply rewarding in the act of giving. Many psychiatric patients beginning therapy are demoralized and possess a deep sense of having nothing of value to offer others. Being useful to others is refreshing and boosts self-esteem, and it is only group therapy that offers clients such an experience. Strength-based approaches such as Martin Seligman’s positive psychology challenge our field’s emphasis on pathology and encourage a focus on members’ strengths, positive attributes, meaning, gratitude, and generosity to one another.[72] The give-and-take of altruism also encourages role versatility, requiring clients to shift between the two roles of help-receivers and help-providers.[73]

And, of course, clients are invariably helpful to one another in the group therapeutic process when they offer support, reassurance,

suggestions, and insight and share their stories of similar problems with one another. Not infrequently, group members will accept observations from another member far more readily than from the group therapist. For many clients, the therapist remains the paid professional; the other members represent the real world and can be counted on for spontaneous and truthful reactions and feedback. Looking back over the course of therapy, almost all group members credit other members as having been important in their improvement. Sometimes they cite their explicit support and advice, sometimes their sheer presence.

An interaction between two group members is illustrative. Derek, a chronically anxious and isolated man in his forties who had recently joined the group, exasperated the other members by consistently dismissing their feedback and concern. In response, Kathy, a thirty-five-year-old woman with chronic depression and substance abuse problems, spoke to him directly to share a pivotal lesson in her own group experience. For months she had rebuffed the concern others offered because she felt she did not merit it. Later, after others informed her that her rebuffs were hurtful to them, she made a conscious decision to be more receptive and appreciative of gifts offered her. She soon observed, to her surprise, that she began to feel much better. In other words, she benefited not only from the support she received but from letting others know they had something of value to offer her.

Altruism is a venerable therapeutic factor in other systems of healing as well. In primitive cultures, a troubled person is often given the task of preparing a feast or performing some type of service for the community.[74] Altruism plays an important part in the healing process at Catholic shrines, such as Lourdes, where the sick pray not only for themselves but also for one another. We humans need to feel we are needed and useful.

Neophyte group members do not at first appreciate the healing impact of other members. They ask, “How can the blind lead the blind?” or, “What can I possibly get from others who are as confused as I am? We’ll end up pulling one another down.” Such resistance is

best worked through by exploring a client's critical self-evaluation. Generally, a member who doubts that other group members can help is really saying, "I have nothing of value to offer anyone."

There is another, more subtle benefit inherent in the altruistic act. Many clients who complain of meaninglessness are immersed in a morbid self-absorption, which takes the form of obsessive introspection or a teeth-gritting effort to actualize oneself. We agree with Viktor Frankl that a sense of life meaning ensues but cannot be deliberately pursued: life meaning is always a derivative phenomenon that materializes when we have transcended ourselves, when we have forgotten ourselves and become absorbed in someone (or something) outside ourselves.[75] A focus on life meaning and altruism are particularly important components of the group psychotherapies provided to patients coping with life-threatening medical illnesses such as cancer.[76]

THE CORRECTIVE RECAPITULATION OF THE PRIMARY FAMILY GROUP

The great majority of clients who enter groups—with the exception of those suffering from posttraumatic stress disorder (PTSD) or from some medical or environmental stress—have had a highly unsatisfactory experience in their first and most important group: the primary family. The therapy group resembles a family in many ways: there are authority/parental figures, peer/sibling figures, deep personal revelations, strong emotions, and deep intimacy as well as hostile, competitive feelings. In fact, therapy groups are often led by a male and female therapy team in a deliberate effort to simulate the parental configuration as closely as possible. Once the initial discomfort and unease is overcome, it is inevitable that, sooner or later, the members will interact with leaders and other members in modes reminiscent of the way they once interacted with parents and siblings.

If the group leaders are seen as parental figures, then they will draw reactions associated with parental/authority figures: some members become helplessly dependent on the leaders, whom they imbue with unrealistic knowledge and power; others blindly defy the leaders, who are perceived as infantilizing and controlling. Some are wary of the leaders, who they believe attempt to strip members of their individuality; others try to split the co-therapists in an attempt to incite parental disagreements and rivalry. Still others envy the extragroup contact the co-therapists have to privately discuss “the children”; disclose more deeply when one of the co-therapists is away; or compete bitterly with other members, hoping to accumulate units of attention and caring from the therapists. Some are enveloped in envy when the leader’s attention is focused on others; expend energy in a search for allies among the other members, in order to topple the therapists; or neglect their own interests in a seemingly selfless effort to appease the leaders and the other members.

Obviously, similar phenomena occur in individual therapy, but the group provides a vastly greater number and variety of recapitulative possibilities. In one of my (IY) groups, Betsy, a member who had been silently pouting for a couple of meetings, bemoaned the fact that she was not in one-to-one therapy. She claimed she was inhibited because she knew the group could not satisfy her needs. She knew she could speak freely of herself in a private conversation with the therapist or with any one of the members. When pressed, Betsy expressed her irritation that others were favored over her in the group. For example, the group had recently welcomed another member who had returned from a vacation, whereas her return from a vacation went largely unnoticed by the group. Furthermore, another group member was praised for offering an important interpretation to a member, whereas she had made a similar statement weeks ago that had gone unnoticed. For some time, too, she had noticed her growing resentment at sharing the group time; she was impatient while waiting for the floor and irritated whenever attention was shifted away from her.

Was Betsy right? Was group therapy the wrong treatment for her? Absolutely not! These very criticisms—which had roots stretching down into her early relationships with her siblings—did not constitute valid objections to group therapy. Quite to the contrary, the group format was particularly valuable for her, since it allowed her envy and her craving for attention to surface. In individual therapy—where the therapist attends to the client's every word and concern, and the individual is expected to use up all the allotted time—these particular conflicts might never emerge.

What is important, though, is not that early familial conflicts are relived, but that they are relived *correctively*. Reexposure without repair only makes a bad situation worse. Growth-inhibiting relationship patterns must not be permitted to freeze into the rigid, impenetrable system that characterizes many family structures. Instead, fixed roles must be constantly explored and challenged, and ground rules that encourage the investigation of relationships and the testing of new behavior must be established. For many group members, then, working out problems with therapists and other

members is also working through unfinished business from long ago. (How explicit the working in the past need be is a complex and controversial issue, which we will address in Chapter 5.)

DEVELOPMENT OF SOCIALIZING TECHNIQUES

Social learning—the development of basic social skills—is a therapeutic factor that operates in all therapy groups, although the nature of the skills taught and the explicitness of the process vary greatly, depending on the type of group therapy. There may be direct emphasis on the development of social skills in, for example, groups preparing patients for discharge from a day hospital program or adolescent groups. Group members may be asked to role-play approaching a prospective employer or asking someone out on a date.

In other groups, social learning is more indirect. Members of interpersonal therapy groups, which have ground rules encouraging open feedback, may obtain considerable information about maladaptive social behavior. Individuals, for example, learn about a disconcerting tendency to avoid looking at the person with whom they are conversing; about others' impressions of their haughty, regal attitude; or about a variety of other social habits that have been undermining their social relationships. For individuals lacking intimate relationships, the group often represents the first opportunity for accurate interpersonal feedback. Many lament their inexplicable loneliness: group therapy provides a rich opportunity for members to learn how they contribute to their own isolation and loneliness. For example, the young man who expects rejection and shaming remains silent and deadens himself to the group, thus assuring the dreaded negative outcome.[77]

Group therapy also provides a valuable opportunity for small talk both before and after each session. This bonus time for socializing is often of much value. One man, for example, who had been aware for years that others avoided social contact with him, learned in the therapy group that his obsessive inclusion of minute, irrelevant details in his social conversation was exceedingly off-putting. Years later he told me (IY) that one of the most important events of his life was when a group member told him, "When you talk about your

feelings, I like you and want to get closer; but when you start talking about facts and details, I want to get the hell out of the room!"

We do not mean to oversimplify: therapy is a complex process and obviously involves far more than the simple recognition, and conscious, deliberate alteration, of social behavior. But, as we will show in Chapter 3, these gains are more than fringe benefits; they are often instrumental in the initial phases of therapeutic change. They permit clients to understand that there can be a huge discrepancy between their intent and their actual impact on others.[78] Learning about one's interpersonal impact is at the heart of interpersonal learning and is knowledge that continues to pay huge dividends.

Frequently, senior members of a therapy group acquire highly sophisticated social skills: they are attuned to process (that is, the dynamics of the relationship between individuals within the group); they have learned how to be helpfully responsive to others; they have acquired methods of conflict resolution; and they are less likely to be judgmental and more capable of experiencing and expressing accurate empathy. These skills cannot but help to serve these clients well in future social interactions, and they constitute the cornerstones of emotional intelligence and adaptive social functioning.[79]

IMITATIVE BEHAVIOR

Clients during individual psychotherapy may, in time, sit, walk, talk, and even think like their therapists. There is considerable evidence that group therapists also influence the communication patterns in their groups by modeling certain behaviors, such as self-disclosure, support, and timely and compassionate feedback.[80] Group members learn not only from the therapist but also from watching one another tackle problems.[81] This element may be particularly potent in homogeneous groups that focus on shared challenges—for example, a cognitive-behavior group that teaches psychotic patients strategies to reduce the intensity of auditory hallucinations.[82]

The importance of imitative behavior in the therapeutic process is difficult to gauge, but social-psychological research suggests that therapists may have underestimated it. Albert Bandura, who has long claimed that social learning cannot be adequately explained on the basis of direct reinforcement, experimentally demonstrated that imitation is an effective therapeutic force.[83] In group therapy, members often benefit by observing the therapy of another member with a similar problem constellation—a phenomenon generally referred to as vicarious or spectator therapy.[84]

Imitative behavior plays a particularly important role in the early stages of a group, as members identify with more senior members or therapists.[85] Even if imitative behavior is, in itself, short-lived, it may help to unfreeze the individual enough to experiment with new behavior, which in turn can launch an adaptive spiral. In fact, it is not uncommon for clients throughout therapy to “try on,” as it were, bits and pieces of other people and then relinquish them as ill fitting. This process may have solid therapeutic impact: finding out what we are not is progress toward finding out what we are.

> **Ken, a thirty-eight-year-old married engineer, began group ther**apy after a very disturbing confrontation with his wife in which he pushed her against the wall in a fit of rage. He was appalled and ashamed of

his impulsive behavior but recognized that it stemmed from his incapacity to recognize and speak about important feelings. He was largely silent but intermittently explosive in the face of emotional engagement. He understood that his emotional numbness emerged from growing up in a very traditional immigrant family in which his authoritarian father ruled the home harshly, using shame as a powerful way to shape behavior. No challenge to paternal authority was tolerated, and Ken learned to repress all oppositional emotions.

In the therapy group, Ken was quiet for long stretches but occasionally made comments that reflected a depth of feeling belying his external poker face. Gradually his life improved, and it was apparent he had grown closer to his wife and children.

When asked about these changes, he said he had been awestruck by the way the members had spoken openly about their emotions and their feelings toward other members. It was a powerful education for him. He was particularly impacted by the co-therapist, who came from a similar cultural background and spoke about his own growing interpersonal openness, and by the useful feedback from other members, who told him it was hard to interpret the flatness of his facial expressions. Ken's identification with the group therapist helped him overcome the cultural contributions to his silence. Though Ken's self-disclosures were more nuanced and less intense than that of other members, he learned that openness bred closeness rather than shame and humiliation. **<<**

Footnotes

i There are several methods of using such information in the work of the group. One effective technique is to redistribute the anonymous secrets to the members, each one receiving another's secret. Each member is then asked to read the secret aloud and reveal how he or she would feel if harboring such a secret. This method usually proves to be a valuable demonstration of universality, empathy, and the ability of others to understand.

ii In 1973, a member opened the first meeting of the first group ever offered for advanced cancer patients by relating this helpful parable to the other members of the group. This woman (whom I've [IY] written about elsewhere, referring to her as Paula West; see I. Yalom, *Momma and the Meaning of Life* [New York: Basic Books, 1999]) had been involved with me from the beginning in conceptualizing and organizing this group (see also Chapter 15). Her parable proved to be prescient, since many members were to benefit from the therapeutic factor of altruism.

- 2 -

Interpersonal Learning

INTERPERSONAL LEARNING, AS WE DEFINE IT, IS A BROAD AND complex therapeutic factor. It is the group therapy analogue of such important therapeutic factors in individual therapy as insight, working through transference, and the corrective emotional experience. But it also represents processes unique to the group setting that unfold only as a result of specific therapist action. Understanding interpersonal learning—its deep connection to the therapeutic relationship and to authentic, accurate empathy—centers the group therapist in the research on effective group leadership.[1] To describe how interpersonal learning mediates therapeutic change in the individual, we first need to discuss three other concepts:

1. The importance of interpersonal relationships
2. The corrective emotional experience
3. The group as social microcosm

THE IMPORTANCE OF INTERPERSONAL RELATIONSHIPS

From whatever perspective we study human society—whether scanning humanity's broad evolutionary history or following the development of the single individual—we are obliged to consider the human being in the matrix of his or her interpersonal relationships. There is convincing data from the study of primitive human cultures and contemporary society that human beings have always lived in groups characterized by intense and persistent relationships among members and that the need to belong is a powerful and fundamental motivation.[2] Attachments in early life have enduring impact: they shape the individual's capacity to recognize and manage emotions and to build relationships across the life span. These conclusions emerge clearly from an eight-decade-long study that followed a cohort of eighty-one men across the generations.[3] Early secure attachment promotes resilience, whereas significant early childhood adversity may confer lifelong vulnerability to a host of medical and psychological ailments.[4] These effects, mediated by stress hormones and our body's inflammatory reactions, take place at the most basic levels, altering gene expression and creating potentially lifelong risk factors.[5]

John Bowlby, from his studies of the early mother-child relationship, concluded that attachment behavior is necessary for survival and that humans are genetically, neurobiologically, "wired" for attachment.[6] If mother and infant are separated, both experience marked anxiety concomitant with their search for the lost object. If the separation is prolonged, the consequences for the infant will be profound. D. W. Winnicott noted, "There is no such thing as a baby. There exists a mother-infant pair."[7] We live in a "relational matrix," according to the noted psychoanalyst Stephen Mitchell, who wrote that "the person is comprehensible only within this tapestry of relationships, past and present."[8] Bowlby and Winnicott anticipated

the contemporary fields of relational neuroscience and interpersonal neurobiology.[9] Both sought an integrative understanding of the psychology and biology of relatedness. Daniel Siegel expanded on these connections, referring to the interconnection of mind, brain, and our interpersonal relationships as the “triangle of health.” These three domains work in concert to process information in the interest of our sense of self-integration and self-regulation.[10] Our relational processes are embedded in our neurobiology. Understanding the reverberation between the relational and the biological helps us attune to and engage our clients more effectively and to utilize verbal, paraverbal, and nonverbal communication to understand—and demonstrate that understanding to—our clients.[11] Our clients’ experience of this understanding can help to normalize their basic emotional needs that have been silenced by shame and judgment. This deepens our therapeutic effectiveness and the creation of a healing therapeutic context.[12]

> **In the first meeting after her return from vacation, Elena, a woman** with bipolar disorder and obsessive-compulsive disorder, updated the group. Prior to the trip, Elena had announced to the group that she planned to go away with her boyfriend, Juan, instead of visiting her mother as she typically did. She dreaded being with her mother, who always shamed and attacked her for her illness.

Earlier in the group she had talked about how hard it was to feel safe and trusting with Juan, or with any loving man, because of her feelings of deep unworthiness. The idea of spending a night with him created so much anxiety she could not sleep, and that, in turn, compounded her feelings of being undeserving of his care. Group members had drawn out for her the link between the difficulty she had asking for the group’s time and support and her feeling that she was undeserving of Juan’s care. The group challenged her constructively at one point when she planned to end the relationship in order to reduce the disruptive stimulation in her life.

It was in response to this that Elena had agreed to go on vacation with him. As anticipated, she had trouble sleeping in the new hotel and sharing the bed with Juan each night. But she had discussed it with Juan beforehand, and he had told her to wake him up if she had trouble sleeping. Elena had been reluctant to do so the first night, but she did

awaken him the second night. He responded by lovingly and soothingly rubbing her back, and she fell back to sleep. Although sleep continued to be somewhat challenging for her throughout the week, she was able to enjoy their time together.

The group enthusiastically supported her openness, but Elena found it hard to accept praise; she was unaccustomed to such support. Over time, the more she worked with the group, the more she was able to relate openly and lovingly with Juan. On one occasion the group broke into applause when she reported that Juan had told her there was no one he enjoyed traveling with more than her. This was powerful confirmation to Elena that her needs for compassion, appreciation, and loving care were indeed legitimate and could be met. **<<**

We are built for connection, and nothing is more important to our well-being and health than deep and meaningful relatedness. There is, for example, persuasive evidence that the rate for virtually every major cause of death is significantly higher for the lonely and disconnected.[13] Social isolation is as much a risk factor for early mortality as such obvious factors as smoking and obesity.[14] The inverse is also true: social connection and integration have a positive impact on the course of serious illnesses, including cancer and HIV/AIDS.[15]

As psychotherapists recognized the primacy of relatedness and attachment, contemporary models of dynamic psychotherapy evolved. We have moved from a “one-person” psychology based on Freudian theory, which focused on analyzing the client’s internal and conflicting drives, to a “two-person” relational psychology, which places the client’s interpersonal experience at the center of effective psychotherapy.[16] Group analysis and modern analytic group approaches also employ “a relational model in which mind is envisioned as built out of interactional configurations of self in relation to others,” as Mitchell put it.[17]

Building on the earlier contributions of Harry Stack Sullivan and his interpersonal theory of psychiatry, interpersonal models of psychotherapy have grown in prominence.[18] Although Sullivan’s work is seminally important, contemporary generations of therapists

rarely read him. For one thing, his language is often obscure (though there are excellent renderings of his work into plain English).[19] For another, his work has so pervaded contemporary psychotherapeutic thought that his original writings seem overly familiar or obvious. However, with the recent focus on integrating cognitive and interpersonal approaches in both individual and group therapy, interest in his contributions has resurged.[20] Donald Kiesler, a leading interpersonal theorist and researcher, has argued that in fact the interpersonal frame is the most appropriate model for meaningfully synthesizing cognitive, behavioral, and psychodynamic approaches and that it is the most comprehensive of the integrative psychotherapies.[21]

Although a comprehensive discussion of interpersonal theory is beyond the scope of this book, we will describe a few key concepts, as Sullivan's formulations are exceedingly helpful for understanding the group therapeutic process and resonate with our growing understanding of interpersonal neurobiology.[22] It is remarkable how his ideas have stood the test of time; indeed, they have been reinforced over time. Sullivan contended that the personality is almost entirely the product of interaction with other significant human beings. The need to be closely related to others is as basic as any biological need and is, in light of the prolonged period of helpless infancy that humans experience, just as necessary to survival. The developing child, in the quest for security, tends to cultivate and to emphasize those traits and aspects of the self that meet with approval and to squelch or deny those that meet with disapproval. Eventually the individual develops a concept of the self based on the perceived appraisals of significant others:

> The self may be said to be made up of reflected appraisals. If these were chiefly derogatory, as in the case of an unwanted child who was never loved, of a child who has fallen into the hands of foster parents who have no real interest in him as a child; as I say, if the self-dynamism is made up of experience which is chiefly derogatory, it will facilitate hostile, disparaging appraisals of other people and it will entertain disparaging

and hostile appraisal of itself.[23]

This process of constructing our self-regard on the basis of reflected appraisals that we read in the eyes of important others continues, of course, throughout the developmental cycle. The study of adolescents stresses that satisfying peer relationships and self-esteem are inseparable concepts.[24] But the same is also true for the elderly. We never outgrow the need for meaningful relatedness.[25]

Sullivan used the term “parataxic distortions” to describe individuals’ proclivity to distort their perceptions of others. A parataxic distortion occurs in an interpersonal situation when one person relates to another not on the basis of the realistic attributes of the other but on the basis of a personification existing chiefly in his or her own inner psychological world. Although parataxic distortion is similar to the concept of transference, it differs in two important ways. First, the scope is broader: it refers not only to an individual’s distorted view of the therapist but also to all other interpersonal relationships (including, of course, distorted relationships among group members). Second, the theory of origin is broader: parataxic distortion comprises not only the simple transfer of attitudes toward real-life figures of the past onto contemporary relationships, but also the distortion of interpersonal reality in response to intrapersonal needs. We will generally use the term “transference” in this book to refer to all interpersonal distortions, whether between client and therapist or between client and group members more generally, as is common practice among therapists today.

The transference distortions emerge from a set of deeply stored memories of early interactional experiences.[26] These memories contribute to the construction of an internal working model that shapes the individual’s attachment patterns throughout life.[27] This internal working model, also known as a schema, consists of the individual’s beliefs about himself, the way he makes sense of relationship cues, and the ensuing interpersonal behavior—not only his own, but the type of behavior he draws from others.[28] Many

contemporary models of psychotherapy are predicated on these principles, including Lester Luborsky's Core Conflictual Relationship Theme, Hans Hermann Strupp and Jeffrey Binder's misconstrual-misconstruction sequence, Paul Wachtel's cyclical psychodynamics, and the Mt. Zion Control Mastery model.[29] For instance, a young woman who grows up with depressed and overburdened parents is likely to feel that if she is to stay connected and attached to others, she must make no demands, suppress her independence, and subordinate herself to the emotional needs of others. Psychotherapy may present her with her first opportunity to disconfirm her rigid and limiting interpersonal road map.

Interpersonal (that is, parataxic) distortions tend to be self-perpetuating. For example, an individual with a derogatory, debased self-image may, through selective inattention or projection, incorrectly perceive another to be harsh and rejecting. Moreover, the process compounds itself, because that individual may then gradually develop mannerisms and behavioral traits—for example, servility, defensive antagonism, or condescension—that eventually will cause others to become, in reality, harsh and rejecting. This sequence is commonly referred to as a "self-fulfilling prophecy." The individual anticipates that others will respond in a certain manner and then unwittingly behaves in a manner that recruits that very response. In other words, causality in relationships is circular and not linear. Research supports this thesis by demonstrating that one's interpersonal beliefs express themselves in behaviors that have a predictable and restrictive interpersonal impact on others.[30] The interpersonal defense is the problem, not the solution.[31] These patterns can be illuminated both by clinical evaluation and by objective interpersonal measurement.[32]

Interpersonal distortions, in Sullivan's view, are modifiable primarily through *consensual validation*—that is, through comparing one's interpersonal evaluations with those of others. Consensual validation is a particularly important concept in group therapy. Not infrequently, a group member alters personal distortions after checking out the other members' views of some important incident.

This brings us to Sullivan's view of the therapeutic process. He suggested that the proper focus of research in mental health is the study of processes that involve or go on between people.[33] Mental disorder, or psychiatric symptomatology in all its varied manifestations, should be translated into interpersonal terms and treated accordingly.[34] Maladaptive interpersonal behavior can be further defined by its rigidity, extremism, distortion, circularity, and seeming inescapability.[35] Accordingly, treatment should be directed toward the correction of interpersonal distortions, thus enabling the individual to lead a fuller, less constricted life and to participate collaboratively with others in the context of realistic, mutually satisfying interpersonal relationships. As Sullivan wrote, "one achieves mental health to the extent that one becomes aware of one's interpersonal relationships."[36] Psychiatric cure is the "expanding of the self to such final effect that the patient as known to himself is much the same person as the patient behaving to others."[37] Although core negative beliefs about oneself do not disappear entirely with treatment, treatment does generate a capacity for interpersonal flexibility and mastery, such that the client can respond with a broadened, flexible, and more empathetic and adaptive repertoire of behaviors and replace vicious cycles with constructive ones.[38]

Improving interpersonal communication is accordingly the focus of many parent and child group psychotherapy interventions that address childhood conduct disorders and antisocial behavior. Poor communication of children's needs and of parental expectations generates feelings of personal helplessness and ineffectiveness in both children and parents. These often lead to acting-out behaviors for the children as well as to parental responses that are hostile, devaluing, and inadvertently amplifying.[39] In these groups, parents and children learn to recognize and correct maladaptive interpersonal cycles through the use of psychoeducation, problem solving, interpersonal skills training, role-playing, and feedback.

These ideas—that psychotherapy is broadly interpersonal, both in

its goals and in its means—are exceedingly germane to group therapy. That does not mean that all, or even most, clients entering group therapy ask *explicitly* for help in their interpersonal relationships. Yet we have observed that the therapeutic goals of clients often undergo a shift after a number of sessions. Their initial goal, relief of suffering, is modified and eventually replaced by new goals, usually interpersonal in nature. For example, goals may change from wanting relief from anxiety or depression to wanting to learn to communicate with others, to be more trusting and honest with others, to learn to love. In the brief group therapies, this translation of client concerns and aspirations into interpersonal ones may need to be front-end loaded collaboratively and transparently at the assessment and preparation phase.[40]

The goal shift from relief of suffering to better interpersonal functioning is an essential early step for the client in the dynamic therapeutic process. It is important in the thinking of the therapist as well. We recognize that depression is caused by many factors, but we believe that interpersonal pathology plays an important causal role and can perpetuate it. *We therefore believe that in working with the depressed client in group therapy it is necessary, first, to translate depression into interpersonal terms, and then to treat the underlying interpersonal pathology*.[41] This would mean, for example, translating depression into interpersonal issues such as passive dependency, isolation, submissiveness, inability to express anger, or hypersensitivity to separation and then addressing those issues in therapy.

The importance of interpersonal relationships to mental health has become so much an integral part of the fabric of psychiatric thought that it needs no further underscoring. People need people—for initial and continued survival, for socialization, and for the pursuit of satisfaction. No one—not the dying, not the outcast, not the mighty—transcends the need for human contact.

During many years of leading groups of individuals who all had some advanced form of cancer, we were repeatedly struck by the realization that, in the face of death, we struggle less with the

prospect of nonbeing or nothingness than with the feeling that we are utterly alone on our journey toward it.[42] Dying patients may be haunted by interpersonal concerns—about being abandoned, or even shunned, by the world of the living.

The isolation of the dying is often double-edged. Patients themselves often avoid those whom they most cherish, fearing that they will drag their family and friends into their quagmire of despair. Their friends and family may contribute to the isolation by becoming tentative about contact and progressively distancing in their communication, not knowing what to say and not wanting to upset the dying person or even themselves. We agree with Elisabeth Kübler-Ross, who said that the question is not *whether* to engage a patient openly and honestly about a fatal illness, but *how* to do so. The patient is always informed covertly that he or she is dying by the demeanor, by the shrinking away, of the living.[43]

> **It is easy to fall prey to avoidance and tentativeness in communi**cation. I (ML) recall that while I was leading groups for women with metastatic breast cancer, my mother was diagnosed with terminal pancreatic cancer. At the kitchen table one night, my mother raised the question of why no one in the family was talking about the bar mitzvah of my son, which was scheduled for eight months later. We endured a long, silent pause. My mother then added, “People are not talking about Benji’s bar mitzvah because everyone knows I will be dead before then.” My normally gentle and self-restrained father became agitated and responded quickly, telling her that she was being too pessimistic, that she should be hopeful and not think such negative things.
>
> She looked crestfallen, and I determined that I would put into action what I had been encouraging my group members and their families to do. I reached over to her and said, “Mom, I hope that you are wrong about your illness, but you may be right, and I realize now that we were not talking about Benji’s bar mitzvah because we were avoiding having to think about the fact that you may not be there with us. I also realize that our avoidance is making you feel alone and disconnected. While we may not be able to change the outcome of your illness, we can certainly change your experience at this moment. I promise you we will tell you everything there is to know about our plans and include you as much as possible.”

My mother smiled, thanked me, and said, “Now I know what kind of work you do.” My mother in fact did not survive to attend the bar mitzvah, but the last few months of her life were spent in a much more open, close, and communicative fashion—which was much better for her and for us all. **<<**

Physicians often add to the isolation by keeping patients with advanced cancer at a considerable psychological distance—perhaps to avoid their sense of failure and futility, or to avoid dread of their own death. They make the mistake of concluding that, after all, there is nothing more they can do. Yet from the patient’s standpoint, this is the very time when the physician is needed the most, not for technical aid but for sheer human presence. What the individual needs is to make contact, to be able to touch others, to voice concerns openly, to be reminded that he or she is not only apart from but also a part of. Psychotherapeutic approaches are beginning to address these concerns of the terminally ill—specifically, their fear of isolation and their desire to retain dignity within their relationships.[44]

Consider the outcasts—those individuals so accustomed to rejection that they may claim that—or act like—they need no one. But while they may seem to be inured to the need for interpersonal connection, they are not. I (IY) once had an experience in a prison that provided a forceful reminder of the ubiquitous nature of this human need. A psychiatric technician consulted me about his therapy group, which was composed of twelve inmates. The members of the group were all hardened criminals, with offenses ranging from aggressive sexual violation of a minor to murder. The group, he complained, was sluggish and persisted in focusing on extraneous, extragroup material. I agreed to observe his group and suggested that first he obtain some sociometric information by asking each member privately to rank-order everyone in the group for general popularity. (I had hoped that the discussion of this task would induce the group to turn its attention upon itself.) Although we had planned to discuss these results before the next group session, unexpected circumstances forced us to cancel our presession consultation.

During the next group meeting, the therapist, enthusiastic but professionally inexperienced and insensitive to interpersonal needs, announced that he would read aloud the results of the popularity poll. Hearing this, the group members grew agitated and fearful. They made it clear that they did not wish to know the results. Several members spoke so vehemently of the devastating possibility that they might appear at the bottom of the list that the therapist quickly and permanently abandoned his plan of reading the list aloud.

I suggested an alternative plan for the next meeting: each member would indicate whose vote he cared about most and then explain his choice. This device, also, was too threatening, and only one-third of the members ventured a choice. Nevertheless, the group shifted to an interactional level and developed a degree of tension, involvement, and exhilaration previously unknown. These men had received the ultimate message of rejection from society at large: they were imprisoned, segregated, and explicitly labeled as outcasts. To the casual observer, they seemed hardened, indifferent to the subtleties of interpersonal approval and disapproval. Yet they cared, and cared deeply.

The need for acceptance by and interaction with others is no different among people at the opposite pole of human fortunes—those who occupy the ultimate realms of power, renown, or wealth. I (IY) once worked with an enormously wealthy client for three years. The biggest issues revolved around the wedge that money created between her and others. Did anyone value her for herself rather than her money? Was she continually being exploited by others? To whom could she complain of the burdens of a $90 million fortune? The secret of her wealth kept her isolated from others. (Loneliness is, incidentally, not irrelevant to the group therapist. In Chapter 7, we will discuss the loneliness inherent in the role of group leader.)

Every group therapist has, we are sure, encountered group members who profess indifference to or detachment from the group. They proclaim, “I don’t care what they say or think or feel about me; they’re nothing to me. I have no respect for the other members,” or words to that effect. Our experience has been that if we can keep such clients in the group long enough, which is not always easy to

do with clients who have avoidant and dismissive attachment styles, their wishes for contact inevitably surface.[45] They are in fact concerned at a very deep level about the group. The challenge in these situations is to address the interpersonal pattern before it evokes irreversible antipathy and resentment from the other group members. One member who maintained her indifferent posture for many months was once invited to ask the group her secret question, the one question she would like most of all to place before the group. To everyone's astonishment, this seemingly aloof, detached woman posed this question: "How can you put up with me?"

Many clients anticipate group meetings with great eagerness or with anxiety; some feel too shaken afterward to drive home or to sleep that night; many have imaginary conversations with the group during the week. Moreover, this engagement with other members is often long-lived. We have known many clients who think and dream about group members months, even years, after the group has ended.

In short, people do not feel indifferent toward others in their group for long. And clients do not quit the therapy group because of boredom. Believe scorn, contempt, fear, discouragement, shame, panic, hatred! Believe any of these! But never believe indifference.

In summary, we have reviewed some aspects of personality development, interpersonal neurobiology, mature functioning, psychopathology, and psychiatric treatment from the point of view of interpersonal theory. Many of the issues that we have raised have a vital bearing on the therapeutic process in group therapy: the concept that an important component of our client's suffering emanates from disturbed interpersonal relationships, that good relationships are essential to the healing process, the role of consensual validation in the modification of interpersonal distortions, the definition of the therapeutic process as an adaptive modification of interpersonal relationships, and the enduring nature and potency of the human being's social needs. Let us now turn to the corrective emotional experience, the second of the three concepts necessary to understand the therapeutic factor of interpersonal learning.

THE CORRECTIVE EMOTIONAL EXPERIENCE

In 1946 Franz Alexander introduced the concept of the "corrective emotional experience." The basic principle of treatment, he stated, "is to expose the patient, under more favorable circumstances, to emotional situations that he could not handle in the past. The patient, in order to be helped, must undergo a corrective emotional experience suitable to repair the traumatic influence of previous experience."[46] Alexander insisted that intellectual insight alone is insufficient: there must be an emotional component and systematic reality testing as well. Patients, while affectively interacting with their therapist in a distorted fashion because of transference, gradually must become aware of the fact that "these reactions… are not suited to the situation between patient and therapist, and they are equally unsuited to the patient's current interpersonal relationships in his daily life."[47]

Although the idea of the corrective emotional experience has been criticized over the years because it was misconstrued as inauthentic, contemporary psychotherapies view it as a cornerstone of therapeutic effectiveness. Change, both at the behavioral level and at the deeper level of internalized images of past relationships, does not occur primarily through interpretation and insight, but through meaningful here-and-now relational experience that disconfirms the client's pathogenic beliefs.[48] When such disconfirmation occurs, change can be dramatic: clients express more emotion, recall more personally relevant and formative experiences, and show evidence of more boldness and a greater sense of self.[49] They gain a more balanced understanding of how relationships work and their role in the relationships.[50] The corrective emotional experience restores or creates, perhaps for the first time, trust in the interpersonal world—what prominent psychotherapy theorist and researcher Peter Fonagy and his colleagues refer to as *epistemic trust*. That is, it fosters the capacity

to trust in what people say and do and to engage in the world without excessive vigilance.[51]

These basic principles—the importance of the emotional experience in therapy and the client's discovery, through reality testing, of the inappropriateness of his or her interpersonal reactions—are as crucial in group therapy as in individual therapy, and possibly more so, because the group setting offers far more opportunities for the generation of corrective emotional experiences. In the individual setting, the corrective emotional experience, valuable as it is, may be harder to come by, because the client-therapist relationship is more insular, and the client is more able to dispute the spontaneity, scope, and authenticity of that relationship. (We believe Alexander was aware of that, because at one point he suggested that the analyst may have to be an actor, playing a role in order to create the desired emotional atmosphere—hence the early criticism about contrivance.)[52] It has regained its presence as an important catalyst in the "healing" nature of our work.[53]

No such simulation is necessary in the therapy group, which contains many built-in tensions—tensions whose roots reach deep into primeval layers: sibling rivalry, competition for leaders'/parents' attention, the struggle for dominance and status, sexual tensions, parataxic distortions, and differences in culture, race, gender, ethnicity, economic status, social class, education, and values among the members. *But the evocation and expression of raw affect is not sufficient*: it has to be transformed into a corrective emotional experience. For that to occur, two conditions are required: (1) the members must experience the group as sufficiently safe and supportive so that these tensions may be openly expressed; (2) there must be sufficient engagement and honest feedback to permit effective reality testing and processing of that feedback.[54]

Over many years of clinical work, we have made it a practice to interview clients after they have completed group therapy. We always inquire about some critical incident, a turning point, or the most helpful single event in therapy. Our clients almost invariably cite an incident that is highly laden emotionally and involves some other

group member. The role of the therapist in these incidents was cited less frequently.

Most often, my (IY) clients have answered by citing an incident where they suddenly expressed strong dislike or anger toward another group member. (Similar results were reported by Jerome Frank and Eduard Ascher.)[55] In each instance, communication was maintained, the storm was weathered, and the client experienced a sense of liberation from inner restraints as well as an enhanced ability to explore his or her interpersonal relationships more deeply.

The important characteristics of such critical incidents were:

1. The client expressed strong negative affect.
2. This expression was a unique or novel experience for the client.
3. The client had always dreaded the expression of anger. Yet no catastrophe ensued: no one left or died; the roof did not collapse.
4. Reality testing ensued. The client realized either that the anger expressed was inappropriate in intensity or direction, or that prior avoidance of affect expression had been irrational. The client may or may not have gained some insight—that is, learned the reasons either for the inappropriate affect or for the prior avoidance of either experiencing or expressing the affect.
5. The client was enabled to interact more freely and to explore interpersonal relationships more deeply.

Thus, when we see two group members in conflict with one another, we believe there is an excellent chance that they will be particularly important to one another in the course of therapy. In fact, if the conflict is particularly uncomfortable, we may attempt to ameliorate some of the discomfort by expressing that hunch aloud, conveying both helpful containment and hopefulness at potential moments of dread.

Clients' second most common response is to cite a critical incident that also involved strong affect—but in these instances, positive affect. For example, an avoidant, obsessional client described an incident in which he ran after and comforted a distressed group member who had bolted from the room; later, he spoke of how profoundly he was affected by learning that he could care for and help someone else. Others spoke of discovering their aliveness or of feeling in touch with themselves. These incidents had in common the following characteristics:

1. The client expressed strong positive affect—an unusual occurrence.
2. The feared catastrophe—derision, rejection, engulfment, the destruction of others—did not occur.
3. The client discovered a previously unknown part of the self and thus was enabled to relate to others in a new fashion.

The third most common response is similar to the second. Clients recall an incident, usually involving self-disclosure, that plunged them into greater involvement with the group. For example, a previously withdrawn, reticent man who had missed a couple of meetings disclosed to the group how desperately he wanted to hear the group members say that they had missed him during his absence. Others, too, in one fashion or another, openly took the risk of acknowledging their need for care, support, or recognition from the group.

To summarize, the corrective emotional experience in group therapy has several components:

1. A strong expression of emotion, which is interpersonally directed and constitutes a risk taken by the client.
2. A group supportive enough to permit this risk-taking.
3. Reality testing, which allows the individual to examine the incident with the aid of consensual validation from the other

members.

4. A recognition of the inappropriateness of certain interpersonal feelings and behavior or of the inappropriateness of avoiding certain interpersonal behavior.
5. The ultimate facilitation of the individual's ability to interact with others more deeply and honestly.

Therapy must be an emotional *and* a corrective experience. Illumination without an opportunity for repair is likely to be punitive and demoralizing. If we encourage our group members to come to the group as they genuinely are, with vulnerability, hope, and fear, it is incumbent upon us to assure that it will be worthwhile for them to do so. This dual nature of the therapeutic process is of elemental significance, and we will return to it again and again in this text. We must experience something strongly; but we must also, through our faculty of reason, understand the implications of that emotional experience. The prototypical sequence involves the client's emotional experience, with emotional expression, and is completed by emotional processing.[56] Over time, the client's deeply held beliefs will change—and these changes will be reinforced if the client's new interpersonal behaviors evoke constructive interpersonal responses. Even subtle interpersonal shifts can reflect a profound change and need to be acknowledged and reinforced by the therapist and group members.

> **Bonnie, a depressed young woman, vividly described her isola**tion and alienation and then turned to Alice, who had been silent. Bonnie and Alice had often sparred because Bonnie would accuse Alice of ignoring and rejecting her. In this meeting, however, Bonnie used a gentler tone and asked Alice about the meaning of her silence. Alice responded that she was listening carefully and thinking about how much they had in common. She then added that Bonnie's softer inquiry allowed her to give voice to her thoughts rather than defending herself against the charge of not caring, a sequence that had ended badly for them both in earlier sessions. The seemingly small but vitally important shift in Bonnie's capacity to approach Alice empathically created an opportunity for repair rather than repetition. **<<**

This formulation has direct relevance to a key concept of group therapy, the "here-and-now," which we will discuss in depth in Chapter 6. At this point we will state only this basic premise: *When the therapy group focuses on the here-and-now, it increases in power and effectiveness.*

But if the here-and-now focus (that is, a focus on what is happening in this room in the immediate present) is to be therapeutic, it must have two components: the group members must experience one another with as much spontaneity and honesty as possible, and they must also reflect back on that experience. This reflecting back, this *self-reflective loop*, is crucial if an emotional experience is to be transformed into a therapeutic one. As we shall see in the discussion of the therapist's tasks in Chapter 5, most groups have little difficulty entering the emotional stream of the here-and-now, but generally, it is the therapist's job to keep directing the group toward the self-reflective aspect of that process. A strong emotional experience is not in itself a sufficient force for change.

Evidence that the psychotherapeutic process involves both emotional and intellectual components was supported by an intensive study I (IY) conducted with two colleagues. We looked at many of the encounter techniques popular in the 1970s that emphasized facilitating or eliciting emotional experiences (expressing and experiencing strong affect, engaging in self-disclosure, giving and receiving feedback).[57] The study explored, in a number of ways, the relationship between group members' experiences in these groups and their outcomes. We obtained surprising results that disconfirmed many contemporary stereotypes about the primary ingredients of the successful encounter group experience. Although emotional experiences were considered extremely important, they did not distinguish successful from unsuccessful group members. In other words, the members who were unchanged or for whom the group proved to be a destructive experience were just as likely as successful members to highly value the emotional incidents of the group. And the study provided clear evidence that a *cognitive component* was essential—some type of

cognitive map or intellectual system that framed the experience and helped the client make sense of the emotions evoked in the group.

THE GROUP AS SOCIAL MICROCOSM

A freely interactive group, with few structural restrictions, will in time develop into a social microcosm of the participant members. Given enough sessions together, group members will begin to be themselves: they will interact with the other members of the group just as they interact with other people in their social sphere and create in the group the same interpersonal universe they have always inhabited. In other words, clients will, over time, automatically and inevitably begin to display their maladaptive interpersonal behaviors in the therapy group. There is no need for them to describe or give a detailed history of their pathology: *sooner or later they will enact it before the other group members' eyes*.[i]

Furthermore, their behavior serves as accurate data and lacks the unwitting but inevitable blind spots of self-report. Character pathology is often hard for the individual to report because it is deeply assimilated into the fabric of the self and is outside of conscious and explicit awareness. As a result, group therapy, with its emphasis on feedback, is a particularly effective treatment for individuals with character pathology.[58] A compelling, personal perspective is provided by David Payne, writing in the *New York Times*. In "Why Group Therapy Worked," he noted:

> Why did group therapy work when individual therapy didn't? Part of it was that having nine different mirrors reflect back my problematic behavior brought into brilliant and incontrovertible light what I had been able to avoid confronting in a one-on-one exchange. Individual therapy also encouraged me to focus on the past, the injuries I'd received in childhood; group therapy forced me to see who I was now, the sometimes-injurious adult I had become. For me, that was the bitter pill that led to change.[59]

This concept is of paramount importance and is a keystone of the entire approach we describe in this text. Each member's

interpersonal style will eventually appear in his or her transactions in the group. Some styles result in interpersonal friction that will be manifest early in the course of the group. Individuals who are, for example, dominating, angry, vindictive, harshly judgmental, intensely passive, or grandly coquettish will generate considerable interpersonal static even in the first few meetings. Their maladaptive social patterns will quickly elicit the group's attention. Others may require more time in therapy before their difficulties manifest themselves in the here-and-now of the group. This includes clients who may be equally or more severely troubled but whose interpersonal difficulties are more subtle, such as those individuals who quietly exploit others, those who achieve intimacy to a point but then disengage out of fear, or those who pseudo-engage, maintaining a subordinate, compliant position.

The initial business of a group usually consists of dealing with the members whose pathology is most interpersonally blatant. Some interpersonal styles become crystal clear from a single transaction or group meeting, and others require many sessions of observation to understand. Some clinical examples may make these principles more graphic.[ii] We also encourage viewing the video based on *The Schopenhauer Cure* novel, titled "Group Therapy: A Live Demonstration" and staged at an annual meeting of the American Group Psychotherapy Association. It illustrates in action the kind of narratives described here with added process commentary and is accompanied by a teaching guide.[60]

Attack First

George entered group therapy motivated by his impending fatherhood. He knew that he intimidated people and was seen as aggressive and bullying at work and in his relationships. In fact, he had been referred to group therapy by his individual therapist, a female social worker, whom he had begun to intimidate with subtle sexualized comments.

George readily recalled his own upbringing—being humiliated and bullied by his father—and he was determined to be a different kind of

father. One of the pivotal memories he recounted in the group was of his father routinely engaging him in what began as friendly father-son wrestling together, only to end each encounter, typically, atop George, mocking him for his disgusting, pathetic weakness. George was repeatedly humiliated and told that if he was not tougher, people would always push him around.

George viewed the world through this road map. His pathogenic beliefs were that closeness was an invitation to humiliation and degradation. How could he become more tender when he had been taught to ensure safety by attacking first? He resisted emotional engagement in the group, provocatively diminishing the value of others' increasing connections to one another, challenging the honesty of people's care for one another, all the while sitting in the group in "manspreading" fashion, occupying a disproportionate amount of physical space. Yet he came on time to each meeting and rarely missed sessions.

In one pivotal session, a member named Diane recounted a depressing weekend in which she had slept with three different men. In great emotional distress, she asked the group for help in addressing why sex came so easily but emotional intimacy was so hard for her. She often felt that her body was the only appealing and worthwhile aspect of herself. Group members responded with expressions of support, endorsing her courage in disclosing her feelings to the group.

Then George spoke: "I know what your problem is, Diane: You are a slut. It is easy to see that." The impact of his statement was predictable and explosive. Diane burst into tears and the group attacked George for his cruelty and destructiveness. At first, he held his ground, claiming "I call 'em like I see 'em." As the group leader, I (ML) knew I did not want to be as harshly judgmental of George as he had sounded when he spoke to Diane. Diane now needed all the more support for being so vulnerable with the group. So I questioned George about his comment to Diane. What was his intent with that feedback? What did he think would be the impact on Diane? How did he think she felt? What did he imagine others in the group would feel toward him? I added that George's comment was so provocative that

it had to be understood, not just reacted to.

Somewhat shaken, George stated that he did not want to hurt Diane—in fact, he liked Diane and was attracted to her. But because he liked her, he felt more vulnerable with her and was concerned about her reaction to him. He preferred to feel less vulnerable and more in control. The group members explored how his feedback to her had issued from his own feelings of vulnerability. Attacking others to reduce his vulnerability ensured only more of the same—witness the group's anger and counterattack. (This group was observed by trainees through a one-way window, and in our postgroup rehash, one observer shared how he'd had to restrain himself from barging in and pummeling George.)

George had turned a safe and welcoming environment into a hostile one. He obtained further feedback that he had a substantial amount of control to wield—that he could engage and make people allies, or he could turn them into rejecting attackers. Diane then said, "I can understand your issues, George, but I'm not here to sacrifice myself for your therapy. How much longer do I have to put up with this?"

George asked for her forgiveness, and Diane responded, "I'm open to it, George, but I can't just instantly produce forgiveness. I need to see you treating me differently over a long period—it won't happen overnight."

This interchange opened the door to valuable work for both members. Experiencing the group members' caring for her and their outrage at George on her behalf encouraged Diane to set limits in her life and to take better care of herself. For George, too, this was a turning point: he began to relinquish his defensive aggression and grew much more tender as he worked to earn the group's acceptance.

Those Damn Men

Linda, forty-six years old and thrice divorced, entered one of my (IY) therapy groups because of anxiety and ensuing chronic gastrointestinal distress. Her major interpersonal issue was her

tormented, self-destructive relationship with her current boyfriend. In fact, throughout her life she had encountered a long series of men (father, brothers, bosses, lovers, and husbands) who had abused her both physically and psychologically. Her account of the abuse that she had suffered at the hands of men, and suffered still, was harrowing.

At first, the group could do little to help her, aside from applying balm to her wounds and listening empathically to her accounts of continuing mistreatment by her current boss as well as by her boyfriend. Then an incident occurred that graphically illuminated her internal dynamics. She called me one morning in great distress: an extremely unsettling altercation with her boyfriend had left her feeling panicky and suicidal. She felt she could not possibly wait for the next group meeting, still four days off, and pleaded for an immediate individual session. Although it was inconvenient, I rearranged my appointments that afternoon and scheduled time to meet with her. Approximately thirty minutes before our meeting, she called and left word with my secretary that she would not be coming in after all.

In the next group meeting, when I inquired what had happened, Linda said that she had decided to cancel the emergency session because she was feeling slightly better by the afternoon. In addition, she said she knew I had a rule that I would see a client only one time in an emergency during the whole course of group therapy. She therefore thought it might be best to save that option for a time when she might be even more in crisis.

I found her response bewildering. I had never made such a rule; I never refuse to see someone in real crisis. Nor did any of the other members of the group recall my having issued such a dictum. But Linda stuck to her guns: she insisted that she had heard me say it, and she was dissuaded neither by my denial nor by the unanimous consensus of the other group members. Nor did she seem concerned in any way about the inconvenience she had caused me. In the group discussion, she grew defensive and acrimonious.

This incident, unfolding in the social microcosm of the group, was highly informative and allowed us to obtain an important perspective on Linda’s contribution to some of her problematic relationships with

men. Up until that point, the group had had to rely entirely on her portrayal of these relationships. Linda's accounts were convincing, and the group had come to accept her vision of herself as a victim of "all those damn men out there." An examination of the here-and-now incident indicated that Linda had distorted perceptions of at least one important man in her life: her therapist. Moreover—and this is extremely important—she had distorted the incident in a highly predictable fashion: she experienced me as far more uncaring, insensitive, and authoritarian than I really was.

This was new data, and it was convincing data displayed before the eyes of all the members. For the first time, the group began to wonder about the accuracy of Linda's accounts of her relationships with men. Undoubtedly, she had faithfully portrayed her feelings, but it became apparent that there were perceptual distortions at work: because of her expectations of men and her highly conflicted relationships with them, she often misperceived their actions toward her.

But there was more yet to be learned from the social microcosm. An important piece of data was the tone of the discussion: the defensiveness, the irritation, the anger. In time, I, too, became irritated by the thankless inconvenience I had suffered by changing my schedule to meet with Linda. I was further irritated by her insistence that I had proclaimed a certain insensitive rule when I (and the rest of the group) knew I had not. I fell into a reverie in which I asked myself, "What would it be like to live with Linda all the time instead of an hour and a half a week?" If there were many such incidents, I could imagine myself often becoming angry, exasperated, and uncaring toward her. This is a particularly clear example of the concept of the self-fulfilling prophecy described earlier: Linda predicted that men would behave toward her in a certain way and then, unconsciously, operated so as to bring this prediction to pass.

The Man Who Could Not Feel

Allen, a thirty-year-old unmarried scientist, sought therapy for a

single, sharply delineated problem: he wanted to be able to feel sexually stimulated by a woman. Intrigued by this conundrum, the group searched for an answer. They investigated his early life, sexual habits, and fantasies. Finally, baffled, they turned to other issues in the group. As the sessions continued, Allen seemed impassive and insensitive to his own and others' pain. On one occasion, for example, an unmarried member in great distress announced in sobs that she was pregnant and was planning to have an abortion. As she discussed her fear and her sense that she was in a bad dream from which she could not awake, she mentioned that she had once had a bad experience using hallucinogenic mushrooms. Allen, seemingly unmoved by her tears, became more interested in this subject than in her current dilemma, and persisted in posing intellectual questions about the effects of various psychedelic drugs. He was puzzled when the group commented on his insensitivity.

So many similar incidents occurred that the group came to expect him to be emotionally disconnected. When directly queried about his feelings, he responded as if he had been addressed in Aramaic. After some months, the group formulated an answer to his oft-repeated question, "Why can't I have sexual feelings toward a woman?" They asked him to consider instead why he couldn't have any type of feeling toward anyone.

Changes in Allen's behavior occurred very gradually. He learned to spot and identify feelings by pursuing telltale autonomic signs: facial flushing, gastric tightness, sweating palms. On one occasion a volatile woman in the group threatened to leave because she was exasperated trying to relate to "a psychologically deaf and dumb goddamned robot." Allen again remained impassive, responding only, "I'm not going to get down to your level."

However, the next week, when he was asked about the feelings he had taken home from the group, he said that after the meeting he had gone home and cried like a baby. (When he left the group a year later and looked back at the course of his therapy, he identified this incident as a critical turning point.) Over the ensuing months he was more able to feel and to express his feelings to the other members.

His role within the group changed from that of tolerated mascot to that of accepted peer, and his self-esteem rose as other members grew to respect him more. Moreover, he was beginning to develop a social life, and, for the first time, was enjoying dating.

Minimum Daily Requirements

Ed, a forty-seven-year-old engineer, sought therapy because of his loneliness and inability to find a suitable mate. Ed's pattern of social relationships was barren: he had never had close male friends and had only sexualized, unsatisfying, short-lived relationships with women, who ultimately and invariably rejected him.

At first, Ed's good social skills and lively sense of humor resulted in his being highly valued by other members, but as time passed and members deepened their relationships with one another, Ed was left behind. After a few meetings, his experience in the group closely resembled his social life outside the group. The most obvious aspect of his behavior was his limited and offensive approach to women. His gaze was directed primarily toward their breasts or crotch; his attention was voyeuristically directed toward their sexual lives; his comments to them were typically simplistic and sexual in nature. For months he did not initiate a single transaction with any of the men in the group.

With so little appreciation for the meaning of attachments, he, for the most part, considered people interchangeable. For example, when a member described her obsessive fantasy that her boyfriend, who was often late, would be killed in an automobile accident, Ed's response was to assure her that she was young, charming, and attractive and would have little trouble finding another man of at least equal quality. To take another example, Ed was always puzzled when other members appeared troubled by the temporary absence of one of the co-therapists, or, later, by the impending permanent departure of a therapist. Doubtless, he suggested, there was, even among the students, a therapist of equal competence. (In fact, he had seen in the hallway a physically attractive female psychologist whom he would particularly welcome as therapist.)

Ed put it most succinctly when he described what he called his “MDR” (minimum daily requirement) for affection; in time it became clear to the group that the identity of the MDR supplier was incidental to Ed, and far less relevant than its availability.

Thus evolved the first phase of the group therapy process: the display of interpersonal pathology. Ed did not relate to others so much as he used them as succor, as objects to supply his life needs. It was not long before he had re-created in the group his habitual—and desolate—interpersonal universe: he was cut off from everyone. Men reciprocated his total indifference; women, in general, were disinclined to service his MDR, and those women he especially craved were repulsed by his narrow, sexualized attentions. Ed’s subsequent group therapy was greatly informed by the display of his interpersonal pathology inside the group, and his therapy profited enormously from focusing exhaustively on his relationships with the other group members.

DYNAMIC INTERACTION WITHIN THE SOCIAL MICROCOSM

There is a rich and subtle dynamic interplay between the group member and the group environment. Members shape their own microcosm. The more spontaneous the interaction, the more rapid and authentic the development of the social microcosm. And that, in turn, increases the likelihood that the central problematic issues of all the members will be evoked and addressed.

Not only does the small group provide a social microcosm in which the maladaptive behavior of members is clearly displayed, but it also becomes a laboratory in which the meaning and the dynamics of the behavior are demonstrated, often with great clarity. The therapist sees not only the behavior but also the events triggering it and the responses others have to it.

The group interaction is so rich that each member's maladaptive transaction cycle is repeated many times, thus providing members with multiple opportunities for reflection and understanding. But if pathogenic beliefs are to be altered, the group members must receive feedback that is clear and usable. If the style of feedback delivery is too stressful or provocative, members may be unable to process what the other members offer them. Sometimes the feedback may be premature—that is, delivered before sufficient trust is present to soften its edge. At other times feedback can be experienced as devaluing, coercive, or injurious.[61] How can we avoid unhelpful or harmful feedback? Members are less likely to attack and blame one another if they can look beyond surface behavior and become sensitive to one another's internal experiences and underlying intentions. Thus, empathy is a critical element in the successful group. But empathy, particularly with provocative or aggressive clients, can be a tall order for group members and therapists alike. The group leader's articulation of empathy is critically important for clients' safety, emotional well-being, and

development.[62] Furthermore, the leader models how communication and genuine engagement can be both caring and challenging. Empathy flows more easily when we are interacting with people with whom we can identify, and it is easier to maintain when we ourselves are less stressed and fearful—hence the great value of therapist self-knowledge and awareness of countertransference.[63]

Recent contributions of intersubjectivity and modern analytic group approaches are relevant and helpful here.[64] These models pose members and therapists such questions as: “How am I implicated in what I construe as your provocativeness? What is my part in it?” In other words, the group members and the therapist continuously affect one another. The patterns of relationships are not fixed or mandated by external influences, but jointly constructed. The distortions in a member’s perceptions of events within the group interaction are not solely the creation of that member. An intersubjective and more balanced perspective acknowledges the contributions of the group leader and other members to each member’s here-and-now experience.

Consider the client who repeatedly arrives late to the group meeting. This is always an irritating event, and group members will inevitably express their annoyance. But the therapist should also encourage the group to explore the *meaning* of that particular client’s behavior. Coming late may mean “I don’t really care about the group,” but it may also have many other, more complex interpersonal meanings: “Nothing happens without me, so why should I rush?” or “I bet no one will even notice my absence—they don’t seem to notice me while I’m there,” or “These rules are meant for others, not me.”

Both the underlying meaning of the individual’s behavior and the impact of that behavior on others need to be revealed and processed if the members are to arrive at an empathic understanding of one another. Group participation promotes members’ emotional intelligence and mentalization—the understanding of the mental states, desires, fears, beliefs, expectations, and aspirations of oneself and of others.[65] It facilitates transfer of learning from the therapy group to the client’s larger world. Without a sense of the

internal world of others, relationships are confusing, frustrating, and repetitive as we mindlessly enlist others as players with predetermined roles in our own stories without regard to their actual motivations and aspirations.

Leonard, for example, entered the group with a major problem of procrastination. In Leonard's view, procrastination was not only a problem but also an explanation. It explained his failures, both professionally and socially; it explained his discouragement, depression, and alcoholism. And yet it was an explanation that obscured meaningful insight and more accurate explanations.

In the group we became well acquainted with Leonard's procrastination and often irritated or frustrated by it. When members worked hard with Leonard, and when it appeared that part of his neurotic character was about to be uprooted, he found ways to delay the group work. "I don't want to be upset by the group today," he would say, or, "This new job is make or break for me"; "I'm just hanging on by my fingernails"; "Give me a break—don't rock the boat"; "I'd been sober for three months until the last meeting caused me to stop at the bar on my way home." The variations were many, but the theme was consistent.

One day Leonard announced a major development, one for which he had long labored: he had quit his job and obtained a position as a teacher. Only a single step remained: getting a teaching certificate, a matter of filling out an application requiring approximately two hours' labor.

Only two hours and yet he could not do it! He delayed until the allowed time had practically expired and, with only one day remaining, informed the group about the deadline and lamented the cruelty of his personal demon, procrastination. Everyone in the group, including the therapists, experienced a strong desire to sit Leonard down, possibly even in one's lap, place a pen between his fingers, and guide his hand along the application form. One client, the most mothering member of the group, did exactly that: she took him home, fed him, and coached him line by line through the application form.

As we began to review what had happened, we could now see his

procrastination for what it was: a plaintive plea for a lost mother. Many things then fell into place, including the dynamics behind Leonard's depressions (which were also desperate pleas for love), alcoholism, and compulsive overeating.

The idea of the social microcosm is, we believe, sufficiently clear: *If the group is conducted such that the members can behave in an unguarded, unselfconscious manner, they will, most vividly, re-create and display their pathology in the group.* Thus, in this living drama of the group meeting, the trained therapist has a unique opportunity to understand the dynamics of each client's behavior and address the familiar negative interpersonal cycle.

RECOGNITION OF BEHAVIORAL PATTERNS IN THE SOCIAL MICROCOSM

If therapists are to turn the social microcosm to therapeutic use, they must first learn to identify the group members' recurrent maladaptive interpersonal patterns. In the incident involving Leonard, the therapist's vital clue was the emotional response of members and leaders to Leonard's behavior. The therapist or other group members may feel angry toward a member, or exploited, or sucked dry, or steamrollered, or intimidated, or bored, or tearful, or any of the infinite number of ways one person can feel toward another.

These feelings represent valid and indispensable data and should be taken seriously by the therapist. If the feelings elicited in others are highly discordant with the feelings that the client would like to engender in others, or if the feelings aroused are desired, yet inhibit growth (as in the case of Leonard), then therein lies a crucial part of the client's problem. Of course, there are many complications inherent in this thesis. Some critics might say that a strong emotional response is often due to pathology not of the subject but of the respondent. If, for example, a self-confident, assertive man evokes strong feelings of fear, intense envy, or bitter resentment in another man, we can hardly conclude that the response is reflective of the former's pathology. This is a distinct advantage that the therapy group format has over individual therapy: because the group contains multiple observers, it is often easier to differentiate idiosyncratic and highly subjective responses from more objective ones.

Group members will not naturally feel authorized to give voice to this kind of feedback. Often they become too supportive and may need therapist encouragement to examine what is being avoided and what is going underground. Our normal social discourse does not typically encourage that level of open reflection and commentary, but it is the essence of effective group therapy.[66]

Therapists look for repetitive patterns over time and for multiple

responses. Additionally, they rely on the most valuable evidence of all: their own emotional responses. If, as Kiesler stated, we get "hooked" by the interpersonal behavior of a member, our own reactions are our best interpersonal information about the client's impact on others.[67] Therapeutic value follows, however, only if we are able to get "unhooked"—that is, to resist engaging in the usual behavior the client elicits from others, which only reinforces the usual interpersonal cycles. This process of retaining or regaining our objectivity provides us with meaningful feedback about the interpersonal transaction. From this perspective, the thoughts, feelings, and actual behavior elicited in the therapist by each group member should be regarded as pure gold. Our reactions are invaluable data, not failings. But we need to distinguish what the client evokes in everyone from what is more subjective to us and emerges from our current or historical experience. Clearly these are not completely distinct, but one of our cardinal tasks as therapists is to discern the source of our reactions to our clients.[68]

Since all therapists have blind spots, their own areas of interpersonal distortion, how can we know when our reactions are objective? Co-therapy—when two or more therapists share leadership of a group—provides one answer to that question. Co-therapists are exposed simultaneously to the same clinical situation. Comparing their reactions permits a clearer discrimination between their own subjective responses and objective assessments of the interactions. Furthermore, group therapists may have a calmer and privileged vantage point, since, unlike individual therapists, they witness countless compelling maladaptive interpersonal dramas unfold without themselves being at the center of all these interactions.

We will address this issue more fully in later chapters on training and on the therapist's tasks and techniques, but for now note only that this argument is a powerful reason for therapists to know themselves as fully as possible. It is incumbent upon the neophyte group therapist to embark on a lifelong journey of self-exploration, a journey that may well include both individual and group therapy and

group experiential learning.[69]

None of this is meant to imply that therapists should not take the responses and feedback of all clients seriously, including those who are highly disturbed. Even the most exaggerated, irrational responses contain a core of reality. Furthermore, the disturbed client may be a valuable, accurate source of feedback at other times: no individual is highly conflicted in every area.

This final point constitutes a basic axiom for the group therapist. Not infrequently, members of a group respond very differently to the same stimulus. An incident may occur in the group that each of seven or eight members perceives, observes, and interprets differently. One common stimulus and eight different responses—how can that be? There seems to be only one plausible explanation: there are eight different inner worlds. Splendid! Thus, analysis of these differing responses is a royal road into the inner world of the group member.

Or, again, consider certain structural aspects of the group meeting: members have markedly different responses to sharing the group's or the therapist's attention, to disclosing themselves, to asking for help or helping others. Nowhere are such differences more apparent than in the transference—the members' responses to the leader. The same therapist will be experienced by different members as warm, cold, rejecting, accepting, competent, or bumbling. This range of perspectives can be humbling and even overwhelming for members and therapists, particularly neophytes.

That the group may serve as a kind of Rorschach test is illustrated in one group's observations about their two co-therapists. One group member opined that the group leaders were professionally accessible and that was adequate for him. Another lamented that both leaders seemed opaque and she was eager to be closer to them. A third member said there had been plenty of information provided already through the course of the group that helped her to feel close to the co-therapists; a fourth noted that one co-leader seemed more transparent than the other, and it made her wonder about the relationship between the co-leaders; a fifth added

that he preferred the group leaders to be opaque and distant so that he need not worry about what they might be feeling or thinking—he had spent his life as a child preoccupied with his mother's reactions to his statements and behavior. In the midst of this energized session, a new member of the group broke down in tears and stated that she felt overwhelmed. Where was the consistency and certainty she needed to know that she was always right? How could she know how to be in the world if the same question could generate so many divergent responses?

THE SOCIAL MICROCOSM: IS IT REAL?

We have often heard group members challenge the veracity of the social microcosm. Members may claim that their behavior in this particular group is not at all representative of their normal behavior. Or that the troubled individuals in the group have difficulties perceiving them accurately. Or even that group therapy is not real; it is an artificial, contrived experience that distorts rather than reflects one's real behavior. To the neophyte therapist, these arguments may seem formidable, even persuasive, but they are in fact truth-distorting. In one sense, the group *is* artificial: members do not choose their friends from the group, and they are not a daily part of one another's lives. Although they relate in a personal manner, their entire relationship consists of meetings in a professional's office once or twice a week. Moreover, the relationships are transient and the end of the relationship is built into the social contract at the very beginning.

When faced with these arguments, I often think of Earl and Marguerite, members in a group I (IY) led earlier in my career. Earl had been in the group for four months when Marguerite was introduced. They both blushed to see the other, because, by chance, only a month earlier, they had gone on a Sierra Club camping trip together for a night and been "intimate." Neither wanted to be in the group with the other. To Earl, Marguerite was a foolish, empty girl, "a mindless piece of ass," as he was to put it later in the group. To Marguerite, Earl was a dull nonentity, whose penis she had made use of as a means of retaliation against her husband.

They nevertheless worked together in the group once a week for about a year. During that time, they came to know each other intimately in a fuller sense of the word: they shared their deepest feelings; they weathered fierce, vicious battles; they helped each other through suicidal depressions; and, on more than one occasion, they wept for each other. Which was the real world and which the artificial?

One group member stated, “For the longest time I believed the group was a natural place for unnatural experiences. It was only later that I realized the opposite—it is an unnatural place for natural experiences.”[70] One of the things that makes the therapy group real is that it eliminates social, sexual, and status games; members go through vital life experiences together; they shed reality-distorting facades and strive to be honest with one another. How many times have we heard a group member say, “This is the first time I have ever told this to anyone”? The group members are not strangers. Quite the contrary: they know one another deeply and fully. Yes, it is true that members spend only a small fraction of their lives together. But psychological reality is not equivalent to physical reality. Psychologically, group members spend infinitely more time together than the one or two meetings a week when they physically occupy the same space.

TRANSFERENCE AND INSIGHT

Before concluding the examination of interpersonal learning as a mediator of change, we wish to call attention to two concepts that deserve further discussion. Transference and insight play too central a role in most formulations of the therapeutic process to be passed over lightly. We rely heavily on both of these concepts in our therapeutic work and do not mean to slight them. What we have done in this chapter is to embed them both into the factor of interpersonal learning.

Transference is a specific form of interpersonal perceptual distortion. In individual psychodynamic psychotherapy, the recognition and the working through of this distortion is of paramount importance. In group therapy, working through interpersonal distortions is, as we have seen, of no less importance; however, the range and variety of distortions are considerably greater. Working through the transference—that is, the distortion in the relationship to the therapist—now becomes only one of a series of distortions to be examined in the therapy process.

For many clients, perhaps for the majority, the client-therapist relationship is the most important relationship to work through, because the therapist is the personification of parental images, of teachers, of authority, of established tradition, of incorporated values. But most clients are also conflicted in other interpersonal domains: for example, power, assertiveness, anger, competitiveness with peers, intimacy, sexuality, generosity, greed, and envy. Considerable research emphasizes the importance many group members place on working through relationships with other members.[71]

Although self-understanding is highly important to group clients, group therapy focuses on the interpersonal and interactional domain, while individual therapy attends more to the intrapersonal and intrapsychic.[72] In one twelve-month follow-up study of a short-term crisis group, a team of researchers asked group members to indicate the source of the help each had received. Forty-two percent felt that

the group members had been helpful and the therapist had not, and 28 percent responded that both had been helpful. Only 5 percent said that the therapist alone was a major contributor to change.[73]

This body of research has important implications for the technique of the group therapist: rather than focusing exclusively on the client-therapist relationship, therapists must facilitate the development and working-through of interactions among members. We will have much more to say about these issues in Chapters 6 and 7.

Insight defies precise description; it is not a unitary concept. We prefer to employ it in the general sense of "sighting inward"—a process encompassing clarification, explanation, and derepression. Insight occurs when one discovers something important about oneself—about one's behavior, one's motivational system, or one's unconscious. It also sets the stage for the individual's greater understanding of the emotional experience of others in one's relational world—what Daniel Siegel refers to as "mindsight."[74]

In the group therapy process, clients may obtain insight on at least four different levels:

1. Clients may gain a more objective perspective on their interpersonal presentation. They may for the first time learn how they are seen by other people: as tense, warm, aloof, seductive, bitter, arrogant, pompous, obsequious, and so on.

2. Clients may gain some understanding of their more complex interactional patterns of behavior. Any of a vast number of patterns may become clear to them: for example, that they exploit others, court constant admiration, seduce and then reject or withdraw, compete relentlessly, plead for love, or relate only to the therapist or either the male or female members.

3. Clients may learn about the motives underlying their interpersonal behavior. Often clients learn that they behave in certain ways because they believe that different behavior would bring about some catastrophe: humiliation, scorn, or abandonment. Aloof, detached clients, for example, may understand that they shun closeness because of fears of being engulfed and losing themselves; competitive, vindictive, controlling clients may understand that they

are frightened of their deep, insatiable cravings for nurturance; timid, obsequious individuals may dread the eruption of their repressed, destructive rage.

4. Finally, in a fourth level of insight, clients understand the deep roots of their behavior. Through an exploration of the impact of early family and environmental experiences, the client understands the genesis of current patterns of behavior. This fourth level of insight has unfortunately become equated with “profound” or “good,” and the other levels have been considered “superficial” or “inconsequential.” A singular focus on the exploration of the past as the solution to current difficulties can interfere with the acquisition of self-awareness and interpersonal skills.[75]

Every therapist has encountered clients who have achieved considerable insight into the ways in which they have been shaped, influenced, or affected by their family of origin, developmental history, or sociocultural environment and yet have made no therapeutic progress. There is no demonstrated, consistent relationship between the acquisition of this sort of insight and the persistence of change. Moreover, it is commonplace for significant clinical change to occur in the absence of such insight. In fact, there is much reason to question the explanatory power of our most revered assumptions about the relationship between types of early experience and adult behavior and character structure.[76]

For one thing, we must take account of recent neurobiological research into the storage of memory. Memory is currently understood to consist of at least two forms, with two distinct brain pathways.[77] We are most familiar with the form of memory known as “explicit memory.” This memory consists of recalled details and events, the autobiographical recollections of one’s life, and it has historically been the focus of much exploration and interpretation in the psychodynamic therapies. A second form of memory, “implicit memory,” houses our earliest relational experiences, many of which precede our use of language. These memories influence how we relate to others. Therefore, talking alone may not alter the impact of these early, shaping memories. It is the actual moment-to-moment

client experience of the therapy relationship that is the engine of change.[78]

Psychoanalytic theory is changing as a result of this new understanding of memory. Peter Fonagy, after conducting an exhaustive review of the psychoanalytic process and outcome literature, concluded that “the recovery of past experience may be helpful, but the understanding of current ways of being with the other is the key to change. For this, both self and other representations may need to alter, and this can only be done effectively in the here-and-now.”[79]

A fuller discussion of causality would take us too far afield from interpersonal learning, but we will return to the issue in Chapters 5 and 6. For now, it is sufficient to emphasize that there is little doubt that understanding lubricates the machinery of change. It is important that insight—“sighting in”—occurs, but in its generic, not its genetic, sense. Psychotherapists need to disengage the concept of “profound” or “significant” intellectual understanding from historical considerations. Something that is deeply felt or has deep meaning for a client may or may not be related to the unraveling of the early genesis of behavior.

OVERVIEW

We have defined and described three distinct components of the therapeutic factor of interpersonal learning:

1. The importance of interpersonal relationships
2. The corrective emotional experience
3. The group as a social microcosm

Now, considering these components collectively and in sequence, the mechanism of interpersonal learning as a therapeutic factor becomes evident:

I. Psychological symptomatology emanates from disturbed interpersonal relationships. The task of psychotherapy is to help the client learn how to develop distortion-free, gratifying interpersonal relationships.

II. The psychotherapy group, provided its development is unhampered by severe structural restrictions, evolves into a social microcosm—a miniaturized representation of each member's social universe.

III. The group members, through feedback from others, self-reflection, and self-observation, become aware of significant aspects of their interpersonal behavior: their strengths, their limitations, their interpersonal distortions, the gap between their interpersonal intent and their impact, and the maladaptive behavior that elicits unwanted responses from other people. Group members have failed to learn from their prior experiences in problematic relationships because other people in their life, sensing their vulnerability and abiding by the rules of etiquette governing normal social interaction, have refrained from communicating how their behavior has contributed to their relationship problems. Therefore, and this is important, clients

have never learned to discriminate between objectionable aspects of their behavior and a self-concept as a totally unacceptable person. The therapy group, by encouraging accurate feedback, makes such discrimination possible.

IV. In the therapy group, a regular interpersonal sequence occurs:
   A. Pathology display: the member displays his or her behavior.
   B. Through feedback and self-observation, clients
      1. become better witnesses of their own behavior;
      2. appreciate the impact of that behavior on
         a. the feelings of others;
         b. the opinions that others have of them;
         c. the opinions they have of themselves.

V. The client who has become fully aware of this sequence also becomes aware of personal responsibility for his or her own interpersonal world.

VI. Individuals who fully accept personal responsibility for the shaping of their interpersonal world may then begin to grapple with the corollary of this discovery: if they created their social-relational world, then they have the power to change it.

VII. The meaningfulness of these understandings is directly proportional to the amount of affect experienced. The more real and the more emotional an experience, the more potent its impact; conversely, the more distant and intellectualized the experience, the less effective the learning.

VIII. As a result of this group therapy sequence, the client gradually changes by risking new ways of being with others. The likelihood that change will occur is a function of
   A. The client's readiness for change coupled with the amount of personal dissatisfaction with current modes of behavior;
   B. The client's involvement in the group—that is, how much the client allows the group to matter;
   C. The rigidity of the client's character structure and interpersonal style.

IX. Once change occurs, the client appreciates that some feared calamity has been irrational and can be disconfirmed: the change in behavior has not resulted in death, destruction, abandonment, derision, or engulfment.[iii]

X. The social microcosm concept is bidirectional: not only does outside behavior become manifest in the group, but the behavior learned in the group appears in clients' interpersonal behavior outside the group.

XI. Gradually, an adaptive spiral is set in motion, at first inside and then outside the group. As a client's interpersonal distortions diminish, his or her ability to form rewarding relationships is enhanced. Social anxiety decreases; self-esteem rises; harsh judgment of others softens; and the need for self-concealment diminishes.

Each of the steps of this sequence requires certain actions by the therapist. At various points, the therapist must offer empathy for the client's distress; must encourage self-observation, responsibility assumption, and risk-taking; must disconfirm fantasized calamitous consequences; must reinforce transfer of learning; and so on.[80] Each of these tasks and techniques will be fully discussed in the chapters ahead.

Footnotes

i A 2015 study examined 207 individual group members' self-ratings on the core interpersonal dimensions of affiliation and dominance. The authors noted significant consistencies between the self-ratings of outside-group behaviors and other group members' ratings of in-group behaviors, adding empirical support to the concept of the social microcosm. S. Goldberg and W. Hoyt, "Group as Social Microcosm: Within-Group Interpersonal Style Is Congruent with Outside Group Relational Tendencies," *Psychotherapy* 52 (2015): 195–204.

ii In the following clinical examples, as elsewhere in this text, we have protected clients' privacy by altering certain facts, such as name, occupation, and age. Also, the interaction described in the text is not reproduced verbatim but has been reconstructed from detailed clinical notes taken after each therapy meeting. In all instances, our clients have given us permission to use these clinical examples.

iii New relational experience may foster neurobiological changes by activating neural pathways in which the more emotional parts of the brain (subcortical) are influenced by the more cognitive, planning, and evaluation parts of the brain (the prefrontal cortex). The neurobiological impacts may even have the potential to repair the individual's genetic substrate damaged by early life adversity, underscoring the mind-brain connection. See D. Siegel, *Pocket Guide to Interpersonal Neurobiology: An Integrative Handbook of the Mind* (New York: W. W. Norton, 2012). S. Gantt and B. Badenoch, eds., *The Interpersonal Neurobiology of Group Psychotherapy and Group Process* (London: Karnac Books, 2013). A. Smith et al., "Epigenetic Signatures of PTSD: Results from the Psychiatric Genomics Consortium PTSD Epigenetics Workgroup," *Biological Psychiatry* 81 (2017): S36.

- 3 -

Group Cohesiveness

IN THIS CHAPTER WE EXAMINE THE PROPERTIES OF COHESIVENESS, the considerable evidence for group cohesiveness as a therapeutic factor, and the various pathways through which cohesiveness exerts its therapeutic influence.

What is cohesiveness and how does it influence therapeutic outcome? The short answer is that cohesiveness is the group therapy analogue to the *relationship* in individual therapy. First, keep in mind that a vast body of research on individual psychotherapy demonstrates that a good therapist-client relationship is essential for a positive outcome. The link between the therapeutic alliance and outcome is one of the most reliable research findings in our field.[1] Is it also true that a good therapy relationship is essential in group therapy? Here again, the literature leaves little doubt that "relationship" is germane to positive outcome in group therapy.[2] But relationship in group therapy is a far more complex concept than relationship in individual therapy. After all, there are only two people in the individual therapy relationship, whereas a number of individuals, generally six to ten, work together in group therapy. Hence it is insufficient to say that a good relationship is necessary for successful group therapy—we must also specify *which* relationship: The relationship between the client and the group therapist (or therapists, if there are co-leaders)? Or between the group member and other members? Or perhaps even between the individual and the "group" taken as a whole? In other words, there are intrapersonal, interpersonal, and group variables to consider as

well.[3]

Over the past sixty years, a vast number of controlled studies of psychotherapy outcome have demonstrated that the average person who receives psychotherapy is significantly improved and that the outcome from group therapy is virtually identical to that of individual therapy.[4] Furthermore, there is evidence that certain clients may obtain greater benefit from group therapy than from other approaches, particularly clients dealing with stigma or social isolation and those seeking new coping skills.[5]

The evidence supporting the effectiveness of group psychotherapy is so compelling that it prompts us to direct our attention toward another question: What are the necessary conditions for effective psychotherapy? After all, not all psychotherapy is successful. In fact, there is evidence that treatment may be for better or for worse—although most therapists help their clients, some therapists make some clients worse.[6] Why? What are the characteristics of a successful therapist? Although many factors are involved, effective therapists are empathically attuned to their clients and are able to provide an understandable, culturally resonant explanation of distress and its treatment that in turn builds the client's self-efficacy.[7] Research evidence overwhelmingly supports the conclusion that successful therapy—indeed, even successful pharmacotherapy treatment—is mediated by a relationship between treater and client that is characterized by agreement on the goals and tasks of treatment and marked by trust, warmth, empathic understanding, and acceptance.[8]

Although a positive therapeutic alliance is common to all effective treatments, it is by no means easily or routinely established. Extensive therapy research has focused on the nature of the therapeutic alliance and the specific interventions required to achieve, maintain, and repair the alliance when it gets strained or frayed.[9]

Is the quality of the relationship related to the therapist's theoretical orientation? The evidence says no. Effective clinicians

from different schools (psychodynamic, psychoanalytic, emotion-focused, humanistic, interpersonal, cognitive-behavioral) resemble one another (and differ from nonexperts in their own school) in their conception of the ideal therapeutic relationship and in the relationship they themselves establish with their clients.[10]

Note that the engaged, cohesive therapeutic relationship is necessary in *all* effective psychotherapies, even in the so-called mechanistic approaches—cognitive, behavioral, or systems-oriented forms of psychotherapy.[11] One of the first large comparative psychotherapy trials, the National Institute of Mental Health's (NIMH) Treatment of Depression Collaborative Research Program, concluded that successful cognitive-behavioral therapy or interpersonal therapy required "the presence of a positive attachment to a benevolent, supportive, and reassuring authority figure."[12] Research has shown that the client-therapist bond and the technical elements of cognitive therapy are synergistic: a strong and positive bond *in itself* disconfirms depressive beliefs and facilitates the work of modifying cognitive distortions. The *absence* of a positive bond renders technical interventions ineffective or even harmful.[13] The experience the client has of the treater is of enormous importance and is a good predictor of outcome.[14] And this experience emerges in large part from the therapist's actions and use of self.[15] More and more, these core therapist relationship capacities are being recognized as key foci in training programs.[16]

As noted, relationship plays an equally critical role in group psychotherapy. But the group therapy analogue of the client-therapist relationship in individual therapy must be a broader concept, encompassing the individual's relationship to the group therapist, to the other group members, and to the group as a whole. In this text we refer to all of these relationships with the term "group cohesiveness." Cohesiveness is a widely researched basic property of groups that has been explored in several hundred research articles, reviews, and meta-analytic studies synthesizing huge data pools.[17] Unfortunately, there is little cohesion in the cohesion

literature, which suffers from the lack of replication studies and the use of different definitions, scales, subjects, and rater perspectives.[18]

In general, however, the studies agree that groups differ from one another in the amount of "groupness" present. Those with a greater sense of solidarity, or "we-ness," value the group more highly and have higher attendance, participation, and mutual support. Nonetheless, it is difficult to formulate a precise definition. A thoughtful review concluded that cohesiveness "is like dignity: everyone can recognize it but apparently no one can describe it, much less measure it."[19] The problem is that cohesiveness refers to overlapping dimensions. On the one hand, there is a group phenomenon—the total *esprit de corps*; on the other hand, there is the individual member cohesiveness (or, more strictly, the individual's attraction to the group and to the leader).[20] Furthermore, both the client's emotional experience and the sense of task effectiveness in the group contribute to cohesion.[21]

In this book, we define cohesiveness as the attractiveness of a group for its members.[22] Members of a cohesive group feel warmth and comfort in the group and a sense of belonging; they value the group and feel they are valued, accepted, and supported by other members.[23]

Esprit de corps and individual cohesiveness are interdependent, and group cohesiveness is sometimes computed simply by summing the individual members' level of attraction to the group. Newer, more sophisticated methods of measuring group cohesiveness, such as the Group Questionnaire (GQ) developed by Gary Burlingame and colleagues, are gaining prominence and promise a more valid and reliable assessment of group cohesion.[i]

The more we examine cohesiveness, the more complexity we encounter. For example, we now know that each client's view of cohesiveness is impacted by the group cohesiveness other members feel. Group cohesiveness is generally considered as a summation of the individual members' sense of belonging, but we

have also learned that group members are differentially attracted to the group—personality, interpersonal patterns, and attachment style all play a large role.[24] Furthermore, while cohesiveness is not fixed but instead fluctuates greatly during the course of the group, we know that early cohesion is essential in setting the stage for the more challenging work to follow.[25] Research has also differentiated between the members' sense of belonging and their appraisal of how well the entire group is working. It is not uncommon for an individual to feel "that this group works well, but I'm not part of it."[26] It is also possible for members (for example, eating disorder clients) to value the interaction and bonding in the group yet be fundamentally opposed to the group goal.

Before leaving the matter of definition, we must point out that group cohesiveness is not only a potent therapeutic force in its own right; it is a precondition for other therapeutic factors to function optimally. When, in individual therapy, we say that it is the relationship that heals, we do not mean that love or loving acceptance is enough; we mean that an ideal therapist-client relationship creates conditions in which the necessary risk-taking, self-disclosure, catharsis, and intrapersonal and interpersonal exploration may unfold. It is the same for group therapy: *Cohesiveness is necessary for other group therapeutic factors to operate.*

THE IMPORTANCE OF GROUP COHESIVENESS

Although we discuss the therapeutic factors separately, they are, to a great degree, interdependent. Catharsis and universality, for example, are not complete processes. It is not the sheer process of ventilation, or the discovery that others have problems similar to one's own, and the ensuing disconfirmation of one's wretched uniqueness, that are important: it is the affective sharing of one's inner world *and then the acceptance by others* that seems of paramount importance. To be accepted by others challenges the client's belief that he or she is basically repugnant, unacceptable, or unlovable. The need for belonging is innate in all of us. Both affiliation within the group and attachment in the individual setting address this need.[27] Therapy groups generate a positive, self-reinforcing loop: trust–self-disclosure–empathy–acceptance–trust.[28] If norms of nonjudgmental acceptance and inclusiveness are established early and the member adheres to the group's procedural norms, a member will be accepted by the group regardless of past transgressions, social failings, alternative lifestyles, or substance abuse or a history of prostitution or criminal offenses.

For the most part, the flawed interpersonal skills of our clients have limited their opportunities for effective sharing in either one-to-one relationships or groups. Not infrequently, the therapy group offers isolated clients their only deeply human contact. After just a few sessions, members often have a stronger sense of being at home in the group than anywhere else. Later, even years afterward, when most other recollections of the group have faded from memory, they may still remember this warm sense of belonging and acceptance.

As one successful client looking back over two and a half years of group therapy put it, "the most important thing in it was just having a group there, people that I could always talk to, that wouldn't walk out on me. There was so much caring and hating and loving in the group, and I was a part of it. I'm better now and have my own life,

but it's sad to think that the group's not there anymore."

Furthermore, group members see that they are not just passive beneficiaries of group cohesion; they also generate that cohesion and create durable relationships—perhaps for the first time in their lives. One group member commented that he had always attributed his aloneness to some unidentified, intractable, and repugnant character failing. It was only after he stopped missing meetings regularly because of his discouragement and sense of futility that he discovered the part he played in his aloneness: that relationships do not inevitably wither. Instead, his previous relationships had been doomed by his choice to neglect them.

Some individuals internalize the group and repopulate their inner world. Years later, one client noted, "It's as though my old group is sitting on my shoulder, watching me. I'm forever asking, *What would the group say about this or that?*" Often therapeutic changes persist and are consolidated because, even years later, the members don't want to let the group down.[29]

Many of our clients have an impoverished history of social connection and have never felt valuable and integral to a group. For these individuals, a positive group experience may *in itself* be healing. Belonging in the group raises self-esteem and meets members' dependency needs, but in ways that also foster responsibility and autonomy.[30]

Still, for some members, belonging can generate feelings of psychological regression: belonging can be frightening because it evokes fear of loss of self and of relinquishing personal autonomy.[31] More typically, however, members of a therapy group come to mean a great deal to one another. The therapy group, at first perceived as an artificial construct that does not matter, may come to matter very much over time as members share their innermost thoughts. We have known groups whose members support one another through times of severe depression, through manic episodes, and through divorce, abortion, suicide, and sexual abuse, or even through the here-and-now feelings of betrayal within the group when two group members violate the group norms through a sexual encounter.

Even the most unlikely clients can form cohesive groups, as shown in a recent study of group therapy for marginalized intravenous drug users from the inner city with hepatitis C.[32] We have seen a group actually carry one of its members to the hospital, and many groups mourning the death of a member. We have seen members of cancer support groups deliver eulogies at the funerals of other members. Relationships are often cemented by emotionally intense shared experiences. How many relationships in life are so richly layered?

Benefits of Group Cohesiveness: Evidence

Empirical evidence for the impact of group cohesiveness may not be as extensive or as systematic as research documenting the importance of relationship in individual psychotherapy, but is still very clear and relevant.[33] Studying the effect of cohesiveness is more complex[34] because it involves variables closely related to cohesion such as group climate (the degree of engagement, avoidance, and conflict in the group),[35] therapist empathy,[36] and alliance (the member-therapist relationship).[37] The Group Questionnaire devised by Burlingame and colleagues synthesizes all these dimensions.[38] The results of the research from all these perspectives, however, point to the same conclusion: *Relationship is at the heart of effective group therapy.*[39]

Group cohesion is no less important in the era of third-party oversight than it was in the past. In fact, the contemporary group therapist has an even larger responsibility to safeguard the therapeutic relationship in the face of imposed restrictions and intrusions from bureaucratic forces.[40]

We now turn to a broad overview of contemporary research and literature on cohesion. It highlights many of the approaches group researchers have used to evaluate and understand group cohesion and its clinical impact. (Readers who are less interested in research methodology and more interested in its direct clinical relevance may wish to proceed directly to the summary section.)

- In an early study of former group psychotherapy clients, investigators found that more than half considered mutual support the primary mode of help in group therapy. Clients who perceived their group as cohesive attended more sessions, experienced more social contact with other members, and felt that the group had been therapeutic. Improved clients were significantly more likely to have felt accepted by the other members and to mention particular individuals when queried about their group experience.[41]
- In 1970, I (IY) reported a study in which successful group therapy clients were asked to look back over their experience and to rate, in order of effectiveness, the series of therapeutic factors I describe in this book.[42] Since that time, a vast number of studies using analogous designs have generated considerable data on clients' views of those aspects of group therapy that have been most useful. We will examine these results in depth in the next chapter; for now, it is sufficient to note that *there is a strong consensus that clients regard group cohesiveness as an extremely important determinant of successful group therapy*.
- In a six-month study of two long-term therapy groups, observers rated the process of each group session by scoring each member on five variables: acceptance, activity, sensitivity, abreaction (catharsis), and improvement.[43] Weekly self-ratings were also obtained from each member. *Both the research raters and group members considered "acceptance" to be the variable most strongly related to improvement.*
- Similar conclusions were reached in a study of forty-seven clients in twelve psychotherapy groups. Members' self-perceived personality change correlated significantly with both their feelings of involvement in the group and their assessment of total group cohesiveness.[44]

- My colleagues and I (IY) evaluated the one-year outcome of all forty clients who had started therapy in five outpatient groups.[45] Outcome was then correlated with variables measured in the first three months of therapy. Positive outcome in therapy significantly correlated with only two predictor variables: group cohesiveness and general popularity—that is, clients who, early in the course of therapy, were most attracted to the group (high cohesiveness), and who were rated as more popular by the other group members at the sixth and twelfth weeks, had a better therapy outcome at the fiftieth week.[46] The popularity finding, which in this study correlated even more positively with outcome than cohesiveness did, is, as we shall discuss shortly, relevant to group cohesiveness and sheds light on the mechanism through which group cohesiveness mediates change.
- The same findings emerge in more structured groups. A study of fifty-one clients who attended ten sessions of behavioral group therapy demonstrated that "attraction to the group" correlated significantly with improved self-esteem and inversely correlated with the group dropout rate.[47]
- The quality of intermember relationships has also been well documented as an essential ingredient in experiential groups intended to teach participants about group dynamics, such as T-groups and process groups. A rigorously designed study found a significant relationship between the quality of intermember relationships and outcome in a T-group of eleven subjects who met twice a week for a total of sixty-four hours.[48] The members who entered into the most two-person mutually therapeutic relationships showed the most improvement during the course of the group.[49] Furthermore, the perceived relationship with the group leader was unrelated to the extent of change.

- My colleagues Morton Lieberman and Matthew Miles and I (IY) conducted a study of 210 subjects in eighteen encounter groups encompassing ten ideological schools that reflected the field at the time. (These were gestalt, transactional analysis, T-groups, Synanon, personal growth, Esalen, psychoanalytic, marathon, psychodrama, and encounter tape, a group led by tape-recorded instructions.)[50] Cohesiveness was assessed in several ways and reliably correlated with outcome.[51] The results indicated that attraction to the group is indeed a powerful determinant of outcome. All methods of determining cohesiveness demonstrated a positive correlation between cohesiveness and outcome. A member who experienced little sense of belonging or attraction to the group, even measured early in the course of the sessions, was unlikely to benefit from the group and, in fact, was likely to have a negative outcome. Furthermore, the groups with the higher overall levels of cohesiveness had a significantly better total outcome than groups with low cohesiveness.
- Another large study (N = 393) of experiential training groups yielded a strong relationship between affiliativeness (a construct that overlaps considerably with cohesion) and outcome.[52]
- Roy MacKenzie and Volker Tschuschke, studying twenty clients in long-term inpatient groups, differentiated members' personal "emotional relatedness to the group" from their appraisal of "group work" as a whole. The individual's personal sense of belonging correlated with future outcome, whereas the total group work scales did not.[53]
- Simon Budman and his colleagues developed a scale to measure cohesiveness via observations by trained raters of videotaped group sessions. They studied fifteen therapy groups and found greater reductions in psychiatric symptoms

and improvement in self-esteem in the most cohesively functioning groups. Group cohesion that was evident early—within the first thirty minutes of each session—predicted better outcomes.[54]

- A number of other studies have examined the role of the relationship between the client and the group leader in group therapy. Elsa Marziali and colleagues examined group cohesion and the client–group leader relationship in a highly structured thirty-session manualized interpersonal therapy group of clients with borderline personality disorder.[55] Cohesion and member-leader relationship correlated strongly, supporting Budman's findings, and both positively correlated with outcome.[56] However, the member–group leader relationship measure was a more powerful predictor of outcome. The relationship between client and therapist may be particularly important for clients who are vulnerable or who have volatile interpersonal relationships, because for them the therapist serves an important containing and supportive function.
- Anthony Joyce and colleagues explored the experience of clients treated in brief group therapy for complicated loss and bereavement. They reported that the client's strength of alliance to the therapist predicted a better outcome and showed a higher correlation with outcome than did group cohesion. This underscores the importance of looking at the individual client's experience and not only the group's cohesiveness, particularly in brief groups where an early positive start is essential.[57]
- Group therapy outcomes for social phobia were significantly better at both the end of treatment and at follow-up when clients reported higher engagement scores on the Group Climate Questionnaire developed by K. R. MacKenzie. Higher

avoidance scores, in contrast, correlated with greater client distress. High conflict was also problematic and may be a sign of group trouble, rather than a necessary phase of group development that group leaders should casually accept.[58]

- In a study of a short-term, structured, cognitive-behavioral therapy group for social phobia, the relationship with the therapist deepened over the twelve weeks of treatment and correlated positively with outcome, but group cohesion was static and not related to outcome.[59] In this study the group was a setting for therapy and not an agent of therapy. Intermember bonds were not cultivated by the study therapists, leading the authors to conclude that in highly structured groups, what might matter most is the client-therapist collaboration around the therapy tasks.[60]
- A study of thirty-four clients with depression and social isolation treated in a twelve-session interactional problem-solving group reported that clients who described experiencing warmth and positive regard from the group leader had better therapy outcomes. The opposite also held true. Negative therapy outcomes were associated with negative client–group leader relationships. This correlative study does not address cause and effect, however: Are clients better liked by their therapist because they do well in therapy, or does being well liked promote more effort and a greater sense of well-being?[61]
- A study on inpatient group therapy for the treatment of PTSD in active military personnel demonstrated the significant contribution of group cohesion in effective outcomes. Group cohesion contributed a remarkable 50 percent of the variance to the outcome, and each soldier's capacity and willingness to work with others in the group was a significant and unique predictor of outcome.[62]
- Evaluation of outcomes in brief intensive American Group

Psychotherapy Association Institute training groups were influenced by higher levels of engagement.[63] Positive outcomes may well be mediated by group engagement that fosters more interpersonal communication and self-disclosure.[64]

- Similar findings were reported in intensive experiential group training for 170 psychiatry residents who ranked group cohesion very highly in promoting openness to self-disclosure and feedback.[65]
- There is good evidence that individual attachment style also influences the relationship between cohesion and outcome. Individuals with anxious attachment who seek security benefit from group cohesion; but group members with a dismissive and avoidant attachment style may reject the strong pull to join and may need to be supported to work in the group at a pace tailored to them.[66]
- A study of 327 group members treated in intensive inpatient programs that centered on psychodynamic groups meeting twice weekly for twelve weeks showed a significant correlation between group cohesion and outcome but with some variations. Interpersonal style also impacts the cohesion-outcome relationship. Group cohesion was of particular importance for members who had a cold and controlling interpersonal style and were harder to engage than more submissive group members.[67]
- Fit matters! A large body of research underscores this. The more the individual's sense of engagement with the group aligns with the engagement level of the group as a whole, the stronger the relationship between engagement and outcome.[68] Fit is also influenced by cultural norms. Western attitudes toward authority, emotional expression, self-disclosure, and individualism may contrast with other traditions.[69]

- Studies also show that group leaders tend to overestimate the degree of cohesion in their groups and their clients' attraction and connection to their groups. Providing group leaders with ongoing feedback using measures such as the Group Questionnaire by the Burlingame team or the Group Session Rating Scale by Barry Duncan and Scott Miller alerts the therapist to members whose cohesion is failing or lagging. The alert provides an opportunity for early repair and is associated with improved outcomes.[70]

Cohesion-Outcome Relationship: Summary

Let's summarize the key findings from the research literature about the cohesion-outcome relationship. Cohesion contributes significantly and consistently to outcome. This is true for both brief and longer-term (more than twenty sessions) group therapies and consistent across settings, client age, gender, and nature of client concerns. The cohesion-outcome relationship is most evident in groups of nine or fewer members and does not hold up as well with larger groups. The correlation is most prominent in groups that are interactional, but it is still relevant even in highly structured groups. The client's attachment and interpersonal style make a difference in the cohesion-outcome relationship. Attending to culture, gender, sexual orientation, and ethnicity enhances the therapist's capacity to build relationships within the group.

Group members deeply value the acceptance and support they receive from their therapy group. Therapy outcome is positively correlated with attraction to the group and with group popularity, a variable closely related to group support and acceptance. Individuals with positive outcomes have had more mutually satisfying relationships with other members. Emotional connectedness, self-disclosure, and the experience of group effectiveness all contribute to group cohesiveness. The presence of cohesion in the early sessions of the group correlates with positive outcomes. It is critical that leaders quickly address problems with cohesion and be alert to

each member's personal experience of the group. Group leaders tend to overestimate the strength of connection and engagement within their groups. Cohesion requires the therapist's diligent attention to the dynamic interplay of member and group, and *regular* feedback about the state of the group and its members can help focus this attention, alerting the group leader to threats to group cohesion in the interest of timely therapist responsiveness.

For some clients and some groups (especially highly structured groups), the relationship with the leader may be the essential factor. A strong therapeutic relationship may not guarantee a positive outcome, but a poor therapeutic relationship will certainly not result in an effective treatment.

A host of studies demonstrate that group cohesiveness results in better group attendance, greater member participation, greater influenceability of members, and many other effects. We will consider these findings in detail shortly, as we discuss the mechanism by which cohesiveness fosters therapeutic change.

THE FOLLOWING CLINICAL EXAMPLE ILLUSTRATES THE IMPORTANCE of attending to members' different reactions to the experience of group cohesion:

> **Karen, a thirty-five-year-old college professor, sought group ther**apy to improve her interpersonal interactions with her students. Though she was a highly effective teacher and always received outstanding teaching evaluations, she resented her students, whom she experienced as intrusive and cloying. She said, "After my class I can scarcely wait to get back to my office and I waste no time putting the 'Do Not Disturb' sign on my door."
>
> Her personal life was not dissimilar: she sought solitude. Though she had once been married for five years, she and her husband had never consummated their marriage. Karen resisted intimate engagement at every point. Relationships threatened her: she felt they diminished her autonomy and personhood.
>
> Upon beginning the group, she made it clear she had no interest in getting closer to others: instead her goal was to learn how to manage and tolerate people. She had little doubt that her disinterest in forming more intimate attachments emanated from her lifelong relationship with

her intensely controlling and devaluing mother, who had imposed her will on every decision Karen had made in her life. It was impossible to be close to her mother, but also impossible, Karen felt, to resist her mother's relentless demands and attempts to control her.

Karen had been in the group for several months when two new members joined the group. One of the new members, Joe, a middle-aged man, was eager to reduce his chronic feelings of isolation and alienation and immediately tried to draw close to the group members. Shortly after beginning the group he asked Karen about her personal life. Was she married? In a relationship?

Karen snapped at him, "Do not ever ask me personal questions about myself. I do not want to talk about that, least of all with someone I do not know."

Taken aback, Joe looked at me (ML) imploringly. He said, "I thought we were here to get to know one another and to develop more openness. I'm confused. How does this group operate?"

Another member, who had known Karen since the group started, spoke to her directly, saying, "I know you're not comfortable sharing much of yourself, but Joe is just trying to get to know all of us here. If you are so committed to not sharing or talking with us, how do you expect to make use of the group?"

I was very aware of how Karen's defensiveness and rigidity would confound the new member and undermine the establishment of vital group norms, such as self-disclosure and feedback. I grew even more concerned when Karen responded to the question by saying, in part, "I am not going to be one of Molyn's trained monkeys, responding to every overture with complete submission to the request."

The "trained monkey" comment felt like a further attack on group cohesion, on group norms, and on me. Angry and protective of my group, I was sorely tempted to respond, "Yes, Karen, why are you here if you refuse to engage?" Fortunately, I caught myself. That comment would have been toxic and might well have driven Karen from the group.

Instead, I said, "I am perplexed by the intensity of your reaction, Karen. It makes me wonder what is going on for you right now in the group. There is an awful lot of heat here."

She responded, "I thought I made it clear in my first session that I was here to learn to tolerate others, not to be grilled by them."

"This takes me back to our first talk, Karen, when you described your relationship with your mother who so much imposed her will on you. You made it clear to us at your first meeting that you were very

sensitive to pressure and you would never again submit to anyone's will. It seems to me that the group has respected that and never inquired into painful issues in your life but accepted you and patiently waited for you to take the lead in sharing what you felt ready to say. Am I right?"

"Yes, until today. Until Joe. I'm not in the mood to be grilled about anything by anyone here."

I turned to the new member and said, "Joe, what's this like for you?"

"Oh," said Joe, turning to Karen. "I'm new to this. I am so sorry. I was sweating and feeling very uncomfortable and just trying to be a member here. I am so clumsy: the last thing I wanted to do was make you feel bad."

Karen looked away, dabbed her eyes, and gestured that it was time to change the subject.

This was a memorable session for Karen, and later in the course of therapy she referred to it as a vital learning experience. She realized no one wanted her to be a trained monkey and that she could be in the group *right now*, participate at her own pace, and address her anxiety about having to expose herself instantly to new members. **<<**

An interesting postscript: Karen stayed in the group for three years as an engaged and valued group member. Several years later, I received a referral to see her current husband. They had two children, and she had strongly suggested he pursue group therapy to address feelings of depression and social avoidance. She had been pressing him for more emotional engagement.

MECHANISM OF ACTION

How do group acceptance and trust help troubled individuals? Surely there must be more to it than simple support or acceptance; therapists learn early in their careers that love is not enough. Although the quality of the therapist-client relationship is crucial, the therapist must do more than simply relate warmly and honestly to the client.[71] The therapeutic relationship creates favorable conditions for setting other processes in motion. What other processes? And how are they important?

Carl Rogers's deep insights into the therapeutic relationship and the centrality of therapist empathy, genuineness, and unconditional positive regard are as relevant today as they were nearly seventy years ago; indeed, these concepts have been heavily reinforced by contemporary research. Let us start our investigation by examining his views about the mode of action of the therapeutic relationship in individual therapy.[72] In his most systematic description of the process of therapy, Rogers stated that when the conditions of an ideal therapist-client relationship exist, the following characteristic process is set into motion:

1. The client is increasingly free in expressing his feelings.
2. He begins to test reality and to become more discriminatory in his feelings and perceptions of his environment, his self, other persons, and his experiences.
3. He increasingly becomes aware of the incongruity between his experiences and his concept of self.
4. He also becomes aware of feelings that have been previously denied or distorted in awareness.
5. His concept of self, which now includes previously distorted or denied aspects, becomes more congruent with his experience.
6. He becomes increasingly able to experience, without threat,

the therapist's unconditional positive regard and to feel an unconditional positive self-regard.

7. He increasingly experiences himself as the focus of evaluation of the nature and worth of an object or experience.
8. He reacts to experience less in terms of his perception of others' evaluation of him and more in terms of its effectiveness in enhancing his own development.[73]

A 2017 research review confirmed these principles by examining the experiential depth in therapy reported by four hundred clients in a range of psychotherapies who completed the Client Experiencing Scale, a seven-point scale based largely on Carl Rogers's work. The study determined that there was a significant correlation between positive outcome and client depth of experiencing.[74] Experiential depth is required to gain meaning, and it is most likely to arise within a strong therapeutic relationship.[75] The therapist does not have to inspirit clients with the wish for growth (as if we could!). Instead, our task is to remove the obstacles that block the process of growth. And one way we do this is by creating an ideal therapeutic atmosphere in the therapy group. A strong bond between members not only disconfirms the client's feelings of unworthiness but also encourages client self-disclosure and interpersonal risk-taking. These changes help deactivate old, negative beliefs about the self.[76]

There is experimental evidence that good rapport—a strong alliance, therapist empathy, and alignment about expectations—in individual therapy, and its equivalent, cohesiveness, in group therapy, encourage client self-reflection. Although it is the client's experience that matters most, it is the therapist's actions and behaviors that most contribute to the formation of the alliance.[77] High cohesion is closely related to high degrees of intimacy, risk-taking, empathic listening, and feedback. The group members' recognition that their group is working well at the task of interpersonal learning produces greater cohesion in a positive and self-reinforcing loop.[78] Success with the group task strengthens the

emotional bonds within the group.

Perhaps cohesion is vital because many of our clients have not had the benefit of ongoing solid peer acceptance either in childhood or in their adult lives. One new member of a group, Ann, disclosed that she dreaded her job as a teacher; though she loved the students, her relationships with colleagues were consistently tense and hostile. Individual therapy had helped little with that, but what emerged quickly in the group was her intense need to always be right, often in ways that others experienced as demeaning and self-righteous. Group members readily saw both the problematic interpersonal behavior and the resultant pain she experienced. She received clear and direct feedback about her impact on others that she was able to hear and use quickly within the group as well as outside of it. Group members find validation by others to be a new and vital experience. Furthermore, acceptance and understanding among members may carry greater power and meaning than acceptance by a therapist. Other group members, after all, do not have to care or understand. They're not paid for it; it's not their "job."[79]

We can also think of the power of group cohesion through the lens of current research on attachment and interpersonal neurobiology. A cohesive group offers its members a secure base for attachment that promotes emotional safety and the willingness to explore and take risks. The members have a safe haven that welcomes them.[80] A cohesive group lowers members' fear of rejection, shame, and rebuke. This promotes more interaction and tolerance for the emotional arousal required for effective therapy.[81] Our connectedness plays a key role in helping us manage emotional distress. Humans emotionally regulate one another through their presence, validation, and empathic responsiveness.[82]

The intimacy developed in a group may be seen as a counterforce in a technologically driven culture that, in all ways—socially, professionally, recreationally—inexorably dehumanizes our relationships. It substitutes a social media preoccupation and virtual relationships for real person-to-person contact. Witness the soaring

rates of depression and social isolation in the generation of youth growing up with their ever-present smartphones, which many prefer to actual human contact.[83] Who has not observed a restaurant scenario in which each person is engaged with a device rather than with other people? The therapy group is a rare device-free zone in which direct human contact is expected and reinforced. (But we must also recognize the value of these devices in facilitating group therapy that meets by online video-teleconference, as we discuss in Chapter 14.)

In a world in which traditional boundaries and structures that maintain relationships are increasingly permeable and transient, there is a greater need than ever for group belonging and group identity. Our contemporary world offers the illusion of connection that too often jeopardizes real connection.

For group members, acceptance of self and acceptance of other members are interdependent: not only is self-acceptance basically dependent on acceptance by others, but acceptance of others is fully possible only after one can accept oneself. This principle is supported by both clinical research and wisdom.[84] Members of a therapy group may at first experience considerable self-contempt and contempt for others. A manifestation of this feeling may be seen in the client's initial refusal to join "a group of nuts," or reluctance to become closely involved with a group of pained individuals for fear of being sucked into a maelstrom of misery. A particularly evocative response to the prospect of group therapy was given by a man in his eighties when he was invited to join a group for depressed elderly men: it was useless, he said, to waste time watering a bunch of dead trees—his metaphor for the other men in his nursing home.[85]

In our experience, most individuals seeking assistance from a mental health professional have in common two paramount difficulties: (1) establishing and maintaining meaningful interpersonal relationships, and (2) maintaining a sense of personal worth (self-esteem). It is hard to discuss these two interdependent areas as separate entities, but since in the preceding chapter we dwelled more heavily on the establishment of interpersonal relationships, we

shall now turn briefly to self-esteem.

Self-esteem refers to an individual's evaluation of what he or she is really worth and is indissolubly linked to that person's experiences in prior intimate relationships. Recall Harry Stack Sullivan's statement: "The self may be said to be made up of reflected appraisals."[86] In other words, during early development, one's perceptions of the attitudes of others toward oneself come to determine how one regards and values oneself. The individual internalizes many of these perceptions, and if they are consistent and congruent, relies on these internalized evaluations for some stable measure of self-worth.

But, in addition to this internal reservoir of self-worth, people are, to a greater or lesser degree, always influenced by the evaluations of others—especially the evaluation provided by their fellow group members. Social psychology research supports this clinical understanding: the groups and relationships in which we take part become incorporated into the self.[87] One's attachment to a group is multidimensional. It is shaped both by the member's degree of confidence in his attractiveness to the group—am I a desirable member?—and the member's relative aspiration for affiliation—do I want to belong? Our identification with our groups plays a central role in our sense of belonging and identity.[88]

The influence of the group's evaluation of an individual depends on several factors: how important the person feels the group to be; the frequency and specificity of the group's communications to the person about that public esteem; and the salience to the person of the traits in question. In other words, the *more the group matters to the person*, and the more that person subscribes to the group values, the more he or she will be inclined to value the group judgment.[89]

Let us suppose that the group's evaluation of the individual is less than the individual's self-evaluation. How does the individual resolve that discrepancy? One recourse is to deny or distort the group's evaluation. In a therapy group, this is not a positive development, for a vicious cycle is generated: the group evaluates the member poorly

because he or she fails to participate in the group task (that is, active exploration of one's self and one's relationships with others). Any increase in defensiveness only further lowers the group's esteem of that particular member. A common method used by members to resolve such a discrepancy is to devalue the group—emphasizing, for example, that the group is artificial or composed of disturbed individuals, and then comparing it unfavorably to some anchor group (for example, a social or occupational group) whose evaluation of the member is different. Members who take this path usually drop out of the group.

Toward the end of a successful course of group therapy, one group member reviewed her early recollections of the group as follows: "For the longest time I told myself you were all nuts and your feedback to me about my defensiveness and inaccessibility was ridiculous. I wanted to quit—I've done that before many times, but I felt enough of a connection here to decide to stay. Once I made that choice, I started to tell myself that you cannot all be wrong about me. That was the turning point in my therapy." This result is more likely if the individual is highly attracted to the group and if the public esteem is not too much lower than the self-esteem.

But is the use of group pressure to change individual behavior or attitudes a form of social engineering? Is it not mechanical? Indeed, group therapy does employ behavioral principles; psychotherapy is, in all its variants, basically a form of learning. Even the most nondirective therapists use, at an unconscious level, operant conditioning techniques: they signal desirable conduct or attitudes to clients, whether explicitly or subtly, and in so doing create greater awareness of the relationship between interpersonal cause and effect.[90]

Behavioral and attitudinal change, regardless of origin, begets other changes. When a group evaluates a member more positively, the member feels more self-satisfied in the group and with the group itself, and the adaptive spiral described in the previous chapter is initiated. When a group's evaluation of a member is higher than the member's self-evaluation (a common experience), the member is

placed in a state of dissonance and will attempt to resolve the discrepancy. What can a member in that position do? Perhaps the person will attempt to lower the public esteem by revealing personal inadequacies. However, in therapy groups, this behavior has the paradoxical effect of raising public esteem; disclosure of inadequacies is a valued group norm and enhances acceptance by the group. Another possible scenario, desirable therapeutically, occurs when group members reexamine and alter their low level of self-esteem. An illustrative clinical vignette will flesh out this formulation:

> **Maryetta, a thirty-four-year-old housewife with an emotionally** impoverished background, sought therapy because of anxiety and guilt stemming from a series of extramarital affairs. Her self-esteem was exceedingly low; nothing escaped her self-excoriation: her physical appearance, her intelligence, her speech, her lack of imagination both as a mother and a wife. Although she received solace from her religious affiliation, it was a mixed blessing, because she felt too unworthy to socialize with the church folks in her community. She married a man she considered unappealing but nonetheless a good man—certainly good enough for her. Only during sex, particularly with several men at once, did she seem to come alive—to feel attractive, desirable, and able to give something of herself that seemed of value to others. However, this behavior clashed with her religious convictions and resulted in considerable anxiety and further self-derogation.

Viewing the group as a social microcosm, the therapist soon noted characteristic trends in Maryetta's group behavior. She spoke often of the guilt issuing from her sexual behavior, and for many hours the group struggled with all the titillating ramifications of her predicament. At all other times in the group, however, she disengaged and offered nothing. She related to the group as she did to her social environment. She could belong to it, but she could not really relate to the other people: the only thing of real interest she felt she could offer was her genitals.

Over time in the group she began to respond and to question others and to offer warmth, support, and feedback. She began disclosing other, nonsexual, aspects of herself and soon found herself increasingly valued by the other members. She gradually disconfirmed her belief that she had little of value to offer and soon she was forced to entertain a more realistic and positive view of herself. Gradually, an adaptive

spiral ensued: she began to establish meaningful nonsexual relationships both in and out of the group, and these, in turn, further enhanced her self-esteem. **<<**

Self-Esteem, Public Esteem, and Therapeutic Change: Evidence

Group therapy research has not specifically investigated the relationship between public esteem and shifts in self-esteem. However, an interesting finding from a study of experiential groups was that members' self-esteem decreased when public esteem decreased.[91] (Public esteem is measured by sociometric data, which involves asking members to rank-order one another on several variables.) Researchers also discovered that the more a group member underestimated his or her public esteem, the more acceptable that member was to the other members. In other words, the ability to face one's deficiencies, or even to judge oneself a little harshly, increases one's public esteem. Humility, within limits, is far more adaptive than arrogance.

It is also interesting to consider data on group popularity, a variable closely related to public esteem. The group members considered most popular by other members after six and twelve weeks of therapy had significantly better therapy outcomes than the other members at the end of one year.[92] Thus, it seems that clients who have high public esteem early in the course of a group are destined to have a better therapy outcome.

What factors foster popularity in therapy groups? Two variables, which did not themselves correlate with outcome, correlated significantly with popularity:

1. Previous self-disclosure.[93]
2. Interpersonal compatibility, which occurs when there are (perhaps fortuitously) individuals whose interpersonal needs happen to blend well with those of other group members.[94]

The most unpopular group members were rigid, moralistic,

nonintrospective, and least involved in the group task. Some were rigidly at cross purposes with the group, attacking the group and isolating themselves. Some schizoid members were frightened of the group process and remained peripheral. A study of sixty-six group therapy members concluded, unsurprisingly, that less popular members were more inclined to drop out of the group.[95]

Social psychology research adds to our understanding of popularity and status in the group. The personality dimension of extraversion (assessed by a questionnaire, the NEO-PI[96]) predicts popularity. Popularity and influence in the group accrue to members by virtue of their active participation, self-disclosure, self-exploration, emotional expression, nondefensiveness, leadership, interest in others, and support of the group. Members who adhere most closely to group norms attain popularity and are more apt to change in therapy.[97]

It is important to note that the individual who adheres to the group norms not only is rewarded by increased public esteem within the group but also uses those same social skills to deal more effectively with interpersonal problems outside the group. Thus, increased popularity in the group acts therapeutically in two ways: by augmenting self-esteem and by reinforcing adaptive social skills. When an individual engages this sequence and acknowledges appreciation to the group for its help, it has an even more profound impact, as it elevates the esteem of the group as well. The rich get richer. The challenge in group therapy is helping the poor get richer as well.

Group Cohesiveness and Group Attendance

Continuation in the group is obviously a necessary prerequisite for successful treatment. Several studies indicate that clients who terminate early in the course of group therapy receive little benefit.[98] In one study, over fifty clients who dropped out of long-term therapy groups within the first twelve meetings reported that they did so because of some stress encountered in the group. They were not satisfied with their therapy experience and they did not improve;

indeed, many of these clients felt worse.[99] However, those clients who remain in the group for at least several months have a high likelihood (85 percent in one study) of profiting from therapy.[100]

The relationship between cohesiveness and maintenance of membership has implications for the total group as well. Not only do the least cohesive members terminate membership and fail to benefit from therapy, but noncohesive groups with high member turnover prove to be less therapeutic for the remaining members as well. Clients who drop out challenge the group's sense of worth and effectiveness and may generate a contagion phenomenon that can scuttle the group endeavor.

Stability of membership is a necessary condition for effective short- and long-term interactional group therapy. Although most therapy groups go through an early phase of instability, during which some members drop out and replacements are added, the groups thereafter settle into a long, stable phase in which much of the solid work of therapy occurs. Some groups seem to enter this phase of stability early, and other groups never achieve it. In a group therapy follow-up study, clients often spontaneously underscored the importance of membership stability.[101]

In Chapter 15, we will discuss the issue of cohesiveness in groups led in clinical settings that preclude a stable long-term membership. For example, drop-in crisis groups or groups on an acute inpatient ward rarely have consistent membership even for two consecutive meetings. In these clinical situations, therapists must radically alter their perspectives on the life development of the group. We believe, for example, that we should consider the appropriate life span for the acute inpatient group to be a single session. Therapists must take significant responsibility for group cohesion by structuring and leading the group in a manner that offers help to as many members as possible during each session. Brief therapy groups pay a particularly high price for poor attendance, and therapists must make special efforts to increase cohesiveness early in the life of the group using specific strategies—including strong pregroup preparation, homogeneous composition, and structured

interventions.

Group Cohesiveness and the Expression of Hostility

It would be a mistake to equate cohesiveness with comfort. Although cohesive groups may show greater acceptance, intimacy, and understanding, there is evidence *that they also permit greater development and expression of hostility and conflict*. Cohesive groups have norms (that is, unwritten rules of behavior accepted by group members) that encourage open expression of disagreement or conflict alongside support. In fact, unless hostility can be openly expressed, persistent covert hostile attitudes may hamper the development of cohesiveness and effective interpersonal learning. Unexpressed hostility simply smolders within, only to seep out in many indirect ways. It is not easy to continue communicating honestly with someone you dislike or even hate. The temptation to avoid the other and to break off communication is very great; yet when channels of communication are closed, so, too, are any hopes for conflict resolution and for personal growth.[102] Group dynamics play an underappreciated role in societal conflict and reconciliation.[ii]

Above all, communication must not be ruptured, and the adversaries must continue to work together in a meaningful way, take responsibility for their statements, and be willing to go beyond name-calling. This is, of course, a major difference between therapy groups and social groups, in which conflicts often result in the permanent rupture of relationships. As we explored in Chapter 2, clients' descriptions of critical incidents in therapy often involve an episode in which they expressed strong negative affect. In each instance, however, the client was able to weather the storm and to continue relating (often in a more gratifying manner) to the other member. Underlying these events is the condition of cohesiveness. The group and the members must mean enough to each other to be willing to bear the discomfort of working through a conflict.

Several studies demonstrate that cohesiveness is positively correlated with risk-taking and intensive interaction.[103] Cohesiveness is not synonymous with love or with a continuous

stream of supportive, positive statements; rather, cohesive groups are able to embrace conflict and to derive constructive benefit from it. Obviously, in times of conflict, scores on cohesiveness scales that emphasize warmth, comfort, and support will temporarily gyrate; thus, many researchers have reservations about viewing cohesiveness as a precise, stable, measurable, unidimensional variable and consider it instead as multidimensional.[104] Measuring cohesion regularly, as noted earlier, can therefore be of great value to group leaders, alerting them to threats to cohesion or member alliance strains that might otherwise escape the therapist's awareness.[105]

Keep in mind that it is the early engagement that later makes possible such successful working-through. The premature expression of excess hostility before group cohesion has been established is a leading cause of group fragmentation. It is important for clients to realize that their anger is not lethal. Both they and others can and do survive an expression of their impatience, irritability, and even outright rage. For some clients, it is also important to have the experience of weathering an attack. In the process, they may become better acquainted with the reasons for their feelings and beliefs and learn to withstand pressure from others.[106]

Conflict may also enhance self-disclosure, as each opponent tends to reveal more and more to clarify his or her position. If members are able to go beyond the mere statement of position, they may begin to understand the other's experiential world, past and present, and begin to grasp that the other's point of view may be as appropriate for that person as their own is for themselves. The working-through of extreme dislike or hatred of another person is an experience of great therapeutic power. The clinical situation described below demonstrates many of these points. (Another example may be found in my [IY] novel *The Schopenhauer Cure* and the video based on it.)[107]

> Two members of a therapy group—Susan, a forty-six-year-old very

proper school principal, and Jean, a twenty-one-year-old high school dropout—became locked into a vicious struggle. Susan despised Jean because of her libertine lifestyle and what she imagined to be her sloth and promiscuity. Jean was enraged by Susan's judgmental attitude, her sanctimoniousness, her dour sexlessness, and her closed posture to the world. Fortunately, both women were deeply committed members of the group. (Fortuitous circumstances played a part here. Jean had been a core member of the group for a year and then married and went abroad for three months. It was during Jean's absence that Susan entered the group and became a very involved member.)

Both had had considerable past difficulty in tolerating and expressing anger. Over a four-month period, they interacted heavily, at times in pitched battles. For example, Susan erupted indignantly when she found out that Jean was obtaining food stamps illegally; and Jean, learning of Susan's virginity, ventured the opinion that she was a curiosity, a museum piece, a mid-Victorian relic.

Much good group work was done because Jean and Susan, despite their conflict, never broke off communication. They learned a great deal about each other and eventually each realized the cruelty of their judgments of the other. Finally, they could both understand how much each meant to the other on both a personal and a symbolic level. Jean desperately wanted Susan's approval; Susan deeply envied Jean for the freedom she had never permitted herself. In the working-through process, both fully experienced their rage, and both encountered and then accepted previously unknown parts of themselves. Ultimately, they developed an empathic understanding and then an acceptance of each other. Neither could possibly have tolerated the extreme discomfort of the conflict were it not for the strong cohesion that, despite the pain, bound them to the group. **<<**

Not only is group cohesiveness positively correlated with greater expression of hostility among group members, but there is also evidence that it is positively correlated with greater expression of hostility toward the leader.[108] Regardless of the personal style or skill of group leaders, the therapy group will nonetheless come, often within the first dozen meetings, to experience some degree of resentment toward them (see Chapter 11 for a full discussion of this issue). Leaders do not fulfill members' fantasized expectations, and, in the view of many members, do not care enough, do not direct

enough, and do not offer immediate relief. If the members suppress these feelings of disappointment or anger, several harmful consequences may ensue. They may attack a convenient scapegoat —another member or some institution, like “psychiatry” or “therapy.” They may experience a smoldering anger within themselves or within the group as a whole. Such free-floating irritation may indicate that aggression is being displaced away from its more rightful source —often the therapist.[109] Leaders who challenge rather than collude with group scapegoating not only safeguard against an unfair attack but also demonstrate their commitment to authenticity and responsibility in relationships.

The group that is able to express negative feelings toward the therapist is almost invariably strengthened by the experience. It provides an important learning experience—namely, that one may express hostility directly without some ensuing irreparable calamity. It is far preferable that the therapist, the true object of the anger, be confronted than for the anger to be displaced onto some other member in the group. Furthermore, the therapist, let us hope, is far better able than a scapegoated member to withstand confrontation. The entire process is self-reinforcing: a concerted attack on the leader who handles it nondefensively serves to increase cohesiveness still further.

A cautionary note about cohesion: misguided ideas about cohesion may interfere with the group task.[110] Social psychologist Irving Janis coined the term “groupthink” to describe groups in which members reject critical thinking and feel compelled to share the same beliefs and emotions.[111] Some groups are so invested in “supporting” their members that the members abandon genuine feedback and avoid all conflict. Effective group leaders need to endorse critical and analytic thought by the group members; it is always wise to respect the perspective of the dissonant voice.[112] Authoritarian leaders discourage such thought, and their groups are less reflective, driven to premature certainty, and close down exploration prematurely.[113]

Group Cohesiveness and Other Therapy-Relevant Variables

Research from both therapy and laboratory groups has demonstrated that group cohesiveness has a plethora of important consequences that have obvious relevance to the group therapeutic process.[114] It has been shown, for example, that the members of a cohesive group, in contrast to the members of a noncohesive group, will:

1. Try harder to influence other group members[115]
2. Be more open to influence by the other members[116]
3. Be more willing to listen to others[117] and more accepting of others[118]
4. Experience greater security and relief from tension in the group[119]
5. Participate more readily in meetings[120]
6. Self-disclose more[121]
7. Protect the group norms and exert more pressure on individuals deviating from the norms[122]
8. Be less susceptible to disruption as a group when a member terminates membership[123]
9. Experience greater ownership of the group therapy enterprise[124]

SUMMARY

By definition, cohesiveness refers to the attraction that members have for their group and for the other members. It is experienced at interpersonal, intrapersonal, and intragroup levels. The members of a cohesive group are accepting of one another, supportive, and inclined to form meaningful relationships in the group. Cohesiveness is a significant factor in successful group therapy outcome. In conditions of acceptance and understanding, members will be more inclined to express and explore themselves, to become aware of and integrate hitherto unacceptable aspects of self, and to relate more deeply to others. Self-esteem is greatly influenced by the client's role in a cohesive group. The social behavior required for members to be esteemed by the group is socially adaptive to the individual out of the group.

In addition, highly cohesive groups are more stable groups, with better attendance and less turnover. This chapter presented evidence that such stability is vital to successful therapy, as early termination precludes benefit for the involved client and impedes the progress of the rest of the group as well. Cohesiveness favors self-disclosure, risk-taking, and the constructive expression of conflict in the group—phenomena that facilitate successful therapy. We will have much more to say in subsequent chapters about the therapist's tasks and techniques in building group cohesion.

Footnotes

i The GQ is a thirty-item self-report that brings together the dimensions of group cohesion, group climate, the therapeutic alliance, and empathy into three scales—Positive Bond, Positive Work, and Negative Relationship—that together capture the entire group relationship experience of the group members. The GQ synthesizes two key dimensions of the group: relationship quality and relationship structure. The relationship quality aspect is the positive or negative component, and the relationship structure reflects whether the relationship at issue is member-member, member-leader, or member-group. The Positive Bond Scale captures member-member cohesion, member-leader alliance, and member-group climate. The Positive Work Scale captures member-member and member-leader tasks and goals. The Negative Relationship Scale captures member-member empathic failures, member-leader alliance ruptures, and member-group conflict. This comprehensive measure may well address previous problems with replicability of the measurement of cohesion and group relationships. See J. Krogel et al., "The Group Questionnaire: A Clinical and Empirically Derived Measure of Group Relationship," *Psychotherapy Research* 23 (2013): 344–54. G. Burlingame, K. Whitcomb, S. Woodland, J. Olsen, M. Beecher, and R. Gleave, "The Effects of Relationship and Progress Feedback in Group Psychotherapy Using the GQ and OQ-45: A Randomized Clinical Trial," *Psychotherapy: Theory, Research and Practice* 55 (2018): 116–31.

ii This is as true on the mega-group level as on the interpersonal. We see echoes of it in our contemporary environment with the growth of tribalism and political nationalism. When this happens at the mega-group level, people often speak and listen only to those who espouse the same views and close themselves off to alternate ideas and perspectives. The drive to belong can create powerful feelings within groups. Members with a strong adherence to what is inside the group may experience strong pressure to exclude and devalue those outside the group. See G. Ofer, *A Bridge over Troubled Water: Conflicts and Reconciliation in Groups and Society* (London: Karnac Books, 2017).

- 4 -

The Therapeutic Factors

An Integration

THE THERAPEUTIC FACTORS DESCRIBED IN THE PREVIOUS chapters can help us formulate a set of effective strategies for the therapist. We know group therapy works, but we want to address more fully *how* it works. We want to look "under the hood" to the processes by which group therapy exerts its effects. While we believe that the compendium of therapeutic factors we have presented is comprehensive, it is not yet fully applicable clinically. That's because, for the sake of clarity, we have considered these therapeutic factors as separate entities, whereas in fact they are intricately interdependent. We believe that group leaders are more effective when they are able to harness the *interplay* of these therapeutic factors.

In this chapter we first consider how the therapeutic factors operate when they are viewed not separately but as part of a dynamic process. Next, we address the comparative potency of the therapeutic factors. Obviously, they are not all of equal value at all times. However, an absolute rank-ordering of therapeutic factors is not possible across all therapeutic groups. Many variables must be considered. The importance of various therapeutic factors depends on the type of group therapy practiced. Groups differ in their clinical populations, therapeutic goals, and treatment settings—for example, whether they are eating disorder groups, panic disorder groups, substance abuse groups, medical illness groups, online groups, outpatient groups, brief therapy groups, inpatient groups, partial

hospitalization groups, or peer support groups. College counseling centers may offer ten or twenty different group therapies with a variety of foci, including LGBTQ concerns, mood and anxiety management, eating disorders, substance abuse, sexual assault, dating, writing blocks, and social justice, anti-racism, and anti-oppression issues.[1] Each of these groups will likely emphasize different clusters of therapeutic factors; moreover, even a single group may change over time, with some therapeutic factors taking precedence at one stage of a group and others predominating at other stages.

Some factors arise naturally in groups and others emerge only through specific therapist intent and skill. Within the same group or even the same session, different clients benefit from different therapeutic factors. Group members will respond to different factors depending on their needs, their attachment models, their social skills, and their character structure.[2] Each group member's use of a therapeutic factor can impact how others in the group experience the group therapeutic factors: one member's self-disclosure can foster a feeling of universality in another member, or generate altruism in yet another. We must also recognize that we are discussing therapeutic factors from a Western perspective on psychotherapy: other cultures may prioritize the therapeutic factors differently.

Some factors are not always independent forces but instead create conditions for change. Instillation of hope, for example, may serve largely to prevent early discouragement and to keep members in the group until other forces for change come into play. Or consider cohesiveness: for some members, the sheer experience of being an accepted, valued member of a group may in itself be the major mechanism of change. Yet for others, cohesiveness is important, because it provides the conditions of the safety and support that allow them to express emotion, request feedback, and experiment with new interpersonal behavior.

Our efforts to evaluate and integrate the therapeutic factors will always remain, to some extent, conjectural. Over the past forty-five years there has been a groundswell of research on the therapeutic

factors; recent reviews have cited hundreds of studies.[3] In efforts to increase the clinical utility of the therapeutic factors, some researchers categorize which groupings of therapeutic factors may be of greatest importance to particular types of groups. All of these formulations are predicated upon the factors described in this chapter.[4] Yet there has been limited definitive research on the comparative value of the therapeutic factors and how they interrelate; indeed, we may never attain a high degree of certainty about these comparative values.

We do not speak from a position of investigative nihilism but instead argue that our data on therapeutic factors is so highly subjective that it challenges scientific methodology. No matter how we try to improve our data collection, we are still left trying to quantify and categorize subjective dimensions that do not fit easily into an objective categorical system.[5] Accepting these research limitations, we must also recognize that there is great value in understanding the client experience through the lens of these therapeutic elements. Consider the following not atypical clinical illustration, which demonstrates the difficulty of determining which factor is most therapeutic within a treatment experience:

> **A new member, Barbara, a thirty-six-year-old chronically de**pressed single woman, sobbed as she told the group that she had been laid off. Although her job had paid little and she disliked the work, she viewed the layoff as evidence that she was unacceptable and doomed to a miserable, unhappy life. Other group members offered support and reassurance, but with minimal apparent impact. Another member, Gail, who was fifty years old and herself no stranger to depression, urged Barbara to stop beating herself up, and added that it was only after a year of hard work in the group that she was able to attain a stable mood and to view negative events as disappointments rather than damning personal indictments.
>
> Barbara nodded and then told the group that she had desperately needed to talk and had arrived early for the meeting. However, seeing no one else in the group room, she assumed not only that the group had been canceled but also that the leader had neglected to notify her. She was angry and contemplating leaving when the group members

began to arrive. As she talked, she smiled knowingly, recognizing the depressive assumptions she continually made.

After a short reflection, she recalled a memory of her childhood—of her anxious mother, and her family's motto, "Disaster is always around the corner." She recalled that at age eight she'd had a diagnostic workup for tuberculosis because of a questionable skin test. Her mother had said, "Don't worry—I will visit you at the sanitarium." The diagnostic workup was negative, but her mother's echoing words still filled her with dread. Barbara then added, "I can't tell you what it's like for me today, in this group, to receive this kind of feedback and reassurance instead." **<<**

We can see in this brief illustration the presence of several therapeutic factors—universality, instillation of hope, self-understanding, imparting of information, family reenactment (corrective recapitulation of the primary family group), interpersonal learning, and catharsis. Which therapeutic factor is primary? How can we determine that with any certainty?

The study of insight in group therapy illustrates this complexity. Four studies attempted to quantify and evaluate insight by comparing insight groups with such groups as assertiveness training groups or interactional here-and-now groups (as though such interactional groups offered no insight).[6] The researchers measured insight by counting the therapist's insight-providing comments. Such a design, however, fails to take into account crucial aspects of the *experience* of insight: for example, how accurate was the therapist's comment? How well timed? The client's state of readiness to accept it? The nature of the client's relationship with the therapist? (If adversarial, the client is apt to reject any interpretation; if dependent, the client may ingest all interpretations without discrimination.) Insight is a deeply subjective experience that *cannot be easily rated by objective measures* (one accurate, well-timed interpretation is worth a score of interpretations that fail to hit home). Keep in mind that empathic and accurate interpretations, delivered without blaming or shaming, do contribute to better and more durable clinical psychotherapy outcomes, particularly for clients whose few and limited relationships have been generally disappointing.[7] In virtually

every form of psychotherapy, the therapist must appreciate the full context of the client's experience to understand the nature of effective therapeutic interventions.[8]

As a result, we fear that empirical psychotherapy research may never provide the certainty we crave, and we must learn to live effectively with uncertainty. We must listen to what clients tell us and consider the best available evidence from research and intelligent clinical observation. Ultimately, we must evolve a reasoned therapy that offers the great flexibility needed to cope with the infinite range of human problems.

COMPARATIVE VALUE OF THE THERAPEUTIC FACTORS: THE CLIENT'S VIEW

How do group members evaluate the various therapeutic factors? Which factors do *they* regard as most salient to their improvement in therapy? In the first two editions of this book, it was possible to take a leisurely approach to reviewing the small body of research bearing on this question. Only two studies had explicitly explored clients' subjective appraisals of the therapeutic factors, and I (IY) discussed these and then gave a detailed description of the results of my first therapeutic factor research project. My colleagues and I had administered a therapeutic factor questionnaire to twenty successful group therapy participants. It was designed to provide some data for us to use in comparing the relative importance of the eleven therapeutic factors identified in Chapter 1.[9] But things have changed. Over the past five decades, a deluge of studies have explored how clients and therapists view the therapeutic factors. This research has demonstrated that focusing on therapeutic factors offers a useful way for therapists to shape their group therapeutic strategies to match their clients' goals.[10]

Most of the researchers have used some version or modification of the therapeutic factors and the research instrument I described in my original 1970 research.[11] Therefore, we will describe that research in detail and then incorporate into our discussion the findings from more recent research on therapeutic factors.[12]

My colleagues and I studied the therapeutic factors in twenty successful long-term group therapy clients.[13] We gathered this cohort by asking twenty group therapists to select their most successful client for us to evaluate. These therapists led groups of outpatients who sought care for neurotic or characterological problems. The subjects had been in therapy for between eight and twenty-two months (the mean duration was sixteen months) and had recently terminated or were about to terminate group therapy.[14] All

subjects completed a therapeutic factor questionnaire in the form of a Q-sort and were interviewed by the investigators.

Twelve categories of therapeutic factors were constructed from the sources outlined throughout this book, and five items describing each category were written, making a total of sixty items (see Table 4.1).[i] These twelve factors, with some changes in nomenclature, eventually evolved into the eleven therapeutic factors we described in Chapter 1. Every item has potential healing impact. Each item was typed on a 3 × 5 card, and then each client was given the stack of randomly arranged cards and asked to place a specified number of cards into seven piles labeled as follows:

> Most helpful to me in the group (2 cards)
> Extremely helpful (6 cards)
> Very helpful (12 cards)
> Helpful (20 cards)
> Barely helpful (12 cards)
> Less helpful (6 cards)
> Least helpful to me in the group (2 cards)[15]

TABLE 4.1 Therapeutic Factors: Categories and Rankings of the Sixty Individual Items

		Rank Order (The Lower the Number, the Higher the Item Is Valued by the Client)
1. Altruism	1. Helping others has given me more self-respect.	40 T*
	2. Putting others' needs ahead of mine.	52 T
	3. Forgetting myself and thinking of helping others.	37 T
	4. Giving part of myself to others.	17
	5. Helping others and being important in their lives.	33 T
2. Group Cohesiveness	6. Belonging to and being accepted by a group.	16
	7. Continued close contact with other people.	20 T
	8. Revealing embarrassing things about myself and still being accepted by the group.	11 T
	9. Feeling alone no longer.	37 T
	10. Belonging to a group of people who understood and accepted me.	20 T
3. Universality	11. Learning I'm not the only one with my type of problem; "We're all in the same boat."	45 T
	12. Seeing that I was just as well off as others.	25 T
	13. Learning that others have some of the same "bad" thoughts and feelings I do.	40 T
	14. Learning that others had parents and backgrounds as unhappy or mixed up as mine.	31 T
	15. Learning that I'm not very different from other people gave me a "welcome to the human race" feeling.	33 T

* "T" denotes a tie

		Rank Order (The Lower the Number, the Higher the Item Is Valued by the Client)
4. Interpersonal Learning—Input	16. The group teaching me about the type of impression I make on others.	5 T
	17. Learning how I come across to others.	8
	18. Other members honestly telling me what they think of me.	3
	19. Group members pointing out some of my habits or mannerisms that annoy other people.	18–19 T
	20. Learning that I sometimes confuse people by not saying what I really think.	13 T
5. Interpersonal Learning—Output	21. Improving my skills in getting along with people.	25 T
	22. Feeling more trustful of groups and of other people.	10
	23. Learning about the way I related to the other group members.	13 T
	24. The group giving me an opportunity to learn to approach others.	27 T
	25. Working out my difficulties with one particular member in the group.	33 T
6. Guidance	26. The doctor suggesting or advising something for me to do.	27 T
	27. Group members suggesting or advising something for me to do.	55
	28. Group members telling me what to do.	56
	29. Someone in the group giving definite suggestions about a life problem.	48 T
	30. Group members advising me to behave differently with an important person in my life.	52 T

		Rank Order (The Lower the Number, the Higher the Item Is Valued by the Client)
7. Catharsis	31. Getting things off my chest.	31 T
	32. Expressing negative and/or positive feelings toward another member.	5 T
	33. Expressing negative and/or positive feelings toward the group leader.	18 T
	34. Learning how to express my feelings.	4
	35. Being able to say what was bothering me instead of holding it in.	2
8. Identification	36. Trying to be like someone in the group who was better adjusted than I.	58
	37. Seeing that others could reveal embarrassing things and take other risks and benefit from it helped me to do the same.	8
	38. Adopting mannerisms or the style of another group member.	59
	39. Admiring and behaving like my therapist.	57
	40. Finding someone in the group I could pattern myself after.	60
9. Family Reenactment	41. Being in the group was, in a sense, like reliving and understanding my life in the family in which I grew up.	51
	42. Being in the group somehow helped me to understand old hang-ups that I had in the past with my parents, brothers, sisters, or other important people.	30
	43. Being in the group was, in a sense, like being in a family, only this time a more accepting and understanding family.	44

		Rank Order (The Lower the Number, the Higher the Item Is Valued by the Client)
9. Family Reenactment (*continued*)	44. Being in the group somehow helped me to understand how I grew up in my family.	45 T
	45. The group was something like my family—some members or the therapists being like my parents and others being like my relatives. Through the group experience I understand my past relationships with my parents and relatives (brothers, sisters, etc.).	48 T
10. Self-Understanding	46. Learning that I have likes or dislikes for a person for reasons that may have little to do with the person and more to do with my hang-ups or experiences with other people in my past.	15
	47. Learning why I think and feel the way I do (that is, learning some of the causes and sources of my problems).	11 T
	48. Discovering and accepting previously unknown or unacceptable parts of myself.	1
	49. Learning that I react to some people or situations unrealistically (with feelings that somehow belong to earlier periods in my life).	20 T
	50. Learning that how I feel and behave today is related to my childhood and development (there are reasons in my early life why I am as I am).	50

		Rank Order (The Lower the Number, the Higher the Item Is Valued by the Client)
11. Instillation of Hope	51. Seeing others getting better was inspiring to me.	42 T
	52. Knowing others had solved problems similar to mine.	37 T
	53. Seeing that others have solved problems similar to mine.	33 T
	54. Seeing that other group members improved encouraged me.	27 T
	55. Knowing that the group had helped others with problems like mine encouraged me.	45 T
12. Existential Factors	56. Recognizing that life is at times unfair and unjust.	54
	57. Recognizing that ultimately there is no escape from some of life's pain and from death.	42 T
	58. Recognizing that no matter how close I get to other people, I must still face life alone.	23 T
	59. Facing the basic issues of my life and death, and thus living my life more honestly and being less caught up in trivialities.	23 T
	60. Learning that I must take ultimate responsibility for the way I live my life, no matter how much guidance and support I get from others.	5 T

After this Q-sort, which took thirty to forty-five minutes, each subject was interviewed for an hour by the three investigators. Their

reasons for their choice of the most and least helpful items were reviewed, and other areas relevant to therapeutic factors were discussed (for example, other, nonprofessional therapeutic influences in the clients' lives, critical events in therapy, goal changes, timing of improvement, and therapeutic factors in their own words).

Results

A sixty-item, seven-pile Q-sort for twenty subjects makes for complex data. Perhaps the clearest way to consider the results is a simple rank-ordering of the sixty items (arrived at by ranking the sum of the twenty pile placements for each item). In Table 4.1, the number after each item represents its rank order. Thus, on average, item 48 (*Discovering and accepting previously unknown or unacceptable parts of myself*) was considered the most important therapeutic factor by the subjects; item 40 (*Finding someone in the group I could pattern myself after*) the least important, and so on.

The ten items the subjects deemed most helpful were, in order of importance, as follows:

1. Discovering and accepting previously unknown or unacceptable parts of myself.
2. Being able to say what was bothering me instead of holding it in.
3. Other members honestly telling me what they think of me.
4. Learning how to express my feelings.
5. The group teaching me about the type of impression I make on others.
6. Expressing negative and/or positive feelings toward another member.
7. Learning that I must take ultimate responsibility for the way I live my life no matter how much guidance and support I get from others.
8. Learning how I come across to others.

9. Seeing that others could reveal embarrassing things and take other risks and benefit from it helped me to do the same.
10. Feeling more trustful of groups and of other people.

Note that seven of the first eight items represent some form of catharsis or of insight. We again use *insight* in the broadest sense; the items, for the most part, reflect the first level of insight described in Chapter 2 (Gaining an objective perspective of one's interpersonal behavior). This remarkable finding lends considerable weight to the principle, also described in Chapter 2, that therapy is a dual process consisting of emotional experience and reflection on that experience. More, much more, about this later.

The administration and scoring of a sixty-item Q-sort is so laborious that most researchers have since used an abbreviated version—generally, one that asks a subject to rank the twelve therapeutic factor categories rather than sixty individual items. However, four studies that replicate the sixty-item Q-sort study reported remarkably similar findings.[16]

If we analyze the twelve general categories,[iii] we find the following rank order of importance:

1. Interpersonal—input (learning how I impact others)
2. Catharsis
3. Cohesiveness
4. Self-understanding
5. Interpersonal—output (learning to change how I interact)
6. Existential factors
7. Universality
8. Instillation of hope
9. Altruism
10. Family reenactment
11. Guidance
12. Identification

A number of other replicating studies are in considerable agreement.[17] The most commonly chosen therapeutic factors are catharsis, self-understanding, and interpersonal—input, closely followed by cohesiveness and universality. The same trio of most helpful therapeutic factors (interpersonal—input, self-understanding, and catharsis) has been reported in studies of personal growth groups.[18] One researcher has suggested that the therapeutic factors fall into three main clusters: the remoralization factor (hope, universality, and acceptance), the self-revelation factor (self-disclosure and catharsis), and the specific psychological work factor (interpersonal learning and self-understanding).[19] This clustering resembles a factor analysis[ix] of therapeutic factors collected from studies of the American Group Psychotherapy Association Institute's experiential groups suggesting that the group therapeutic factors fall into three main categories: early factors of belonging and remoralization common to all therapy groups, factors of guidance and instruction, and specific skill-development factors. Another empirical study clustered the therapeutic factors reported by five hundred group clients into two overarching dimensions: the group's emotional and relationship climate and psychological work.[20] Despite different terminology, contemporary clustering approaches suggest that the group therapeutic factors consist of universal mechanisms, mediating mechanisms, and specific change mechanisms.[21]

Which therapeutic factors are least valued? All the studies of therapy groups and personal growth groups report the same results: family reenactment, guidance, and identification. These results all suggest that the defining core of the therapeutic process in these therapy groups is an affectively charged, self-reflective, interpersonal interaction in a supportive and trusting setting.[22] This is true as well in individual psychotherapy. Comparisons of therapeutic factors in individual and group therapy consistently underscore this finding and the importance of the basic concepts discussed in Chapter 2—the concept of the corrective emotional experience and the concept of

the therapeutic here-and-now focus, which includes both the process of deep experiencing and a subsequent process where the client makes sense of that experience and derives meaning from it.[23]

If our objective is to create the best possible climate for support, self-exploration, and interpersonal learning, then group leaders must understand each of the individual factors and how they relate to one another. All are in play virtually at every moment. An effective group therapist is like an expert chef who appreciates the contribution made by each ingredient to the meal as a whole.

The following vignette illustrates these principles:

> **The session began with the members welcoming Meena back** from a two-week trip to India, where she had been born. Meena replied she had a lot to share about her trip but first had to ask about Samantha, who at the last meeting she'd attended was struggling with a huge decision about changing her career and returning to university to finish her pre-med studies.
>
> Samantha raised both hands and said, "I did it—I'm going to be a doctor," and she and Meena exchanged high fives.
>
> Meena commented, "Samantha, you give me inspiration. I admire your courage to go after what you want and need in life. And I'm going to follow your lead and today say some things I've never uttered to anyone before."
>
> Meena went on to explain that she had always feared others' judgment, and that her anticipation of shame had silenced her. "I feel like I've been caught between a rock and a hard place. In America I feel foreign and 'the other' because I am a woman of color, and when I'm in India, I feel foreign and 'other' because everyone views me as a westernized American woman. This tension has always caused me to avoid romantic engagement—until now. I see others like Samantha stand up for themselves and go after what they really want. I'm inspired by her." Meena hesitated, took a deep breath, and continued, "I'm nervous about saying this because in India we were prohibited from seeing or dating men from certain castes. It would not be an issue in the West but at home it was shameful."
>
> "Yes… and?" asked Samantha.
>
> Meena gulped and took the plunge. "I'm in love with a former classmate who loves me back," she said. "But I've always rebuffed him because of what people there would say. This group has encouraged

me to pay attention to my own desires and I've now decided to follow my heart. I know now that life is short and should not be squandered because of what I fear others think."

"Such good news. So, you've told him?" asked Samantha.

"Not yet, I wanted first to talk about this here in the group."

A chorus of encouragement emanated from the group. "Go for it, Meena." "Yes, follow your heart." "No risk, no gain." "I love to see you taking charge of your life. Good for you."

All her fears about being criticized if she opened up to the group were disconfirmed and Meena exhaled loudly, signaling enormous relief. She said, "A huge weight has been lifted off me tonight. I just hope it's not too late and he is still there for me."

Then another member of the group, Bella, an immigrant from Albania, talked about her multicultural experience. The cultural divergence she experienced was much less than the one Meena had experienced, but she recognized there were aspects of child rearing in her former country that were unacceptable here. It was evident that Bella introduced this subject as a way of joining with Meena and letting her see that she was not alone in negotiating cross-cultural tensions.

Bella went on to say that it was time to talk about the real reason she joined the group—her brutal self-judgment. She recounted an episode with her husband three days earlier in which she misheard a comment he made to her. Her husband was not feeling well, and when she asked him to do something, he grew angry and said, "Get off my back!" She heard instead "Get out of my life," and immediately was flooded with self-loathing. She left her house and retreated to her old bed in her mother's home only a few blocks away. During the group session, as she was just emerging from this episode, she resolved that it was time to take the bull by the horns and work on her catastrophic reaction to criticism. "The same kind of thing happened to me recently in group, but it involved Mark, who's absent today, and I don't know if I should say it."

The group therapist encouraged Bella to continue, making clear that the group ground rules were that a member could talk about anything, including something that concerned another member, even in that person's absence, with the proviso that we would revisit the subject in that person's presence at the next opportunity.

Bella hesitantly continued: "It was that meeting when Mark criticized me for not being compassionate or supportive to him. I've brooded about that for weeks but kept it to myself until today. I'm beginning to understand what I need to work on: I am supersensitive, and it is crippling me in life.… I don't know how I got to be this way, but I think it

goes back to my father—he was always on my case. I can still hear him saying, “If you can’t do it right, don’t do it at all.”

Another member, Rick, said, “I liked the way you showed compassion to Meena just now. I wish you’d start to be more compassionate with yourself. And I do hope you’re giving yourself credit for bringing up Mark’s criticism of you—that was gutsy."

Meena then said to Bella, “I’m still thinking about what you said about your father and the impact of what he said to you. Makes me wonder what is at the heart of getting better here in therapy. What’s most important? Knowing the roots of your difficulty, or understanding things that are impacting right now on your life?”

The group members’ response was unanimous: “What matters is any knowledge that allows you to change in the present.”

Rick commented further, “I’ve been in and out of therapy for many years and although understanding my early life has enriched me in some ways, it was really only in the group that I began to change how I relate to people. Insight without change in fact can make you feel worse, more hopeless and more helpless. It’s not just insight that’s important: it’s insight that leads to change.” **<<**

Let’s examine the interplay of the therapeutic factors in this session:

- Meena applauds Samantha’s courage in resetting her life course (instillation of hope and vicarious learning) and gains trust in the group’s nonjudgmental support (group cohesion).
- Meena internalizes Samantha and the group. Keeping the group alive in her thinking encourages her to try new behaviors. She trusts the group and is eager to dive into work (group cohesion). A sense of security and connection helps Meena to stay with her strong emotions and express her feelings.
- Meena takes responsibility for the impact of her earlier rejection of the man she loves and determines that she will now act and take responsibility for her choice (existential factors). This encourages Meena to take a risk in the here-and-now, and she reveals her feelings of shame and explores

intertwining psychological and cultural factors (catharsis, self-disclosure, and self-understanding).

- Meena is endorsed for her courage and obtains group support rather than the judgment she dreaded (interpersonal learning).
- Bella's self-disclosure emerges from her wish to support and join Meena compassionately (altruism, universality) and her recognition that her harsh self-judgment is at the core of her own difficulties (self-understanding).
- Bella also tries a new behavior in the group. In response to being criticized in the group by Mark, she comes prepared to explore and examine what happened; this is a constructive departure from her former tendency to withdraw and shut down when someone finds fault with her (interpersonal learning).
- The group addresses the importance of insight and concludes that the most critical knowledge acquired in therapy is that which that leads to behavioral change (guidance and self-understanding).

In the following sections, we will explore the questions posed at the beginning of this chapter on the interrelationships and comparative potency of the therapeutic factors. Keep in mind that these findings pertain to a specific type of therapy group: an interactionally based group with the ambitious goals of symptom relief and behavioral and characterological change. Later in this chapter we will present some evidence that other groups with different goals and of shorter duration may capitalize on different clusters of therapeutic factors.

Catharsis

Catharsis has always assumed an important role in the healing process. For centuries, sufferers have been purged to eliminate excessive bile, evil spirits, and infectious toxins. (The word *catharsis* is derived from the Greek "to clean"). But dynamic psychotherapists have learned that *catharsis is not enough*. After all, we have

emotional discharges, sometimes very intense ones, all our lives that do not lead to change.

The data support this conclusion. Although clients consider catharsis important, the research notes important qualifications. My (IY) study on encounter groups with Morton Lieberman and Matthew Miles starkly illustrates the limitations of catharsis per se.[24] We asked 210 clients to describe the most significant incident that occurred in the course of their group therapy, a thirty-hour encounter-group experience they had all been part of at different times in previous years. The group members frequently cited experiencing and expressing feelings (both positive and negative). Yet for most of the subjects, this critical incident was unrelated to positive outcome: incidents of catharsis were just as likely to be selected by members with poor outcomes as by those with good outcomes. Catharsis was *necessary but not sufficient for change*. Indeed, members who cited *only* catharsis were somewhat more likely to have had a negative experience in the group. The high learners characteristically experienced catharsis plus some form of cognitive learning: the ability to reflect on one's emotional experience in the context of a caring relationship is what drives change.[25]

In the Q-sort therapeutic factor studies, the two items that are ranked most highly and are most characteristic of the catharsis category in factor analytic studies are items 34 (*Learning how to express my feelings*) and 35 (*Being able to say what was bothering me*). Both of these items convey something other than the sheer act of ventilation or abreaction. They connote a sense of liberation and acquiring skills for the future. The other frequently chosen catharsis item—item 32 (*Expressing negative and/or positive feelings toward another member*)—indicates the role of catharsis in the ongoing interpersonal process. Note that item 31, which most conveys the purest sense of sheer ventilation (*Getting things off my chest*), was not highly ranked by group members.

Interviews with clients to investigate the reasons for their selection of items confirmed this view. Catharsis was viewed as *part of an interpersonal process*: no one ever obtains enduring benefit

from ventilating feelings in an empty closet. Furthermore, as we discussed in Chapter 3, catharsis is intricately related to cohesiveness. Catharsis is more helpful once supportive group bonds have formed; it is more valued late rather than early in the course of the group.[26] In fact, clinical practice guidelines caution that group cohesion may be damaged by the premature expression of strong affect before a sense of safety is established.[27] In a research trial with women who had advanced breast cancer, talking about death and dying was a critically important therapeutic objective, but only after the group had consolidated.[28] Strong timely expression of emotion enhances the development of cohesiveness: members who express strong feelings toward one another and work honestly with these feelings will develop close mutual bonds. In groups of clients dealing with loss, researchers found that expression of positive affect was associated with positive outcomes, whereas the expression of negative affect was therapeutic only when paired with genuine attempts to understand oneself or other group members.[29]

Emotional disclosure is also linked to the ability to cope; articulation of one's needs permits oneself and the people in one's environment to respond productively to life's challenges. Women with early-stage breast cancer who are emotionally expressive achieve a much better quality of life than those who avoid and suppress their distress.[30] Women with late-stage breast cancer who avoided expressing affect experienced adverse impacts on their blood pressure, signaling autonomic nervous system overload; conversely, appropriate expression of hostility contributed to better autonomic nervous system regulation and better social connectedness.[31] Recently bereaved HIV-positive men who are able to express emotions, grieve, and find meaning in their losses maintain significantly higher immune function and live longer than those who minimize their distress and avoid the mourning process.[32]

In summary, then, the timely, open expression of affect is vital to the group therapeutic process; in its absence, a group would degenerate into a sterile academic exercise. *Yet it is only part of the*

process and must be complemented by other factors. One last point: the intensity of emotional expression is highly relative and must be appreciated not from the leader's perspective but from that of each member's subjective world. A seemingly muted expression of emotion may, for a highly constricted individual, represent an event of considerable intensity.

Self-Understanding

The therapeutic factor Q-sort also underscores the important role that the intellectual components play in the therapeutic process. Of the twelve categories, the two pertaining to the intellectual task in therapy (interpersonal input and self-understanding) are both ranked highly. *Interpersonal learning*, discussed at some length in Chapter 2, encompasses the process by which the individual learns how he or she is perceived by other people. It is the crucial first step in the sequence of the therapeutic factor of interpersonal learning.

The category of *self-understanding* is more problematic. It was constructed to permit investigation of the importance of derepression and to foster understanding of the relationship between past and present: that is, to spark insight about the early roots of one's difficulties (sometimes called "genetic insight"). Looking at the five items under the "self-understanding" category in Table 4.1 (46–50), however, one sees that the category is an inconsistent one. It contains several very different elements, and there is poor correlation among the items, some being highly valued by group therapy members and some less so. Item 48, *Discovering and accepting previously unknown or unacceptable parts of myself*, is the *single most valued item* of the sixty. Two items (46 and 47), referring to understanding the causes of one's problems and to recognizing the existence of interpersonal distortion, are also highly valued. The item that most explicitly refers to insight about one's early life, item 50, is considered of little value by group therapy clients.

This finding has been corroborated regularly by other researchers.[33] A number of studies, for example, concluded that interpretations about one's early life were significantly less effective

than here-and-now interpersonal feedback in producing positive group therapy outcomes. When making links to the past, co-members' feedback contained less jargon and was connected more directly to actual experience than were the therapists' more conceptual, less "real" explanations.[34]

When we interviewed the subjects in our study, we found that the most popular item—48, *Discovering and accepting previously unknown or unacceptable parts of myself*—had a very specific implication to group members. More often than not, they discovered *positive* areas of themselves: the ability to care for another, to relate closely to others, to experience compassion.

There is an important lesson to be learned here. Too often, psychotherapy, especially in naive, popularized, or early conceptualizations, is viewed as a detective search, as a digging or a stripping away. But excavation may uncover our riches and treasures as well as the shameful, fearful, or primitive aspects of ourselves.[35] Our clients want to be liberated from pathogenic beliefs, and, as they gain fuller access to themselves, they become emboldened and take ownership of their personhood. Psychotherapy has grown beyond its emphasis on eradicating the "pathological" and now aims at increasing clients' breadth of positive emotions, cognitions, and access to strengths. A group therapy approach that encourages members to create and inhabit a powerful and caring environment is a potent approach to these contemporary goals.[36]

Thus, one way that self-understanding promotes change is by encouraging individuals to recognize, integrate, and then give free expression to previously obscured parts of themselves. When we deny or stifle parts of ourselves, we pay a heavy price: we feel a deep, puzzling, amorphous sense of restriction. When we are able to reclaim these disavowed parts, we experience a wholeness and sense of liberation.

So far, so good. But what of the other components of the intellectual task? For example, how does the highly ranked item *Learning why I think and feel the way I do* (item 47) result in therapeutic change?

First, we must recognize that there is an urgent need for intellectual understanding in the psychotherapeutic enterprise, a need that comes from both client and therapist. Our search for understanding is deeply rooted. Abraham Maslow, in a treatise on motivation, suggested that the human being has cognitive needs that are as basic as the needs for safety, love, and self-esteem.[37]

In an analogous fashion, our clients automatically search for understanding, and therapists who prize the intellectual pursuit join them. Often, it all seems so natural that we lose sight of the *raison d'être* of therapy. After all, the object of therapy is change, not self-understanding. Or is it? Are the two synonymous? Does any and every type of self-understanding lead automatically to change? Or is the quest for self-understanding simply an interesting, appealing, reasonable exercise for clients and therapists, serving, like mortar, to keep the two joined together while something else—"relationship"—develops? Perhaps it is relationship that is the real mutative force in therapy. In fact, there is considerable evidence that a supportive psychotherapy relationship in a noninterpretive therapy can produce substantial change in interpersonal behavior.[38]

It is far easier to pose these questions than to answer them. We will present some preliminary points here, and in Chapter 6, after developing some material on the interpretative task and techniques of the therapist, we will attempt to present a coherent thesis.

If we examine the motives behind our curiosity and our proclivity to explore our environment, we shed some light on the process of change. These motives include *effectance* (our desire for mastery and power), *safety* (our desire to render the unexplained harmless through understanding), and *pure cognizance* (our desire for knowledge and exploration for its own sake).[39] The babysitter who explores a mysterious and frightening noise in the house; the senior citizen who discovers the power of the Internet to increase her access to and mobility in the world; the refugee who explores his new and peaceful home environment; the medieval alchemist or the New World explorer probing uncharted and proscribed regions—all receive their respective rewards: safety, a sense of personal

keenness and satisfaction, and mastery in the guise of knowledge and self-efficacy.[40]

Of these motives, the one least relevant for the change process is pure cognizance. But the desires for safety and for mastery play an important and obvious role in psychotherapy. They are, of course, as Robert White has ably discussed, closely intertwined.[41] The unexplained—especially the frightening unexplained—cannot be tolerated for long.

One of our chief methods of control is through language. Giving a name to chaotic, unruly forces provides us with a sense of mastery or control. In the psychotherapeutic situation, information decreases anxiety by removing ambiguity. There is considerable research evidence supporting this observation.[42] If one can name it, one can tame it. We engage the thinking prefrontal cortex to soothe the more emotional, limbic parts of the brain and then plan a course of constructive action.[43]

The converse is, incidentally, also true: anxiety increases ambiguity by distorting perceptual acuteness. Anxious subjects show disturbed organization of visual perception; they are less capable of perceiving and organizing rapid visual cues than nonanxious subjects and distinctly slower in completing and recognizing incomplete pictures in a controlled experimental setting.[44] If we are unable to order the world cognitively, we experience anxiety, which, if severe, interferes with the perceptual apparatus. Thus, anxiety begets anxiety, a sequence that is countered by the two-step process of psychotherapy for highly stressed, emotionally overwhelmed clients. First, the relational experience provides calming and containment to reduce emotional arousal to more workable levels, at which point the therapist can then begin to help the client make sense of powerful experience.[45]

In psychotherapy, clients are enormously reassured by the belief that their chaotic inner world, their suffering, and their tortuous interpersonal relationships are all explicable and thereby governable. Presumably it follows that if we know what is ultimately good for us, we will act in our own best interests.

Therapists, too, are less anxious if, when confronted with great suffering and voluminous, chaotic material, they can believe in a set of principles that will permit an ordered explanation. Frequently, therapists will cling tenaciously to a particular system in the face of considerable contradictory evidence. Though such tenacity of belief may carry many disadvantages, it performs one valuable function: it enables the therapist to preserve equanimity in the face of considerable affect emerging within the transference or countertransference.

Self-knowledge permits us to integrate all parts of ourselves, decreases ambiguity, permits a sense of effectance and mastery, and allows us to act in concert with our own best interests. An explanatory scheme also permits generalization and transfer of learning from the therapy setting to new situations in the outside world (akin to Peter Fonagy's concept of epistemic trust discussed in Chapter 2). Psychotherapy promotes the client's ability to transfer knowledge about how the world works from the therapy relationship to the world at large, propelling the adaptive spiral.[46]

The great controversies arise when we discuss not the process or the purpose or the effects of explanation but the *content* of explanation. As we hope to make clear in Chapter 6, we think these controversies are irrelevant. When we focus on change rather than on self-understanding as our ultimate goal, we can only conclude that insight is of greatest value if it leads to personal change. Each clarifying or interpretive act of the therapist is ultimately designed to exert leverage on the client's will to change.

Imitative Behavior (Identification)

Group therapy participants rate imitative behavior among the least helpful of the twelve therapeutic factors. However, we learned from debriefing interviews that the five items in this category seem to have failed to describe this therapeutic mode in ways that evoked clients' identification of it or experiences with it. The items failed to distinguish clearly between mere mimicry, which apparently has only a restricted value for clients, and the acquisition of general styles

and strategies of behavior, which may have considerable value. To clients, conscious mimicry is an especially unpopular concept as a therapeutic mode because it suggests subordination or a relinquishing of individuality—a basic fear of many group participants.

On the other hand, clients may acquire from others a general strategy that may be used across a variety of personal situations. Members of groups for medically ill patients and in twelve-step groups often benefit from seeing other members manage a shared problem effectively.[47] This process also works at both overt and subtle levels. Clients may begin to approach problems by considering, consciously or unconsciously, what some other member or the therapist would think or do in the same situation. (Recall the vignette earlier in which Meena was empowered by Samantha's risk-taking). If the therapist is tolerant and flexible, then clients may also adopt these traits. If the therapist is judiciously self-disclosing and accepts his or her limitations without becoming insecure or defensive, then clients are more apt to learn to accept their personal shortcomings.[48] The group leader's capacity, and even courage, to acknowledge personal disappointment and imperfection reduces clients' dread of shame about their imperfections and disappointments.[49]

Initially, imitative behavior is, in part, an attempt to gain approval, but it does not end there. The more psychologically intact clients retain their autonomy and flexibility as they road-test new behaviors, and they soon realize that some of those changes result in greater acceptance by others. Such acceptance can then lead these clients to change their self-concept and self-esteem in the manner described in Chapter 3, and an adaptive spiral is instigated. It is also possible for an individual to identify with aspects of two or more other people, resulting in an amalgam. Although the behaviors of others are imitated, the amalgam represents a creative synthesis, a highly innovative individualistic identity.

What of "spectator therapy"? Is it possible that clients may learn much from observing the solutions arrived at by others who have

similar problems? We have no doubt that such learning occurs in the therapy group. Every experienced group therapist has at least one story of a member who came regularly to the group for months on end, was extremely inactive, and finally terminated therapy much improved.

I (IY) clearly remember Rod, who was so shy, isolated, and socially phobic that in his adult life he had never shared a meal with another person. When I introduced him into a rather fast-paced group, I was concerned that he would be in over his head. And, in a sense, he was. For months he sat and listened in silent amazement as the other members interacted intensively with one another. That was a period of high learning for Rod: simply to be exposed to the possibilities of intimate interaction enriched his life. But then things changed! The group began to demand more reciprocity and placed great pressure on him to participate more personally in the meetings. Rod grew more uncomfortable and ultimately, with my encouragement, decided to leave the group. Since he and I worked at the same university, our paths crossed several times in the ensuing years, and he never failed to inform me how important and useful the group had been. It had shown him what was possible and how individuals could engage one another, and it offered him an internal reference point to which he could turn for reassurance as he gradually reached out to others in his life.

Clients learn not only from observing the substantive work of others who are like them but also from watching the process of the work. In that sense, imitative behavior is a transitional therapeutic factor that permits clients subsequently to engage more fully in other aspects of therapy. Proof of this is to be found in the fact that one of the five imitative behavior items (item 37, *Seeing that others could reveal embarrassing things and take other risks and benefit from it helped me to do the same*) was tied for eighth place in the rankings of sixty therapeutic factors. A large-scale study in the Netherlands found that clients considered identification to be more important in the early stages of therapy, when novice members looked for more senior members with whom to identify.[50] Watching group interaction

contributes to group members developing an observing ego onto their interpersonal interactions.[51]

Family Reenactment (The Corrective Recapitulation of the Primary Family Group)

Family reenactment, subsequently modified to the corrective recapitulation of the primary family group—a therapeutic factor highly valued by many therapists—is not generally considered helpful by most group members. Unsurprisingly, little has been published in this specific area over the past many years. The clinical populations that do place a high value on this factor are very specific: groups for incest survivors[52] and groups for sex offenders.[53] For these members the early failure of the family to protect and care for them looms as a powerful issue.

That this factor is not cited often by most group members, though, should not surprise us, since it operates at a different level of awareness from such explicit factors as catharsis or universality. Family reenactment becomes more a part of the general horizon against which the group is experienced. Few therapists will deny that the primary family of each group member is an omnipresent specter haunting the group therapy room. That specter, carrying a lifetime of family memories, will undoubtedly influence how clients express interpersonal distortions, what roles they assume in the group, and how they view their group leaders.

There is little doubt in our minds that the therapy group reincarnates the primary family. It acts as a time machine, flinging the client back several decades and evoking deeply etched ancient memories and feelings. In fact, this phenomenon is one of the major sources of power of the therapy group. In my (IY) last meeting with a group before departing for a year's sabbatical, a client related the following dream: "My father was going away for a long trip. I was with a group of people. My father left us a thirty-foot boat, but rather than giving it to me to steer, he gave it to one of my friends, and I was angry about this." This is not the place to discuss this dream fully. Suffice it to say that the client's father had deserted the family when

the client was young, leaving him to be tyrannized thereafter by an older brother. The client said that this was the first time he had thought of his father in years. The events of the group—my departure, my place being taken by a new therapist, the client's attraction to the co-therapist (a woman), his resentment toward another dominating member in the group—all acted in concert to awaken long-slumbering memories. Clients reenact early family scripts in the group and, in successful group therapy, they experiment with new behaviors and break free from the rigid family roles into which they had long been locked. These themes may be particularly prominent when sibling transferences or rivalries develop regarding the group or group leader's attention, interest, and care.[54]

While we believe these are important phenomena in the therapeutic process, it is altogether a different question whether the group should focus explicitly on them. We think not, as this process is part of the internal, generally silent, homework of the group member. Shifts in our perspective on the past occur because of the vitality of the work in the present—not through a direct summons and inquiry of the spirits of the past. There are, as we will discuss in Chapter 6, many overriding reasons for the group to maintain an ahistorical focus even as we move between past and present in our interactions.

> **Gordon, a chronically depressed man, shared with the group that** he'd had a lot of physical pain recently and had learned that he had a hernia in his groin that would require surgery. He wanted us to know how apprehensive he was about the pending surgery and sought some support from the group, even if, in so doing, he needed to, in his words, "drop his pants" in the meeting to tell us about it.
>
> Later in that session, when I (ML) responded to an important self-disclosure made by another member of the group about a sexual encounter, I commented that Gordon's "dropping of his pants" had encouraged others to take more risks in the meeting.
>
> In the next session, Gordon commented, "Your joking about 'dropping my pants' hurt me deeply." He said he felt that I had been teasing him and had humiliated him in front of the group. He had not been aware of experiencing that feeling in the actual moment in the session, but it had

built over the days between our meetings.

"I'm so sorry," I said. "I was hoping to support your openness, but my comment had an unintentional and hurtful impact. Could we examine what that might represent?"

Gordon seemingly welcomed my apology but was unable to do anything more with the exploration. His reference to feeling humiliated, however, evoked in another group member, Sally, a recollection of a story Gordon had shared with us sessions before. "I remember you describing your father's glee in humiliating you when the extended family would get together for dinners. I remember that he would ask you to stand up at the table and answer arithmetic questions that he knew you couldn't do."

I asked Gordon if there was any possible connection, and he became quite energized. "Yes, right on, I felt like you were embarrassing me in front of the group, like he did in front of my family."

"Gordon, please believe me, I had no such intention in mind."

"I do believe you. Thanks. Never once did my father apologize to me." **<<**

Existential Factors

The category of existential factors was almost an afterthought. My (IY) colleagues and I first constructed the Q-sort instrument with eleven major factors. It appeared neat and precise, but something was missing. Important sentiments expressed by both clients and therapists had not been represented, so we added a factor consisting of these five items:

1. Recognizing that life is at times unfair and unjust
2. Recognizing that ultimately there is no escape from some of life's pain or from death
3. Recognizing that no matter how close I get to other people, I must still face life alone
4. Facing the basic issues of my life and death, and thus living my life more honestly and being less caught up in trivialities
5. Learning that I must take ultimate responsibility for the way I live my life, no matter how much guidance and support I get from others

Several issues are represented in this cluster: responsibility, basic isolation, contingency, the capriciousness of existence, the recognition of our mortality, and the ensuing consequences for the conduct of our life. What to label this category? I finally settled, with some hesitation, on *existential factors*, meaning that all these factors relate to existence—to our confrontation with the human condition. This confrontation informs us of the four harsh existential facts of life: our mortality, our freedom and responsibility for constructing our own life design, the isolation we experience from being thrust alone into existence, and our search for life meaning despite the misfortune of having been born into a universe without intrinsic meaning. These four harsh facts of life later were to provide the structure of my (IY) book *Existential Psychotherapy*. It is clear that the existential items strike responsive chords in clients, and many cite some of the five items as having been crucially important to them. In fact, the entire category of existential factors is often ranked highly, ahead of other valued therapeutic factors such as universality, altruism, recapitulation of the primary family experience, guidance, identification, and instillation of hope. Item 60, *Learning that I must take ultimate responsibility for the way I live my life, no matter how much guidance and support I get from others*, was ranked fifth overall of the sixty items.

Similar findings are reported by other researchers. Every project that includes an existential category reports that subjects rank that category at least in the upper 50th percentile. In some studies, for example, with therapy groups in prison, in day hospitals, in psychiatric hospitals, and in alcohol treatment groups, the existential category is ranked among the top three factors.[55] Existential factors are also central to many of the current group therapy interventions for the seriously medically ill and in groups for caregivers of ill family members.[56] A group of older women ranked existential factors first, as did a sample of sixty-six patients on an alcoholism treatment unit.[57] What unites these divergent clinical populations is the participants' awareness of immutable limits in life—limits of time, power, or health. Even in groups led by therapists who do not

conceptualize existential factors as relevant, the existential factors are highly valued by the group members.[58]

It is important to attend to our data. Obviously, existential factors in therapy deserve far more consideration than they generally receive. Surveys of senior group therapists consistently endorse the emphasis on relationships and personal choice.[59] Unsurprisingly, existentially informed group therapies are even more prominent in the psychological care of medically ill and cancer patients, for whom mortal illness is a powerful existential force, and are generally more effective than general support groups alone.[60]

Even therapists who nominally adhere to other orientations are often surprised when they look deeply at their techniques and at their basic view of the human situation and find that they are existentially oriented.[61] If you feel that we are more than a sum of parts, that some of the central features that make us human—purpose, responsibility, sentience, will, values, courage, spirit—should be part of our therapeutic focus, then to that degree you have an existentialist sensibility.

I (IY) must be careful not to slip off the surface of these pages and glide into another book. This is not the place to discuss in any depth the existential frame of reference in therapy. I refer interested readers to my book *Existential Psychotherapy*.[62]

The existential therapeutic approach—with its emphasis on awareness of death, freedom, isolation, and life purpose—has been, until recently, far more acceptable to the European therapeutic community than to the American one. The European philosophic tradition, the geographic and ethnic confinement, and the greater familiarity with limits, war, death, and uncertain existence all favored the spread of the existential influence. The American zeitgeist of expansiveness, optimism, limitless horizons, and pragmatism was instead fertile ground for the scientific positivism proffered by a mechanistic Freudian metaphysics or a hyperrational, empirical behaviorism (strange bedfellows!). Morris Nitsun has described how the European and American cultures, influenced by their histories of wars, illness, and the development of nationhood, have shaped the

dominant models of group therapy on each continent. Our psychotherapy models are inevitably influenced by the societies in which they are embedded.[63]

Our conceptual models continue to evolve. During the past six decades, there have been major developments in American psychotherapy, among them the emergence of what has come to be known as the third force in American psychology (after Freudian psychoanalysis and Watsonian behaviorism). This force, often labeled “existential” or “humanistic,” has had an enormous influence on modern therapeutic practice. This evolution continues as we recognize limitations of earlier models and expand our thinking to include spiritual, multiculturalist, and social justice dimensions.[64]

We have done more than import the European existential tradition; we have Americanized it. Thus, although the syntax of humanistic psychology is European, the accent is unmistakably New World. The European focus is on the tragic dimensions of existence, on limits, on facing and taking into oneself the anxiety of uncertainty and nonbeing. The American humanistic psychologists, on the other hand, speak less of limits and contingency than of human potentiality; less of acceptance than of awareness; less of anxiety than of peak experiences and oceanic oneness; less of life meaning than of self-realization; less of apartness and basic isolation than of “I-Thou” and meaningful encounter.

Of course, when a basic doctrine has a number of postulates and the accent of each is systematically altered in a specific direction, there is a significant risk of divergence from the original doctrine. To some extent this has occurred; some humanistic psychologists have lost touch with their existential roots and espouse a monolithic goal of self-actualization, using quick techniques that promise personal transformation. This is a most unfortunate development. It is important to keep in mind that the existential approach in therapy is not a set of technical procedures, but, basically, an attitude, a sensibility toward the facts of life inherent in the human condition.

Existential therapy is a dynamic approach based on concerns that are rooted in existence. Earlier we mentioned that a “dynamic”

approach refers to a therapy that assumes that the deep structures of personality encompass forces that are in conflict with one another, and that these forces exist at different levels of awareness; indeed, some exist outside of conscious awareness. But what about the *content* of the internal struggle?

The existential view of the *content* differs greatly from the view taken in other theories of dynamic systems. A traditional psychoanalytic approach, for example, addresses the struggle between the individual's fundamental drives (primarily sexual and aggressive) and an environment that frustrates satisfaction of those drives. Alternatively, a self-psychology approach would attend to the individual's efforts to preserve a stable sense of self as vital and worthwhile in the context of affirming or disappointing self-object relationships, while a modern analytic approach would address the transferences and resistances to emotional engagement.

The existential approach holds that the human being's paramount struggle is with the unavoidable "givens" of existence—the ultimate concerns of the human condition, which include death, isolation, freedom, and meaninglessness. Anxiety emerges from basic conflicts in each of these realms: (1) we wish to continue to be, and yet are aware of our inevitable death; (2) we crave imposed structure, and yet must confront the truth that we are the authors of our own life design, and our beliefs and neural apparatus are responsible for the form of our reality—underneath us there is *Nichts*, groundlessness, the abyss; (3) we desire contact and protection, to be part of a larger whole, yet experience the unbridgeable gap between self and others; and (4) we are meaning-seeking creatures thrown into a world that has no intrinsic meaning.

The items in the Q-sort that resonated for the subjects in the study reflected some of these painful truths about existence. Group members realized that there were limits to the guidance and support they could receive from others and that the ultimate responsibility for the conduct of their lives was theirs alone. They learned also that though they could be close to others, there was a point beyond which they could not be accompanied: there is a basic aloneness to existence that must be faced and borne. Many clients learned to face

their limitations and their mortality with greater candor and courage. Coming to terms with their own deaths in a deeply authentic fashion permitted them to cast the troublesome concerns of everyday life in a different perspective. It permitted them to trivialize life's trivia.

We often ignore these existential givens until life events demand our attention. We may at first respond to illness, bereavement, and trauma with denial, but ultimately the impact of these life-altering events may break through. They create a therapeutic opportunity to catalyze constructive changes in oneself, in one's relationships, and in one's relationship to life in general. Posttraumatic growth occurs regularly when individuals are helped to process the traumatic disruptions in their lives.[65]

In one study, after attending ten sessions of group therapy, women with early-stage breast cancer were more optimistic and less depressed and anxious than other women with cancer who did not attend group therapy. They were also more likely to conclude that their cancer had contributed positively to their lives by causing them to realign their life priorities.[66] In another study, a similar group showed a significant reduction in levels of the stress hormone cortisol.[67] Studies comparing different types of groups for individuals with advanced cancer are also notable. The existentially informed, meaning-focused group therapies produced a higher quality of life and a greater sense of spiritual well-being than the traditional support groups, with participants experiencing less depression, less hopelessness, and less distress from physical symptoms.[68]

The course of therapy for Sheila, a client who at the end of treatment selected the existential Q-sort items as having been instrumental in her improvement, illustrates many of these points:

> **A twenty-five-year-old perennial student, Sheila, complained of** depression, loneliness, purposelessness, and severe gastric distress for which no organic cause could be found. In a pregroup individual session, she lamented repeatedly, "I don't know what's going on!"
>
> I (IY) could not understand precisely what she meant, and since this complaint was embedded in a litany of self-accusations, I soon forgot it. However, she did not understand what was happening to her in the

group, either: she could not understand why others were so uninterested in her, why she had developed a host of somatic ailments, why she entered sexually masochistic relationships, or why she so idealized the therapist.

In the group, Sheila was boring and absolutely predictable. Before every utterance, she scanned the sea of faces in the group searching for clues to what others wanted and expected. She was willing to be almost anything so as to avoid offending others and possibly driving them away from her. (Of course, she did drive others away, not from anger but from boredom.) Sheila was in chronic retreat from life, and the group tried endless approaches to halt the retreat, and to find Sheila within the cocoon of compliance she had spun around herself.

No progress occurred until the group stopped encouraging Sheila, stopped attempting to force her to socialize, to study, to write papers, to pay bills, to buy clothes, to groom herself, but instead urged her to consider the blessings of failure. What was there in failure that was so seductive and so rewarding? Quite a bit, it turned out! Failing kept her young, kept her protected, kept her from deciding. Idealizing the therapist served the same purpose. Help was out there. He knew the answers. Her job in therapy was to enfeeble herself to the point where the therapist could not in all good conscience withhold his royal touch.

A critical event occurred when she developed an enlarged axillary lymph node. She had a biopsy performed, and later that day came to the group still fearfully awaiting the results (which ultimately proved the enlarged node to be benign). Never before had she so closely considered her own death, and we helped Sheila plunge into the terrifying loneliness she experienced. There are two kinds of loneliness: the primordial, existential loneliness that Sheila confronted in that meeting, and social loneliness, an inability to be with others.

Social loneliness is commonly and easily worked with in a group therapeutic setting. Existential loneliness is more hidden, obscured by the distractions of everyday life, and more rarely faced. Sometimes groups confuse the two and make an effort to resolve or to heal a member's basic loneliness. But, as Sheila learned that day, it cannot be taken away; it cannot be resolved; it can only be known and ultimately embraced as an integral part of existence.

Rather quickly, then, Sheila changed. She reintegrated far-strewn bits of herself. She began to make decisions and to take over the helm of her life. She commented, "I think I know what's going on" (I had long forgotten her initial complaint). More than anything else, she had been trying to avoid the specter of loneliness. I think she tried to elude it by

staying young, by avoiding choice and decision, by perpetuating the myth that there would always be someone who would choose for her, would accompany her, would be there for her. **<<**

Choice and freedom invariably imply loneliness, and, as Erich Fromm pointed out long ago in *Escape from Freedom*, freedom often holds more terror for us than tyranny.[69]

TURNING BACK AGAIN TO TABLE 4.1, LET US CONSIDER ITEM 60, which so many clients rated so highly: *Learning that I must take ultimate responsibility for the way I live my life, no matter how much guidance and support I get from others.* In a sense, this is a double-edged factor in group therapy. Group members learn a great deal about how to relate better with others, how to develop greater intimacy with others, and how to give help to others and ask for help from others. At the same time, they discover the limits of intimacy; they learn what they cannot obtain from others. It is a harsh lesson and leads to both despair and strength. One cannot stare at the sun for very long, and Sheila on many occasions looked away and avoided her dread. But she was always able to return to it and, by the end of therapy, had made major shifts within herself.

An important concept in existential therapy is that human beings may relate to the ultimate concerns of existence in one of two possible modes. On the one hand, we may suppress or ignore our situation in life and live in what Martin Heidegger termed a state of *forgetfulness of being*.[70] In this everyday mode, we live in the world of things, in everyday diversions; we are absorbed in chatter, tranquilized, lost in the "they"; we are concerned only about the way things are. On the other hand, we may exist in a state of *mindfulness of being*, a state in which we marvel not at the way things are, but *that* they are. In this state, we are aware of being; we live authentically; we embrace our possibilities and limits; we are aware of our responsibility for our lives. (This state is captured well by Jean-Paul Sartre's definition of responsibility: "To be responsible is to be the 'uncontested author of…'")[71]

Being aware of one's self-creation in the authentic state of mindfulness of being provides one with the power to change and the hope that one's actions will bear fruit. Thus, the therapist must pay special attention to the factors that transport a person from the *everyday* to the *authentic* mode of existing. One cannot create such a shift merely by bearing down, by gritting one's teeth. But there are certain jolting experiences (often referred to in the philosophical literature as "boundary experiences") that effectively transport one into the mindfulness-of-being state.[72]

Some group leaders attempt to generate such experiences by using a form of existential shock therapy. With a variety of techniques, they try to bring clients to the edge of the abyss of existence. We have seen leaders begin personal growth groups, for example, by asking clients to compose their own epitaphs. An extreme experience—such as Sheila's encounter with a possibly malignant tumor—is a good example of a boundary experience: an event that brings one sharply back to reality and helps one put one's concerns in their proper perspective. Extreme experience, however, occurs in its natural state only rarely during the course of a therapy group, and the adept leader finds other ways to introduce these factors. The growing emphasis on brief therapy offers an excellent opportunity: the therapist may use the looming end of therapy or the departure of a member to urge clients to consider other terminations, including death, and to reconsider how to improve the quality and satisfaction of their remaining time. It is in this domain that the existential and interpersonal intersect as clients begin to ask themselves fundamental questions: What choices do I exercise in my relationships and in my behavior? How do I wish to be experienced by others? Am I truly present and engaged in this relationship, or am I managing the relationship inauthentically to reduce my anxiety? Do I care about what this person needs from me, or am I motivated by my constricted self-interest?

Every encounter matters and may set in motion far-reaching impacts. I (ML) experienced a powerful illustration of this principle when discussing group psychotherapy in a regional affiliate of the

American Group Psychotherapy Association. I had returned there twelve years after my first two-day visit, and as I had done twelve years previously, I blended lectures with demonstration groups. These groups were composed of volunteers who participated in three sessions observed by the rest of the attendees. These are not psychotherapy groups, of course, but deeply personal material does emerge.

> **In the last of our three sessions, I stressed our time limit and the** importance of using time well, making every moment count, and reducing regrets of things unsaid. Susan, a therapist in her fifties, asked for time and then floored me and everyone in the room. “I have been waiting twelve years for this opportunity to come and participate in this demonstration group with you. I want to tell you that the last time you were here, you saved my life. Your presentation about group therapy for women with metastatic breast cancer and what you said about not leaving things unaddressed pushed me into a mammogram that I had avoided because I dreaded the prospect of being touched and prodded in that way. I booked an appointment shortly after that session and was shocked to learn I had an aggressive form of breast cancer. I was treated for it effectively at that time and I have been cancer-free since. I believe my characteristic neglect and avoidance would have resulted in this becoming metastatic disease and killing me. I have never put myself forward for a demo group before even though I have attended dozens of these trainings. But I was not going to miss this opportunity.”
>
> I acknowledged the profound impact her disclosure had on me. I thanked her and told her that what she had shared would stay with me forever. It underscored, better than I could have possibly imagined, the theme I had hoped to demonstrate that day about using time meaningfully and not leaving things unaddressed. **<<**

Our capacity for denial is enormous, and it is the rare group that perseveres and does not slip back into less threatening concerns. Natural events in the course of a group—illness, death, termination, and loss—may jolt the group back to a more existential frame of mind, but always temporarily.

In 1974, I (IY) began to lead groups of individuals who lived continuously in the midst of extreme experience.[73] All the members had a terminal illness, generally metastatic carcinoma, and all were

entirely aware of the nature and implications of their illness. I learned a great deal from these groups, especially about the fundamental but concealed issues of life that are so frequently neglected in traditional psychotherapy (see Chapter 15 for a detailed description of this group and current applications of the supportive-expressive group approach).

As we reflect back on our therapy groups for cancer patients, several features stand out. For one thing, the members were deeply supportive to one another, and being useful to someone else drew them out of morbid self-absorption and provided them with a sense of purpose and meaning. Almost every terminally ill person we have worked with has expressed deep fear of helpless immobility—not only of being a burden, but of being useless and without value to others. Living then becomes reduced to pointless survival, and the individual searches within, ever more deeply, for meaning. The group offered these participants the opportunity to find meaning outside themselves by extending help to another person. By caring for others, they found the sense of purpose that so often eludes sheer introspective reflection.

These approaches, these avenues to self-transcendence, if well-traveled, can increase one's sense of meaning and purpose as well as one's ability to bear what cannot be changed. Finding meaning in the face of adversity can be transformative.[74] Long ago, Nietzsche wrote: "He who has a why to live can bear with almost any how."[75]

It was clear, through observation and empirical research, that the members of these groups who plunged most deeply into themselves, who confronted their fate most openly and resolutely, passed into a richer mode of existence.[76] Their life perspective was radically altered, and the trivial, inconsequential diversions of life were seen for what they were. Their neurotic phobias diminished. They appreciated more fully the elemental features of living: the changing seasons, the loving of others, and the joy in the seemingly mundane, such as meeting one's child after school. Rather than resignation, powerlessness, and restriction, some members experienced a great sense of liberation and autonomy.

Some even spoke of the gift of cancer. What some considered tragic was not their death per se, but that they had learned how to live life fully only after being threatened by serious illness. They wondered if it was possible to teach their loved ones this important lesson earlier in life, or whether it could be learned only *in extremis*. It may be that, though the act of death ends life, the *idea* of death revitalizes life: death becomes a co-therapist pushing the work of psychotherapy ahead.

What can you as therapist do in the face of the inevitable? I think the answer lies in the verb *to be*. You do by being, by being there with the client. Presence is the hidden agent of help in all forms of therapy.[77] Clients looking back on their therapy rarely remember a single interpretation you uttered, but they always remember your presence, that you were there with them. It is asking a great deal of the therapist to join such a group, yet it would be hypocrisy not to join. The group does not consist of you (the therapist) and them (the dying); it is *we* who are dying, *we* who are banding together in the face of our common condition. In my (IY) book *The Gift of Therapy*, I propose that the most accurate or felicitous term for the therapeutic relationship might be “fellow traveler.”

The group well demonstrates the double meaning of the word *apartness*: we are separate, lonely, *apart from*, but also *a part of*. One group member put it elegantly when she described herself as a lonely ship in the dark. Even though no physical mooring could be made, it was nonetheless enormously comforting to see the lights of other ships sailing the same water.

COMPARATIVE VALUE OF THE THERAPEUTIC FACTORS: DIFFERENCES BETWEEN CLIENTS' AND THERAPISTS' VIEWS

Do clients and therapists agree about what helps in group psychotherapy? Research comparing therapists' and clients' assessments is instructive. First, keep in mind that therapists' published views of the range of therapeutic factors are broadly analogous to the factors we have described.[78] But, of course, leaders from different ideological schools differ in their weighting of the therapeutic factors, even though they often resemble one another in the way they actually practice psychotherapy.[79]

The research data tells us that therapists and clients differ in their valuation of the group therapeutic factors. A study of one hundred acute inpatient group members and their thirty behaviorally oriented therapists showed that the therapists and clients differed significantly in their ranking of therapeutic factors. The therapists valued modeling and experimenting with new behaviors, whereas the group members valued self-responsibility, self-understanding, and universality.[80] Another study showed that members of alcohol addiction groups ranked existential factors far higher than their therapists did.[81] It should not be surprising that substance abuse clients value accountability and personal responsibility highly. These factors are cornerstones of twelve-step groups.

Fifteen HIV-positive men treated in time-limited cognitive-behavioral therapy groups for depression also cited different therapeutic factors than their therapists did. Members selected social support, cohesion, universality, altruism, and existential factors, whereas the therapists (in line with their ideological school) considered cognitive restructuring as the mutative agent.[82]

A large survey of prison therapy groups noted that inmates agreed with their group leaders about the importance of interpersonal learning, but valued existential factors far more highly

than their therapists did.[83] As noted earlier, incest victims in group therapy highly value the therapeutic factor of family reenactment.[84]

Therapists are wise to be alert to these divergences and to honor the client relationship over professional ideology. This issue is not restricted to group therapy. Client-therapist discrepancies on therapeutic factors also occur in individual psychotherapy. A large study of psychoanalytically oriented therapy found that clients attributed their successful therapy to relationship factors, whereas their therapists gave precedence to technical skills and techniques.[85] In general, analytic therapists value the coming to consciousness of unconscious factors and the subsequent linkage between childhood experiences and current symptoms far more than their clients do. Indeed, their clients often deny the importance or even the existence of these elements in therapy and instead emphasize the personal elements of the relationship and the encounter with a new, accepting type of authority figure. Keep in mind that it is the client perspective that matters most.[86] Such client-therapist divergence may strain or even rupture the alliance if the therapist fails to respect and understand the client's attribution of value in the therapy.[87]

A turning point in the treatment of one client starkly illustrates the differences. In the midst of treatment, the client had an acute anxiety attack and was seen by the therapist in an emergency session. Both therapist and client regarded the incident as critical, but for very different reasons. To the therapist, the emergency session unlocked the client's previously repressed memories of early incestuous sex play and facilitated a working-through of important Oedipal material. The client, however, entirely dismissed the *content* of the emergency session and instead valued the relationship implications: the caring and concern expressed by the therapist and his willingness to see him in the middle of the night.

A similar discrepancy between client and therapist views of therapy is described in *Every Day Gets a Little Closer*, a book I (IY) coauthored with a client.[88] Throughout the treatment, she and I wrote independent, impressionistic summaries of each meeting and

handed them in, sealed, to my secretary. Every few months we read each other's summaries, and we discovered that we valued very different aspects of the therapeutic process. All my elegant interpretations? She never even heard them! What she remembered and treasured were the soft, subtle, personal exchanges, which, to her, conveyed my interest and caring for her.

Reviews of process and outcome research reveal that clients' ratings of therapist engagement and empathy are more predictive of therapeutic success than therapists' ratings of these same variables.[89] These findings compel us to pay close attention to the client's view of the most salient therapeutic factors. In research as in clinical work, we do well to heed the adage: *Listen to the client.*

To summarize: Therapists and their clients differ in their views about important therapeutic factors. Clients consistently emphasize the relationship and the personal, human qualities of the therapist, whereas therapists attribute their success to their techniques. When, in group therapy, the therapist-client discrepancy is too great, and therapists emphasize therapeutic factors that are incompatible with the needs and capacities of the group members, the therapeutic enterprise will be derailed: clients will become bewildered and resistant, and therapists will become discouraged and exasperated. The therapist's capacity to respond to client vulnerability with warmth and tenderness is pivotal, and may lie at the heart of the transformative power of therapy.

THERAPEUTIC FACTORS: MODIFYING FORCES

It is not possible to construct an absolute hierarchy of therapeutic factors. There are many modifying forces: therapeutic factors are influenced by the type of group therapy, the stage of therapy, extragroup forces, and individual differences. The therapist's flexibility and responsiveness are better guides than any arbitrary hierarchy of value could be in maximizing the use of the therapeutic factors.

Therapeutic Factors in Different Group Therapies

Different types of group therapy use different clusters of therapeutic factors. Consider, for example, the therapy group on an acute psychiatric inpatient ward. Members of inpatient therapy groups rarely select the same constellation of three factors (interpersonal learning, catharsis, and self-understanding) that most members of outpatient groups cite.[90] Rather, they select a wide range of therapeutic factors that reflect both the heterogeneous composition of inpatient therapy groups and the cafeteria theory of improvement in group therapy. Clients who differ greatly from one another in ego strength, motivation, goals, and type and severity of psychopathology meet in the same inpatient group and, accordingly, select and value different aspects of the group procedure. Many more inpatients than outpatients select the therapeutic factors of instillation of hope and existential factors. Instillation of hope looms large in inpatient groups because so many individuals enter the hospital in a state of utter demoralization. Until the individual acquires hope and the motivation to engage in treatment, no progress will be made. Often the most effective antidote to demoralization is the presence of others who have recently been in similar straits and discovered a way out of despair.

Existential factors (defined on the research instruments generally as "assumption of ultimate responsibility for my own life") are of particular importance to inpatients, because often hospitalization

confronts them with the limits of other people: external resources have been exhausted; family, friends, and therapists have failed; they have hit bottom and realize that, in the final analysis, they can rely only on themselves. (On one inpatient Q-sort study, the assumption of responsibility, item 60, was ranked first of the sixty items.)[91]

A vast range of homogeneously composed groups exist. The range of therapeutic factors chosen by the members of various groups is summarized in the box "Therapeutic Factors and Diverse Therapy Groups."

THERAPEUTIC FACTORS AND DIVERSE THERAPY GROUPS

- Alcoholics Anonymous members emphasize the instillation of hope, imparting information, universality, and cohesion.[92]
- Successfully treated clients in a fifteen-session group treatment of drug addiction in Egypt reported high valuation of the therapeutic factors of catharsis, cohesion, and interpersonal learning; identification was ranked lowest. These findings are remarkably similar to the findings described in successfully treated general outpatients in North America.[93]
- Textual analysis of transcriptions of tape-recorded therapy sessions of an interactional inpatient therapy group for patients with concurrent addiction and mental illness revealed an evolution in therapeutic factors valuation beginning with early expression of feelings, learning about group therapy, and feeling cared for, and later maturing into catharsis and group cohesion.[94]
- Children treated in sixteen sessions of group therapy for emotional and behavioral difficulties demonstrated, through a posttreatment analysis of critical incidents, that the most important therapeutic factor was "relationship-climate." Feeling

safe, accepted, and that they belonged ranked higher for the children than learning and problem-solving factors, suggesting that an important developmental need was met in the group. Self-disclosure emerged only after that sense of belonging was secure.[95]

- Participants of occupational therapy groups most valued the factors of cohesiveness, instillation of hope, and interpersonal learning.[96]
- Members of psychodrama groups in Israel, despite differences in culture and treatment format, selected factors consistent with those selected by group therapy outpatients: interpersonal learning, catharsis, group cohesiveness, and self-understanding.[97]
- Members of self-help groups (women's consciousness raising, bereaved parents, widows, heart surgery patients, and mothers) commonly chose factors of universality, followed by guidance, altruism, and cohesiveness.[98]
- Members of an eighteen-month-long group of spouses caring for a partner with a brain tumor chose universality, altruism, instillation of hope, and the provision of information.[99]
- Psychotic clients with intrusive, controlling, auditory hallucinations successfully treated in cognitive-behavioral therapy groups valued universality, hope, and catharsis. For them, finally being able to talk about their voices and feeling understood by peers was enormously valuable.[100]
- Spousal abusers in a psychoeducational group selected the imparting of information as a chief therapeutic factor.[101]
- Adolescents in learning disability groups cited the effectiveness of "mutual recognition"—of seeing oneself in others and feeling valued and less isolated.[102]
- Geriatric group participants confronting limits, mortality, and the passage of time selected existential factors as critically

important.[103]

When therapists form a new therapy group in some specialized setting or for some specialized clinical population, the first step is to determine the appropriate goals and, after that, the therapeutic factors most likely to help that particular group reach those goals. Everything else, all matters of therapeutic technique, follow from that framework.

In all groups, we can deepen our clients' therapeutic experience through thoughtful and deliberate employment of the therapeutic factors in the service of creating and sustaining an energized, therapeutic group climate marked by empathy and connectedness.[104] We should always be asking ourselves, "How can I maximize this therapeutic opportunity?" Thus, it is vitally important to keep in mind that there is persuasive research suggesting that different therapeutic factors can be effective in group therapy at different points in time and for different purposes.

For example, consider more structured groups, such as a time-limited psychoeducational group for panic attacks, whose members may receive considerable benefit from group leader instruction on cognitive strategies for preventing and minimizing the disruptiveness of the attacks (guidance). The experience of being in a group of people who suffer from the same problem (universality) is also likely to be very comforting. Although difficulties in relationships may indeed contribute to the clients' symptoms, an undue focus on the therapeutic factor of interpersonal learning would not be warranted given the time frame of the group.

Cognitive-behavioral group therapy is enhanced as well by the leader's attention to the utilization of therapeutic factors: remoralization through instillation of hope; reduced isolation and stigma through universality; a sense of belonging through cohesion; acquisition of knowledge through guidance; self-esteem enhancement through altruism; and skill development through socialization and practice.[105]

Understanding the client's experience of the therapeutic factors

can lead to enlightened and productive group innovations. An excellent illustration is a multimodal group approach for bulimia nervosa that offers three effective therapeutic components: imparting information, learning coping skills, and exploring interpersonal relationships. This twelve-week group starts with a psychoeducation module about bulimia and nutrition; next is a cognitive-behavioral module that examines distorted cognitions about eating and body image; and the group concludes with an interpersonally oriented group segment that examines here-and-now relationship concerns and their impact on eating behaviors.[106]

Therapeutic Factors and Stages of Therapy

Intensive interactional group therapy exerts its chief therapeutic power through interpersonal learning (encompassing catharsis, self-understanding, and interpersonal input and output) and group cohesiveness, but the other therapeutic factors play an indispensable role in the intensive therapy process. To appreciate the interdependence of the therapeutic factors, we must consider the entire group process from start to finish.[107]

Many clients expressed difficulty in rank-ordering therapeutic factors because they found different factors helpful at different stages of therapy. Factors of considerable importance early in therapy may be far less salient late in the course of treatment. In the early stages of development, the group's chief concerns are with establishing boundaries and maintaining membership. In this stage, factors such as the instillation of hope, guidance, and universality are especially important.[108]

The first dozen meetings of a group present a high-risk period for potential dropouts, and it is often necessary to awaken hope in the members in order to keep them attending through this critical phase. Factors such as altruism and group cohesiveness operate throughout therapy, but their nature changes with the stage of the group. Early in therapy, altruism takes the form of offering suggestions or helping one another talk by asking appropriate questions and giving attention. Later it may take the form of a more

profound caring and presence.

Group cohesiveness operates as a therapeutic factor at first by means of group support, acceptance, and the facilitation of attendance, and later by means of the interrelation of group esteem and self-esteem and through its role in interpersonal learning. It is only after the development of group cohesiveness that members may engage deeply and constructively in the self-disclosure, feedback, confrontation, and conflict essential to the process of interpersonal learning. Cohesion continues to mount over time in long-term groups and requires the therapist's ongoing focus and attention.[109]

Therapists must appreciate this necessary group and individual developmental sequence to help prevent early group dropouts. In a study of therapeutic factors in long-term inpatient treatment in Germany, clinical improvement was related to the experience of early cohesion, which set the stage for greater personal self-disclosure, which generated the interpersonal feedback that produced behavioral and psychological change.[110] An outpatient study demonstrated that the longer group members participated in the group, the more they valued cohesiveness, self-understanding, and interpersonal output.[111]

In a study of twenty six-session growth groups, universality and hope declined in importance through the course of the group, whereas the importance of catharsis increased.[112] In a study of spouse abusers, universality was the prominent factor in early stages, while the importance of group cohesion grew over time.[113] This emphasis on universality may be characteristic in the treatment of clients who feel shame or stigma. The cohesion that promotes change, however, is best built on a respect for and acceptance of personal differences, which take time to mature. In another study, psychiatric inpatients at first valued universality, hope, and acceptance, but later, when they participated in outpatient group psychotherapy, they valued self-understanding more, underscoring the relationship between therapeutic factors and the client's trajectory of change.[114]

In summary, the therapeutic factors clients deem most important vary with the stage of group development. Clients' needs and goals change during the course of therapy. In Chapter 2, we described a common sequence in which group members first seek symptomatic relief and then, during subsequent sessions, formulate new goals, often interpersonal ones of relating more deeply and honestly to others. Clients change, the group goes through a developmental sequence, and the therapeutic factors shift in primacy and influence during the course of therapy. Therapists begin by ensuring group integrity, safety, belonging, connection, and cohesion; progress into catharsis, self-understanding, and interpersonal learning; and end with consolidation, internalization, and accepting personal responsibility for change in one's life.

Therapeutic Factors Outside the Group

Although we suggest that major behavioral and attitudinal shifts require a degree of interpersonal learning, occasionally group members make major changes without appearing to be fully invested in the group work. This brings up an important principle in therapy: *The therapist or the group does not have to do the entire job.* Forces outside of active treatment play a huge role in our clients' outcomes, accounting for up to 40 percent of the variability in outcome.[115] These extra-therapeutic forces include opportunities in employment, relationships, religion, community, and social relationships. And, of course, there are times when good fortune plays a role: various opportunities may arise in our clients' lives at just the right time for them developmentally.

Personality reconstruction as a therapeutic goal is as unrealistic as it is presumptuous. Our clients have many adaptive coping strengths that may have served them well in the past, and a boost from some event in therapy may be sufficient to help a client draw on these strengths. We have used the term "adaptive spiral" to refer to the process in which one change in a client begets changes in his or her interpersonal environment that beget further personal change. The adaptive spiral is the reverse of the vicious cycle in which so

many clients find themselves ensnared—a sequence of events in which dysphoria has interpersonal manifestations that weaken or disrupt interpersonal bonds and consequently create further dysphoria.

These points are documented when we ask clients about other therapeutic influences or events in their lives that occurred concurrently with their therapy course. In one sample of twenty clients, eighteen described a variety of extragroup therapeutic factors. Most commonly cited was a new or improved interpersonal relationship with one or more of a variety of figures (member of the opposite sex, parent, spouse, teacher, foster family, or new set of friends).[116] Two clients claimed to have benefited by going through with a divorce that had long been pending. Many others cited successes at work, at school, or in their community that raised their self-esteem as they established a reservoir of real accomplishments.

Perhaps these fortuitous, independent factors deserve credit, along with group therapy, for successful outcomes. In one sense, that is true: the external event augments therapy. Yet it is also true that the potential external event had often *always* been there; the therapy group simply mobilized members to take advantage of resources that *had long been available to them in their environment*. Clients in one study referred to these as “transfer factors,” that is, factors supporting the transfer of in-group skills and knowledge to home and work.[117]

Consider Bob, a lonely, shy, and insecure man who attended a time-limited twenty-five-session group. Though he spent considerable time discussing his fear about approaching women, and though the group devoted much effort to helping him, there seemed to be little change in his outside behavior. But at the final meeting of the group, Bob arrived with a big smile and a going-away present for the group: he brought in a profile he planned to post on an online dating site. The group eagerly listened to him as he described himself in a new and positive light that he attributed to the feedback he received in the group.

Partners, lovers, dating apps, relatives, potential friends, social

organizations, and academic or job opportunities are always out there, available, waiting for the client to seize them. The group may give a client only the necessary slight boost to allow him or her to exploit these previously untapped resources. At times, the group may end with no evidence of what the group may have launched. Therapists are often pleasantly surprised to get an email years after a client has ended group therapy with an update about personal and professional achievements. Later, when we discuss combined treatment, we will emphasize the point that therapists who continue to see clients in individual therapy long after the termination of the group often learn that members make use of the internalized group months, even years, later.

We have considered, at several places in this text, how group members acquire skills that prepare them for new social situations in the future. Not only are extrinsic skills, such as greater emotional intelligence and empathic capacity, acquired, but intrinsic capacities are also released. Psychotherapy removes neurotic obstructions that have stunted the development of the client's own resources. The view of therapy as *obstruction removal* lightens the burden of therapists and enables them to retain respect for the rich, never fully knowable, capacities of their clients.

Individual Differences and Therapeutic Factors

There is considerable individual variation in the rankings of therapeutic factors, and some researchers have attempted to determine the individual characteristics that influence these choices. There is evidence that level of functioning is significantly related to the ranking of therapeutic factors: for example, higher-functioning individuals with greater psychological-mindedness value interpersonal learning (the cluster of interpersonal input and output, catharsis, and self-understanding) more than the lower-functioning members in the same group do.[118] It has also been shown that inpatient group members with less psychological awareness value the instillation of hope, whereas higher-functioning members in the same groups value universality, vicarious learning, and interpersonal

learning.[119] A large number of other studies demonstrate differences between individuals based on other differential criteria (high encounter group learners vs. low learners, dominant vs. nondominant clients, overly responsible vs. nonresponsible clients, high self-acceptors vs. low self-acceptors, high-affiliative vs. low-affiliative students).[120]

Not everyone needs the same things or responds in the same way to group therapy. Attachment style is a source of much divergence. Insecure and anxiously attached individuals will draw comfort from the sense of belonging in a group and use that as a platform for therapy and developing more secure attachment. In contrast, clients with a dismissive and avoidant attachment style may experience the same group degree of cohesiveness as intrusive and demanding, even aversive.[121] They disclose little and are less engaged with other members. Yet if they are supported and persevere, they eventually engage and show significant and durable improvements in attachment security, mood, and interpersonal functioning.[122] Clients with a secure attachment style readily make excellent use of cohesion and dive in with self-disclosures and openness to feedback.[123] As always in our work, the relationally rich get richer. The challenge is helping the relationally poor get richer.

There are many therapeutic pathways through the group therapy experience. Consider, for example, catharsis. Some restricted individuals benefit by experiencing and expressing strong affect, whereas others, who have problems of impulse control and great emotional lability, may not benefit from catharsis but instead from reining in emotional expression and acquiring intellectual structure. Narcissistic individuals need to learn to share and to give, whereas passive, self-effacing individuals need to learn to express their needs and to become *more* self-focused. Some clients may need to develop even rudimentary social skills; others may need to work with more complex issues—for example, a male client who needs to stop competing with all the members of the group, demonstrating his superior intellect at the expense of any warmth or closeness with others.

In sum, the comparative potency of the therapeutic factors is complex. Different factors are valued by different types of therapy groups, by the same group at different developmental stages, and by different clients within the same group, depending on individual needs and strengths. We also see that the power of the interactional outpatient group emanates from its interpersonal focus. Interpersonal interaction, exploration (encompassing catharsis and self-understanding), and group cohesiveness are the *sine qua non* of effective group therapy, and effective group therapists must direct their efforts toward maximizing these therapeutic forces. We now turn our attention to the role and the techniques of the group therapist from the viewpoint of these therapeutic factors. Later chapters will address the group therapist's role and techniques in specialized groups and settings.

Footnotes

i The list of sixty factor items passed through several versions and was circulated among senior group therapists for suggestions, additions, and deletions. Some of the items are nearly identical, but it was necessary methodologically to have the same number of items representing each category. The twelve categories are altruism, group cohesiveness, universality, interpersonal learning—input, interpersonal learning—output, guidance, catharsis, identification, family reenactment, self-understanding, instillation of hope, and existential factors. They are not quite identical to those described in this book; we attempted, unsuccessfully, to divide interpersonal learning into two parts: input and output. One category, self-understanding, was included to permit examination of derepression and insight regarding the early life contributions to current psychological difficulties. Imparting information replaces guidance. Corrective recapitulation of the primary family group replaces family reenactment. Development of socializing techniques replaces interpersonal learning—output. Interpersonal learning replaces Interpersonal learning—input and self-understanding. Finally, imitative behavior replaces identification. The therapeutic factor survey was meant to be an exploratory instrument constructed a priori on the basis of clinical intuition (my own and that of experienced clinicians); it was never meant to be posited as a finely calibrated research instrument. But it has been used in so much subsequent research that much discussion has arisen about construct validity and test-retest reliability. Multilevel statistical analysis may further refine our understanding beyond descriptive analysis. In a series of papers, Dennis Kivlighan and colleagues noted that clear patterns of therapeutic factor rankings across groups do not readily emerge; they categorized therapeutic factors according to the type of group studied and distinguished between affective insight, affective support, cognitive insight, and cognitive support groups. Giorgio Tasca and colleagues realigned the therapeutic factors into four overarching ones: social learning, secure emotional expression, instillation of hope, and awareness of relational impact. This classification shows good internal consistency and predictive value for outcome. Mark Stone, Carol Lewis, and Ariadne Beck have also constructed a brief, modified form with considerable internal consistency.

iii In considering these results, we must keep in mind that the subject's task was a forced sort, which means that the lowest-ranked items are not necessarily unimportant but are simply less important than the others. Each item carries some therapeutic potency.

ix Factor analysis is a statistical method that identifies the smallest number of hypothetical constructs needed to explain the greatest degree of consistency in a data set. It is a way to compress large quantities of data into smaller but conceptually and practically consistent data groupings.

- 5 -

The Therapist

Basic Tasks

NOW THAT WE HAVE CONSIDERED HOW PEOPLE CHANGE IN group therapy, it is time to turn to the therapist's role in the therapeutic process. In this chapter, we consider the basic tasks of the therapist and the techniques by which they may be accomplished.

The four previous chapters contended that therapy is a complex process consisting of elemental factors that interlace in an intricate fashion. The group therapist's job is to create the machinery of therapy, to set it in motion, and to keep it operating with maximum effectiveness. These tasks require different types of knowledge and skills but build atop a consistent therapeutic attitude and approach that we will return to again and again.

Underlying all considerations of technique must be a consistent, positive, empathic, and culturally attuned relationship between therapist and client. The basic posture of the therapist to a client must be one of concern, genuineness, empathy, and emotional engagement. *Nothing, no technical consideration, takes precedence over this attitude*. Of course, there will be times when the therapist challenges the client, shows frustration, even suggests that if the client is not going to work, he or she should consider leaving the group. But these efforts (which in the right circumstances may have therapeutic clout) are never effective unless they are experienced against a horizon of an accepting and caring therapist-client relationship. Research consistently demonstrates that all effective psychotherapists share these common features.[1]

We will discuss the techniques of the therapist in respect to three fundamental tasks:

1. Creation and maintenance of the group
2. Building a group culture
3. Activation and illumination of the here-and-now

CREATION AND MAINTENANCE OF THE GROUP

Group leaders are solely responsible for creating and convening the group and setting the time and place for meetings. Much of their work is performed before the first meeting, and, as we will elaborate in later chapters, their expertise in the selection and preparation of members in composing the group will greatly influence the group's fate. In agency and institutional settings, an additional consideration includes their relationship with the administration whose practical support is essential in creating and sustaining successful therapy groups.[2]

Once the group begins, the therapist attends to gatekeeping, especially the prevention of member attrition. Clients who complete the anticipated course of therapy generally improve significantly. The challenge is keeping them in treatment.[3] Occasionally an individual will have an unsuccessful group experience and leave therapy prematurely. Yet such an experience may play some useful function in his or her overall course of therapy; failure in or rejection by a group may so unsettle clients as to prime them ideally for subsequent treatment. For example, in my role as the clinical supervisor and coordinator of trainee-led group therapy, I (ML) received an email from Amy, a client who had angrily dropped out of her first group experience and then attended and completed another therapy group: *"Thank you for giving me a second chance with group therapy to work through my stuff. My second experience could not have been more different from the first group—I am sure I learned some things about myself after the first fiasco but I must tell you that the members of the 2nd group and I were a much better fit and the group leaders in my second group were so caring that I felt safe to open up for the first time."* Amy's email powerfully reminds us to be open to therapy second chances.

Generally, however, a client who drops out early in the course of the group should be considered a therapeutic failure. Not only does the client fail to receive benefit, but the progress of the remainder of

the group is adversely affected. Stability of membership is an absolutely essential condition for successful therapy. If dropouts do occur, the therapist must, except in the case of a closed group (see Chapter 9), add new members to maintain the group at its ideal size.

Initially, the clients are strangers to one another and know only the therapist, who is the group's primary unifying force. The members relate to one another at first through their common relationship with the therapist, and these therapist-client alliances set the stage for the eventual development of group cohesion.

The therapist must recognize and deter any forces that threaten group cohesiveness. Continued lateness, absences, the formation of subgroups, disruptive extragroup socialization, and scapegoating all threaten the functional integrity of the group and require therapist intervention. Each of these issues will be discussed fully in later chapters. For now, it is necessary only to emphasize the therapist's responsibility to supra-individual needs. Your first developmental task is to help create and maintain a physical entity: a cohesive group. There will be times when you must delay dealing with the pressing needs of an individual client, and even times when you will have to remove a member from the group for the good of the other members.

A clinical vignette illustrates some of these points:

> **I (IY) introduced two new members, both women, into an outpa**tient group. This particular group, with a stable core of five men and two women, had difficulty retaining female members. Two women had dropped out in the previous month. This meeting began inauspiciously for one of the new members when her perfume triggered a sneezing fit in one of the men, who moved his chair away from her and then, while vigorously opening the windows, informed her of his perfume allergy and of the group's "no scent" rule.
>
> At this point another member, Mitch, arrived a couple of minutes late and, without even a glance at the two new members, announced, "I need some time today from the group. I was really shaken up by the meeting last week. I went home from the group very disturbed by the feedback about my being a time hog. I didn't like those comments from any of you, or from you [meaning me] either. It threw me off completely and later that evening I had an enormous fight with my wife, who took

exception to my reading my iPad at the dinner table, and we haven't been speaking since."

Now this particular opening would have been a good one for most group meetings. It had many things going for it. The client stated that he wanted some time. (The more members who come to the group asking for time and eager to work, the more energized a meeting will be.) Also, he wanted to work on issues that had been raised in the previous week's meeting. (As a general rule, the more group members work on continuing themes from meeting to meeting, the more effective the group becomes.) Furthermore, he began the meeting by attacking me, the therapist, and that was a good thing; this group had been treating me much too gently. Mitch's attack, though uncomfortable, was, I felt certain, going to produce important group work.

I had many different options in the meeting, but one task had highest priority: *maintaining the functional integrity of the group*. I had introduced two female members into a group that had had some difficulty retaining women. And how had the members of the group responded? Not well! They had virtually disenfranchised the new members. After the sneezing incident, Mitch had not even acknowledged their presence and had launched into a discussion of his marriage—a subject that, though personally important, inherently excluded the new women by referring to the previous meeting.

It was important, then, for me to find a way to address this task and, if possible, also to address the issues Mitch had raised. Earlier in this book I offered the basic principle that therapy should strive to turn all issues into here-and-now issues. It would have been folly to deal explicitly with Mitch's fight with his wife. The data that Mitch would have given about his wife would have been biased and he might well have "yes, but-ted" the group into submission.

Fortunately, however, there was a way to tackle both issues at once. Mitch's treatment of the two women in the group bore many similarities to his treatment of his wife at the dinner table. He had been as insensitive to their presence and needs as to his wife's. In fact, it was precisely his insensitivity that the group had confronted the previous meeting.

Therefore, about a half hour into the meeting, I pried the group's focus away from Mitch and his wife by saying, "Mitch, I wonder what hunches you have about how our two new members are feeling in the group today?"

This inquiry led Mitch into the general issue of empathy and his inability or unwillingness in many situations to enter the experiential

world of the other. Fortunately, this tactic not only turned the other group members' attention to the way they all had ignored the two new women, but also helped Mitch work effectively on his core problem: his failure to recognize and appreciate the needs and wishes of others. Even if it were not possible to address some of Mitch's central issues around empathy and his self-absorption, I still would have opted to attend to the integration of the new members. The integration of new members and the physical survival of the group takes precedence over other tasks. **<<**

BUILDING A GROUP CULTURE

Once the group is a physical reality, the therapist's energy must be directed toward shaping it into a therapeutic social system. An unwritten code of behavioral rules, or *norms*, must be established that will guide the interaction of the group. And what are the desirable norms for a therapeutic group? They follow logically from the discussion of the therapeutic factors.

Consider for a moment the therapeutic factors outlined in the first four chapters: acceptance and support, universality, advice, interpersonal learning, altruism, and hope. Who provides these? Obviously, the other members of the group! Thus, to a large extent, *it is the group and group members that are the agents of change*.

Herein lies a crucial difference in the basic roles of the individual therapist and the group therapist. In the individual format, the therapist functions as the solely designated direct agent of change. The group therapist functions far more indirectly. In other words, *if it is the group members who, in their interaction, set into motion the many therapeutic factors, then it is the group therapist's task to create a group culture maximally conducive to effective group interaction*.

A jazz pianist, and group member, once commented on the role of the leader by reflecting that very early in his musical career, he deeply admired the great instrumental virtuosos. It was only much later that he grew to understand that the truly great jazz musicians were those who knew how to augment the sound of others, how to be quiet, how to enhance the functioning of the entire ensemble. European group analysts even refer to the group leader as the conductor.[4]

It is obvious that the therapy group has norms that radically depart from the rules, or etiquette, of typical social intercourse. Unlike almost any other kind of group, the members must feel free to comment on the immediate feelings they experience toward the group, the other members, and the therapist. Honesty and

spontaneity of expression must be encouraged in the group. If the group is to develop into a true social microcosm, members must interact freely with one another and not funnel their comments through the group leader.

Other desirable norms include active involvement in the group, nonjudgmental acceptance of others, honoring and protecting the group's work, extensive self-disclosure, desire for self-understanding, and an eagerness to change current modes of behavior. Norms may be a *prescription for* as well as a *proscription against* certain types of behavior. Strong client and therapist alignment about therapy expectations is a significant predictor of good outcome.[5] Norms may be implicit as well as explicit. In fact, the members of a group cannot generally consciously articulate the norms of the group. Researchers studying norms might best be advised to present the members with a list of behaviors and ask them to indicate which are appropriate and which inappropriate in the group.

Norms invariably evolve in every type of group—social, professional, and therapeutic.[6] By no means is it inevitable that a therapeutic group will evolve norms that facilitate the therapeutic process. Systematic observation reveals that many therapy groups are encumbered with crippling norms. A group may, for example, so value hostile catharsis that positive sentiments are eschewed; conversely, a group may become so afraid of causing injury that no conflict is permitted, and the group becomes stagnant. A group may develop a "take turns" format in which the members sequentially describe their problems; or a group may have norms that do not permit members to question or challenge the therapist. Ready acceptance of group member absences will erode the attendance of even the most committed clients.[7] Shortly we will discuss some specific norms that hamper or facilitate therapy, but first we will consider how norms come into being.

The Construction of Norms

Norms of a group are constructed both from expectations of the

members for their group and from the explicit and implicit directions of the leader and more influential members. In institutional settings group norms are also shaped by the larger unit's or organization's culture.[8] If the members' expectations are not fully formed, then the leader has even more opportunity to shape a group culture that, in his or her view, will be optimally therapeutic. The group leader's comments in the meetings play a powerful, though usually implicit, role in determining group norms. In one study, researchers observed that when the leader made a comment following closely after a particular member's actions, that member became a center of attention in the group and often assumed a major role in future meetings. Furthermore, the relative infrequency of the leaders' comments augmented the strength of their interventions.[9] In general, leaders who set norms of increased engagement and decreased conflict have better clinical outcomes.[10]

By discussing the leader as norm-shaper, we are not proposing a new or contrived role for the therapist. Wittingly or unwittingly, leaders *always* shape the norms of the group and must be aware of this function. I (ML) had a yearlong, unavoidable, once a month commitment to chair an important hospital committee meeting, the ending of which conflicted with the start of my ongoing group. Once monthly, with great chagrin, I would arrive to the group ten to fifteen minutes late. It was ably led by my co-therapist, and the group started on time, but punctuality in the group that year was consistently poor. Despite my apologies and processing of my unavoidable lateness, the group's punctuality was restored only after I concluded my competing duties and could realign my own behavior with our expressed norm. Just as one cannot not communicate, the leader *cannot not influence norms*; virtually all of his or her early group behavior is influential. Moreover, what one does *not* do is often as important as what one does do.

Once I (IY) observed a group led by a group analyst in which a member who had been absent the six previous meetings entered the meeting a few minutes late. The therapist in no way acknowledged the arrival of the member; after the session, he explained to the

student observers that he chose not to influence the group, since he preferred that the members make their own rules about welcoming tardy or prodigal members. It appeared clear to me, however, that the therapist's non-welcome was an influential act and very much of a norm-setting message. His group had evolved, no doubt as a result of many similar previous actions, into an uncaring, insecure one whose members sought methods of currying the leader's favor.

To summarize: Every group evolves a set of unwritten rules or norms that determine the course of the group. The ideal therapy group has norms that permit the therapeutic factors to operate with maximum effectiveness. Norms are shaped both by the expectations of the group members and by the behavior of the therapist. The institutional setting also plays a norm-shaping role. Therapists are enormously influential in setting norms; in fact, they cannot avoid doing so. Norms constructed early in the group have considerable perseverance. The therapist is thus well advised to go about this important function in an informed, deliberate manner.

HOW DOES THE LEADER SHAPE NORMS?

There are two basic roles the therapist may assume in a group: technical expert and model-setting participant. In each of these roles, the therapist helps to shape the norms of the group.

The Technical Expert

When assuming the role of technical expert, therapists deliberately slip into the traditional garb of expert and employ a variety of techniques to move the group in a direction they consider desirable. They explicitly attempt to shape norms during their early preparation of clients for group therapy. In this procedure, described fully in Chapter 10, therapists carefully instruct clients about the rules of the group, and they reinforce the instruction in two ways: first, by backing it with the weight of authority and experience; and second, by explaining the rationale for the group approach and tying it directly to the clients' goals.

At the beginning of a group, therapists have at their disposal a wide choice of techniques to shape the group culture. These range from explicit instructions and suggestions to subtle reinforcing techniques. For example, as we described earlier, the leader must attempt to create a network in which the members freely interact with each other rather than directing all their comments to or through the therapist. To this end, therapists may implicitly instruct members in their pregroup interviews or in the first group sessions; they may, repeatedly during the meetings, ask for all members' reactions to another member or toward a group issue; they may ask why conversation is invariably directed toward the therapist; they may ask the group to engage in exercises that teach clients to interact—for example, asking each member of the group in turn to give his or her first impressions of every other member; or therapists may, in a much less obtrusive manner, shape behavior by rewarding members who address one another: by nodding or smiling at them, addressing them warmly, or shifting their posture into a more receptive position.

Exactly the same approaches may be applied to the many other norms the therapist wishes to inculcate: self-disclosure, open expression of emotions, promptness, self-exploration, and so on. In early sessions particularly, the therapist can underscore the emerging group norms and seize natural opportunities to highlight and articulate these norms. This leads to a “smoother” group and is preferable to reading a laundry list of principles.

Therapists vary considerably in style. Although many prefer to shape norms explicitly, all therapists, to a degree often greater than they suppose, perform their tasks through the subtle technique of social reinforcement.

Advertising and social media are two examples of a systematic harnessing of reinforcing agents whose impact far exceeds our conscious awareness. Psychotherapy, no less, relies on the use of subtle, often nondeliberate social reinforcers. Although few self-respecting therapists like to consider themselves social reinforcing agents, they nevertheless continuously exert influence in this manner, unconsciously or deliberately. They may positively reinforce behavior by means of numerous types of verbal and nonverbal acts, including nodding, smiling, leaning forward, or offering an interested “mmm” or a direct inquiry for more information. On the other hand, therapists attempt to extinguish behavior not deemed salubrious by not commenting, not nodding, ignoring the behavior, turning their attention to another client, looking skeptical, raising their eyebrows, and so on. In fact, research suggests that therapists who reinforce members’ pro-group behavior indirectly are often more effective than those who prompt such behavior explicitly.[11] Every form of psychotherapy is a learning process, relying in part on operant conditioning. Therapy without some form of therapist reinforcement or manipulation is a mirage that disappears on close scrutiny.[12]

Considerable research demonstrates the efficacy of operant techniques in the shaping of group behavior.[13] Using these techniques deliberately, one can reduce silences or increase the number of personal and group comments, expressions of hostility to the leader, or intermember acceptance.[14] Though there is evidence

that therapists owe much of their effectiveness to these learning principles, they often eschew this evidence because of their unfounded fear that such a mechanistic view will undermine the essential human component of the therapy experience. The facts are compelling, however, and an understanding of their own behavior does not strip therapists of their spontaneity. After all, the objective of using operant techniques is to foster authentic and meaningful engagement. Our clients can distinguish our facilitation from manipulation.[15]

The Model-Setting Participant

Leaders shape group norms not only through explicit or implicit social engineering but also through the example they set in their own group behavior.[16] The therapy group culture represents a radical departure from the social rules to which clients are accustomed. Clients are asked to discard familiar social conventions, to try out new behavior, and to take many risks. How can therapists best demonstrate to their clients that new behavior will not have the anticipated adverse consequences?

One method, which has considerable research backing, is modeling: clients are encouraged to alter their behavior by observing their therapists engaging freely and without adverse effects from the desired behavior.[17] Albert Bandura, a prominent psychologist, has demonstrated in many well-controlled studies that individuals may be influenced to engage in more adaptive behavior (for example, the overcoming of specific phobias) or less adaptive behavior (for example, unrestrained aggressivity) through observing and adopting others' behavior.[18]

The public nature of group therapy makes the dynamics of shame or humiliation particularly powerful for all, and group leaders' humility and courage in addressing their own therapeutic errors and missteps demonstrate humanity and compassion.[19] It can be remarkably helpful to say something like, "I have been thinking a lot about the last meeting. I wish I understood then what I understand now. I

would have approached this differently. I welcome the opportunity to revisit this with you." The leader may, by offering a model of nonjudgmental acceptance and appreciation of others' strengths as well as their problem areas, help shape a group that is health oriented. If leaders conceptualize their role as that of a detective of psychopathology, the group members will follow suit.

For example, one group member had actively worked on the problems of other members for months but had steadfastly declined to disclose her own problems. Finally, in one meeting she confessed that one year earlier she had had a two-month stay in a state psychiatric hospital. The therapist responded reflexively, "Why haven't you told us this before?"

This comment, emerging from the therapist's irritation, was perceived as punitive by the client and served only to reinforce her fear and discourage further self-disclosure. Obviously, there are questions and comments that will close people down and others that will help them open up. The therapist had many "opening-up" options: for example, "I think it's great that you now trust the group sufficiently to share these facts about yourself. How difficult it must have been for you in the group previously, wanting to share this disclosure and yet being afraid to do so"; "What is it like to bring this up now?"; or, "How did you determine that you would share this with us tonight?"

The leader sets a model of interpersonal honesty and spontaneity but must also keep the current needs of the members in mind and demonstrate behavior that is congruent with those needs. We do not suggest that group therapists should freely express all feelings. Total disinhibition is no more helpful in therapy groups than in other forms of human encounter and may lead to ugly, destructive interaction. Although we encourage spontaneity, generally it is wise for a therapist to model appropriate restraint as well as honesty.[20] Not only is it therapeutic to our clients that we let them matter to us, but we can also use our own reactions as valuable data about our clients —provided we know ourselves well enough. We want to engage our clients and allow ourselves to be affected by them. Our "disciplined

personal involvement" is an invaluable part of the group leader's armamentarium.[21]

Consider the following therapeutically effective intervention:

> **In the first session of a group of business executives meeting for** a five-day intensive communication training program that I (IY) was co-leading, an aggressive, swaggering twenty-five-year-old group member who had obviously been drinking heavily proceeded to dominate the meeting and make a fool of himself. He boasted of his accomplishments, belittled the group, monopolized the meeting, and interrupted, outshouted, and insulted every other member. All attempts to deal with the situation—feedback about how angry or hurt he had made others feel, interpretations about the meaning and cause of his behavior—failed. Then my co-leader commented sincerely, "You know what I like about you? Your fear and lack of confidence. You're scared here, just like me. We're all scared about what will happen to us this week." That statement permitted the client to discard his facade and, eventually, to become a valuable group member. Furthermore, the leader, by modeling an empathic, nonjudgmental style, helped establish a gentle, accepting group culture. **<<**

This effective intervention required that the co-leader first recognize the negative impact of this member's behavior and work with her own initial hostility and countertransference; only then could she supportively articulate the vulnerability that lay beneath the client's offensive behavior.[22] We aim to be both honest and compassionate in understanding our members' best (if ineffective) adaptive efforts. This, in turn, contributes to group cohesiveness as others begin to experience the group as a safe place where forthrightness is valued.[23]

How can we expect our clients to be braver than we are? Our group interaction demands—among other things—that group therapists accept and admit their personal fallibility. A group member in a beginning group accused a neophyte group therapist of making long-winded, confusing statements. Since this was the first confrontation of the therapist in this young group, the members were tense and perched on the edge of their chairs. The therapist responded by wondering whether he didn't remind the client of

someone from the past. The attacking member clutched at the suggestion and volunteered his father as a candidate; the crisis passed, and the group members settled back in their chairs. However, it so happened that this therapist had himself previously been a member of a process group for trainees, and his colleagues had repeatedly focused on his tendency to make long-winded, confusing comments. In fact, then, what had transpired was that the client had seen the therapist quite correctly but was persuaded to relinquish his perceptions. If one of the goals of therapy is to help clients test reality and clarify their interpersonal relationships, then this transaction was *antitherapeutic*. This is an instance in which the therapist's needs were given precedence over the client's needs. In psychotherapy *we must never damage our clients by protecting our own interests*.[24]

Another consequence of the need to be perfect occurs when therapists become overly cautious. Fearing error, they weigh their words so carefully, interact so deliberately, that they sacrifice spontaneity and mold a stilted, lifeless group. Often a therapist who maintains an omnipotent, distant role is saying, in effect, "Do what you will; you can't hurt or touch me." This pose may have the counterproductive effect of stifling the collaborative nature of group therapy and aggravating a sense of interpersonal impotence in clients that impedes the development of an autonomous group.

> **In one group, Les, a young man, had made little movement for** months despite vigorous efforts by the leader. In virtually every meeting the leader attempted to bring Les into the discussion, but to no avail. Instead, Les became more defiant and withholding, and the therapist became more active and insistent. Finally, Joan, another member, commented to the therapist that he was like a stubborn father treating Les like a stubborn son, and was bound and determined to make Les change. Les, she added, was relishing the role of the rebellious son who was determined to defeat his father. Joan's comment rang true for the therapist; it clicked with his internal experience, and he acknowledged this to the group and thanked Joan for her comments. **<<**

The therapist's behavior in this example was extremely important

for the group. In effect, he said, “I value you group members, this group, and this mode of learning.” Furthermore, he reinforced norms of self-exploration and honest interaction with the therapist. The transaction was doubly helpful—to the therapist (unfortunate are the therapists who cannot learn more about themselves in their therapeutic work) and to Les, who proceeded to explore the payoff in his defiant stance toward the therapist.

Occasionally, less modeling is required of the therapist because of the presence of some ideal group members who fulfill this function. Early studies even used “confederates”—people trained in collaboration with the group leaders as ideal group members, who were planted in groups to pose as actual members. They were clearly impactful regarding group cohesion and group work, though such tactics are not ethical by today’s standards.[25]

Although a trained “plant” would contribute a form of deceit incompatible with the process of group therapy, the concept has intriguing clinical implications regarding group composition and placement of prospective group members. For example, an individual who recently completed a time-limited group therapy satisfactorily and seeks further treatment might serve as a model-setting veteran member for a new group. Perhaps an ongoing group might choose to add new members in advance of the graduation of senior members, rather than afterward, to capitalize on the modeling provided by the experienced and successful senior members.

These possibilities aside, it is the therapist who, wittingly or unwittingly, will continue to serve as the chief model-setting figure for the group members. Consequently, it is of the utmost importance that therapists have sufficient self-confidence and self-awareness to fulfill this function. If not, they will be more likely to encounter difficulties in this aspect of their role and will often veer to one extreme or the other in their personal engagement in the group: either they will fall back into a comfortable, concealed professional role, or they will escape from the anxiety and responsibility inherent in the leader’s role by abdicating and becoming simply one of the gang.[26]

Novice therapists are particularly prone to these positions of exaggerated activity or inactivity in the face of the emotional demands of leading therapy groups. Either extreme has unfortunate consequences for the development of group norms. An overly opaque and detached leader will create norms of caution and guardedness. A therapist who retreats from his requisite authority and purports to be a member will be unable to use the wide range of methods available for the shaping of constructive norms; furthermore, such a therapist creates a group that is unlikely to work fruitfully on important transference issues.

The issue of the therapist's transparency has implications far beyond the task of norm setting. When therapists are self-disclosing in the group, not only do they model behavior, but they perform an act that has considerable significance in many other ways for the therapeutic process. Many clients develop conflicted and distorted feelings toward the therapist; the transparency of the therapist helps members work through their transference. We shall discuss the ramifications of therapist transparency in great detail in Chapter 7. Let us turn now from this general discussion of norms to the specific norms that enhance the power of group therapy.

THERAPEUTIC GROUP NORMS

The Self-Monitoring Group

It is important that the group begin to assume responsibility for its own functioning. If this norm fails to develop, a passive group ensues whose members are dependent on the leader to supply movement and direction. The leader of such a group who feels fatigued and irritated by the burden of making everything work is aware that something has gone awry in the early development of the group. When we lead groups like this, we often experience the members of the group as moviegoers. It's as though they visit the group each week to see what's playing; if it happens to interest them, they become engaged in the meeting. If not, "Too bad! Hope there'll be a better show next week!" The therapist's task in the group then is to help members understand that they *are* the movie. If they do not perform, there is no performance; the screen is blank.

From the very beginning, we attempt to transfer the responsibility of the group to the members. We keep in mind that, in the beginning of a group, we are the only members in the room who have a good definition of what constitutes a good work meeting, and it is our task to teach the members and share that definition with them. Thus, if the group has a particularly good meeting, label it so. For example, you might comment at the end, "It's time to stop. It's too bad, I hate to bring a meeting like this to an end." In future meetings, we often make a point of referring back to that meeting. It becomes a benchmark. In a young group, a particularly hardworking meeting is often followed by a meeting in which the members step back a bit from the intensive interaction. In such a meeting, you might comment, after a half hour, "I wonder how everyone feels about the meeting today? How would you compare it with last week's meeting? What did we do differently last week?"

It is also possible to help members develop a definition of a good meeting by asking them to examine and evaluate parts of a single

meeting. For example, in the very early meetings of a group, you may jump in with a process reflection: “I see that an hour has gone by and I’d like to ask, ‘How has the group gone today? Are you satisfied with it? What’s been the most engaging part of the meeting so far today? The least engaging part?’” The general point is clear: endeavor to shift the evaluative function from yourself to the group members, in effect saying, “You have the ability—and responsibility—to determine when this group is working effectively and when it is wasting its time.” Best yet is when a group member comments that this was a great meeting. This is a golden invitation to examine what made it a great meeting and deconstruct the meeting into its key components—risk-taking, deepening closeness, inspiration, support, feeling valued, disconfirming shame—so that the members can reliably be engaged again and again. This will not happen without the group leader’s initiative in launching the process.

If a member laments, for example, that “the only involving part of this meeting was the first ten minutes—after that we’ve just chatted for forty-five minutes,” it begs the response: “Then why did you let it go on? How could you have stopped it?” Or, “All of you seemed to have known this. What prevented you from acting?” Soon there will be excellent consensus about what is productive and unproductive group work. (And it will generally be the case that productive work occurs when the group maintains a here-and-now focus—which we will discuss in the next chapter.)

Self-Disclosure

Group therapists may disagree about many aspects of the group therapeutic procedure, but there is great consensus about one issue: *Client self-disclosure is absolutely essential in the group therapeutic process.* Group members will not benefit from group therapy unless they commit to self-disclose. We prefer to lead a group with norms that indicate that self-disclosure must occur—but at each member’s own pace: it’s important that members not experience the group as a forced confessional where deep revelations are wrung from members one by one.[27]

During pregroup individual meetings, we make these points explicit to clients so that they enter the group fully informed that if they are to benefit from therapy, sooner or later they must share very intimate parts of themselves with the other group members.

Keep in mind that it is the subjective aspect of self-disclosure that is truly important. There may be times when therapists or group observers will mistakenly conclude that the group is not truly disclosing or that the disclosure is superficial or trivial. Many group therapy members have had few intimate confidants, and what appears in the group to be a minor self-disclosure may represent the very first time a member has shared the material with anyone. Appreciating the context of each individual's disclosure is a crucial part of mentalizing about others and developing empathy.

> **One group member, Mark, spoke slowly and methodically about** his intense social anxiety and avoidance. Marie, a, chronically depressed and bitter young woman, bristled at his long and labored elaboration of his difficulties. At one point she wondered aloud why others seemed to be so encouraging of Mark and excited about his speaking, whereas she felt so impatient with the slow pace of the group. She was concerned that she could not get to her personal agenda: to learn to make herself more likable. The feedback she received surprised her. Many members felt alienated from her because she rarely empathized with others. What was happening in the meeting with Mark was a case in point, they told her. For many members Mark's self-disclosure in the meeting was a great step forward for him. What interfered with her seeing what others saw? That was the critical question, and exploring that question ultimately led to important learning for Marie. **<<**

What about the big secret? Members may come to therapy with important secrets about some central aspect of their lives—for example, promiscuity, transgender identity, substance abuse, criminality, bulimia, incest. They feel trapped. Though they wish to work in the therapy group, they are too frightened to share such secrets with a large group of people.

In pregroup individual sessions, we make it clear to such clients that sooner or later they will *have* to share their secrets with the other group members. We emphasize that they may do this at their

own pace, that they may choose to wait until they feel greater trust in the group, but that, ultimately, the sharing must come if therapy is to proceed. Group members who decide not to share a big secret are destined merely to re-create in the group the same duplicitous modes of relating to others that exist outside the group. To keep the secret hidden, they must guard every possible avenue that might lead to it. Hence, they are vigilant and guarded, and spin an ever-expanding web of inhibition around themselves. Sometimes the subjective meaning of a secret is not easily understood at first.

> **Vijay, a forty-two-year-old police officer, sought group therapy** after an episode of domestic violence. He felt enormous shame about his behavior and realized he did not know how to deal with strong emotion. He was spared criminal proceedings on the condition he participate in group and individual therapy. Although willing to tell the group about the violence, he refused to tell the group about his occupation, despite members' mounting curiosity and rampant guessing. For months, he denied its relevance and was firm and fixed in maintaining this secret. I (ML) knew about his profession but felt I had no choice but to wait for him to share this information. He was otherwise clearly engaged with the group and working on emotional recognition and self-expression.

After a short leave to attend his grandmother's funeral in India, his birthplace, he returned to the group and declared, "I want to shed my remaining secrets—I am a police officer and I have behaved dishonorably. Going home for the funeral made me realize how destructive it can be to keep secrets. I had been estranged from my parents for years because of my father's physical abuse, but I had been very close to his mother as a boy. Visiting back home I learned for the first time that my grandmother was Muslim and that even her name was shunned in my family's Hindu village.

"My grandmother's religion was a deeply shameful and lethally dangerous secret. No one ever spoke of it. I also learned for the first time that, because of his mother's religion, my father was discriminated against and bullied mercilessly as a child. Learning these things was eye-opening, and I felt, for the first time in my life, compassion for my father. I understood how the brutality my father experienced contributed to his becoming a brutal father and husband. I see now that shutting down many areas of my own world and silencing myself has made me abusive as well."

He became quite emotional in the meeting, and the group members

—many of whom had already suspected he was a police officer—helped him look at this as an unlocking from the various cul-de-sacs in his emotional world. At the end of the session, the group told him they felt incredibly close to him and were honored by his trust. **<<**

Sometimes it is adaptive to delay the telling of the secret. Consider the following two group members, John and Charles. John had been cross-dressing since the age of twelve. This was something he did frequently but secretly. Charles entered the group with cancer. He stated that he had done a lot of work learning to cope with his cancer. He knew his prognosis: he would live for two or three more years. He had sought group therapy in order to live his remaining life more fully, and he especially wanted to relate more intimately with the important people in his life. This seemed like a legitimate goal for group therapy, and I (IY) introduced him into a regular outpatient therapy group. (I have fully described this individual's course of treatment elsewhere.)[28]

Each client had told me his secret but chose not to disclose it in the group for many sessions. By that time, I was getting edgy and impatient. I gave them knowing glances or subtle invitations. Eventually each became fully integrated into the group, developed a deep trust in the other members, and, after about a dozen meetings, chose to reveal very fully. In retrospect, both of their decisions to delay were wise ones. The group members had grown to know them as people, as John and Charles, who were faced with major life problems, not as a cross-dresser and a cancer patient. John and Charles had been justifiably concerned that if they revealed themselves too early, they would be stereotyped, and that the stereotype would block other members from knowing them fully.

How can the group leader determine whether a client's delay in disclosure is appropriate or countertherapeutic? Context matters. Even without full disclosure, is there, nonetheless, movement, albeit slow, toward increasing openness and trust? Will the passage of time make it easier to disclose, as happened with John and Charles, or will tension and avoidance mount?

Rarely is a high-risk self-disclosure met with frank rejection. There

is usually some therapeutic leverage that protects against this happening. The serial cheater wants to own his infidelity and build intimacy with his current wife; the disbarred lawyer wants to rehabilitate himself and repay those he defrauded; the IV drug user is terrified of dying and life now has become more worth living. If a client is shamed and wholly rejected by the group after a difficult disclosure, the therapist must examine whether he or she is colluding with the group members' attack because of his or her own reaction or countertransference. If that is the case, it is doubly incumbent upon the group leaders to initiate the repair process as quickly as possible.

Often, hanging onto the big secret for too long is counterproductive. Consider the following example:

> **Lisa, a client in a six-month, time-limited group, had practiced as** a psychologist for a few years, but had given up her practice fifteen years earlier to enter the business world, where she soon became extraordinarily successful. She entered the group because of dissatisfaction with her social life. Lisa felt lonely and alienated. She knew that she, as she put it, played her cards "too close to the vest"—she was cordial to others and a good listener but tended to remain distant. She attributed this to her enormous wealth, which she felt she must keep concealed so as not to elicit envy and resentment from others.
>
> By the fifth month, Lisa had yet to reveal much of herself. She retained her psychotherapeutic skills, and this proved helpful to many members, who admired her greatly for her unusual perceptiveness and sensitivity. But she had replicated her outside social relationships in the group, and she felt hidden and distant from the other members. She requested an individual session with the group leader to discuss her participation in the group. During that session the therapist exhorted Lisa to reveal her concerns about her wealth and, especially, her psychotherapy training, warning her that if she waited too much longer, someone would throw a chair at her when she finally told the group she had once been a therapist. Finally, Lisa took the plunge and in the very few remaining meetings did more therapeutic work than in all the earlier meetings combined. **<<**

What stance should the therapist take when someone reveals the

big secret? To answer that question, we must first make an important distinction. We believe that when an individual reveals the big secret, the therapist must help him or her disclose even more about the secret, but in a *horizontal* rather than a *vertical mode*. By *vertical disclosure* we refer to content, to greater in-depth disclosure about the secret itself. For example, when John disclosed his cross-dressing to the group, the members' natural inclination was to explore the secret in *vertical* detail. They asked about details of his cross-dressing: "How old were you when you started?" "Whose underclothes did you begin to wear?" "What sexual fantasies do you have when you cross-dress?" "How do you publicly pass as a woman with that facial hair?" But John had already disclosed a great deal of detail about his secret, and it was more important for him now to engage in horizontal disclosure, i.e., how he felt about disclosing the secret to the group members:

Accordingly, when John first divulged his cross-dressing in the group, I (IY) asked questions that would lead to horizontal disclosure:

- "John, you've been coming to the group for approximately twelve meetings and have not been able to share this with us. I wonder what it's been like for you to come each week and remain silent about your secret?"
- "How uncomfortable have you been about the prospect of sharing this with us? It hasn't felt safe for you to share this before now. Today you chose to do so. What's happened in the group or in your feelings toward the group today that's allowed you to do this?"
- "What were your fears in the past about revealing this to us? What did you think would happen? Whom did you feel would respond in which ways?"

These are part of a host of here-and-now reflection questions that move from the content of the disclosure to the interactional aspects

of the disclosure.

John responded that he feared he would be ridiculed or laughed at or thought weird. In keeping with the here-and-now inquiry, I guided him deeper into the interpersonal process by inquiring, "*Who* in the group would ridicule you?" "*Who* would think you were weird?" And then, after John selected certain members, I invited him to check out those assumptions with them. By welcoming the belated disclosure, rather than criticizing the delay, the therapist supports the client and strengthens the therapeutic collaboration. As a general rule, it is always helpful to move from general statements about the "group" to more personal statements: in other words, ask members to differentiate between the members of the group.

Self-disclosure is always an interpersonal act. What is important is not that one discloses oneself but that one discloses something important in the context of a relationship to others. The act of self-disclosure takes on real importance because of its implications for the nature of ongoing relationships; even more important than the actual unburdening of oneself is the fact that disclosure results in a deeper, richer, and more complex relationship with others.

The disclosure of sexual abuse or incest is particularly charged in relational terms. Often victims of such abuse have been traumatized not only by the abuse itself but also by the way others have responded to their disclosure of the abuse in the past. Not uncommonly, the initial disclosure within the victim's family is met with denial, blame, and rejection. As a result, the thought of disclosing oneself in the therapy group evokes fear of further mistreatment and even retraumatization rather than hope of working through the abuse.[29] This phenomenon is prevalent as well in organizational and educational settings. Frequently, the administrative blindness and denial that shames and faults the victim feels to that victim as traumatic and as much of a betrayal as the initial abuse.[30]

If undue pressure is placed on a member to disclose, we will, depending on the problems of the particular client and his or her stage of therapy, respond in one of several ways. For example, a

therapist may relieve the pressure by commenting, “There are obviously some things that John doesn’t yet feel like sharing,” or, “The group seems eager, even impatient, to bring John aboard, while John doesn’t yet feel safe or comfortable enough.” (The word “yet” is important, since it conveys the appropriate expectational set.) We might proceed by suggesting that we examine the unsafe aspects of the group, not only from John’s perspective but from other members’ perspectives as well. We shift the emphasis of the group from wringing out disclosures to exploring the obstacles to disclosure. What generates the fear? What are the anticipated dreaded consequences? From whom in the group do members anticipate disapproval? But the client is the final arbiter of the when and what of disclosure. The group leader can exhort and cajole and request but cannot reveal information about the client from pregroup meetings or from concurrent therapy without the client’s permission.

No one should ever be punished for self-disclosure. One of the most destructive events that can occur in a group is for members to use personal, sensitive material that has been disclosed and entrusted to the group against one another in times of conflict. The therapist should intervene vigorously if this occurs. Not only is such behavior dirty fighting, but it undermines important group norms. This vigorous intervention can take many forms. In one way or another, the therapist must call attention to the violation of trust. Often, we will simply stop the action, interrupt the conflict, and point out that something very important has just happened in the group. We ask the offended member for his or her feelings about the incident, or ask others for theirs, or wonder whether others have had experiences that are difficult to reveal in the group. Any other work in the group is temporarily postponed. It is important to reinforce the norm that self-disclosure is not only important but safe. Only after the norm has been established should we turn to examine other aspects of the incident.

Procedural Norms

The optimal procedural format in therapy is that the group be

unstructured, spontaneous, and freely interacting. *But such a format never evolves naturally: much active culture shaping is required on the part of the therapist*. There are many trends the therapist must counter. The natural tendency of a new group is to devote an entire meeting to each of the members in rotation. Often the first person to speak or the one who presents the most pressing life crisis that week obtains the group floor for the meeting. Some groups have enormous difficulty changing the focus from one member to another, because a procedural norm has somehow evolved whereby a change of topic is considered bad form, rude, or rejecting. Members may lapse into silence: they feel they dare not interrupt and ask for time for themselves, yet they refuse to keep the other member supplied with questions because they hope, silently, that he or she will soon stop talking.

These patterns hamper the development of a potent group and ultimately result in group frustration and discouragement. We prefer to deal with these antitherapeutic norms by calling attention to them and indicating that since the group has constructed them, it has the power to change them.

For example, a group leader might say, “I’ve been noticing that over the past few sessions the entire meeting has been devoted to only one person, often the first one who speaks that day, and also that others seem unwilling to interrupt and are, I believe, sitting silently on many important feelings. I wonder how this practice ever got started and whether or not we want to change it.” A comment of this nature may be liberating to the group. The therapist has not only given voice to something that everyone knows to be true but has also raised the possibility of other procedural options.

Some groups evolve a formal “check-in” format in which each member in turn gets the floor to discuss important events of the previous week or certain moments of great distress. Sometimes, especially with groups of highly dysfunctional, anxious members, such an initial structure is necessary and helps facilitate engagement. But, in our experience, such a formal structure in most groups generally encourages an inefficient, taking-turns, noninteractive, “then-and-there” meeting that severely restricts the

scope of what can be worked with in the group and avoids such issues as feelings of entitlement, envy, and competitiveness. The check-in employs a "content" solution to address a "process" problem. We prefer a format in which distressed members may simply announce at the beginning, "I want some time today," and the members and the therapist attempt, during the natural evolution of the session, to turn to each of those members.

Specialized groups, especially those with brief life spans, often require different procedural norms. Compromises must be made for the sake of efficient time management, and the leader must build in an explicit structure. We will discuss such modifications of technique in Chapter 15 but for now wish only to emphasize a general principle: the leader must attempt to structure the group in such a way as to instill the therapeutic norms we discuss in this chapter—support and confrontation, self-disclosure, self-monitoring, interaction, spontaneity, and the importance of the group members as the agents of help.

The Importance of the Group to Its Members

The more important the members consider the group to be, the more effective it becomes. We believe that the ideal therapeutic condition is present when clients consider their therapy group meeting to be one of the most important events in their lives each week and zealously protect the group time. The therapist is well advised to reinforce this belief in any available manner. If you are forced to miss a meeting, inform the members well in advance and convey to them your concern about your absence. Arrive punctually for meetings, and if you have been thinking about the group between sessions, share some of these thoughts with the members. Any self-disclosures you make should be made in the service of the group. Though some therapists eschew such personal disclosure, we believe that it is important to articulate how much the group matters to you. Clients value knowing that they and the group matter to you. I (ML) attended a group while dealing with a middle ear infection that made it hard for me to hear, which I noted at the start of the session.

Nonetheless, we had a productive meeting. Near the end of the session, my ear drum perforated, and liquid began to drain from my ear in obvious fashion. I had not anticipated that this might happen, but group members subsequently referred to the event several times as a reflection of my commitment to the group. It also, not surprisingly, encouraged the group to give me feedback about the importance of my own self-care.

We reinforce members when they testify to the group's usefulness or comment that they have been thinking about other members during the week. If a member expresses regret that the group will not meet for two weeks over the Christmas holidays, we urge that member to express his or her feelings about their connection to the group. What does it mean to them to cherish the group? To protest its disruption? To have a place in which to describe their concerns openly rather than submerging them? A young man, Marcus, unavoidably missed his last session of a time-limited group treatment but emailed his group leaders with a message that he asked to be shared with the group members. His message had profound impact on the group and group leaders as he articulated his deep appreciation: "The seven months of group therapy has been extraordinary." He added, "I leave group therapy with my head held up high. I am proud of the person I am and continue to become. I have been humbled to sit, listen and learn from each and every one of you. For this I'm forever indebted to each of you. You have allowed me to mend." It was a powerful statement of the value of the group.

A well-functioning group continues to work through issues from one meeting to the next: the more continuity between meetings, the better. The therapist does well to encourage continuity. More than anyone else, the therapist is the group historian, connecting events and fitting experiences into the temporal matrix of the group: "That sounds very much like what John was working on two weeks ago," or, "Ruthellen, I've noticed that ever since you and Debbie had that run-in three weeks ago, you have become more depressed and withdrawn. What are your feelings now toward Debbie?"

We rarely start a group meeting by discussing a specific issue

other than scheduling and absences, but when we do, it is invariably in the service of providing continuity between meetings. Thus, when it seems appropriate, we might begin a meeting with something like, “The last meeting was very intense! I wonder what types of feelings you took home from the group and what those feelings are now?”

In Chapter 13, we will describe the group summary, a technique that serves to increase the sense of continuity between meetings. For many years, I (IY) wrote a detailed summary of the group meeting each week and mailed it to the members between sessions. The advent of email makes this practice even easier. One of the many important functions of the summary is that it offers the client another weekly contact with the group and increases the likelihood that the themes of a particular meeting will be continued in the following one.

The group increases in importance when members come to recognize it as a rich reservoir of information and support. When members express curiosity about themselves, we, in one way or another, attempt to convey the belief that *any information members might desire about themselves is available in the group room, provided they learn how to tap it*. Thus, when Ken wonders whether he is too dominant and threatening to others, our reflex is to reply, in effect, “Ken, there are many people who know you very well in this room. Why not ask them?”

Events that strengthen bonds between members enhance the potency of the group. It bodes well when the whole group holds long discussions in the parking lot or goes out for coffee after a meeting, as long as it does not lead to secrets and subgrouping. (Such extragroup contact is not without potential adverse effects, as we shall discuss in detail in Chapter 11.)

Members as Agents of Help

The group functions best if its members appreciate the valuable help they can provide one another. If the group continues to regard the therapist as the sole source of aid, then it is most unlikely that the group will achieve an optimal level of autonomy and self-respect. To

reinforce this norm, the therapist may call attention to incidents demonstrating the mutual helpfulness of members. The therapist may also teach members more effective methods of assisting one another. For example, after a client, Reid, has been working with the group on some issue for a long portion of a meeting, the therapist may ask, “Reid, could you think back over the last forty-five minutes? Which comments have been the most helpful to you and which the least?”

Another example: “Brandon, I can see you’ve been wanting to talk about that for a long time in the group and until today you’ve been unable to. Somehow Aliya helped you to open up. What did she do? And what did Ben do today that seemed to close you down rather than open you up?” Behavior undermining the norm of mutual helpfulness should not be permitted to go unnoticed. If one member challenges another concerning his treatment of a third member, stating, for example, “Fred, what right do you have to talk to Antonio about that? You’re a hell of a lot worse off than he is in that regard,” you might intervene by commenting, “Phil, I think you’ve got some negative feelings about Fred today, perhaps coming from somewhere else in your life. Maybe we should get into that. I can’t, however, agree with you when you say that because Fred is similar to Antonio, he can’t be helpful. In fact, here in the group, quite the contrary has often been true.”

Support and Confrontation

As we emphasized in our discussion of cohesiveness, it is essential that the members perceive their therapy group as safe and supportive. Ultimately, in the course of therapy, many uncomfortable issues must be broached and explored. Many clients have problems with rage or are arrogant or condescending or insensitive or just plain cantankerous. The therapy group cannot offer help without such traits emerging during the members’ interactions. In fact, their emergence is to be welcomed as a therapeutic opportunity. Ultimately, conflict must occur in the therapy group, and, as we will discuss in Chapter 11, conflict is essential for the work of therapy. At

the same time, however, too much conflict early in the course of a group can cripple its development. Before members feel free enough to express disagreement, they must feel safe enough and must value the group highly enough to be willing to tolerate uncomfortable meetings.

Thus, the therapist must build a group with norms that permit conflict, but only after firm foundations of safety and support have been established. It is often necessary to intervene to prevent the proliferation of too much conflict too early in the group, as the following incident illustrates:

> **In a new therapy group, there were two particularly hostile mem**bers, and by the third meeting there was a considerable amount of open sniping, sarcasm, and conflict. The fourth meeting was opened by Sofia (one of these two members), who emphasized how unhelpful the group had been to her thus far. Sofia had a way of turning every positive comment made to her into a negative, combative one. She complained, for example, that she could not express herself well, and that there were many things she wanted to say but was so inarticulate she couldn't get them across. When another member of the group disagreed and stated that she found Sofia to be extremely articulate, Sofia challenged the other member for doubting her judgment about herself. Later in the group, she complimented another member by stating, "Ilene, you're the only one here who's ever asked me an intelligent question." Obviously, Ilene was made quite uncomfortable by this hexed compliment.
>
> At this point I (IY) felt it was imperative to challenge the norms of hostility and criticism that had developed in the group and I intervened forcefully by asking Sofia, "What are your guesses about how your statement to Ilene makes others in the group feel?"
>
> Sofia hemmed and hawed but finally offered that they might possibly feel insulted. I suggested that she check that out with the other members of the group. She did so and learned that her assumption was correct. Not only did every member of the group feel insulted, but Ilene also felt irritated and put off by the statement. I then inquired, "Sofia, it looks as though you're correct: you did insult the group. Also, it seems that you knew that this was likely to occur. But what's puzzling is the payoff for you. What do you get out of it?"
>
> Sofia suggested two possibilities. First, she said, "I'd rather be

rejected for insulting people than for being nice to them." That seemed a piece of twisted logic but nonetheless comprehensible. Her second statement was, "At least this way I get to be the center of attention." "Like now?" I asked. She nodded. "How does it feel right now?" I wondered. Sofia said, "It feels good." "How about in the rest of your life?" I asked. She responded sadly, "It's lonely. In fact, this is it. This group—you folks, are the people in my life." I ventured, "Then this group is a really important place for you?" Sofia nodded. I commented, "Sofia, you've always stated that one of the reasons you're critical of others in the group is that there's nothing more important than total honesty. If you want to be absolutely honest with us, however, I think you've got to tell us also how important we are to you and how much you like being here. That you never do, and I wonder if you can begin to investigate why it is so painful or dangerous for you to show others here how important they are to you."

By this time Sofia had become much more conciliatory, and I was able to obtain more leverage by enlisting her agreement that her hostility and insults did constitute a problem for her and that it would help her if we called her on it—that is, if we instantaneously labeled any insulting behavior on her part. It is always helpful to obtain this type of contract from a member: consent that in future meetings, the therapist can confront the member about some particular aspect of behavior that the member has asked to be called to his or her attention. Since such clients will then experience themselves as allies in this spotting and confrontative process, they are far less likely to feel defensive about the intervention. **<<**

Many of these examples of therapist behavior may seem heavy-handed, or even pontifical. They are not the nonjudgmental, nondirective, mirroring, or clarifying comments we would hope to hear from a therapist at other points in the therapeutic process. It is vital, however, that the therapist attend deliberately to the tasks of group creation and culture building. What happens in the group either builds therapeutic opportunity or hampers it. These tasks underlie and, to a great extent, precede much of the other work of the therapist.

It is time now to turn to the third basic task of the therapist: the activation and illumination of the here-and-now.

- 6 -

The Therapist

Working in the Here-and-Now

A MAJOR DIFFERENCE BETWEEN A PSYCHOTHERAPY GROUP that hopes to effect extensive and enduring behavioral and characterological change and other kinds of groups—twelve-step groups, psychoeducational groups, social skills training groups, and cancer support groups—is that the psychotherapy group strongly emphasizes the importance of the here-and-now experience. Yet *all* group approaches, including highly structured groups that use the group only as a *setting* to deliver an intervention, benefit from the group therapist's capacity to recognize, understand, and utilize the here-and-now. Therapists who are aware of group dynamics and the nuances of the relationships between all the members of the group are more adept at working on the group task even when deeper group and interpersonal exploration or interpretation is not the therapy focus.[1]

In Chapter 2, we presented some of the theoretical underpinnings of the use of the here-and-now. Now it is time to focus on the clinical application of the here-and-now in group therapy. First, keep in mind this important principle—perhaps the single most important point we make in this entire book: *The here-and-now focus, to be effective, consists of two symbiotic tiers, neither of which has full therapeutic power without the other.*

The first tier is an experiencing one: the members live in the here-and-now, and they develop strong feelings toward the other group members, the therapist, and the group. These here-and-now feelings

become the major discourse of the group. The thrust is ahistorical: *The immediate events of the meeting take precedence over events both in the current outside life and in the distant past of the members.* This focus greatly facilitates the development and emergence of each member's social microcosm. It facilitates feedback, catharsis, meaningful self-disclosure, and acquisition of socializing techniques. The group becomes more vital, and *all* of the members (not only the ones directly working in that session) become intensely involved in the meeting.

But the here-and-now focus rapidly reaches the limits of its usefulness without the second tier, which is *the illumination of process*. If the powerful therapeutic factor of interpersonal learning is to be set in motion, the group must recognize, examine, and understand process. It must examine itself; it must study its own transactions; it must transcend pure experience and apply itself to the meaningful integration—the making-sense aspect—of that experience.

Thus, the effective use of the here-and-now requires two steps: the group lives in the here-and-now, and it also doubles back on itself and examines the here-and-now behavior that has just occurred.

If only the first—the experiencing of the here-and-now—is present, the group experience will still be intense, members will feel deeply involved, emotional expression may be high, and members will finish the group agreeing, "Wow, that was a powerful experience!" *Yet it will also prove to be an evanescent experience.* Members will have no cognitive framework permitting them to retain the group experience, to generalize from it, to identify and alter their interpersonal behavior, and to transfer their learning from the group to situations beyond the group. This is precisely the error made by many group leaders during the encounter group era.

If, on the other hand, only the *second* part of the here-and-now—the examination of process—is present, then the group loses its liveliness and meaningfulness. It devolves into a sterile intellectual exercise. This is the error made by overly formal, aloof, rigid therapists.

Accordingly, the therapist has two discrete functions in the here-and-now: *to steer the group into the here-and-now and to facilitate the self-reflective loop (or process commentary)*. Much of the here-and-now steering function can be shared by the group members, but for reasons we will discuss later, process commentary remains largely the task of the therapist.

The majority of group therapists understand that their emphasis must be on the here-and-now. Though it is challenging to maintain that focus, it is an essential component of effective group therapy and correlates with improved clinical outcomes.[2] A large survey of seasoned group therapists underscored activation of the here-and-now as a core skill of the contemporary group therapist.[3] A smaller but careful study codified group therapists' interpretations and found that over 60 percent of interpretations focused on the here-and-now (either behavioral patterns or impact of behavior), while approximately 20 percent focused on historical causes and 20 percent on motivation.[4]

DEFINITION OF PROCESS

The term *process*, used liberally throughout this text, has a highly specialized meaning in many fields, including law, anatomy, sociology, anthropology, psychoanalysis, and descriptive psychiatry. In interactional psychotherapy, too, process has a specific technical meaning. It refers to the *nature of the relationships between interacting individuals—members and therapists*.[5] Moreover, as we shall see, a full understanding of process must take into account a large number of factors, including the internal psychological worlds of each member, interpersonal interactions, group-as-a-whole forces, the clinical setting of the group, and the larger sociocultural or political environment in which the group is embedded.[6]

It is useful to contrast *process* with *content*. Imagine two individuals in a discussion. The *content* of that discussion consists of the explicit words spoken, the substantive issues, the arguments advanced. The *process* is an altogether different matter. When we ask about process, we ask, *"What do these explicit words and the style of the participants reveal about the interpersonal relationship of the participants?"*

Therapists who are process-oriented are concerned not primarily with the verbal content of a client's statement, but with the "how" and the "why" of that statement, especially insofar as the how and the why illuminate aspects of the client's interpersonal relationships. Thus, therapists focus on the metacommunicational[i] aspects of the message and wonder why, from the relationship aspect, an individual makes a statement at a certain time in a certain manner to a certain person. Some of the message is conveyed verbally and directly; some of the message is expressed paraverbally (by nuance, inflection, pitch, and tone); and some of the message is expressed behaviorally, and even somatically, through one's posture and physical presence.[7] Identifying the connection between the intent and the actual impact of the communication is at the heart of the

therapy process. Such an exploration illuminates, within the social microcosm of the group, the individual's interpersonal patterns, beliefs, fears, and wishes.

Consider, for example, this transaction: During a lecture, a student raised her hand and asked when the American Psychiatric Association had stopped labeling homosexuality as a mental disorder. The lecturer replied, "1974," only to have the student inquire, "But wasn't it earlier, in 1973?" Since the student already knew the answer to her question, her motivation was obviously not a quest for information. (A question ain't a question if you know the answer.) The process of this transaction? Most likely, the student wished to demonstrate her knowledge, or to humiliate or defeat the lecturer!

Frequently, the understanding of process in a group is more complex than in a two-person interaction. We must search for the process not only behind individual statements but behind a sequence of statements made by several group members. The group therapist must endeavor to understand what a particular sequence reveals about the relationship between one client and the other group members, or between clusters or cliques of members, or between the members and the leader, or, finally, between the group as a whole and its primary task. John Schlapobersky, a prominent group analyst, encourages group leaders to reflect regularly on the following as a way to examine group process: Who is speaking? Who is being spoken to? What is being said and what is not being said?[8]

A clinical vignette may further clarify the concept:

> **Early in the course of a group therapy meeting, Burt, a tenacious,** intense graduate student, exclaimed to the group in general, and to Rose (an unsophisticated mother of four), in particular, "Parenthood is degrading!" This provocative statement elicited considerable response from the group members, all of whom had parents and many of whom were parents. The free-for-all that followed consumed the remainder of the group session. **<<**

Burt's statement can be viewed strictly in terms of *content*. In fact,

this is precisely what occurred in the group; the members engaged Burt in a debate about the virtues versus the dehumanizing aspects of parenthood—a discussion that was affect-laden but impersonal and intellectualized and brought none of the members closer to their goals in therapy. Subsequently, the group felt discouraged about the meeting and angry with themselves and with Burt for having wasted a session.

On the other hand, the therapist might have considered the *process* of Burt's statement from any one of a number of perspectives:

1. Why did Burt attack Rose? What was the interpersonal process between them? In fact, the two had had a smoldering conflict for many weeks, and in the previous meeting Rose had wondered aloud why, if Burt was so brilliant, he was still, at the age of thirty-two, a student. Burt viewed Rose as an inferior being who functioned primarily as a breast-milk dispensary; once, when she was absent, he referred to her as a brood mare.
2. Why was Burt so judgmental and intolerant of nonintellectuals? Why did he always have to maintain his self-esteem by standing on the carcass of a vanquished or humiliated adversary?
3. Assuming that Burt's chief intent was to attack Rose, why did he proceed so indirectly? Is this characteristic of Burt's expression of aggression? Or is it characteristic of Rose that no one dares, for some unclear reason, to attack her directly?
4. Why did Burt, through an obviously provocative and indefensible statement, set himself up for a universal attack by the group? Although the lyrics were different, this was a familiar melody for the group and for Burt, who had on many previous occasions placed himself in a similar position. Why? Was it possible that Burt was most comfortable when relating to others in this fashion? He once stated that he had always loved a fight; indeed, he glowed with anticipation at the

appearance of a quarrel in the group. His early family environment was one in which there was a lot of fighting. Was fighting, then, a form (perhaps the only available form) of engagement for Burt?

5. The process may be considered from the even broader perspective of the entire group. Other relevant events in the life of the group must be considered. For the past two months, the session had been dominated by Kate, a deviant, disruptive, and partially deaf member who had, two weeks earlier, dropped out of the group with the face-saving proviso that she would return when she obtained a hearing aid. Was it possible that the group needed a Kate, and that Burt was merely filling the required role of scapegoat and channeling aggression away from other targets—like the therapist?
6. Through its continual climate of conflict, through its willingness to spend an entire session discussing in nonpersonal terms a single theme, was the group avoiding something—possibly an honest discussion of members' feelings about Kate's rejection by the group, or their guilt or fear of a similar fate? Or were they perhaps avoiding the anticipated perils of self-disclosure and intimacy?
7. Was the group saying something to the therapists through Burt (and through Kate)? For example, Burt may have been bearing the brunt of an attack really aimed at the co-therapists but displaced from them. The therapists—aloof figures with a proclivity for rabbinical pronouncements—had never been attacked or confronted by the group. Their co-therapy relationship had also escaped any comment to date. Surely there were strong unspoken feelings toward the therapists, which may have been fanned by their failure to support Kate and by their complicity through inactivity in her departure from the group.

Which one of these many process observations is correct? Which one could the therapists have employed as an effective intervention?

The answer is, of course, *that any and all may be correct*. They are not mutually exclusive; each views the transaction from a slightly different vantage point. What is critical, however, is that the focus on *process* begins with the therapist's reflection on the host of factors that may underlie an interaction. By clarifying each of these in turn, the therapist could have focused the group on many different aspects of its life. *Which one, then, should the therapist have chosen?* It is a daunting question with multiple choice points to pursue, particularly for neophyte group leaders who may respond reactively to one potential dynamic without recognition of the larger patterns or group processes.[9]

The therapist's choice should be based on one primary consideration: *the immediate needs of the group*. What will draw the group's focus back to those needs? The therapists had many options. If they felt there had been too much focus on Burt of late, leaving the other members feeling bored and excluded, then they might have wondered aloud what the group was avoiding. The therapists might have next reminded the group of previous sessions spent in similar discussions that left them dissatisfied. Or they might have helped one of the members verbalize this point by inquiring about that member's inactivity or apparent uninvolvement in the discussion. If they felt that the indirectness of the group communication was a major issue, they might have commented on the indirectness of Burt's attacks, or asked the group to help clarify, via feedback, what was happening between Burt and Rose. If they felt that an exceptionally important group event (Kate's departure) was being strongly avoided, then they might have focused on that event and the conspiracy of silence around it.

> **In another group, a member, Saul, sought therapy because of his** deep sense of isolation. He was particularly interested in a group therapeutic experience because he had never before been a part of a primary group. Even in his primary family, he had felt himself an outsider. He had been a spectator all his life, pressing his nose against cold windowpanes, gazing longingly at warm, convivial groups within.
>
> At Saul's fourth therapy meeting, another member, Barbara, began the meeting by announcing that she had just broken up with a man who

had been very important to her. Barbara's major reason for being in therapy had been her inability to sustain a relationship with a man, and she was now profoundly distressed. Barbara had an extremely poignant way of describing her pain, and the group was swept along with her feelings. Everyone in the group was very moved; I (IY) noted silently that Saul, too, had tears in his eyes.

The group members (with the exception of Saul) did everything in their power to offer Barbara support. They passed Kleenex; they reminded her of all her good qualities and assets; they reassured her that she had made the right choice, that the man was not good enough for her, that she was "lucky to be rid of that jerk."

Suddenly, Saul interjected: "I don't like what's going on here in the group today, and I don't like the way it's being led" (an obvious allusion to me). He went on to explain that the group members had no justification for their criticism of Barbara's ex-boyfriend. They didn't really know what he was like. They could see him only through Barbara's eyes, and probably she was presenting him in a distorted way. (Saul had a personal ax to grind on this matter, having gone through a divorce a couple of years earlier. His wife had attended a women's support group, and he imagined he had been the "jerk" of that group.)

Saul's comments, of course, changed the entire tone of the meeting. The softness and support disappeared. The room felt cold; the warm bond among the members was broken. Everyone was on edge. I felt justifiably reprimanded. Saul's position was technically correct: the group was wrong to condemn Barbara's ex-boyfriend in such a sweeping and uncritical manner.

So much for the content. Now let's examine the process of this interaction. First, note that Saul's comment had the effect of putting him outside the group. The rest of the group was caught up in a warm, supportive atmosphere from which he excluded himself. Recall his chief complaint that he was never a member of a group, but always the outsider. The meeting provided an in vivo demonstration of how that came to pass. In his fourth group meeting, Saul had, kamikaze-style, attacked and voluntarily ejected himself from a group he wished to join.

A second issue had to do not with what Saul said but what he did *not* say. In the early part of the meeting, everyone except Saul had made warm, supportive statements to Barbara. I had no doubt that Saul felt supportive of her; the tears in his eyes indicated that. But why had he chosen to be silent? Why did he always choose to respond from his critical self and not from his warmer, more supportive self?

The examination of this aspect of the process led to some very important issues for Saul. Obviously, it was difficult for him to express the softer, affectionate part of himself. He feared being vulnerable and exposing his dependent cravings. He feared losing himself and his own uniqueness by getting too close to another or becoming a member of a group. Behind the aggressive, ever-vigilant, hard-nosed defender of honesty (but a selective honesty: honesty of expression of negative but not positive sentiments), there is often the softer, submissive child thirsting for acceptance and love. **<<**

> In a T-group (an experiential training group) of clinical psychology interns, one of the members, Robert, commented that he genuinely missed the contributions of some of the members who had been generally very silent. He turned to two of these members and asked if there was anything he or others could do that would help them participate more. The two members and the rest of the group responded by launching a withering attack on Robert. He was reminded that his own contributions had not been substantial, that he was often silent for entire meetings himself, that he had never really expressed his emotions in the group, and so forth.

Viewed at the content level, this transaction is bewildering. Robert expressed genuine concern for the silent members, and for his solicitude he was soundly buffeted. Viewed at the process—that is, relationship—level, however, it makes perfectly good sense: the group members were involved in a struggle for dominance, and their inner response to Robert's statement was, "Who are you to issue an invitation to speak? Are you the host or leader here? If we allow you to comment on our silence and suggest solutions, then we acknowledge your dominion over us." **<<**

> In another group, Kevin, an overbearing business executive, opened the meeting by asking the other members—housewives, teachers, clerical workers, freelance software developers, and store owners—for help with a problem: he had received "downsizing" orders. He had to cut his staff immediately by 50 percent—to fire twenty of his staff of forty.

The content of the problem was intriguing but impersonal. The group spent forty-five minutes discussing such aspects as justice versus mercy: that is, whether one retains the most competent workers or workers with the largest families or those who would have the greatest difficulty in finding other jobs. Despite the fact that most of the members

engaged animatedly in the discussion, which involved important problems in human relations, the co-therapists regarded the session as unproductive: the discussion could have appropriately occurred at a dinner party or any other social gathering. Furthermore, as time passed, it became abundantly clear that Kevin had already spent considerable time thinking through every aspect of the problem, and no one was able to provide him with novel approaches or suggestions. The session was not truly a work session: instead it was a flight-from-work session.

Such a dedicated focus on content is inevitably frustrating for the group, and the therapists began to wonder about process—that is, what this content revealed about the nature of Kevin's relationship to the other members. As the meeting progressed, Kevin, on two occasions, let slip the amount of his salary (which was more than double that of any other member). In fact, the overall interpersonal effect of Kevin's presentation was to make others aware of his affluence and power.

The process became even more clear when the therapists recalled previous meetings in which Kevin had been soundly attacked by the group for his evangelical religious convictions, which he used to criticize others' behavior but never his own—which included extramarital affairs and compulsive lying. At a recent meeting, he had been termed "thick-skinned" because of his apparent insensitivity to others. However, despite the criticism he had received, Kevin was a dominant member: he was the most active and central figure in almost every meeting.

With this information about process, let's examine the alternatives available to consider. The therapists might have focused on Kevin's bid for prestige, especially after the attack on him and his loss of face in the previous meeting. Phrased in a nonaccusatory manner, a clarification of this sequence might have helped Kevin become aware of his desperate need for the group members to respect and admire him. At the same time, the self-defeating aspects of his behavior could have been pointed out. Despite his yearning for respect, the group had come to resent and at times even to scorn him. Perhaps, too, Kevin was attempting to repudiate the charge of being thick-skinned by sharing his personal agony over the staffing issue in such a melodramatic fashion.

There are many therapist options. The style of the therapists' intervention would depend on Kevin's degree of defensiveness: if he had seemed particularly brittle or prickly, then the therapists might have underscored how hurt he must have been at the previous meeting. If he had been more open, they might have asked him directly what type of response he would have liked from the others.

Other therapists might have preferred to interrupt the content

discussion and simply ask the group members what Kevin's question had to do with last week's session. Still another alternative would be to call attention to an entirely different type of process by reflecting on the group's apparent willingness to permit Kevin to occupy center stage in the group week after week. By encouraging the members to discuss their response to his monopolization, the therapist could have helped the group initiate an exploration of their relationship with Kevin. **<<**

Keep in mind that therapists need not wait until they have all the answers before asking a process question. In fact, the initial process inquiry may be essential in understanding the process, and rather than waiting for greater certainty, therapists may begin the process inquiry by simply asking the members a question at a very low level of inference: "How are each of you experiencing the meeting so far?" Or they may use slightly more inference: "You look like you are having some reaction to this." At other times, the therapist's level of inference may be raised and interventions may be more precise and ultimately interpretive: "Kevin, I have a sense that you yearn for respect here in the group, and I wonder if the comment last week about you being 'thick-skinned' wasn't hurtful to you and is related to your bringing in this work dilemma."

Although our focus is on group therapy applications, the skills of process recognition and metacommunication makes group therapy training indispensable to mental health professionals across all forms of practice. It is a form of X-ray vision that helps us see what team or organizational dynamics may lie beneath the more manifest communication, as the following example illustrates:

> As chief of psychiatry in a university teaching hospital, I (ML) was involved in planning meetings regarding the impending COVID-19 pandemic. Several years previously, our hospital and surrounding community had been severely impacted by the severe acute respiratory syndrome pandemic (SARS).[10] Many of our staff members had been quarantined; some became gravely ill and required ICU care; and a number of nurses and doctors in our surrounding community had succumbed to SARS.

In this planning meeting involving all of the hospital's department chiefs and our senior administrative leadership, the discussion became

progressively more polarized and more heated. One senior member felt that we were heading for a catastrophe of epic proportion. Another senior member responded that that was a grossly exaggerated and dramatic response and that we would weather it without much impact. Emotional tensions grew, the polarization deepened, and we were approaching an impasse.

At that point I commented that it would be helpful to look at this discussion from a psychological perspective. “It is human nature, after our SARS trauma, that our reactions in the face of a potential new threat range from feelings of powerful reexperiencing and deep dread, on the one hand, and avoidance, minimization, or denial, on the other hand. Both polarized reactions carry some elements of truth; both need to be integrated into meaningful planning for the hospital, our patients and staff.”

That process intervention identified and defused our mounting tensions and we were able to resume our task and planning process with greater mutual understanding. **<<**

PROCESS FOCUS: THE POWER SOURCE OF THE GROUP

The focus on process—that is, on the here-and-now—is not just one of many possible procedural orientations; on the contrary, it is indispensable and a common denominator of all effective interactional groups. One so often hears words to this effect: “No matter what else may be said about experiential groups (therapy groups, T-groups, group therapy conference institute groups, and so on), one cannot deny that they are potent—that they offer a compelling experience for participants.” *Why* are these groups potent? *Precisely because they encourage process exploration.* The process focus is the power cell of the group.

A process focus is the one truly unique feature of the experiential group; after all, there are many socially sanctioned activities in which one can express emotions, help others, give and receive advice, confess secrets, and discover similarities between oneself and others. But where else is it permissible, in fact encouraged, to comment, in depth, on here-and-now behavior—on the nature of the immediately current relationship between people?

Consider the cocktail party. Imagine confronting a narcissistic, self-absorbed individual who looks through or over you while talking to you, searching for someone more attractive or appealing. In place of an authentic encounter, we are most likely to comment, “Good talking with you…” or, “I need to refill my drink…”—rather than, “Are you aware that you are talking to me while scanning the room for more attractive people? Do you know how that makes me feel?” The cocktail party is not the place for authentic process examination: most likely it would result in a dramatic decrease of one’s party invitations.

Process commentary among adults is generally taboo social behavior; it is considered rude, intrusive, or impertinent. Positive comments about another’s immediate behavior often denote a seductive or flirtatious relationship. Negative comments about

another's manners, gestures, speech, or physical appearance foreshadow a bitter battle looming ahead.

Why should this be so? What are the sources of this taboo? One researcher suggested that process commentary is eschewed in social interaction because of socialization anxiety, social norms, fear of retaliation, and power maintenance.[11]

Socialization Anxiety

Process commentary evokes early memories and anxieties associated with parental criticism of the child's behavior. Parents comment on the behavior of children. Although some of this process focus is positive, much more is critical and serves to control and alter the child's behavior. Adult process commentary often awakens old socialization-based anxiety and is experienced as judging, critical, and controlling.

Social Norms

If individuals felt free to comment at all times on the behavior of others, social life would become intolerably self-conscious, complex, and conflicted. Underlying adult interaction is an implicit contract that a great deal of immediate behavior will be invisible to the parties involved. This provides an autonomy and a freedom that would be impossible if we all knew that others were continually observing our behavior and were free to comment on it. This is a lesson often taught to many young therapists by their partners: "Don't try that stuff with me at home…"

Fear of Retaliation

We cannot monitor or stare at another person too closely, because (unless the relationship is exceedingly intimate) such intrusiveness is almost always dangerous and anxiety-provoking and evokes retribution. There exist no forums, aside from such intentional systems as therapy groups, for interacting individuals to test and to correct their observations of one another.

Power Maintenance

Process commentary undermines arbitrary authority structure. Organizational consultants have long known that an organization's open investigation of its own structure and process leads to power equalization—that is, a flattening of the hierarchical pyramid. The more rigid the authority structure of an organization, the more stringent the precautions against open commentary about process (as in, for example, the military or the church). The individual who wishes to maintain a position of arbitrary authority is wise to inhibit the development of any rules permitting reciprocal process observation and commentary.

In psychotherapy, process commentary involves a great degree of therapist transparency, exposure, and even intimacy: many therapists resist this approach because of their own uneasiness about the hierarchical flattening that ensues.[12]

THE THERAPIST'S TASKS IN THE HERE-AND-NOW

In the first stage of the here-and-now focus—*the activating phase*—the therapist's task is to move the group into the here-and-now. By a variety of techniques, which we will discuss shortly, group leaders steer the group members *away* from outside material and focus instead on their relationship with one another. Group therapists expend more time and effort on this task early than late in the course of the group, because as the group matures, the members begin to share much of this task, and the here-and-now focus often becomes a natural part of the group flow. In fact, many of the norms described in the previous chapter, which the therapist must establish in the group, foster a here-and-now focus. For example, the leader who sets norms of interpersonal feedback, of emotional expression, of self-monitoring, of valuing the group as an important source of information, is, in effect, reinforcing the importance of the here-and-now. Gradually, members, too, come to value the here-and-now and will themselves focus on it; by a variety of means, they will also encourage their fellow members to do likewise.

It is altogether another matter with the second phase of the here-and-now orientation, *process illumination*. Forces prevent members from fully sharing that task with the therapist. Recall the earlier T-group vignette, when a group member made observations about what was happening in the group, and the others responded resentfully about his presumptuousness in seeking to elevate his status above the others.

Similar instances abound. If a member comments, for example, that "nothing is happening today," or that "the group is stuck," or that "no one is self-revealing," or that "there seem to be strong feelings toward the therapist," then that member is courting danger. The response of the other members is predictable. They will challenge the challenging member: "*You* make something happen today," or "*You* reveal yourself," or "*You* talk about your feelings toward the therapist." Only the therapist is relatively exempt from that charge.

Only the therapist has the right to suggest that others work or that others reveal themselves without having to engage personally in the act he or she suggests.

Throughout the life of the group, the members are involved in a struggle for position on the hierarchy of dominance. At times, the conflict around control and dominance is flagrant; at other times, quiescent. But it never vanishes and should be explored in therapy, both because it is a rich source of material and to prevent it from hardening into a source of continuing, fractious conflict.

Some members strive nakedly for power; others strive subtly; still others desire it but are fearful of assertion, or always assume an obsequious, submissive posture. Statements by members that suggest that they place themselves above or outside the group generally evoke responses that emerge from the dominance struggle rather than from consideration of the content of the statement. Even therapists are not entirely immune from evoking this response; some clients are inordinately sensitive to being controlled by the therapist. They find themselves in the paradoxical position of applying to the therapist for help and yet being unable to accept help, because all statements by the therapist are viewed through spectacles of distrust. This is a function of the specific pathology of some clients (and it is, of course, good grist for the therapeutic mill).

The therapist is an observer-participant in the group. The observer status affords the objectivity necessary to store information, to make observations about sequences or cyclical patterns of behavior, and to connect events that have occurred over long periods of time. Therapists act as group historians. Only they are permitted to maintain a temporal perspective; only they remain immune from the charge of not being one of the group, of elevating themselves above the others. It is also chiefly the therapists who keep in mind the original goals of the group members and the relationship between these goals and the events that gradually unfold in the group.[13]

> **Two group members, Tim and Marjorie, had a sexual affair that** eventually came to light in the group. The other members reacted in

various ways, but none so condemnatory or so vehemently as Diana, a harsh forty-five-year-old moralist who criticized them for breaking group rules: Tim, for "being too intelligent to act like such a fool," Marjorie for her "irresponsible disregard for her husband and child," and the libertine therapist (IY) who "just sat there and let it happen." I eventually pointed out that, in her formidable moralistic broadside, some individuals had been obliterated, that the Marjorie and Tim whom Diana had known for so long, with all their struggles and doubts and fears, had suddenly been replaced by faceless one-dimensional stereotypes. Furthermore, I was the only one to recall, and to remind the group of, the reasons (expressed at the first group meeting) why Diana had sought therapy: namely, that she needed help in dealing with her rage toward a rebellious nineteen-year-old daughter who was in the midst of a sexual awakening and searching for her identity and autonomy! From there it was but a short step for the group, and then for Diana herself, to understand that her conflict with her daughter was being played out in the here-and-now of the group. **<<**

There are many occasions when the process is obvious to all the members in the group but cannot be commented upon simply because the situation is too hot: the members are too much a part of the interaction to separate themselves from it. In fact, often, even at a distance, the therapist, too, feels the heat and is wary about naming the beast. Sometimes an inexperienced therapist may naively determine it best that some group member speak to an issue in the group that the leader himself feels too anxious to address. That is usually an anxiety-driven error: the therapist has developed, we hope, a greater ability to speak the unspeakable and to find palatable ways to say unpalatable things than the client. Language is to the therapist what the scalpel is to the surgeon.

> **One neophyte leader facilitating an experiential group of pediat**ric oncology nurses (a support group intended to help members decrease the stress experienced in their work) inferred through the collusive glances between members in the first meeting that there was considerable unspoken tension between the young, progressive nurses and the older, conservative charge nurses in the group. The leader felt that the issue, reaching deep into taboo regions of authority and tradition, was too sensitive and potentially explosive to touch. Her

supervisor assured her that it was too important an issue to leave unexplored and that she should broach it, since it was highly unlikely that anyone else in the group could do what she dared not.

In the next meeting, she raised the issue in a manner that is almost invariably effective in minimizing defensiveness: she described her own dilemma about the issue. She told the group that she sensed a hierarchical struggle between the junior nurses and the powerful senior nurses, but that she was hesitant to bring it up lest the younger nurses either deny it or attack their supervisors, who might be so wounded that they would decide to scuttle the group. Her comment was enormously helpful and plunged the group into an open and constructive exploration of a vital issue. **<<**

Articulating the dilemma in a balanced, nonblaming, self-revealing fashion is often the most effective way to reduce the tension that obstructs the group's work. Group leaders need not have a complete answer to the dilemma—but they do need to be able to identify and speak to it.

By no means do we suggest that *only* the leader should make process comments. As we shall discuss later, other members are entirely capable of performing this function; in fact, there are times when their process observations will be more readily accepted by group members than those of the therapists.

Cultivating an ability to recognize process in interactions—a form of emotional intelligence, perhaps—is an important outcome of group therapy that will serve members well in life. (Often, students observing a mature group at work are amazed by group members' high level of psychological-mindedness.) It is a good thing for members to learn to identify and comment on process. But it is important that they not assume this function for defensive reasons—for example, to avoid the client role or in any other way to remove themselves from the group work.

Thus far in this discussion we have, for pedagogical reasons, overstated two fundamental points that we must now qualify. Those points are: (1) the here-and-now approach is an ahistorical one, and (2) there is a sharp distinction between here-and-now experience and here-and-now process illumination.

Strictly speaking, an ahistorical approach is an impossibility: every process comment refers to an act that already belongs to the past. Not only does process commentary involve behavior that has just transpired, but it frequently refers to cycles of behavior or repetitive acts that have occurred in the group over weeks or months. *Thus, the past events of the therapy group are a part of the here-and-now and an integral part of the data on which process commentary is based.*

Often it is helpful to ask clients to review their past experiences in the group. If a member feels that she is exploited every time she trusts someone or reveals herself, it is good to inquire about her history of experiencing that feeling in the group. Other clients, depending upon the relevant issues, may be encouraged to discuss such experiences as the times they have felt the closest to others, the angriest, the most accepted, or the most ignored. It is wise to search for analogues in the room of relationships and situations in the outside world.

Our qualification of the ahistorical approach goes even further. As we will discuss later in a separate section in this chapter, no group can maintain a total here-and-now approach. There will be frequent excursions into the "then-and-there"—that is, into personal history and into current life situations. In fact, such excursions are so inevitable that one becomes curious when they do not occur. It is not that the group doesn't deal with the past; *it is what is done with the past*. The crucial task is not to uncover, to piece together, to fully understand the past, *but to use the past for the help it offers in understanding (and changing) the individual's mode of relating in the present*. It is a matter of relative emphasis—a form of figure-ground phenomena. Keep in mind that this does not usually make intuitive sense to our clients, who anticipate that therapy will be a deep dive into their past. (More about that when we address pregroup preparation.)

The distinction between here-and-now experience and here-and-now process commentary is not sharp; there is much overlap. For example, low-inference commentary (feedback) is both experience and commentary. When one member remarks that another refuses

to look at her, or that she is furious at another for continually deprecating her, she is at the same time commenting on process and involving herself in the affective here-and-now experience of the group. Process commentary exists for only a short time; it rapidly becomes incorporated into the experiential flow of the group and forms part of the data from which future process comments will flow.

For example, in an experiential group of mental health trainees (a group experience that was part of their group therapy training curriculum), one member, Paulo, began the session by describing his extreme feelings of depression and depersonalization. Instead of exploring the member's dysphoria, the group immediately began offering him practical advice about his life situation. The leader commented on the process—on the fact that the group veered away from inquiring more about Paulo's experience. The leader's intervention seemed useful: the group members became more emotionally engaged, and several discussed their admiration of Paulo's risk-taking and their own fear of self-revelation.

Soon afterward, however, a couple of members who predictably challenged the leader's influence stated their objections to this intervention. They felt that the leader was dissatisfied with their performance in the group, that he was criticizing them, and, in his usual subtle manner, was manipulating the group to fit in with his preconceived notions of the proper conduct of a meeting. Other members took issue with the tendency of some members to challenge every move of the therapist. Thus, the leader's process comments became part of the experiential ebb and flow of the group. Even the members' criticism of the leader (which was at first process commentary) soon also became part of the group experience, and itself subject to process commentary. The processing of the group experience can go deeper and deeper if we are willing to take it there and not leave important material unexamined.

Summary

The effective use of the here-and-now focus requires two steps: experience in here-and-now and process illumination. The

combination of these two steps imbues an experiential group with compelling potency.

The therapist has different tasks in each step. First, the group must be plunged into the here-and-now interactional experience; second, it must be helped to understand the process of the here-and-now experience—that is, what the interaction conveys about the nature of the members' relationships with one another.

The first step, here-and-now activation, becomes part of the group norm structure; eventually the group members will assist the therapist in this task. The second step, process illumination, is more difficult. There are powerful injunctions against process commentary in everyday social interaction that the therapist must overcome. The task of process commentary, to a large extent (but not exclusively), remains the responsibility of the therapist and consists, as we will discuss shortly, of a wide and complex range of behavior—from labeling single behavioral acts, to juxtaposing several acts, to combining acts over time into a pattern of behavior, to pointing out the undesirable consequences of a client's behavioral patterns, to identifying here-and-now behaviors that are analogues to the member's behavior in the world at large, to more complex inferential explanations or interpretations about the meaning and motivation of such behavior.

TECHNIQUES OF HERE-AND-NOW ACTIVATION

In this section we wish to describe (but not prescribe) some techniques for establishing a here-and-now orientation in group therapy. Each therapist must develop techniques consonant with his or her personal style. Indeed, therapists have a more important task than mastering a technique: they must fully comprehend the strategy and theoretical foundations upon which all effective technique must rest.[14] Trainees often are very interested in the specific language their supervisors or experts employ with their interventions. More important than copying the language, however, is gaining clarity about the principles guiding the selection of these techniques.

First step: We suggest that you *think* here-and-now. When you grow accustomed to thinking of the here-and-now, you automatically steer the group into the here-and-now. Sometimes we feel like shepherds herding a flock into an ever-tightening circle. We head off errant strays—forays into personal historical material, discussions of current life situations, politics, the economy—and guide them back into the circle. Whenever an issue is raised in the group, we think, "How can we relate this to the group's primary task? How can we make it come to life in the here-and-now?" *We are relentless in this effort, and begin it in the very first meeting of the group.*

Consider a typical first meeting of a group. After a short, awkward pause, the members generally introduce themselves and proceed, often with help from the therapist, to tell something about their life problems, why they have sought therapy, and perhaps the type of distress they suffer. We generally intervene at some convenient point well into the meeting and make a remark such as, "We've done a great deal here today so far. Each of you has shared a great deal about yourself, your pain, your reasons for seeking help. But we have a hunch that something else is also going on, and that is that you're sizing one another up, each arriving at some impressions of the others, each wondering how you'll fit in with the others. Could we spend some time discussing what each of us has come up with thus

far?” Now this is no subtle, artful statement: it is heavy-handed, explicit, and directive. Yet most groups respond favorably to such clear guidelines and readily appreciate the therapeutic facilitation. Group members will not go there without that encouragement. Articulating the purpose and methodology of your interventions will demystify the group and foster better alignment around goals, tasks, and relationships. It also sets the stage for creating the social microcosm necessary for potential corrective emotional experiences to emerge.[15]

The therapist is on a perpetual mission, moving the focus from outside the group to inside the group, from the abstract to the specific, from the generic to the personal, from the personal into the interpersonal. If a member describes a hostile confrontation with a spouse or roommate, the therapist may, at some point, inquire, “If you were to be angry like that with anyone in the group, with whom would it be?” or, “With whom in the group can you foresee getting into the same type of struggle?” If a member comments that one of his problems is that he lies, or that he stereotypes people, or that he manipulates groups, the therapist may inquire, “What is the main lie you’ve told in the group thus far?” or, “Can you describe the way you’ve stereotyped some of us?” or, “To what extent have you manipulated the group thus far?” If a client complains of mysterious flashes of anger or suicidal compulsions, the therapist may urge the client to signal to the group the very moment such feelings occur during the session, so that the group can track down and relate these experiences to events in the session.

If a member describes her problem as being too passive, too easily influenced by others, the therapist may move her directly into the issue by asking, “Who in the group could influence you the most? The least?” These interventions are useful even in very brief groups, such as on inpatient units, with the proviso that the more positive and supportive aspects of the here-and-now engagement be emphasized. It is a misconception, perhaps stemming from more confrontational group models, that working in the here-and-now is divisive and inflammatory. On the contrary, it can be powerfully

supportive and emotionally intimate. The therapist must be alert to the risks of shaming or devaluing group members through feedback. The tone the leader sets and models is part of the norm-setting responsibilities we described in the preceding chapter.

If a member comments that the group is too polite and too tactful, the therapist may ask, “Who do you think are the leaders of the peace-and-tact movement in the group?” If a member is terrified of revealing himself and fears humiliation, the therapist may bring it into the here-and-now by asking him to identify those in the group he imagines might be most likely to ridicule him. Don’t be satisfied by answers of “the whole group.” Press the member further. Often it helps to rephrase the question in a gentler manner—for example, “Who in the group is *least* likely to ridicule you?”

In each of these instances, the therapist can deepen interaction by encouraging further responses from the others. For example, “How do you feel about his fear or prediction that you would ridicule him? Can you imagine doing that? Do you, at times, feel judgmental in the group?” Even simple techniques of asking group members to speak directly to one another, to use second person (“you”) rather than third-person pronouns, and to look at one another are very useful. It may, at first, feel a bit heavy-handed and far removed from the traditional view of the therapist as neutral, detached, and silent. Keep in mind that group therapists use the here-and-now to activate therapy and promote therapeutic interaction, not because we wish to exercise power or dominion over others. And if the therapist worries that his or her interventions may feel too controlling of others, that, too, can be processed productively, by asking for the group’s feedback about how they are experiencing the group leader(s).

Easier said than done! Such group therapist inquiries are not always heeded. To some group members, these suggestions are threatening indeed, and the therapist must here, as always, employ good timing and attempt to experience what the client is experiencing. Search for methods that lessen the threat. For example, *begin by focusing on positive interaction*: “Toward whom in the group do you feel most warm?” “Who in the group is most like you?” or, “Obviously, there are some strong vibes, both positive and

negative, going on between you and John. I wonder what you most envy or admire about him? And what parts of him do you find most difficult to accept?"

> **Members of a group of elderly clients attending a psychiatric day** hospital for treatment of depression groaned with feelings of disconnection and despair. The initial focus of the meeting was Sara—an eighty-seven-year-old Holocaust survivor. Sara lamented the persistent prejudice, hatred, and racism so prominent in the news headlines. Feeling scared and helpless, she discussed her wartime memories of being dehumanized by those who hated her without knowing anything about her as a real person. Group members, including other Holocaust survivors, also shared their tortured memories.
>
> I (ML) attempted to break into the group's intense preoccupation with the painful past by shifting into the here-and-now. What did Sara experience in sharing these memories with the group today? Did she feel that the group members were engaging her as a real person? Why had she chosen to be different today—to speak out rather than silence herself as she has done so often before? Could she take credit for that? How did others feel about Sara speaking out in this meeting?
>
> Gradually the meeting's focus shifted from the recounting of despairing memories to lively interaction, support for Sara, and strong feelings of member connection. **<<**

Sometimes, it is easier for group members to work in tandem or in small functional subgroups than to work with the whole group, because it feels less isolating and safer. For example, if clients learn that there is another member (or more) with fears or concerns similar to theirs, then these members can more readily discuss their here-and-now concerns as a less threatened subgroup.[16] This may occur spontaneously or by the therapist directly bridging between specific members—for example, by pointing out that the concerns just disclosed by one member have also been expressed by another. Or the therapist can invite a group member who has worked on this particular issue in earlier sessions to comment on what it might be like at this moment for their co-member.[17] We seek to capitalize on both the lived experience of our group members and their personal

expertise as we bring them into closer contact with one another.

Using the conditional verb form provides safety and distance and often is miraculously facilitative. We use it frequently when we encounter initial resistance. If, for example, a client says, “I don’t have any response or feelings at all about Mary today. I’m just feeling too numb and withdrawn,” we often say something like, “If you were *not* numb or withdrawn today, what *might* you feel about Mary?” The client generally answers readily; the once-removed position affords a refuge and encourages the client to answer honestly and directly. Similarly, the therapist might inquire, “If you *were* to be angry at someone in the group, whom would it be?” or, “If you *were* to go on a date with Albert (another group member), what kind of experience might it be?”

The therapist must teach members the art of requesting and offering feedback by explicit instruction, by modeling, or by reinforcing effective feedback.[18] One important principle to teach clients is the avoidance of global questions and observations. Specificity and an interpersonal focus help, as does taking a risk in both the giving and receiving of feedback. Questions such as “Am I boring?” or “Do you like me?” are not usually productive. A client learns a great deal more by asking, “What do I do that causes you to tune out?” or, “What parts of me or aspects of my behavior do you like least and most?” In the same vein, feedback such as “You’re okay” or “You’re a nice guy” is far less useful than “I feel closer to you when you’re willing to be honest with your feelings, like in last week’s meeting, when you said you were attracted to Mary but feared she would scorn you. I feel most distant from you when you’re impersonal and start analyzing the meaning of every word said to you, like you did early in the meeting today.”

At times, it is not the blandness of feedback that is problematic—it is its sheer hostility. Perhaps the worst and most damaging example of feedback I (ML) have encountered was a member’s explosive burst after weeks of silent, suppressed anger and frustration that had resisted all therapeutic interventions. Sue, a woman with a history of trauma, turned to a very difficult, controlling, and devaluing

narcissistic man in the group and yelled, “Keith, you are subhuman and a waste of oxygen.” Keith turned to me and asked, “How am I supposed to work with that?” Sue’s feedback was so humiliating and wholly rejecting that he was left no path for learning or remediation.

Feedback has to contain a path to working in the here-and-now, such as, “Keith, you control and squash this group by the way you criticize us all and monopolize the sessions, leaving no time for anyone else. I am so frustrated and angry because of your disregard for everyone here. Do you want to push us all out of here? How will that help you work on being less isolated and lonely—isn’t that what you told us your goals were?”

Resistance occurs in many forms. But generally, it serves the purpose of regulating the client’s pace of recognizing and expressing emotional truth.[19] Often it appears in the cunning guise of total equality. Clients, especially in early meetings, often respond to the therapist’s here-and-now urgings by claiming that they feel exactly the same toward all the group members: that is, they say that they feel equally warm toward all the members, or no anger toward any, or equally influenced or threatened by all. *Do not be misled. Such claims are never true.* Guided by your sense of timing and empathy, push the inquiry further and help members differentiate one another. Eventually they will disclose that they do have slight differences of feeling toward some of the members. These slight differences are important and are often the vestibule to full interactional participation. We explore the slight differences (no one ever said they had to be enormous); sometimes we suggest that the client hold up a magnifying glass to these differences and describe what he or she then sees and feels. Often resistance is deeply ingrained, and the client is heavily invested in maintaining a position that is known and familiar even though it is undermining or personally destructive.

Resistance is not usually conscious obstinacy but more often stems from sources outside of awareness. Sometimes the here-and-now task is so unfamiliar and uncomfortable to the client that it is not unlike learning a new language, or it generates an intense sense of vulnerability and fear of retaliation. The client must apply maximal

concentration in order not to slip back into habitual modes of relating. Considerable therapist ingenuity is often required to focus the group on the here-and-now, as the following illustration demonstrates:

> **Claudia resisted participation on a here-and-now level for many** sessions. Typically, she brought to the group some pressing current life problem, often one of such crisis proportions that the group members felt trapped. First, they felt compelled to deal immediately with the precise problem Claudia presented; second, they had to tread cautiously, because she explicitly informed them that she needed all her resources to cope with the crisis and could not afford to be shaken up by interpersonal confrontation. “Don’t push me right now,” she might say. “I’m just barely hanging on.” Efforts to alter this pattern were unsuccessful, and the group members felt discouraged in dealing with Claudia. They cringed when she brought problems into the meeting.
>
> One day she opened the group with a typical gambit. After weeks of searching she had obtained a new job, but she was convinced that she was going to fail and be dismissed. The group dutifully but warily investigated the situation. The investigation met with many of the familiar, treacherous obstacles that generally block the path of work on outside problems. There seemed to be no objective evidence that Claudia was failing at work. She seemed, if anything, to be trying too hard, working eighty hours a week. The evidence, Claudia insisted, simply could not be appreciated by anyone not there at work with her: the glances of her supervisor, the subtle innuendos, the air of dissatisfaction toward her, the general ambiance in the office, the failure to live up to her (self-imposed and unrealistic) sales goals. It was difficult to evaluate what she was saying because she was a highly unreliable observer. She typically downgraded herself and minimized her accomplishments.
>
> I (IY) moved the entire transaction into the here-and-now by asking a question. “Claudia, it’s hard for us to determine whether you are, in fact, failing at your job. But let me ask you another question: What grade do you think you deserve for your work in the group, and what do each of the others get?”
>
> Claudia, not unexpectedly, awarded herself a “D–” and staked her claim for at least eight more years in the group. She awarded all the other members substantially higher grades. I replied by awarding Claudia a “B” for her work in the group and then went on to point out the reasons: her commitment to the group, perfect attendance, willingness

to help others, great efforts to work despite anxiety and often disabling depression.

Claudia laughed it off, trying to brush off this exchange as a gag or a therapeutic ploy, but I insisted that I was entirely serious. Claudia then insisted that I was wrong and pointed out her many failings in the group (one of which was the avoidance of the here-and-now). However, Claudia's disagreement with me created dissonance for her, since it was incompatible with her long-held, frequently voiced, total confidence in me. (Claudia had often invalidated the feedback of other members in the group by claiming that she trusted no one's judgment except mine.) **<<**

The intervention was enormously useful. It transferred the process of Claudia's evaluation of herself from a secret chamber lined with the distorting mirrors of her self-perception to the open, vital arena of the group. No longer was it necessary for the members to accept Claudia's perception of her boss's glares and subtle innuendoes. The boss (the therapist) was there in the group. The whole transaction was visible to the group. Finding the here-and-now *experiential* analogue of the untrustworthy "then-and-there" *reported* difficulties unlocked the therapeutic process for Claudia.

We never cease to be awed by the rich, subterranean lode of data that exists in every group and in every meeting despite the pressure to focus on the manifold external problems for which our clients seek assistance. But how to tap these unvoiced riches? Sometimes after a long silence in a meeting, a group leader might express this very thought: "There is so much information that could be valuable to us all today if only we could excavate it. I wonder if we could, each of us, tell the group about some thoughts that occurred to us in this silence, which we thought of saying but didn't."

The exercise is more effective, incidentally, if you participate personally, even start it going. Substantial empirical evidence supports the principle that therapists who employ judicious and disciplined self-disclosure, centered in the here-and-now of the therapeutic relationship, increase their therapeutic effectiveness and facilitate clients' exploration and openness.[20] For example, you might say, "I've been feeling on edge in this silence, wanting to break

it, not wanting to waste time, but on the other hand feeling irritated that it always has to be me doing this work for the group." Or, "I've been feeling uneasy about the struggle going on in the group between you and me, Mike. I'm uncomfortable with this much tension and anger, but I don't know yet how to help understand and resolve it."

When we feel there has been a great deal left unsaid in a meeting, we have often found the following technique useful: "It's now six o'clock and we still have half an hour left, but I wonder if you each would imagine that the meeting has ended and that you're on your way home. What disappointments would you have about the meeting today?"

Many of the inferences the therapist makes may be off-target. But objective accuracy is not the issue: *As long as you persistently direct the group from the nonrelevant, from the then-and-there, to the here-and-now, you are operationally correct.* For example, if a group spends time in an unproductive meeting discussing dull, boring parties, and the therapist wonders aloud if the members are indirectly referring to the present group session, there is no way of determining with any certainty whether that is an accurate statement. Yet, by shifting the group's attention from then-and-there to here-and-now material, the therapist performs a service to the group—a service that, consistently reinforced, will ultimately result in a cohesive, interactional atmosphere maximally conducive to therapy. Following this model, the effectiveness of an intervention should be gauged by its success in focusing the group on itself and toward the center of the room.

According to this principle, the therapist who has had to cancel a meeting because of illness might ask a group that dwells at length on the general subject of health care, or on a member's sense of guilt over remaining in bed during times of sickness, "Is the group really wondering about *my* recent illness?" Or a group suddenly preoccupied with death and the losses each member has incurred in his or her own life might be asked whether they are also concerned with the group's impending four-week summer vacation. In these instances, the leader attempts to make meaningful connections

between the overt content and the underlying, unexpressed group-related issues.[21]

Obviously, these interventions would be pointless if the group had already thoroughly worked through all the implications of the therapist's recent absence or the impending summer break. The technical procedure is not unlike the sifting process in any traditional psychotherapy. Presented with voluminous data in considerable disarray, the therapist selects, reinforces, and interprets those aspects he or she deems most helpful to the client at that particular time. Remember that the process is overdetermined and influenced by multiple factors that are embedded one atop the other, as this example illustrates. The contemporary environment impacts clients' emotional experience and may connect to their early life experience as well.

> **Political issues loomed large during this particular period of** time, and understandably made their way into the group. There was a particularly intense reaction to the extant policy of separating children from their families as they crossed the border from Mexico to the United States. Group themes of "the bad guys win and get away with it," as well as feelings of hopelessness and helpless rage, were prominent. The morale in the group was somber, almost despairing.
>
> I (ML) encouraged the members of the group to reflect on their feelings, and Nate, a depressed man in his mid-seventies, recalled a traumatic echo from his childhood. The recent forced separations reminded him of his own parents telling him, during the McCarthy era, that they might be arrested, because they were communists and would be separated from him. He added that the anxiety provoked led to a mistrust of others and a lifelong fear of losing important relationships.
>
> We then turned our attention to his experience with us—how did he experience the group? Was he drawing closer or distancing himself? Were there times when he felt helpless in the group? How could we best comfort and support him? How did others feel about Nate's personal disclosure? How well were we providing what he needed from us? **<<**

Implicit here is the assumption that the therapist knows the most propitious direction for the group at a specific moment. Again, this is

not a precise matter. What is most important is that the therapist has formulated broad principles of ultimately helpful directions for the group and its members, and this is where a grasp of the therapeutic factors is essential.

Often, when activating the group, the therapist performs two simultaneous acts: steering the group into the here-and-now, and interrupting the content flow in the group. Not infrequently, some members will resent the interruption, and the therapist must attend to these feelings, for they, too, are part of the here-and-now.

Often it is difficult for the therapist to intervene. Early in our socialization process we learn not to interrupt, and not to change the subject abruptly when in a conversation with another person or in a group. Furthermore, there are often times in the group when everyone seems keenly interested in the topic under discussion. Even though the therapist is certain that the group is not harvesting the full benefit of the session, it is not easy to buck the group current. As we've noted, social-psychological small-group research demonstrates the compelling power of group pressure. To take a stand opposite to the perceived consensus of the group requires considerable therapeutic courage and conviction.[22] But doing so serves the therapy group twice over—both by deepening the work possible and by demonstrating that the group leader is also invested in taking risks and overcoming apprehension and anxiety. Process commentary by the therapist signals empathic attunement to the group and builds a sense of predictability, attachment security, and safety.[23]

Our experience is that the therapist faced with many other types of dilemmas can increase the clients' receptivity by expressing both sets of feelings to the group. For example, "Lily, I feel very uncomfortable as you talk. I'm having a couple of strong feelings. One is that you're into something that is very important and painful for you, and the other is that Jason [a new member] has been trying hard to participate in the group for the past few meetings, and the group seems unwelcoming. This didn't happen when other new members joined the group. Why do you think it's happening now?"

Or, “Lenore, I’ve had two reactions as you started talking. The first is that I’m delighted you feel comfortable enough now in the group to participate, but the other is that it’s going to be hard for the group to respond to what you’re saying, because it’s very abstract and far removed from you personally. Are there some incidents or interactions that have happened here in the group, that you’ve been especially tuned in to? What reactions have you had to other members?”

There are, of course, many more such activating procedures. (In Chapter 15, we describe some basic modifications in the group structure and procedure that facilitate here-and-now interaction in short-term specialized groups.) But our goal here is not to offer a compendium of techniques. Rather, we describe techniques only to illuminate the underlying principle of here-and-now activation. These group techniques, or gimmicks, are servants, not masters. To use them injudiciously, to fill voids, to jazz up the group, to acquiesce to the members’ demands that the leader lead, is seductive but not constructive for the group.[24]

Overall, group leader activity correlates with outcome in a curvilinear fashion—too much or too little activity leads to unsuccessful outcomes. Too *little* leader activity results in a floundering group. Too *much* activation by a leader results in a dependent group that persists in looking to the leader to supply too much.

Remember that sheer acceleration of interaction is not the purpose of these techniques. The therapist who moves too quickly—using gimmicks to make interactions, emotional expression, and self-disclosure too easy—misses the whole point. Resistance, fear, guardedness, distrust—in short, everything that impedes the development of satisfying interpersonal relations—must be permitted expression. The goal is to create not a slickly functioning, streamlined social organization, but one that functions well enough and engenders sufficient trust for the unfolding of each member’s social microcosm to take place.

Thus, the effective therapist doesn’t go *around* obstacles but

works *through* them. Louis Ormont, one of the early modern group analysts, put it well: Though we urge clients to engage deeply in the here-and-now, we expect them to fail, to default on their contract. In fact, we *want* them to default because we hope, through the nature of their failure, to identify and ultimately dispel each member's particular resistances to intimacy—including each member's resistance style (for example, detachment, fighting, diverting, self-absorption, distrust) and each member's underlying *fears of intimacy* (for example, lack of control, humiliation, abandonment, merger, vulnerability).[25] We want our clients to be curious about themselves, and we need to create the conditions that promote our clients' personal curiosity.[26]

TECHNIQUES OF PROCESS ILLUMINATION

As soon as clients have been successfully steered into a here-and-now interactional pattern, the group therapist must attend to turning this interaction to therapeutic advantage. This task is complex and consists of several stages:

- Clients must first recognize what they are doing in their interactions with other people (ranging from simple acts to complex patterns unfolding over a long time).
- They must then appreciate the impact of this behavior on others and how it influences others' opinions of them, and consequently its impact on their own self-regard.
- They must decide whether they are satisfied with their habitual interpersonal style.
- They must exercise the will to change.
- They must transform intent into decision and decision into action.
- Lastly, they must solidify the change and transfer it from the group setting into their larger life.

Each of these stages may be facilitated by some specific input by the therapist, and we will describe each step in turn. First, however, we must discuss several prior considerations: How does the therapist recognize process? How can the therapist help the members assume a process orientation? How can therapists increase client receptivity to process commentary?

Recognition of Process

Before therapists can help clients understand process, they must themselves learn to recognize it. In other words, they must be able to reflect prior to responding in the midst of the group interaction and

wonder, “Why is *this* unfolding in this group in *this* particular way and at *this* particular time?”[27] The experienced therapist develops this skill and reliably maintains a process perspective naturally and effortlessly, observing the group proceedings from several different perspectives, including the specific individual interactions and the developmental issues in the group (which we will discuss in more depth in Chapter 10). Assuming this process perspective is a major difference in the role between the client and the therapist. Consider some clinical illustrations:

> **At one meeting, Elena disclosed much deep personal material.** The group was moved by her account and devoted much time to listening, to helping her elaborate more fully, and to offering support. The therapist shared in these activities but entertained many other thoughts as well. For example, the therapist wondered why, of all the members, it was invariably Elena who revealed first and most. Why did Elena so often put herself in the role of the group member whom all the members must nurse? Why must she always display herself as vulnerable? And why today? And that last meeting! So much conflict! After such a meeting, one might have expected Elena to be angry. Instead, she showed her throat. Was she avoiding giving expression to her rage? **<<**

> **At the end of a session in another group, Jay, a young, rather fragile** young man who had been inactive in the group, revealed that he was gay and HIV positive—his first deep personal disclosure in the group. At the next meeting the group urged him to continue to describe his feelings. He attempted to do so, but, overcome with emotion, blocked and hesitated. Just then, with indecent alacrity, Vicky filled the gap, saying, “Well, if no one else is going to talk, I have a problem.” Vicky, an aggressive forty-year-old single woman who sought therapy because of social isolation and bitterness, proceeded to discuss in endless detail a complex situation involving an unwelcome visiting aunt. For the experienced, process-oriented therapist, the phrase “I have a problem” is a double entendre. Far more trenchantly than her words, Vicky’s behavior declares, “I have a problem,” and her problem is manifest in her insensitivity to Jay, who, after months of silence, had finally mustered the courage to speak. **<<**

It is not easy to tell the beginning therapist how to recognize

process; the acquisition of this perspective is one of the major tasks in your education. And it is an interminable task; throughout your career, you learn to penetrate ever more deeply into the substratum of group discourse. This deeper vision increases the therapist's interest in the meeting. Generally, beginning students who observe meetings find them far less meaningful, complex, and interesting than do experienced therapists. When we observe groups led by our trainees, for example, we have often had the experience of writing several pages of detailed notes covering a ten-minute segment of the group that our trainees might barely mention in their account during supervision of that session.

Certain guidelines, though, may facilitate the neophyte therapist's recognition of process. Note the simple nonverbal sense data available. Who chooses to sit where? Which members sit together? Who chooses to sit close to the therapist? Far away? Who sits near the door? Who comes to the meeting on time? Who is habitually late? Who looks at whom when speaking? Do some members, while speaking to another member, look at the therapist? If so, then they are relating not to one another but instead to the therapist through their speech to the others. Who looks at his watch? Who slouches in her seat? Who yawns? Do the members pull their chairs away from the center at the same time as they are verbally professing great interest in the group? How quickly do the group members enter the room? How do they leave it? Are coats kept on? When in a single meeting or in the sequence of meetings are coats removed? A change in dress or grooming not uncommonly indicates change in a client or in the atmosphere of the entire group. These sources of information are much less accessible in online groups, but attention to group process continues to be paramount in that setting as well (see Chapter 14).

A large variety of postural shifts may signal discomfort; foot flexion, for example, is a particularly common sign of anxiety. Indeed, it is common knowledge that nonverbal behavior frequently expresses feelings of which a person is yet unaware. The therapist, through observing and teaching the group to observe nonverbal behavior, may hasten the process of self-exploration.

Assume that every communication has meaning and salience within the individual's interpersonal schema until proven otherwise. Make use of your own reactions to each client as a source of process data.[28] Pay attention to the reactions that group members elicit in one another. Which seem to be consensual reactions shared by most, and which are unique or idiosyncratic reactions?[29]

Sometimes the process is clarified by *attending not only to what is said but also to what is omitted*: the female member who offers suggestions, advice, or feedback to the male members but never to the other women in the group; the group that never confronts or questions the therapist; the topics (for example, the taboo trio: sex, money, death) that are never broached; the individual who is never attacked; the one who is never supported; the one who never supports or inquires—all these omissions are part of the transactional process of the group.

> **In one group, for example, Sonia stated that she felt others dis**liked her. When asked who in particular disliked her, she selected Eric, a detached, aloof man who habitually related only to those who could be of use to him. Eric bristled, "Why me? Tell me one thing I've said to you that makes you pick me." Sonia stated, "That's exactly the point. You've never said anything to me. Not a question, not a greeting. Nothing. I just don't exist for you. You have no use for me." Eric, later, at a debriefing session after completing therapy, cited this incident as a particularly powerful and illuminating experience. **<<**

We may learn a great deal about the role of a particular member by observing the here-and-now process of the group when that member is absent. For example, if the absent member is aggressive and competitive, the group may feel liberated. Other members, who had felt threatened or restricted in the missing member's presence, may suddenly blossom into activity. If, on the other hand, the group has depended on the missing member to carry the burden of self-disclosure or to coax other members into speaking, then it will feel helpless and threatened when that member is absent. Often an absence elucidates interpersonal feelings that previously were entirely out of the group members' awareness. The therapist may

then encourage the group to discuss these feelings toward the absent member both at that moment and later in his or her presence. A common myth that may need to be dispelled is that talking about a group member when that member is not present at a meeting is politically or socially incorrect. It is not “talking behind someone’s back,” and it will not lead to scapegoating, provided that the group adopts the practice of sharing the discussion with that member at the following meeting.

Similarly, a rich supply of data about feelings toward the therapist often emerges in a meeting in which the therapist or a co-therapist is absent. Even if the group diminishes the importance of the absence, it is worth exploring, because doing so helps to train the group to think about itself and each relationship in the group. Does a co-leader’s absence generate group member apprehension, relief, greater risk-taking, lessened risk-taking? Your inquiry is not about your self-importance; it is about the group mindset, and it will enrich the work of therapy.

> **One leader led an experiential training group of mental health** professionals composed of one woman and twelve men. The woman habitually took the chair closest to the door, but she felt reasonably comfortable in the group until a leaderless meeting was scheduled when the therapist was out of town. At that meeting the group discussed sexual feelings and experiences far more blatantly than ever before, and the woman had terrifying fantasies of the group locking the door and raping her. She realized how the therapist’s presence had offered her safety against fears of unrestrained sexual behavior by the other members and against the emergence of her own sexual fantasies. (She realized, too, the meaning of her occupying the seat nearest the door!) **<<**

Search in every possible way to understand the relationship messages in any communication. Look for incongruence between verbal and nonverbal behavior. Be especially curious when there is something arrhythmic about a transaction: when, for example, the intensity of a response seems disproportionate to the stimulus statement, or a response seems to be off target or to make no sense, look for possible explanations. For example, could you be

witnessing *parataxic distortion* (where the responder experiences the sender unrealistically), or *displacement* (where the responder reacts not to the current transaction but to feelings stemming from previous transactions). A disproportionately strong emotional reaction—what one group member called “A Big Feeling”—may be the tip of an iceberg formed by deeper, historical concerns that get reactivated in the present.[30]

Common Group Tensions

Remember that, to some degree, certain tensions are present in every therapy group. The group is subject to influences from within the group and its interactions, and it is also influenced by surrounding organizational, cultural, and societal forces. Some of these influences are manifest and apparent. Others are latent and obscure. Sometimes group phenomena are hiding in plain sight.[31] One of the key aspects of group leadership is recognizing that multiple layers of feelings, thoughts, wishes, and fears underpin each issue or statement that emerges in the group. Things are never one-dimensional when we examine group process. Consider, for example, tensions such as the conflict between mutually supportive feelings and sibling rivalrous ones; between greed and selfless efforts to help the other; between the desire to immerse oneself in the comforting waters of the group and the fear of losing one’s precious individuality; between the wish to get better and the wish to stay in the group, between the wish that others improve and the fear of being left behind. Sometimes these tensions are quiescent for months until some event awakens them, and they erupt into plain view.

Do not forget these tensions. They are omnipresent, always fueling the hidden motors of group interaction. Knowledge of these tensions often informs the therapist’s recognition of process. One of the most powerful covert sources of group tension is *the struggle for dominance and status*. Earlier in this chapter, we described an intervention in which the therapist, in an effort to steer a client into the here-and-now, gave her a grade for her work in the group. The

intervention was effective for that particular person. Yet that was not the end of the story: there were later repercussions on the rest of the group. In the next meeting, two group members asked the therapist to clarify some seemingly positive remarks he had made to them at a previous meeting. Deeper investigation revealed that the two members, and later others, too, were requesting grades from the therapist.

> **In another experiential group of mental health professionals at** several levels of training, the leader was much impressed by the group skills of Stewart, one of the youngest and least experienced members. The leader expressed his fantasy that Stewart was a plant—that he could not possibly be just beginning his training, since he conducted himself like a veteran with ten years' group experience. The comment evoked a flood of tensions. It was not easily forgotten by the group and, for sessions to come, was periodically revived and angrily discussed. With his comment, the therapist placed the kiss of death on Stewart's brow, since thereafter the group systematically challenged and undermined him. It is to be expected that the therapist's positive evaluation of one member will evoke feelings of sibling rivalry among the others. Every step the group leader makes will be scrutinized by each member **<<**.

The struggle for dominance, as we will discuss in more depth in Chapter 10, fluctuates in intensity throughout the group. It is much in evidence at the beginning of the group as members jockey for status and position. Once a hierarchy is established, the issue may become quiescent, with periodic flare-ups, for example, when some member, as part of his or her therapeutic work, begins to grow in assertiveness and to challenge the established order.

When new members enter the group—especially aggressive members who do not respectfully search out and honor the rules of the group—you may be certain that the struggle for dominance and authority will rise to the surface.

> **In one group a veteran member, Cora, was much threatened by** the entrance of a new, aggressive woman, Jocelyn. A few meetings later, when Cora discussed some important material concerning her inability to assert herself, Jocelyn attempted to help by commenting that she

herself used to be like that, and then presenting various methods she had used to overcome it. Jocelyn reassured Cora that if she continued to talk about her lack of assertion openly in the group, she, too, would gain considerable confidence. Cora's response was silent fury of such magnitude that several meetings passed before she could discuss and work through her feelings. To the uninformed observer, Cora's response would appear puzzling; but in the light of Cora's seniority in the group and Jocelyn's vigorous challenge to that seniority, her response was entirely predictable. She was responding not to Jocelyn's manifest offer of help, but instead to Jocelyn's implicit communication: "I'm more advanced than you, more mature, more knowledgeable about the process of psychotherapy, and more powerful in this group despite your longer presence here." **<<**

Primary Task and Secondary Gratification

The concepts of *primary task* and *secondary gratification*, and the dynamic tension between the two, provide the therapist with a useful guide to the recognition of process (and, as we will discuss later in this chapter, a guide to the factors underlying a client's resistance to process commentary).

First, some definitions. The *primary task* of the client is, quite simply, to achieve his or her original goals: relief of suffering, better relationships with others, or living more productively and fully. Yet, as we examine it more closely, the task often becomes much more complicated. Generally, one's view of the primary task changes considerably as one progresses in therapy.[ii]

Even though their goals may evolve through the course of therapy, clients initially have some clear conception of a primary task —generally, relief of some type of discomfort. By methods discussed in Chapter 9, therapists, in pregroup preparation and in the first group meetings, make clients aware of what they must do in the group to accomplish their primary tasks. Yet once the group begins, peculiar things may occur; though clients consciously wish for change, they often avoid change and cling to old familiar modes of behavior. It is often through the recognition of resistance, a clinging to one's familiar, albeit maladaptive approach to life, that the first real opportunity for repair and growth emerges.

Some clinical vignettes illustrate this paradox:

> **Cal, a young man, was interested in attracting the women of the** group and shaped his behavior in an effort to appear "together" and charming. He concealed his feelings of awkwardness, his desperate wish to be admired, his fear of women, and his envy of some of the men in the group. He could never discuss his compulsive masturbation and occasional voyeurism. When another male member discussed his disdain for the women in the group, Cal (purring with pleasure at the withdrawal of competition) praised him for his honesty. When another member discussed, with much anxiety, his homosexual fantasies, Cal deliberately withheld the solace he might have offered by sharing his own, similar fantasies. He never dared to discuss the issues for which he entered therapy; nothing took precedence over maintaining his image.
>
> Another member devoted all her energies to achieving an image of mental agility and profundity. She, often in subtle ways, continually took issue with me (IY). She scorned any help I offered her and took great offense at my attempts to interpret her behavior. Finally, I reflected that working with her made me feel I had nothing of value to offer. That was her finest hour! She flashed a sunny smile as she said, "Perhaps you ought to join a therapy group to work on your problem."
>
> Another member enjoyed an enviable position in the group because of his girlfriend, a beautiful actress, whose picture he delighted in passing around in the group. She was his showpiece, living proof of his natural superiority. When one day she suddenly and peremptorily left him, he was too mortified to face the group and dropped out of therapy. **<<**

What do these examples have in common? In each, *the client gave priority not to the declared primary task of personal growth and self-understanding, but to some secondary gratification arising in the group*: a relationship with another member, an image a client wished to project—the most sexually desirable, the most influential, the most wise, the most superior. If this here-and-now behavior were available for study—if the members could, as it were, be pulled out of the group matrix to observe their actions in a more dispassionate manner—then the entire sequence would become part of good therapeutic work. But that did not happen! In all these instances, *the*

gratification took precedence over the work to be done. Group members concealed information, misrepresented themselves, rejected the therapist's help, and refused to give help to one another.

The group offers a wide range of secondary gratifications, including satisfying many social needs in an individual's life. Moreover, the gratification offered is often compelling. Our social needs to be dominant, to be admired, to be loved, or to be revered are powerful indeed. For some, the psychotherapy group provides satisfying relationships and becomes a destination, rather than being a bridge to forming better relationships in their world at large. This presents a clinical challenge particularly with certain populations, such as the elderly, who have genuinely reduced opportunities for human connection outside of the therapy group. In such instances, offering ongoing, less frequent booster sessions, perhaps monthly, after a shorter intensive phase may be the best way to respond to the reluctance to end therapy.[32]

Is the tension that exists between primary task and secondary gratification nothing more than a slightly different way of referring to the familiar concept of resistance and acting out? In the sense that the pursuit of secondary gratification obstructs the therapeutic work, it may generically be labeled resistance. Yet there is an important shade of difference: *Resistance* ordinarily refers to pain avoidance.[33] Obviously, resistance in this sense is much in evidence in group therapy, on both an individual and a group level. But what we wish to emphasize is that the *therapy group offers an abundance of secondary gratifications*. The therapeutic work in a group is derailed not only because members are too defensively anxious to work but also because they find themselves unwilling to relinquish certain gratifications. Groups can become defensive and passive, failing to challenge their members, as though group cohesion were to be viewed naively as an end in itself rather than a means to a therapeutic end.[34]

Often, when the therapist is bewildered by the course of events in the therapy group, the distinction between primary task and secondary gratification is extremely useful. It is often clarifying for

therapists to ask themselves whether the client is working on his or her primary task. And when the substitution of secondary gratification for primary task is well entrenched and resists intervention, therapists have no more powerful technique than reminding the group members of the primary task—the reasons for which they seek therapy.

As a group leader, you will likely have access to much historical information and depth data about each client, but it may be an ethical breach to prod the therapy by introducing that background without the client's consent, as the following example demonstrates:

> **In exasperation, after weeks in which Joan had done no real work** in the group and had thwarted each effort at engagement with her thorough evasion and denial, the group therapist blurted out to the group that nothing would progress until Joan shared with the group what she had shared with him in the assessment interview—that she was addicted to opioids. The client was outraged, felt betrayed, and filed an ethics complaint to the state board about this breach of confidentiality. **<<**

The same principle applies to the *entire group*. It can be said that the entire group has a primary task that consists of the development and exploration of all aspects of the relationship of each member to each of the others, to the therapist, and to the group as a whole. The therapist, and, later, the group members, can sense easily enough when the group is working, when it is involved in its primary task, and when it is avoiding that task.

At times the therapist may be unclear about what a group is doing but knows that it is not focused on either developing or exploring relationships between members. If therapists have provided the group with a clear statement of its primary task, then they must conclude that the group is actively evading the task—either because of some anxiety, fear, or distress associated with the task itself, or because of some secondary gratification that is sufficiently satisfying to supplant the therapy work.

The Therapist's Feelings

All of these guides to the therapist's recognition and understanding of process have their uses. But there is an even more important clue: the therapist's own feelings in the meeting, feelings that he or she has come to trust after living through many similar incidents in group therapy. If therapists feel impatient, frustrated, bored, confused, discouraged—any of the panoply of feelings available to a human being—they should consider this valuable data and learn to put it to work.

Remember, this does not mean that therapists always have to understand their feelings and arrange and deliver a neat interpretive corsage. The simple expression of feelings is often sufficient to help a client proceed. A certain degree of tentativeness, coupled with genuine therapist humility, makes these process comments more accessible to the group members.[35]

> **> One therapist experienced a forty-five-year-old woman in an un**real, puzzling manner because of her rapidly fluctuating method of presenting herself. He finally commented, "Sharon, I have several feelings about you that I'd like to share. As you talk, I often experience you as a competent, mature woman, but sometimes I see you as a very young, almost preadolescent child, unaware of your sexuality, trying to cuddle, trying to be pleasing to everyone. I don't think I can go any further with this now, but I wonder whether this has meaning for you." The observation struck deep chords in the client and helped her explore her conflicted sexual identity and her need to be loved by everyone. **<<**

It is often very helpful to the group if you share feelings of being shut out by a member. Such a comment rarely evokes defensiveness, because it always implies that you wish to get closer to that person. It models important group therapy norms: risk-taking, collaboration, and taking relationships seriously.

To express such feelings in the therapeutic process, the therapist must have a reasonable degree of confidence in their appropriateness. The more you respond to the client based solely upon your personal, subjective experience (on the basis of your countertransference, or possibly because of pressing personal emotional problems), the less helpful—in fact, the more

antitherapeutic—you may be in presenting these feelings as if they were the client's problem rather than your own. You need to use the delicate instrument of your own feelings, and to do so frequently and spontaneously. But it is of the utmost importance that this instrument be as reliable and accurate as possible.

Countertransference refers broadly to the reactions therapists have to their clients. It is critically important to distinguish between your *objective* countertransference, reflecting on the client's characteristic interpersonal impact on you and others, and your *subjective* countertransference, those idiosyncratic reactions that reflect more specifically on what you, personally, carry into your relationships from past or current shaping experiences.[36] The former is an excellent source of interpersonal data about the client and grist for supervision. The latter, however, often says a good deal more about the therapist than it does about the client or group, and as such is grist for one's own self-exploration, which may include personal psychotherapy. To discriminate between the two requires not only experience and training but also deep self-knowledge. It is for this reason that we believe every therapist should obtain personal psychotherapy. (More about this in Chapter 16.)

HELPING CLIENTS ASSUME A PROCESS ORIENTATION

It has long been known that observations, viewpoints, and insights arrived at through one's own efforts are valued more highly than those that are thrust upon one by another person. The mature leader resists the temptation to make brilliant virtuoso interpretations, but searches instead for methods that will permit clients to achieve self-knowledge through their own efforts. As S. H. Foulkes and E. J. Anthony put it, "there are times when the therapist must sit on his wisdom, must tolerate defective knowledge and wait for the group to arrive at solutions."[37]

The task, then, is to influence members to assume and to value the process perspective. Many of the norm-setting activities of the leader described in Chapter 5 serve this end. For example, the therapist emphasizes process by periodically tugging the members out of the here-and-now and inviting them to consider more dispassionately the meaning of recent transactions. Though techniques vary depending on a therapist's style and therapy model, the intention of these interventions is to switch on a self-reflective beacon. Process commentary generates an immediacy that makes the treatment come alive.[38]

The therapist may, for example, interrupt the group at an appropriate point to comment, in effect, "We are about halfway through our time for today, and I wonder how everyone feels about the meeting thus far?" Again, by no means do you have to understand the process to ask for members' analyses. You might simply say, "I'm not sure what's happening in the meeting, but I do see some unusual things. For example, Bill has been unusually silent, Jack's moved his chair back, Mary's been shooting glances at me for the past several minutes. What ideas do you all have about what's going on today?"

A process review of a highly charged meeting is often necessary. It is important for the therapist to demonstrate that intense emotional expression provides material for significant learning. Sometimes you

can divide such a meeting into two parts: the experiential segment and the analysis of that experience. At other times you may analyze the process at the following meeting; you can ask about the feelings that members took home with them after the previous meeting, or simply solicit further thoughts they have since had about what occurred there.

Obviously, you teach through modeling your own process orientation. There is generally nothing to lose and much to gain by your sharing your perspective on the group whenever possible. But stay alert to the alignment of your impact and desired intent. Don't assume they always match up as you expect them to do, and check regularly about the group's reactions to your efforts. Sometimes you may do this in an effort to clarify the meeting: "Here are some of the things I've seen going on today." Sometimes you may wish to use a convenient device, such as summarizing the meeting to a late arrival, whether co-therapist or member. One technique that systematically shares process observations with members is to write a detailed summary immediately after the meeting, including a full description of the therapist's spoken and unspoken process observations, and to mail it to the members before the next meeting. With this approach the therapist uses considerable personal and professional disclosure in a way that facilitates the therapy work, particularly by increasing the members' perceptivity to the process of the group. We will discuss these techniques in more depth in Chapter 13.

It is useful to encourage members to describe their views on the process of group meetings. Many group therapy instructors who teach by leading an experiential group of their students often begin each meeting with a report, prepared by a designated student, of the process of the previous meeting. Some therapists learn to call upon certain members who display unusual intuitive ability to recognize process. For example, Louis Ormont described a peripheral member in his group who had unusual sensitivity to the body language of others. He made a point of harnessing that talent for the service of therapy. A question such as, "Michael, what was Pam saying to Abner with that wave of her hand?" served a double purpose:

illumination of process and helping Michael gain centrality and respect.[39]

HELPING CLIENTS ACCEPT PROCESS-ILLUMINATING COMMENTS

Throughout therapy, we ask our clients to examine the consequences of their behavior. It is hard work, and it is often unpleasant, frightening work. It is not enough simply to provide clients with information or explanations; you must also facilitate the assimilation of the new information. There are strategies to help clients in this work.

Be concerned with the framing of interpretive remarks and feedback. No comments, not even the most brilliant ones, can be of value if their delivery is not accepted, if the client rejects the package unopened and uninspected. The relationship, the style of delivery, and the timing are thus as essential as the content of the message. Although we are highlighting technical steps in the process of change in this section with a heavy emphasis on the client's responsibility, our therapeutic effectiveness is tied to establishing and maintaining an environment that is collaborative and maximizes the client's sense of attachment security and safety. Nothing productive will emerge without the creation of that healing context.[40]

Clients are *always* more receptive to observations that are framed in a supportive and nonblaming fashion. Rarely do individuals reject an observation that they shut out others, or that they are too unselfish and never ask for anything for themselves, or that they are stingy with their feelings, or that they conceal much of what they have to offer. All of these observations contain a supportive message: that the member has much to give and that the observer wishes to be closer, wishes to help, wishes to know the other more intimately. If you come to understand something only after the session, don't hesitate to say so. It can be of great impact to say in the next group, "I wish I understood then what I understand now. I would have approached this issue differently. I hope we can continue to discuss this." It is an interesting phenomenon in training that we spend so much time learning to understand our clients and less time

learning how best to communicate that understanding effectively to them.[41]

Beware of comments that are categorizing or limiting: they are counterproductive; they threaten; they raise defenses. Clients reject global accusations—for example, of dependency, narcissism, exploitation, or arrogance—and with good reason, since a person is always more than any label or combination of labels. It is far more acceptable (and true) to speak of traits or parts of an individual—for example, "I often can sense you very much wanting to be close to others, offering help as you did last week to Debbie. But there are other times, like today, when I see you as aloof, almost scornful of the others. What do you know about this part of you?" Always avoid using the word *always* and never use the word *never* in describing clients' behavior or impact. Stay honest, but try to maximize the clients' openness to your feedback.

Often in the midst of intense group conflict, members hurl important truths at one another. Under these conditions, one cannot acknowledge the truth: it would be aiding the aggressor, committing treason against oneself. To make the conflict-spawned truths available for consumption, the therapist must appreciate and neutralize the defensiveness of the combatants.

You may, for example, appeal to a higher cause (the member's desire for self-knowledge), or increase receptivity by limiting the scope of the accusation. For example, "Farrell, I see you now closed up, threatened, and fending off everything that Jamie is saying. You've been very adroit in pointing out the weaknesses of her arguments. But what happens is that you (and Jamie, too) end up getting nothing for yourself. I wonder if you could take a different tack for a while and ask yourself this [and, later, "Jamie, I'd like to ask you to do the same"]: Is there *anything* in what Jamie is saying that is true for you? What parts seem to strike an inner chord? Could you forget for a moment the things that are *not* true and stay with those that *are* true?"

Sometimes group members, in an unusually open moment, make a statement that may at some future time provide the therapist with

great leverage. The adept therapist underscores these comments in the group and stores them for later use. For example, one man, who was both proud of and troubled by his ability to manipulate the group with his social charm, pleaded at one meeting, “Listen, when you see me smile like this, I’m really hurting inside. Don’t let me keep getting away with it.” Another member, who tyrannized the group with her tears, announced one day, “When I cry like this, I’m angry. I’m not going to fall apart, so stop comforting me, stop treating me like a child.” Be sure to store these moments of truth; they can be of great value if recalled later, in a constructive, supportive manner, when the client is closed and defensive.

Often it is useful to enlist the client more actively in establishing contracts. For example, if a client has worked hard in a session on some important trait, you might say something like, “Jane, you worked hard today and were very open to our feedback about the way you mother others and avoid facing your own needs and pain. How did it feel? Did we push you too hard?” If the client agrees that the work was helpful (as the client almost always does), then it is possible to nail down a future contract by asking, “Then is it all right for us to keep pressing you, to give you feedback whenever we note you doing this in future meetings?” This form of “contracting” consolidates the therapeutic alliance.[42]

PROCESS COMMENTARY: A THEORETICAL OVERVIEW

It is not easy to discuss, in a systematic way, the actual practice of process illumination. How can one propose crisp, basic guidelines for a procedure of such complexity and range, such delicate timing, so many linguistic nuances? We are tempted to beg the question by claiming that herein lies the art of psychotherapy: it will come as you gain experience; you cannot, in a systematic way, come to it. To a degree, this is accurate. Yet we also believe that it is possible to blaze crude trails, to provide the clinician with general principles that will accelerate education without limiting artistry.

The approach we take in this section closely parallels the approach we used in the beginning of this book to clarify the basic therapeutic factors in group therapy. At that time, we asked the questions: “How does group therapy help clients? In the group therapeutic process, what is core and what is front?” We proceed now in a similar fashion. Here the issue is not how group therapy helps but how process illumination leads to change. The issue is complex and requires considerable attention, but the length of this discussion should not suggest that the interpretive function of the therapist take precedence over other tasks.

First, let us proceed to view in a dispassionate manner the entire range of therapist interventions. We ask of each intervention a simplistic but basic question, “How does this intervention, this process-illuminating comment, help a client to change?” Underlying this approach is a set of basic operational patterns shared by many contemporary interpersonal and relational models of therapy.[43]

Let’s begin by considering a series of process comments that a group therapist made to a male client who sought therapy to address his social isolation. Here are comments from several sessions of group therapy:

1. You are interrupting me.

2. Your voice is tight, and your fists are clenched.
3. Whenever you talk to me, you take issue with me.
4. When you do that, I feel threatened and sometimes frightened.
5. I wonder if you don't feel competitive with me and are trying to devalue me.
6. I've noticed that you've done the same thing with the men in the group. Even when they try to approach you helpfully, you strike out at them. Consequently, they see you as hostile and threatening.
7. In the three meetings when there were no women present in the group, you were more approachable.
8. I think you're so concerned about your sexual attractiveness to women that you view men only as competitors and deprive yourself of the opportunity of ever getting close to a man.
9. Even though you always seem to spar with me, there seems to be another side to it. You often stay after the group to have a word with me; you frequently look at me in the group. And there's that dream you described three weeks ago about the two of us fighting and then falling to the ground in an embrace. I think you very much want to be close to me, but somehow you've got closeness and eroticism entangled and you keep pushing me away.
10. You are lonely here and feel unwanted and uncared for. That rekindles so many of your feelings of unworthiness.
11. I remember that one of your major goals when you started the group was to find out why you haven't had any close male friends and to do something about that, but what's happened in the group now is that you've distanced yourself, estranged yourself, from all the men here. What are your feelings about that?

Note, first of all, that the comments form a progression: they start with simple observations of single acts and proceed to a description

of feelings evoked by an act, to observations about several acts over a period of time, to the juxtaposition of different acts, to speculations about the client's intentions and motivations, to comments about the unfortunate repercussions of his behavior, to the inclusion of more inferential data (dreams, subtle gestures), to calling attention to the similarity between the client's behavioral patterns in the here-and-now and in his outside social world. Inexperienced group therapists sometimes feel lost because they have not yet developed an awareness of this progressive sequence of interventions. If we use only the more charged and higher inferential statements, we may force the client into a polarized stance and compromise the collaborative nature of therapy.[44]

Note that in this progression, the comments become more inferential. They begin with observations and gradually shift to complex statements based on sequences of behavior, interpersonal patterns, fantasy, and dream material. As the comments become more complex and more inferential, their author becomes more removed from the other person—in short, more a therapist process-commentator. Members often make some of the earlier statements to one another, but, for reasons we have already presented, they rarely make the ones at the end of the sequence.

There is, incidentally, an exceptionally sharp barrier between comments 4 and 5. The first four statements issue from the experience of the commentator. They are the commentator's observations and feelings; the client can devalue or ignore them but cannot deny them, disagree with them, or take them away from the commentator. The fifth statement ("I wonder if you don't feel competitive with me and are trying to devalue me") is much more likely to evoke defensiveness and to close down constructive interactional flow. This genre of comment is intrusive; it is a guess about the other's intention and motivation and is often rejected unless a trusting, supportive relationship has been previously established. If members in a young group make many comments of this type to one another, they are not likely to develop a constructive therapeutic climate.[45] Using the phrase "I wonder" of course softens

it a bit. (Where would we therapists be without the use of “I wonder”?) At no point is the feedback devaluing or critical of the person as a whole: behavior, not personhood, is the focus.

But back again to our basic question: How does this series (or any series) of process comments help the client change? The answer is that the group therapist initiates change by escorting the client through the following sequence:

1. *Here is what your behavior is like.* Through feedback and later through self-observation, members learn to see themselves as seen by others. This is a key step in the understanding of how the client’s pathogenic beliefs shape his interpersonal behavior.
2. *Here is how your behavior makes others feel.* Members learn about the impact of their behavior on the feelings of other members.
3. *Here is how your behavior influences the opinions others have of you.* Members learn that, as a result of their behavior, others value them, dislike them, find them unpleasant, respect them, avoid them, and so on.
4. *Here is how your behavior influences your opinion of yourself.* Building on the information gathered in the first three steps, clients formulate self-evaluations; they make judgments about their self-worth and their lovability. (Recall Harry Stack Sullivan’s keen aphorism that *the self-concept is largely constructed from reflected self-appraisals*.)

Once this sequence is fully understood by the individual, once clients have a deep understanding that their behavior is not in their own best interests, that the texture of relationships to others and to themselves is *fashioned by their own actions rooted in their long-held beliefs and assumptions*, then they have come to a crucial point in therapy: they have entered the antechamber of change. Considerable research underscores that what unfolds is a circular process of change, with interpersonal exploration followed by a period of consolidation and retreat to safety, in turn followed by more

interpersonal exploration.[46]

The therapist is now in a position to pose a question that initiates the real crunch of therapy. The question, presented in a number of ways by the therapist but rarely in direct form, is: *This is what you do to others, to others' opinions of you, and to your opinion of yourself—Are you satisfied with your actions and the world you have created?* [47]

When the inevitable negative answer arrives ("No, I am not satisfied with my actions"), the therapist embarks on a many-layered effort to transform a sense of personal dissatisfaction into a decision to change and then into the act of change. In one way or another, the therapist's interpretive remarks are designed to encourage the act of change. Only a few psychotherapy theoreticians—for example, Otto Rank, Rollo May, Silvano Arieti, Stephen Mitchell, and Leslie Farber[48]—include the concept of will in their formulations, yet it is implicit in most interpretive systems. I (IY) offer a detailed discussion of the role of will in psychotherapy in my text *Existential Psychotherapy*.[49] For now, broad brushstrokes are sufficient.

The intrapsychic agency that initiates an act, that transforms intention and decision into action, is will. Will is the primary responsible mover within the individual. Although analytic metapsychology historically chose to emphasize unconscious motivations and drives as the movers of our behavior, it is difficult to do without the idea of will in our understanding of change.[50] We cannot bypass it under the assumption that it is too nebulous and too elusive and, consequently, consign it to the black box of the mental apparatus to which the therapist has no access.

Relational models recognize the role of will more fully. Mitchell cautioned that attention to the role of client will and choice is essential; without it, therapy can devolve into intellectual explanation and rationalization. Relationships involve personal authorship and choice, which in turn entail the role of one's creative will.[51] Group therapy teaches members that they have the agency to repeat patterns or to create new ones. Little is neutral; our clients' choices are either moving them ahead or perpetuating the status quo.

Knowingly or unknowingly, most therapists assume that each client possesses the capacity to change through willful choice. Using a variety of strategies and tactics, the therapist attempts to escort the client to a crossroads where he or she can choose, willfully, in the best interests of his or her own integrity. The therapist's task is not to create will or to infuse it into the client. That, of course, you cannot do. *What you can do is to help remove encumbrances from the bound or stifled will of the client and enhance the client's motivation to change.*[52]

The concept of will provides a useful construct for understanding the procedure of process illumination. The interpretive remarks of the therapist can all be viewed in terms of how they bear on the client's will. The most common, most simplistic, and least effective therapeutic approach is *exhortative*: "Your behavior is, as you yourself now know, counter to your best interests. You are not satisfied. This is not what you want for yourself. Damn it, change!"

However, clients with significant and well-entrenched psychopathology will need much more than sheer exhortation. The therapist, through interpretative comments, then proceeds to help clients liberate their will and accept one, several, or all of the following basic premises:

1. Only I can change the world I have created for myself.
2. There is no danger in change.
3. To attain what I really want, I must change.
4. I can change; I am potent.

Each of these premises, if fully accepted by a client, can be a powerful stimulant to willful action. Each exerts its influence in a different way. Though we will discuss each in turn, we do not wish to imply a sequential pattern. Each, depending on the need of the client and the style of the therapist, may be effective independently of the others. All contribute to the development of self-efficacy and a sense of effectiveness in one's interpersonal world.[53]

"Only I can change the world I have created for myself."

Behind the simple group therapy sequence we have described (seeing one's own behavior and appreciating its impact on others and on oneself), there is a mighty overarching concept, one whose shadow touches every part of the therapeutic process. That concept is *responsibility*. Although it is rarely discussed explicitly, it is woven into the fabric of most psychotherapeutic systems. Responsibility has many meanings—legal, religious, ethical. We use it in the sense that a person is "responsible for," by being the "basis of," the "cause of," or the "author of" something.

One of the most fascinating aspects of group therapy is that *everyone is born again, born together in the group*. In other words, each member starts off on an equal footing. In the view of the others (and, if the therapist does a good job, in their own views of themselves), each member gradually scoops out and shapes a life space in the group. Each one, in the deepest sense of the concept, is *responsible for this space and for the sequence of events that will occur to him or her in the group*.

The therapist helps the client understand that the interpersonal world is arranged in a generally predictable and orderly fashion; that it is not that the client *cannot* change, but that he or she *will not* change; that the client bears the responsibility for the creation of his or her world, and therefore the responsibility for its transmutation. The client must regain or develop anew a sense of interpersonal agency in the world. Early life experience may have squashed or undermined that capacity, but it can be reclaimed and redeveloped. Group members regularly report that they are inspired to action by seeing others take risks, or they feel accountable, knowing the group will ask whether an undertaking discussed in the group was completed. Whenever possible, we highlight the personal choices group members make in relating to others and addressing issues.

One group member with a history of chronic depression and social anxiety reported that after her boyfriend commented she was socially anxious, she felt like a victim and withdrew. (She had ended relationships over lesser affronts.) This time, she declared to the

group, she decided to work from her increasing strengths and tell him she was now committed to overcoming her avoidance. She then worked through in the group how choosing this course, rather than the path she would have taken in the past, impacted her sense of self and improved her relationship with her boyfriend.

"There is no danger in change."

These well-intentioned efforts may not be enough. The therapist may tug and tug at the therapeutic cord and learn that individuals, even after being thus enlightened, still make no significant therapeutic movement. In this case, therapists apply additional therapeutic leverage by helping clients face the paradox of continuing to act contrary to their basic interests. In a number of ways therapists must pose the question, "How come you continue to defeat yourself?"

A common method of explaining "How come?" is to assume that there are formidable obstacles to the client's exercising willful choice, obstacles that prevent clients from seriously considering altering their behavior. The presence of the obstacle is generally inferred; the therapist makes an "as if" assumption: "You behave *as if* you feel some considerable danger would befall you if you were to change." The therapist helps the client clarify the nature of the imagined danger and then proceeds, in several ways, to detoxify and disconfirm the reality of this danger.

The client's reason may be enlisted as an ally. The process of identifying and naming the fantasized danger may, in itself, enable one to understand how far removed one's fears are from reality. Another approach is to encourage the client, in carefully calibrated doses, *to commit the feared act in the group*. The fantasized calamity does not, of course, ensue, and the dread is gradually extinguished. This is often the pivotal piece of effective therapy. Change is probably not possible, let alone enduring, without the client's having a lived experience of direct disconfirmation of pathogenic beliefs. Insight alone is unlikely to be effective.

For example, suppose a client avoids any aggressive behavior because at a deep level he fears that he has a dammed-up reservoir

of homicidal fury and must be constantly vigilant, lest he unleash it and face retribution from others. An appropriate therapeutic strategy is to help the client express aggression in *small doses* in the group: pique at being interrupted, irritation at members who are habitually late, anger at the therapist for charging him money, and so on. Gradually, the client is helped to relate openly to the other members and to demythologize himself as a destructive being. Although the language and the view of human nature are different, this is precisely the same approach to change used in systematic desensitization—a major technique of behavior therapy.

"To attain what I really want, I must change."

Another explanatory approach used by many therapists to deal with clients who persist in behaving counter to their own best interests is to consider the *payoffs* of their behavior. Although their behavior sabotages many of their mature needs and goals, it may at the same time satisfy another set of needs and goals that cannot be simultaneously satisfied. For example, a client may wish to establish mature intimate sexual relationships; but at another, often unconscious, level, may wish to be nurtured, to be cradled endlessly, to avoid the abandonment anticipated as the punishment for adult strivings, or, to use an existential vocabulary, to be sheltered from the terrifying freedom of adulthood. Obviously, the client cannot satisfy both sets of wishes: to establish an adult sexual relationship with another adult, while also saying (and much more loudly), "Take care of me, protect me, nurse me, let me be a part of you."

It is important to clarify this paradox empathically and without blaming clients. We might, for example, point out, "Your behavior makes sense if we assume that you wish to satisfy the deeper, earlier, more primitive need." We try to help the client understand the nature of these conflicting desires and to choose between them; to relinquish those that cannot be fulfilled except at enormous cost to personal integrity and autonomy. Once clients realize what they really want as *adults*, and that their behavior is designed instead to fulfill opposing, growth-inhibiting needs, they gradually come to a

logical conclusion: *To attain what I really want, I must change.*

"I can change; I am potent."

Perhaps the major therapeutic approach to the question "How come you act in ways counter to your best interests?" is to offer *explanation*. The therapist says, in effect, "You behave in certain fashions *because…"* and the "because" clause generally involves motivational factors outside the client's awareness. It is true that the previous two options we have discussed also proffer explanation but—and we will clarify this shortly—the purpose of the explanation (the nature of the leverage exerted on will) is quite different in the two approaches.

What *type* of explanation does the therapist offer the client? And which explanations are correct, and which incorrect? Which are "deep"? Which are "superficial"? It is at this juncture that the great metapsychological controversies of the field arise, since the nature of therapists' explanations are a function of the ideological school to which they belong, and our ideology may narrow our vision and restrict our understanding. It may even serve as a therapist's defense against clinical complexity.[54]

I think we can sidestep the ideological struggle by keeping a fixed gaze on the *function* of the interpretation, on the relationship between explanation and the final product: change. After all, our goal is change. Self-knowledge, derepression, analysis of transference, and self-actualization—all are worthwhile, enlightened pursuits, all are related to change, preludes to change, cousins and companions to change—and yet they are not synonymous with change.

Explanation provides a system by which we can order the events in our lives into some coherent and predictable pattern. To name something and to place it into a causal sequence is to experience it as being under our control. No longer is our behavior or our internal experience frightening, inchoate, out of control; instead, we behave (or have a particular inner experience) *because…* It offers us freedom, mastery, and self-efficacy. As we move from a position of being motivated by unknown forces to a position of identifying and

controlling those forces, we move from a passive, reactive posture to an active, acting, changing posture.

If we accept this basic premise—that a major function of explanation in psychotherapy is to provide the client with a sense of personal mastery—it follows that the value of an explanation should be measured by this criterion. To the extent that it offers a sense of potency, a causal explanation is valid, correct, or "true." Such a definition of truth is completely relativistic and pragmatic. It argues that no explanatory system has hegemony or exclusive rights, that no system is the correct, fundamental one, or the "deeper" (and therefore better) one.

Therapists may offer the client any of several interpretations to clarify the same issue; each may be made from a different frame of reference, and each may be "true." Freudian, interpersonal, transcultural, feminist, object relation, self-psychology, attachment theory, existential, transactional analytic, Jungian, gestalt, transpersonal, cognitive, and behavioral explanations—all of these may be true simultaneously. None, despite vehement claims to the contrary, have sole rights to the truth. *They justify their existence only by virtue of their explanatory powers.*[55]

Do we therefore abandon our attempts to make precise, thoughtful interpretations? Not at all. We only recognize the purpose and function of the interpretation. Some may be superior to others not because they are deeper, but because they have more explanatory power, are more credible, provide more mastery, and are therefore more useful. Obviously, interpretations must be tailored to the recipient. In general, therapeutic interventions are more effective if they make sense, if they are logically consistent with sound supporting arguments, if they are bolstered by empirical observation, if they "feel" right or are congruent and "click" with a client's frame of reference, culture, and internal world, and if they can be generalized and applied to many analogous situations in the client's life.[56] They can become self-reinforcing as clients realize that addressing interpersonal issues helps to improve depression and emotional distress.[57]

Psychoanalytic revisionists argue that reconstructive attempts to capture historical "truth" are futile; it is far more important to the process of change to construct plausible, meaningful personal narratives.[58] The past is not static: every experienced therapist knows that the process of exploration and understanding alters the recollection of the past. Moreover, our clients' early and shaping emotional experiences are often stored as implicit memories and cannot be reached by appealing to explicit memory: they can only be accessed and worked through the relationship and the interactional focus in therapy.[59]

Do not always expect the client to accept your intervention. Sometimes the client hears the same statement many times until one day it seems to "click." Why does it click that one day? Perhaps the client just came across some corroborating data from new events in the environment or from the surfacing in fantasy or dreams of some previously unconscious material. Note also that *your intervention will not click until the client's relationship with you is just right*. A group member who feels unsafe, threatened, or competitive with the therapist is unlikely to be helped by any interpretation (except perhaps one that clarifies the transference).[60] Even the most seemingly thoughtful interpretation will fail because the client may feel defeated or humiliated by the proof of the therapist's superior insight. An interpretation becomes maximally effective only when it is delivered in a context of acceptance and trust.

Sometimes a client will accept from another member an interpretation that he or she would not accept from the therapist. (Remember, group members are entirely capable of making interpretations as useful as those of the therapist *provided the other member has accepted the client role and does not offer interpretations to acquire prestige, power, or a favored position with the leader*.)

A comprehensive discussion of the types of effective interpretations would require describing the vast number of explanatory schools and group therapy models—a task well beyond the scope of this book.[61] However, three venerable concepts are so

deeply associated with interpretation that they deserve coverage here:

1. The use of the past
2. Group-as-a-whole process commentary
3. Transference

We will discuss the first two in the remainder of this chapter. We devote the next chapter entirely to the issue of transference and transparency.

THE USE OF THE PAST

Too often, explanation is confused with "originology" (the study of origins). Although, as we have discussed, an explanatory system may effectively postulate a "cause" of behavior from any of a large number of perspectives, many therapists continue to believe that the "real," the "deepest," causes of behavior are only to be found in the past.[62] Yet, by no means are the powerful and unconscious factors that influence human behavior limited to the past. Analytic theory makes a distinction between the *past unconscious* (the child within the adult) and the *present unconscious* (the currently existing unconscious thoughts, fantasies, and impulses that influence our feelings and actions).[63]

Furthermore, the future is also a significant determinant of behavior, and the concept of future determinism is fully defensible. We have at all times within us a sense of purpose, an idealized self, a series of goals for which we strive, a death toward which we travel. Certainly, the knowledge of our isolation, our destiny, and our ultimate death deeply influences our conduct and our inner experience. Though we generally keep them out of awareness, the terrifying contingencies of our existence play upon us without end. We either strive to dismiss them, by enveloping ourselves in life's many diversions, or we attempt to vanquish death by faith in an afterlife, or by striving for symbolic immortality in the form of children, material monuments, and creative expression. In addition to the explanatory potency of the past and the future, there is a third temporal concept that attempts to explain behavior—the impact of *current forces*.

In summary, explanations ensue from the exploration of the concentric rings of conscious and unconscious current motivations that envelop our clients. Take one example: clients may have a need to attack that covers a layer of dependency wishes that they do not express for fear of rejection. Note that *we need not ask how they got to be so dependent*. In fact, the future (a person's anticipation of

rejection) plays a more central role in the explanation. Thus, as we hurtle through space, our behavioral trajectory may be thought of as triply influenced: by the past—the nature and direction of the original push; by the future—the goal that beckons us; and by the present—the ways in which clients repeat unhealthy relationship patterns. Consider this clinical example:

> **Two clients, Ellen and Carol, expressed strong sexual feelings** toward the male therapist of the group. (Both women, incidentally, had histories of early abuse and sexual trauma, both in their past and in recent relationships.) At one meeting, they discussed the explicit content of their fantasies of longing regarding the therapist. Ellen fantasized about her husband being killed; herself having a psychotic breakdown; and the therapist hospitalizing her and personally nurturing her, rocking her, and caring for all her bodily needs. Carol had a different set of fantasies. She wondered whether the therapist was well cared for at home. She frequently fantasized that something happened to his wife and that she would care for him by cleaning his house and cooking his meals.
>
> The manifestly shared sexual attraction (which, as the fantasies indicate, was not actually sexual) that Ellen and Carol articulated had very different explanations. The therapist pointed out to Ellen that throughout the course of the group, she had suffered frequent physical illness or severe psychological relapses. He wondered whether, at a deep level, she felt as though she could get his love and that of the other members only by a form of self-immolation. If this were the case, however, it never worked. More often than not, she discouraged and frustrated others. Even more important was the fact that as long as she behaved in ways that caused her so much shame, she could not love herself. He emphasized how that hampered her therapy: she was afraid to get better, because she felt that to do so would entail an inevitable loss of love and nurturance.
>
> In his comments to Carol, the therapist juxtaposed several aspects of her behavior: her self-derogation, her refusal to assume her rights, her inability to get men interested in her. Her fantasy of taking care of the therapist was illustrative of her motivations: she believed that if she could be self-sacrificing enough, if she could put the therapist deeply into her debt, then she should, in reciprocal fashion, receive the love she sought. However, Carol's search for love, like Ellen's, always failed. Her dread of self-assertion and her continued self-devaluation

> succeeded only in making her appear dull and spiritless to those whose regard she most desired. Carol, like Ellen, whirled about in a vicious circle of her own creation: the more she failed to obtain love, the more frantically she repeated the same self-destructive pattern—the only course of behavior she knew of or dared to enact. **<<**

So here we have two clients with a similar behavioral pattern: "sexual" infatuation with the therapist. Yet the therapist offered two different interpretations reflecting two different dynamic pathways to psychological suffering. In each, the therapist assembled several aspects of the client's behavior in the group as well as fantasy material and suggested that, if certain "as if" assumptions were made (for example, that Ellen acted as if she could obtain the therapist's love only by offering herself as severely damaged, and that Carol acted as if she could obtain his love only by serving him and thus placing him in her debt), then the rest of the behavior "made sense."

Both interpretations were potent and had a significant impact on future behavior. Yet neither broached the question "*How did you get to be that way?* What happened in your earlier life to create such a pattern?" Durable and meaningful change ensued without much historical exploration. The past cannot be altered—only the present and future can be. Both dealt instead with currently existing patterns: the desire for love, the conviction that it could be obtained only in certain ways, the sacrifice of autonomy, the consequent shame, the ensuing increased need for a sign of love, and so on.

One formidable problem with explanations based on the distant past is that they contain within them the seeds of therapeutic despair. Thus the paradox: if we are fully determined by the past, whence comes the ability to change? The past, however, no more determines the present and the future than it is determined by them. The past exists for each of us only as we constitute it in the present against the horizon of the future. Jerome Frank, a pioneer in exploring what makes psychotherapy effective, reminded us that clients, even in prolonged therapy, recall only a minute fraction of their past experience, and they may selectively recall and synthesize

the past so as to achieve consistency with their present view of themselves.[64] In the same way that a client (as a result of therapy) alters her self-image, she may reconstitute the past. She may, for example, recall long-forgotten positive experiences with her parents; she may humanize them and forgive them, and begin to understand them as harried, well-intentioned individuals struggling with the same overwhelming facts of the human condition that she faces herself. Once she reconstitutes the past, a new past can further influence her self-appraisal. Indeed, it may be the *reconstitution*, not simply the *excavation*, of the past that is crucial. Note an allied research finding: effective therapy generates further recollection of past memories that may have shaped the individual's fundamental view of self and others, which in turn further modify the reconstitution of the past.[65]

If explanations are not to be sought from excavating the past, and if the most potent focus of the group is the ahistorical here-and-now, does the past therefore play no role at all in the group therapeutic process? By no means! The past is an incessant visitor to the group and an even more incessant visitor to the inner world of each of the members during the course of therapy. Not infrequently, for example, a discussion of the past plays an important role in the development of group cohesiveness by increasing intermember understanding and acceptance. But even groups that focus on life review or reminiscing therapy—for example, in geriatric populations—are enhanced by then turning attention to the here-and-now of the experience of sharing and recollecting together; of being known more fully by the other members.[66]

The past is often invaluable in conflict resolution through the generation of compassion and mentalization. A man with a regal air of condescension may suddenly seem understandable and approachable when we learn of his immigrant parents, and his desperate struggle to transcend the degradation of an impoverished inner-city childhood. Individuals benefit through being fully known by others in the group and being fully accepted.

An ahistorical here-and-now interactional focus is never fully attainable. Discussions of future anticipations, both feared and

desired, and of past and current experiences are an inextricable part of human discourse. What is important in group therapy is the emphasis: the past is the servant, not the master; it explicates the current reality of the client, who is in the process of unfolding in relation to the other group members. As one prominent psychotherapist stated, “It makes better sense to say that the analyst makes excursions into historical research in order to understand something which is interfering with his present communication with the patient (in the same way that a translator might turn to history to elucidate an obscure text) than to say that he makes contact with the patient in order to gain access to biographical data.”[67]

To employ the past in this manner involves an anamnestic technique differing from that often employed in individual therapy. Rather than a careful global historical survey, group therapists periodically attempt a sector analysis, in which they explore the development of some particular interpersonal stance. Consequently, many other aspects of a client’s past remain undiscussed in group therapy. Often group therapists conclude a course of successful therapy with a client and yet be unfamiliar with many significant aspects of the individual’s early life.

At the end of therapy, clients commonly report significant attitudinal improvements in relationships that have not been discussed in the group. Many of these involve family relationships stretching far back into the past. Many clients, in fact, change their feelings about family members who are long dead. So the past plays a role in the working-through process, albeit an implicit role. To make repetitive use of the group meeting for explicit discussion of the past would sacrifice the therapeutic potency of the here-and-now interactional focus.

GROUP-AS-A-WHOLE PROCESS COMMENTARY

Some group leaders choose to focus heavily on group-as-a-whole phenomena and frequently refer to the "group," or "we," or "all of us." They attempt to clarify the relationship between the group and its primary task, or between the group and the leader or one of its members, or the group and a subgroup of members, or to elicit examination of some shared group-centered concern. Recall, for a moment, the "parenthood is degrading" incident described earlier in this chapter. In that incident, the therapist had many process commentary options, some of which were group-as-a-whole explanations. He might, for example, have raised the issue of whether the "group" needed a scapegoat, and whether, with Kate gone, Burt filled the scapegoat role; or whether the "group" was actively avoiding an important issue—that is, the members' guilty pleasure and fears about Kate's departure.

Throughout this text we weave in comments related to group-as-a-whole phenomena. Examples include norm setting, the role of the deviant, scapegoating, emotional contagion, role suction, subgroup formation, group cohesiveness, group pressure, the regressive dependency fostered by group membership, and the group's response to termination, to the addition of new members, to the absence of the leader, and so on. In addition to these common group phenomena, earlier editions of this book described some comprehensive group-as-a-whole approaches, particularly the work of Wilfred Bion, which offers an elaborate description of the psychology of groups and the unconscious forces that obstruct effective group functioning.[iii] His approach, also known as the Tavistock approach, persists as a useful model for understanding group-as-a-whole dynamics and the psychology of organizational life. Its emphasis, however, on an inscrutable, detached leader who serves as "conductor" of the group, and who limits participation solely to group-as-a-whole interpretations, has not proved to be clinically effective. As a result, the traditional Tavistock approach for

clinical group psychotherapy has virtually been abandoned.[68] Tavistock conferences, however, are still used as an educational vehicle to inform participants about the nature of group forces, leadership, and authority.

There is little question of the importance of group-as-a-whole phenomena. All group leaders would agree that inherent forces in a group significantly influence behavior; individuals behave differently in a group than they do in dyads (a factor that, as we will discuss in Chapter 8, complicates the selection of group therapy members). There is wide agreement that an individual's behavior cannot be fully understood without an appreciation of his or her social and environmental context. But there remains the question of how best to apply this knowledge in the course of the therapy group. Examining the rationale of group-as-a-whole commentary provides some guidelines.

Rationale of Group-as-a-Whole Process Commentary

Group-as-a-whole phenomena influence the clinical course of the group in two significant ways: they can act in the service of the group or they can impede effective group therapy.

Group-as-a-whole forces acting in the service of therapy. We have, throughout this text, already considered many therapeutic uses of group-as-a-whole phenomena: for example, many of the major therapeutic factors, such as cohesiveness—the esprit de corps of the entire group—obviously relate to group-as-a-whole properties, and therapists are, in fact, harnessing group-as-a-whole forces when they facilitate the development of cohesiveness. However, *it does not follow that the leader must make explicit group-as-a-whole comments*.

Group-as-a-whole forces impeding therapy. There are times when group-as-a-whole processes significantly impede therapy, and then commentary is necessary. In other words, *the purpose of a group-as-a-whole interpretation is to remove some obstacle that has arisen that obstructs the progress of the entire group*.[69] The two most common types of obstacles are *anxiety-laden issues* and

antitherapeutic group norms.

Anxiety-Laden Issues

Often an issue arises in the group that is so threatening that the members refuse to confront the problem and take some evasive action. This evasion can take many forms, all of which are commonly referred to as *group flight*—a regression from the group's normal functions. The anxiety may stem from a number of different sources, including anything that poses a threat to group integrity, group safety, and group function. Although the entire group may share in the group tension, the tension may activate different reactions in members based upon their core concerns. Here is a clinical example of flight from an anxiety-laden issue:

> **Six members were present at the twenty-fifth group meeting I** (IY) led; one member, John, was absent. For the first time, and without previous mention, one of the members, Mary, brought her dog to the meeting. The group members, usually animated and active, were unusually subdued and nonproductive. Their speech was barely audible, and throughout the meeting they discussed safe topics on a level of impersonality appropriate to a large social gathering or cocktail party. Much of the content centered on study habits (three of the members were graduate students), examinations, and professors (especially their untrustworthiness and defects). Moreover, the most senior member of the group discussed former members who had long since departed from the group—the "good old days" phenomenon. Mary's dog, a restless creature who spent most of the group session noisily licking its genitals, was never mentioned.
>
> Finally, thinking I was speaking for all the group members, I brought up the issue of Mary's having brought her dog to the meeting. Much to my surprise, Mary—a highly unpopular, narcissistic member—was unanimously defended. Everyone denied that the dog was in any way distracting, leaving me, the protesting therapist, dangling in the wind. **<<**

I considered the entire meeting as a "flight" meeting, and accordingly made appropriate group-as-a-whole interpretations. But first, what was the evidence that the meeting was in flight? And flight

from what? First, consider the age of the group. In a young group, meeting, say, for the third time, such a session may be a manifestation not of resistance but of the group members' uncertainty about their primary task and of their groping to establish procedural norms. However, this group had already met for many months and had consistently operated at a more mature level.

It becomes very evident that the group was in a flight mode when we examine the preceding group meeting. At that meeting, John, the member absent from the meeting under consideration, had been twenty minutes late, and he happened to walk down the corridor at the precise moment when a student opened the door of the adjoining observation room in order to enter it. For the few seconds while the door was open, John heard the voices of the other group members and saw a room full of observers viewing the group; moreover, the observers at that moment happened to be giggling at some private joke. John, like all the group members, had of course been told that the group was being observed by students. Nevertheless, this shocking and irreverent confirmation stunned him. When John, in the last moments of the meeting, was finally able to discuss it with the other members, they were equally stunned. John, as I mentioned, did not show up for the next session.

This event was a catastrophe of major proportions for the entire group—as it would be for any group. It raised serious questions in the minds of the members. Was the therapist to be trusted? Was he, like his colleagues in the observation room, inwardly giggling at them? Was anything he said genuine? Was the group, once perceived as a deeply human encounter, in fact a sterile, contrived, laboratory specimen being studied dispassionately by a therapist who probably felt closer allegiance to "them" (the others, the observers) than to the group members?

Despite—or, rather, *because* of—the magnitude of these painful group issues, the group declined to confront the matter. Instead, it engaged in flight behavior, which now became understandable. Exposed to an outside threat, the group members banded tightly together for protection. They spoke softly about safe topics so as to avoid sharing anything with the outside menace (the observers, and,

through association, the therapist). I was unsupported by all the group members when I asked about the obviously distracting behavior of Mary's dog. The "good old days" was a reference to and yearning for those bygone times when the group was pure and open, and I could be trusted. The discussion of examinations and untrustworthy professors was also a thinly veiled expression of members' attitudes toward me.

The precise nature and timing of the intervention is largely a matter of individual style, and the intervention itself can involve varying levels of inference, starting with a direct observation and moving as required to an interpretation of deeper explanatory meaning. Some therapists, as is our preference, tend to intervene when they sense the presence of group flight even if they do not clearly understand its source. We make such comments as, "I feel puzzled or uneasy about the meeting," or, "I have a sense there's a 'hidden agenda' today. Could we talk about this?" Or perhaps inquire, "Is there something the group is not talking about today?"

We may increase the power of an inquiry by citing the evidence for such a conclusion—for example, in this instance, the whispering, the shift toward neutral topics and a noninteractive, impersonal mode of communication, or my experience of being left out or of being deserted by the others regarding the obvious distraction of the dog. Furthermore, we might add that the group is strangely avoiding all discussion both of the previous meeting and of the absent member. In one way or another, however, the problems of the group as a whole must be addressed before any meaningful interpersonal work can resume.

In this clinical example, would we be satisfied merely with getting the group back on the track of discussing more meaningful personal material? No! More is needed: the issues being avoided are too crucial to the group's existence to be left submerged. This consideration was particularly relevant in this group, whose members had insufficiently explored their relationship to me. Therefore, I repeatedly turned the group's attention back to the main issue—their trust and confidence in me—and tried not to be misled by substitute behavior, such as the group offering another theme for

discussion, perhaps even a somewhat charged one. My task was not simply to circumvent the resistance, to redirect the group to work areas, but to plunge the members into the source of the resistance—in other words, not *around* anxiety, but *through* it.

Another clue to the presence and strength of resistance is the group's response to therapists' resistance-piercing commentary. If therapists' comments, even when repeated, fall on deaf ears, if therapists feel ignored by the group, or if they find it extraordinarily difficult to influence the meeting, then it is clear that the resistance is powerful and that the group needs to be addressed as well as the individual members. Doing so is not an easy undertaking. It is anxiety-provoking to buck the entire group, and therapists may feel deskilled in such meetings.

The group may also avoid work by more literal flight—absence or tardiness. Whatever the form, however, the result is the same: *Movement toward the attainment of group goals is impeded*, and the group is no longer engaged in its primary task.

Not uncommonly, the issue precipitating the resistance is discussed symbolically. We have seen groups deal with their uneasiness about observers metaphorically by conducting long discussions about other types of confidentiality violations: for example, computer hacking of private information, family members checking smartphones, and invasive credit card company procedures. Discomfort about the therapist's absence may prompt discussions of parental inaccessibility or death or illness. Generally, the therapist may learn something of what is being resisted by pondering a key question: "Why is this particular topic being discussed, and *why now?*"

An experience in a therapy group at the height of a very disruptive and challenging influenza epidemic is illustrative:

> **A group in a partial hospitalization program for depressed seniors** was canceled for several weeks and finally reconvened, but with the proviso that all participants were required to wear uncomfortable and oppressive face masks (heeding the recommendation of infection control) that obscured nonverbal communication. The meeting was characterized by unusually hostile comments about deprivations:

uncaring adult children, incompetent public health officials, and unavailable, neglectful therapists. Soon the members began to attack one another, and the group seemed on the brink of total disintegration.

I (ML) was also struggling with the restrictive mask and asked for a "process check"—that is, I asked the group to stop for a moment and reflect on what had been happening so far in the meeting. The members all agreed that they hated what the flu crisis had done to their group. The masks not only were physically irritating, but they also blocked them from feeling close to others in the group. They realized, too, that the generalized anger in the group was misplaced, but they did not know what to do with their strong feelings.

I made a group-as-a-whole interpretation: "There's a sort of paradox here today. It's evident that you cherish this group and are angry at being deprived of it, yet, on the other hand, the anger you experience and express threatens the warm supportive group atmosphere you so value." A lot of head nodding followed my interpretation, and the anger and divisiveness soon dissipated. **<<**

Antitherapeutic Group Norms

Another type of group obstacle warranting a group-as-a-whole interpretation occurs when antitherapeutic group norms are elaborated by the group. For example, a group may establish a "take turns" format in which an entire meeting is devoted, sequentially, to each member of the group. "Taking turns" is a comfortable or convenient procedure, but it is an undesirable norm, because it discourages free interaction in the here-and-now. Furthermore, members are often forced into premature self-disclosure and, as their turn approaches, may experience extreme anxiety or even decide to terminate therapy. It is a *content* solution for a *process* problem that must be addressed directly at the *process* level. Alternatively, a group may establish a pattern of devoting the entire session to the first issue raised in that session, with strong invisible sanctions against changing the subject. Or there may be a "Can you top this?" format, in which the members engage in a spiraling orgy of self-disclosure. Or the group may develop a tightly knit, closed pattern that excludes outlying members and does not welcome new ones.

To intervene effectively in such instances, therapists may need to make a group-as-a-whole commentary that clearly describes the process and the deleterious effects of the taking-turns format (or other patterns) on the members or on the group, emphasizing that there are alternatives to this mode of opening each meeting.

Frequently, a group, during its development, bypasses certain important phases, or never incorporates certain norms into its culture. For example, a group may develop without ever going through a period of challenging or confronting the therapist. Or a group may develop without a whisper of intermember dissension, without status bids or struggles for control. Or a group may meet at length with no hint of real intimacy or closeness arising among the members. Such avoidance is a collaborative result of the group members implicitly constructing norms dictating this avoidance.

Therapists who sense that the group is providing a one-sided or incomplete experience for the members often facilitate the progress of the group work by commenting on the missing aspect of the group's life. (Such an intervention assumes, of course, that there are regularly recurring, predictable phases of small group development with which the therapist is familiar—a topic we will discuss in Chapter 10.)

The Timing of Group Interventions

For pedagogical reasons, we have discussed interpersonal phenomena and group-as-a-whole phenomena as though they were quite distinct. In practice, of course, the two often overlap, and the therapist is faced with the question of when to emphasize the interpersonal aspects of the transaction and when to emphasize the group-as-a-whole aspects. This matter of clinical judgment cannot be neatly prescribed. As in any therapeutic endeavor, judgment develops from experience (particularly supervised experience) and from intuition. As Leonard Horwitz suggested, the group therapist must listen with a "fourth ear" to supplement the traditional "third ear" of the individual therapist. The fourth ear allows us to draw from the interplay of individual, interpersonal, and group-as-a-whole

experiences.[70]

As a general rule, *an issue critical to the existence or functioning of the entire group always takes precedence over narrower interpersonal issues*. As an illustration, let us return to the group that engaged in whispering, discussion of neutral topics, and other forms of group flight during the meeting after a member had inadvertently discovered the indiscreet group observers. In that meeting, Mary, who had been absent at the previous meeting, brought her dog. Under normal circumstances, this act would clearly have become an important group issue: Mary had consulted neither with the therapist nor with other members about bringing her dog to the group; she was, because of her narcissism, an unpopular member, and her act was representative of her insensitivity to others. However, in this meeting there was a far more urgent issue—one threatening the entire group—and the dog was discussed not from the perspective of facilitating Mary's interpersonal learning but as a way to enable the group to persist in its flight. Only later, after the obstacle to the group's progress had been worked through and removed, did the members return to a meaningful consideration of their annoyance about Mary bringing the dog.

To summarize, group-as-a-whole forces are continuously at play in the therapy group. The therapist needs to be aware of them in order to harness group forces in the service of therapy and to counter them when they obstruct therapy. We treat individuals and not the group entity, but at pivotal points our attention must turn to the group as a whole in order to treat the members of the group.

Footnotes

i Metacommunication refers to communication about a communication. Compare, for example: “Close the window!” “Wouldn’t you like to close the window? You must be cold.” “I’m cold, would you please close the window?” “Why is this window open?” Each of these statements contains a great deal more than a simple request or command. Each conveys a metacommunication: that is, a message about the nature of the relationship between the two interacting individuals.

ii Such phenomena play havoc with outcome research strategies that focus on initial target symptoms or goals and then simply evaluate the clients’ change on these measures. Using more comprehensive global outcome questionnaires instead, such as the Outcome Questionnaire 45, or Partners for Change Outcome Management System (PCOMS), can provide meaningful feedback to therapists that keeps them aligned productively with their clients. See G. Burlingame, K. Whitcomb, S. Woodland, J. Olsen, M. Beecher, and R. Gleave, “The Effects of Relationship and Progress Feedback in Group Psychotherapy Using the Group Questionnaire and Outcome Questionnaire-45: A Randomized Clinical Trial,” *Psychotherapy* 55 (2018): 116–31. B. Wampold, “Routine Outcome Monitoring: Coming of Age—With the Usual Developmental Challenges,” *Psychotherapy* 52 (2015): 458–62.

iii Bion’s rich understanding of groups emphasized that group life occurred at two levels: the work group, which was conscious, rational, and focused on its tasks; and the basic assumption group, which was unconscious, irrational, and resistant to and avoidant of its task or duties. The basic assumption group is a regressive response to group anxiety and takes three forms: Dependency Assumption—in which the group members feel helpless and desperate for rescue by the leader, who may also be attacked for being unresponsive; Fight-Flight Assumption—in which the group is paranoid and mistrustful, looking to attack or preparing to be attacked; and Pairing Assumption—in which the group fantasizes about rescue by virtue of a new mating relationship being formed. See R. Billow, “On Resistance,” *International Journal of Group Psychotherapy* 60 (2010): 313–46. W. Bion, *Experiences in Groups and Other Papers* (New York: Basic Books, 1959). For more information about Bion’s contributions, see an earlier edition of this text.

- 7 -

The Therapist

Transference and Transparency

HAVING DISCUSSED THE MECHANISMS OF THERAPEUTIC CHANGE in group therapy, the tasks of the therapist, and the techniques by which the therapist accomplishes these tasks, we now turn from *what the therapist must do* in the group to *how the therapist must be* in the group. To what degree are you free to be yourself? How "honest" can you be? How do you utilize transparency and judicious self-disclosure effectively as a therapeutic tool?

Any discussion of the group therapist's scope and presence must begin with an examination of transference, which can be either an effective therapeutic tool or shackles that encumber your every movement. In his first and extraordinarily prescient essay on psychotherapy—the final chapter of *Studies on Hysteria* (1895)—Freud noted several possible impediments to the formation of a good working relationship between client and therapist.[1] Most of them could be resolved easily, but one stemmed from deeper sources and resisted efforts to banish it from the therapeutic work. Freud labeled this impediment *transference*, since it consisted of attitudes toward the therapist that had been "transferred" from earlier attitudes toward important figures in the client's life. These feelings toward the therapist were "false connections"—new editions of old impulses. Contemporary definitions of transference characterize it as a common relational phenomenon with both conscious and unconscious roots. Transference stems from the client's fears, wishes, and developmental gaps. Today's relationships are distorted

by echoes of the past and reinforced by the client's selective inattention to experiences that disconfirm these distortions.[2] Group therapy adds the dimension of peer or horizontal transference to the more familiar vertical transference to the group leader.[3]

Freud soon realized that transference was far from an impediment to therapy; on the contrary, if used properly, it could be the therapist's most effective tool.[4] Many of today's psychotherapeutic approaches, including cognitive therapy, acknowledge a concept similar to transference but may refer to it as the client's "schema."[5]

Contemporary psychodynamic psychotherapy suffuses the work of virtually all effective therapists. Effective therapists use the therapy relationship as a window into understanding and addressing the early, shaping influences and pathogenic beliefs that affect our clients.[6] The ultimate objectives for the client are to: (1) reconfigure a new view of self; (2) establish a different relational experience with the therapist than with significant others in the past; and (3) translate that new understanding of self and other into a new narrative, new behavior, and adaptive function.[7] We can see here the hallmarks of the corrective emotional experience described earlier. Hannah Levenson described it as the "gift that keeps on giving," because it emancipates the client from the past and encourages continued growth and development even after therapy concludes.[8]

Considerable evolution in theory and technique has occurred in psychoanalysis and psychodynamic therapy over the past half century, with a powerful focus on the actual therapeutic relationship augmenting, but not discarding, the earlier focus on interpretation of transference. This focus emphasizes the therapist's presence, emotional availability, and use of self in place of the opaque, emotionally aloof therapist.[9]

This is well captured by Stephen Mitchell:

> Many patients are now understood to be suffering not from conflictual infantile passions that can be tamed and transformed through reason

> and understanding but from stunted personal development. Deficiencies in caregiving in the earliest years are understood to have contributed to interfering with the emergence of a fully centered, integrated sense of self, of the patient's own subjectivity. What the patient needs is not clarification or insight so much as a sustained experience of being seen, personally engaged, and, basically valued and cared about.[10]

Mitchell and many others argue that the "curative" factor in both individual and group therapy is the *relationship*, which requires the therapist's authentic engagement and empathic attunement to the client's internal emotional and subjective experience.[11] Note that this new emphasis on the nature of the relationship means that psychotherapy has changed its focus from a one-person psychology (emphasizing the client's pathology) to a two-person psychology (emphasizing mutual impact and shared responsibility for the relationship).[12] In this model, the therapist's emotional experience in the therapy is a relevant and powerful source of data about the client. How to make wise use of this data will be elaborated shortly when we discuss countertransference.

Psychoanalysts and psychodynamic therapists have disagreed about the degree of permissible therapist disclosure—ranging from extensive disclosure to complete opaqueness.[13] But they agree that transference is "inappropriate, intense, ambivalent, capricious, and tenacious," and they also largely agree that transference, and well-timed, accurate, and empathic interpretation of transference, should be central to treatment.[14]

The difference between group therapists who consider the resolution of therapist-client transference as the paramount therapeutic factor and those who attach equal importance to the interpersonal learning that ensues from relationships between members and from other therapeutic factors is more than theoretical; in practice, they use markedly different techniques.[15] Emphasizing the transference to the leader makes the group leader-centric and obscures attention to other group dynamics and group forces. Contemporary group therapy recognizes the value of focusing both

on transference reactions to the group leader *and* to group peers.[16]

The following vignette from a session led by a traditional group analyst who made only therapist-related transference interpretations illustrates this point:

> **In one group session, two male members were absent, and four** women members bitterly criticized the one male client present, who was gay, for his detachment and narcissism, which precluded any interest in the lives or problems of others. The therapist suggested that the women were attacking the male client because he did not desire them sexually, and that, moreover, he was not the real target; the women really wanted to attack the therapist for his refusal to engage them sexually. **<<**

The therapist selectively attended to the data and, from the vantage point of his particular conception of the paramount therapeutic factor—that is, transference resolution—made an interpretation that was technically correct, since it focused the members' attention on their relationship with the leader. However, in our view, these therapist-centered interpretations are incomplete: they deny important intermember relationships. In fact, in this case, the male client *had* in fact been self-absorbed and detached from the other members of the group, and it was exceedingly important for him to recognize and understand his behavior.

Any mandate that limits group therapists' flexibility renders them less effective. This is a pitfall of ideological rigidity, which often arises as a compromised way for the therapist to manage clinical complexity.[17] We have seen some therapists hobbled by a conviction that they must at all times remain totally anonymous and neutral, others by their crusade to be at all times totally "honest" and transparent, and still others by the dictum that they must make interpretations only of transference or only of mass group phenomena.

The therapist's approach to the group can amplify or moderate the expression of members' transferences. If the therapist emphasizes his centrality, the group will become more regressive and dependent. In contrast, if the therapist values the peer interactions and peer transferences as primary expressions and not

merely as displacements from the therapist, then the intensity of the transference experience in the group will be better modulated. Of course, the therapist has only limited vision of his or her own impact and how that influences the group's process.[18]

In this chapter we make the following points about transference:

- Transference *does* occur in therapy groups; indeed, it is omnipresent and radically influences the nature of the group discourse.
- Without an appreciation of transference and its manifestations, the therapist will often not be able to understand fully the process of the group.
- Therapists who ignore transference considerations may seriously misunderstand some transactions and confuse rather than guide the group members; therapists who attend *only* to the transference aspects of their relationships with members may fail to relate authentically to them.
- There are clients whose therapy hinges on the resolution of transference distortion; there are others whose improvement will depend on interpersonal learning stemming from work not with the therapist but with another member, around such issues as competition, exploitation, or sexual and intimacy conflicts; and there are many clients who choose alternative therapeutic pathways in the group and derive their primary benefit from other therapeutic factors entirely.
- Transference distortions between group members can be worked with as effectively, and perhaps even more effectively, than transference reactions to the therapist.[19]
- Attitudes toward the therapist are not all transference based: many are reality based.
- By maintaining flexibility, you may make good therapeutic use of these irrational attitudes toward you without neglecting your many other functions in the group.

TRANSFERENCE IN THE THERAPY GROUP

Every client, to a greater or lesser degree, perceives the therapist incorrectly because of transference distortions, sometimes even before beginning therapy. One prominent psychiatrist tells the story of going out to meet a new client in the waiting room and having the client dispute that the therapist was who he said he was, because he was so physically different from the client's imaginings of him.[20] Few clients are entirely conflict free in their attitudes toward such issues as parental authority, dependency, God, autonomy, and rebellion—all of which are often personified in the person of the therapist. These distortions are continually at play under the surface of the group discourse. Indeed, hardly a meeting passes without some clear token of the powerful feelings evoked by the therapist.

Witness the difference in the group when the therapist enters. Often the group may have been engaged in animated and lighthearted conversation only to lapse into heavy silence at the sight of the therapist. (Someone once said that the group therapy meeting officially begins when suddenly nothing happens!) The therapist's arrival not only reminds the group of its task but may also evoke early constellations of feelings in each member about the adult, the teacher, the evaluator, and the apprehension about impending judgment and shame.

Seating patterns often reveal some of the complex and powerful feelings toward the leader. Frequently, the members attempt to sit as far away from the leader as possible. As members filter into the meeting they usually occupy distant seats, leaving the seats on either side of the therapist as the penalty for late arrivals. A paranoid client often takes the seat directly opposite you, perhaps in order to watch you more closely; a dependent client generally sits close to you, often on your right. If co-therapists sit close to each other with only one vacant chair between them, you can bet it will be the last chair occupied. One member, after months of group therapy, still described a feeling of great oppression when seated between the

therapists. (There is a practical reason, however, for co-therapists to sit apart, and that is so they can see one another's reactions and nonverbal communication.)

Over several years, for research purposes, I (IY) asked group members to fill out a questionnaire after each meeting. One of their tasks was to rank-order every member for activity (according to the total number of words each spoke). There was excellent intermember reliability in their ratings of the other group members, *but exceedingly poor reliability in their ratings of the group therapist*. In the same meetings some clients rated the therapist as the *most* active member, whereas others considered him the *least* active. The powerful and unrealistic feelings of the members toward the therapist prevented an accurate appraisal, even on this relatively objective dimension.

One client, when asked to discuss his feelings toward me, stated that he disliked me greatly because I was cold and aloof. He reacted immediately to his disclosure with intense discomfort. He imagined possible repercussions: I might be too upset by his attack to be of any more help to the group; I might retaliate by kicking him out of the group; I might humiliate him by mocking him for some of the lurid sexual fantasies he had shared with the group; or I might use my psychiatric wizardry to harm him in the future.

On another occasion many years ago, a group noted that I was wearing a copper bracelet. When they learned it was for tennis elbow, their reaction was extreme. They felt angry that I should be superstitious or ascribe credibility to any quack cures. (They had berated me for months for being too scientific and not human enough!) One member suggested that if I would spend more time with my clients and less time on the tennis court, everyone would be better off. One woman, who idealized me, said that she had seen copper bracelets advertised in a local magazine, but guessed that mine was more special—perhaps something I had bought in Switzerland.

The following illustration underscores the scope of different responses to the same phenomena, rooted in different transferential reactions to the group leader:

> **I (ML) met with a therapy group two days after I had published a** column about my father in a large circulation newspaper. He had passed away three months before, and I had been close to him. I was very pleased that I could tell his compelling story and heartened that it had been selected for publication in the paper's prominent "Lives Lived" column.
>
> The group knew of my father's death because, when he died, I had explained to them why I would be missing two meetings. My announcement had not drawn much attention at the time, beyond some expressions of condolence. The publication of my column, however, provoked a variety of responses by group members.
>
> At the start of the meeting, Karen, an often hostile and dismissive woman, angrily commented to me, "Have you not learned anything about keeping your private life private? It is inappropriate for you to share with the public, particularly your patients, this kind of personal detail about your father and your family. I do not want to see it, read it, or know this; you are imposing yourself on us."
>
> Sue, who was depressed and socially anxious, commented, "I wanted to express my condolences to you more fully when your father passed away, but I hesitated to do so, thinking that nothing I could offer would be meaningful or helpful to you. I want to express those condolences now—I don't want to miss that opportunity twice."
>
> Bob, an older man recovering from alcohol addiction, commented, "I was pleased to read about your father and wished that I had grown up with a father like the man you had described. I felt sad for myself, but reading that column helped me understand you better and made me feel closer to you."
>
> Danny, an isolated, passive man, asked me, "How did you manage with your grief? How did the loss of your father affect you? My sorrow over my father's death feels present every day of my life."
>
> Angry, self-absorbed Rob interjected, "Enough of this already—we are not here to talk about you, Molyn. I imagine you must be enjoying all the attention. We are here to talk about us, so let's get to it." **<<**

This vignette illustrates how the exact same stimulus can elicit many different transferential reactions. Here a broad gamut of them are on display, including the fear of getting close, the feeling of being undeserving of closeness, envy, admiration, and competitiveness with me for the group's time and attention.

What are other common manifestations of transference? Some

members characteristically address all their remarks to the therapist, or speak to other members only to glance furtively at the therapist at the end of their statement. It is as though they speak to others in an attempt to reach the therapist, seeking the stamp of approval for all their thoughts and actions. They forget, as it were, their reasons for being in therapy, instead seeking continuously to gain conspiratorial eye contact; to be the last to leave the session; to be, in a multitude of ways, the therapist's favorite child.

Transference is so powerful and so ubiquitous that the dictum "the leader shall have no favorites" seems to be essential for the stability of every working group. In his early writings about groups, Freud suggested that group cohesiveness, curiously, derives from the universal wish to be the favorite of the leader and the mutual identifications the group members make with the idealized leader.[21] Consider the prototypic human group: the sibling group. It is rife with intense rivalrous feelings: each child wishes to be the favorite and resents all rivals for their claims to parental love. The older child wishes to rob the younger of privileges or to eliminate the child altogether. *And yet each realizes that the rival children are equally loved by their parents* and that therefore one cannot destroy one's siblings without incurring parental wrath and thus destroying oneself.

There is only one possible solution: *equality*. If one cannot be the favorite, then *there must be no favorite at all*. Everyone is granted an equal investment in the leader, and out of this demand for equality is born what we have come to know as group spirit. Often, the group members do not wish to be equal to the leader. Quite the contrary: they have a thirst for obedience—a "lust for submission," as Erich Fromm put it.[22] We have regrettably often witnessed the marriage of weak, devitalized, and demoralized followers to charismatic, often malignantly narcissistic group leaders.[23] It is one of the deep psychological forces in the current growth of populism and authoritarian leaders around the globe.[24]

The great writers also recognized this dynamic of followers and their leaders. To cite only one example, Tolstoy in the nineteenth century was keenly aware of the subtle intricacies of the member-

leader relationship in the two most important groups of his day: the church and the military. His insight into the overvaluation of the leader gives *War and Peace* much of its pathos and richness. Consider Rostov's regard for the Tsar:

> He was entirely absorbed in the feeling of happiness at the Tsar's being near. His nearness alone made up to him by itself, he felt, for the loss of the whole day. He was happy, as a lover is happy when the moment of the longed-for meeting has come. Not daring to look around from the front line, by an ecstatic instance without looking around, he felt his approach.… Nearer and nearer moved this sun, as he seemed to Rostov, shedding around him rays of mild and majestic light, and now he felt himself enfolded in that radiance, he heard his voice—that voice caressing, calm, majestic, and yet so simple. And Rostov got up and went out to wander about among the campfires, dreaming of what happiness it would be to die—not saving the Emperor's life (of that he did not dare to dream), but simply to die before the Emperor's eyes. He really was in love with the Tsar and the glory of the Russian arms and the hope of coming victory. And he was not the only man who felt thus in those memorable days that preceded the battle of Austerlitz: nine-tenths of the men in the Russian army were at that moment in love, though less ecstatically, with their Tsar and the glory of the Russian arms.[25]

Indeed, it would seem that submersion in the love of a leader is a prerequisite for war. How ironic that more killing has probably been done under the aegis of love than of hatred!

Napoleon, that consummate leader of men, was, according to Tolstoy, not ignorant of transference, nor did he hesitate to utilize it in the service of victory. In *War and Peace*, Tolstoy had him deliver this dispatch to his troops on the eve of battle:

> Soldiers! I will myself lead your battalions. I will keep out of fire, if you, with your habitual bravery, carry defeat and disorder into the ranks of the enemy. But if victory is for one moment doubtful, you will see your Emperor exposed to the enemy's hottest attack, for there can be no uncertainty of victory, especially on this day, when it is a question of the honor of the French infantry, on which rests the honor of our nation.[26]

As a result of transference, the therapy group may impute special powers to the leaders to provide comfort, certainty, and refuge. Therapists' words are often given more weight and wisdom than the words of others. Equally astute contributions made by other members are ignored or distorted. Group members believe that there are great, calculated depths to each of your interventions; that you predict and control all the events of the group. Even when you confess puzzlement or ignorance, this, too, is regarded as part of your clever technique, intended to have a particular effect on the group.

Ah, to be the favorite child—of the parent, of the leader! For many group members, this longing serves as an internal horizon against which all other group events are silhouetted. However much each member cares for the other members of the group, however much each is pleased to see others work and receive help, there is a background of envy, of disappointment, that one is not basking alone in the light of the leader. The leader's inquiries into these domains—who gets the most attention and who the least?—almost invariably plunge the members into a profitable examination of the group's innards.

> **Daniela, new to the group, emailed me (ML) prior to her third** meeting, noting she would be unavoidably late by ten minutes. She was still uncomfortable sitting in the chairs that faced the one-way mirror, behind which sat observers, and asked whether I could secure a chair for her with its back to the mirror? Email was clearly not the vehicle to address my dilemma of both wanting to support Daniela—and her early anxiety about self-exposure—and also wanting to explore the dynamic processes carried by her request. Would I look out for her? Could she make a special request? Did she warrant extra attention and care? What did it mean for her to ask? What did Daniela anticipate others would say in response to her request of the group leader?
>
> I responded simply acknowledging her message and telling her that I looked forward to seeing her in the group and talking further. Daniela's seemingly innocent request led to a rich exploration of sibling transferences, parental favoritism, competition for group and therapist attention and care, and my dilemma. At the end of the session Daniela stated that she learned a lot from the meeting, and joked that she could

save herself a lot of stress by coming on time, while acknowledging, more seriously, that this was exactly the kind of work she needed to do. She had long wrestled with the apprehension of asking for care and recognition, and this seemingly simple request of the therapist opened up an important discussion of her deep longings. **<<**

Money often acts as a lightning rod for members' feelings about the leader. The discussion of any hint of difference in fees—a sliding scale, perhaps—is particularly provocative and enlightening. How much one pays is often one of the group's most tightly clutched secrets, since differing fees (and the silent, insidious corollary, different rights and different degrees of ownership) threaten the very foundation of the group: equality for all members. Are fees discussed in the group? Are bills covertly emailed? Handed out in each session? Is direct communication embraced or avoided? The therapist's unease will foster the group's unease and reduce the scope of group exploration. Therapists often feel awkward talking about money and fees, since it may open difficult issues such as the therapist's income, perceived greed, entitlement, or members' dependence, resentment, or dissatisfaction with the therapist.[27]

Members often expect the leader to sense their needs. One member wrote a list of major issues that troubled him and brought it to meeting after meeting, waiting for the therapist to divine its existence and ask him to read it. Obviously, the content of the list meant little—if he had really wanted to work on the problems enumerated there, he could have presented the list to the group himself. No, what was important was his belief in the therapist's prescience. This member's transference was such that he had incompletely differentiated himself from the therapist. Their ego boundaries were blurred; to know or feel something was, for him, tantamount to the therapist knowing and feeling it.

When several members of a group share this desire for an all-knowing, all-caring leader, the meetings take on a characteristic flavor. The group seems helpless and dependent. The members deskill themselves and seem unable to help themselves or others. Deskilling is particularly dramatic in a group composed of

professional therapists who suddenly seem unable to ask even the simplest questions of one another. They are all waiting—waiting for the touch of the therapist. No one wants to encourage anyone else to talk for fear of lessening his or her chance of obtaining the leader's ministrations.

Then, at other times or in other groups, the opposite occurs. Members challenge the leader continuously. The therapist is distrusted, misunderstood, treated like an enemy. Examples of such negative transference are common. One client, who had just joined a group, expended considerable energy in an effort to dominate the other members. Whenever the therapist attempted to point this out, the client regarded his intentions as malicious: the therapist was interfering with his growth; the therapist was threatened by him and was attempting to keep him subservient; or, finally, the therapist was deliberately blocking his progress, lest he improve too quickly and thus diminish the therapist's income. Both of these positions in the extreme—idealization and devaluation—are destructive, anti-group-therapy norms. They represent resistance and regression in the group that demands attention before the norms concretize.[28]

In a group of adult female incest survivors, I (IY) was the only male in the group and was continually challenged. Unlike my female co-therapist, I could do nothing right. My appearance was attacked: I was too formal, too relaxed, too professional, not professional enough. Virtually every one of my interventions was met with criticism. My silence was labeled disinterest, and my support was viewed with suspicion. When I did not inquire deeply enough into the nature of their abuse, I was accused of lacking interest and empathy. When I did inquire, I was accused of being a voyeuristic deviant who was "getting off" by listening to stories of sexual violation. Though I had known that transferential anger from a group of women who were abuse victims would be inevitable, and also useful to the therapy process—and that the attacks were against my role rather than against me personally—the attacks were still difficult to tolerate, even to the point of destabilizing me. I began to dread each meeting and felt anxious, deskilled, and incompetent. The transference was

not just being felt or spoken; it was being enacted powerfully.[29] Not only was I attacked as a representative of the prototypical male in these group members' lives, but I was also being "abused" in a form of role reversal: I was now the victim and they the perpetrators. This offered me a useful window on "knowing" the group members' experience of being abused and helpless in the face of their abusers. Understanding the nature of transference and not retaliating with countertransference outrage was essential in retaining a therapeutic posture and avoiding another interactional cycle of victims and abusers.[30]

In another group, a member habitually became physically ill with flu symptoms whenever she grew depressed. The therapist could find no way to work with her without her feeling he was accusing her of malingering—a replay of the accusatory process in her relationships in her family. In yet another group, the therapist, on a couple of occasions, accepted a cough lozenge from a female member, and another member responded strongly, accusing him both of mooching and of exploiting the women in the group.

Many irrational reasons exist for these attacks on the therapist, but some stem from the same feelings of helpless dependency that can also result in the worshipful obedience we have described. Some clients with a dismissive attachment style respond counterphobically to their vulnerability by incessantly defying the leader.[31] Others validate their integrity or potency by attempting to triumph over the big adversary, feeling a sense of exhilaration and power from twisting the tail of the tiger and emerging unscathed.

The most common charge members level against the leader is that of being too cold, too aloof, too inhuman. This charge has some basis in reality. For both professional and personal reasons, as we shall discuss shortly, many therapists do keep themselves hidden from the group. Also, their role as process commentator requires a certain distance from the group. But there is more to it. Although the members insist that they wish therapists to be more human, they have the simultaneous counter-wish that they be *more than human* (see *The Schopenhauer Cure* for a fictional portrayal of this

phenomenon).

Freud often made this observation. In *The Future of an Illusion*, he based his explanation for religious belief on the human being's thirst for a superbeing.[32] Freud believed that the integrity of groups depended on the existence of some superordinate figure who, as we discussed earlier, fosters the illusion of loving each member equally. Solid group bonds become chains of sand if the leader is lost.

Hence, there is great ambivalence in the members' directive to the leader to be "more human." They complain that you tell them nothing of yourself, yet they rarely inquire explicitly. They demand that you be more human yet excoriate you if you wear a copper bracelet, accept a throat lozenge, or forget to tell the group that you have had an email exchange with a member. They prefer not to believe you if you profess puzzlement or ignorance. The illness or infirmity of a therapist always arouses considerable discomfort among the members, as though somehow the therapist should be beyond biological limitation. Groups can even collude to deny the reality of a beloved therapist's evident decline.[33]

A group of psychiatry residents in a process group put the dilemma very clearly. They often discussed the "big people" out in the world: their therapists, team leaders, staff supervisors, and the adult community of senior practicing psychiatrists. The closer these residents came to completing their training, the more important and problematic the big people became. I (IY) wondered aloud whether they, too, might soon become "big people." Could it be that even I had my own "big people"?

There were two opposing sets of concerns about the "big people," and they were equally troubling: first, that the "big people" were real, that they possessed superior wisdom and knowledge and would dispense an honest but terrible justice to the young, presumptuous frauds who tried to join their ranks; or, second, that the "big people" themselves were frauds, and the members were all Dorothys facing the Wizard of Oz. The second possibility had more frightening implications than the first: it brought them face to face with their intrinsic loneliness and apartness. It was as if, for a brief time, life's

illusions were stripped away, exposing the naked scaffolding of existence—a terrifying sight, one that we conceal from ourselves with the heaviest of curtains. The “big people” are one of our most effective curtains. As frightening as their judgment may be, it is far less terrible than that other alternative—that *there are no “big people”* and that one is finally and utterly alone.

The leader is thus seen unrealistically by members for many reasons. True transference or displacement of affect from some prior relationship is one reason; conflicted attitudes toward authority (dependency, distrust, rebellion, counterdependency) that become personified in the therapist is another; what the leader evokes or provokes by virtue of his or her presence and style is yet another; and still another reason is the tendency to imbue therapists with great protective powers so as to use them as a shield against existential anxiety.

An additional but entirely rational source of members’ strong feelings toward the group therapist lies in the members’ explicit or intuitive appreciation of the therapist’s great and real power. Group leaders’ presence and impartiality are, as we have already discussed, essential for group survival and stability; they have the power to expel members, add new members, and mobilize group pressure against anyone they wish.

In fact, the sources of intense, irrational feelings toward the therapist are so varied and so powerful that transference will always occur. The therapist need not make any effort to generate or facilitate the development of transference. An illustrative example of transference developing in the presence of and despite therapist transparency occurred with a client who often attacked me (IY) for aloofness, deviousness, and hiddenness. He accused me of manipulation, of pulling strings to guide each member’s behavior, of not being clear and open, and of never really coming out and telling the group exactly what I was trying to do in therapy. Yet this man was a member of a group in which I had been writing very clear, honest, transparent group summaries and mailing them to the members before the next meeting. A more earnest attempt to demystify the therapeutic process would be difficult to imagine. When asked by

some of the members about my self-disclosure in the summaries, he acknowledged that he had not read them—they remained unopened on his desk.

Exploring the gap between the client's and the therapist's view of the same encounter provides rich learning opportunities.

> **In a second pregroup preparation meeting, I (ML) asked Ron, a** middle-aged executive with chronic depression and a history of adversarial relationships, how he felt our first meeting had gone. Ron responded that he was very angry that I had presumed power over him and diminished him. He said he had come for a second meeting largely to voice his outrage.
>
> I was stunned, expressed my concern and regret for generating that kind of reaction, and said I hoped we could explore what happened. Ron responded, "I offered you my permission to speak with my individual therapist who referred me to you. That was a big step for me in trusting you—and then you responded (here he mimicked a high-handed tone) 'I don't need your permission to speak with him.' That pissed me off big time. Here I was offering you a gift of my trust and you were telling me you could do what you want anyways."
>
> I responded, "I am so sorry that you felt that, but I am very grateful that you have returned today to talk with me, rather than blowing this and me off. I did not mean to make you feel diminished. I am sorry that it felt like a power move on my part. What I had hoped to convey was that I assumed that permission was a component of the referral process and that as your group therapist I anticipated I would work collaboratively with your individual therapist in your interest. I want to understand what happened between us, and believe we can both learn from it."
>
> Ron accepted the apology, calmed considerably, and added, "Isn't it funny how power became such a hot issue so quickly? That happens to me a lot." **<<**

As long as a group therapist assumes the responsibility of leadership, transference will occur. We have never seen a group develop without a deep, complex underpinning of transference. The problem is thus not evocation but resolution of transference. The therapist who is to make therapeutic use of transference must help clients recognize, understand, and work through their distorted view

of the leader.

How does the group resolve transference distortions? Two major approaches are seen in therapy groups: *consensual validation* and *increased therapist transparency*.

Consensual Validation

The therapist may encourage a client to compare his or her impressions of the therapist with those of the other members. If many or all of the group members concur in the client's view of and feelings toward the therapist, then it is clear that either the member's reaction stems from global group forces related to the therapist's role in the group *or* the reaction is not unrealistic at all—the group members are perceiving the therapist accurately. If, on the other hand, there is no consensus, if one member alone has a particular view of the therapist, then this member may be helped to examine the possibility that he or she sees the therapist, and perhaps other people too, through an internal distorting prism. In this process the therapist must take care to operate with a spirit of open inquiry and self-reflection, lest it turn into a process of majority rule or mobilizing the group members against a member. Also, remember: There can be truth even in the idiosyncratic reaction of a single member. The wise group leader pays careful heed to even the single dissonant voice.

Increased Therapist Transparency

The other major approach relies on the therapeutic use of the self. Therapists help clients confirm or disconfirm their impressions of them by gradually revealing more of themselves. The client is pressed to deal with the therapist as a real person in the here-and-now. Thus, you respond to the client, you share your feelings, you acknowledge or refute motives or feelings attributed to you, you look at your own blind spots, you demonstrate respect for the feedback the members offer you. In the face of this mounting real-life data, clients are impelled to examine the nature and the basis of their powerful distorted beliefs about the therapist.

The group therapist undergoes a gradual metamorphosis during the life of the group. In the beginning you busy yourself with the many functions necessary in the creation of the group; with the development of a social system in which the many therapeutic factors may operate; and with the activation and illumination of the here-and-now. Gradually, as the group progresses, you begin to interact more personally with each of the members, and as you become more of a fleshed-out person, the members find it more difficult to maintain the early stereotypes they had projected onto you. Your disclosure about the client's impact on you is a particularly effective intervention because it deepens understanding of the bidirectional impact between therapist and group member.[34]

This process between you and each of the members is not qualitatively different from the interpersonal learning taking place among the members. After all, you have no monopoly on authority, dominance, wisdom, or aloofness, and many of the members work out their conflicts in these areas not only with the therapist but also with other group members.

Attention to the degree of transparency of the therapist is by no means limited to group therapy. However, the pace, the degree, and the nature of the therapist's transparency, along with the relationship between this activity of the therapist and the therapist's other tasks in the group, are problematic and deserve careful consideration. More than any other single characteristic, the nature and degree of therapist self-disclosure differentiate the various schools of group therapy. Judicious therapist self-disclosure is a defining characteristic of the interpersonal model of group psychotherapy.[35]

THE PSYCHOTHERAPIST AND TRANSPARENCY

Psychotherapeutic innovations appear and vanish with bewildering rapidity.[36] Only a truly intrepid observer would attempt to differentiate evanescent from potentially important and durable trends in the diffuse, heterodox American psychotherapeutic scene. Nevertheless, there is evidence, in widely varying settings, of a shift in therapists' transparency with their clients. It matches the greater exposure and transparency in the world at large fostered by modern social media.

Consider the following vignettes:

> **Students who have observed a therapy group through a one-way** mirror reverse roles at the end of the meeting. Here, the clients are permitted to observe while the therapist and the students discuss or rehash the meeting. Or, in inpatient groups, the observers enter the room twenty minutes before the end of the session to discuss their observations of the meeting. In the final ten minutes, the group members react to the observers' comments.[37] **<<**

> **At a university training center, a tutorial technique has been** employed in which four psychiatric residents meet regularly with an experienced clinician who conducts an interview in front of a one-way mirror. The client is often invited to observe the post-interview discussion. **<<**

> **Tom, one of two group co-therapists, began a meeting by ad**dressing a client who had been extremely distressed at the previous meeting. He asked him how he was feeling and whether that session had been helpful to him. The co-therapist then said, "Tom, I think you're doing just what I was doing a couple of weeks ago—pressing the clients to tell me how effective our therapy is. We both seem on a constant lookout for reassurance. I think we are reflecting some of the general discouragement in the group. I wonder whether the members may be feeling pressure that they have to improve to keep up our spirits." **<<**

> **In an ongoing group, a member reported to the group that she** had seen a YouTube video of a lecture on group therapy and a group

demonstration given by their group leader. She distributed the link to the group and wanted to discuss why the group leader was more relaxed and personable in the video than in their therapy group. What accounted for the difference? **<<**

Without discussing the merits or the disadvantages of the approaches demonstrated in these vignettes, it can be said that there is no evidence that these approaches corroded the therapeutic relationship or situation. In none of these situations did the group members lose faith in their all-too-human therapists. On the contrary, group members developed more faith in therapists who were willing to reveal their thinking. For example, the clients who observed their therapists disagree with one another learned that although no single true way exists, the therapists are nonetheless dedicated and committed to finding ways of helping their clients.

In each of the vignettes, the therapists abandon their traditional role and share human uncertainties with their clients. Gradually the therapeutic process is demystified and becomes more collaborative. One study examined the reaction of therapy clients to sessions in which the therapist cried. This is a common experience: a recent survey reported such events in 70 percent of therapists across all models, age groups, and genders.[38] What is the impact of such an event? Therapists believe it has a positive and humanizing effect on the therapeutic relationship. And the clients' perspective? It depends! The therapist's emotionality strengthens strong relationships and undermines weak ones.[39]

The reevaluation of the therapist's role and authority is not just a modern phenomenon but a long-standing trend away from therapeutic detachment and toward therapeutic human engagement. There were adumbrations of this shift among the earliest dynamic therapists. For example, Sándor Ferenczi, a close associate of Freud's who was dissatisfied with the therapeutic results of psychoanalysis, continually challenged the aloof, omniscient role of the classical psychoanalyst. Ferenczi and Freud in fact parted ways because of Ferenczi's conviction that it was the tender, nonauthoritarian, mutual, honest, transparent relationship that

therapist and client created together, not the rational interpretation, that was the mutative force of therapy.[40]

In his pioneering emphasis on the interpersonal relationship, Ferenczi influenced American psychotherapy through his impact on future leaders in the field such as William Alanson White, Harry Stack Sullivan, and Frieda Fromm-Reichman. Ferenczi also had a significant but overlooked role in the development of group therapy, underscoring the interpersonal base of many of the group therapeutic factors.[41] During his last several years, he openly acknowledged his fallibility to clients and, in response to a just criticism, felt free to say, "I think you may have touched upon an area in which I am not entirely free myself. Perhaps you can help me see what's wrong with me."[42] S. H. Foulkes, a British pioneer group therapist, stated more than eighty years ago that the mature group therapist was truly modest, one who could sincerely say to a group, "Here we are together facing reality and the basic problems of human existence. I am one of you, not more and not less."[43]

I (IY) explore therapist transparency more fully in other literary forms: four books of stories based on my psychotherapy cases—*Love's Executioner*, *Momma and the Meaning of Life*, *Staring at the Sun*, and *Creatures of a Day*—and three novels—*When Nietzsche Wept*, in which the client and therapist alternate roles; *Lying on the Couch*, with a therapist protagonist who reruns Ferenczi's mutual analysis experiment by revealing himself fully to a client; and *The Schopenhauer Cure*, where the therapist engages in heroic transparency, sharing with the group members his mortal illness.[44] After the publication of each of these books, I received a deluge of letters, from both clients and therapists, attesting to the widespread interest in and craving for a more human relationship in the therapy venture.

Those therapists who attempt greater transparency argue that therapy is a rational, explicable process. They recognize that it is impossible not to be self-disclosing—what you wear, how you set up your office, what decorates your wall—all reveal aspects of who you are. So it makes sense to harness it for therapeutic benefit. As

therapists gain experience, they inevitably become more transparent in their therapy.[45] The more transparent therapists espouse a humanistic attitude to therapy, in which the client is considered a full collaborator in the therapeutic venture.

No mystery need surround the therapist or the therapeutic procedure; aside from the ameliorative effects stemming from expectations of help from a magical being, there is little to be lost and much to be gained through the demystification of therapy. This helps align expectations and strengthens the therapeutic alliance.[46] A therapy based on a true alliance between therapist and enlightened client reflects a greater respect for the capacities of the client and, with it, a greater reliance on the client's self-awareness rather than on the easier but precarious comfort of reliance on the sage therapist.

Greater therapist transparency is, in part, a reaction to the long tenure of the old authoritarian medical healer, who, for many centuries, has colluded with the distressed human being's wish for succor from a superior being. Healers have harnessed, and indeed cultivated, this need as a powerful agent of treatment: Latin prescriptions, specialized language, secret institutes with lengthy and severe apprenticeships, imposing offices, and power displays of diplomas—all have contributed to the image of the healer as a powerful, mysterious, and prescient figure.

In unlocking the shackles of this ancestral role, some overly disclosing therapists have at times sacrificed effectiveness on the altar of self-disclosure. However, the dangers of indiscriminate therapist transparency (which we shall consider shortly) should not deter us from exploring the *judicious* use of therapist self-disclosure.

The Effect of Therapist Transparency on the Therapy Group

The classic objection to therapist transparency emanates from the traditional analytic belief that the paramount therapeutic factor is the resolution of client-therapist transference. This view holds that the therapist must remain relatively anonymous or opaque in order to foster and unencumber the development of transference feelings

toward him or her. It is our position, however, that other therapeutic factors are of equal or greater importance, and that the therapist who judiciously uses his or her own person increases the therapeutic power of the group by encouraging the development of these other group factors. In doing so, you gain considerable role flexibility and maneuverability and may contribute to shaping group norms (there is considerable research evidence that therapist self-disclosure facilitates greater openness between group members, as well as between family members in family therapy),[47] and to here-and-now activation and process illumination. By decentralizing your position in the group, you also elevate the place of peer-to-peer transferences and hasten the development of group autonomy and cohesiveness. We see corroborating evidence from individual therapy: therapist self-disclosure is often experienced by clients as supportive and normalizing. It reduces distress and correlates with better outcome, and it fosters deeper exploration on the client's part and strengthens the therapeutic relationship.[48] Therapist self-disclosure is particularly effective when it serves to engage the client authentically, conveys therapeutic warmth, and does not serve to control or direct the therapeutic relationship.[49]

Therapist self-disclosure is not a "one-size-fits-all" action. It must be tailored to the client and guided by specific therapeutic intent. It includes both here-and-now interpersonal feedback, aimed at promoting change by illustrating the client's interpersonal impact, and more general therapist self-disclosure that aims to humanize the relationship. We disclose to support and draw closer to the client. We are the agent of the self-disclosure, but it is always the client who is the focus.[50] And though we encourage our clients to strike while their iron is hot, group leaders should wait for their irons to cool before disclosing to avoid the expression of unprocessed countertransference reactions.[51]

One objection to therapist self-disclosure is the fear of escalation —the fear that once you reveal yourself, the group will insatiably demand even more, and you will carom into all kinds of messy boundary situations. Recall that powerful forces in the group oppose

this trend and that you are committed to self-disclosure for therapeutic purposes only and never for self-aggrandizement. The members are extraordinarily curious about you, yet at the same time wish you to remain unknown and powerful. Some of these points were apparent in a meeting many years ago when I (IY) had just begun to lead therapy groups. I had just returned from leading a week-long residential leadership training program T-group sponsored by the National Training Laboratory. Since greater leader transparency is the rule in such groups, I returned to my therapy group primed for greater self-revelation:

> **Four members—Don, Rolando, Janelle, and Martha—were pres**ent at the twenty-ninth meeting of the group. One member and my co-therapist were absent; one other member, Peter, had dropped out of the group at the previous meeting. The first theme that emerged was the group's response to Peter's termination. The group discussed this gingerly, from a great distance, and I commented that we had, it seemed to me, never honestly discussed our feelings about Peter when he was present, and that we were avoiding them now, even after his departure. Among the responses was Martha's comment that she was glad he had left, that she had felt they couldn't reach him, and that she didn't feel it was worth it to try. She then commented on his lack of education and noted her surprise that he had even been included in the group—an oblique swipe at the therapists.
>
> I felt the group had not only avoided discussing Peter but had also declined to confront Martha's judgmental attitude and incessant criticism of others. I thought I might help Martha and the group explore this issue by asking her to go around the group and describe those aspects of each person she found herself unable to accept. This task proved very difficult for her, and she generally avoided it by phrasing her objections in the past tense, as in, "I once disliked some trait in you but now it's different." When she had finished with each of the members, I pointed out that she had left me out; indeed, she had never expressed her feelings toward me except through indirect attacks. She proceeded to compare me unfavorably with the co-therapist, stating that she found me too retiring and ineffectual; she then immediately attempted to undo the remarks by commenting that "Still waters run deep," and recalling examples of my sensitivity to her.
>
> The other members suddenly volunteered to tackle the same task

and, in the process, revealed many long-term group secrets: Don's passivity, Janelle's sloppy and inappropriate attire, and Rolando's lack of empathy with the women in the group. Martha was compared to a golf ball: "tightly wound up with an enamel cover." I was attacked by Rolando for my deviousness and lack of interest in him.

The members then asked me to go around the group in the same manner as they had done. Being fresh from a seven-day T-group and no admirer of generals who led their army from the rear, I took a deep breath and agreed. I told Martha that her quickness to judge and condemn others made me reluctant to show myself to her, lest I, too, be judged and found wanting. I agreed with the golf-ball metaphor and added that her inclination to be critical made it difficult for me to approach her, save as an expert technician. I told Don that I felt his gaze on me constantly; I knew he desperately wanted something from me, and that the intensity of his need and my inability to satisfy that need often made me very uncomfortable. I told Janelle that I missed a spirit of opposition in her; she tended to accept and exalt everything that I said so uncritically that it became difficult at times to relate to her as an autonomous adult.

The meeting continued at an intense, involved level, and at its end the observers expressed grave concerns about my behavior. They felt that I had irrevocably relinquished my leadership role and become a group member, that the group would never be the same, and that, furthermore, I was placing my co-therapist, who would return the following week, in an untenable position.

In fact, none of these predictions materialized. In subsequent meetings, the group plunged more deeply into work; several weeks were required to assimilate the material generated in that single meeting. My co-therapist and the other member who had missed the session were quickly able to catch up. In addition, the group members, following the model of the therapist, related to one another far more forthrightly than before and made no demands on me or my co-therapist for escalated self-disclosure. **<<**

There are many different types of therapist transparency, depending on the therapist's personal style and the stage of the group. Therapists may self-disclose to facilitate transference resolution; to model therapeutic norms; to assist the interpersonal learning of the members who want to work on their relationship with the group leader; or to support and accept members by saying, in

effect, “I value and respect you and demonstrate this by giving of myself.” But one’s aim must always be guided by the needs of the clients and the therapy and not by one’s personal needs.

> **An illustrative example of therapist disclosure that facilitated ther**apy occurred in a meeting when all three women members discussed their strong sexual attraction to me (IY). Much work was done on the transference aspects of the situation, on the women being attracted to a man who was obviously professionally off-limits and unattainable, older, in a position of authority, and so on. I then pointed out that there was another side to it. None of the women had expressed similar feelings toward my co-therapist (also male); furthermore, other female clients who had been in the group previously had had the same feelings. I could not deny that it gave me pleasure to hear these sentiments expressed, and I asked them to help me look at my blind spots: What was I doing unwittingly to encourage their positive response to me?
>
> My request opened up a long and fruitful discussion of the group members’ feelings about both therapists. There was much agreement that the two of us were very different: I was vainer, took much more care about my physical appearance and clothes, and had an exactitude and preciseness about my statements that created about me an attractive aura of suaveness and confidence. The other therapist was sloppier in appearance and behavior; he spoke more often when he was unsure of what he was going to say; he took more risks and was willing to be wrong, and, in so doing, was more often helpful to the clients. The feedback sounded right to me. I had heard it before and told the group so. I thought about their comments during the week and, at the following meeting, thanked the group members and told them that they had been helpful to me. **<<**

Making errors is commonplace; it is what is done with the errors that is often critical in therapy. Our clients do not expect us to be perfect—but they do expect us to be honest and decent. One of the more common errors therapists make is to respond defensively and shirk responsibility for their errors, which tends to isolate and fault the client.[52] We must expect and anticipate alliance strains and even alliance ruptures as part of the “tear and repair” process of therapy.[53] The good news is that, once recognized, these strains

can indeed be gainfully repaired, and, like a healing fractured bone, may even become stronger as a result of the repair. The correlation to better clinical outcomes is predictably robust.[54]

Therapists are not omniscient, and it is best to acknowledge that.

> **After an angry exchange between two members, Barbara and** Mae, the group found it difficult to repair the damage Barbara had experienced. Although Barbara was eventually able to work through her differences with Mae, Barbara continued to struggle with how she had been left so unprotected by me (ML). Numerous attempts at explanation and understanding failed to break the impasse, until I stated, "I regret what happened very much. I have to acknowledge that Mae's criticism of you took me by surprise—it hit like a tropical storm, and I was at a loss for words. It took me some time to regroup, but by then the damage had been done. If I knew then what I know now, I would have responded differently. I am sorry for that."
>
> Rather than feeling that I was not competent because I had missed something of great importance, Barbara felt relieved and said that what I'd said was exactly what she needed to hear. Barbara did not need me to be omnipotent—she wanted me to be human, to be able to acknowledge my error, and to learn from what had happened so that it would be less likely to occur in the future. **<<**

> **Another illustrative clinical example occurred in the group of** women survivors of sexual abuse described earlier in this chapter. The ongoing, withering anger toward me (IY, and, to a slightly lesser degree, toward my female co-therapist) had gotten to us, and toward the end of one meeting, we both openly discussed our experience in the group. I revealed that I felt demoralized and deskilled, that everything I tried in the group had failed to be helpful, and furthermore that I felt anxious and confused in the group. My co-leader discussed similar feelings: her discomfort about the competitive way the women related to her, and about the continual pressure placed on her to reveal any abuse that she may have experienced. We told them that their relentless anger and distrust of us was fully understandable in the light of their past abuse, but that, nonetheless, we both wanted to shriek, "These were terrible things that happened to you, but we didn't do them."
>
> This episode proved to be a turning point for the group. There was still one member (who reported having undergone savage ritual abuse as a child) who continued in the same vein—"Oh, you're uncomfortable

and confused? What a shame! But at least now you know how it feels." The others, however, were deeply affected by our admission. They were astounded to learn of our discomfort and of their power over us, and gratified that we were willing to relinquish authority and relate to them in an open, egalitarian fashion. From that point on, the group moved into a far more profitable work phase. **<<**

It was constructive for us to acknowledge and work with these feelings openly rather than simply allowing ourselves to be continually pummeled by the group. Our distress gave us a window into the experience of our clients, but simply to absorb it would have been destructive to us and to the clients. There is no healing in repetition alone without recognition and working through.[55] Being so intensely devalued is unsettling to almost all therapists, especially in the public domain of the group. Yet it also creates a remarkable therapeutic opportunity if therapists can maintain their dignity and honestly address their experience in the group. Such confrontation is particularly challenging to the neophyte group therapist and underscores the value of supervision to sustain therapist perspective and equanimity.[56]

These clinical episodes illustrate some general principles that prove useful to the therapist when receiving feedback, especially negative feedback:

- Take it seriously. Listen to it, consider it, and respond to it. Respect the clients and let their feedback matter to you; if you don't, you merely increase their sense of frustration and impotence.
- Do not respond defensively or fault the client. It is a grave error to pathologize the client without looking at your role in the interaction.
- Try to stay in the here-and-now and focus on the present and ahistorical as much as possible in your response.
- Obtain consensual validation by finding out how other members feel. Do so in a way that does not seek to marshal

others' opinion against the feedback, but is in the interest of being complete and comprehensive in your understanding.

- Check your internal experience: Does the feedback fit? Is it primarily a transference reaction, or is it in fact a piece of reality about you? If it is reality, you must confirm it; otherwise, you impair rather than facilitate your clients' reality testing. If it feels like it is off target, then it becomes an opportunity for further work on the client's patterns in relationships.

With these principles as guidelines, the therapist may offer a response such as, "You're right. There are times when I feel some irritation with you. But at no time do I feel I want to impede your growth, seduce you, get a voyeuristic pleasure from listening to your account of your abuse, or slow your therapy so as to earn more money from you. That simply isn't part of my experience of you." Or, "It's true that I dodge some of your questions. But often I find them unanswerable. You tend to imbue me with too much wisdom. I feel uncomfortable with your deference to me. I often feel that you've put yourself down very low, and that you're looking up at me." Or, "I've rarely heard you challenge me so directly before. Even though it's a bit scary for me, it's also very refreshing." Or, "I feel restrained, very unfree with you, because you give me so much power over you. I feel I have to check every word I say because you give so much weight to all of my statements."

What is common to these therapist responses is that they de-emphasize jargon; they do not overstate the concerns; they avoid adjectives and adverbs that are condemnatory (never say "never"; always avoid "always"). The responses acknowledge the strength and potential of the client and express a wish for the relationship to grow. A mix of therapist confidence and humility is particularly helpful in finding an effective path. Language is a key therapeutic tool of the therapist and we should polish our skills in this domain.[57] Harry Stack Sullivan wrote, many years ago, "Words are the implements with which therapists work, attention to their most effective use

should be included in teaching psychotherapy."[58]

Note that these therapist disclosures are *all part of the here-and-now of the group*. We advocate that therapists relate authentically to clients in the here-and-now of the therapy hour, not that they reveal their past and present in a detailed manner—although we have never seen harm in therapists answering such broad personal questions as whether they are married or have children, where they are going on vacation, where they were brought up, and so on. Keep in mind that the therapist's human presence encourages more of the same in the group.[59]

> **A group therapy trainee, Samantha, raised the question, in su**pervision, of whether or not to share news of her impending wedding and week-long honeymoon with the group. She and I (ML) discussed the fact that it was likely impossible to conceal this information: the group would notice her wedding band when she returned to the next meeting.
>
> So why the hesitancy? What would be the impact of not disclosing this news? In supervision we discussed several salient points. This was a positive development in her life. We expected our clients to share everything with us, and our reluctance to share this kind of news with them would separate us from them. Instead, we could honor their openness with us by reciprocating with information that was in essence public information. Sharing the news of the wedding did not mean talking about the attributes of her partner, or how she had worried she would never find a match. But it did mean respecting the group and trusting them to respond in ways that would be welcoming, or benign, or at most grist for discussion.
>
> We talked as well about the importance of reducing our clients' shame by our humanness. If we purport ourselves to never being touched by life for better or for worse, it reduces our clients' willingness to share their disappointments, discouragement, or feelings of shame. Therapist humanness begets therapy humanness. The group responded at the next session with congratulations, wishing Samantha well, thanking her for sharing her good news, and then getting on with their work—a constructive contrast to sitting together and colluding in avoiding an evident fact in the room. **<<**

Some therapists carry it much further and may wish to describe

some personal problems they encountered and overcame similar to those of group members. We personally have rarely found this useful or necessary.[i]

A study of the effects of therapist disclosure on a group over a seven-month period noted many beneficial effects from therapist transparency.[60] First, therapist disclosure was more likely to occur when therapeutic communication among members was not taking place. Second, the effect of therapist disclosure was to shift the pattern of group interaction into a more constructive direction. Finally, therapist self-disclosure resulted in an immediate increase in cohesiveness. Group therapist self-disclosure can serve to promote clients' relinquishing of old, unhealthy, internalized models of relationships and an openness to new relationships.[61] Yet many therapists shrink from self-disclosure without being clear about their reasons for doing so. Perhaps it stems from feeling loyal to an anachronistic model that demands less personal exposure, or from the fear of disrupting therapy boundaries and turning the therapy into a session about the therapist. There is little doubt, we would add, that the personal qualities of a therapist influence professional style, choice of ideological school, preferred clinical models, and use of self.[62]

In debriefing sessions after termination, we have often discussed therapist disclosure with clients. The great majority have expressed the wish that the therapist had been more open, more personally engaged in the group. Very few would have wanted therapists to have discussed more of their private life or personal problems with them, however. A study of individual therapy had the same findings —clients prefer, and in fact thrive on, therapist engagement, and prefer therapists who are "not too quiet."[63] No one expressed a preference for full therapist disclosure.

> **Client feedback about therapist transparency is even more im**pactful when it is provided before therapy ends. Nearing the end of his tenure as a co-leader trainee in an ongoing group, Niran, a Southeast Asian man, teared up, uncharacteristically, as he spoke about leaving the group: "I feel privileged to have worked with this

group; I learned a great deal that will help my future clients, and I developed as a group leader—I hope. I also hope I have contributed to the group. I will miss you all."

One of the group members, Binh, a reserved, anxious, and depressed man, also Southeast Asian, and normally very distant from his emotions, responded that Niran's openness in the meeting was a gift to him: "I think you and I are alike. It is not easy to show what we feel; that is not how we were raised. Even though you are younger than I am, your manner here reminded me of my father's silent inscrutability. He was always so silent and distant from his emotions, but every once in a while, he exploded in rage. That is why your showing me warmth and decency means so much to me."

Niran welcomed the feedback and spoke about how touched he was by Binh 's comments, saying he would carry that message with him in his future work. **<<**

Furthermore, there is evidence that leaders are more transparent than they know. The issue is not that we reveal ourselves—that is unavoidable [64]—rather, it is what use we make of our transparency and our clinical honesty. Some self-revelation is inadvertent or unavoidable—for example, pregnancy and bereavement.[65] In some groups, particularly homogeneous groups with a focus such as substance abuse, sexual orientation, or specific medical illness, leaders will likely be asked about their personal experience with the common group focus: Have they had personal experience with substance abuse? An eating disorder? Are they part of the LGBTQ community? Have they personally had the medical disease that is the focus of the group? Increasingly, clients will inquire about therapist values and religious beliefs or affiliations, and the growing number of clients from an increasingly wider variety of cultural backgrounds invites questions about the therapist's cultural identity and personal connection to that culture. The arenas of inquiry are broad and expanding as our field grows beyond its old monochromatic worldview.[66] For that reason, it can be helpful to anticipate the inquiry and have clear ethical and therapeutic principles to guide your responses.

Although the research literature shows that therapist self-

disclosure generally strengthens the therapeutic relationship, such disclosure does require tact, sensitivity, and nuance. We suggest you ask yourself these types of questions: Why am I sharing this information? What is my impact? Could I be foisting my beliefs or identity concerns upon my clients?[67] Therapists need to reveal relevant material about themselves in a way that helps group members realize that the therapist can understand and empathize with their experiences. That does not mean, however, that the therapist must provide extensive personal historical details. Such revelations are usually unhelpful to the therapy because they blur the difference in role and function between the therapist and the group members. And always explore with your clients the meaning to them of your self-disclosure.

Though members rarely press a therapist for inappropriate disclosure, occasionally one particular personal question arises that group therapists dread. It is illustrated in a dream of a group member shared with me (IY): *"The whole group is sitting around a long table with you [the therapist] at the head. You had in your hand a slip of paper with something written on it. I tried to snatch it away from you, but you were too far away."* Months later, after this woman had made some significant personal changes, she recalled the dream and added that she knew all along what I had written on the paper but hadn't wanted to say it in front of the group. It was my answer to the question, "Do you love me?" This is a threatening question for the group therapist. And there is an even more alarming follow-up question: "How much do you love each of us?" or, "Whom do you love best?"

These questions threaten the very essence of the psychotherapeutic contract. They challenge tenets that both parties have agreed to keep invisible. They are but a step away from a commentary on the "purchase of friendship" model: "If you really care for us, would you see us if we had no money?" They come perilously close to the ultimate, terrible secret of the psychotherapist, which is that the intense drama in the group room plays a smaller, more compartmentalized role in his or her life than it does in the lives

of the members themselves.

The issue of therapist transparency is vastly complicated by widely publicized instances of therapist-client sexual abuse. Unfortunately, the irresponsible or impulse-ridden therapists who, to satisfy their own needs, betray their professional and moral covenant have not only damaged their own clients but caused a backlash that has damaged trust in the client-therapist relationship everywhere, undermining the credibility of our field. It is a commentary on our times that our news cycles are replete with reports of those in power sexually exploiting those who are subordinate to or dependent upon them.

Many professional mental health associations have taken a highly reactionary stance toward the professional relationship, advising therapists to practice defensively and always keep potential litigation in mind. The lawyers and juries, they say, will reason that "where there is smoke, there is fire," and that since every sexual encounter between therapist and client started on the slippery slope of slight boundary crossings, human interactions between client and therapist are in themselves evidence of wrongdoing. Consequently, professional organizations have warned therapists to veer away from the very humanness that is the core of the therapeutic relationship. A leading and still influential article with a high Victorian tone in the *American Journal of Psychiatry*, for example, advocated a stifling formality and warned psychiatrists not to offer their clients coffee or tea, not to address them by their first names, not to use their own first names, never to run over the scheduled time period, never to see any client during the last working hour of the day (since that is when transgressions most often occur), and never to touch a client—even an act such as squeezing the arm or patting the back of an AIDS patient who needs therapeutic touch should be scrutinized and documented.[ii] Obviously, these instructions and the sentiment behind them are deeply corrosive to the therapeutic relationship. To their credit, the authors of the original article recognized the antitherapeutic impact of their first article and wrote a second paper five years later aimed at correcting the overreaction it had generated.

The second article pled for common sense and for recognition of the importance of the clinical context in understanding or judging boundary issues in therapy. The later article aptly distinguished between *boundary crossings*—therapeutic actions that humanize the therapy and are in the service of the client—and *boundary violations*—therapeutic transgressions driven by the therapist that damage the client and the therapy. Therapists are always encouraged to be reflective and to obtain consultation or supervision whenever they are uncertain about their therapeutic posture or actions.[68]

Certainly, there is a proper place for therapist concealment, and the most helpful therapist is by no means the one who is most fully and most consistently self-disclosing. Let us turn our attention to the perils of transparency.

Pitfalls of Therapist Transparency

Some time ago I (IY) observed a group led by two neophyte therapists who were at that time much dedicated to the ideal of therapist transparency. They formed an outpatient group and conducted themselves in an unflinchingly honest fashion, expressing openly in the first meetings their uncertainty about group therapy, their inexperience, their self-doubts, and their personal anxiety. One might admire their courage, but not their results. In their overzealous obeisance to transparency, they neglected their function of group maintenance, and the majority of the members dropped out of the group within the first six sessions.

The leader who strives only to create an atmosphere of egalitarianism between member and leader may in the long run provide no leadership at all. Effective leader role behavior is by no means unchanging; as the group develops and matures, different forms of leadership are required.[69] "The honest therapist," as Morris B. Parloff noted, "is one who attempts to provide that which the client can assimilate, verify and utilize."[70] Sándor Ferenczi, years ago, underscored the necessity for proper timing. The analyst, he said, must not admit his flaws and uncertainty too early.[71]

Research on group members' attitudes toward therapist self-

disclosure points to the importance of timing and the content of disclosure.[72] Therapists' disclosures that are judged as harmful in early phases of the group may be considered facilitative as a group matures. Furthermore, experienced group members are far more desirous of therapist self-disclosure than are inexperienced group members. Content analysis demonstrates that members prefer leaders who disclose positive ambitions (for example, personal and professional goals) and personal emotions (loneliness, sadness, anger, worries, and anxieties); they disapprove of a group leader expressing negative feelings about any individual member or about the group experience (for example, boredom or frustration).[73] Not all emotions can be expressed by the therapist. Expressing hostility is almost invariably damaging and often irreparable, contributing to premature termination and negative therapy outcomes.[74] Our language skills are seminal strengths—finding palatable ways of saying unpalatable things allows us to maintain our authenticity and our empathy while fulfilling our therapeutic mandate and responsibility of "first do no harm."[75]

Is full disclosure even possible in the therapy group or in the outside world? Or desirable? Some degree of personal and interpersonal concealment is an integral ingredient of any functioning social order. Eugene O'Neill illustrated this in dramatic form in the play *The Iceman Cometh*.[76] A group of derelicts live, as they have for twenty years, in the back room of a bar. The group is exceedingly stable, with many well-entrenched group norms. Each man maintains himself by a set of illusions ("pipe dreams," O'Neill calls them). One of the most deeply entrenched group norms is that no member may challenge another's pipe dreams. Then enters Hickey, the iceman, a traveling salesman, a false prophet who believes he brings fulfillment and lasting peace to each man by forcing him to shed his self-deceptions and stare with unblinking honesty at his life. Hickey's surgery is deft. He forces Jimmy Tomorrow (whose pipe dream is to get his suit out of hock, sober up, and get a job "tomorrow") to act now. He gives him clothes and sends him, and then the other men, out of the bar to face today.

The effects on each man and on the group are calamitous. One commits suicide, others grow severely depressed, “the life goes out of the booze,” the men attack one another’s illusions, the group bonds disintegrate, and the group veers toward dissolution. In a sudden, last-minute, convulsive act, the group labels Hickey psychotic, banishes him, and gradually reestablishes its old norms and cohesion. These “pipe dreams”—or “vital lies,” as Henrik Ibsen called them in *The Wild Duck* [77]—are often essential to personal and social integrity. They should not be taken lightly or impulsively stripped away in the service of honesty.

Commenting on the social problems of the United States, Viktor Frankl once suggested that the Statue of Liberty on the East Coast be counterbalanced by a Statue of Responsibility on the West Coast.[78] In the therapy group, freedom becomes possible and constructive *only* when it is coupled with responsibility. None of us is free from impulses or feelings that, if expressed, could be destructive to others. We suggest that we encourage clients and therapists to speak freely, to shed all internal censors and filters save one—the filter of responsibility to others.

We do not mean that unpleasant sentiments are never to be expressed; indeed, growth cannot occur in the absence of conflict. We do mean, however, that *responsibility*, not total disclosure, is the superordinate principle. The therapist has a particular type of responsibility—responsibility to clients and to the task of therapy. Group members have a human responsibility toward one another. As therapy progresses, as solipsism diminishes, as empathy increases, they come to exercise that responsibility in their interactions among themselves.

Thus, your *raison d’être* as group therapist is not primarily to be honest or fully disclosing. You must be clear about why you reveal yourself. What impact can you anticipate from your self-disclosure? In times of confusion about your behavior, you may profit from stepping back momentarily to reconsider your primary tasks in the group. Therapist self-disclosure is an aid to the group because it sets a model for the clients and permits some members to reality-test

their feelings toward you. When considering a self-disclosure, ask yourself where the group is now. Is it a concealed, overly cautious group that may profit from a leader who models personal self-disclosure? Or has it already established vigorous self-disclosure norms and is in need of other kinds of assistance? Again, you must consider whether your behavior will interfere with your group-maintenance function. You must know when to recede into the background. Unlike the individual therapist, the group therapist does not have to be the axle of therapy. In part, you are midwife to the group: you must set a therapeutic process in motion and take care not to interfere with that process by insisting on your centrality.

An overly restricted definition of the role of group therapist—whether based on transparency or any other criterion—may cause the leader to lose sight of the individuality of each client's needs. Despite your group orientation, you must retain some individual focus; not all clients need the same thing. Some, perhaps most, clients need to relax controls; they need to learn how to express their affect, whatever it may be—anger, love, tenderness, hatred. Others, however, need the opposite: they need to gain impulse control because their lifestyles are already characterized by labile, immediately acted-upon affect.

One final consequence of more or less unlimited therapist transparency is that the cognitive aspects of therapy may be completely neglected. As we noted earlier, *mere catharsis is not in itself a corrective experience*. Cognitive learning or restructuring (much of which is provided by the therapist) seems necessary for the client to be able to generalize group experiences to outside life. Without the acquisition of some knowledge about general patterns in interpersonal relationships, the client may, in effect, have to reinvent the wheel in each subsequent interpersonal transaction.

Footnotes

i A small study of individual therapy demonstrated that certain non-here-and-now therapist self-disclosure could be effective in strengthening the real (nontransference) relationship between client and therapist. Personal disclosure by the therapist about common interests or activities, when it followed the client's lead, served to normalize and support clients and indirectly deepened their learning. See S. Knox, S. Hess, D. Peterson, and C. Hill, "A Qualitative Analysis of Client Perceptions of the Effects of Helpful Therapist Self-Disclosure in Long-Term Therapy," *Journal of Counseling Psychology* 49 (1997): 274–83.

ii We recall, not that long ago, booths at psychotherapy conferences at which manufacturers promoted video systems that therapists could use to record every session as a safeguard against frivolous litigation.

- 8 -

Selecting Clients and Composing Groups

GOOD GROUP THERAPY BEGINS WITH GOOD CLIENT SELECTION. Clients improperly assigned to a therapy group are unlikely to benefit from their therapy experience. Furthermore, a poorly composed group may not be helpful to its members or may even disintegrate early in its life. It is therefore understandable that contemporary psychotherapy researchers are actively examining how best to match clients to psychotherapy groups according to their specific characteristics.[1]

In this chapter we begin by considering both the research evidence bearing on selection and the clinical methods of determining whether a given individual is a suitable candidate for group therapy. We next address the question of group composition: once it has been decided that a client is a suitable group therapy candidate, into which specific group should he or she go? Group therapy is complex, and at every step of the way the group leader should be guided by this question: What must I do to ensure the success of this group?

We focus particularly on a specific type of group therapy: the heterogeneous outpatient group pursuing the ambitious goals of symptomatic relief and characterological change. However, many of the general principles we discuss have relevance to other types of groups as well, including the brief problem-oriented group.[2] Here, as elsewhere in this book, we provide the reader with fundamental group therapy principles coupled with strategies for adapting these principles to a wide variety of clinical situations. (We will discuss

some more specialized clinical situations in Chapter 15.)

We would only refer a client to group therapy if we believe that this would be an effective form of treatment for that individual. We start therefore with observations about the benefits of group therapy.

Research consistently shows that *group therapy is a potent modality producing significant benefit to its participants*.[3] It also indicates that group therapy offers unique benefits that in certain situations may make it more helpful than individual therapy.

The evidence for the effectiveness of group therapy is so persuasive that some experts advocate that group therapy be utilized as the primary model of contemporary psychotherapy, though they also acknowledge that it is a more complex treatment that requires therapists have specific training.[4] Individual therapy may be preferable for clients who require active clinical management, or when relationship issues are less important and personal insight and depth understanding are particularly important.[5]

Group therapy is superior to individual therapy in providing social learning and in helping clients develop social support and improve social networks, factors of great importance for clients with substance use disorders.[6] Clients with a medical illness acquire coping skills better in therapy with a group of peers than in individual therapy.[7] Adding group therapy to the treatment of women who are survivors of childhood sexual abuse provides benefits beyond individual therapy: it results in reduced shame and greater empowerment and psychological well-being.[8]

Of course, personal choice matters. Clients tend to do better when they engage the type of therapy they prefer: a therapy that matches their expectations.[9] We also recognize that clients may be reluctant to engage in group therapy for a host of reasons that the group leader will need to address as part of the selection and preparation process—an issue we will discuss later in this chapter.[10]

Predicting which clients will do best in group therapy and which are better referred to another form of therapy is not a simple matter. Each client is different, and decisions about treatment must be

tailored to the individual. Our inclusion and exclusion criteria are best viewed as general guidelines, and even experienced clinicians are often surprised by who does much better or much worse than expected.[11] Our limited clinical capacity to evaluate who will do well, and how our clients are actually doing, is part of the rationale for incorporating more empirical measurement in our clinical care.[12] In many instances, the variables that seem to forecast a client's failure in group therapy can be offset by thorough preparation, through empathic therapist responsiveness, and by securing a fit with a group that is better suited to that particular client at that point in the client's treatment trajectory. We want to get this process as right as possible to safeguard the client's care and to avoid the impact on the entire group of a member who is a poor fit.

CRITERIA FOR EXCLUSION

Question: How do group clinicians select clients for group psychotherapy? Answer: The great majority of clinicians do not select for group therapy. Instead, they *deselect*. Given a pool of clients, experienced group therapists determine that certain people cannot possibly work in a therapy group and should be excluded. *And then they proceed to accept all the other clients.*

That approach seems crude. We would all prefer the selection process to be more elegant, more finely tuned. But, in practice, it is far easier to specify exclusion than inclusion criteria; one characteristic may be sufficient to exclude an individual, whereas a more complex profile must be delineated to justify inclusion. Mistakes in selection are costly not only to the individual client but to the entire group. Here is a major guideline: *We can predict that clients will fail in group therapy if they are unable to participate in the primary task of the group, be it for logistical, intellectual, psychological, or interpersonal reasons.*

There is considerable and consistent clinical consensus[13] that clients are poor candidates for a heterogeneous outpatient therapy group if they have a significant brain injury,[14] are paranoid,[15] somatizing,[16] addicted to drugs or alcohol,[17] acutely psychotic,[18] or antisocial.[19] More recent studies using validated questionnaires like the Group Selection Questionnaire (GSQ) or the Group Therapy Questionnaire (GTQ) echo this clinical consensus and expand it by indicating that a certain degree of interpersonal skill is required to work in an interpersonal group.[20]

An additional important point: if clients have no expectation of the group being of value, there is little chance of a successful outcome, and the therapeutic alliance—the alignment of client and therapist about the goals and tasks and quality of the therapeutic relationship—is undermined from the start.[21] These considerations are even more compelling for brief, time-limited groups, which are particularly

unforgiving of poor client selection.

What traits must a client possess to participate in a dynamic, interactional therapy group? Members must have a capacity and willingness to examine their interpersonal behaviors, to self-disclose, to reflect psychologically on themselves and others, to give and receive feedback, and to have some capacity and willingness to engage with the other group members. Unsuitable clients are those who tend to construct an interpersonal role that is rigid and that would prove detrimental to themselves as well as to the group. For such clients the group becomes a venue for re-creating and reconfirming maladaptive patterns.

Antisocial clients are exceptionally poor candidates for interactional group therapy. Although early in therapy they may be influential and active members, they will eventually manifest their basic inability to relate, often with considerable dramatic and destructive impact, as the following clinical example illustrates:

> **Felix, a highly intelligent thirty-five-year-old man with a history of** alcoholism and impoverished, exploitative interpersonal relationships, was added with two other new clients to an ongoing group that had been reduced to three by the recent graduation of members. The group had shrunk so much that it seemed in danger of collapsing, and the therapists were eager to reestablish its size. They realized that Felix was not an ideal candidate, but they had few referrals and decided to take the risk. In addition, they were intrigued by his stated determination to change his lifestyle. (Many antisocial individuals are forever “reaching a turning point in life.”)
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> By the third meeting, Felix had become the social and emotional leader of the group. He seemed to feel more acutely and suffer more deeply than the other members. He presented the group, as he had the therapists, with a largely fabricated account of his background and current life situation. By the fourth meeting, as the therapists learned later, he had seduced one of the female members, and in the fifth meeting he spearheaded a discussion of the group’s dissatisfaction with the brevity of the meetings. He proposed that the group, with or without the permission of the therapists, meet more often, perhaps at one of the members’ homes, without the therapists. By the sixth meeting, Felix had vanished, without notifying the group. The therapists learned later that he had suddenly decided to take a two-thousand-mile bicycle trip,

hoping to sell an article about it to a magazine. **<<**

This extreme example illustrates many of the reasons why the inclusion of antisocial and exploitative individuals in heterogeneous outpatient groups is ill advised. Their social fronts are deceptive; they often consume such an inordinate amount of group energy that their departure leaves the group bereft, puzzled, and discouraged; they rarely assimilate the group therapeutic norms and instead often exploit other members and the group as a whole for their immediate gratification. *We do not mean that group therapy per se is always contraindicated for antisocial clients.* In fact, a specialized form of group therapy with a more homogeneous population and a wise use of strong group and institutional pressure may well be the treatment of choice.[22]

Most clinicians agree that clients in the midst of some acute situational crisis are not good candidates for group therapy; they are far better treated in a crisis-intervention therapy format.[23] Deeply depressed suicidal clients are best not placed in an interactionally focused heterogeneous therapy group because the group cannot give them the specialized attention they require (except at enormous expense of time and energy to the other members); furthermore, the threat of suicide or self-harm is too taxing, too anxiety provoking, for the other group members to manage.[24] This does not rule out group therapy for these clients, but they may require group therapy combined with individual therapy. Structured homogeneous groups for clients with chronic suicidality may be quite effective.[25]

Good attendance is so necessary for the development of a cohesive and effective group that it is wise to exclude clients who, for any reason, may not attend regularly. Poor attendance may be due to unpredictable and hard-to-control work demands, and it is best not to place individuals in the group whose work requires extensive travel that would cause them to miss even one out of every four or five meetings. Similarly, we are hesitant to select clients who have a very long commute to the group. Too often, especially early in the course of a group, a client may feel neglected or dissatisfied with a

meeting, perhaps because another member may have received the bulk of the group time and attention, or the group may have been busy building its own infrastructure—work that may not offer obvious immediate gratification. Deep feelings of frustration may, if coupled with a long, strenuous commute, dampen motivation and result in sporadic attendance.

Obviously, there are many exceptions: some therapists tell of clients who faithfully fly to meetings from remote regions month after month or make a long commute through the winter season. One group member reliably left work in another city at 3:30 p.m. to attend a 6:00 p.m. group, getting home close to 10:00 p.m. each week. She was determined "to make the drive to the group worthwhile," and her manifest commitment to the group was cited by others as reinforcing their valuing of the group. As a general rule, however, the therapist does well to take account of hardships imposed by time and distance. Online groups are an exception to this concern.

Exclusion criteria apply only for the type of group under consideration. Almost all clients will fit into *some* group. A characteristic that excludes someone from one group may be the exact feature that secures entry into another group. In our breast cancer group work, for example, women with advanced, metastatic disease fit poorly in groups in which most of the other women had early breast cancer—a cancer that carried a much better and much less frightening prognosis. A secretive, non-psychologically minded client with an eating disorder is generally a poor candidate for a long-term interactional group, but may be ideal for a homogeneous, cognitive-behavioral eating-disorders group. And keep in mind that some individuals may fail in their first interpersonal group, learn from that experience, and thrive in a later group.

Dropouts

There is evidence that premature termination from group therapy is bad for the client and bad for the group. A pioneering study of thirty-five clients who dropped out of long-term heterogeneous interactional outpatient groups in twelve or fewer meetings found that

only three reported themselves as improved.[26] Moreover, those three individuals had only marginal symptomatic improvement. None of the thirty-five clients left therapy because they had satisfactorily concluded their work; they had all been dissatisfied with the therapy group experience. Their premature terminations also had an adverse effect on the remaining members of their group, who were threatened and demoralized by the early dropouts. In fact, many group leaders report a contagion or "wave effect," with dropouts begetting other dropouts. The proper development of a group requires membership stability; a rash of dropouts may delay or obstruct the maturation of a group for months.

Early group termination is thus a failure for the individual and a detriment to the therapy of the remainder of the group. Unfortunately, dropping out prematurely is common across the psychotherapies.[27] Reviews of dropout rates in group therapy across a range of settings, from private practice to university hospital clinics to VA outpatient clinics, consistently demonstrate group therapy attrition ranges from 17 percent to 57 percent.[28] Although this rate is no higher than the dropout rate from individual therapy, the dropout phenomenon is more concerning to group therapists because of the deleterious effects of dropouts on the rest of the group.

A study of early dropouts may help establish sound exclusion criteria and, furthermore, may provide an important goal for the selection process. If, in the selection process, we learn merely to screen out members particularly vulnerable to dropping out of therapy, *that in itself* would constitute a major achievement. It would allow us to direct these clients to other treatments, to invest much more in their pregroup preparation, or to be alert to our own countertransference contributions to their negative group experience. Although the early terminators are not the only failures in group therapy, they are unequivocal failures.[29] We may dismiss as unlikely the possibility that early dropouts have gained something positive that will manifest itself later. As noted in an earlier outcome study of encounter group participants, those who reported a negative experience when they left the group continued to feel that way long

after the group ended. When interviewed six months later, none of these participants reported having "put it all together" and enjoying a delayed benefit from the group experience.[30] If they left the group shaken or discouraged, they were very likely to remain that way.

Keep in mind that the study of group dropouts tells us little about those who continued to attend. Group continuation is a necessary but insufficient factor in successful therapy, although consistent evidence exists that clients who continue in treatment and avoid a premature ending achieve the best therapy outcomes.[31]

Reasons for Dropouts and Premature Termination

A number of rigorous studies of group therapy in various settings have convergent findings on the characteristics of people who drop out prematurely from group therapy.[32] These studies demonstrate that such clients are likely, at the initial screening or in the first few meetings, to have one or more of the following characteristics:

- Lower psychological-mindedness
- Tendency to act out
- Lower motivation
- More reactive and less reflective
- Less positive emotion
- Greater denial of distress or need for therapy
- Higher somatization
- Abuse of substances
- Greater anger and hostility
- Lower socioeconomic status
- Lower social effectiveness
- Lower intelligence
- Lack of understanding of how group therapy works
- The experience or expectation of cultural insensitivity
- Poorer social skills
- Very high levels of emotional or psychological distress

- In acute crisis and unable to turn attention to the group
- Strong preference for individual therapy
- Early dissatisfaction with the group or group leader

TABLE 8.1 Group Therapy Dropout Rates

Type of Group: University outpatient clinic
Length of Group: General, open-ended
Number of Sessions: 12 or fewer
Percent Dropping Out: 50%[1]

Type of Group: University outpatient clinic
Length of Group: Bereavement, closed
Number of Sessions: 12 or fewer
Percent Dropping Out: 28%[2]

Type of Group: University outpatient clinic
Length of Group: Short-term
Number of Sessions: 8 or fewer
Percent Dropping Out: 39%[3]

Type of Group: University outpatient clinic
Length of Group: Open-ended
Number of Sessions: 3 or fewer
Percent Dropping Out: 57%[4]

Type of Group: VA outpatient clinic
Length of Group: Open-ended
Number of Sessions: 9 or fewer
Percent Dropping Out: 51%[5]

Type of Group: VA outpatient clinic
Length of Group: Open-ended
Number of Sessions: 16 or fewer
Percent Dropping Out: 50%[6]

Type of Group: University outpatient clinic
Length of Group: Open-ended
Number of Sessions: 12 or fewer

Percent Dropping Out: 35%[7]

Type of Group: Private and clinic
Length of Group: Open-ended
Number of Sessions: 3 or fewer
Percent Dropping Out: 30%[8]

Type of Group: Clinic and hospital
Length of Group: Inpatient and outpatient
Number of Sessions: 20 or fewer
Percent Dropping Out: 25%[9]

Type of Group: Private practice
Length of Group: Long-term, analytic
Number of Sessions: 12 months or less
Percent Dropping Out: 35%[10]

Type of Group: Outpatient clinic
Length of Group: Open-ended
Number of Sessions: 12 or fewer
Percent Dropping Out: 17%[11]

Type of Group: Outpatient clinic
Length of Group: Short-term
Number of Sessions: 5 or fewer
Percent Dropping Out: 17%[12]

Type of Group: Private and clinic
Length of Group: Analytic
Number of Sessions: 10 or fewer
Percent Dropping Out: 24%[13]

Type of Group: Clinic
Length of Group: Dynamically oriented
Number of Sessions: 6 months or less
Percent Dropping Out: 17%[14]

Type of Group: Private practice
Length of Group: Dynamic/analytic
Number of Sessions: 6 months or less

Percent Dropping Out: 27% therapist A
38% therapist B[15]

Type of Group: Private practice
Length of Group: Analytic/long-term
Number of Sessions: 1 year or less
Percent Dropping Out: 55%[16]

Type of Group: University counseling center
Length of Group: Interactional/ interpersonal
Number of Sessions: 12 or fewer
Percent Dropping Out: 31% therapist A
45% therapist B[17]

Type of Group: Outpatient clinic
Length of Group: Complicated grief
Number of Sessions: 8 or fewer
Percent Dropping Out: 23%[18]

Type of Group: Outpatient clinic
Length of Group: CBT for depression
Number of Sessions: 12 or fewer
Percent Dropping gOut: 48%[19]

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These conclusions suggest that, all too often, the rich get richer and the poor get poorer. What a sad paradox! The clients who have the least skills and attributes needed for working in a group, *who most need what the group has to offer*, are the very ones most likely to fail! It is this irony that has stimulated attempts to modify the therapy group experience so that it accommodates more of these at-

risk clients. We need to fit our groups to our clients rather than the other way around.[33]

Keep in mind that these characteristics should therefore be seen as relative cautions rather than absolute contraindications. The person who fails in one group may do well in a different one. We should aim to reduce, not eliminate, dropouts. If we create groups that never experience a dropout, then it may be that we are setting our bar for entry too high, thus eliminating clients whom we may be able to help.

We will discuss one final study here in great detail, since it has considerable relevance for the selection process and its findings have been replicated in other studies.[34] I (IY) studied the first six months of nine therapy groups in a university teaching hospital outpatient clinic and investigated all clients who terminated in twelve or fewer meetings. A total of ninety-seven clients were involved in these groups (seventy-one original members and twenty-six later additions); of these, thirty-five were early dropouts. Considerable data were generated from interviews and questionnaire studies of the dropouts and their therapists and from observers of the groups.

An analysis of the data revealed nine major reasons for the clients dropping out of therapy:

1. External factors
2. Group deviancy
3. Problems of intimacy
4. Fear of emotional contagion
5. Inability to share the therapist
6. Complications of concurrent individual and group therapy
7. Early provocateurs
8. Inadequate orientation to therapy
9. Complications arising from subgrouping

Usually more than one factor is involved in the decision to

terminate. Some factors are more closely related to external circumstances or to enduring character traits that the client brings to the group, and thus are relevant to the selection process, whereas others are related to therapist actions, or to problems arising within the group (for example, the therapist's skill and competence).[35] Most relevant to the establishment of useful selection criteria are the clients who dropped out because of *external factors, group deviancy, and problems of intimacy*.

External Factors. Logistical reasons for terminating therapy (for example, irreconcilable scheduling conflicts, or moving out of the geographic area) played a negligible role in decisions to terminate. When this reason was offered by the client, closer examination usually revealed that group-related stress was more pertinent to the client's departure. Nevertheless, in the initial screening session, the therapist should always inquire about any pending major life changes, such as a move and the client's capacity to commit to the group at the planned time. Although clients show variable rates of progress in treatment, there is considerable evidence that therapy aimed at both relieving a client's symptoms and making major changes in his or her underlying character structure is not brief therapy—a minimum of six months is necessary.[36] Hence, clients should not be accepted into such therapy if there is a considerable likelihood of forced termination within the next few months. Instead, these clients are better candidates for shorter-term, problem-oriented groups.

External stress was considered a factor in the premature dropout of several clients who were so disturbed by external events in their lives that it was difficult for them to expend the energy for involvement in the group. They could not explore their relationships with other group members while they were consumed with the threat of disruption of relationships with the most significant people in their lives. It seemed especially pointless and frustrating to them to hear other group members discuss their problems when their own problems seemed so compelling. Among the external stresses were severe marital discord with impending divorce, impending career or

academic failure, disruptive relationships with family members, bereavement, and severe physical illness. In such instances, referrals should be made to groups explicitly designed to deal with such situations: acute grief, for example, is generally a time-limited condition, and the acutely bereaved client is best referred to a shorter-term bereavement group, particularly if the grief is complex and unremitting.[37]

Note an important difference! If the goal is specifically to ameliorate the pain of a breakup, then a brief, problem-oriented therapy is indicated. But for clients who wish to change something in themselves that causes them to thrust themselves repeatedly into painful situations (for example, repetitive involvement with people who invariably leave them), then longer-term group work is indicated.

The importance of external stress as a factor in premature group termination was difficult to gauge, since often it appeared secondary to internal forces. A client's psychic turmoil may cause disruption of his or her life situation, so that secondary external stress occurs; or a client may magnify external problems to escape anxiety originating from the group therapy. Several clients considered external stress the chief reason for termination, but in each instance, careful study suggested that external stress was, at best, a contributory, rather than a sufficient, cause for the dropout.

In the selection process, therefore, consider a client's unwarranted focus on external stress to be an unfavorable sign for intensive group therapy. If such a client does enter group therapy, try to encourage the client to keep attending while addressing the external stressor—a new job, for example, that appears to prohibit leaving work in time to attend the group. As the client's resistance is worked through, often the external stressor becomes more manageable.

Group Deviancy. Studying group therapy dropouts who were identified as group deviants offers rich information relevant to the selection process. But first, the term *deviant* must be carefully defined. We use the word to describe a member who does not fit into a particular group in a substantive way that *interferes with the group*

task. Almost every group member is a group outlier on one key characteristic: the youngest member, the oldest member, the only unmarried member, the only LGBTQ member, the sickest, the only Asian American, the only student, the angriest, the quietest.

However, in this study, one-third of the dropouts deviated significantly from the rest of the group *in areas crucial to their group participation*. The behavior of these clients in the group varied: some were silent, and others were loud, angry group disrupters. But all were isolates and were perceived by the therapists and by the other members as obstructing the progress of the group. The group and the therapists described them as "just not fitting in." Indeed, often the deviants said that of themselves. They failed to appreciate psychological process, were disengaged or concrete and directive, and were disconnected from the here-and-now of the group. The most commonly described characteristics were a lack of psychological-mindedness and a lack of interpersonal sensitivity. They tended to have a lower socioeconomic status and educational level than the rest of the group members. In terms of communication, they remained at the symptom-describing, advice-giving and -seeking, or judgmental level, avoiding discussion of immediate feelings and here-and-now interaction. Similar results have been reported by others.[38]

An important subcategory of dropouts had chronic mental illness and were making a marginal adjustment. Given the negative psychological impact of high expressed emotionality on clients with chronic mental illness such as schizophrenia, an intensive interactional group therapy would be contraindicated in their treatment. Structured, supportive, and psychoeducational groups are more effective.[39]

Notably, two clients in the study who did *not* drop out differed vastly from the other remaining members in their life experience. One had a history of prostitution, the other had prior problems with drug addiction and drug dealing. However, these clients did not differ from the others in ways that impeded the group's progress (psychological insight, interpersonal sensitivity, and effective

communication) and never became group deviants.

The group deviancy findings of this study are consistently echoed by social psychology research, clinical experience, and the use of new selection aids, such as the Group Selection Questionnaire. A summary of this literature highlights what most group leaders have experienced firsthand. Clients who do not fit with the group are unlikely to benefit, even if much initial attention is directed to them. These clients slow the group down. They undermine the group's interactional process by a rigid, controlling, or dismissive style and adversely impact the other group members. They lack motivation for change. The group deviant re-creates his core difficulties in the social microcosm of the group but lacks the psychological capacity to reflect on these difficulties and work with them, often damaging his self-esteem and others' therapeutic work. The group holds no real sway or influence on the deviant, and group members will sooner or later disengage from the deviant in futility. These group members typically experience lower group social status, which diminishes personal well-being and has a negative impact on the individual's emotional experience in social groups.[40]

A closer look at one of the group deviants in this study is illustrative. This man—middle-aged, isolated, and rigidly defended—was able to continue in the group because of the massive support he received in concurrent individual therapy. However, he remained an isolate in the group and, in the opinion of the therapists and the other members, impeded the group's progress. At first, considerable group energy was expended on him; eventually the group gave up, and he was, to a great extent, excluded from the communicational network. But the group could never entirely forget or ignore him, which slowed the pace of the work. If there is something important going on in the group that cannot be talked about, there will always be a degree of inhibition in communication. With a disenfranchised member, the group is never really free; in a sense, it cannot move much faster than its slowest member.

Morton Lieberman, Matthew Miles, and I (IY) demonstrated that deviant group members (members considered "out of the group" by

the other members, or members who grossly misperceived the group norms) *had virtually no chance of benefiting from the group and an increased likelihood of suffering negative consequences*.[41]

Now, let's apply these research findings and clinical observations to the selection process. The clients who will assume a deviant role in therapy groups are not difficult to identify in screening interviews. Their denial, their de-emphasis of intrapsychic and interpersonal factors, their unwillingness to be influenced by interpersonal interaction, and their tendency to attribute distress to somatic and external factors will be evident in a carefully conducted interview. Some of these individuals stand out by virtue of significantly greater impairment in function. They are often referred to group therapy by their individual therapists, who feel discouraged or frustrated by their client's lack of progress—perhaps hoping to transfer care away from the individual setting. Occasionally, postponing entry into group therapy may be appropriate, with group therapy becoming possible at a later date. The deferral can provide time for clients to benefit from psychopharmacological treatment, or to consolidate some stability through individual therapy.

Clinicians often err in assuming that even if certain clients will not click with the rest of the group, they will nevertheless benefit from the overall group support and the opportunity to improve their socializing techniques. In our experience, this expectation is rarely realized. Eventually the group will extrude the deviant. Therapists also tend to withdraw overtly and covertly from such clients, putting their therapeutic energies into those clients who reward their effort.[42]

Occasionally however, clients whose initial clinical presentation suggests that their selection and group entry will end in therapeutic failure can achieve a surprisingly positive outcome.

> **Sandra, a divorced sixty-year-old woman, was referred by her** psychiatrist to a newly forming interpersonal thirty-two-session group. She had a history of intense social isolation and a significant problem with hoarding. So great was her shame about hoarding that she had avoided any discussion of it even in a homogeneous group focused on hoarding. She skipped meetings and refused to participate when she

did attend. Sandra was referred this time to an interpersonal group with the hope of reducing her anxious avoidance and intense social isolation. She would continue in individual treatment as well.

In the first pregroup assessment meeting, what jumped out to me (ML) were all the reasons her group therapy would likely fail again. Sandra evinced many of the factors we have just reviewed: an odd and eccentric presentation with mismatched clothes, intense social avoidance, a sense of shame about the hoarding and unwillingness to talk about it, and interpersonal rigidity. We also discussed her failure in prior group therapy. She was, however, persuasive in the pregroup assessment, articulating that she was determined not to fail this group as she had done with prior groups. Moreover, as the interview progressed, despite the first impression she made, I found Sandra engaging.

We determined together that the focus of her group work would be engaging other members and managing the emotions that would emerge. She agreed that no matter the nature of her distress, she would speak of it in the group. To her credit, she began the first session talking about her wish not to fail or flee. She described her life-long expectation of interpersonal catastrophes and her dread of rejection, humiliation, and shame. The other group members appreciated her openness and courage. There were a few early crises that prompted Sandra to email after meetings asking if she should continue in the group. She was concerned about her misinterpretation of others' actions, her overreaction to group events, and her great fear that the other members would ask her to leave. In each such instance, however, the group and I offered support. She attended thirty of the thirty-two meetings and graduated as a valued member of the group, feeling "human among other humans."[43] **<<**

To summarize, it is important that the therapist screen out clients who are likely to become marked deviants in the group for which they are being considered. Augmenting a clinical assessment with empirical measures, such as the Group Selection Questionnaire, can be very helpful. Selection, however, is still an inexact science; clients become deviants because of their interpersonal behavior in the group sessions, not because of a deviant lifestyle or history.

Problems of Intimacy. Several clients dropped out of group therapy because of conflicts associated with intimacy, manifested in

various ways, including schizoid withdrawal, uninhibited or overly inhibited self-disclosure, and unrealistic demands for instant intimacy.[i]

Several clients who were diagnosed as having a schizoid personality disorder (reflecting their social withdrawal, interpersonal coldness, aloofness, introversion, and tendency toward internal preoccupation) experienced considerable difficulty relating and communicating in the group. Each began the group resolved to express feelings and to correct previous maladaptive patterns of relating, but each failed to accomplish this aim and experienced frustration and anxiety. Their therapists described these members as "isolates," "silent members," "peripheral members," and "nonrevealers."

In contemporary diagnostic terms, some of the group members diagnosed then as schizoid might well today be diagnosed with Level 1 Autism. The clinical distinction can be quite subtle. Significant impairments in relationships are characteristic of individuals in both diagnostic groups. The schizoid individual's impairment is a lack of interest in others, detachment, emotional flatness, and preference for isolation.[44] Individuals with autism spectrum disorder, in contrast, generally miss social cues and are often socially anxious, and eager for social contact—but at a loss as to how to get it right. They may make good use of structured social skills groups that de-emphasize interpersonal exploration.[45] Most of the schizoid group members in this study terminated treatment discouraged about the possibility of ever obtaining help from group therapy (see Chapter 12).

Another intimacy-conflicted client dropped out for a different reason—his fear of his own aggression against other group members. He originally applied for treatment because of his "fear of killing someone when I explode… which results in my staying far away from people." He participated intellectually in the first four meetings he attended, but was frightened by the other members' expressions of emotion. When a group member monopolized the entire fifth meeting with a repetitive, tangential discourse, he was enraged with the monopolizer, as well as with the rest of the group

members for their complacency in allowing this to happen. With no warning, he abruptly terminated therapy.

Other clients experienced a constant, pervasive dread of self-disclosure that precluded participation in the group and ultimately resulted in their dropping out. Still others engaged in premature, unconstrained self-disclosure and abruptly terminated. Some clients made such inordinate demands on their fellow group members for immediate, prefabricated intimacy that they created a nonviable group role for themselves. One early dropout unsettled the group in her first meeting by announcing to the group that she gossiped compulsively and doubted that she would be able to maintain people's confidentiality.

Clients with severe problems in the area of intimacy present a particular challenge to the group therapist both in selection and in therapeutic management (to be considered in Chapter 12). The irony is that these individuals are the very ones for whom a group experience could be particularly rewarding. Therefore, these clients, whose life histories are characterized by ungratifying interpersonal relationships, stand to profit much from an intimate group experience. Yet, if their interpersonal history has been *too* deprived, they will find the group threatening and may drop out of therapy more demoralized than before.[46]

> **Jake, a fifty-eight-year-old single man, believed that the group** was very helpful to others but not to him. He declared that he was just much less interested in relationships than the others in the group. He had been in foster care throughout much of his childhood, shuttled from one family to another and, as an adult, he believed relationships were always motivated by self-interest. Despite Jake's regular attendance and our (ML) apparent agreement about his core issues, little progress was made. Though the group continued to be encouraging and respectful, Jake, after several months, wished the group well and left. Later, in a state of some desperation, he asked for a referral to individual therapy, which ultimately proved more helpful. **<<**

Recent research demonstrates that clients with dismissive and avoidant attachment styles are challenging in groups. They are self-

reliant, resist the pull of belonging, and mistrust the care provided by others.[ii] At the least, it takes more time for them to engage with others in the group.[47] Highly resistant and reactive clients will challenge the therapist's authority and require respect for their pace and their need for autonomy.[48] Personality inventories also provide helpful information. Clients who are highly distressed and experience high levels of shame, for instance, are vulnerable to dropping out. They stand in contrast to those who score high on measures of extraversion and conscientiousness, who are more likely to commit themselves to the work of group therapy.[49]

Clients who crave social connectedness but are hampered by poor interpersonal skills are particularly prone to psychological distress. They are frustrated by being in a group rich with opportunities for connectedness that they cannot make use of. Though they may report high levels of cohesion in the group, they continue to feel they are on the outside looking in—akin to the old sailor's adage of "water, water everywhere but not a drop to drink." It is of course the individual's personal sense of belonging rather than group scores of high cohesion that best predicts outcome.[50]

Thus, clients with problems in intimacy represent both an indication and a potential contraindication for group therapy. The problem is twofold: how to identify and screen out those who will likely be overwhelmed in a group, and how to identify those who will likely succeed in a group. Both can be difficult to predict from the pregroup assessment alone.

Individuals with narcissistic pathology or a pervasive dread of self-disclosure may be unfavorable candidates for interactional group therapy. But if such individuals are dissatisfied with their ability to relate, express a strong motivation for change, and manifest curiosity about their inner lives, then they warrant a trial of group therapy. Keep in mind, however, that such interpersonal defenses as withdrawal, devaluation, or self-aggrandizement may push such individuals into dysfunctional group roles.[51]

Tailored pregroup preparation can mitigate the risk of an early dropout. (We discuss preparation at length in Chapter 9.) Even

greater caution should be exercised when the therapist adds a replacement member to an already established, fast-moving group. Often, combining individual and group therapy may be necessary to launch or sustain vulnerable clients in the group.[52]

Fear of Emotional Contagion and Other Factors. We have discussed the most prominent factors contributing to premature termination and will now examine other relevant factors. Several clients who dropped out of group therapy reported being adversely affected by hearing the problems of the other group members, as though emotional distress were contagious. This is a prominent concern and is the reason that some clients prefer individual therapy over group therapy.[53] One man stated that during his three weeks in the group he was very upset by the others' problems, dreamed about those problems every night, and relived them during the day. Other clients reported being upset by a particularly disturbed client in each of their groups. They were all frightened by seeing aspects of the disturbed client in themselves and feared that such exposure would evoke a personal regression. These are often individuals with a vulnerable sense of self and permeable ego boundaries.

A fear of emotional contagion, unless it is extremely marked and clearly manifest in the pretherapy screening procedure, is not a particularly useful reason either to select or to exclude a client for group therapy. Therapists who are sensitive to the problem can deal with it effectively in the therapeutic process. Occasionally, clients must gradually desensitize themselves. We have known individuals who dropped out of several therapy groups but who persevered until they were finally able to remain in one. The therapist may help by clarifying for the client the crippling effects of his or her attitudes toward others' distress. How can one develop friendships if one cannot bear to hear of another's difficulties? If the discomfort can be contained, the group may well offer the ideal therapeutic format for such a client.

The other reasons for group therapy dropouts—inability to share the therapist, complications of concurrent individual and group therapy, early provocateurs, problems in orientation to therapy, and

complications arising from subgrouping into smaller cliques that may fragment the larger group—generally resulted from faulty therapeutic technique and will be discussed in later chapters. Sometimes, though, these problems arise neither solely from poor selection nor from faulty therapy technique, but from incorrect assumptions and misunderstandings about how group therapy works. For example, some clients who terminated because of an inability to share the therapist never relinquished the notion that progress in therapy was dependent solely on the amount of goods (time, attention, and so on) they received from the group therapist. One group member was preoccupied with the basic arithmetic of group therapy: "There are nine of us and ninety minutes—so we each get ten minutes—how much value can that be?"

Some dependent and authority-oriented clients are referred to group therapy with a covert aim: their individual therapists attempt to use a group to wean their clients from the individual therapy. Obviously, group therapy is not a modality to be used to facilitate the termination phase of individual therapy, and the group therapist should be alert to inappropriate client referrals. There are, however, times when the thoughtful addition of group therapy to an individual treatment aimed at diluting a client's dependence on the individual therapist is an excellent choice, and group and individual work can proceed concurrently.

As we saw in earlier chapters, there is compelling evidence that the strength of the therapeutic alliance predicts therapy outcome.[54] The failure to secure a strong alliance warrants therapist self-examination: this failing should not be ascribed to the client alone.[55] A study of ten dropouts noted that several had been inadequately prepared for the group or misunderstood their referral to a group.[56] No clear set of goals had been formulated, and some clients were suspicious of the therapists' motives, questioning whether they had been placed in the group simply because the group needed a warm body. Some were wounded by being placed in a group with significantly dysfunctional members, taking this as a statement of the therapist's judgment of their condition. Some were wounded simply

by being referred to a group at all, as though they were being reduced from a state of specialness to a state of ordinariness.

CRITERIA FOR INCLUSION

Group trainees observing a heterogeneous interpersonal group always ask the same questions: Who should be referred to group therapy? How did the people we just observed get into this group? An obvious clinical criterion for inclusion is client motivation.[57] The client must be highly motivated for therapy in general and for group therapy in particular. Group therapy is neither simple nor easy; motivation is essential. It will not do to start group therapy just because one has been sent—whether by a spouse, a probation officer, an individual therapist, or an agency. Many erroneous prejudgments of the group may be corrected in the preparation procedure, but if you discern in the interview, or see in the client's responses on selection questionnaires, a deeply rooted aversion to entering a group, you should not accept that person as a member.[58]

Most clinicians agree that an important criterion for inclusion is significant problems in the interpersonal domain: for example, loneliness, shyness, social withdrawal, inability to be intimate, abrasiveness, issues with authority, narcissism, obsequiousness, dependency, feelings of unlovability, or a continuous need for admiration. Once we identify a key problematic interpersonal area in a client, an interesting question arises: Do we employ a therapy that *avoids* or *addresses* that area of vulnerability? We do not have firm group therapy research to guide us in answering this question. But we can draw some inferences from a large National Institute of Mental Health (NIMH) study of time-limited individual therapy in the treatment of depression. This study concluded that individuals need some interpersonal competence to make use of an interpersonal therapy.[59] It is also helpful if prospective group clients can appreciate the interpersonal core of their difficulties. That alignment will strengthen the therapeutic alliance.[60]

Some clinicians suggest group therapy for clients who do not work well in individual therapy because of their limited ability to be

accountable for their conduct or to report accurately on events in their lives (because of blind spots or because of ego-syntonic character pathology).[61] Louis Ormont described the value of group therapy for many clients who are challenging in individual therapy and may benefit from the group members' provision of multiple sources of feedback and interpretation.[62]

Impulsive individuals who tend to act immediately on their feelings often work better in groups than in individual therapy.[63] The therapist working with these clients in individual therapy often finds it difficult to remain both participant and observer, whereas in the group these two roles are divided among the members: some members may, for example, rush to battle with the impulsive client, while others act as disinterested, reliable witnesses, whose testimony the impulsive client is often far more willing to trust than the therapist's.

In cases where interpersonal problems are not paramount (or not obvious to the client), group therapy may still be the treatment of choice. For example, clients who persistently intellectualize as a defense against feeling may do better with the affective stimuli available in a group. Other clients fare poorly in individual therapy because of severe problems in the transference: they may not be able to tolerate the intimacy of the dyadic situation and need the reality testing offered by other group members to make therapy possible. Others are best treated in a group because they characteristically elicit strong negative countertransference from an individual therapist.[64]

> **George, a thirty-eight-year-old man referred to group therapy by** his female individual therapist, struggled with his anger and his avoidance of tenderness or dependence that he traced back to the physical abuse he suffered at the hands of his brutal father. (George was also described in Chapter 2 ["Attack First"].) When his young son's physical playfulness and roughhousing became frightening to him, he sought individual therapy because of his concern that he, too, would become an abusive father.
>
> At first the individual therapy progressed well, but soon his therapist became uneasy with George's crude and aggressive sexual

declarations to her. She became particularly concerned when George suggested that he could best express his gratitude to her through sexual means. Stymied in working this through, yet reluctant to end the therapy because of George's other gains, the therapist referred him to a therapy group, hoping that the concurrent group and individual format would clarify and dilute the intensity of the transference and countertransference. The group provided both support and challenge, and George's treatment was able to proceed effectively in both venues. **<<**

Many clients seek therapy without an explicit interpersonal complaint. They may cite the common problems that propel the contemporary client into therapy: a sense of something missing in life, feelings of meaninglessness, diffuse anxiety, anhedonia, identity confusion, mild depression, self-derogation or self-destructive behavior, compulsive workaholism, fears of success, or alexithymia.[65] But if one looks closely, each of these complaints has its interpersonal underpinnings, as we have noted. Each generally may be treated as successfully in group therapy as in individual therapy if the client can appreciate the value of the interpersonal group approach.[66]

Research on Inclusion Criteria

Any systematic approach to defining criteria for inclusion must emerge from the study of successful group therapy participants. Though this is difficult research to conduct, there have been advances in our understanding of who is likely to benefit from group therapy. Those likely to succeed represent the mirror image of the dropouts we have just reviewed.[67] But at times it can be difficult to discern who is progressing and who is failing in the group. Obtaining feedback from clients via outcome and process questionnaires can be very helpful in this regard.[68]

A study of forty clients in five outpatient therapy groups through one year of group therapy aimed to identify factors evident before group therapy that might predict successful outcomes. Outcomes were evaluated and correlated with many variables measured before

the start of therapy. None of the pretherapy factors that had been measured predicted success in group therapy, including level of psychological sophistication, therapists' prediction of outcome, previous self-disclosure, and demographic data. However, two factors measured after the sixth and twelfth meetings did predict success one year later: the clients' attraction to the group and the clients' general popularity in the group.[69] The finding that popularity correlated highly with a successful outcome has some implications for selection, because researchers have found that high self-disclosure, activity in the group, and the ability to introspect were some of the prerequisites for group popularity.[70] Members who help a group achieve its goals gain popularity and status.[71] These findings underscore the value of including in each group some members whose openness promotes group interaction and makes it safer for all to take risks. More recent research corroborates these findings.[72] The psychologically "rich" get richer in therapy, and one way to help the "poor" get rich is by having them participate in groups with these kinds of successful group members.

Early encounter group studies reported similar findings. Those who profited most from encounter groups were people who highly valued and desired personal change, who had high expectations for the group, who viewed themselves as deficient both in understanding their own feelings and in their sensitivity to the feelings of others, and who anticipated that the group would provide relevant opportunities for communication and help them correct their deficiencies. When these attitudes were linked with a willingness to take risks in the group, the individual's group work flourished.[73]

The finding that positive expectation predicts favorable outcome has substantial research support: *The more a client expects therapy—either group or individual—to be useful, the more useful will it be.*[74] As we have noted, group therapy is a challenging therapy for an individual's first therapeutic encounter. The role of prior therapy is important in this regard: experienced clients have more positive and more realistic expectations of therapy. Agreement between therapist and client about therapy expectations strengthens the therapeutic

alliance.[75] Not only is this an important selection issue, but it reminds us that pregroup preparation should help to create positive client expectations.

The Client's Effect on Other Group Members

Unlike individual therapy recruitment, where we need consider only whether the client will profit from therapy and whether he or she and a specific therapist can establish a working relationship, recruitment for group therapy cannot, in practice, ignore the other group members. Recent group dynamics research identifies this mutual member impact—for better and for worse—as the *actor-partner interdependence*.[76] As we compose a group or add members to an existing one, we must consider how the new client will respond to the particular others who are already in the group, and they to him or her.

There may also be clients who would do well in a variety of treatment modalities but are placed in a group to meet some specific group needs. For example, some groups at times seem to need an aggressive member, or a strong male, or a more tender member. While clients with borderline personality disorder often have a stormy course of therapy, some group therapists intentionally introduce them into a group because of their beneficial influence on the group therapy process. Generally, such individuals are more in touch with their unconscious, less inhibited, and less dedicated to social formality than most people, and they may lead the group into a more candid and intimate culture. Considerable caution must be exercised, however, in including a member whose ego strength is significantly less than that of the other members. If these clients have socially desirable behavioral traits, they may be valued by the other members because of their openness and deep perceptivity, and will generally do very well. If, however, their behavior alienates others, they may impede the group; they will be driven into a deviant role and will likely have a countertherapeutic experience.

The Group Therapist's Feeling Toward the Client

One final, and important, criterion for inclusion is the therapist's personal feeling toward the client. Regardless of the source, the therapist who strongly dislikes or is disinterested in a client (and cannot understand or alter that reaction) should refer that person elsewhere.[77] This caveat is obviously relative, and you must establish for yourself which feelings would preclude effective therapy.

It is our impression that this issue is somewhat more manageable for group therapists than for individual therapists. With the consensual validation available in the group from other members, and potentially from one's co-therapist, many therapists find that they are more often able to work through initial negative feelings toward clients in group therapy than in individual therapy. As therapists gain experience and self-knowledge, they usually develop greater generosity and tolerance and find themselves actively disliking fewer and fewer clients.

SUMMARY: CLIENT SELECTION

Selection of clients for group therapy is, in practice, a process of deselection: group therapists exclude certain clients from consideration and accept all others. Although empirical outcome studies, selection aids, and clinical observation have generated *inclusion criteria*, the study of failures in group therapy, especially of clients who drop out early in the course of the group, provides important *exclusion* criteria.

Clients should not be placed in a group if they are likely to fail at the main group tasks of self-exploration, self-disclosure, and care and respect for the group and its members, whether the cause is logistical, practical, motivational, or due to a lack of psychological-mindedness.

Clients should be excluded from a heterogeneous, interpersonal group if they are in the midst of a life crisis that can be more efficiently addressed in brief, problem-specific groups or in other therapy formats. Clients whose care requires a high degree of clinical management should have their entry deferred until the crisis has become sufficiently manageable to permit consistent group participation.

Conflicts in the sphere of intimacy represent both indication and contraindication for group therapy. Group therapy can offer considerable help in this domain—but if the conflicts are too extreme, the client will choose to leave (or be extruded by) the group. The therapist's task is to select those clients who are as close as possible to the border between need and impossibility. If no markers for exclusion are present, the vast majority of clients seeking therapy can be treated effectively in group therapy.

GROUP COMPOSITION

We now shift our focus from selecting group therapy members to composing therapy groups. Group composition principles complement the earlier guidelines for group selection: both also inform our work in pregroup preparation (see Chapter 9). Although we address these areas separately, they are clinically very much interwoven. We shift from a focus on who is suitable for group therapy in general to a discussion of individual suitability for a *particular* group. Moreover, we believe that *the principles of group composition are relevant in all therapy groups, even the most structured and seemingly homogeneous groups*. If therapists fail to attend to issues of diversity in interpersonal, cognitive, personality, attachment, and ethnoracial and cultural dimensions, they will fall prey to a simplistic and ineffective "one-size-fits-all" approach to group therapy.[78]

Let's begin by imagining these two scenarios:

1. Intake coordinators wish to form three new therapy groups and have selected twenty-one clients whom they believe will benefit from group therapy. But how to assign clients to the three groups?
2. An intake coordinator considers a client to be a suitable candidate for group therapy, and there are several groups operating in the clinic, each with one vacancy. Which group would offer the best fit for that particular client?

Both situations raise similar questions: Will the proper blend of individuals form an ideal group? Will the wrong blend fail to coalesce into a working group? *Is there an evidence-informed, superior method of composing a group?*

In the next few pages, we discuss the current state of knowledge about composing therapy groups. As in preceding chapters, we will

focus our attention particularly on heterogeneous groups with ambitious goals that focus on here-and-now member interaction. Let us begin with a cautionary note: human behavior and human interaction is so complex that our answers to these questions should be considered as tentative: they are a work in progress. And yet, keep in mind that the stakes are high. Errors in forming a group or introducing a group member into an ongoing group affect not only the new member but all the group members. Furthermore, the constraints of closed, time-limited groups leave little opportunity to correct group composition errors.

Group therapists struggle to compose a group with the right blend of clients. But what do we mean by right and wrong “blends”? Blends of what? Which of the infinite number of human characteristics are germane to the composition of an interactional therapy group? Since each member must continually communicate and interact with the other members, we must hope for a blend that allows members to interact in a manner that maximizes engagement with one another and promotes interpersonal learning.

The entire procedure of group composition and selection of group members is thus based on the important assumption that we can, with some degree of accuracy, predict the interpersonal or group behavior of an individual from our pretherapy screening and assessment. But are we able to make that prediction?

THE PREDICTION OF CLIENT BEHAVIOR IN THE GROUP

Earlier in this chapter, we advised against including individuals whose group behavior would render their own therapy unproductive and impede the therapy of the rest of the group. Generally, predictions of the group behavior of individuals with extreme and fixed maladaptive interpersonal behavior or extreme deficits in interpersonal function are reasonably accurate: *In general, the more profound the pathology, the greater the predictive accuracy.* However, in everyday clinical practice, the problem is far more subtle than this general rule may suggest. Most clients who seek treatment have a wide repertoire of behavior, and their ultimate group behavior can be difficult to predict. We'll begin by examining the most common procedures used to predict behavior in the group.

The Standard Diagnostic Interview

The most common method of screening clients for groups is the standard individual interview, in which the interviewer explores the reasons for seeking therapy as well as environmental stresses, personal history, cultural factors, physical health, and prior mental health treatments.[79]

One of the traditional end products of the mental health interview is a diagnosis that, in capsule form, is meant to summarize the client's condition and convey useful information from practitioner to practitioner. Ideally it should also offer an explanatory formulation that leads to a comprehensive treatment plan. But does it succeed in offering practical information relevant to group therapy? Group therapists will attest that it generally does not! Psychiatric diagnoses based on standard classificatory systems—for example, the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*—are of limited value as an indicator of interpersonal behavior.[80] Traditional diagnostic nomenclature was never meant for this purpose; it stemmed from a disease-oriented medical discipline

based on aggregates of certain signs and symptoms. Personality has generally been classified in a similar fashion, emphasizing discrete *categories* of interpersonal behavior.

Overall, *the standard intake interview has been shown to have little value in predicting subsequent client in-group behavior*.[81] That a diagnostic label fails to predict much about human behavior should neither surprise us nor cause chagrin. No label or phrase can adequately encompass an individual's essence or entire range of behavior.[82] Any limiting categorization is not only erroneous and stigmatizing, but offensive, and stands in opposition to the basic human foundations of the therapeutic relationship. In our opinion, during the process of psychotherapy, the less we think in terms of diagnostic labels, the better. (Albert Camus once described hell as a place where one's identity was eternally fixed and displayed on personal signs: Adulterous Humanist, Jittery Philosopher, Charming Janus, and so on.[83] To Camus, hell is where one has no way of explaining oneself; where one is fixed, classified—once and for all time.)

The Interpersonal Intake Interview

If our aim is to make better use of the initial interview, then the interview should focus on the client's relationships. The interviewer should explore the client's interpersonal and group experiences, including earliest relationships, long-term friendships, and the degree of intimacy experienced with people of both genders. How do relationships typically start? How do they end? It is often fruitful to ask for a detailed description of a typical twenty-four hours, taking particular note of how the client's life is peopled. With whom are they close? How often does the client's cell phone ring? Who texts them? How do they use social media?

Moving beyond the history, we encourage turning attention to the process of the interview itself, which offers information about the client's ability to deal with the interpersonal here-and-now interaction of a group. Is the client able to comment on the process of the intake interview, or to understand and accept the therapist's process

commentary? For example, is the client obviously tense, but denies it when the therapist asks? Is the client able and willing to identify the most uncomfortable or pleasant parts of the interview? Can the client reflect on the experience of being emotional in the interview? Or comment on how he or she wishes to be thought of by the therapist? Or check out what the therapist is thinking? All these observations can help to predict the client's in-group behavior.

The predictive power of this type of interview has yet to be determined empirically, but it seems far more relevant to subsequent group behavior than does the traditional clinical intake interview.[84] Contemporary psychotherapists examine the client's pathogenic beliefs and expectations about relationships, which give form to the client's interpersonal behavior.

The following vignette illustrates how therapists' attention to their own emotional responses to the client anticipates how the client is likely to interact in the group:

> **Connie, a woman in her forties, was referred by her family physi**cian for group therapy because of her social anxiety, dysthymia, and interpersonal isolation. Immediately on entering the office, she told me (ML) she had a "bone to pick" with me. "How could you leave a message on my answering machine calling me 'Connie' and yourself 'Dr. Leszcz'? Don't you understand the power imbalance that promotes? Haven't you heard of feminism and empowerment? Do you treat all the women you know like this, or only your clients?"
>
> I was at first jolted and a bit irritated, but after a few moments' reflection, I considered that she indeed had a point, and I apologized for the wording of my message.
>
> Later in the session, as we developed rapport, I returned to her anger about my phone message. She described feeling regularly devalued and bulldozed into silence. It reminded her of the way her father and her ex-husband had treated her.
>
> "So how did you feel about my response to your anger?" I asked.
>
> "A bit surprised. Almost shocked. I'm not used to apologies from men."
>
> This gave us a useful interpersonal behavior forecast for the group. I suggested to Connie that she may be inclined initially to relate to the group members in the same way that she did with me, but she did have

a choice. She could make the group experience yet another in a series of angry disappointments, or she could engage a process of learning and understanding that could interrupt this interpersonal sequence. **<<**

The Client's Prior Group Therapy History

What is the most powerful method of predicting an individual's group behavior? It is to observe that individual engaged in a task closely related to the group therapy situation. In other words, *the closer we can examine individuals in an activity closely approximating the therapy group, the more accurately we can predict their in-group behavior*.

Thus, the client's history of prior group experiences may be of significant value. Some clients will move along a continuum of group treatments that may include psychiatry inpatient groups, day treatment, or addiction groups. A careful inquiry into their experiences in these groups may be illuminating and help the therapist foresee potential challenges. The client's capacity to engage and to disclose personal information early on in a prior group therapy bodes well and suggests a readiness to trust.[85]

One possibility for assessing clients who do not have prior group experiences is via very brief training groups. Research on very brief groups established for clients who were on a waiting list for formal group therapy indicates that these groups were well received by clients, served to prepare them for the group to follow, and reliably predicted their subsequent group behavior.[86] In one well-designed project, thirty clients on a group therapy waiting list were placed into four one-hour training sessions. The sessions were all conducted according to a single protocol, which included an introduction to here-and-now interaction. The researchers found that each client's participation in the training sessions correlated with his or her subsequent behavior during the first sixteen group therapy sessions. Similar findings were reported in another, larger project.[87] For practitioners or clinics facing time or resource pressures, however, the use of trial groups may be an intriguing but highly impractical idea.

Specialized Diagnostic Procedures

Easy to use and free self-report questionnaires that capture attachment, interpersonal, and coping styles are readily accessible to supplement clinical assessment of the client's way of relating to and engaging others.[88] Evaluating interactional tendencies more accurately can improve our methods of matching clients to groups and anticipating how they will affect and experience their groups.[89] If the critical variable in group therapy selection is interpersonal in nature, why not develop an interpersonally based diagnostic scheme?

An Interpersonal Nosological System

The advent of the object-relations and interpersonal systems of conceptualizing psychopathology, together with the increase in the number of people seeking treatment for less severe problems in living, has stimulated more sophisticated attempts to classify individuals according to a host of interpersonal styles of relating.[90]

Attachment Style

There is an increasing amount of clinical and research focus on the nature and ramifications of an individual's attachment style.[91] John Bowlby's seminal work on relationship attachment categorizes individuals on the basis of four fundamental styles: (1) secure; (2) insecure-anxious; (3) insecure-detached, or dismissive and avoidant; and (4) insecure-fearful.[92] It is important for group therapists to recognize attachment styles because they have predictive value regarding clients' group behaviors. We can assess client attachment by looking at the client's history and experience of relationships and by using self-report questionnaires.[93]

Clients with secure attachment do well in almost all therapy groups. They seek connection and can tolerate frustration. In contrast, group members with attachment insecurity may struggle in the group. Anxiously attached clients will be hungry for connection and apprehensive about its reliability. Group members with

attachment avoidance are dismissive of human connections and slow to warm up. The insecure, fearful client may be overwhelmed by the demands for relationships in the group. All three varieties of insecurely attached clients can generate challenges in the development of group cohesion.

Although insecurely attached clients can benefit from group therapy, they will engage with the group very differently from securely attached ones. The closeness that might be welcomed by the anxiously attached client may be challenging and even overwhelming to the avoidant, dismissive client. The anxiously attached individual tends to amplify emotional signals, seeking evidence of group members' and the therapist's responsiveness. In contrast, the dismissively attached individual minimizes any signs of distress and is disinterested in engagement with others. Hence, the dismissively attached individual may fare better in a mature group, where the slowness to engage may be better accommodated without negatively impacting the group's cohesion, than in a newly formed group. Although groups that have members with heterogeneous attachment styles are likely to be most effective, we still have more to learn about whether groups should be more or less homogeneous on these attachment dimensions.[94]

Attending to attachment style can be very instructive at all phases of the group therapy trajectory, starting with the pregroup assessment. By identifying prominent attachment factors, we may be able to anticipate potential problems and tilt things in a positive direction.

> **Anne, a sixty-year-old single woman, was referred by her family** doctor for an evaluation for group therapy. She worked in IT, lived alone, and felt safe in her solitude. She described herself as "friendly enough" at work, and she made token appearances at office social functions, eagerly counting down the time until it was acceptable to leave. She was an expert at escape behaviors. She had recently dislocated her shoulder, however, and her struggle coping with that injury forced her to confront her extreme social isolation. She became frightened: without friends, social groups, or anyone to call for help, she realized she had to change and sought therapy.

Anne reported no other emotional distress. Of note, she had once had a severe drinking problem, for which she had been successfully treated in residential care twenty-five years earlier. She had had two courses of individual therapy for several years each when she was in her forties, but had little good to say about either therapy or therapists. She acknowledged growing up with a terrifying and emotionally abusive father. She had not been physically or sexually abused, but that threat always loomed large, and it had led her to adopt a defensive policy of "keep my head down and my mouth shut," which she did with great expertise.

The results of Anne's self-report questionnaires confirmed the clinical picture: Anne was a person with a strongly dismissive, avoidant attachment style. She had experienced significant early life adversity, and she now regarded relationships as dangerous and not worth the risk of engagement.

After I (ML) shared my formulation and impressions, Anne expressed particular interest in the traumatic roots of her difficulties. Although she did not have symptoms of psychological trauma in the form of flashbacks, intense anxiety symptoms, or hyperarousal, she showed significant interpersonal consequences of early life exposure to physical threat and emotional abuse. At the same time, she recognized that the isolation was unhealthy for her over the long term, and she acknowledged fears of returning to alcohol. She was eager to learn, and her motivation for engagement in group therapy seemed to build as we were able to focus on how group therapy worked.

What seemed most helpful to Anne was understanding that the group would be a safe, cohesive environment and would be led by able therapists who would allow her to proceed at a pace that felt safe. The objective of her group work would be to liberate herself from the fear engendered by her father that had influenced all her relationships. The group would aim to increase her zone of safety in relationships, first within the group and then hopefully outside the group. We talked as well about her propensity to distance herself in relationships, acknowledging that the risk for her would be to dismiss others in the group or flee when afraid. In contrast, I noted that her openness and her risk-taking with me boded well for her participation in group therapy.
<<

Interpersonal and Personality Inventories

Contemporary interpersonal theorists have attempted to develop a

classification of diverse interpersonal styles and behavior based on data gathered through interpersonal inventories (often, the Inventory of Interpersonal Problems—IIP).[95] The client's responses are placed onto a schematic circumplex of interpersonal relations that portrays the client's tendencies to relate along two key intersecting interpersonal dimensions: *control*, ranging from domineering to nonassertive/submissive, and *affiliation*, ranging from warm and overly nurturant to cold (see Figure 8.1).[96]

Two early studies that used a form of the interpersonal circumplex in a twelve-session training group of graduate psychology students found that hostile, dismissive members were much more likely to experience other group members as hostile. Strongly dominant (domineering) individuals resisted group engagement and tended to devalue or discount the group.[97]

Subsequent research reinforces these findings. Clients who tend to seek affiliation generally engage well in group therapy, but the pleasure of belonging is not an end in itself and must be utilized to increase the client's risk-taking within the group.[98] Individuals who are dominant and cold typically are more difficult to engage, but interesting work by the group analyst Steiner Lorentzen and colleagues has demonstrated that with proper pregroup preparation and active, supportive group leaders, these dismissive and hard-to-engage clients can do well, even in time-limited interactional group treatments.[99] A longer course of treatment may be required for clients with this interpersonal profile to become less defensive and more trusting.[100]

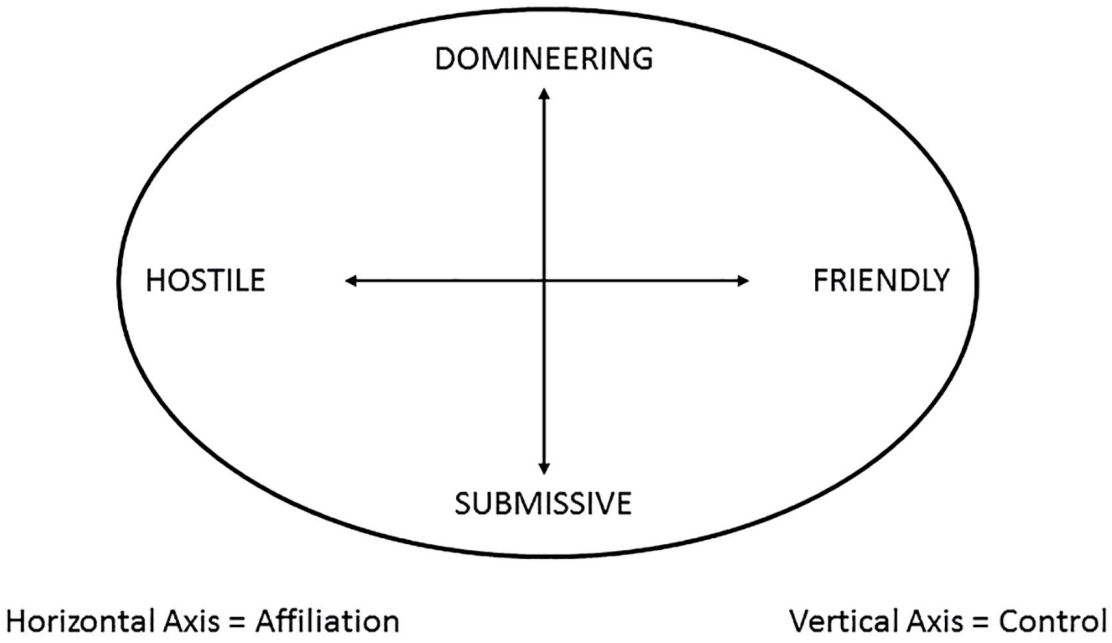

FIGURE 8.1 Interpersonal Circumplex

Here again, we see the value of these findings as a clinical alert that can increase the group leader's attention to the impact of clients' attachment and interpersonal styles on the group. The group leader can also review these findings with the client, determine if they resonate with the client, and utilize the information to inform the client's therapeutic goals and tasks.[101]

A further illustrative example of this type of research is found in the well-constructed studies by William Piper, John Ogrodniczuk, and colleagues that tested the comparative effectiveness of two kinds of group therapy and the effects of clients' personality traits on the results.[102] The researchers randomly assigned clients seeking treatment for loss and complicated grief to either a twelve-session interpretive/expressive group therapy, which aimed at depth psychological exploration, or a much more supportive group therapy. Client outcome assessments included measures of depression, anxiety, self-esteem, and social adjustment. Before therapy, each client was given the NEO-Five Factor Inventory (NEO-FFI), which measures five personality variables: neuroticism, extraversion,

openness, conscientiousness, and agreeableness.[103] What did the study find? Both group therapies were demonstrably effective, although the interpretive group generated much greater affect and anxiety among the group members. Personality features carried much impact: neuroticism predicted poorer outcome in both types of groups; extraversion, conscientiousness, and openness predicted positive outcomes in both groups; and the fifth factor, agreeableness, predicted success in the interpretive/expressive group therapy but not in the supportive group therapy. Clients who score high on the agreeableness factor make others feel welcome and safer in the group and help strengthen group members' sense of belonging.

Two other personality measures relevant to group therapy outcome have also been studied by this research team: Psychological-Mindedness [104] and the Quality of Object Relations (QOR) Scale.[105] Both of these measures have the drawback of requiring that the client participate in a thirty- to sixty-minute semistructured interview instead of a client self-report. Psychological-mindedness[iii] predicts good outcome in all forms of group therapy. Psychologically minded clients are better able to work in therapy—to explore, reflect, and understand.[106] Clients with higher QOR scores (i.e., greater maturity in their relationships) are more likely to achieve positive outcomes in interpretive/expressive, emotion-activating group therapy. These clients are also more trusting and able to express a broader range of negative and positive emotions in the group. Clients with low QOR scores are less able to tolerate this more demanding form of therapy and do better in supportive group formats that do not seek to activate distressing emotions.[107] Hence there is good evidence that placing clients with very poor relationship capacity into very active and dynamic groups, in the hope that they will benefit from the exposure in the group, is often unsuccessful for the client and has an inhibiting impact on the group.

SUMMARY: PREDICTING CLIENT BEHAVIOR

Of all the methods used to predict a member's behavior in a therapy group, the traditional individual intake interview oriented toward establishing a diagnosis is the *most limited in its accuracy* even though it is the most commonly used. We can enhance its utility, however. Keep in mind that *the more the intake procedure resembles the here-and-now focus of the group situation, the more accurate the interviewer's prediction of a client's behavior becomes. Hence we recommend that group therapists modify their intake interview to focus on the client's interpersonal functioning.*

PRINCIPLES OF GROUP COMPOSITION

How do we apply our insights from individual client assessment to the project of composing a group? Group composition is still a soft science. But predictions of how each of our clients is likely to experience the group and of how others will likely experience them in the group helps group therapists to construct more effective groups. Some key findings to consider in composing intensive interactional psychotherapy groups emerge from the empirical and clinical literature and are summarized here:

- Clients will re-create their typical relational patterns within the microcosm of the group. This is the essential therapeutic opportunity, and clients should not be discouraged by—but even welcome—the times when their core difficulties emerge in the group.
- Clients require a certain amount of interpersonal competence to make the best use of interactional group therapy.
- Psychologically minded clients contribute substantially to an interactional therapy group.
- Personality and attachment variables are more important predictors of a client's behavior in a group than diagnosis alone.
- We can augment our clinical evaluations with simple, validated questionnaires that add to our understanding of our clients' ways of interacting.
- We can anticipate these interpersonal patterns and address them in pregroup preparation.
- Members eager for engagement and willing to take social risks will advance the group's work.
- Clients who are securely attached typically do well in group therapy and promote cohesion.

- Clients who are rigidly domineering or dismissive of others may impair the work of the therapy group. This is a cautionary note and not a prohibition, as this risk can be offset by good preparation, therapist flexibility, and empathy.
- Clients who have an insecure attachment style will engage in the group in contrasting ways. Some will be anxiously eager for connection and others dismissive and distancing.
- Clients who are more rigid, less trusting, and less cooperative will likely struggle with interpersonal exploration and feedback and may require more supportive groups that build communication and coping skills without generating emotional distress.
- Clients with high degrees of neuroticism will likely require a longer course of therapy to effect meaningful change in symptoms and functioning.

We return now to our important question: Given ideal circumstances—a large number of client applicants and a wealth of information by which we can predict behavior—how then to compose the therapy group? There is no doubt that composition affects the character and process of the group, but the actual mechanism of influence has eluded full clarification.[108] At the same time, it is clear that composition is not equivalent to destiny. It is instructive to keep in mind that the therapist's skill can offset problematic and challenging relational styles among clients.[109]

We have had the opportunity to study the conception, birth, and development of more than 350 therapy groups—our own and our students'—and have been struck repeatedly by the fact that some groups seem to jell immediately, some come together more slowly, and others founder painfully or fail entirely. It also seems clear that the jelling and success of a group is only partly related to the competence or efforts of the therapist or to the number of "good" members in the group. To a degree, the critical variable is some as yet unclear blending of the members.

A clinical experience many years ago vividly crystallized this conclusion for me (IY). I was scheduled to lead a six-month experiential group of clinical psychology interns, all at the same level of training and approximately the same age. At the first meeting, over twenty participants appeared—too many for one group—and I decided to split them into two groups. I asked the participants simply to move in random fashion around the room and talk to one another and, after five minutes, to form two equal-sized groups. Thereafter, each group met for ninety minutes, one group immediately following the other.

Although the members of the two groups had much in common, it was immediately apparent that the two groups were radically different. One group assumed an extraordinarily dependent posture. In the first group meeting, I arrived on crutches with my leg in a cast because I had injured my knee in an accident a couple of days earlier. Yet the group made no inquiry about my condition. Nor did they themselves arrange the chairs in a circle. (Remember that all were mental health professionals, and most had led therapy groups!) They asked my permission for such mundane acts as opening the window and closing the door. Most of the group life was spent analyzing my aloofness and coldness and their fear of me.

In the other group, I was only halfway through the door before several members asked, “Hey, what happened to your leg?” The group moved immediately into hard work, and each of the members used his or her professional skills in a constructive manner. In this group I often felt redundant to the work and occasionally inquired about the members’ disregard of me.

This “tale of two groups” illustrates how the makeup and composition of groups dramatically influence the character of the subsequent group work. If these groups had been ongoing rather than time limited, the different environments they created might eventually have made little difference in the beneficial effect each group had on its members. In the short run, however, the members of the first group felt more tense, more deskilled, and more restricted. Had it been a therapy group, some members of this group might have felt so dissatisfied that they would have dropped out of

the group.

Another pertinent narrative occurred in a large encounter group study.[110] Two short-term groups were randomly composed but had an absolutely identical leader: a tape recording that provided instructions about how to proceed at each meeting. Hence, any variance in group outcome could not be attributed to effects of leadership. Within a few meetings, two very different cultures emerged: one group was obedient and subordinate whereas the other group was irreverent. The members of the second group mocked the tape's instructions and nicknamed the taped voice "George." Not only did the two groups evolve different cultures, but they had very different outcomes. At the end of the thirty-hour group experience (ten meetings), the irreverent (less dependent) group had an appreciably better outcome.

HOMOGENEITY OR HETEROGENEITY?

It is generally accepted clinical wisdom that intensive interactional therapy groups with the ambitious goal of deep interpersonal learning and change are more effective if their members are homogeneous in ego strength and the capacity to tolerate strong emotions, but heterogeneous in areas of conflict and interpersonal concerns.[111] Homogeneous groups, on the other hand, have many advantages if the therapist wishes to offer support for a shared problem or to help clients rapidly develop skills needed for symptomatic relief.[112] Such groups jell more quickly, become more cohesive, offer more immediate support to group members, are better attended, have less conflict, and provide more rapid relief of symptoms.

Homogeneous groups can be tailored for specific kinds of difficulties that would preclude an interactional group—for example, a skill-building group for individuals on the autism spectrum with Level 1 difficulties, many of whom may have been diagnosed previously as Asperger's.[113] Even with homogeneous groups, however, composition is not irrelevant. A seemingly homogeneous group for men with HIV, clients with Parkinson's, or women with breast cancer will be strongly affected by the stage of illness of the members. An individual with advanced disease may ignite the other members' greatest fears and lead to members' disengagement or withdrawal.[114] Even in highly specialized, manual-guided group therapies, such as groups for individuals dealing with a genetic predisposition to developing breast or colorectal cancer, the degree of member openness and capacity to care for one another will affect the group's work.[115]

The issue becomes further clouded when we ask, "Homogeneous for what?" Age? Sexual orientation? Symptoms? Ethnoracial identity? Gender? Life developmental stage? Education? Socioeconomic status? Psychiatric diagnoses? Which of these

variables are the critical ones? Is a group composed of women with bulimia, university students with social anxiety, or seniors with depression *homogeneous* because of the shared symptom, or *heterogeneous* because of the wide range of personality traits of the members? It is essential for the group leader to stay alert to these potential sources of difference and keep the uniqueness of each group member in mind. Homogeneous groups are most effective when the group leader does not homogenize the group members.

Similarly, when we look at utilizing member heterogeneity to maximize interpersonal learning, we must avoid the hazard of creating an isolate or marginalizing an individual. S. H. Foulkes and E. J. Anthony, influential group analysts, suggested blending diagnoses and disturbances to form a therapeutically effective group.[116]

Consider the age variable: If there is one seventy-year-old member in a group of young adults, that individual may choose (or be forced) to personify the older generation. He or she may be stereotyped as the "transferential parent" and not seen as an authentic individual. A similar process may occur in an adult group with a lone late adolescent who assumes the unruly teenager role. Yet there are also advantages to having a wide age spread in a group. Most of our ambulatory groups have members ranging in age from twenty-five to eighty. Through working out their relationships with other members, they come to understand their past, present, and future relationships with a wider range of significant people: parents, peers, and children. The interaction between a seventy-five-year-old man working at repairing his relationship with his estranged daughter can be powerfully informed by a forty-year-old group member reconciling her relationship with her elderly, dying father. At the same time, it is important that members do not get locked into specific roles, whether they are roles they pursue or that the group projects onto them.[117] We want the group to be a social microcosm, but one that is flexible rather than rigid.

Ethnoracial, Cultural, and Gender Diversity

Contemporary group leaders must pay great attention to group members' sexual orientation, gender identity, cultural background, and ethnoracial factors. Our therapy groups should mirror our society and should model openness and acceptance to enhance in-depth exploration into members' personal identities and desires.[118] Group members from minority and racialized backgrounds will need reassurance that they will be seen and accepted as individuals and not as stereotypes. The group participants need to be alert to the risks of micro-aggressions—inadvertent or intentional slights and indignities rooted in societal bias and privilege. Therapists must be open to learning about each client's personal sense of self in terms of sexual orientation identity and in ethnoracial and cultural terms.[119]

At times, some clients may actively avoid groups with members from their own ethnocultural background because of feelings of shame and fear of exposure within their larger community. At other times, as in the case of group therapy for veterans with posttraumatic stress disorder (PTSD), a powerful shared experience and the accompanying psychological sequelae can outweigh ethnoracial factors.[120]

What about gender and group composition? Some authors advocate single-gender groups. The group therapy research, however, does not strongly support this approach. Mixed-gender groups are clearly effective, though all-female groups may be indicated when issues of sexual abuse and shame are prominent.[121] Gender dynamics and the intertwining of the political and the personal will likely emerge in mixed-gender groups, mirroring our contemporary environment. Therapy groups may reinforce gender stereotypes or challenge them, particularly around the dynamics of power, vulnerability, and tenderness.[122] Women in general carry more positive attitudes toward group therapy than men.[123] The presence of women in groups benefits the male group members. Men in all-male groups are often less intimate and more competitive than they are in mixed-gender groups, where they tend to be more self-disclosing and less aggressive. Unfortunately, the benefit of gender heterogeneity does not always accrue to the women in these

groups: women in mixed-gender groups may become less active and more deferential to the male participants. Mixed-gender groups consisting of only one or two men and several women may result in the men feeling peripheral, marginalized, and isolated.[124]

A discussion of gender and group composition also reminds us that for many clients seeking group therapy, gender identity is nonbinary. Both trans and gender-nonconforming individuals need assurance that a safe space will exist in their groups for disclosure, exploration, and interaction. It is essential that their identity and preferred ways of being addressed are respected and honored in the group.[125]

GENERAL CLINICAL CONSIDERATIONS

Groups do better if some members are advocates of constructive group norms. Placing one or two "veterans" of group therapy into a new group may pay large dividends. Leaders must attend to the fit and the timing of entry of a new member. A challenging, controlling, and devaluing client may very much need group therapy but may overwhelm a group early in its development. Such a client is more likely to succeed in a mature and cohesive group.[126] We can sometimes predict that clients will fit poorly with a particular group at a particular time because of the likelihood that they will assume an unhealthy role in it. Consider this clinical illustration:

> **Alicia, a twenty-nine-year-old woman with prominent narcissistic** personality difficulties, was evaluated for group therapy. She was professionally successful but interpersonally isolated, and experienced chronic dysthymia that was only partially ameliorated with antidepressants. When I (IY) saw her for a pregroup consultation, I experienced her as brittle, explosive, highly demanding, and devaluing of others. In many ways, Alicia's difficulties echoed those of another woman, Lisa, who had just quit the group (thereby creating the opening for which Alicia was being evaluated). Lisa's intense, domineering need to be at the center of the group, coupled with an exquisite vulnerability to feedback, had paralyzed the group members, and her departure had been met with clear relief by all. At another time, this group and Alicia could have been a constructive fit. So soon after Lisa's departure, however, it was very likely that Alicia's characteristic style of relating would trigger strong responses of "here we go again," reawakening feelings that group members had just painfully processed. An alternative group for Alicia was recommended. **<<**

One additional clinical observation: As a supervisor and researcher, I (IY) had an opportunity to closely study an entire thirty-month course of an outpatient clinic group led by two effective psychiatric residents. The group was remarkably homogeneous in composition and consisted of seven members, all in their twenties.

Six of them were identified at the time as having schizoid personality disorder. To observers the group seemed remarkably dull, slow, and plodding. And yet attendance was nearly perfect, and group cohesiveness extraordinarily high.[127] Thorough evaluations of clinical progress were available at the end of one year and again at thirty months. The members of this group (both the original members and the replacements) did extraordinarily well and underwent both substantial characterological changes and significant symptomatic remission.

This apparently homogeneous group, contrary to the clinical dictum, did not remain at a superficial level and effected significant personality changes in its members. Although the interaction seemed lumbering to the therapists and researchers, it did not to the participants. None of them had ever had intimate relationships, and many of their disclosures, though objectively unremarkable, were subjectively exciting first-time disclosures for them.

What emerges from this illustration is the recognition that many so-called homogeneous groups remain superficial *not because of homogeneity, but because of the psychological mindset of the group leaders and the restricted group culture they fashion*. Therapists leading a group of individuals with a common symptom or life situation must be careful not to convey implicit messages that generate group norms of restriction, a search only for similarities, and discouragement of self-disclosure and differentiation. Norms, as we elaborated in Chapter 5, once set into motion, may become self-perpetuating and difficult to change.

One other perspective on composition comes from the rare, but impossible-to-forget, experience of asking a client to leave a group. In our experience, over many years, many groups, and thousands of clients, this situation has come up only a handful of times. Invariably, the clients were asked to leave their group because their participation made the group unworkable. They made the group unsafe for others by attacking, shaming, and devaluing group members. They refused to be accountable for their impact, despite much feedback, and would double down on their attacks. In

essence, these clients all assumed a similar rigid approach, stating, “I call it the way I see it and people are just being babies here.” There was no spirit of collaboration, and every therapeutic tactic employed was met with fierce resistance. The groups affected were literally withering over time, and the group leaders had no choice but to ask the offensive members to leave. In such instances the therapist still has clinical responsibility for the client and should offer a referral for further individual therapy in which the client may be able to process the events in the group.

SUMMARY: GROUP COMPOSITION

In our examination of the research and clinical literature about client selection and group composition, we are on much surer footing when discussing the selection of clients for group therapy than when discussing the composition of the therapy group. However, though there is no certainty about the best composition of groups, there are some instructive principles to guide us.

Our approach to composition is informed by our understanding of the group's tasks: First, we wish to capitalize fully on the group as a social microcosm—a miniature social universe in which members understand and improve their interactions with a variety of other individuals. Hence the group should resemble the real social universe, composed of members with varying interpersonal styles, conflicts, gender, occupations, cultural and ethnoracial backgrounds, ages, and socioeconomic and educational levels. Yet the group should be sufficiently homogeneous for its members to engage the demands of group therapy.

It is a delicate balance. If the challenges are too great, and the staying forces (the attraction to the group) too small, the individual does not change but instead physically or psychologically leaves the group. On the other hand, if the challenge is too small, no learning occurs, members will collude, and exploration will be inhibited.

Second, the group must be able to respond to members' needs both for emotional support *and* for constructive challenge. On the basis of our current knowledge, therefore, we propose *that cohesiveness be the primary guideline in the composition of therapy groups*. Cohesive groups with higher engagement generally produce better clinical outcomes than noncohesive groups.[128] Hence, group therapists must select clients with the lowest likelihood of premature termination. Individuals with a high likelihood of being irreconcilably incompatible with the prevailing group ethos and culture should not be included in the group. It bears repeating that *group cohesiveness is not synonymous with group comfort or ease. Quite the contrary: it*

is only in a cohesive group that conflict can be tolerated and transformed into productive work.

Thus, we advocate forming a group by accepting, within limits, the first suitable seven or eight candidates screened and deemed to be good group therapy candidates. We suggest having an equal number of men and women and a wide range of ages, interactional styles, and expected levels of activity and engagement.

The therapist's paramount task is to create a group that coheres. There is no question that composition radically affects a group's character. Yet, given the current state of our knowledge and clinical practice, there is no justification for spending a great deal of time and energy on delicately casting and balancing a group. We believe that therapists do better to invest their time and energy in careful selection of clients for group therapy in general, as well as in pretherapy preparation, which we will discuss in the next chapter. If the group coheres and the leaders appreciate the therapeutic factors, and are flexible and thoughtful in their leadership role, they can make therapeutic use of virtually any conditions (other than lack of motivation) that arise in the group.

Footnotes

[i] The dropout categories have substantial overlap. Many of the clients who dropped out because of problems of intimacy began to occupy a deviant role because of the manifestations of their intimacy problems.

[ii] Adding a measure of attachment to the initial evaluation can be very helpful. Although the gold standard for the measurement of attachment is an intensive, structured interview, such as the Adult Attachment Interview, simpler and quicker self-reports add value and can be accessed online at "The Self-Assessment Kiosk," Sinai Health System and University of Toronto, at Survey Gizmo, www.surveygizmo.com/s3/2998552/The-Self-Assessment-Kiosk. The Relationship Style Q, a modified form of the ECR—Experiences in Close Relationships Scale—is a well-validated attachment self-report, and the Kiosk scores it automatically and quickly, providing both quantitative and qualitative client feedback.

[iii] Psychological-mindedness is the ability to identify intrapsychic factors and relate them to one's difficulties. The Quality of Object Relations (QOR) Scale evaluates clients' characteristic manner of relating along a continuum ranging from mature to primitive.

- 9 -

Creating the Group

ONCE THE CLIENTS FOR A THERAPY GROUP ARE SELECTED, group therapists must turn their attention to launching the group.[1] First, therapists must secure an appropriate meeting place and make a number of practical decisions about the structure of their group: its size and life span, the admission of new members, the frequency of meetings, and the duration of each session. Considerations for leading psychotherapy groups online will be discussed in Chapter 14.

In addition to the therapy group itself we must also consider a second "group"—the group of colleagues who will refer clients; the administrators who support the structure required for success; and the third-party payer, insurer, or managed care organization that may be paying for the treatment.[2] Good collaboration with this second group is essential to the success of the therapy group.

Groups that meet under the auspices of an organization (for example, a community agency or hospital clinic) may be affected by that organization's culture, level of stability, and attitudes toward psychotherapy.[3]

In private practice, many practitioners publicize their clinical work and their models of therapy through the use of engaging websites and social media. Although marketing may feel commercial at first, it is merely the contemporary version of professional networking. A professional presence on Facebook, Twitter, LinkedIn, YouTube, and Instagram can inform prospective referral sources and clients of your group therapy offerings. Workshops for group therapists on using

social media to help grow their practices have become popular.[4]

Publicizing one's work is more than self-promotion. Clinicians have a responsibility to educate the public, destigmatize group therapy, and build strong clinical practice organizations with well-trained clinicians who are properly credentialed, ideally as Certified Group Psychotherapists (CGPs).[5] They must urge third-party payers to attend to the robust empirical research supporting group therapy's effectiveness. The recognition of group psychotherapy as a designated professional specialty by the American Psychological Association will elevate the status of group therapy and underscore the importance of proper group therapy training and continued professional development.[6] Many colleagues and administrators unfamiliar with group therapy tend to devalue it until they are educated about its effectiveness and its equivalence to individual therapy in outcome. Our clinical and administrative colleagues also need to understand that group therapy is a complex treatment to deliver and requires therapist expertise. Many college counseling centers, for example, have a group therapy coordinator who is responsible for informing referral sources and prospective clients about the efficacy and mechanics of therapy groups. It is constructive to have a group therapy champion in institutional settings.[7]

SETTING AND STRUCTURE

Group meetings may be held in any room that affords privacy and freedom from distractions. In institutional settings, the therapist must negotiate with the administration to establish an inviolate time and space for the therapy group. The first step of a meeting is to form a circle so that members can all see one another. To be avoided are seating arrangements that block members' views of one another, such as long, rectangular tables, or sofas that seat three or four people. If members are absent, most therapists prefer to remove the empty chairs and form a tighter circle to foster cohesion.

If the group session is to be videotaped or observed through a one-way mirror by trainees, the group members' permission must be obtained in advance and ample opportunity provided for discussion of the procedure. Written consent is essential if any audiovisual recording is planned, even if it is to be used only for supervision purposes. A group that is observed usually seems to forget about the observation after a few sessions, unless there are unresolved group issues about trust, power, or safety. If only one or two students are regular observers, we suggest seating them in the room but outside of the group circle. This avoids the intrusion of the mirror and allows the students to sample more of the group affect, which inexplicably is often filtered out by the mirror. Observers should be cautioned to remain silent and to resist any attempts by group members to engage them in the discussion. (See Chapter 16 for further discussion about group observation.)

Open and Closed Groups

The leader determines if the group is to be open or closed. A closed group, once begun, shuts its gates; accepts no new members, except perhaps within the first two or three sessions; and meets for a predetermined length of time. An open group, by contrast, maintains a consistent size by replacing members as they leave the group. Groups may have a predetermined life span—for example, groups in

a college counseling service may plan to meet only through the academic year. In other settings, many open groups continue indefinitely, even though every couple of years there may be a complete turnover of group membership—at times including leadership changes. We know of therapy groups in psychotherapy training centers that have endured for twenty or thirty years and are bequeathed every year or two by a graduating therapist to an incoming student therapist. Open groups tolerate changes in membership better if there is some consistency in leadership. One way to achieve this in the training setting is for the group to have co-therapists, and when the senior co-therapist leaves, the remaining therapist continues as the senior group leader and a new co-therapist joins.[8] Such continuity maintains the culture and cohesion of the group.

Most closed groups are briefer therapy groups that meet weekly for eight months or less. A longer closed group may have difficulty maintaining membership stability. Invariably, members drop out, move away, or face some unexpected scheduling incompatibility. Groups do not function well if they become too small, and new members must be added lest the group perish from attrition. For that reason, we advise starting closed groups with nine or ten members so that a core of six or seven is likely to remain in the group until its conclusion. A long-term closed-group format is feasible in a setting that assures considerable stability, such as a prison, a military base, and occasionally an outpatient group in which all members are concurrently in individual psychotherapy with the group leader (see Chapter 13). Some therapists lead a closed group for six months, at which time members evaluate their progress and decide whether to commit themselves to another six months.[9]

Some intensive partial hospitalization programs begin with an intensive phase of closed group therapy, which is followed by an extended, open group therapy aftercare maintenance phase. The closed phase emphasizes common concerns and acquisition of fundamental skills. The open phase aims to reduce relapse, reinforces the gains made during the intensive phase, and helps

clients apply their gains more broadly in their own social environments. Some clients may attend monthly booster group sessions indefinitely. This model has worked well in the treatment of substance abuse, trauma, and geriatric depression.[10]

Size of the Group

What is the optimal size for a successful therapy group? Our own experience and a consensus of the clinical literature suggest that the ideal size of a cohesive interactional therapy group is seven or eight members, with an acceptable range of five to nine members.[11] Louis Ormont reported good success with a group size as large as twelve to fourteen members, a model employed by some practitioners of the modern group analytic model.[12]

And the smallest size of an effective group? When a group is reduced to four or fewer members, it often ceases to operate as a group; member interaction diminishes, and therapists can find themselves engaged in individual therapy within the group. A small group is manageable over a short period due to vacations and absences, but in the long run, members disengage; many of the advantages of a group, especially the opportunity to interact and analyze one's interactions with a large variety of individuals, are compromised. Small groups become passive, suffer from stunted development, and frequently develop a negative group image.[13] Obviously, the group therapist must replace members quickly, but appropriately. If new members are unavailable, therapists do better to meld two small groups rather than to continue limping along with insufficient membership in both. Acknowledging that a group has too few members to flourish emancipates the clients and therapist for new therapeutic opportunities.

The upper limit of therapy group members is determined by sheer economic principles. As the group increases in size, less and less time is available for the working through of any individual's problems. If members do not feel they are at the center of the group, cohesion will suffer. Subgrouping may emerge as clients try to find some way

to reduce their sense of isolation in the group.[14]

Since it is likely that one, or possibly two, clients will drop out of the group in the course of the initial meetings, many therapists start a new group with eight to ten members. Starting with a group size much larger than ten in anticipation of dropouts may become a self-fulfilling prophecy. Some members will quit because the group is simply too large for them to participate productively.

Larger groups of twelve to sixteen members may meet productively in day hospital settings, because each member is likely to have many other therapeutic opportunities over the course of each week. Alcoholics Anonymous and other twelve-step groups that do not focus on interpersonal interaction (these groups in fact discourage interpersonal feedback and label it as *crosstalk*; see Chapter 13) may range from twenty to eighty participants. Psychoeducational groups for conditions such as generalized anxiety may meet effectively with twenty to thirty participants; these groups actively discourage individual disclosure and interaction, relying instead on imparting information about anxiety and stress reduction.[15] Similar findings have been reported in the treatment of panic disorder and agoraphobia as well as a range of other conditions.[16]

The large-group format has also been used with cancer patients, often accompanied by training in stress reduction and self-management of illness symptoms or medical treatment side effects. These groups may contain forty to eighty participants meeting weekly for two hours over a course of six weeks.[17] If we think of the health-care system as a pyramid, large groups of this type are part of the broad base of accessible, inexpensive treatments at the system's entry level. For many, this provision of knowledge and skills is sufficient. Clients who require more assistance may move up the pyramid to more focused or intensive interventions.[18]

A range of therapeutic factors may operate in these groups. Large homogeneous groups accept, humanize, normalize, destigmatize, activate feelings of universality, and offer skills and knowledge that enhance self-efficacy. AA groups offer inspiration, guidance, and

practical tools for dealing with the challenges of a sober life. Altruism also plays a role—helping others reinforces self-esteem and deepens a personal sense of mastery.

Duration and Frequency of Meetings

For many years, the length of a psychotherapy session has been static: the fifty-minute individual hour and the eighty- to ninety-minute group therapy session were part of the entrenched wisdom of the field. Most group therapists agree that, even in well-established groups, at least sixty minutes is required for the warm-up interval and for the unfolding and working through of the major themes of the session. There is also some consensus among therapists that after about two hours, the session reaches a point of diminishing returns: the group becomes weary, repetitious, and inefficient. Moreover, therapists appear to function best in segments of eighty to ninety minutes; with longer sessions therapists often become fatigued and less effective.

Although the frequency of meetings varies from one to five times a week, the overwhelming majority of groups meet once weekly. It is often logistically difficult to schedule multiple weekly outpatient group meetings, and few therapists have led an outpatient group that meets more than once a week. But, were it possible, we would choose to meet with groups twice weekly: such groups are more intense, the members continue to work through issues raised in the previous session, and the entire process takes on the character of a continuous meeting. Some therapists meet twice weekly for two or three weeks at the start of a time-limited group to launch the group and turbocharge its intensity before moving to a once-weekly model.[19]

Weekly sessions promote a greater therapeutic connection, whereas groups meeting less frequently have difficulty maintaining an interactional focus and instead tend to focus on life events and crisis resolution. Less frequent meetings are less efficient and result in lengthened treatment.[20] Set a meeting time that facilitates group members' attendance. Group therapists in private practice recognize

the demands of consistently working some evenings as a fact of life.

In efforts to achieve “time-efficient therapy,” group leaders have experimented with many aspects of the frame of therapy, but none more than the duration of the meeting.[21] Back in the heyday of encounter groups in the 1960s and 1970s, therapists held weekly meetings that lasted four, six, even eight hours—a protocol that now seems both worrisome and wondrous. Some group therapists referred their entire group for a weekend with another therapist or, more commonly, conducted a marathon meeting with their own group sometime during the course of therapy. The objective was to accelerate therapy by exhausting group members and mobilizing group pressure to wear down member resistance and promote deeper and deeper disclosure. The time-extended format was later adapted by such commercial enterprises as EST (Erhard Seminars Training) or Lifespring. Today, these large group awareness training programs have virtually disappeared.[22]

The therapists who still regularly or periodically hold time-extended group meetings represent a small minority of practitioners. There have been occasional recent reports of intensive, and effective, retreat weekends for various conditions, such as substance abuse, panic disorder, PTSD, and bulimia.[23] These approaches consist of a comprehensive program that includes group therapy and psychoeducation but not the intensive confrontation and fatigue characteristic of the marathon approach. Some therapists augment weekly group therapy for clients with cancer with an intensive weekend retreat for skill building, reflection, and meditation. Mindfulness group therapies often supplement weekly sessions with one or two full-day weekend meetings. But the purpose is intensive meditational practice rather than wearing down clients’ ego defenses.[24]

We make reference to the marathon movement not because it has much current usage, or to pay homage to it as a chapter in the history of psychotherapy, but because of what it reveals about how therapists make clinical practice decisions. Over the past several decades, our field has been taken by storm through a series of

ideological and stylistic fads. Reliance on the fundamentals of our work and on well-constructed systematic research is the best bulwark against being swept along and zealously embracing and then quickly discarding the fashion of the day.

Highly extravagant claims about the effectiveness of marathon group therapy were widely publicized at the time but were based entirely on anecdotal reports of various participants or on questionnaires distributed shortly after the end of a meeting—an exceedingly unreliable approach to evaluation. In fact, any outcome study based solely on interviews, testimonials, or client self-administered questionnaires obtained immediately at the end of the group is of questionable value. At no other time is the client more loyal, more grateful, and less objective about a group than at termination, when there is a powerful tendency to recall and to express only positive, tender feelings. Experiencing and expressing negative feelings about the group at this point would be unlikely for at least two reasons: (1) there is strong group pressure at termination to participate in positive testimonials—few group participants, as Solomon Asch has shown, can maintain their objectivity in the face of apparent group unanimity;[25] and (2) members reject critical feelings toward the group at this time to avoid a state of cognitive dissonance. In other words, once an individual invests considerable emotion and time into a group and develops strong positive feelings toward other members, it becomes difficult to question the value or activities of the group.

Is it possible, as is sometimes claimed, that a time-extended meeting accelerates the maturation of a therapy group, and that it increases openness, intimacy, and cohesiveness, thus facilitating insight and therapeutic breakthroughs? My (IY) colleagues and I studied this question and found that *marathon sessions at the start of a course of group therapy did not favorably influence the communication patterns in subsequent meetings*.[26] In fact, there was a trend in the opposite direction: after the six-hour meetings, the groups appeared to engage in less here-and-now interaction. The influence of the six-hour meeting on cohesiveness was quite

interesting. In the three groups that held a six-hour initial meeting, there was a trend toward *decreased* cohesiveness in subsequent meetings. In the three groups that held a six-hour *eleventh* meeting, however, there was a significant *increase* in cohesiveness in subsequent meetings. Thus, timing is a consideration: it is entirely possible that, at a particular juncture in the course of a group, a time-extended session may help increase member involvement in the group. These results showed that cohesiveness can be accelerated but not brought into being by time-extended meetings.

The marathon group phenomenon makes us mindful of the issue of transfer of learning. There is no question that the time-extended group can evoke powerful affect and can encourage members to experiment with new behavior. But does a change in one's behavior in the group invariably beget a change in one's outside life? Clinicians have long known that change in the therapy session is not tantamount to therapeutic success. Change, if it is to be consolidated, must be carried over into important outside interpersonal relationships and endeavors and tested again and again in these natural settings. Of course, therapists wish to accelerate the process of change, but the evidence suggests that it is the duration, consistency, and frequency of treatment that is central to therapy's effectiveness. *The transfer of learning is laborious and demands a certain irreducible amount of time—even more so for individuals who have had chronic mood, characterological, and interpersonal difficulties.*[27]

Consider, for example, a male client who, because of his early experience with an authoritarian, distant, and harsh father, tends to see other males, especially those in a position of authority, as having similar qualities. In the group he may have an entirely different emotional experience with a male therapist and perhaps with some of the male members. What has he learned? Well, for one thing he has learned that not all men are frightening bastards—at least there are one or two who are not. Of what lasting value is this experience to him? Probably very little unless he can generalize the experience to future situations. He must learn how to differentiate among people

so as not to perceive all men in a predetermined manner. Once he is able to make the necessary discriminations, he must learn how to go about forming relationships on an egalitarian, distortion-free basis. For the individual whose interpersonal relationships have been impoverished and maladaptive, these are formidable and lengthy tasks that often require the continual testing and reinforcement available in the long-term therapeutic relationship.

BRIEF GROUP THERAPY

Brief group therapy has become an important and widely used therapy format. Third-party insurers and therapists as well strive relentlessly for briefer, less expensive, and more efficient forms of therapy.[i] A survey of managed care administrators responsible for the health care of over seventy-three million participants noted that they were interested in the use of more groups but favored brief, problem-homogeneous, structured groups.[28] Other factors also favor brief therapy. For example, many geographic locations have high service demands and low availability of mental health professionals; here, brevity translates into greater access to services. College counseling centers use a wide range of brief, tailored group therapies to meet the growing mental health needs of their student clients.[29] Brief group therapy can also play a key role in a stepped care model: as a starting point, or setting the stage for further therapy, or sufficient in itself.

How long is "brief"? Some clinicians define brief as sixteen to twenty-five sessions, and others as fifty or sixty meetings.[30] Inpatient groups, with rapid turnover, may be thought of as having a life span of a single session. The research on cohesion suggests twelve sessions as the shortest duration for an effective brief therapy group.[31] Twelve sessions also appears to be the minimum "dose" required to ensure that at least 50 percent of clients in therapy will improve.[32] Alternately, we can offer a functional rather than a temporal definition: *A brief group is the shortest group life span that can achieve some specified goal—hence the felicitous term "time-efficient group therapy."*[33] A group dealing with an acute life crisis, such as a job loss, might last four to eight sessions, whereas a group addressing major relationship loss, such as divorce or bereavement, might require twenty or more. A group for dealing with a specific symptom complex, such as eating disorders or sexual abuse victims, might last eighteen to twenty-four sessions. A "brief" group with the

goal of changing enduring characterological problems might last twenty or more sessions.[34] There are promising approaches that are even briefer, often eight sessions, and utilize intensive preparation to identify a specific interpersonal focus for each group member to work on in the group.[35]

Explorations into the "dose-effect" of individual psychotherapy shed some light on the question of duration of therapy as it relates to patterns of improvement. This research looks at patterns of improvement over time for clients with a range of clinical concerns.[36] Although no comparable dose-effect research in group therapy has been reported, it seems reasonable to assume that there are similar patterns of response to group therapy.

Researchers note that clients who normally cope well but who are facing a crisis generally require a small number of therapy hours to achieve significant improvement. Often eight sessions or fewer are sufficient to return many clients to their precrisis level. The vast majority of clients with more chronic difficulties require about fifty to sixty sessions to improve, and those with significant personality disturbances require even more. The greater the impairment in trust and the earlier in one's development the individual has suffered loss or trauma, the greater the likelihood that brief therapy will be insufficient. Many clients with chronic depression who show initial improvement require a longer continuation phase of therapy to reduce the risk of relapse. Failure of prior brief therapies is also often a sign of the need for a longer therapy.[37] The reality that many of our clients need longer treatments is often neglected and clients are often undertreated. The actual measurement of client progress coupled with regular objective feedback about the client's experience of therapy can aid in determining how much therapy is sufficient (see Chapter 13).[38]

Whatever the precise length of therapy, all brief psychotherapy groups share many common features. They all strive for efficiency; they contract for a discrete set of goals and attempt to stay focused on goal attainment; they tend to stay in the present (with either a here-and-now focus or a "there-and-now" recent-problem-oriented

focus); they draw attention to the temporal restrictions to accelerate client engagement; they emphasize the transfer of learning from the group to the real world; their composition is often homogeneous for some problem, symptomatic syndrome, or life experience; and they focus more on *interpersonal* than on *intrapersonal concerns*.[39] Pregroup preparation, clarity about goals, attention to client culture and identity, and a clear therapeutic focus are of particular importance in brief group therapy.[40]

For some clients a brief course of group therapy may be the entire treatment, whereas for others it may be considered an installment of treatment—an opportunity to do a piece of important work, which may or may not require other installments in the future.[41] It is important that we recognize both the power and the limits of brief group therapy. Keep in mind that if the brief group therapy has been effective, it is likely that client gains will continue to consolidate after active therapy ends.[42]

When leading a brief therapy group, a group therapist is wise to heed these general principles:

- The brief group is not a truncated long-term group.[43] Group leaders must have a different mental set: they must clarify goals, focus the group, manage time, and be active and efficient. Since group members tend to deny their group's temporal limits, leaders of brief groups must act as group timekeeper, periodically reminding the group how much time has passed and how much remains. The leader should regularly make comments such as: "This is our twelfth meeting. We're two-thirds done, but we still have six more sessions. It might be wise to spend a few minutes today reviewing what we've done, what goals remain, and how we should invest our remaining time. Let's make sure we leave as little unsaid and undone as possible."
- Leaders must attend to the transfer of learning by encouraging

clients to apply what they have learned in the group to their situations outside the group. They must emphasize that treatment is intended to set change in motion, but not necessarily to complete the process within the confines of the scheduled treatment.

- Leaders should attempt to turn the disadvantages of time limitations into an advantage. Since the time-limited therapy contributions of Carl Rogers, we have known that imposed time limits may increase efficiency and energize the therapy.[44] Also, the fixed, imminent ending may be used to heighten awareness of the existential dimensions of life: time is not eternal; the immediate encounter matters; the ultimate responsibility rests within, not without: there will be no magic solution to problems.[45] This approach counters the posture of resistance common to clients of "What can we do in so short a time?" and is useful in even the briefest of groups.
- Keep in mind that the official name of the group *does not determine the work of therapy*. Just because the group is made up of recently divorced individuals or survivors of sexual abuse does not mean that the focus of the group is "divorce" or "sexual abuse." It is far more effective for the group's focus to be interactional, directed toward those aspects of divorce or abuse that have ramifications in the here-and-now of the group. For example, clients who have been abused can work on their shame, their rage, their reluctance to ask for help, their distrust of authority (often focused upon the leaders), and their difficulty in establishing intimate relationships. Groups of recently divorced members will work most profitably not by a prolonged historical focus on what went wrong in their marriages but by examining each member's problematic interpersonal issues as they manifest in the here-and-now of the group. Members must be helped to recognize and change these patterns so that they do not impair future relationships.

This may feel like an unnatural focus for clients seeking support and comfort and therefore should be anticipated and addressed in the pregroup preparation sessions. Processing *within* the here-and-now ("hot processing") is more powerful than processing external relationships outside of the group ("cold processing").[46]

- Effective group therapists should be flexible and use all means available to increase efficacy. Techniques from cognitive or behavioral therapy may be incorporated into the interactional group to alleviate symptomatic distress. For example, the leader of a group for binge eating may recommend that members explore the relationship between their moods and their eating in a written journal, or log their food consumption, or meditate to reduce emotional distress. But by no means is this the sole approach available: brief group work that focuses on the interpersonal concerns that reside beneath the food-related symptoms *is as effective as brief group work that targets the disordered eating directly*.[47] In other words, therapists can think of symptoms as issuing from disturbances in interpersonal functioning and alleviate the symptom by repairing the interpersonal disturbances.
- Time is limited, but leaders must not make the mistake of trying to save time by abbreviating the pregroup individual session. On the contrary, leaders must exercise particular care in preparation and selection.[48] The most important single error made by busy clinics is to screen new clients by phone and immediately introduce them into a group without an individual screening or preparatory session. Such an approach undermines the client's alliance with the group leader and hampers the development of group cohesion. Brief groups are less forgiving of errors than long-term groups. When the life of the group is only, say, twelve sessions, and two or three of

those sessions are consumed by attending to an unsuitable member who then drops out (or must be asked to leave), the cost is very high: the development of the group is obstructed, levels of trust and cohesion are slower to develop, and a significant proportion of the group's precious time and effectiveness is sacrificed.

- Use the pregroup individual meeting not only for standard group preparation but also to help clients reframe their problems and sharpen their goals so as to make them suitable for brief therapy.[49] Some group therapists will use the first group meeting to ask each client to present his or her interpersonal issues and treatment goals as a way of jump-starting the group.[50]

Some clinicians have sought creative ways to bridge the gap between brief and longer-term treatment. One approach is to follow the brief group with booster group sessions scheduled at greater intervals, perhaps monthly, for another six months.[51] Another approach offers clients a brief group but provides them with the option of signing on for another series of meetings. One program for clients with chronic illness consists of a series of twelve-week segments with a two-week break between segments.[52] Members may enter a segment at any time until the sixth week, at which time the group becomes a closed group. A client may attend one segment and then choose at some later point to enroll for another segment. The program has the advantage of keeping all clients, even the long-term members, goal-focused.

Are brief groups effective? Outcome research on brief group therapy has increased substantially, and for many clients, the answer is a clear *yes*. We summarize only a few notable findings here and encourage readers to examine the comprehensive summary of this literature published by the American Group Psychotherapy Association and other comprehensive reviews.[53]

An analysis of forty-eight reports of brief therapy groups (both cognitive-behavioral and dynamic/interpersonal) for the treatment of depression demonstrated that groups that met, on average, for twelve sessions produced significant clinical improvement: group members were almost three times more likely to improve than clients waiting for treatment.[54] Furthermore, therapy groups add substantially to the effect of pharmacotherapy in the treatment of depression.[55] Both expressive-interpretive groups and supportive groups for clients with loss and grief have been proven effective.[56] Meta-analyses and reviews also confirm that brief group therapy is effective for clients with binge eating disorders or with panic disorder.[57] Clients with borderline personality disorder reported improvement in mood and behavior at the end of twenty-five sessions.[58] Brief group therapy is also effective in the psychological treatment of the medically ill. It improves coping and stress management, reduces mood and anxiety symptoms, and improves self-care.[59]

How do brief and longer-term group therapy compare? A well conducted comparative trial of brief versus longer-term group analytic therapy (twenty sessions vs. eighty sessions) showed remarkable and equivalent effectiveness across a range of clinical difficulties. The briefer treatment also had much lower dropout rates. The researchers noted that the brief group therapy was more challenging to deliver well and required much higher levels of therapist activity. Not surprisingly, however, clients with personality disorders benefited more from the longer-term treatment.[60]

In sum, research demonstrates the effectiveness of brief group therapy.[61] We can lead brief groups with confidence; we know there is much we can offer clients in the brief format. But clients with evidence of chronic psychological or characterological difficulties and a history of failed brief therapies require a longer-term group. Don’t be swept away by the powerful contemporary push for efficiency at the expense of client need. One of the architects of the NIMH Collaborative Treatment of Depression Study, one of the largest

psychotherapy trials ever conducted, raised a caution that our field has likely oversold the power of brief psychotherapy.[62]

PREGROUP MEETINGS AND PREPARATION FOR GROUP THERAPY

There is great variation in clinical practice regarding individual sessions with clients prior to group therapy. Some therapists, after seeing prospective clients once or twice in selection interviews, do not meet with them individually again, whereas others continue individual sessions until the client starts in the group. If several weeks are required to accumulate sufficient members, the therapist is well advised to continue to meet with each member periodically to prevent significant attrition. At the very least we recommend a follow-up meeting closer to the start of the group, which is also an ideal time for a preparation session. Even in settings with plenty of appropriate group therapy referrals, it is important to maintain client momentum and interest. One way to do this is to set a firm start date for the group and then focus energetically on recruitment and assessment. A group leader may need to invest twenty to twenty-five hours in selection and preparation to assemble one group. It is always time well spent.

It is our clinical impression that the more often clients are seen by their group leader before entering the group, the less likely they are to terminate prematurely from the group. Often the first step in the development of bonds among group members is their mutual identification with the therapist. Keep in mind that the purpose of the individual pregroup sessions is to build a therapeutic alliance in which client and therapist agree about the goals and tasks of group therapy as well as the nature of the relationship they hope to develop. This, in turn, sets the stage for the development of group cohesion.

One other overriding task must be accomplished in the pregroup interview or interviews: *the preparation of the client for group therapy*. If we had to choose the one area where research has the greatest relevance for practice, this would be it: *There is highly persuasive evidence that pregroup preparation plays a very positive*

—even an essential—role in the course of group therapy. Group leaders must achieve several specific goals in the preparatory procedure:

- Clarify misconceptions and unrealistic fears about group therapy
- Anticipate and diminish the emergence of problems in the group's development
- Provide clients with a cognitive structure that facilitates effective group participation
- Generate realistic and positive expectations about the group therapy
- Challenge clients' stigmatizing myths and negative assumptions about group therapy

Misconceptions About Group Therapy

Certain misconceptions and fears about group therapy are so common that if the client does not mention them, the therapist should point them out as potential problems. Despite powerful research evidence on the efficacy of group therapy, many people still believe that group therapy is second-rate. Clients may think of group therapy as cheap therapy—an alternative for people who cannot afford individual therapy or a way for insurers to increase profits. Others regard it as diluted therapy because each member has only twelve to fifteen minutes of the therapist's time each week. Still others believe that the *raison d'être* of group therapy is to accommodate more clients with fewer therapists. Such misunderstandings continue to pose a challenge for many clients, even in the current era of greater public attention regarding mental health.

Let us illustrate by examining some representative surveys of public beliefs about group therapy. A number of surveys of individuals seeking mental health care, including college students and community members, identify common concerns and

misconceptions:[63]

- Group therapy is wild and unpredictable and involves a loss of personal control—for example, groups may coerce members into uncomfortable self-disclosure.
- Group therapy is not as effective as individual therapy because effectiveness is proportional to the attention received from the therapist.
- Group therapy generates greater risk of feelings of shame and rejection.
- Being in a group with many individuals with significant emotional disturbance is in itself detrimental and can worsen the mental health of vulnerable individuals.

Individual therapy is widely preferred to group therapy, particularly by men. Culture plays a role as well. Clients from non-Western and collectivist traditions may be apprehensive about public displays of emotion or of personal need. Fear of shame may be crippling.[64]

A British National Health Service study of sixty-nine moderately distressed clients seeking therapy reported that more than 50 percent declared that they would not enter group therapy even if no other treatment were available. Clients feared ridicule and shame, the lack of confidentiality, and being made worse through some form of contagion. What are some of the sources of this strong antigroup bias? For many of our clients, the natural groups that have been part of their lives have usually been “part of the problem,” not “part of the solution.” The client’s initial reaction to the idea of participating in group therapy may be recollections of bullying and marginalization. Hence, groups in general are distrusted, and the individual therapy setting is considered a more protected, safe, and familiar zone. This is particularly the case for those with no prior experience in therapy.[65]

In general, the media and fictional portrayals of group therapy are vastly inaccurate, often portraying therapy groups in a mocking,

ridiculing fashion.[ii] Reality television shows may also play a role. They speak to our unconscious fears of being exposed and extruded from our group because we are found to be defective, deficient, or are deemed to be the "weakest link."[66] Whatever their sources, such misconceptions and apprehensions must be countered; otherwise these strong negative expectations may make successful group therapy outcome unlikely.

Nor are these unfavorable expectations limited to the general public or to clients. A survey of psychiatric residents found similar negative attitudes toward group therapy.[67] Lack of exposure in psychiatry training programs is part of the problem, but the strength of resistance to remedying these training shortfalls suggests that antigroup attitudes may be deeply rooted and even unconscious. Thus, it should not surprise us to find such attitudes within institutional and administrative leadership. The biological-psychological split in current psychiatry fuels these kinds of prejudices as the field polarizes between a focus on the brain and a focus on the mind, as though these were disconnected in the experience of our clients.[68] Furthermore, the challenge of learning to lead groups is significant, and human nature often leads us to devalue that which makes us anxious.[69]

In addition to evaluative misconceptions, clients usually harbor procedural misconceptions and unrealistic interpersonal fears. Many of these are evident in the following dream that a client reported at her second pregroup individual session shortly before she was to attend her first group meeting:

> **I dreamed that each member of the group was required to bring** cookies to the meeting. I went with my mother to buy the cookies that I was to take to the meeting. We had great difficulty deciding which cookies would be appropriate. In the meantime, I was aware that I was going to be very late to the meeting, and I was becoming more and more anxious about getting there on time. We finally selected the cookies and proceeded to go to the group. I asked directions to the room and was told that it was meeting in room 129A. I wandered up and down a long hall in which the rooms were not numbered consecutively

and in which I couldn't find a room with an "A." I finally discovered that 129A was located behind another room and entered. While looking for the room, I had encountered many people from my past, schoolmates and folks I had known for years. The group was large: about forty or fifty people were milling about. I saw members of my family—most specifically, two of my brothers. Each member had to stand up and talk about their problems. The whole dream was very anxiety-provoking—especially being late and the huge number of people in the group. **<<**

Several themes are abundantly clear in this dream. The client anticipated the first group meeting with considerable dread. Her concern about being late reflected a fear of being excluded or rejected by the group. Furthermore, since she was starting in a group that had already been meeting for several weeks, she feared that the others had progressed too far, that she would be left behind and could never catch up. (She could not find a room with an "A" marked on it.) She dreamed that the group would number forty or fifty. Concerns about the size of the group are common; members fear that their unique individuality will be lost as they become one of the mass. Moreover, clients erroneously apply the model of the economic distribution of goods to the group therapeutic experience, assuming that the size of the crowd is inversely proportional to the goods received by each individual.

The dream image of each member confessing problems to the group audience reflects one of the most common and pervasive fears of individuals entering a therapy group: the horror of having to reveal oneself and confess shameful transgressions and fantasies to a large alien audience. What's more, members imagine a critical, scornful, ridiculing, or humiliating response from the other members. The experience is fantasized as an apocalyptic trial before a stern tribunal. The dream also suggests that pregroup anxiety stemmed from anxiety linked to early group experiences, including those of school, family, and play groups. It is as if her entire social network—all the significant people and groups she had encountered in her life—would be present in this group. (In a metaphorical sense, this is true: to the degree that she had been shaped by other groups and other individuals she would carry them into the group with her, since

they were part of her character structure; furthermore, she would, transferentially, re-create in the therapy group her early significant relationships.)

It is clear from the reference to room 129 (an early schoolroom in her life) that the client was associating her impending group experience with a time in her life when few things were more crucial than the acceptance and approval of a peer group. Furthermore, she anticipated that the therapist would be like her early teachers: an aloof, unloving evaluator.

Closely related to the dread of forced confession is the concern about confidentiality. The client anticipated that there would be no group boundaries, that every intimacy she disclosed would be known by every significant person in her life. Other common concerns of individuals entering group therapy, not evident in this dream, include a fear of mental contagion, of being made sicker through association with ill co-members. Often, but not exclusively, this is a preoccupation of clients with fragile ego boundaries who lack a solid, stable sense of self.

The anxiety about regression in an unstructured group and being helpless to resist the pull to merge and mesh with others can be overwhelming. In part, this concern is also a reflection of the self-contempt of individuals who project their feelings of worthlessness onto others. Such dynamics underlie the common query, “How can the blind lead the blind?” Convinced that they themselves have nothing of value to offer, some clients find it inconceivable that they might profit from others like themselves. Others fear their own hostility. They think that if they ever unleash their rage, it will engulf them as well as others. The notion of a group where anger is freely expressed is terrifying. They think silently, “If others only knew what I really thought about them.”

All of these unrealistic expectations—which, if left unchecked, lead to a rejection or a blighting of group therapy—can be allayed by adequate preparation of the client. There is compelling research evidence that addressing clients’ negative treatment expectations contributes significantly to improved treatment outcomes.[70] It is also

notable that many neophyte group therapists report similar dreams on the cusp of starting their first group.

Anticipating Common Group Problems

Before outlining a preparation procedure, we will consider four problems commonly encountered early in the course of groups that may be ameliorated by pregroup preparation.

- One important source of confusion and discouragement for clients early in therapy is *perceived goal incompatibility*. They may be unable to discern the congruence between group goals (such as group integrity, construction of an atmosphere of trust, and an interactional focus) and their individual goals (relief of suffering). What bearing, members may wonder, does a discussion of their personal reactions to other members have on their own symptoms of anxiety, depression, phobias, compulsions, or insomnia?
- *A high turnover* in the early stages of a group is, as we have discussed, a major impediment to the development of an effective group. From the very first contact with a client, the therapist should discourage irregular attendance and premature termination. We often employ the analogy of group therapy being a team sport: if you are part of the team, you have to show up. The issue is more pressing than in individual therapy, where absences and tardiness can be profitably investigated and worked through. In the initial stages of the group, irregular attendance results in a discouraged and disconnected group. It is good to discuss this issue preemptively, as it is enormously frustrating to address it in the group when the offending client is yet again absent.
- Group therapy, unlike individual therapy, often *does not offer immediate comfort*. Clients may be frustrated by not getting enough “airtime” in the first few meetings; they may feel

deprived of their specialness, or they may feel anxious about the task of direct interpersonal interaction. The therapist should anticipate and address this frustration and anxiety in the preparatory procedure. This is a particular challenge for clients who have found individual therapy to be narcissistically gratifying. It is also a challenge for clients familiar with twelve-step groups, in which interpersonal feedback or "crosstalk" are often actively discouraged.

- *Subgrouping and extragroup socializing*, which has been referred to as the Achilles' heel of group therapy, may be encountered at any stage of the group. This complex problem will be considered in detail in Chapter 11. Here it is sufficient to point out that the therapist may begin to shape the group norms regarding these group phenomena in the very first contact with the clients.

The Process of Preparation

There are many approaches to preparing clients for group therapy. The simplest and most practical in the harried world of everyday clinical practice is to offer the necessary information in the pregroup interview. We suggest setting aside sufficient time for this discussion and meeting with clients at least twice before introducing them into the group. But even if we see a client only once, we reserve at least half the time to address each of the foregoing misconceptions and initial problems of group therapy.

We share our predictions with the client about the early problems that may arise in the group and the probable emergence of familiar patterns. In addition, we present a conceptual framework and clear guidelines for effective group behavior. Each of these meetings must be individualized according to the client's presenting questions, concerns, and level of sophistication regarding the therapy process. Two situations require particular attention from the therapist: the therapy neophyte and the client with ethnocultural, diversity, and identity concerns. The client who has never been in any form of

therapy may find group therapy particularly challenging and may require additional pregroup individual preparation. Clients from non-Western cultures may be particularly threatened by the prospect of intimate personal exposure in the group. The pregroup preparation sessions provide the therapist the opportunity to explore the impact of the client's culture on his or her attitudes and beliefs and also to demonstrate the therapist's genuine willingness to enter the client's world.[71] Similar attention is required for clients with LGBTQ identity and diversity concerns. Clients who do not identify as cisgendered will need reassurance that the group will be an open and welcoming space for them.[72]

We routinely approach the preparation session with the following objectives:

- We offer a clear conceptual framework of the interpersonal basis of pathology. Keep in mind that the contemporary emphasis on the biological base of psychological disorders is disheartening to most clients. It increases stigma and helplessness. Clients' preference for therapy stems from their wish to feel active and effective in their own care and the psychosocial therapies offer that.[73]
- Describe how the therapy group addresses and corrects interpersonal problems.
- Offer guidelines about how best to participate in the group.
- Anticipate the frustrations and disappointments of group therapy, especially of the early meetings.
- Offer guidelines about duration of therapy. Make a contract about attendance in group.
- Instill faith in group therapy. Welcome your client's query—"Will this help me?" Your realistic optimism (harder, of course, to muster for neophyte therapists) can offset your clients' pessimism. The client is often seeking reassurance to counter their discouragement.

- Set ground rules about confidentiality, including communication with other providers for those clients in concurrent treatments.
- Address subgrouping and extragroup socializing.

Now, to flesh out each of these points.

First, we present clients whom we believe will benefit from group therapy with a brief explanation of the interpersonal theory of psychiatry, beginning with the statement that although each person manifests his or her problems differently, they *often have in common the basic difficulty of establishing, maintaining, or navigating close and gratifying relationships with others*. We remind them of the many times in their lives that they have undoubtedly wished to be really honest about their positive and negative feelings with someone and get reciprocally honest feedback. The general structure of society, however, does not often permit such open communication. Feelings are hurt, relationships are ruptured, misunderstandings arise, and eventually, communication ceases.

In simple, clear language we describe the therapy group as a social laboratory in which such honest interpersonal exploration is not only permitted but encouraged. If people are conflicted in their methods of relating to others, then a therapy group provides a precious opportunity to learn many valuable things about themselves. We emphasize that working on their relationships directly with other group members will not be easy; in fact, it may even be stressful. *But if they can completely understand and work out their relationships with the other group members, there will be an enormous carryover into their outside world:* they will discover pathways to more rewarding relationships with significant people in their life now and with people they have yet to meet. We remind clients not to be discouraged when their familiar patterns emerge in the group. What happens in the group mirrors life, but now with an opportunity to achieve a different outcome.

We advise members that the way to use therapy best is to be honest and direct with their immediate feelings in the group, especially their feelings toward the other group members and the

therapists. Over and over again, we emphasize this point, referring to it as the core of group therapy. We point out that the group is not a forced confessional; members have different rates of developing trust and revealing themselves. The group therapy benefits from members' risk-taking, and we urge members to try new types of behavior in the group setting.

We predict certain stumbling blocks and warn clients that they may feel puzzled and discouraged in the early meetings. At times they will not understand how working on group problems and intermember relationships can be of value in solving the problems that brought them to therapy. This puzzlement, we stress, is to be expected in the typical therapy process. We tell them that many people at first find it painfully difficult to reveal themselves or to express positive or negative feelings, and members need to resist the tendency to withdraw emotionally, hide feelings, and let others do the work of expressing feelings. We also predict that they are likely to develop feelings of frustration or annoyance with the therapist, who may not be able to supply answers to many of their questions. Help will often be forthcoming from other group members, though at the onset of the group it may be difficult to accept this fact.

For clients entering an open-ended psychotherapy group, we emphasize that the therapeutic goals of group therapy are ambitious, because we are attempting to change behavior and attitudes many years in the making. Treatment is therefore gradual. We strongly urge clients to stay with the group and to ignore any inclination to leave it before giving it a real chance. It is almost impossible to predict the eventual effectiveness of a group during the first dozen meetings. Thus, we urge clients to suspend judgment and to make a good-faith commitment to participate in at least twelve meetings before even attempting to evaluate the ultimate usefulness of the group. For clients who are entering a briefer group therapy, we say that the group offers an outstanding opportunity to do a piece of important work upon which to build in the future. Each session is precious, and it is in their interest and the interest of the other group members to attend each session.

It is vitally important for the therapist to raise expectations, to

instill faith in group therapy, and to dispel the false notion that group therapy is second-class therapy. Research tells us that clients who enter therapy expecting it to be successful will exert much greater effort in the therapy, will develop a stronger therapeutic alliance, and are significantly more likely to succeed.[74] This effect of client pretherapy expectancies is even greater for less structured therapies that may generate more client anxiety and uncertainty.[75] Therefore, we provide a brief description of the history and development of group therapy—how group therapy passed from a stage during World War II, when it was valued for its economic advantages (that is, it allowed psychotherapists to reach a large number of people in need), to its current position in the field, where it clearly has unique features to offer and is the treatment of choice for many individuals. We will add some background about our professional experience and expertise and why we believe this approach could be of value to the client and compare it to alternative treatments. We inform clients that psychotherapy outcome studies demonstrate that group therapy is as efficacious as any mode of individual therapy. We may refer them to websites such as the American Group Psychotherapy Association, which provides accessible information for consumers. Articles written independently about group therapy by group therapy participants can be particularly impactful.[76]

There are a few ground rules. Nothing is more important than honestly sharing perceptions and feelings about oneself and other members in the group. *Confidentiality* is as essential in group therapy as it is in any therapist-client relationship. For members to speak freely, they must have confidence that their statements will remain within the group. In our decades of group therapy experience, we can scarcely recall a single harmful breach of confidence and can therefore reassure group members on this matter. But the literature does report that this occurs. Ethical practice requires therapists to note that the group members, unlike the therapists, are not legally bound to confidentiality.[iii] In most jurisdictions, disclosure in group therapy does not have the protection of a privileged communication, as is the case in individual

therapy, on account of the presence of other group members. A related point is that in light of ever-increasing attention to client privacy and the stringent protections regarding client health information, we should obtain formal client consent to discuss their personal issues in the group at our therapeutic discretion, when indicated and necessary, including when the client may be absent from a session. This consent also includes communication with other providers and team members if the client is in concurrent treatment.[77]

It is important not to corrode client trust regarding confidentiality. However, at the same time, we must also inform the client of mandatory professional reporting obligations.[78] In virtually all jurisdictions the therapist must report situations in which the actions of the client are, or will imminently be, harmful to self or others. These situations may involve child mistreatment or abuse or sexual abuse of a client by a health-care professional.[79] Occasionally, members may inquire whether they can relate aspects of the group therapy discussion with a spouse or a confidant. We urge them to discuss *only* their own experience: the other members' experiences, and certainly their names, should be kept in strictest confidence.

In addition to the ground rules of honesty and confidentiality, we make a point of discussing the issue of contacts outside the group between members, which, in one form or another, will occur in every psychotherapy group. Two particularly important points must be stressed.

First, the group provides an opportunity for learning about one's problems in social relationships, and *it is not an assembly for meeting and making social friends*. Indeed, if the group is used as a source of friends it loses its therapeutic effectiveness. In other words, the therapy group teaches one *how to* develop intimate, long-term relationships, but it does not *provide* these relationships. It is a bridge, not the destination. Expect some clients to resist this. In groups that have been meeting for some weeks, we have had group clients say that they have never before felt such a close connection with another person, and they are frustrated by the limits this

contract imposes. It can be helpful to underscore that they have achieved the kind of closeness they thought would never happen—now the task is to learn as much as possible about how they created that and how they can replicate it with others outside the group.

If, by chance or design, however, members *do* meet outside the group, it is their responsibility to discuss the salient aspects of that meeting *inside* the group. It is particularly useless for therapists to prohibit extragroup socializing. Almost invariably during the therapy, group members will engage in some outside socializing, and in the face of a therapist's prohibition they may be reluctant to disclose it in the group. As we shall elaborate in Chapter 10, extragroup relationships are not harmful per se (in fact, they may be extremely important in the therapeutic process); *what impedes therapy is the conspiracy of silence that often surrounds such meetings*.

An approach of injunction and prohibition merely draws group members into the issue of rule setting and rule breaking. It is far more effective to explain why certain actions may interfere with therapy. With subgrouping, for example, we explain that friendships among group members often prevent them from speaking openly to one another in the group. Members may develop a sense of loyalty to a dyadic relationship, and may thus hesitate to betray the other by reporting their conversations back to the group. Yet such secrecy will conflict with the openness and candor so essential to the therapy process. This is a particular challenge in day treatment and partial hospitalization programs in which clients may see one another throughout the day. *The primary task of therapy group members is, we remind them, to learn as much as possible about the way each individual relates to each other person in the group.* Secrets and private alliances obstruct that goal and render the treatment less effective by creating a tentativeness or guardedness in communication. Secrets may even place some clients at risk if there are covert conversations about self-harm. Occasionally group members may wish to make a secret disclosure to the group leader. It is almost always best for the disclosure to be shared with the group. Group leaders must never agree to secrecy in advance but should instead promise to use discretion and their best clinical

judgment.

There is an important corollary. Group leaders who, in the pregroup assessment, have obtained pertinent information about a client who resists sharing in the group should not introduce that material without client permission. You may urge, encourage, even cajole the client, you may even point out the negative effects of the client withholding pertinent information, but you cannot take the step of unilaterally overriding the client's objection; doing so will damage the alliance and may well be a professional ethics violation.

This strategy of providing full information to the members about the effects of secretiveness, subgrouping, and extragroup socializing provides the therapist with far greater leverage than the strategy of the *ex cathedra* "thou shalt not." If group members engage in secretive subgrouping, you do not have to resort to the ineffectual "Why did you break my rules?" Instead you can plunge into the heart of resistance by inquiring, "How come you're sabotaging your own therapy?"

Thus far, we've emphasized *content* in our pregroup preparation of clients. We may augment that through the use of a printed handout. But we can also address the underlying *process* that may occur during the preparation meeting. The divergent responses clients have to the exact same preparation session can be illuminating with regard to key interpersonal processes. This can be particularly vivid when they are juxtaposed one after another in pregroup sessions led by the same co-therapy team.

> **After going through the content of the preparation session, Shelley,** a fifty-year-old woman with a history of chronic depression and social anxiety, commented, "I so appreciate your diligence around the entry and preparation for people into the group. I take it as a sign of how serious an undertaking this is, and it increases my sense of hope about it helping me; I feel valued and cared for." The co-therapists welcomed her spontaneous feedback and noted that she was already addressing her stated goals of taking more interpersonal risks and moving into the center of her life from the sidelines she typically inhabits.
>
> In the very next hour, the two therapists had a preparation session

with Norma, a forty-year-old single mother, also with chronic depression, who characteristically adopted a harsh, judgmental stance. She expected people to fall short and to disappoint her. Her dismissive and irritable stance throughout the preparation session was palpable, and when we asked her how the session was for her, she responded with, "Why are you wasting time doing this? You haven't told me anything that I can't read myself in the handout. Why all the rigmarole?"

The co-therapists both felt rebuked and diminished but recalled that Norma had stated that one of her goals in therapy was "learning what I do that pisses off so many people around me." One of the therapists commented that Norma seemed irritated with them, and Norma apologized for being so critical, stating that she realized the therapists were trying to be helpful. She also requested that they not just give her feedback about what she did wrong, but also try to help her change. **<<**

In summary, this cognitive approach to group therapy preparation has several goals: to provide a rational explanation of the therapy process; to describe what types of behavior are expected of group members; to establish a contract about attendance; to raise expectations about the effects of the group; and to predict (and thus to ameliorate) problems and discomfort in early meetings. Underlying the therapists' words in the preparation session is a process of demystification. Therapists convey the message that they respect the client's judgment and intelligence; that therapy is a collaborative venture; and that leaders are experts who operate on a rational basis and are willing to share their knowledge with the client. One final point is that comprehensive preparation also enables the client to make an informed decision about entering a therapy group.

Though much of this discussion is geared toward preparing clients for a long-term interactional group, its basic features may be adapted to any other type of group therapy. Brief therapy groups that rely on different therapeutic factors—for example, cognitive-behavioral groups—would require a presentation with altered details. But every therapy group profits from the preparation of its members. If clinical exigencies preclude a thorough preparation, then a short preparation is better than none at all. In Chapter 15, we describe a three-minute preparation offered at the start of an acute inpatient group.

Other Approaches to Preparation

Straightforward cognitive preparation presented to a client only once may not be sufficiently powerful. Clients are anxious during their pregroup interviews and often recall astonishingly little of the content of the therapist's message, or grossly misunderstand key points. For example, some group participants whom we asked to remain in the group for twelve sessions before evaluating its usefulness understood us to say that the group's entire life span would be twelve sessions.

Consequently, it is necessary to repeat and to emphasize deliberately many key points of the preparation both during the pregroup sessions and during the first few sessions of the group. One example: For my outpatient groups that met once a week, the weekly written summary I (IY) sent out to all the group members after each session provided an excellent forum in which to repeat essential parts of the preparation procedure.

Many therapists have described other methods of increasing the potency of the preparatory procedure. Some therapists have used another group member to orient and prepare a new member.[80] This can work well in day treatment programs. Others have used a written document for the new client to study before entering a group. In agency settings, detailed handouts can be prepared for prospective clients. In settings with long waiting lists for treatment and limited scope for preparation sessions, clients can be asked to attend a pregroup meeting focused on orientation and preparation. We can add further impact by including written handouts here as well, perhaps even with testimonials from former participants of the group program (identities concealed of course).[81] Adding a "Frequently Asked Questions" section can be very helpful. It is important to adapt materials to the culture of the community being served. In short, know your objectives and recognize that there is room to be creative. The appendix to this book contains a model of a handout for group therapy preparation.

Other preparation techniques include observation of an audiotape or videotape of meetings. For reasons of confidentiality, this must be

a professionally marketed tape in the public domain or a tape of a simulated group meeting with staff members or professional actors playing the roles of members. The scripts may be deliberately designed to demonstrate the major points to be stressed in the preparatory phase. The video “Group Therapy: A Live Demonstration” can be used in this way.[82] Orientation videos to group therapy are now also available and provide an enlivened introduction to group therapy.[83]

A 2018 study utilized client responses on the Group Therapy Questionnaire (GTQ) to identify negative attitudes and expectations about group therapy. The importance of aligning client goals with the group format and group therapy expectations was then discussed in a tailored one-hour pregroup orientation group meeting, after which clients were placed into CBT therapy groups. These pregroup preparation groups improved participation and attendance rates.[84]

An even more powerful mode of preparing clients is to provide them with personal training in desired group behavior.[85] Several experiential formats have been described. One brief group therapy team employs a two-part preparation. First, each group member has an individual meeting to establish a focus and goals for therapy. Afterward, prospective group members participate in an experiential single-session workshop at which eighteen to twenty clients perform a series of structured exercises that promote interaction and discussion of the experience, some involving dyads, some triads, and some the entire group.[86]

Another study used four preparatory sessions, each of which focused on a single concept of pregroup training: (1) using the here-and-now, (2) learning how to express feelings, (3) learning to become more self-disclosing, and (4) becoming aware of the impact one has and wishes to have on others. The researchers handed out didactic material in advance and designed structured group exercises to provide experiential learning about each concept.[87] Other projects use role playing to simulate group therapy interaction.[88]

In general, the more emotionally alive and relevant the preparation is, the greater its impact will be. Some research suggests that it is the active, experiential aspect of the pretraining, rather than the cognitive or passive, observer aspect, that may have the greatest impact.[89]

Much current preparation research focuses on the client's motivation and change readiness.[90] The focus on motivation as a target for intervention (rather than as a prerequisite for treatment) originated in the treatment of addiction and has subsequently been applied effectively for clients with eating disorders and perpetrators of sexual abuse—clinical populations in which denial and resistance to change is endemic.[91] These resistances do not dissipate readily; they require ongoing attention. Interventions that promote client motivation, such as motivational interviewing, can be readily integrated into many models of group therapy by focusing attention on the gap between the client's preferred way of being and their actual behaviors.[92]

In the future, we can expect interactive computer technology to generate even more effective preparatory programs. However, the existing approaches, used singly or in combination, can be highly effective. Consistent research evidence, to which we now turn, attests to the general effectiveness of these techniques.

Research Evidence on Pregroup Preparation

In a controlled experiment, my (IY) colleagues and I tested the effectiveness of a brief cognitive preparatory session.[93] Of a sample of sixty clients awaiting group therapy, half were seen in a thirty-minute preparatory session, and the other half were seen for thirty minutes in a conventional interview dedicated primarily to history-taking. Six therapy groups (three of prepared clients, three of unprepared clients) were organized and led by group therapists who were unaware that there had been an experimental manipulation. (The therapists believed only that all clients had been seen in a standard intake session.) A study of the first twelve meetings

demonstrated that the prepared groups had more faith in therapy than the unprepared groups and engaged in significantly more group and interpersonal interaction, and that this difference was as marked in the twelfth meeting as in the second.[94] We know that increased faith in therapy translates to improved outcomes. Moreover, the research design required that identical preparation be given to each participant. Had the preparation been more thorough and more individualized for each client, its effectiveness might have been even greater.

The basic design and results of this study—a pregroup preparation sample, which is then studied during its first several group therapy meetings and shown to have a superior course of therapy compared with a sample that was not properly prepared—has been replicated many times. The clinical populations have varied, and particular modes of preparation and process and outcome variables have grown more sophisticated. But the amount of corroborative evidence supporting the efficacy of pregroup preparation *on both group processes and client outcomes* is impressive.[95] Furthermore, few studies fail to find positive effects of preparation on clients' work in group therapy.[96] In fact, an extensive literature review concluded that proper pregroup preparation is a cornerstone of evidence-based group therapy.[97] Virtually all the research demonstrates the beneficial impact of preparation on client participation. A direct effect on global client outcome is more difficult to demonstrate, however, because the contributions of other important therapy variables obscure the effects of preparation.[98] For those readers who wish to explore the research we have summarized the studies below.

Pregroup preparation improves attendance[99] and increases self-disclosure, self-exploration, and group cohesion,[100] although the evidence for lower dropout rates is less consistent.[101] Prepared group members express more emotion than unprepared members;[102] assume more personal responsibility in a group;[103] disclose more of themselves;[104] show increased verbal, work-

oriented participation;[105] are better liked by the other members;[106] report less anxiety;[107] are more motivated to change;[108] show a significant decrease in depression;[109] improve in marital adjustment and ability to communicate;[110] are more likely to attain their primary goals in therapy;[111] and have fewer erroneous conceptions about the group procedure.[112] Even notoriously hard-to-engage populations, such as domestic abusers, respond very positively to measures aimed at enhancing attendance and participation.[113]

Some Final Comments on Pregroup Preparation

The first meetings of a therapy group are both precarious and vitally important. Many members grow unnecessarily discouraged and terminate therapy, and the group is in a highly fluid state and maximally responsive to the influence of the therapist—who has the opportunity to help the group elaborate therapeutic norms. The early meetings are a time of considerable client anxiety—both *intrinsic*, unavoidable anxiety and *extrinsic*, unnecessary anxiety. Preparation can assist in both domains.

Intrinsic anxiety issues from the very nature of the group. Individuals who have encountered lifelong disabling difficulties in interpersonal relationships will invariably be stressed by a therapy group that demands not only that they attempt to relate deeply to other members but also that they discuss these relationships with great candor. In group therapy, anxiety arises from interpersonal conflict as well as from dissonance springing from one's desire to remain in the group while at the same time feeling highly threatened by the group task. An imposing body of evidence demonstrates that there are limits to the adaptive value of anxiety in therapy.[114] An optimal degree of anxiety enhances motivation and increases vigilance, but excessive anxiety will obstruct one's ability to cope with stress. In his masterful review of the evidence supporting the innate human pursuit of mastery of one's environment, Robert White noted that excessive anxiety and fear are the enemies of environmental exploration; they impede learning and decrease

exploratory behavior in proportion to the intensity of the fear.[115] In group therapy, crippling amounts of anxiety may prevent the introspection, interpersonal exploration, and testing of new behavior essential to the process of change.

Much of the anxiety experienced by clients early in the group is not intrinsic to the group task but *extrinsic*, unnecessary, and sometimes iatrogenic. This anxiety is a natural consequence of being in a group situation in which one's expected behavior, the group goals, and their relevance to one's personal goals are exceedingly unclear.

Effective preparation for the group will reduce the uncertainty and the accompanying extrinsic anxiety by clarifying the group goals, by explaining how group and personal goals are confluent, by presenting unambiguous guidelines for effective behavior, and by providing the client with an accurate formulation of the group process.

Standards of practice add another essential component to preparation. Informed consent is particularly important. Contemporary therapists are increasingly required to document that they have provided sufficient information to their clients about treatment benefits, side effects, costs, and alternatives so that clients can make informed choices about their therapy.[116] Informed consent cannot be dispensed with in a single discussion but must be revisited on a timely basis. Obtaining informed consent is a standard of practice enshrined in the Ethics Guidelines of the American Psychological Association, the American Group Psychotherapy Association, and the American Psychiatric Association.[117] Rather than resisting it as one more bureaucratic intrusion, therapists should recognize that periodic frank discussions about the course of therapy convey respect for the client and strengthen the therapeutic alliance. This type of communication, in turn, sets the stage for effective group work.

Footnotes

i One is reminded of the farmer who attempted to train his horse to do with smaller and smaller amounts of food, but eventually lamented, “Just as I taught it to manage with no food at all, the darn critter went and died on me.”

ii It is for this very reason that I (IY) decided to write a group therapy novel, *The Schopenhauer Cure* (New York: HarperCollins, 2005), in which I attempt to offer an honest portrayal of the effective therapy group in action. We subsequently adapted the novel into a comprehensive training video about group psychotherapy. See I. Yalom and M. Leszcz, “Group Therapy: A Live Demonstration,” 2011, available at www.agpa.org.

iii The limits of confidentiality in group therapy is an area that has only recently been explored in the professional literature. There are reports of co-members being called to testify in criminal or civil proceedings, but these are extremely rare.

- 10 -

In the Beginning

THE WORK OF THE GROUP THERAPIST BEGINS LONG BEFORE the first group meeting. As we have emphasized, successful group outcome is rooted largely in the therapist's effective performance of the pretherapy tasks: proper group selection and composition, securing a proper setting, and client preparation. In this chapter we consider the birth and development of the therapy group: first, its stages of development, and then the important issues of attendance, punctuality, membership turnover, and the addition of new members.[1] As we noted earlier, the added considerations for online group therapy will be addressed in Chapter 14.

FORMATIVE STAGES OF THE GROUP

Every therapy group, with its unique cast of characters and complex interaction, undergoes a singular development. All the members begin to manifest themselves interpersonally, each creating his or her own social microcosm. In time, if therapists do their job effectively, members will begin to identify their own interpersonal styles and will eventually begin to experiment with new behavior. Given the richness of human interaction, compounded by the grouping of several individuals with problematic interpersonal styles, it is obvious that the course of a group over many months or years will be complex and, to a great degree, unpredictable. Nevertheless, group dynamic forces operate in all groups and influence their development, and it is possible to describe an imperfect but nonetheless useful schema of developmental phases. Clinicians and researchers have proposed several models of group developmental stages. All these models share a move toward greater interactional depth and complexity, encompassing four or five main stages.[2] We will address the first stages in this chapter and consider termination in the next chapter.

One well-known group developmental theory postulates five stages: forming, storming, norming, performing, and adjourning.[3] This simple, rhythmic phrase captures well the range of group development models articulated by diverse researchers and applies to both time-limited and open-ended groups.[4] Another leading model describes four stages: engagement, differentiation, interpersonal work, and termination.[5] It is best not to think of stages rigidly; as we will discuss later, many group and member factors will impact and influence the group's development. This developmental sequence requires a group duration of at least ten sessions to unfold. Group development is often accelerated in briefer groups.[6] Ongoing groups may return to earlier developmental stages as current members graduate and new ones join.

In general, groups are first preoccupied with the tasks of member engagement and affiliation, followed by a focus on control, power, status, competition, and individual differentiation. Next comes a long, productive working phase marked by intimacy, engagement, and genuine cohesion. The final stage is termination of the group. There is debate in the field whether group development is linear or cyclical, but most models share the premise that each stage is shaped by and builds upon the success of preceding ones.[7] Hence, early developmental failures will express themselves throughout the group's life. Another premise of development is that threats to group integrity will cause groups to regress from higher levels of function to less mature stages.

As group development unfolds, we see shifts in member behavior and communication. As the group matures, increased empathic, positive communication will be evident. Members describe their experience in more personal and affective and less intellectual ways. Group members focus more on the here-and-now, are less avoidant of productive conflict, offer constructive feedback, are more self-disclosing, and are more collaborative. Advice giving, a telltale sign of group immaturity, is replaced by exploration, and the group grows to be more interactional, more self-directed, and less leader centered.[8] This developmental shift to more meaningful work has also been demonstrated repeatedly in reliable studies of task and work groups and correlates significantly with enhanced productivity and achievement.[9]

There are compelling reasons for you as the therapist to familiarize yourself with the developmental sequence of groups. If you are to perform your task of assisting the group to establish therapeutic norms, and if you are to diagnose group blockage and intervene strategically to encourage healthy development, you must have a sense of both favorable and flawed development. Furthermore, knowledge of a broad developmental sequence will provide you with a sense of direction in the group; a confused and anxious leader engenders similar feelings in the group members. Familiarity with group development is essential to understanding

group process and group dynamics. The group therapist must be reliably able to address the fundamental question of *why this is happening in this way at this point*.

The First Meeting

Despite the trepidation involved in preparing for the launch of the group, the first group therapy session is invariably a success. Clients (as well as neophyte therapists) generally anticipate it with such dread that they are always relieved by the actual event. Any actions therapists take to reduce clients' anxiety and unease are generally useful. It is often helpful to call members a few days before the first meeting to reestablish contact and remind them of the group's beginning. Greeting group members outside the room before the first meeting, or posting signs in the hallway directing clients to the meeting room, are easy and reassuring steps to take. Placing a sign on the door identifying it as the group therapy meeting room reduces the risk of a late arrival missing the session over uncertainty about where the group is meeting and whether it is acceptable to enter late.

Some therapists begin the first meeting with a brief introductory statement about the purpose and method of the group (especially if they have not thoroughly prepared the clients beforehand); others may simply mention one or two basic ground rules—for example, honesty and confidentiality. Knowing that most members will be apprehensive, we like to begin with a warm welcome and convey our excitement about starting the group. Some therapists suggest that the members introduce themselves; others remain silent, knowing that invariably some member will suggest that the members introduce themselves. In Western groups, the use of first names is usually established within minutes. Then a very loud silence ensues, which, like most psychotherapy silences, seems eternal but lasts only a few seconds.

Generally, the silence is broken by the individual destined to dominate the early stages of the group, who will say, "I guess I'll get the ball rolling," or words to that effect. Usually that person then

recounts his or her reasons for seeking therapy, which often elicits similar descriptions from other members. An alternative course of events occurs when a member (perhaps spurred by the tension of the group during the initial silence) comments on his or her social discomfort or fear of groups. This remark may stimulate related comments from others who have similar feelings.

As we stressed in Chapter 5, the therapist, wittingly or unwittingly, begins to shape the norms of the group at its inception. This critical developmental task can be more efficiently performed while the group is still young. The first meeting is therefore no time for the therapist to be passive or inert.[10] Group members' anxiety will be high at the start, and it is helpful to acknowledge and normalize that. Even if the group is off to a very good start with self-disclosure and interaction, there is important work to do: the group leader's observations about what is happening in the group demystifies group therapy and reinforces pro-group behavior. A member might ask the group leader for clarification.

"This kind of interaction is so welcome but so foreign to me. What is the group's methodology? The more I can understand it, the more I can work with it," one client said in the first session of one of my groups (ML). Other group members echoed her comments, and it led to a useful exploration of the work of group therapy. Although hers was an intellectual question, it easily led to exploration of group members' feelings about group therapy and the back and forth we should expect between the *thinking* and *feeling* components of our work together.

The Initial Stage: Orientation, Hesitant Participation, Search for Meaning, Dependency

Two tasks confront members of any newly formed group. First, they must understand how to achieve their primary task—the purpose for which they joined the group. Second, they must attend to their social relationships in the group so as to create a niche for themselves. Ideally, they will forge roles that provide both the comfort and safety necessary to achieve their primary task and personal gratification

from the sheer pleasure of group membership. In many groups, such as athletic teams, health-care teams, college classrooms, and work settings, the primary task and the social task are well differentiated.[11] In therapy groups, the tasks are confluent—a fact vastly complicating the group experience of socially challenged individuals.

Several simultaneous concerns are present in the initial meetings. Members, especially if not well prepared by the therapist, search for the rationale of therapy; commonly, they may be confused about the relevance of the group's activities to their personal goals in therapy. The initial meetings are often peppered with questions reflecting this confusion. Even many weeks later, members may wonder aloud, "How is this going to help? What does all this have to do with solving my problems?"

At the same time, the members are attending to their social relationships: they size up one another and the group. They search for viable roles for themselves and wonder whether they will be liked and respected or ignored and rejected. Although clients ostensibly come to a therapy group for treatment, social forces impel them to invest energy in a search for approval, acceptance, respect, or domination. To some, acceptance and approval appear so unlikely that they defensively depreciate the group by mentally derogating the other members and by reminding themselves that the group is unreal and artificial. Clients with a dismissive attachment style may reject group engagement and dismiss others who may be eager for engagement. Many members are particularly vulnerable at this time as the push and pull for engagement and belonging is strongly activated.[12]

In the beginning, the therapist is well advised to keep one eye on the group as a whole, and the other eye on each individual's subjective experience in the group. Members wonder what membership entails. What are the admission requirements? How much must one reveal or give of oneself? At a conscious or near-conscious level, they seek the answers to questions such as these and maintain a vigilant search for the types of behavior that the

group expects and approves. Most clients crave both a deep, intimate one-to-one connection and a connection to the whole group.[13] Occasionally, however, a member with a very tenuous sense of self may fear losing his or her identity through submersion in the group. If this fear is particularly pronounced it may impede engagement. For such individuals, differentiation trumps belonging.[14]

Not only is the early group puzzled, testing, and hesitant, but it is also dependent. Overtly and covertly, members look to the leader for structure and answers as well as for approval and acceptance. Many comments and reward-seeking glances are cast at you as members seek to gain approval from authority. Your early comments are carefully scrutinized for directives about desirable and undesirable behavior. Clients appear to behave as if salvation emanated solely or primarily from you, if only they can discover what it is you want them to do. There is considerable realistic evidence for this belief: you have a professional identity as a healer, you host the group by providing a room or the online platform, you have prepared the members, and you charge a fee for your services. All of this reinforces their expectation that you will take care of them. Some therapists respond to the narcissistic stimulation of this idealization in ways that compound this belief.[15]

The existence of initial dependency thus stems from many sources: the therapeutic setting, the therapist's behavior, a morbid dependency state on the part of the client, and, as we discussed in Chapter 7, the many irrational sources of the members' powerful feelings toward the therapist. Among the strongest of these is the need for an omniscient, all-caring parent or rescuer.[16]

The content and communicational style of the initial phase tends to be relatively stereotyped, resembling the interaction occurring at a cocktail party or similar social encounters. Problems are approached rationally; clients suppress irrational aspects of their concerns in the service of support, etiquette, and group tranquility. Thus, at first, groups may endlessly discuss topics of apparently little substantive interest to any of the participants. These cocktail party issues,

however, serve as a vehicle for the first interpersonal exploratory forays. The content of the discussion is less important than the unspoken process: members size each other up and attend to such matters as who responds favorably to them, who sees things the way they do, whom to fear, whom to respect.

In the beginning, therapy groups often spend time on symptom description, previous therapy experience, medications, and the like. The members often search for similarities. They are fascinated by the notion that they are not unique in their distress, and most groups invest considerable energy in demonstrating how the members are similar. This process often offers considerable relief to members (see the discussion of universality in Chapter 1) and provides part of the foundation for group cohesiveness. These first steps set the stage for the later deeper engagement that is a prerequisite for effective therapy.[17] This early-stage comfort should not be confused with the more durable and difficult-to-attain group cohesion to follow.

Giving and seeking advice is another characteristic of the early group: clients seek advice for problems with spouses, children, employers, and so on, and the group attempts to provide some practical solutions. This guidance is rarely of functional value but serves as a vehicle through which members can express mutual interest and caring. It is also a familiar mode of communication that can be employed before members understand how to work fully in the here-and-now.

In the beginning the group needs direction and structure. The leader's support and presence promote safety and create a secure base for group members. The leader can bolster the client's therapeutic alliance by building safety and trust and offering a road map for what lies ahead. A silent, aloof leader will cause members high levels of avoidable, antitherapeutic anxiety. This phenomenon occurs even in groups of psychologically sophisticated members. In a training group of psychiatry residents led by a silent, nondirective leader, the members grew anxious during their first meeting and expressed fears of what could happen in the group and who might become a casualty of the experience. One member spoke of a

recent news report of a group of seemingly “normal” high school students who beat a homeless man to death. Their anxiety lessened when the leader commented that they were all concerned about the harmful forces that could be unleashed as a result of joining this group of seemingly “normal” psychiatry residents. Wilfred Bion, a British analyst, long ago described the primitive unconscious group forces that operate beneath and alongside the more rational and conscious group forces.[18]

The Second Stage: Conflict, Dominance, Rebellion

If the first core concern of a group is with “in or out,” then the next is with “top or bottom.”[19] In this second, “storming” stage, the group shifts from preoccupation with acceptance, approval, commitment to the group, definitions of accepted behavior, and the search for orientation, structure, and meaning to a preoccupation with dominance, control, and power. The conflict characteristic of this phase, among members or between members and leader, is what gives it its “stormy” character. Each member attempts to establish his or her preferred amount of initiative and power. Gradually, a hierarchy of control—a social pecking order—emerges.

Negative comments and intermember criticism are more frequent in this stage than in the first, and members often appear to feel entitled to a one-way analysis and judgment of others’ experiences. As in the first stage, members give advice, but in the context of a different social code; social conventions are abandoned, and members feel free to make personal critiques about other members’ behavior or attitudes. It is a time of “shoulds” and imperatives in the group, a time when the locker-room court is in session. Members make suggestions or give advice not as a manifestation of deep acceptance and understanding—sentiments yet to emerge in the group—but in the service of jockeying for status and position.

The struggle for control is part of the infrastructure of every group. It is always present: sometimes quiescent, sometimes smoldering, sometimes in full conflagration. If there are members with strong needs to dominate, control may be the major theme of the early

meetings. A covert struggle for control often becomes more overt when new members are added to the group, especially new members who do not “know their place” and, instead of paying obeisance to the older members in accordance with their seniority, make strong early bids for dominance.

The emergence of hostility toward the therapist is inevitable in the development of a group. Many observers have emphasized an early stage of ambivalence toward the therapist coupled with resistance to self-examination and self-disclosure. Hostility toward the leader has its source in the unrealistic, indeed magical, attributes with which clients secretly imbue the therapist. Their expectations are so limitless that they are bound to be disappointed by any therapist, however competent. Gradually, as group members recognize the therapist’s humanity and concern for them, reality sets in and their hostility dissipates. The group therapist must attend to managing and containing conflict without responding defensively or, worse, hostilely, to group members’ challenges. It is easier for the group leader to stay grounded if he or she understands that such conflict generally emerges from natural group developmental forces.[20]

This is by no means a clearly conscious group process. The members may intellectually advocate a democratic group that draws on its own resources, but nevertheless, on a deeper level, crave dependency and attempt first to create and then destroy an authority figure. Group therapists refuse to fill the traditional authority role: they do not provide answers and solutions; they urge the group to explore and to employ its own resources. The members’ dependency cravings linger, however, and it is usually only after several sessions that the group members come to realize that the therapist will frustrate their yearning for the ideal leader.

Yet another source of resentment toward the leader lies in the gradual recognition by each member that he or she will not become the leader’s favorite child. During the pretherapy session, each client comes to harbor the fantasy that the therapist is his or her very own therapist, intensely interested in the minute details of that client’s past, present, and fantasy world. In the early meetings of the group,

however, each member begins to realize that the therapist is no more interested in him or her than in the others. Seeds are thus sown for the emergence of rivalrous, hostile feelings toward the other group members. Echoes of prior issues with siblings may emerge, and members begin to appreciate the importance of peer interactions in the work of the group.[21]

These unrealistic expectations of the leader and consequent disenchantment are by no means a function of a childlike mentality or psychological naïveté. The same phenomena occur, for example, in groups of professional psychotherapists. In fact, there is no better way for the trainee to appreciate the group's proclivity both to elevate and to attack the leader than to be a member of a training or therapy group and to experience these powerful feelings firsthand. (We will discuss the training role of experiential learning in Chapter 16.)

The members are never unanimous in their attack on the therapist. Invariably, some champions of the therapist will emerge from the group. The lineup of attackers and defenders may serve as a valuable guide for the understanding of characterological trends useful for future work in the group. Generally, the leaders of this phase, those members who are earliest and most vociferous in their attack, are heavily conflicted in the area of dependency and have dealt with intolerable dependency yearnings by reaction formation. These individuals, initially considered counterdependents, may also have an avoidant and dismissive attachment style and are inclined to reject prima facie all statements by the therapist.[22] Some may even entertain the fantasy of unseating and replacing the leader.

For example, approximately three-fourths of the way through the first meeting of a group for clients with bulimia, I (IY) asked for the members' reflections on the meeting: How had it gone for them? Disappointments? Surprises? This is generally an effective process intervention that causes the group members to reflect on their experience. One member, who was to control the direction of the group for the next several weeks, commented that it had gone precisely as she had expected; in fact, it had been almost disappointingly predictable. The strongest feeling that she had had

thus far, she added, was anger toward me, because I had asked one of the members a question that evoked a brief period of weeping. She had felt, at that moment, “You’ll never break me down like that!” Her first reactions were very predictive of her behavior for some time to come. She remained on guard and strove to be self-possessed and in control at all times. She regarded me not as an ally but as an adversary, and was sufficiently forceful to lead the group into a major emphasis on control issues for the first several sessions.

If therapy is to be successful, counterdependent, dismissive members must at some point experience their flip side. This entails recognizing and working through deep dependency needs buried beneath the assertiveness and fear of rejection and unresponsiveness. They need to experience some comfort with belonging and asking for help. The challenge in their therapy is first to understand that their counterdependent behavior often evokes rebuke and rejection from others; only then can their wish to be nourished and protected be experienced or expressed.

Some members invariably side with the leader and they must be helped to investigate their need to defend the therapist at all costs, regardless of the issue involved. Occasionally, clients defend you because they have encountered in their past a series of unreliable care providers, and they misperceive you as extraordinarily frail; others need to preserve you because they fantasize an eventual alliance with you against other powerful members of the group. Beware that you do not inadvertently transmit covert signals of personal distress to which the rescuers appropriately respond.

Many of these conflicted feelings crystallize around the leader’s title. Are you to be referred to by professional title (“Dr. Jones”) or, even more impersonally, as “the group instructor” or “the counselor,” or by first name? We always address this issue in the preparation process and invite clients to use our first names. We link the use of first names to our wish for a flattened hierarchy in the group and to remind clients that each member of the group carries therapeutic impact and responsibility. Some members will immediately use the therapist’s first name or even a diminutive of the name before inquiring about the therapist’s preference. Others, even after the

therapist has wholeheartedly agreed to proceeding on a first-name basis, still cannot bring themselves to mouth such irreverence and continue to bundle the therapist up in a professional title. One client, a successful businessman who had been consistently shamed and humiliated in childhood by a domineering father, insisted on addressing me (ML) as “the Doctor,” because he claimed this was a way to ensure that he was getting his money’s worth. Another member also addressed me as “the Doctor” as a way to distance herself from me because, in her experience, closeness and familiarity with older men were a setup for exploitation and sexual abuse. Establishing a formal distance helped her to manage her negative transference. Later, when she began to call me by my first name, as all the other group members did, it was a big step for her, representing both greater trust and liberation from the past.

Although we have posited disenchantment and anger with the leader as a ubiquitous feature of small groups, the process is by no means constant across groups in form or degree. The therapist’s behavior may potentiate or mitigate both the experience and the expression of rebellion. What kind of leader evokes the most negative responses? Generally, it is those who are ambiguous or deliberately enigmatic; those who are authoritative yet offer no structure or guidelines; or those who covertly make unrealistic promises to the group early in therapy.[23]

This developmental stage is often difficult and personally unpleasant for group therapists. For your own comfort, you must learn to discriminate between an attack on your person and an attack on your role in the group. The group’s response to you is similar to transference distortions in individual therapy in that it is not directly related to your behavior. Its source in the group must be understood from both an individual psychodynamic and a group dynamic viewpoint. The power of multiple critical voices can be daunting even to a seasoned therapist, but it is essential that the leader explore and understand the criticism without being defensive, hostile, or blaming. If you feel you have missed the mark in your approach, own the error and repair it.[24] In so doing you model that

everyone in the group can be the focus of feedback: no one and nothing is off limits.[25] Keep in mind that group conflict may be a way for members to differentiate themselves after achieving an initial sense of belonging. Conflict can be a developmental response to members' dependent feelings. It is also an excellent time to highlight the fact that differences in perspective are welcome and will make the group an even richer experience for all. We seek to foster acceptance of difference, assertiveness, and freedom to challenge, but not destructive hostility, which may hinder the group's development into the next stage of intimacy and interpersonal work.[26]

Therapists who are particularly threatened by a group attack protect themselves in a variety of ways.[27] Once I (IY) served as a consultant for two therapy groups, each approximately twenty-five sessions old, that had developed similar problems. Both groups seemed to have plateaued, and the members seemed to have withdrawn their interest in the therapy. A study of current and recent meetings revealed that neither group had yet dealt directly with any negative feelings toward the therapists. However, the reasons for this inhibition were quite different in the two groups. In the first group, the two co-therapists (first-time leaders) had clearly exposed their throats, as it were, to the group, and, through their obvious anxiety, uncertainty, and avoidance of hostility-laden issues, pleaded frailty. In addition, they both desired to be loved by all the members and had been at all times so benevolent and so solicitous that an attack by the group members would have appeared unseemly and ungrateful.

The therapists of the second group had forestalled an attack in a different fashion: they remained aloof, Olympian figures whose infrequent, ostensibly profound interventions were delivered in an authoritarian manner. At the end of each meeting they summarized, often in unnecessarily complex language, the predominant themes and each member's contributions. To attack these therapists would have been both blasphemous and perilous.

Therapist countertransference in these two instances obstructed

the group's work. Placing one's own emotional needs ahead of the group's needs is a recipe for failure.[28] Either of these two leadership styles tends to inhibit a group: suppression of important ambivalent feelings about the therapist results in a counterproductive taboo that opposes the desired group norm of interpersonal honesty and emotional expression. Furthermore, an important model-setting opportunity is lost. The therapist who withstands an attack without being either destroyed or vindictive, but instead attempts to understand and work through the sources and effects of the attack, demonstrates to the group that aggression need not be lethal but can be expressed and understood in the group.

One of the consequences of suppression of therapist-directed anger for the two groups in question, and for most groups where this occurs, is the emergence of displaced, off-target aggression. For example, one group persisted for several weeks in attacking doctors in general. Previous unfortunate experiences with doctors, hospitals, and individual therapists were described in detail, often with considerable group consensus on the injustices and inhumanity of the medical profession. In one group, a member attacked the field of psychotherapy by bringing in a newspaper article purporting that psychotherapy is ineffective.

Scapegoating of other group members is another off-target manifestation. The roots of the concept are biblical, going back to the Book of Leviticus, where a goat is selected to carry all the sins of the people and then banished into the desert.[29] Like many group phenomena, scapegoating is often the result of the intersection of individual and group dynamics. Nonetheless, it is the group members who do not conform to the group who are most likely to become scapegoats.[30] The factors that set the scapegoated individual apart may be related to socioeconomic, political, or ethnocultural factors or to disability, gender, sexual orientation, age, or any of a host of factors that make one different from others.[31] However, scapegoating rarely persists in a therapy group without the therapist deflecting aggression away from him or herself and onto a group member (or members). Peer attack is a safer way of

expressing aggression and rivalry or of elevating one's status in the group than an attack on the therapist. Added to this dynamic is the group members' unconscious need to export and project unacceptable aspects of self, such as envy, neediness, or shame, onto a susceptible group member.

At worst, this scapegoated member can be sacrificed by the group under the covert and misguided belief that if only it were not for this one member, the group would become a utopia.[32] Be very cautious regarding that violent fantasy. The deviant voice often carries a message, wish, or fear that is covertly shared by others. The group leader should work to reduce the isolation of the scapegoat by humanizing that person and linking him or her to others in the group. Create a functional subgroup that joins the potential scapegoat with others by asking, "Is there anyone else in the group who feels what others are criticizing in this member (for example, mistrust of others' intentions, hunger for more attention, fear of vulnerability)?"[33] Do not be seduced by the idea that cohesion will arise from the extrusion of the scapegoat: that idea is illusory. Group members will feel guilt for their attack and apprehension that they could be next. Encourage group members to reflect on any attack that takes place and to reclaim their projected affects and wishes. This is not easy work, but it is therapeutically and ethically necessary.

Yet another source of group conflict originates in the intrinsic process of change. Rigidly entrenched attitudes and behavioral patterns are challenged by other members, and each individual is faced with the discomfort of discarding old patterns. This is the inevitable tear-and-repair process of psychotherapy—coming together, coming apart, and coming together again.[34]

The Third Stage: Development of Cohesiveness

A third commonly recognized formative phase of a group is the development of mature group cohesiveness. Many phrases with similar connotations have been used throughout the literature to describe this phase: in-group consciousness;[35] common goal and

group spirit;[36] consensual group action, cooperation, and mutual support;[37] group integration and mutuality;[38] we-consciousness unity;[39] and support and freedom of communication.[40] In this phase, the interpersonal world of the group is one of balance, resonance, safety, increased morale, trust, and self-disclosure.[41] Some members reveal more fully the real reason they have come for treatment: sexual secrets, past trauma, and long-buried transgressions are shared. Desires for extragroup contact begin to bubble up. Attendance improves, and clients evince considerable concern about missing members.

The chief concern of the group is with greater intimacy. If we characterize clients' concerns in the first phase as "in or out" and the second as "top or bottom," then we can think of the third phase as dealing with "near or far." The members' primary anxieties have to do with not being liked, not being close enough to others, or being too close to others.[42]

Although there may be greater freedom of self-disclosure in this phase, there may also be communication restrictions of another sort: often the group suppresses all expression of negative affect in the service of cohesion. Compared with the previous stage of group conflict, all is sweetness and light, and the group basks in the glow of its newly discovered unity.[43] Eventually, however, unless differentiation and conflict in the group are permitted to emerge, the glow will pale and the group embrace will seem ritualistic. Only when all affects can be expressed and constructively worked through in a cohesive group does the group become a mature work group—a state lasting for the remainder of the group's life, with periodic short-lived regressive recrudescence of each of the earlier phases. Thus, one may think of the maturation of cohesiveness as consisting of two phases: an early stage of great mutual support (the group against the external world), and a more advanced stage of group work, or true teamwork, in which tension emerges, not out of the struggle for dominance, but out of each member's struggle with his or her own resistances.

Group Development in Practice

Now that we have outlined the stages of group development, let us qualify our statements, lest the novice take the proposed developmental sequence too literally. The developmental phases are essentially constructs—entities that exist for the semantic and conceptual convenience of group leaders. Although the research shows persuasively, using different measures and client populations, that group development occurs, the evidence is less clear on whether there is a precise, inviolate sequence of development.

The use of measures such as the Group Climate Questionnaire (GCQ) can provide more objective monitoring of the development and function of the group by tracking the members' engagement, conflict, and avoidance.[44] The GCQ is a twelve-item self-report widely used in clinical research in both brief and longer-term group therapies (twenty sessions and eighty sessions, respectively). High engagement and lower avoidance scores are more consistently associated with better clinical outcomes. A conflict phase is by no means necessary for group development or improved therapeutic outcome, but its emergence can be usefully understood developmentally. Unsurprisingly, groups marked by low engagement and high conflict and avoidance are doomed to fail. Do not focus only on measurement at the group-wide level alone. The individual client's GCQ results are a better predictor of individual outcome than the group-wide scores are.[45] Throughout, the group leader's task is to foster engagement, reduce avoidance, and harness conflict.[46] A concluding, termination phase marked by high client engagement and low avoidance is also essential to consolidate client gains.[47]

Another approach to group development research is to track the course of particular variables such as cohesion,[48] emotionality,[49] or intimacy[50] through the course of the group. No linear course exists. In considering group development, think of replacing an automobile wheel: one tightens the bolts one after another just enough so that the wheel is in place; then the process is repeated, each bolt being tightened in turn, until the wheel is entirely secure. In the same way,

phases of a group emerge, become dominant, and then recede only to have the group return to the same issues with greater thoroughness later. Thus, it is more accurate to speak of developmental tasks than to speak of developmental phases or a predictable developmental sequence. We may, for example, see a sequence of high engagement and low conflict followed by lower engagement and higher conflict, followed, in turn, by a return to higher engagement.[51] David Hamburg suggested the term *cyclotherapy* to refer to this process of returning to the same issues but from a different perspective and each time in greater depth.[52] Often a therapy group will spend considerable time dealing with dominance, trust, intimacy, or the relationship between the co-therapists and then, months later, return to the same topics from an entirely different perspective.

The group leader is well advised to consider not only the forces that promote the group's development but also those that oppose development and have been identified as antigroup forces.[53] These common forces encompass individual and societal resistance to joining: the fear of merging; the fear of loss of one's sense of independence; the loss of one's fantasy of specialness, or the fear of being turned away.

THE IMPACT OF CLIENTS AND OTHER FACTORS ON GROUP DEVELOPMENT

The developmental sequence we have described portrays the unfolding of events in a theoretical, unpeopled therapy group. In the course of the group, we must anticipate the richness and unpredictability of human interaction, which complicates treatment and yet contributes to its excitement and challenge. Many factors will modify the group's development and alter its trajectory. Some can be anticipated; some emerge unexpectedly; but all require therapist attention.

Our experience is that group development is heavily and invariably influenced by chance—by the unique composition of each group. Often the course of the group is set by a single member, generally the one with the loudest interpersonal pathology. By *loudest* we refer not to severity of pathology but to pathology that is most immediately manifest in the group. For example, in the first meeting of a group of victims of childhood sexual abuse, a member made a number of comments to the effect that she was disappointed that so many members were present whose healing was at such an earlier state than hers. Naturally, this evoked considerable anger from the others, who attacked her for her condescending remarks. Before long, this group developed into the angriest and least caring group we had ever encountered. We cannot claim that this one member put anger into the group. It would be more accurate to say that she acted as a lightning rod to release anger that was already present in each of the participants. But had she not been in the group, it is likely that the anger may have unfolded more slowly, perhaps in a context of greater safety, trust, and cohesiveness. Groups that do not start well face a far more difficult challenge than ones that follow the kind of developmental sequence described in this chapter.

Many individuals who seek group therapy struggle with relating and engaging; indeed, that is often why they seek therapy. Many say

of themselves, “I am not a group person.” Clients with a dismissive or fearful attachment style exemplify this.[54] A group composed of several such individuals will doubtless struggle with the group tasks more than a group containing several members who have had constructive and effective experience with groups.[55] That is why, in the preceding chapter, we advised therapists to seed new groups with a veteran or two with prior constructive group experience.

Other individuals who may alter typical group developmental trends include those with monopolistic proclivities, exhibitionism, promiscuous self-disclosure, or an unbridled inclination to exert control. Not infrequently, such individuals receive covert encouragement from the therapist and other group members. Therapists value these clients because they provide a focus of irritation in the group, stimulate the expression of affect, and enhance the interest and excitement of a meeting. The other members often initially welcome the opportunity to hide behind the protagonist as they themselves hesitantly examine the terrain.

Recall the study of the dropouts of nine therapy groups, which we reviewed in Chapter 8. In five of the groups, a client with a characteristic pattern of attention-seeking behavior fled the therapy group within the first dozen meetings.[56] These clients (“early provocateurs”) differed from one another dynamically but assumed similar roles in their groups: they stormed in, furiously activated the group, and then vanished. Some of these early provocateurs were active counterdependents and challenged the therapist early in the group. One, for example, challenged the leader in the third meeting in several ways: he suggested that the members hold longer meetings and regular leaderless meetings, and, only half-jokingly, tried to launch an investigation into the leader’s personal problems. Other provocateurs prided themselves on their honesty and bluntness, mincing no words in giving the other members candid feedback. Still others, heavily conflicted in intimacy, both seeking it and fearing it, engaged in considerable self-disclosure and exhorted the group to reciprocate, often at a reckless pace. Although the early provocateurs usually claimed that they were impervious to the

opinions and evaluations of others, in fact they cared very much; in each instance, they deeply regretted the nonviable role they had created for themselves in the group.[57]

Therapists must recognize this phenomenon early in the group and, through clarification and interpretation, help prevent these individuals from committing social suicide. Perhaps even more important, therapists must recognize and discontinue their own covert encouragement of an early provocateur's behavior. They may so welcome the behavior of these clients that they fail to appreciate the client's distress as well as their own dependence on these individuals for keeping the group energized.

It is useful for therapists to take note of their reactions to the absence of the various members of the group. If some members are never absent, you may fantasize their absences and your reaction to it. Consider what thoughts, feelings, fantasies, and actions these individuals generate in you, and what they do to generate that impact.[58] If you dread the absence of certain members, feeling that there would be no life in the group that day, then it is likely that there is too much burden on those individuals, and so much secondary gratification that they will not be able to deal with their primary task in therapy. Their restricted role will inevitably undermine their therapy.

We believe much of the confusion about group development is that each group is, at the same time, *like all groups, like some groups, and like no other group! Of course*, all therapy groups go through some change as they proceed. *Of course*, there is some early awkwardness as the group deals with its *raison d'être* and its boundaries. *Of course*, this is followed by some tension and by repeated attempts to develop intimacy. And *of course*, all groups must face termination—the final phase. And from time to time, but only from time to time, one encounters a group that runs "on schedule."

Large group experiences can provide dramatic insight into the powerful dynamics of group participation and group development. I (IY) took part in a week-long Tavistock Clinic intergroup exercise in which the sixty participants were asked to form four groups in any

manner they wished and then to study their in-group relationships. The sixty participants, in near panic, stampeded from the large room toward the four rooms designated for the four small groups. Lest we forget, all sixty were mental health professionals, underlining the power of regression in unstructured groups. The panic, an inevitable part of this exercise, probably stemmed from primitive fears of exclusion from a group.[59] In the group in which I participated, the first words spoken after approximately sixteen members had entered the room were, “Close the door. Don’t let anyone else in!” Once the group’s boundaries were defined and its identity vis-à-vis the outside world established, the group turned its attention to regulating the distribution of power by speedily electing a chairman, before multiple bids for leadership could immobilize the group. Only later did the group experience and discuss feelings of trust and intimacy, and then, much later, feelings of sadness as the group approached termination.

Research also notes that in addition to leader and individual client variables, there are other factors that will influence a group’s developmental trajectory. In cultures in which collectivism and authority are held in great respect and deference, groups show less conflict and less storming and may stay in a more dependent mode.[60] I (ML) have experienced that in my cross-cultural group work in China. Group members were initially reluctant to talk to one another for fear that it would impede the authoritative leader from speaking.

Therapy groups for women influenced by women’s relational models may not experience conflict until there is a solid platform of safety and intimacy.[61] A study of brief group cognitive-behavioral therapy (CBT-G) and group interpersonal therapy for social phobia reported very little conflict and much less storming in both groups, but particularly in CBT-G. This is likely a manifestation of the avoidant nature of the primary condition that brought the members into treatment.[62] Briefer groups of fewer than ten sessions, and groups that are highly structured and may be homogeneous in composition, will not likely proceed through these developmental

stages but instead stay in a position of early engagement.[63] Structured groups that follow an agenda should include information and education about group development as part of the curriculum.[64]

In summary, there are some advantages to group therapists' possessing some broad schema of a group developmental sequence: it enables them to maintain objectivity and to chart the voyage of a group despite considerable yawing, and to recognize if a group is either not progressing past a certain stage or omitting some stage entirely. At times, therapists may demand something for which the group is not yet ready: mutual caring and concern, for example, develop late in the group; in the beginning, caring may be more pro forma, as members view one another as interlopers or rivals for the healing touch of the therapist. The therapist who is aware of normative group development is able to remain more finely attuned to the group and shape interventions accordingly.

But there is a downside to the boilerplate clinical application of group developmental ideas. The inexperienced therapist may take them too seriously and use them as a template for clinical practice. We have seen beginning therapists exert energy on forcing a group, in procrustean fashion, to progress in lockstep through set phases. Such formulaic therapy—and it grows more common with standardized therapy via treatment manual—lessens the possibility of real therapist-client engagement. The sacrifice of realness, of authenticity, in the therapeutic relationship is no minor loss: It is the loss of the very heart of psychotherapy.

Certainly, the first generations of psychotherapy manuals diminished therapists' authenticity in therapy by their slavish attention to adherence to the model. There is strong evidence that this is frankly counterproductive. More contemporary therapy manuals do less micromanaging of treatment and provide more scope for therapist flexibility and naturalness.[65]

Psychotherapy, whether with a group or with an individual client, should be a shared journey of discovery. There is danger in every system of "stages"—in the therapist having fixed, preconceived ideas and procedural protocols—in any kind of growth-oriented therapy.

In the mid-1970s, I (IY) began the first group for cancer patients with Katy Weers, a remarkable woman with advanced breast cancer. She often railed about the harm brought to the field by Elisabeth Kübler-Ross's "stages" of dying, and dreamed of writing a book to refute this concept. To experience the client against a template of stages interferes with the very thing so deeply desired by clients: "therapeutic presence."[66] Katy and I both suspected that therapists cloaked themselves in the mythology of "stages" to muffle their own death anxiety.

MEMBERSHIP PROBLEMS

The early developmental sequence of a therapy group is powerfully influenced by membership problems. Turnover in membership, tardiness, and absences are facts of life in the developing group and often threaten its stability and integrity. Considerable absenteeism may redirect the group's attention and energy away from its developmental tasks toward the problem of maintaining membership. It is the therapist's task to discourage irregular attendance and, when necessary, to replace dropouts appropriately by adding new members.

Turnover

In the normal course of events, a substantial number of members drop out of interactionally based groups in the first twelve meetings. If two or more members drop out, new members are usually added—but often a similar percentage of these additions drop out in their first dozen or so meetings. Only after membership has stabilized does the group solidify and begin to engage in matters other than those concerning group stability. Generally, by the time clients have remained in the group for approximately twenty meetings, they have made the necessary long-term commitment. In a very well conducted study, briefer groups (twenty sessions) had a much lower dropout rate (8.6 percent) than longer-term (eighty sessions) groups (33 percent). This result may reflect in part the more manageable commitment clients are asked to make to the briefer group. Some of the dropout variance reflects the heightened activity of the brief therapy group leaders, who were very mindful of the pressure of time and the need to create a cohesive group quickly.[67]

In another study of five groups, there was considerable turnover in membership within the first twelve meetings, a settling in between the twelfth and twentieth, and near-perfect attendance, with excellent punctuality and no dropouts, between the twentieth and forty-fifth

meetings (the end of the study).[68] Most studies demonstrate similar findings.[69] It is unusual for the number of later dropouts to exceed that of earlier phases.[70] In one study in which attrition in later phases was higher, the authors attributed the large numbers of later dropouts to mounting discomfort arising from the greater intimacy of the group. Some groups had a wave of dropouts, where one dropout seemed to seed others.[71] Prior or concurrent individual therapy substantially reduces the risk of premature termination.[72]

As noted, short-term groups generally report lower dropout rates.[73] In closed, time-limited groups, it is useful to start with a large enough number of clients that the group can withstand some attrition and yet be sufficiently robust for the duration of the group's course. Too large a starting size invites dropout from those individuals who will feel marginalized and peripheral to the group. Starting with nine or ten members is probably ideal in this situation.

Attendance and Punctuality

Despite the therapist's initial encouragement of regular attendance and punctuality, these difficulties usually arise in the early stages of a group. At times the therapist, buffeted by excuses from clients—childcare problems, work demands, vacations, commute difficulties, bad weather and bad traffic, work emergencies, out-of-town guests—becomes resigned to the impossibility of synchronizing the schedules of eight busy people. Resist that! Tardiness and irregular attendance usually signify resistance to therapy. When several members are often late or absent, search for the source of the group resistance; for some reason, cohesiveness is limited, and the group is foundering. If a group solidifies into a hardworking cohesive group, then—*mirabile dictu*—the scheduling problems vanish and there may be perfect attendance and punctuality for many months.

At other times, the resistance is individual rather than group based. We are continually amazed by the transformation in some individuals, who for long periods have been tardy because of "absolutely unavoidable" contingencies—for example, periodic

business conferences or family demands—and then, after recognizing and working through the resistance, become the most punctual members for months on end. One habitually late member hesitated to involve himself in the group because of shame about his bisexuality and his infidelity to his wife. After he disclosed these concerns and worked through his feelings of shame, he found that the crucial business commitments responsible for his lateness—commitments that, he later revealed, consisted of perusing his email and checking social media—suddenly evaporated.

Whatever the basis for resistance, it is behavior that must, for several reasons, be modified before it can be understood and worked through. For one thing, irregular attendance is destructive to the group. It is contagious and leads to group demoralization. This statement is supported both by clinical experience and research. A study of member attendance demonstrates that a culture of absence foredooms the group. Each absence encourages further absences. Missing one meeting increases the likelihood of that member missing a subsequent one. These absences, in turn, will undermine the more committed members, who then also begin to miss sessions.[74] Obviously, it is impossible to work on this issue when the relevant members are not present. Few exercises are more futile than addressing the wrong audience, and deploring irregular attendance with the group members who are present—the regular, punctual participants.

Occasionally, a therapeutic dilemma may emerge regarding attendance. These are situations in which the personal growth of the member may conflict temporarily with the contract of attending the group. One group member needed to miss two months of meetings because of her hard-earned return to university after twenty years of doing unvalued and poorly paid work. Returning to school was a key step in her growth, and the group members readily supported her choice.

In another situation, a young, single woman, Sara, entered group therapy to deal with chronic depression, much of which was rooted in her submission to the demands of her elderly parents and her self-

abnegation. She described spending each weekend driving up to her parents' home to shop, cook, and clean for them. Her older brothers provided virtually no meaningful support, and she initially defended them by noting that in her culture, it was the duty of unmarried daughters to care for their parents. But it grew harder for her to tolerate her anger toward her brothers, and she began to appreciate that her self-denial and self-sacrifice were feeding her depression. One group member commented that she could hardly form a significant relationship with a man if she spent every weekend with her parents. Nothing would change if she did not change it. In the here-and-now of the group, Sara began to find her voice, and she regularly began to ask for time and attention. Several months into her therapy, she asked the group if it was okay that she leave midway through the meeting to go to a concert that a friend invited her to attend. It was her favorite performer, in town for only this performance. The group's response was unanimously supportive. They recognized this as the burgeoning of Sara's ability to carve out time for herself despite feelings of obligations to others.

We stress the importance of attendance and tell clients in the preparation for group therapy that they need to treat the group time as sacrosanct. If they are in the city and not ill, then they are expected to attend the group. Group therapy is a team sport and every member must show up.

Clients who appear likely to have scheduling or transportation problems are best referred for individual therapy, as are those who must be out of town once a month or who, a few weeks after the group begins, plan an extended out-of-town vacation. Group therapy carries many unique advantages, but has no flexibility in terms of scheduling. Each session missed produces the effect of reading a novel with a chapter missing. The occasional missed chapter can be managed, but too many missed chapters will distort the understanding of the novel. Charging full fees for missed sessions is standard practice. Many private practitioners set a fixed monthly rate that is not reduced for any reason of absence.

Men who have physically abused their partners are typically resistant group members, but at the same time, there is robust

evidence that if they remain in treatment group interventions are effective. However, dropout rates of 40 to 60 percent within three months are not uncommon. Clinicians working with this population have tackled the problem of poor motivation directly with intensive pregroup training, including psychoeducational videos to increase empathy for the victims and inform abusers about the physiology and psychology of violence.[75] An even simpler intervention has also proven to be powerfully effective. In a study of 189 men, group leaders who reached out actively via phone calls, expressions of concern, and personalized alliance-building measures produced dramatic results. These simple, low-tech interventions significantly increased both attendance and tenure in both interpersonal and cognitive-behavioral group therapies and significantly reduced the incidence of domestic violence.[76] The simple act of a telephone, email, or text prompt has repeatedly been shown to increase attendance, and although it may feel like coddling or fostering dependence, it at least provides the opportunity to address the issues in person.[77]

It is critical that the therapist be utterly convinced of the importance of the therapy group and of regular attendance. The therapist who acts on this conviction will transmit it to the group members. Thus, therapists should arrive punctually, award the group high priority in their own schedule, and, if they must miss a meeting, inform the group of their absence weeks in advance. It is not uncommon to find that therapist absence or group cancellation may be followed by poor members' attendance. If you miss meetings with regularity, aside from planned vacations, you encourage group members to prioritize other competing activities as well. When launching a new group, it is wise to start after a planned therapist vacation rather than start and then miss the second or third meeting.

> **Upon arriving at a psychotherapy group for elderly men, I (ML)** discovered that half the group of eight was absent. Illness, family visits, and conflicting appointments had all conspired to diminish turnout. As I surveyed the room strewn with empty chairs, one man spoke up and suggested with some resignation that we cancel the group, since so

many members were away. My first reaction was one of quiet relief at the prospect of unexpected free time in my day. My next thought was that canceling the meeting was a terrible message to those present. In fact, the message would echo the diminishment, isolation, and unwantedness that the men felt in their lives. I suggested that it might be even more important than ever to meet today. The men actively embraced my comment as well as my suggestion that we remove the unnecessary chairs and tighten the circle so that we could hear one another better. **<<**

A member who has a poor attendance record (whatever the reason) is unlikely to benefit from the group. In a study of ninety-eight group participants, one study found that poor attendance early in the group was linearly related to later dropout (at six to twelve months).[78] Thus, inconsistent attendance demands decisive intervention.

> In a new group, one member, Dan, was consistently late or absent. Whenever the co-therapists discussed his attendance, it was clear that Dan had valid excuses: his life and his business were in such crisis that unexpected circumstances repeatedly arose to make attendance impossible. The group as a whole had not jelled; despite the therapists' efforts, other members were often late or absent, and there was considerable flight during the sessions. At the twelfth meeting, the therapists decided that decisive action was necessary. They advised Dan to leave the group, explaining that his schedule was such that the group could be of little value to him. They offered to help Dan arrange individual therapy, which would provide greater scheduling flexibility. Although the therapists' motives were not punitive, and they were thorough in their explanation, Dan was deeply offended and walked out in anger midway through the meeting. The other members, feeling extremely threatened, supported Dan to the point of questioning the therapists' authority to ask a member to leave.

Despite the initial, emotionally laden reaction of the group, it was soon clear that the therapists had made the proper intervention. One of the co-therapists phoned Dan and saw him individually for two sessions, then referred him to an appropriate therapist for individual therapy. Dan soon appreciated that the therapists were acting not punitively but in his best interests: irregularly attending a therapy group would not have been effective therapy for him. In the group, meanwhile,

attendance immediately improved, and it remained near perfect over the next several months. Once the members recovered from their fear of similar banishment, they gradually disclosed their approval of the therapists' decision and their resentment toward Dan for having treated the group in such a cavalier fashion. **<<**

Some therapists attempt to improve attendance by harnessing group pressure—for example, by refusing to hold a meeting until a predetermined number of members (usually three or four) are present. Even without formalization of this sort, the pressure exerted by the rest of the group is an effective lever to bring to bear on errant members. The group is often frustrated and angered by the repetitions and false starts necessitated by irregular attendance. The therapist should encourage the members to express their reactions to late or absent members. Be mindful, though, that the therapist's concern about attendance is not always shared by the members: a young or immature group often welcomes the small meeting, regarding it as an opportunity for more individual attention from the leader. Similarly, be careful not to punish the regular participants by withholding treatment in the process of applying group pressure on the absent members.

Like any event in the group, absenteeism or tardiness is a form of behavior that reflects an individual's characteristic patterns of relating to others. Be sure to examine the personal meaning of the client's action. If Maria arrives late, does she apologize? Does Joe enter in a thoughtless, noisy, exhibitionistic manner? Does Sally arrive late because she experiences herself as a nonentity who makes no contribution to the group's life in any event? Does Antoine come as he chooses because he believes nothing of substance happens without him anyway? Does Jess ask for a recap of the events of the meeting? Is her relationship with the group such that the members provide her with a recap? If Ronin is absent, does he call or text in advance to let the group leader know? Does he offer complex, overelaborate excuses, as though convinced he will not be believed? Not infrequently, a client's psychopathology is responsible for poor attendance. For example, one man who sought therapy

because of a crippling fear of authority figures and a pervasive inability to assert himself in interpersonal situations was frequently late because he was unable to muster the courage to interrupt a conference call with a business associate. An obsessive-compulsive client was late because he felt compelled to clean his desk over and over before leaving his office. Don't settle easily for explanations such as bad traffic on the way or subway delays if you have concerns about client resistance.

Absenteeism and lateness are part of the individual's social microcosm and, if handled properly, may be harnessed in the service of self-understanding. For both the group's and the individual's sake, however, *they must be corrected before being analyzed*. No feedback can be heard by an absent group member. In fact, the therapist must attend to the timing of his comments to the returning member. Clients who have been absent or are late often enter the meeting with some defensive guilt or shame and are not in an optimal state of receptiveness for immediate observations about their behavior. The therapist does well to attend first to group maintenance and norm-setting tasks, and then, later, when the timing seems right and defensiveness has diminished, to attempt to help the individual explore the meaning of his or her behavior. The timing of feedback is particularly important for members who have greater psychological vulnerability and mistrust of relationships.[79]

Group members who must miss a meeting or arrive late should, as they were advised in pregroup preparation, alert the therapist in advance, in order to spare the group the tendency to waste time expressing curiosity or concern about their absence. Often, in advanced groups, the fantasies of group members about why someone is absent can provide valuable material for the therapeutic process; in early groups, however, such speculations tend to be superficial and unfruitful, and may be needlessly anxiety provoking.

An important adage of interactional group therapy, which we emphasize throughout this book, is that any event in the group can serve as grist for the interpersonal mill. Seize the opportunity that each new constellation of members creates through a change in the

group dynamics. As this vignette demonstrates, the absence of a member can generate important, previously unexplored material:

> **A group composed of four women and three men held its eighth** meeting in the absence of two of the men. Albert, the only male present, had previously been withdrawn and submissive in the group, but in this meeting a dramatic transformation occurred. He erupted into activity, talked about himself, questioned the other members, spoke loudly and forcefully, and, on a couple of occasions, challenged the therapist. His nonverbal behavior was saturated with quasi-courtship bids directed at the women members: for example, frequent adjustment of his shirt collar and stroking his beard. Later in the meeting, the therapist engaged the group in processing Albert's change, and Albert realized and expressed his fear and envy of the two missing males, both of whom were aggressive and assertive. He had long experienced a pervasive sense of social avoidance and failure, which was reinforced by his feeling that he never made a significant impact on groups of people, especially groups of women. In subsequent weeks, Albert did valuable work on these issues, now in the presence of his rivals—issues that might not have become accessible for many months without the chance absence of the two other male group members on the same day. **<<**

Our clinical preference is to encourage attendance but never, regardless of how small the group is, to cancel a session. There is considerable therapeutic value for the client in knowing that the group is always there, that it is stable and reliable; indeed, its constancy will in time beget constancy of attendance. We have held meetings with very small numbers when a confluence of legitimate factors, such as planned summer vacations, conspires to reduce attendance over a period of one or two weeks—even with as few as two members. These meetings proved to be critical for those attending. The technical problem with such meetings is that without the presence of interaction, the therapist may often revert to focusing on intrapsychic processes in a manner characteristic of individual therapy and forgo group and interpersonal issues. It is far more therapeutically consistent to focus in-depth on group and interpersonal processes, even in the smallest of sessions. Consider

the following clinical example from a ten-month-old group:

> **For various reasons—vacations, illnesses, resistance—several** members of one of my (IY) groups were absent for one session, and only two members and I attended. The two members were Wendy, a depressed thirty-eight-year-old woman with borderline personality disorder, and Martin, a twenty-three-year-old man who was socially avoidant and highly immature.
>
> Wendy spent much of the early part of the meeting describing the depth of her despair, which during the past week had reached such proportions that, preoccupied with suicide, she had gone to the hospital emergency room. While there, she had surreptitiously read her medical chart, which contained a consultation note I had written a year earlier. I had diagnosed her with borderline personality disorder in the note, and Wendy said she had been anticipating this diagnosis, and now she wanted to be hospitalized.
>
> Martin then recalled a fragment of a dream he'd had several weeks before but had not yet discussed. In the dream, I was sitting at a large desk interviewing him, and Martin stood up and looked at the paper on which I was writing. There he saw in huge letters one word covering the entire page: IMPOTENT. I helped both Wendy and Martin discuss their feelings of awe, helpless dependence, and resentment toward me as well as their inclination to shift responsibility and project their bad feelings about themselves onto me.
>
> Wendy proceeded to underscore her sense of helplessness by describing her inability to cook for herself and her delinquency in paying her bills, which was so extreme that she now feared legal action against her. Martin and I commented on her persistent reluctance to talk about her positive accomplishments—for example, her continued excellence as a teacher. I wondered aloud whether her presentation of herself as helpless was not designed to elicit responses of caring and concern from the other members and me—responses that she felt would be forthcoming in no other way.
>
> Martin then mentioned that he had gone to the medical library the previous day to read some of my professional articles. In response to my question about what he really wanted to find out, Martin answered that he guessed what he really wanted to know was how I felt about him. He proceeded to describe, for the first time, his longing for my sole attention and love.
>
> Later, I expressed my concern about Wendy reading my note in her medical record. I candidly discussed both my own discomfort at having

to use diagnostic labels for hospital records and the confusion surrounding psychiatric diagnostic terminology. I explained as best I could my reasons for using that particular label and its implications.

Wendy then commented on the absent members and wondered whether she had driven them from the group (a common reaction). She dwelled on her unworthiness and, at my suggestion, made an inventory of her destructive characteristics, citing her slovenliness, selfishness, greed, envy, and hostile feelings toward all those in her social environment. Martin both supported Wendy and identified with her, since he recognized many of these feelings in himself. He discussed how difficult it was for him to reveal himself in the group with others present.

Later, he discussed his fear of getting drunk or losing control in other ways: for one thing, he might become indiscreet sexually. He then discussed, for the first time, his fear of sex, his inability to maintain an erection, and his last-minute refusals to take advantage of sexual opportunities. Wendy empathized deeply with Martin; although she had for some time regarded sex as abhorrent, she expressed a strong wish (a wish, not an intention) to help him by offering herself to him sexually. Martin then described his strong sexual attraction to her, and later both he and Wendy discussed their sexual feelings toward the other members of the group.

I commented that Wendy's interest in Martin and her desire to offer herself to him sexually belied many of the items in her inventory: her selfishness, greed, and ubiquitous hostility to others. This observation subsequently proved to be of great therapeutic importance to Wendy. **<<**

Although only two members were present at this meeting, they met as a group and not as two individual clients. The other members were discussed in absentia, and previously undisclosed interpersonal feelings between the two clients and toward the therapists were expressed and analyzed. It was a valuable session, deeply meaningful to both participants. It is worth noting again here that talking about group members in their absence is not "talking behind people's backs." A member's absence cannot dictate what gets addressed by those in attendance, although it is essential that absent members be brought back into the loop upon their return. As with extragroup contact, that discussion is less of a problem than

secretiveness about it would be.

Dropouts

There is no problem more threatening for the neophyte group therapist (and for many experienced therapists for that matter) than the dropout from group therapy. Dropouts concerned me (IY) greatly when I first started to lead groups, and my first group therapy research was a study of all the group participants who had dropped out of the therapy groups in a large psychiatric clinic.[80] It is a significant issue. As we discussed earlier, the group therapy demographic research demonstrates that a substantial number of clients will leave a group prematurely regardless of what the therapist does. In fact, some clinicians suggest that dropouts are not only inevitable but necessary in the sifting process involved in achieving a cohesive group.[81] But we believe that we should always aim to reduce dropout rates even as we acknowledge their inevitability. Aim to reduce but not eliminate dropouts. If you have no dropouts, you may be setting the bar for admission into your groups too high and sidelining some clients who could be helped in your groups.

Consider, too, that the existence of an escape hatch may be essential to allow some members to make their first tentative commitments to the group. The group must have some decompression mechanism; mistakes in the selection process are inevitable, unexpected events occur in the lives of new members, and group incompatibilities develop.

There are various reasons for premature termination, as we will briefly review here. Consider the dropout phenomenon from the perspective of the interaction of three factors: the client, the group, and the therapist.[82] In general, client factors stem from problems caused by client deviancy, severe interpersonal deficits and conflicts in intimacy and disclosure, the role of the early provocateur, external life stress, inability to share the leader, and fear of emotional contagion. Misaligned client expectations also may play a large role through a negative impact on the therapeutic alliance. All these

factors will be amplified by the potential stress of early group development. Potential dropouts are exposed to unaccustomed demands for candor and intimacy; they are often confused about the group procedures; they believe that the group activities bear little relevance to their problems; and, finally, they feel too little support in the early meetings. Group factors include the consequences of subgrouping, poor compositional matches among clients, scapegoating, member-member impasses, or unresolved conflict.

The therapists also play an essential role. What errors do therapists make that increase the risk of dropouts? They may select members too hurriedly; they may not prepare members adequately; they may not attend to building group cohesion and addressing group developmental tasks; they may neglect cultural and diversity issues; and they may be influenced by unresolved countertransference reactions.[83] Research shows that there can be a fourfold difference between therapists in the rate of clients dropping out of individual therapy, and we suspect the same is true for group therapists.[84] Even the organizational setting contributes if it creates an unstable environment that compromises therapist morale and undermines the value of the clinical work.[85]

As we discussed earlier, the two most important methods of decreasing the dropout rate are proper selection and comprehensive pretherapy preparation. Both actions foster a stronger therapeutic alliance, a powerful predictor of good outcomes.[86] It is especially important that in the preparation procedure, the therapist make it clear that periods of discouragement are to be expected in the therapy process. Clients are less likely to lose confidence in a therapist who appears to have the foreknowledge that stems from experience. In fact, the more specific the prediction, the greater its power. For example, it may be reassuring to socially anxious and phobic individuals to anticipate that there will be times in the group when they will wish to flee, or will dread coming to the next meeting. The therapist can emphasize that the group is a social laboratory and suggest that the client has the choice of making the group yet another instance of failure and avoidance or, for the first time,

staying in the group and experimenting, in a low-risk situation, with new behaviors. We have often told clients in pregroup meetings that there will be times when the last place they want to be is in the group. “Try to welcome that discomfort,” we tell them. “Alert us to it, as it may be a sign of you hitting on a key point in your therapy.” Often groups contain experienced group members who assume some of this predictive function, as demonstrated in the following case:

> **One group graduated several members and was reconstituted by** adding five new members to the remaining three veteran members. In the first two meetings, the old members briefed the new ones and told them, among other things, that by the sixth or seventh meeting some member would decide to drop out, and then the group would have to drop everything for a couple of meetings to persuade him to stay. The old members went on to predict which of the new members would be the first to decide to terminate. Rendered with compassion and the wish to retain the new members, this form of prediction is a most effective manner of ensuring that it is not fulfilled. **<<**

Despite painstaking preparation, many clients will still consider dropping out. When a member informs a therapist that he or she wishes to leave the group, a common approach is to urge the client to attend the next meeting to discuss it with the other group members. Underlying this practice is the assumption that the group will help the client work through resistance and thereby dissuade him or her from terminating. This approach, however, is rarely successful. In one study of thirty-five dropouts from nine therapy groups (with a total original membership of ninety-seven clients), we found that *every SINGLE one of the dropouts had been urged to return for another meeting, but not once did this final session avert premature termination*.[87] In short, asking the client who has decided to drop out to return for a final meeting is usually an ineffective use of group time. The exception to this rule is the client who believes himself to be undesirable and worthless and hopes the group will disconfirm his beliefs. Many clients approach therapy with juxtaposed dread and hope: *dread* of repetition of their poor

relationship experiences and *hope* that this time it might be different.[88] Even when the dropout is very critical of the group, there may be deeply hidden wishes to be embraced by the group.

After dropping out of a group and rejecting the offer of a follow-up individual session with me (ML), one woman asked for a consultation several months later regarding a question about a change in her antidepressants. We addressed the matter quickly and then moved on to discuss her departure from the group. Much to my surprise, she spent most of the rest of our session expressing disappointment that there had been no goodbye card for her at her last meeting, which she had seen at a prior departure by another member. I was surprised by the depth of her emotion, which she had previously concealed from the group, and I acknowledged that we had been unaware of her well-concealed hope for acceptance by the group despite her evident rejection of the group.

Generally, the therapist is well advised to see a potential dropout for a short series of individual interviews to discuss the sources of group stress. A therapeutic impasse may present a unique therapeutic opportunity: impasses arise at critical points when core wishes and fears are activated and the client feels it is unsafe or useless to proceed.[89] Occasionally an accurate, penetrating interpretation will keep a client in therapy.

> **Joseph, a socially avoidant man with a profound sense of alien**ation, announced in the eighth meeting that he felt he was getting nowhere in the group and was contemplating termination. In an individual session set up before the next group, he told me (IY) something he had been unable to say in the group—namely, that he had many positive feelings toward a couple of the group members. Nevertheless, he insisted that the therapy was ineffective and that he desired a more accelerated and precise form of therapy.
>
> I correctly interpreted Joseph's intellectual criticism of the group therapy format as a rationalization: he was, in fact, fleeing from the closeness he had felt in the group. I again explained the social microcosm phenomenon and informed Joseph that he was repeating his lifelong style of relating to others in the group. Joseph had always avoided or fled intimacy, and he no doubt would always do so in the

future unless he stopped running and allowed himself the opportunity to explore his interpersonal problems in vivo. The intervention was successful. Joseph continued in the group and eventually made considerable gains in therapy. **<<**

In general, the therapist can decrease premature terminations by attending assiduously to early-phase problems. We will have much to say later in this text about self-disclosure, but for now keep in mind that outliers—excessively active members and excessively quiet members—are both dropout risks. Try to keep client self-disclosure balanced and well-paced. It may be necessary to slow down the client who too quickly reveals deeply personal details in the very first sessions. Try to help the client shift from *vertical* disclosure of the details of their life to *horizontal* disclosure that examines how it feels to open these issues up with the members of the group. The client will not feel silenced and yet will not overexpose herself. It converts self-disclosure into an interpersonal engagement. On the other hand, members who remain silent session after session may become demoralized: each session of silence makes it exponentially harder for these group members to return and talk at the next session.

Negative feelings, misgivings, and apprehensions about the group or the therapeutic alliance must be openly addressed and not pushed underground. Moreover, the expression of positive affects should also be encouraged and, whenever possible, modeled by the therapist.[90] This is part of your norm-setting role. In one session of supervision, the co-therapists reported that the meeting (the sixth of twenty-eight sessions) went so well that they remained quiet and felt they had little to add. I (ML) challenged them, noting that though the group indeed was working well, there was more they could do to reinforce the group's work and norms. Could they share their reactions and ask the group to reflect on this session to foster the continuation of that good work? They could help the group discuss the experience of clients' risk-taking; the quality of the feedback they provided to each other; their high level of care for one another; their taking responsibility for the work; and other related pro-group

themes.

Inexperienced therapists are particularly threatened by the client who expresses a wish to drop out. They begin to fear that, one by one, their group members will leave, and that they will one day come to the group and find themselves alone in the room. (And what, then, do they tell their group supervisor?) Therapists for whom this fantasy truly takes hold cease to be therapeutic to the group. The balance of power shifts. They feel blackmailed. They begin to be seductive, cajoling—anything to entice the clients back to future meetings. Once this happens, of course, any therapeutic leverage is lost entirely.

After struggling in our own clinical work with the problem of group dropouts over many years, we have finally achieved some resolution on the issue. By shifting our personal attitude, we have fewer group therapy dropouts. But we do have more group therapy throw-outs! We do not mean that we frequently ask members to leave a therapy group, but we are perfectly prepared to do so if it is clear that the member is not working in the group. We are persuaded (from our clinical experience and from empirical research findings) that group therapy is a highly effective mode of psychotherapy. If an individual is not going to be able to profit from it, then we want to get that person out of the group and *into a more appropriate mode of therapy*, and bring someone else into the group who will be able to use what the group has to offer.

This method of reducing dropouts reflects a posture on the part of the therapist that increases the commitment to work. Once you have achieved this particular mental set, you communicate it to your clients in direct and indirect ways. You convey your confidence in the therapeutic modality and your expectation that each client will use the group for effective work.

Removing a Client from a Group

Taking a client out of a therapy group is an act of tremendous significance for both that individual and the group and as such it must be approached thoughtfully. Once a therapist determines that a

client is not working effectively, the next step is to identify and remove all possible obstacles to the client's productive engagement in the group. If the therapist has done everything possible yet is still unable to alter the situation, there is every reason to expect one of the following outcomes: (1) the client will ultimately drop out of the group without benefit (or without further benefit); (2) the client may be harmed by further group participation (because of negative interaction or the adverse consequences of the deviant role); or (3) the client will substantially obstruct the group work for the remaining group members. Hence, it is folly to adopt a laissez-faire posture: *The time has come to remove the client from the group.*

How? There is no adroit, subtle way to remove a member from a group. Often the task is better handled in an individual meeting with the client than in the group. The situation is so anxiety-provoking for the other members that generally the therapist can expect little constructive group discussion; moreover, an individual meeting reduces the member's public humiliation. Is it helpful to invite the client back for a final meeting to work things through with the group? That is generally not a useful option: if the individual were able to work things through in an open, nondefensive manner, there would have been no need to ask him or her to leave the group in the first place.

Whenever you remove a client from a group, you should expect a powerful reaction from the rest of the group. The ejection of a group member stirs up deep levels of anxiety in the others associated with primal fears of rejection or abandonment. You may get little support from the group, even if there is unanimous agreement among the members that the client should have been asked to leave. Even if, for example, the client consistently disrupted the entire group, the members will still feel threatened by your decision.

There are two possible interpretations the members may give to your act of removing the member. One interpretation is rejection and abandonment: that is, that you did not like the client; you resented him, you were angry, you're an authoritarian and a bully, and you wanted him out of the group and out of your sight. Who might be next?

The other interpretation (the correct one, let us hope) is that you are a responsible mental health professional who acted in the best interests of that client and of the remaining group members. Every individual's treatment regimen is different, and you made a responsible decision about the fact that this form of therapy was not suited to a particular client at this particular moment. Furthermore, you acted in a professionally responsible manner by ensuring that the client would receive another form of therapy more likely to be helpful. No single effective treatment works universally well for all. It is as true for psychotherapies as for biological therapies.

The remaining group members often lean toward the first—the "rejection"—interpretation. Your task is to help them arrive at the second interpretation. You may facilitate the process by making the reasons for your actions clear and sharing your decisions about future therapy for the extruded client, such as individual therapy with you or a referral to a colleague. Be mindful of privacy limitations in this situation. You can certainly be transparent about your own thinking, but do safeguard the client's personal information unless you have clear consent to disclose it.

Occasionally, the group may receive the decision to remove a member with relief and appreciation. A sexually abused woman described the removal of a sadistic, destructive male group member as the first time in her life that the "people in charge" were not helpless or blind to her suffering.

The Departing Member: Therapeutic Considerations

When a client is asked to leave or chooses to leave a group, the therapist must endeavor to make the experience as constructive as possible. Such clients ordinarily are considerably demoralized, and they tend to view the group experience as one more failure. Even if the client denies this feeling, the therapist should still assume that it is present and, in a private discussion, provide alternative methods of viewing the experience. For example, the therapist may present the notion of readiness or group fit. Some clients are able to profit from group therapy only after a period of individual therapy; others,

for reasons unclear to us, are never able to work effectively in a therapy group. It is also entirely possible that the client may achieve a better fit and a successful course of therapy in another group, and this possibility should be explored. We have seen this happen many times. In any case, you should help the removed member understand that this outcome is not a failure on his or her part but that, for several possible reasons, a form of therapy has proved unsuccessful. It is usually more than just the client's failing when therapy falters, and by sharing that responsibility with the client, you may both help the client and further your own self-exploration about your work as a therapist.[91]

It may be useful in the final interview to review the client's experience in the group in some detail. Occasionally, a therapist is uncertain about the advisability of confronting someone who is terminating therapy. Should you, for example, confront the denial of an individual who attributes his dropping out of the group to his hearing difficulties, when in fact he had not been a good fit and had been rejected by the group? As a general principle, it is useful to consider the client's entire career in therapy. If the client is very likely to reenter therapy, a constructive, gentle confrontation will, in the long run, make any subsequent therapy more effective. If, on the other hand, it is unlikely that the client will pursue a dynamically oriented therapy, there is little point in presenting a final interpretation, because the client will never be able to use or extend these insights in the future. Test the denial. If it is deep, leave it be. There is no point in undermining defenses, even self-deceptive ones, if you cannot provide a satisfactory substitute. Avoid adding insight to injury.[92]

The Addition of New Members

Whenever the group census falls too low (generally five or fewer members), the therapist should introduce new members. This may occur at any time during the course of the group, but in the long-term group there are major junctures when new members are usually added: during the first twelve meetings (to replace early dropouts)

and after twelve to eighteen months (to replace improved, graduating members). With closed, time-limited groups, there is a narrow window of the first three to four weeks in which it is possible to add new members and yet provide them with an adequate duration of therapy.

The success of introducing new members depends in part on proper timing. There are favorable and unfavorable times to add members. Generally, a group that is in crisis, that is actively engaged in an internecine struggle, or that has suddenly entered into a new phase of development does not favor the addition of new members; it will often reject the newcomers or else evade confrontation with the pressing group issue and instead redirect its energy toward the newcomers. Examples include a group that is dealing for the first time with hostile feelings toward a controlling, monopolistic member, or a group that has recently developed such cohesiveness and trust that a member has, for the first time, shared an extremely important secret. Your attention to the group's developmental stage is helpful here. Better to add members in the forming or norming/performing stages than in the midst of conflict and high tension.[93]

Some therapists postpone the addition of new members if the group is working well, even when the census is down to four or five. We prefer not to delay, and promptly begin to screen candidates. Small groups, even highly cohesive ones, will eventually grow even smaller through absence or termination and soon will lack the interaction necessary for effective work. The most auspicious period for adding new members is during a phase of stagnation in the group. Many groups, especially older ones, sensing the need for new stimulation, actively encourage the therapist to add members.

Some groups are very clear about the timing of new members joining. This was the case for a group where the members are all women with metastatic breast cancer, for example. In a group dealing with a very ill, dying, or recently deceased member, the members may prefer not to have new additions, because they need all of their energy and time to address their loss and grief.[94]

Response of the Group to New Members

A cartoon cited by a British group therapist portrays a harassed woman and her child trying to push their way into a crowded train compartment. The child looks up at his mother and says, “Don’t worry, Mother, at the next stop it will be our turn to hate!”[95] The parallel to new members entering the group is trenchant. Hostility to the newcomer is evident even in a group that has beseeched the therapist to add new members, and it may reach potent levels. The attention to group process and group dynamics is always essential but even more so at these important developmental points.

The addition of new members is also an opportunity for the existing members to reevaluate their progress and reset goals. One member who had long refused to disclose his occupation to his group announced that he wanted to share that information now before new members entered. He was embarrassed at his obstinacy and secretiveness. His early refusal to share that information was initially a control issue for him. Then he felt stuck in the secret, but now he saw how absurd it would be to hold that position as a “group veteran” with new members arriving. His trust had grown, as had his desire for openness, and he wanted to start there with the new members.

At other times the entry of new members may prompt regressive behavior by the older group members. We have observed many times that when new members are slated to enter a meeting, existing members begin to arrive late; they may even remain for a few minutes talking together animatedly in the waiting room while the therapists and the new clients wait in the therapy room. A content analysis of sessions in which a new member or members are introduced reveals several themes that are hardly consonant with benevolent hospitality. The group suddenly spends far more time than in previous meetings discussing the good old days. Long-departed group members and events of bygone meetings are avidly recalled, reminding new members, as if they could possibly have forgotten, of their novitiate status. Old battles are reengaged to make the group as unwelcoming as possible. Similarly, members may

remark on resemblances they perceive between a new member and some departed, failed member. The newcomer may get grilled.

A group may also express its ambivalence by discussing, in a newcomer's first meeting, threatening and confidence-shaking issues. For example, one group "welcomed" two new members by noting that the therapists were listed on the psychiatry website as second-year residents and suggesting that they might be leading their first group. This issue—an important one that should be discussed—was nonetheless highly threatening to new members. It is of interest that this information was widely known to several group members but had never been mentioned until that meeting.

On the other hand, there can be strong feelings of welcome and support if the group has been eager to add new members. The members may exercise great gentleness and patience in dealing with new members' initial fear or defensiveness. The group may attempt, in a variety of ways, to increase its attractiveness to the newcomer. Often members gratuitously offer testimonials and describe the various ways in which they have improved. In one group, a newcomer asked a disgruntled, resistant member about her progress, and before she could reply, two other members, sensing that she would devalue the group, interrupted and described their own progress. Although groups may unconsciously wish to discourage newcomers, members are generally not willing to do so by devaluing their own group.

Groups may have ambivalent responses to new members for several reasons. Some members, who highly prize the solidarity and cohesiveness of the group, may feel threatened by any proposed change to the status quo. Will the new members undermine the group? In one group, I (ML) was grilled by the existing members about the proposed entry of new members after a hostile dropout had shaken the group. How could I have brought such a disruptive person into their midst? Could I be trusted to make a good selection this time? Powerful sibling rivalry issues may be evoked at the prospect of a new drain on the group's supplies: members may envision newcomers as potential rivals for the therapist's and the group's attention and perceive their own fantasized role as favored

child to be in jeopardy.[96]

A common concern of a group is that new members will slow the group down: the group fears that familiar material will have to be repeated for the newcomers and that the group must recycle and relive the tedious stages of gradual social introduction and ritualistic etiquette. Fortunately, this expectation generally proves to be unfounded. New clients introduced into an ongoing group generally move quickly into the prevailing level of group communication and bypass the early testing phases characteristic of members in a newly formed group.

Commonly, the new members of the group have a unique and constructive perspective on the group members. They see the older members as they currently are, rather than how they used to be, often admiring their perceptiveness, social comfort, and interpersonal skills, and thus reinforcing the changes veteran members have achieved. This feedback can serve as a powerful reminder of the value of the therapeutic work done to date. The morale of the new and the old members can be enhanced simultaneously, and cohesion strengthened.

Therapeutic Guidelines for Adding New Members

Clients entering an ongoing group require not only the comprehensive preparation to group therapy we discussed in Chapter 9 but also additional preparation to help them deal with the unique stresses of joining an established group. Entry into any established culture—a new living situation, job, school, and so on—produces anxiety and, as extensive research indicates, demands orientation and support.[97]

We tell new members to expect feelings of exclusion and bewilderment on entering a new and unusual culture and we reassure them that they will be allowed to enter and participate at their own pace. New clients entering established groups may be daunted by the sophistication, openness, interpersonal facility, and daring of more experienced members. They may also be frightened or fear contagion, since they are immediately confronted with

members revealing more of their pathology than is revealed in the first meetings of a new group. These contingencies should be discussed with the client. It is generally helpful to describe the major events of the past few meetings to the incoming participant. If the group has been going through some particularly intense, tumultuous events, it is wise to provide an even more thorough briefing. If the therapist uses a written summary technique (described in Chapter 13), then the new member, with the group's permission, may be asked to read the summaries of the past few meetings.

We make an effort to engage the new client in the first meeting or two. Often it is sufficient merely to inquire about his or her experience of the meeting—something to the effect of: "Sally, this has been your first session. So far, what has the meeting felt like for you? Does it seem like it will be difficult to get into the group? What concerns about your participation are you aware of so far?" It's often useful to help new clients assume some control over their participation. For example, the therapist might say, "I note that several questions were asked of you earlier. How did that feel? Too much pressure? Or did you welcome them?" Or, "Sally, I'm aware that you were silent today. The group was deeply engaged in business left over from meetings when you were not present. How did that make you feel? Relieved? Or would you have welcomed questions directed at you?" Note that all of these questions are here-and-now centered.

Many therapists prefer to introduce two new members at a time, a practice that may have advantages for both the group and the new members. Occasionally, if one client is integrated into the group much more easily than the other, it may backfire and create even greater discomfort for the other newcomer, who may feel that he is already lagging behind his cohort. Nevertheless, introduction in pairs has much to recommend it: the group conserves energy and time by assimilating two members at once, and the new members may ally with each other and thereby feel less alien. Many months later, we have heard clients who joined an ongoing group at the same time refer to the support and comfort of joining with someone else.

The number of new members introduced into the group distinctly

influences the pace of absorption. A group of six or seven can generally absorb a new member with scarcely a ripple; the group continues work with only the briefest of pauses and rapidly pulls the new member along. On the other hand, a group of four confronted with three new members often comes to a screeching halt: ongoing work ceases and the group devotes all its energy to the task of incorporating the new members. The old members will wonder how much they can trust the new ones. Dare they continue with the same degree of self-disclosure and risk-taking? To what extent will their familiar, comfortable group be changed forever? The new members will be searching for guidelines to behavior. What is acceptable in this group? What is forbidden? If their reception by the established members is not gracious, they may seek comfort in an alliance of newcomers. The therapist who notes frequent use of “we” and “they,” or “old members” and “new members,” should heed these signs of schism. Until incorporation is complete, little further therapeutic work can be done. Research into groups that have old members regularly departing and new ones entering shows that the alliance and approach to the work of the group is reliably transmitted.[98]

A similar situation often arises when the therapist attempts to amalgamate two groups that have been reduced in number. This procedure is not easy. A clash of cultures and cliques formed along the lines of the previous groups can persist for a remarkably long time, and the therapist must actively prepare clients for the merger. It is best in this situation to end both groups and then resume as a totally new entity.

An important principle of group therapy, which we have discussed, is that every major stimulus presented to the group elicits a variety of responses by the group members. It is like a projective test. The investigation of the reasons behind these different responses is generally rewarding and clarifies aspects of character structure. Thus, the introduction of new members may shed light on the inner world of the old members, who may respond to a newcomer in highly idiosyncratic styles. Members who observe others responding to a situation in ways remarkably different from

their own may obtain considerable insight into their own behavior. Such an opportunity is unavailable in individual therapy but constitutes one of the chief strengths of the group therapeutic format.

The group's capacity to reflect on itself is essential. Much learning emerges from examining the process of what is unfolding without becoming enmeshed in the content. An illustrative clinical example may clarify this point:

> **A new member, Alexia—forty years old, attractive, divorced—**was introduced at a group's eighteenth meeting. The three men in the group greeted her in strikingly different fashions.
>
> Peter arrived fifteen minutes late and missed the introduction. For the next hour, he was active in the group, discussing issues left over from the previous meeting as well as events occurring in his life during the past week. He totally ignored Alexia, avoiding even glancing at her—a formidable feat in a group of seven people in close physical proximity. Later in the meeting, as others attempted to help Alexia participate, Peter, still without introducing himself, fired questions at her like a harsh prosecuting attorney. He had sought therapy because he "loved women too much," as he phrased it, and had had a series of extramarital affairs. In subsequent meetings, the group used the events of Alexia's first meeting to help Peter investigate the nature of his "love" for women. Gradually, he came to recognize how he used women, including his wife, as sex objects, valuing them for their bodies alone and remaining insensitive to their feelings and experiential world.
>
> The two other men in the group, Arturo and Brian, on the other hand, were preoccupied with Alexia during her first meeting. Arturo, a twenty-nine-year-old who had sought therapy because of his massive sexual inhibition, reacted strongly to Alexia and found that he could not look at her without experiencing an acute sense of embarrassment. His discomfort and blushing were apparent to the other members, who had previously helped him explore his relationship with the other women in the group. Arturo had desexualized the other two women in the group by establishing in his fantasy a brother-sister relationship with them. Alexia, who was attractive and available and at the same time old enough to evoke in him affect-laden feelings about his mother, presented a special problem for Arturo, who had previously been settling into too comfortable a niche in the group.
>
> Brian transfixed Alexia with his gaze and delivered a broad, unwavering smile to her throughout the meeting. An extraordinarily

dependent thirty-three-year-old, Brian had sought therapy for depression after the breakup of a love affair. Having lost his mother in infancy, he was a poor little rich boy, raised by a succession of nannies and housekeepers; he had had only occasional contact with his aloof, powerful father, of whom he was terrified. His romantic affairs, always with considerably older women, had invariably collapsed because of the insatiable demands he made on the relationship. The other women in the group in the past few meetings had similarly withdrawn from him. With progressive candor, they had confronted him about, as they termed it, his puppy-dog presentation of himself. Brian thus welcomed Alexia, hoping to find in her a new source of succor. In subsequent meetings, Alexia proved helpful to Brian. During her first meeting, she revealed her extreme discomfort at his beseeching smile and her persistent sense that he was asking for something important from her. She said that although she was unsure of what he wanted, she knew it was more than she had to give. **<<**

Freud once compared psychotherapy to chess in that far more is known and written about the opening and the end games than about the middle game. Accordingly, the opening stages of therapy and termination may be discussed with some degree of precision, but the vast bulk of therapy cannot be systematically described. Thus, the subsequent chapters follow no systematic group chronology but deal in a general way with the major issues and problems of later stages of therapy as well as with some specialized therapist techniques.

11

The Advanced Group

ONCE A GROUP ACHIEVES A DEGREE OF MATURITY AND STABILITY, it no longer exhibits discrete, easily described stages of development. The rich and complex working-through process begins, and the major therapeutic factors we described earlier operate with increasing force and effectiveness. Members engage more deeply in the group and use the group interaction to address the concerns that first brought them to therapy. The advanced group is characterized by members' growing capacity for self-disclosure, feedback, and reflection.[1] Hence, it is difficult to formulate specific procedural guidelines for all contingencies. In general, the therapist must strive to encourage development and operation of the therapeutic factors. The application of the basic principles of the therapist's role and technique to specific group events and to each client's therapy, as discussed in Chapters 5, 6, and 7, constitutes the art of psychotherapy, and for this there is no substitute for clinical experience, reading, supervision, and intuition.

HOW INTERPERSONAL LEARNING WORKS

In our discussion of the therapeutic factors, we emphasized that helping clients understand and improve their interpersonal relationships is at the very core of the group therapy endeavor. The following vignette illustrates some of the complexities and subtleties of helping group members understand and alter their modes of relating to others:

> **Four men and four women were members of an open-ended group.** Andie, a forty-two-year-old single woman working as a health-care aide, began the session. She had sought group therapy to deal with chronic issues of depression, poor self-esteem, and a pattern of making poor choices concerning partners. She had also struggled with substance abuse and significant feelings of shame and self-devaluation. Noah, a forty-five-year-old married businessman, was another key member in the meeting. He had sought group therapy to deal with issues of interpersonal isolation and chronic relational dissatisfaction. He consistently felt neglected and unrecognized for his talents and abilities, and his marriage was marked by chronic tension and distress.

Andie, who had been in the group for approximately four months, began the group meeting in obvious emotional distress. Crying as she spoke, she told us that she was very grateful to be in the group, but felt badly about herself for not having made as much use of the group as she had hoped. She said she'd come to the group that day determined not to leave without opening up about her core concerns. She had often seen others in the group do so to good effect, and she had lamented going home session after session feeling that she had barely scratched the surface. She was apprehensive about how the group would respond but decided that she would take that risk.

In compelling detail, Andie described how she had struggled all of her life with poor self-esteem. She had grown up with a single mom and never knew her father. Her relationships with men were exploitative and abusive—if not physically, then certainly emotionally and financially. To deal with her strong negative emotions, she had used marijuana and cocaine to such an extent that she had accumulated significant financial debt. This, in turn, meant that she had to work long hours to stay afloat financially. She had considered declaring bankruptcy but refused to do

so, feeling that it would be yet another capitulation to her inability to manage her life with integrity. This was a powerful revelation on Andie's part and the group was attentive to her every word.

Some members shared similar experiences about substance abuse, bankruptcy, and poor relationship choices. One member commented how she could palpably feel the kind of shame that Andie harbored, and reassured Andie that she, and others, as well, could relate to her and identify with her situation. The best way to deal with shame, she added, was to bring it into the light of day just as she was doing now. Another member commented on his increased respect for Andie.

This was an eye-opening experience for Andie: not only did group members identify with her, but she was admired and respected for her courage. The impact on her shame was profound. Tears of relief flowed as she acknowledged her gratitude for the group's support.

Everyone in the group was deeply involved with Andie except for Noah, who sat absolutely silent with his chair a half inch out of the circle. I (ML) felt irritated by this. We had worked hard on Noah's narcissistic self-absorption and his tendency to seek attention from the group without giving back to it. He seemed disinterested in Andie's declaration to the group, and the hard work we had done with him was not evident in his reaction.

During a momentary pause—the kind of pause that groups often use to shift focus—Noah jumped in and said that he also had important things to talk about. He described another round of difficulties with his wife and his anger at her lack of responsiveness toward him. In contrast to the earlier segment of the meeting, in which people were literally leaning forward in their chairs, drawing as close as they could to Andie, people listened politely but with little engagement. I made a process inquiry, asking the group to compare how they felt in the first part of the meeting with how they were feeling now. Despite a couple of inquiries, there was little response to my question, and I decided to express my feelings more openly.

"Noah," I began, "I want to share something with you that I hope I can convey clearly. I am going to take a bit of a risk here, and I hope you don't experience this as harsh. I'm finding it hard to generate interest in what you are saying to the group, and it's not because what you feel isn't important, but because I feel disappointed and irritated that you were silent throughout the meeting until you began to talk about your own issues. I want to ask you a question: How did you feel about what Andie shared with us?"

Noah acknowledged that he felt supportive of Andie but had chosen

not to say anything to her. He was eager to talk about his own concerns, however, and he wanted to make sure there would be time for him in the group. I commented that his lack of response to Andie made it harder for me to respond to him, and wondered whether the group's subdued response to his disclosure reflected similar feelings that others had. Several heads nodded. I then told Noah that his waiting for an opening to turn the group's attention onto him, rather than providing support and feedback for Andie's important self-disclosure, was very problematic for him. I asked him to consider the idea that the more he gave to others, the more others would reciprocate. I added that I knew this was a foreign concept to him, based upon what he had shared with us earlier about his very competitive and narcissistic family, a family in which the loudest and most demanding individual got whatever little bit of attention was available.

Noah acknowledged that he felt hurt by my feedback and wondered how long I had harbored that feeling before speaking to him. I told him I had been thinking about it throughout the meeting and spoke about it as soon as it was clear in my mind. I hoped he heard it in the spirit in which I had intended it. He commented that he valued our relationship and he would have to think about this. He then asked others in the group what they thought about my feedback to him. Jack, an older group member, commented that he felt it was incredibly important feedback, and he hoped Noah would be able to hear it. He had wanted to give similar feedback but had not been able to think of a way to do it without possibly hurting Noah.

Noah seemed to take this in, and as we explored these ideas more fully in the group as a whole, Sharon—a woman who had grown up in an environment of great emotional deprivation and neglect, asked me, "How did you decide to say what you did? Was that just technique or was it coming from a real place in you?"

I responded to Sharon, "Choosing to share it and how to share it involved technique but, without doubt, it came from a real place inside me." Sharon responded that she tended to mistrust care providers—she expected us to be disinterested in her. That was why she had wondered if I was truly present or just going through the motions. **<<**

This illustration underscores some of the key elements that make group therapy and the group therapist effective:

- The group functioned as a social microcosm, with members

genuinely bringing themselves into the here-and-now. Noah's behavior in the group closely paralleled his behavior in his life outside the group.

- Group cohesion provided the safety that encouraged Andie's risk-taking and self-disclosure.
- Andie's self-disclosure was followed by feedback that disconfirmed her expectation of being judged and shamed.
- Noah displayed his interpersonal pathology in the group, which, in his social world, alienated people and left him isolated.
- Group members responded in a perfunctory manner to Noah, depriving him of meaningful engagement.
- I paid close attention to my feelings about Noah.
- I recognized that I had been hooked by Noah interpersonally and I knew that if I didn't get unhooked, I would stay either disinterested or angry with him.
- Instead, I used my awareness of my irritation as a way to understand Noah's contributions to his being neglected and invalidated.
- When I metabolized my reactions sufficiently, I described what I saw him doing and what its impact was on me and on others.
- I tried to embed my feedback with care for him, and I bolstered the feedback by linking it to his primary goals in therapy.
- I modeled risk-taking and judicious self-disclosure in my comments to Noah. I commented about something that was alive and palpable in the group that others at that moment felt unable to express.
- When Sharon asked about my comments, I was careful to answer in an open and authentic way, responding to what I believed were questions about my genuineness and my respect for and involvement with the group members.
- At every step along the way, we examined what the group experience felt like and what it meant to the group members.

For example, I asked Andie, “What was it like coming home after each group for the last several sessions having not spoken to us?” Toward the end of the meeting, I asked her, “What will it be like going home tonight knowing that you have opened this up?”

- Lastly, I tried to draw a parallel for Noah between his way of relating to us and how he may have been relating to his wife and to others in his life.

We begin this chapter with this detailed example to illustrate many of the key concepts and principles that we have addressed earlier in the book. We now turn our attention to some key challenges of the advanced group. While it is not possible to anticipate all contingencies, certain issues and problems occur with sufficient regularity to warrant discussion. In this chapter, we consider subgrouping, conflict, self-disclosure, and termination of therapy. In the next chapter, we’ll discuss certain recurrent behavioral configurations in individuals that present a challenge to the therapist and to the group.

SUBGROUPING

Subgrouping—the splitting off of smaller units—occurs in every social organization. Who among us has not sought the comfort of connection with others in a smaller section of a larger group? The process may be transient or enduring, helpful or harmful, for the parent organization. The subgroup may express itself subtly in emotional terms alone, or the subgroup may be transparent and visible to the entire group. Therapy groups are no exception. Subgroup formation is an inevitable and often disruptive event in the life of the group, yet there, too, the process, if understood and harnessed properly, may advance the therapeutic work.[2]

How do we account for the phenomenon of subgrouping? We need to consider both individual and group factors in the creation of the subgroup. At times the subgroup is concealed and blocks group functioning and understanding in ways that are disruptive, even destructive, to the group.

At other times, the subgroup exists in plain sight and coalesces around difficult emotions, such as wishes and fears present in the larger group related to strong feelings of dependence, vulnerability, envy, or mistrust. When we examine a subgroup in depth we can deepen our understanding of what the subgroup is holding for the members of the group at large.[3]

Individual factors, such as members' concerns about personal connection and status, often motivate the creation of the subgroup within in the therapy group. A subgroup arises from the belief of two or more members that they can derive more gratification from a relationship with one another than from the entire group. Members who violate group norms by forming secret liaisons are opting to gratify needs rather than to pursue personal change—their primary reason for being in therapy (see the discussion of primary task and secondary gratification in Chapter 6). Need frustration occurs early in therapy: for example, members with strong needs for intimacy, dependency, or dominance may soon sense the challenge of

gratifying these needs in the group, and thus attempt to gratify them outside the formal group.

In one sense, these members are “acting out”: they are engaging in behavior *outside* the group therapy setting that relieves inner tensions and avoids direct expression or exploration of feeling or emotion. Sometimes it is only possible in retrospect to discriminate “acting out” from participating in the therapy group. Let us clarify.

The course of the therapy group is a continual cycle of action and then analysis of this action. The social microcosm of the group depends on members engaging in their habitual patterns of behavior, which are then examined by the individual and the group. Acting out turns into resistance only *when one refuses to examine one’s behavior*. Extragroup behavior that is not examined in the group becomes a particularly potent form of resistance, whereas *extragroup behavior that is subsequently brought back into the group and worked through may prove to be of considerable therapeutic import*. It is the secretiveness and silence that is most destructive to the group.[4]

Subgrouping may also come about as a consequence of “group factors”: for example, it may be a manifestation of a considerable degree of unaddressed emotion or undischarged hostility in the group, especially toward the leader. Research on styles of leadership demonstrates that a group is more likely to develop disruptive in-group and out-group factions under an authoritarian, restrictive style of leadership.[5] This kind of leadership impedes cohesion and a sense of safety in the group. Group members, unable to express their anger and frustration directly to the leader, release these feelings obliquely by binding together or by scapegoating one or more of the other members.

At other times, subgrouping is a sign of problems in group development. A lack of group cohesion will encourage members to retreat from large and complex group relationships into simpler, smaller, more workable subgroups. Hence, any sustained threat to group integrity and group stability can foster subgrouping.

Clinical Appearance of Subgrouping

Extragroup socializing is often the first stage of subgrouping. A clique of three or four members may begin to have telephone conversations, text, email, or Facebook exchanges, or they may meet over coffee, ride the subway home together, look after one another's pets, or visit each other's homes. Occasionally, two members will become sexually involved. A subgroup may also occur completely within the confines of the group therapy room, as members who perceive themselves to be similar form coalitions. In settings such as day hospitals and residential treatment programs, subgrouping becomes even more likely owing to the large amounts of time members spend with one another between sessions and outside of the actual therapy group meetings.

In forming into subgroups, members seek to reduce the anxiety that stems from being part of the larger group and find comfort by joining with others with whom they share some common bond: a comparable educational level, similar values, or the same ethnocultural background, age group, sexual orientation, marital status, or group status (for example, the old-timer original members). As one clique forms, the members who are left out may feel diminished and excluded. The stage is set for polarization, marginalization, and scapegoating.

The members of a subgroup may be identified by a general code of behavior. For example, they may agree with one another regardless of the issue and avoid confrontations among their own membership; they may exchange knowing glances when a member not in the clique speaks; they may arrive at and depart from the meeting together; or their wish for friendship may override their commitment to examination of their behavior.[6] Their perspective is shaped by the pressure to maintain the subgroup rather than the commitment to doing the work of therapy (a process all too painfully familiar in the world of tribal politics).

The Effects of Subgrouping

Subgrouping can have an extraordinarily disruptive effect on the

course of the therapy group. In a study of thirty-five clients who prematurely dropped out from group therapy, I (IY) found that eleven of them (31 percent) did so largely because of problems arising from subgrouping. Complications arise whether the client is included in or excluded from a subgroup.[7]

Inclusion. Those included in a twosome or a larger subgroup often find that group life becomes vastly more complicated, and ultimately, less rewarding. As a group member transfers allegiance from the group goals to the subgroup goals, loyalty becomes a major and problematic issue. For example, should one abide by the group procedural rules of free and honest discussion of feelings if that means breaking a confidence established secretly with another member?

> **Christine and Jerry often met after the therapy session to have** long, intense conversations. Jerry had remained withdrawn in the group and had sought out Christine because, as he informed her, he felt that she alone could understand him. After obtaining her promise of confidentiality, he soon was able to reveal his gender identity confusion to her and his deep distrust of the group leader and the group leader's judgment. In the group, Christine felt restrained by her promise and avoided interaction with Jerry, who eventually dropped out unimproved. Ironically, Christine was an exceptionally sensitive member of the group and might have been particularly useful to Jerry by encouraging him to participate in the group, had she not felt restrained by the antitherapeutic subgroup norm (that is, her promise of confidentiality). **<<**

Sharing with the rest of the members what one has learned in extragroup contacts is tricky, and it is for that reason that leaders must explain clearly, as early as the preparation stage, that subgrouping undermines therapy. Members who conceal secret information about one another arising from extragroup meetings are placed in a difficult antitherapeutic situation.

> **An older, avuncular man often gave two other group members a** ride home after group meetings. On one occasion he invited them to watch a ball game on television at his house. The visitors witnessed an

argument between the man and his wife and at a subsequent group session said that they felt he was mistreating his wife. The older member felt betrayed by the two members, whom he had considered his friends, and began concealing issues from the group. Ultimately, he dropped out of treatment. **<<**

Severe clinical problems can occur when two group members engage in an intimate relationship. Therapy group members who become involved intimately *will almost inevitably come to award their dyadic relationship higher priority than their relationship to the group*. In forming this partnership, they sacrifice their value for each other as helpmates in the group. They will refuse to betray confidences, and rather than being honest in the group, they will attempt to be charming to each other. They perform for each other, blotting out the therapists and other members of the group, and, most important, they lose sight of their primary goals in therapy. Often the other group members are dimly aware that something important is being actively avoided in the group discussion, a state of affairs that usually results in global group inhibition. An unusual chance incident provided empirical evidence substantiating these comments:[8]

> A research team happened to be closely studying a therapy group in which two members developed a clandestine sexual relationship. Since the study had begun months before the liaison occurred, good baseline data was available. Several observers (as well as the clients themselves, in postgroup questionnaires) had for months rated each meeting along a seven-point scale for the amount of affect expressed, the amount of self-disclosure, and the general value of the session. In addition, the communication-flow system was recorded, with the number and direction of each member's statements charted on a who-to-whom matrix.

During the observation period, Bruce and Hailey developed a sexual relationship. They kept it secret from the therapist and the rest of the group for three weeks. During that time, the data (when studied in retrospect) showed a steep downward gradient in the scoring of the quality of the meetings, with reduced verbal activity, expression of affect, and self-disclosure. Moreover, very few verbal exchanges were recorded between Hailey and Bruce. **<<**

This last finding is the quintessential reason that subgrouping impedes therapy. The primary goal of group therapy is to facilitate each member's exploration of his or her interpersonal relationships. Here were two people who knew each other well, had the potential of being deeply helpful to each other, and yet barely spoke to each other in the group.

The couple resolved the problem by deciding that one of them would drop out of the group (not an uncommon resolution). Hailey dropped out, and in the following meeting, Bruce discussed the entire incident with relief and great candor. (The ratings by both the group members and the observers indicated this meeting to be exceptionally valuable, with active interaction, strong affect expression, and much disclosure from others as well as Bruce.)

The positive, affiliative effects of subgrouping *within* the therapy group may be turned to therapeutic advantage.[9] The therapy group is generally a large and dynamic group made up of several smaller subgroups. Subgrouping occurs (and may even be judiciously encouraged by the therapist) as a component of addressing areas of conflict or distress within the group. Clients who have difficulty acknowledging their feelings or disclosing themselves may do better if they sense they are not alone. Hence, the therapist may actively point out clusters of members who share some basic intrapersonal or interpersonal concern. Other members may be invited to explore their own relationships to the emotions, fears, wishes, or aspirations carried by others. The question of "Anyone else?"[10] following a personal disclosure underscores that many in the group may resonate with what has been shared. Encouraging such interaction across the subgroup boundaries promotes a safer, more inclusive therapy environment. It fosters universality and integration rather than isolation.[11]

Exclusion. Exclusion from the subgroup complicates group life. Anxious memories associated with earlier peer exclusion experiences are evoked and may become disabling if they are not discharged by working through the issue in the group. Often it is difficult for members to comment on their feelings of exclusion: they

may not want to reveal their envy of the special relationship, or they may fear angering the involved members by "outing" the subgroup in the session.

Nor are therapists immune to this problem. I (IY) recall a group therapist, one of my supervisees, who told me he had observed two of his group members walking arm in arm along the street. The therapist found himself unable to bring his observation back into the group. Why? He offered several reasons:

- He knew these members were married to other people and he did not want to assume the position of spy or disapproving parent in the eyes of the group.
- He works in the here-and-now and is not free to bring up nongroup material.
- He hoped the involved members would, when psychologically ready, discuss their relationship.

These are rationalizations, however. There is no more important issue than the interrelationship of the group members. Anything that happens between group members is part of the here-and-now of the group. The therapist who is unwilling to bring in all material bearing on member relationships can hardly expect members to do so. If you feel yourself trapped in a dilemma—on the one hand, knowing that you must bring in such observations, and, on the other, not wanting to seem to be playing detective—then generally the best approach is to *share your dilemma with the group*—both your observations *and* your personal uneasiness and reluctance to discuss them.[12]

Therapeutic Considerations

By no means is subgrouping, with or without extragroup socializing, invariably disruptive. If the goals of the subgroup are consonant with those of the parent group, subgrouping may ultimately enhance group cohesiveness. The key is to improve communication across the boundaries of the subgroup and to reduce the isolation of its

members. Some of the most significant therapeutic opportunities arise as a result of some extragroup contacts that are then fully worked through in therapy.

> **Two women members who had gone to a dance together after a** meeting discussed, in the following meeting, their observations of each other in that purely social setting. One of them had been far more flirtatious, even openly seductive, than she had been in the group; furthermore, much of this was "blind spot" behavior—out of her awareness. **<<**

> **In another group, a dramatic example of effective subgrouping** occurred when the members became concerned about one member who was in such despair that she considered suicide. Several group members maintained a week-long telephone vigil, which proved to be beneficial both to that client and to the cohesiveness of the entire group. **<<**

> **In another example of subgrouping that enhanced therapeutic** work, a client attempted to form an extragroup alliance with every member of the group. Ultimately, as a result of his extragroup activity and the exploration of it in the group, he arrived at important insights about his manipulative modes of relating to peers and about his adversarial stance toward authority figures. **<<**

The principle is clear: any extragroup contact may prove to be of value, *provided that the goals of the parent group are not relinquished*. If such meetings are viewed as part of the group's rhythm of action and subsequent analysis, much valuable information can be made available to the group. To achieve this end, the involved members must inform the group of every important extragroup event. If they do not, the disruptive effects on cohesiveness we have described will occur. The cardinal principle is this: *It is not the subgrouping per se that is destructive to the group, but the conspiracy of silence that surrounds it.*

The therapist should encourage open discussion and analysis of all extragroup contacts and all in-group coalitions while continuing to emphasize the members' responsibility to bring extragroup contacts into the group. We must utilize all the interpersonal data accessible

to us. The therapist who surmises from glances between two members in the group, or from their appearance together outside the group, that a special relationship exists between them should not hesitate to present this thought to the group. No criticism or accusation is implied, since the investigation and understanding of an affectionate relationship between two members may be as therapeutically rewarding as the exploration of a hostile impasse. Furthermore, other members must be encouraged to discuss their reaction to the relationship, whether it be envy, jealousy, or vicarious satisfaction.[13]

Clients engaged in some extragroup relationship that they are not prepared to discuss in the therapy group may ask the therapist for an individual session and request that the material discussed not be divulged to the rest of the group. If you make such a promise, you may soon find yourself in an untenable collusion from which extrication is difficult. We suggest that you refrain from offering a promise of confidentiality; instead, assure the clients that you will be guided by your professional judgment and will try to act with sensitivity on their therapeutic behalf. Though this promise may not offer sufficient reassurance to all members, it will protect you from entering into awkward, antitherapeutic pacts. It is impossible to function as a group leader with pertinent information about members you are unable to address within the group as a whole.

Therapy group members sometimes develop sexual relationships with one another, but not with great frequency. The therapy group is not prurient; clients often have sexual conflicts resulting in such problems as impotence, nonarousal, and sexual guilt. Our experience suggests that far less sexual involvement occurs in a therapy group than in any equally long-lasting social or professional group.

The therapist cannot, by edict, prevent the formation of sexual relations or any other form of subgrouping. Sexual acting out is often symptomatic of the relationship difficulties that led to therapy in the first place. As in all situations, we want our clients to bring themselves as they genuinely are to the group. The emergence of

sexual acting out in the group may well present a unique therapeutic opportunity to examine the behavior.

Though extragroup subgrouping cannot be forbidden, it should never be encouraged. We have found it most helpful to make our position on this problem explicit to members in the preparatory or initial sessions. We tell them that extragroup activity often impedes therapy, and we clearly describe the complications caused by subgrouping. We emphasize that if extragroup meetings occur, fortuitously or by design, then it is the subgroupers' responsibility to the other members and to the group to keep the others fully informed. As we noted earlier, the therapist must help the members understand that the group therapy experience is a dress rehearsal for life; it is the bridge, not the destination. It will teach the skills necessary to establish durable relationships but will not provide the relationships. If group members do not transfer their learning to their lives outside the group, and instead derive their social gratification exclusively from the therapy group, therapy becomes unproductive and interminable.

For these reasons, it is unwise to include two members in a group who already have a long-term special relationship: husband and wife, roommates, professional colleagues, business associates, and so on. Occasionally, the situation may arise in which two members naïvely arrive for a first meeting and discover that they know one another from a prior or preexisting personal or employment relationship. It is not the most auspicious start to a group, but the therapist must not avoid examining the situation openly and thoroughly. Is the relationship ongoing? Will the two members be less likely to be fully open in the group? Are there concerns about confidentiality? How will it affect other group members? Is there a better or more workable option? The therapist must reach a quick and a shared decision, including potentially finding other groups for the affected members.

It is possible for group therapy to focus on current long-term relationships between members, but that entails a different kind of therapy group than that described in this book—for example, a marital couples' group, conjoint family therapy, and multiple-family

therapy.[14]

As we noted earlier, the problem of extragroup relationships in inpatient psychotherapy groups and day hospital programs is even more complex, since the group members spend their entire day in close association with one another. The following case is illustrative:

> **In a group in a state psychiatric hospital for criminal offenders, a** subgrouping problem had created great divisiveness. Two male members—by far the most intelligent, articulate, and educated of the group—had formed a close friendship and spent much of every day together. The group sessions were characterized by an inordinate amount of tension and hostile bickering, much of it directed at these two men, who by this time had lost their separate identities and were primarily regarded, and regarded themselves, as a dyad. Much of the attacking was off target, and the therapeutic work of the group had become overshadowed by the attempt to destroy the dyad.
>
> As the situation progressed, the therapist, with good effect, helped the group explore several themes. First, the group had to consider that the two members could scarcely be punished for their subgrouping, since everyone had had an equal opportunity to form such a relationship. The issue of envy was thus introduced, and gradually the members discussed their own longing for friendships and their inability to establish them. Furthermore, they discussed their feelings of intellectual inferiority to the dyad as well as their sense of exclusion and rejection by them.
>
> The two members had, however, exacerbated these responses by their actions. Both had maintained their self-esteem by demonstrating their intellectual superiority whenever possible. When addressing other members, they deliberately used polysyllabic words, and they maintained a conspiratorial attitude that accentuated the others' feelings of inferiority and rejection. Both members profited from the group's description of the subtle rebuffs and taunts they had meted out and came to realize that others had suffered painful effects from their behavior. **<<**

Nota bene, our comments on the potential dangers of subgrouping apply to groups that rely heavily on the therapeutic factor of interpersonal learning and self-understanding. In other types of groups, such as cognitive-behavioral groups for eating

disorders, extragroup socializing has been shown to be beneficial—for example, in altering eating patterns.[15] Twelve-step groups, self-help groups, and support groups also make good use of extragroup contact. In groups of cancer patients, extragroup contact becomes an essential part of the process, and participants may be actively encouraged to contact one another between sessions as an aid in coping with the illness and its medical treatment.[16] On many occasions, we have seen the group rally around members in deep despair and provide extraordinary support. In our groups for women with advanced breast cancer, group members may attend medical appointments together, prepare meals for ill members, and even deliver eulogies at the funerals of group members.

CONFLICT IN THE THERAPY GROUP

Conflict cannot be eliminated from human groups, whether they are dyads, small groups, macrogroups, or megagroups, such as nations and blocs of nations. If overt conflict is denied or suppressed, it will invariably manifest itself in oblique, corrosive, and often ugly ways. Although our immediate association with conflict is negative—destruction, bitterness, war, violence—a moment of reflection brings to mind positive associations: drama, excitement, change, and development. Therapy groups are no exception. Some groups become "too nice" and diligently avoid conflict and confrontation, often mirroring the therapist's avoidance of aggression. In the supervision of hundreds of group leaders, we have seen a spectrum of behavior by therapists when it comes to conflict, ranging from avoidance to comfort to a frank attraction to aggression. Therapists should cultivate self-awareness of their personal attitudes toward conflict, as these attitudes will shape group norms.

Conflict is so inevitable in the course of a group's development that its absence suggests some impairment of the developmental sequence. Furthermore, conflict can be exceedingly valuable to the course of therapy, provided that its intensity does not exceed the members' tolerance and the group understands how to work with it. Learning how to deal effectively with conflict is an important therapeutic step that contributes to individual maturation and emotional resilience.[17] Culture and gender may influence group members' comfort with the expression of anger and conflict. It is particularly important that female clients who have been abused or exploited learn to be more assertive in dealing with conflict and aggression during the course of therapy.[18] In this section, we consider conflict in the therapy group—its sources, its meaning, its contribution to therapy, and its therapeutic management.

Sources of Hostility

There are many sources of hostility in the therapy group and an equal number of relevant explanatory models and perspectives, ranging from ego psychology to object relations to trauma theory to gender psychology to self-psychology.[19] The group leader's capacity to identify the individual, interpersonal, group dynamic, and societal contributions to the hostility in the group is essential.[20]

Some antagonisms are projections of the client's self-contempt. Some clients project their own feelings of shame onto other members and then attack the recipient of their projection. Devaluation begets devaluation, and a destructive interpersonal loop of attack and counterattack may easily ensue.

Transference often generates hostility in the therapy group. One may respond to others not on the basis of reality but on the basis of an image of the other that is distorted by one's own past relationships and current interpersonal needs and fears. Should the distortion be negatively charged, then a mutual antagonism may be initiated. The group may function as a "hall of mirrors" that aggravates hostile and rejecting feelings and behaviors.[21] Individuals may have long suppressed some traits or desires of which they are much ashamed; when they encounter another person who embodies these very traits, they generally shun the other or experience a strong but inexplicable antagonism toward the person. Think of the contempt a former smoker may show a current smoker. The process may be close to consciousness and recognized easily with guidance by others, or it may be deeply buried and understood only after many months of investigation.

> **One client, Vincent, a second-generation Italian American who** had grown up in the Boston slums and obtained a good education with great difficulty, had long since dissociated himself from his roots. Having invested in his intellect with considerable pride, he spoke with great care in order to avoid betraying any part of his accent or background. In fact, he abhorred the thought of his lowly past and feared that he would be found out, that others would see through his front to his core, which he regarded as ugly, dirty, and repugnant. In the group, Vincent experienced extreme antagonism for another member, also of Italian descent, who had, in his values and in his facial and hand gestures,

retained his identification with his ethnic group. Through his investigation of his antagonism toward this member, Vincent arrived at many important insights about himself and gained the group acceptance he longed for but had undermined by his attacking stance. **<<**

> In a group of psychiatric residents, Bob agonized over whether to transfer to a more academically oriented residency. The group, with one member, Rick, as spokesman, resented the group time Bob took up for this problem, rebuking him for his weakness and indecisiveness and insisting that he "crap or get off the pot." When the therapist guided the group members into an exploration of the sources of their anger toward Bob, many dynamics became evident. One of the strongest sources was uncovered by Rick, who discussed his own paralyzing indecisiveness. He had, a year earlier, faced the same decision as Bob; unable to act decisively, he had resolved the dilemma passively by suppressing it. Bob's behavior reawakened that painful scenario for Rick, who resented Bob not only for disturbing his uneasy slumber but also for struggling with the issue more honestly and more courageously than he had. **<<**

The psychiatrist Jerome Frank described a reverberating double-mirror reaction:

> In one group, a prolonged feud developed between two Jewish members, one of whom flaunted his Jewishness while the other tried to conceal it. Each finally realized that he was combating in the other an attitude he repressed in himself. The militant Jew finally understood that he was disturbed by the many disadvantages of being Jewish, and the man who hid his background confessed that he secretly nurtured a certain pride in it.[22]

Another source of conflict in groups arises from *projective identification*, an unconscious process which consists of projecting some of one's own (but disavowed) internal attributes onto another. The projector (or exporter) generally feels an uncanny attraction-repulsion toward the recipient. A stark literary example of projective identification occurs in Dostoevsky's nightmarish tale "The Double," in which the protagonist encounters a man who is his physical

double and yet a personification of all the dimly perceived, hated aspects of himself. The tale depicts with astonishing vividness both the powerful attraction and the horror and hatred that develop between the protagonist and his double.[23] Projective identification has intrapsychic and interpersonal components. It is both a defense—primitive in nature because it polarizes, distorts, and fragments reality—and a form of interpersonal relationship.[24] Elements of one's disowned self are put not only *onto* another and shunned, as in simple projection, but *into* another. The behavior of the recipient actually changes within the ongoing relationship, because the projector's overt and covert interpersonal communication influences the recipient's psychological experience and behavior.[25] An abused and traumatized client, for example, may export the vulnerable and abused part of herself into others in the group, including the leader, and become abusive toward them. These projections may overwhelm other group members and deskill the group leader. This bodes poorly for all unless the group leader is able to understand the impact of the client's projection and ensure that group safety is maintained.[26]

There may be many other sources of anger in a therapy group. Individuals with a fragile sense of self can respond with rage to experiences of shame, dismissal, or rejection and seek to bolster their personal stature by retaliation. At times anger can be a desperate reaction to one's sense of fragmentation and may represent the client's best effort at avoiding total emotional collapse.[27]

Rivalry and envy may also fuel conflict. Group members may compete with one another in the group for the largest share of the group's or therapist's attention or for some particular role: for example, the most powerful, respected, sensitive, disturbed, or needy person in the group. Members search for signs that the therapist may favor one or another of the members. In one group, for example, a member asked the therapist where he was going on vacation. When the therapist answered with uncharacteristic candor, another member became bitter and upset: she soon recalled how

her sister had always received things from her parents that she had been denied.[28]

The addition of a new member can ignite rivalrous feelings, as the following example illustrates:

> **In the fiftieth meeting of one group, a new member, Ginny,[i] was** added. In many ways she was similar to Douglas, one of the original members: they were both artists, mystical in their approach to life, often steeped in fantasy, and seemingly all too familiar with their unconscious. It was not affinity, however, but antagonism that soon developed between the two. Ginny immediately established her characteristic role by behaving in a spirit-like, irrational, and disorganized fashion in the group. Douglas, who saw his role as the sickest and most disorganized member being usurped, reacted to her with intolerance and irritation. Only after active interpretation and Douglas's assumption of a new role ("most improved member") was an entente between the two members achieved. **<<**

Certain clients, because of their character structure, will invariably be involved in conflict and will engender conflict in any group they attend. Consider a man with paranoid tendencies whose assumptive world is that there is danger in the environment. He is eternally suspicious and vigilant. He examines all experience with an extraordinary bias as he searches for clues and signs of danger. He is tight, never playful, and looks suspiciously upon such behavior in others, anticipating their efforts to exploit him. Obviously, such traits will not endear that individual to the other group members: sooner or later, anger will erupt all around him. The more severe and rigid his character structure, the more extreme the conflict will be. Eventually, if therapy is to succeed, the client must access and explore the feelings of vulnerability that reside beneath the hostile mistrust.

> **In supervision, two female co-leaders addressed the difficulty** they had in empathizing with Mark, an aggressive, narcissistic man who had been very critical of Sandi, a vulnerable woman in the group. He resented her for avoiding group interaction and silently watching him. It was much easier for the group leaders to understand and side with Sandi than to consider Mark's concerns.

Mark was a big man, a body builder with an imposing presence who intimidated the group and the leaders. As group supervisor, I (ML) encouraged the group leaders to examine Mark's sense of vulnerability rather than focusing on his manifest aggressive behavior. Once the leaders approached him in this more compassionate spirit, Mark softened and was able to speak to his fear of silence.

To him, silence suggested impending harsh judgment by others. He lamented that everyone was concerned about Sandi's feelings and her tears, but no one paid attention to his feelings of distress. He shared for the first time his early experience of abuse, and realized that his bigness and bluster were a defense to ward off attack. The group responded by honoring his courage and need for care. **<<**

The group setting invites a greater degree of interpersonal interaction than is typical of individual therapy and therefore may provide a safer exposure to interpersonal conflict. A playful, jousting tone can emerge that promotes a developmentally healthy "give-and-take" repartee. When done in the spirit of healthy assertion it can strengthen cohesion and broaden the opportunity to address and examine competition, rivalry, and healthy aggression.[29]

Disappointment with the therapist for falling short of expectations can be another source of group hostility. If the group is unable to confront the therapist directly, it may create a scapegoat—a highly unsatisfactory solution for both victim and group.[30]

Recognizing that hostility emerges from multiple sources is essential in avoiding reductionistic explanations.[31] The group may give voice to every potential perspective on aggression—the victim, the perpetrator, protective intervenors, or disinterested witnesses.[32] Hostility in the group can also be understood from the perspective of stages of group development. In the early phase, the group fosters regression and the emergence of irrational, uncivilized parts of individuals. The young group is also beset with anxiety (from fear of exposure, shame, feelings of powerlessness) that may be expressed as hostility. A range of aggressions may emerge from cultural and racial misunderstandings and assumptions among the members. These microaggressions may seem small to the perpetrator but may cut the targeted individual deeply, through the invalidation or

diminishment of the targeted member's personhood and ethnocultural identity.[33] These are essential to recognize, address, and repair. The first step is making the aggression visible so that it can be worked with in the group.

Throughout the course of the group, narcissistic injury (wounds to self-esteem from feedback or from being overlooked, unappreciated, excluded, or misunderstood) is often suffered and responded to through angry retaliation. Later in the course of the group, anger may stem from other sources: projective tendencies, sibling rivalries, transference, or the premature termination of some members. And, of course, let us not forget the group leader's defensiveness and self-protectiveness in the face of critics as a source of fuel for conflict in the group. Therapist countertransference can be an important contributor to destructive hostility in the therapeutic process.[34]

Management of Hostility

Regardless of its source, discord, once begun, often follows a predictable sequence. The antagonists develop the belief that they are right and the others are wrong, that they are good and the others bad. Moreover, these beliefs are characteristically held with equal conviction and certitude by each of the two opposing parties. Where such a situation of opposing beliefs exists, we have all the ingredients for a deep and continuing tension, even to the point of impasse.

Not uncommonly, a breakdown in communication ensues. The two parties cease to listen to each other with any understanding. If they were in a social situation, the two opponents would most likely completely rupture their relationship at this point and never be able to correct their misunderstandings. Not only do the opponents stop listening, but they may also unwittingly distort their perceptions of one another. The opponent's words and behavior are distorted to fit a preconceived view. Contrary evidence is ignored; conciliatory gestures may be perceived as deceitful tricks. (The parallel to international relations is all too obvious.) In short, there is a greater investment in verification of one's beliefs than in understanding the

other.[35]

Opponents view their own actions as honorable and reasonable, and the behavior of others as scheming and evil. If this sequence, so common in human events, were permitted to unfold in therapy groups, the group members would have little opportunity for change or learning. A group climate and group norms that preclude such a sequence must be established early in the life of the group. Therapy groups must be places that enable “difficult dialogues” to take place that look at the conflict from the perspective of all those involved, whether they are about race or gender relations or interpersonal tensions.[36]

Cohesiveness is the primary prerequisite for the successful management of conflict. Members must develop a feeling of mutual trust and respect and come to value the group as an important means of meeting their personal needs. They must understand the importance of maintaining communication if the group is to survive; all parties must continue to deal directly with one another, no matter how angry they become. Furthermore, everyone is to be taken seriously. When a group treats one member as a “mascot,” someone whose opinions and anger are lightly regarded, the hope of effective treatment for that individual has all but officially been abandoned. Covert exchanges between members, sometimes bordering on the “rolling of one’s eyes” in reaction to the mascotted member’s participation, are an ominous sign. Mascotting jeopardizes group cohesiveness; no one is safe, particularly the next most peripheral member, who will have reason to fear similar treatment.

The cohesive group in which everyone is taken seriously soon elaborates norms that obligate members to go beyond name calling and superficial judgments. Members must pursue and explore derogatory labels and be willing to search more deeply within themselves to understand their antagonism and to make explicit those aspects of others that anger them. Norms must be established that make it clear that group members are there to understand themselves, not to defeat or ridicule others.

In one group I (ML) led, a member became involved in a vitriolic

exchange with another member who had earlier mocked her for her guardedness. She yelled in the group, “Either Joe leaves or I leave. This group is not big enough for the two of us.” I responded, “We are a therapy group, not an old TV Western; the group is indeed big enough for you both and we need to understand what’s driving this heat.”

Effective therapy groups work with words, not actions; treat all members with respect; and understand that there is rarely a single objective truth—more typically, there are multiple subjective truths that group members need to understand together.[37] It is particularly useful if members try to reach within themselves to identify feelings and impulses they have in common. Terence, a Roman dramatist of the second century BC, gave us a valuable perspective when he said, “I am human and nothing human is alien to me.”[38] We all contain every element of the human experience.

Empathy is an important element in conflict resolution and facilitates humanization of the struggle. But empathy is harder to muster when one’s feelings are too strong. At such times the therapist needs to lower the temperature in the group by encouraging empathy, leaning forward in the chair, making eye contact with the antagonists, and validating their distress.[39] Often, understanding the past plays an important role in the development of empathy: once an individual appreciates how aspects of an opponent’s earlier life have contributed to his or her current stance, then the opponent’s position not only makes sense but may even appear right. Empathy emerges more readily when there is greater familiarity and knowledge of the other.[40] This is one of the reasons why it is wise to reduce hostile exchanges in the early stages of the group’s life: mutual knowledge of one another has not yet been sufficiently achieved.

Conflict resolution is often impossible in the presence of off-target or oblique hostility.

> **Maria began a group session by requesting and obtaining the** therapist’s permission to read a letter she was writing in conjunction

with a court hearing on her impending divorce, which involved complex issues of property settlement and child custody. The letter reading consumed a considerable amount of time and was often interrupted by the other members, who disputed the contents of the letter. The sniping by the group and defensive counterattacks by the protagonist continued until the group atmosphere crackled with irritability.

The group made no constructive headway until the therapist explored the process of the meeting with them. The therapist was annoyed with himself for having permitted the letter to be read, and annoyed with Maria for having put him in that position. The group members were angry at the therapist for having given Maria permission, and at Maria both for consuming so much time and for relating to them in the frustrating, impersonal manner of letter reading. Once the anger had been directed away from the oblique target of the letter's contents onto the appropriate targets—the therapist and Maria—steps toward conflict resolution could begin. **<<**

Permanent conflict abolition, let us note, is *not* the final goal of the therapy group. Conflict will continually recur in the group despite successful resolution of past conflicts and despite the presence of considerable mutual respect and warmth. Although some people relish conflict, the vast majority of group members (and therapists) are highly uncomfortable when expressing or receiving anger. The therapist's task is to harness conflict and use it in the service of growth. One important principle is to find the right level; too much or too little conflict is counterproductive. The leader is always fine-tuning the dial of conflict. When there is persistent conflict, when the group cannot agree on anything, the leader searches for resolution and wonders why the group denies any commonality. But when the group consistently agrees on everything, the leader searches for diversity and differentiation. Thus, group leaders need to titrate conflict carefully. Generally, it is unnecessary for the leader to evoke conflict deliberately; if the group members are interacting with one another openly and honestly, conflict will emerge. More often, the therapist must intervene to keep conflict within constructive bounds.[41]

Keep in mind that the therapeutic use of conflict, like all other behavior in the here-and-now, is a two-step process: experience

(affect expression) and reflection upon that experience. You may control conflict by switching the group from the first to the second stage. Often a simple, direct appeal is effective: for example, “We’ve been expressing some intense negative feelings here today as well as last week. To protect us from overload, it might be valuable to stop what we’re doing and try together to understand what’s been happening and where all these powerful feelings come from.”

Group members will have different capacities to tolerate conflict. One client responded to the therapist’s “freezing the frame” (shifting the group to a reflective position) by criticizing the therapist for cooling things off just when things were getting interesting. Another member immediately commented that she could barely tolerate more tension and was grateful for a chance to regroup. It may be useful to think of the shift to *process* as creating a space for reflection—a space in which members may explore their *mutual* contributions to the conflict. The creation of this space for thoughtful reflection may be of great import—indeed, it may make the difference between therapeutic impasse and therapeutic growth.[42]

Receiving negative feedback is painful and yet, if accurate and sensitively delivered, helpful. The therapist can render it more palatable by making the benefits of feedback clear to the recipient and enlisting that client as an ally in the process. Often you can facilitate that sequence by remembering the original presenting interpersonal problems that brought the individual to therapy. If you have obtained verbal contracts from group members early in therapy, you can refer back to these when a member is getting feedback. This point underscores the therapeutic opportunity that arises in the midst of the client’s wish to retreat or flee.

For example, if at the beginning of therapy a client commented that her partner often accused her of trying to tear her down, and that she wished to work on that problem in the group, you may nail down a contract by a statement such as: “Carolyn, it sounds as though it would be helpful to you if we could identify similar trends in your relationships to others in the group. How would you feel if, from now on, we point this out to you as soon as we see it happen?” Once

this contract has been agreed upon, store it in your mind and, when the occasion arises (for example, when the client receives similar feedback in the group), remind the client that, despite the discomfort, this precise feedback may be exceptionally useful to her in understanding her relationship with her partner. The principles regarding effective interpersonal feedback noted in Chapter 2, notably the here-and-now focus and the shared risk-taking of the feedback provider and feedback receiver, are instructive.

Almost invariably, two group members who feel considerable mutual antagonism have the potential to be of great value to each other. Each obviously cares about how he is viewed by the other. In their anger, each will point out important (though unpalatable) truths to the other. The self-esteem of the antagonists may even be increased by the conflict. When people become angry at one another, this in itself may be taken as an indication that they are important to one another and take one another seriously. Individuals who truly care nothing for each other ignore each other. Individuals may learn another important lesson as well: that individuals may respond negatively to a trait, mannerism, or attitude of another person but still value the person.

For clients who have been unable to express anger, the group may serve as a testing ground for taking risks and learning that such behavior is neither dangerous nor necessarily destructive. In Chapter 2, we described incidents cited by group members as turning points in their therapy. A majority of these critical incidents involved the first-time expression of strong negative affect. It is also important for clients to learn that they can withstand attacks and pressure from others and that they will not be silenced. Emotional resilience and healthy insulation can be products of work involving conflict.[43]

> **Ron had struggled with debilitating chronic depression for much** of his life, so much so that he could not work for several years. He was in treatment for decades and many approaches had been tried—medications, electroconvulsive therapy (ECT), and neuromodulation—with little enduring effect. Raised by a single mother who was riddled with extreme anxiety, and who in essence used him as a prop to help

her manage her life, made him feel invisible. For example, he said, she would take him out of elementary school to accompany her somewhere if she needed his presence to reduce her social anxiety; and would have him sleep in her bedroom as a young teen when she had anxiety or nightmares. He had no independent existence. He often told the group that he felt as though he had worn a straitjacket throughout his life.

Ron struggled mightily to assert and take his proper space in the group. In one meeting he reported with great animation and anger that he had felt terrible after the prior week's session and had spent twenty-four hours in a state of virtual vegetation. His reaction had been provoked by another member of the group, Bette, who had dismissed him and the comments he had made about her depression. Although Bette was absent this session, the group encouraged him to keep talking about his experience.

He dove in with uncharacteristic intensity, talking about how he had felt as invisible and silenced by Bette as he had with his mother. It shut him down and he'd lost the capacity to do anything meaningful for the entire day following the meeting. He was, however, determined to address this, and he had chosen to do so in the here-and-now. Even though Bette was away, he would not silence himself and wait one more week, although he would address it again the next week with her present. The group was enthusiastic about his protest and noted that they had not seen Ron like this before.

Despite positive feedback from around the room, Ron began to question whether he was taking up too much time—a resurgence of his pathogenic beliefs. He was encouraged to check that out with others in the group, which drew this memorable response from a co-member, Pete: "I am fully and deeply committed to you, Ron, at this moment and unaware of any other feelings in my inner world other than wanting to be present with you." **<<**

This powerful statement underscores the importance of thoroughly processing group members' behavior. If we are to achieve a corrective emotional experience, we need to do more than provide clients with novel experiences. We also need to challenge the tendency of clients to neglect constructive feedback that challenges their negative assumptions.

In contrast to Ron and others like him who must overcome barriers to speaking up for themselves, overly aggressive individuals

may learn some of the interpersonal consequences of blind outspokenness. Through feedback, they, too, come to appreciate the impact they have on others and gradually come to terms with the self-defeating pattern of their behavior. For many of these individuals, angry confrontations provide valuable learning opportunities because the group members learn to remain in mutually useful contact with one another despite their anger.

Clients may be helped to express anger more directly and more fairly. Even in all-out conflict there are tacit rules of war that, if violated, make satisfactory resolution all but impossible. For example, combatants in therapy groups will occasionally take information disclosed by the other in a previous spirit of trust and use it to scorn or humiliate that person. Or they may refuse to examine the conflict because they claim to have so little regard for the other that they do not wish to waste any further time. These postures require vigorous intervention by the therapist.

When therapists belatedly realize that an earlier or different intervention would have been helpful, they should acknowledge that. As Donald Winnicott once said, the difference between good parents and bad parents was not the number of mistakes they made, but what they did with them.[44] We have both frequently commented to a group, “I wish I understood then what I understand now; I would have done things differently in the group.”

Sometimes in unusually sustained and destructive situations the leader must forcefully assume control and set limits. The leader cannot leave a situation to the group alone if doing so gives license to an individual’s destructive behavior.[45] One of the most common indirect and self-defeating modes of fighting is when the client, in one form or another, “injures” himself or herself in the hope of inducing guilt in the other—the “see what you’ve done to me?” strategy. Usually, much therapeutic work is required to change this pattern. It is generally deeply ingrained, with roots stretching back to earliest childhood (as in the common childhood fantasy of attending your own funeral and watching as parents and other grief-stricken tormentors pound their breasts in guilt).

Group leaders must endeavor to turn the process of habitually disagreeing into something positive—a learning situation that encourages members to evaluate the sources of their position and to relinquish those that are irrationally based. Clients must also be helped to understand that *regardless of the source of their anger, their method of expressing it may be self-defeating*. Feedback is instrumental in this process. For example, members may learn that, unbeknownst to themselves, they characteristically display scorn, irritation, or disapproval. Through feedback about our facial gestures and nuances of expression, we learn that we may communicate something we do not intend, or, for that matter, something we do not even consciously experience.[46]

The therapist should also attempt to help the conflicting members learn more about their opponents' position. For example, the therapist can ask a member to take the part of their opponent for a few minutes in order to apprehend the other's reasons and feelings.[47]

Other group approaches have been utilized effectively in a range of settings and with clinical populations ranging from burdened caregivers of family members with dementia to war veterans suffering posttraumatic stress disorder. These groups usually combine psychoeducation (focusing on the connections between thoughts, emotions, and behavior) and skill building in addressing intense emotions.[48] Emotional regulation is a learnable skill that involves muscle relaxation, deep breathing, and practice building distress tolerance.

Many clients have the opposite problem to those who might benefit from learning anger management skills: they too often suppress and avoid angry feelings. In groups they learn that others in their situation would feel angry; they learn to read their own body language ("My fists are clenched so I must be angry"); they learn to magnify rather than suppress the first flickerings of anger; they learn that it is safe, permissible, and often in their best interests to feel and to express anger. Most important, their fear of such behavior is extinguished: their fantasized catastrophe does not occur when they

express anger, and their comments do not result in destruction, guilt, rejection, or escalation of the anger.

Strong shared affect may enhance the importance of a relationship. In Chapter 3, we described how group cohesiveness is increased when members of a group go through intense emotional experiences together, regardless of the nature of the emotion. In this manner, members of a successful therapy group are like members of a close-knit family, who may battle each other yet derive much support from their family allegiance. A dyadic relationship that has weathered much stress is likely to grow increasingly rewarding. A situation in which two individuals in group therapy experience an intense mutual hatred, and then, through some of the mechanisms we have described, resolve the hatred and arrive at mutual understanding and respect, is always of great therapeutic value. It can provide comfort to the beginning group leader to know that the two members who are most disparaging to one another early on may become the most useful members to one another over time.

SELF-DISCLOSURE

Self-disclosure, both feared and valued by participants, plays an integral part in all group therapies. Without exception, group therapists agree that it is important for clients to reveal personal material in the group—material that the client would rarely disclose to others. The self-disclosure may involve past or current events in one's life, fantasy or dream material, hopes or aspirations, and current feelings toward other individuals. In group therapy, feelings toward other members often assume such major importance that the therapist must devote energy and time to creating the preconditions for disclosure: trust and cohesiveness.[49]

Self-Disclosure and Risk

Every self-disclosure involves some risk on the part of the discloser. Disclosing material that has previously been kept secret or that is highly personal and emotionally charged obviously carries great risk. First-time disclosure—that is, the first time one has shared certain information with anyone else—feels particularly risky. The degree of risk is shaped by the discloser's life experience. Pete's comment in the preceding clinical illustration had a profound impact on Ron. It had a profound impact as well on Pete, whose goal in group therapy was to access his deeply shut down emotional world.

The amount of risk also depends on the audience. Disclosing members, wishing to avoid shame, humiliation, and rejection, feel safer if they know that the audience is sensitive and has also previously disclosed highly personal material.[50]

Sequence of Self-Disclosure

Self-disclosure has a predictable sequence. If the receiver of the disclosure is involved in a meaningful relationship with the discloser, the receiver is likely to reciprocate with some personal disclosure of his or her own. Now the receiver as well as the original discloser is

vulnerable, and the relationship usually deepens, with the participants continuing to make slightly more open and intimate disclosures in turn until some optimal level of intimacy is reached. Thus, in the cohesive group, self-disclosure draws more disclosure, ultimately generating a constructive loop of trust, self-disclosure, feedback, and interpersonal learning.[51] An illustrative example:

> **Halfway through a thirty-session course of group therapy, Cam, an** avoidant, socially isolated thirty-year-old engineer, opened a session by announcing that he wanted to share a secret with the group: for the past several years, he had frequented strip clubs, often befriending the exotic dancers. He had a fantasy that he would rescue a dancer, who would then, in gratitude, fall in love with him. Cam went on to describe how he had spent thousands of dollars on his "rescue missions."
>
> The group members welcomed his disclosure, especially since it was the first substantially personal disclosure he had made in the group. Cam responded that time was running out, and he had wanted to relate to the others in a real way before the group ended. This encouraged Marie, a recovering alcoholic, to reciprocate with her own disclosure: many years before, she had worked as an exotic dancer and prostitute.
>
> Marie warned Cam that he could expect nothing but disappointment and exploitation in that environment. She had never disclosed her past for fear of the group's judgment, but she had felt compelled to respond to Cam, because she hated to see such a decent man getting into self-destructive relationships. The mutual disclosure, support, and caring in this exchange accelerated the work in the subsequent meeting for all the members. **<<**

Adaptive Functions of Self-Disclosure

As disclosures proceed in a group, the members gradually grow more engaged with and more responsible toward one another. If the timing is right, nothing will commit an individual to a group more than sharing some intimate, secret material.[52] Harry Stack Sullivan and Carl Rogers long ago maintained that self-acceptance must be preceded by acceptance by others; in other words, to accept oneself, one must gradually permit others to know one as one really is. A group member's disclosures provide the opportunity for the group to offer that essential acceptance.[53]

Self-disclosure underpins both the group bonding and the group task components of group therapy. It benefits the individual making the self-disclosure, and it benefits the entire group as well.[54] In Chapter 3, we described the relationship between self-disclosure and popularity in the group. Popularity (as determined from sociometric measurement) correlates with therapy outcome.[55] Group members who disclose extensively in the early meetings are often very popular in their groups. People reveal more to individuals they like; conversely, those who reveal themselves are more likely to be liked by others.[56] Several research inquiries have demonstrated that high disclosure (either naturally occurring or experimentally induced) increases group cohesiveness.[57] But the relationship between liking and self-disclosure is not linear. One who discloses too much arouses anxiety in others rather than affection.[58] In other words, both the content and the pace of self-disclosure need to be considered and processed within the group. Group members communicate in nonverbal ways as well as verbal ways, and the entirety of the communication should be kept in mind. Experienced group leaders maintain a *process* perspective and are aware: Who is saying what to whom? What is not being expressed or shared?[59] Self-disclosure is an essential step in the work of therapy, but not as an end in itself. It must be fully processed by the client and the group to achieve therapeutic benefit.[60]

Research supports the crucial role of self-disclosure in successful therapy outcome.[61] Early research showed that successfully treated participants in group therapy made almost twice as many self-disclosing personal statements during the course of therapy as clients with poorer outcomes did.[62] Morton Lieberman, Matthew Miles, and I (IY) found that in encounter groups, individuals who had negative outcomes revealed significantly less of themselves than those with positive outcomes.[63]

The concept of transfer of learning is vital here: *Not only are clients rewarded by the other group members for self-disclosure, but the behavior, thus reinforced, is integrated into their relationships*

outside the group, where it is similarly rewarded. Often the first step toward revealing something to a spouse or a potential close friend is disclosing it in the therapy group.

Hence, to a significant degree, the impact of self-disclosure is shaped by the relationship of the individuals with one another. What is truly validating to the client is to reveal oneself and *then* to be accepted and supported. Once that happens, the client experiences a genuine sense of connection and of understanding.[64] Keep in mind also that here-and-now ("hot-processing") disclosure, in particular, has a far greater effect on group cohesion than then-and-there (cold-processing) disclosure.[65]

Often clients manifest great resistance to self-disclosure. Frequently a client's dread of rejection or ridicule from other members coexists with the hope of acceptance and understanding.[66] Group members often entertain some calamitous fantasy about self-disclosure, and *to disclose and to have that calamitous fantasy disconfirmed is highly therapeutic*. Contrariwise, attacking or shaming a member for a self-disclosure is terribly destructive to the individual and to the group and requires immediate exploration and repair.

In one bold teaching experiment, students were asked to share a deep secret with the class. Great care was taken to ensure anonymity. Secrets were written on uniform pieces of paper, read by the instructor in a darkened classroom, so as to conceal blushing or other facial expressions of discomfort, and immediately destroyed. The secrets included various sexual preferences, illegal or immoral acts (including sexual abuse, cheating, stealing, drug dealing), psychological disturbances, abuse suffered in alcoholic families, and so on. Immediately after the reading of the secrets, there was a powerful response in the classroom: "a heavy silence… the atmosphere [was] palpable… the air warm, heavy, and electric… you could cut the tension with a knife." Students reported a sense of relief at hearing their secrets read—as though a weight had been lifted from them. But there was even greater relief in the subsequent class discussion, in which students shared their responses to

hearing various secrets and exchanged similar experiences. Many of them chose to identify which secret they wrote. The peer support was invariably positive and powerfully reassuring.[67] We seek acceptance from others and are comforted in learning that the deep secrets we maintain and hold in are often shared by others.

Maladaptive Self-Disclosure

Self-disclosure is related to optimal psychological and social adjustment in a curvilinear fashion: too much or too little self-disclosure signifies maladaptive interpersonal behavior.

Too little self-disclosure usually limits the opportunity for reality testing: those who fail to disclose themselves in a relationship generally forfeit the opportunity to obtain valid feedback. Furthermore, they prevent the relationship from developing further; without reciprocation, the other party will either desist from further self-disclosure or else abandon the relationship entirely.

Group members who do not disclose themselves have little chance of genuine acceptance by the other members and therefore little chance of experiencing a rise in self-esteem.[68] If a member is accepted on the basis of a false image, no enduring boost in self-esteem occurs; moreover, that person will then be even less likely to engage in valid self-disclosure because of the added risk of losing the acceptance gained through the false presentation of self.[69]

Some individuals dread self-disclosure, not primarily because of shame or fear of nonacceptance but because they are heavily conflicted in the area of control. To them, self-disclosure is dangerous because it makes them vulnerable to the control of others. It is only when several other group members have made themselves vulnerable through self-disclosure that such a person is willing to reciprocate.

Self-disclosure blockages will impede individual members as well as entire groups. Members who have an important secret that they dare not reveal to the group may find participation on anything but a superficial level very difficult, because they will have to conceal not only the secret itself but also *all possible avenues to it*. In Chapter 5

we discussed in detail how, in the early stages of therapy, the therapist might best approach the individual who has a big secret. To summarize, it is advisable for the therapist to counsel the client to share the secret with the group in order to benefit from therapy. The pace and timing are up to the client, but the therapist may offer to make the act easier in some way if the client so wishes.

When the long-held secret is finally shared, it is often illuminating to learn what made it possible for the client to come forward at that point in time. Despite potential frustration at the long delay in access to important client information, always welcome the disclosure. We will often make such statements as, "You've been coming to this group for many weeks wanting to tell us about this secret. What has changed in you or in the group to make it possible to share it today? What has happened to allow you to trust us more today?" And, later, "What will it be like to return to the group now having shared this?"[70] Consider the client's secret as having both content and process elements. Disclosing a secret can be an expression of trust; it can be a gift to the group; it can be a request for containment and support; it can represent a wish for absolution from guilt and shame. It can also be helpful to explore the secret as we would a dream (see Chapter 13). Some aspects of the secret are hidden even to the client making the disclosure and will be accessed only by joint exploration of its meaning with the group.[71]

Therapists sometimes unwittingly discourage self-disclosure. The most terrifying secret I (IY) have known a client to possess was in a newly formed group I supervised that was led by a neophyte therapist. This client, suffering from a postpartum psychotic illness, had murdered her two-year-old child and then attempted suicide. The courts ruled her not to be criminally responsible on account of mental illness. She was subsequently treated to good effect and had begun group therapy as part of a courageous effort at rebuilding her life. After fourteen weeks of therapy, she still had not told the group anything about herself; moreover, by her militant promulgation of denial and suppressive strategies (such as invoking astrological tables), she had impeded the work of the entire group. Despite his

manifest best efforts and much of my supervisory time, the therapist had not been able to help the client (or the group) move into productive therapy.

I then observed several sessions of the group through the two-way mirror and noted, to my surprise, that the client had provided the therapist with many opportunities to help her discuss the secret (for example, she made references to loss that he did not pursue). We devoted a supervisory session to the therapist's countertransference. His feelings about his own two-year-old child and his horror (despite himself) at the client's act had colluded with her guilt to silence her in the group. In the following meeting, the gentlest question by the therapist was sufficient to free the client's tongue and to change the entire character of the group.

In some groups, self-disclosure is discouraged by a generally judgmental climate. Members are reluctant to disclose shameful aspects of themselves for fear that others will lose respect for them. In training or therapy groups of mental health professionals, this issue is even more pressing. Since our chief professional instrument is our own person, at risk is professional as well as personal loss of respect. In a group of psychiatric residents, for example, one member, Omar, discussed his lack of confidence as a physician and his panic whenever he was placed in a life-or-death clinical situation. Ted, an outspoken, burly member, acknowledged that Omar's fear of revealing this material was well founded, since Ted did lose respect for him; in fact, Ted doubted whether he would refer patients to Omar in the future. The other members supported Omar and condemned Ted for his judgmental position, suggesting that they would be reluctant to refer patients to *him*. An infinite regress of judgment can easily ensue, and it is incumbent on the therapist at these times to make a vigorous process intervention. Training groups for mental health professionals that promote open sharing of concerns about the demands of contemporary practice and the fear of burnout can provide support and enhance practitioner resilience.[72]

The therapist must differentiate, too, between a healthy need for privacy and neurotic compulsive secrecy. Some people (though they

seldom find their way into groups) are private in an adaptive way: they share intimacies with only a few close friends and shudder at the thought of self-disclosure in a group. Moreover, they enjoy private self-contemplative activities. This is a very different thing from privacy based on fear, shame, or crippling social inhibitions. Men appear to have more difficulty with self-disclosure than women: they often view relationships from the perspective of competition and dominance rather than tenderness and connectedness.[73]

Too much self-disclosure can be as maladaptive as too little. Indiscriminate self-disclosure is neither a goal of mental health care nor a pathway to mental health. Some individuals make the grievous error of reasoning that if self-disclosure is desirable, then total and continuous self-disclosure must be a very good thing indeed. Life would become unbearably sticky if every contact between two people entailed sharing personal concerns and secrets. Obviously, the relationship that exists between discloser and receiver should be the major factor in determining the pattern of self-disclosure. Several studies have demonstrated this truth experimentally: individuals disclose different types and amounts of material depending on whether the receiver is a mother, father, best same-sex friend, opposite-sex friend, work associate, or spouse.[74]

However, some maladaptive disclosers disregard, and thus jeopardize, their relationship with the receiver. The self-disclosing individual who fails to discriminate between intimate friends and distant acquaintances perplexes associates. We have all experienced confusion or betrayal on learning that supposedly intimate material confided to us has been shared with many others. Furthermore, a great deal of self-disclosure may frighten off an unprepared recipient. In a rhythmic, flowing relationship, one party leads the other in self-disclosures, but never by too great a leap.

In group therapy, members who reveal early and promiscuously will often drop out soon in the course of therapy. Group members should be encouraged to take risks in the group, but if they reveal *too much too early*, they may feel so much shame and exposure that any interpersonal rewards are offset. Furthermore, their

overabundant self-disclosure may threaten others who would be willing to support them but are not yet prepared to reciprocate.[75] High disclosers are then placed in a position of such great vulnerability in the group that they may choose to flee. Pacing is essential. As we discussed in Chapter 5, a shift from vertical disclosure, regarding the *content* of the disclosure (what happened? who did what to whom?), to horizontal disclosure, regarding the *process* of the disclosure (how is it to share this with us?), is a way to maximize engagement and ensure a workable pace.

All of these observations suggest that self-disclosure is a complex social act that is situation and role bound. One does not self-disclose in solitude: time, place, and person must always be considered. Appropriate self-disclosure in a therapy group, for example, may be disastrously inappropriate in other situations, and appropriate self-disclosure for one stage of a therapy group may be inappropriate for another stage.

These points are particularly evident in the case of self-disclosure of feelings toward other members. It is our belief that the therapist should help the members be guided as much by responsibility to others as by freedom of expression. We have seen vicious, destructive events occur in groups under the aegis of honesty and self-revelation: "You told us that we should be honest about expressing our feelings, didn't you?" *But, in fact, we always selectively reveal our feelings.* There are always layers of reactions toward others that we rarely share—feelings about unchangeable attributes, physical characteristics, deformity, professional or intellectual mediocrity, social class, lack of charm, and so on.

Part of the benefit of group therapy lies in the fact that clients develop the skills required to be authentic, empathic, and nuanced in the kind of feedback they give others. One member noted that she never had any doubts about what was right or wrong and never hesitated to say so—until she joined the group and appreciated how harsh and insensitive she was to others. The newly acquired uncertainty was unsettling, but it clearly had a positive impact on her personal and professional relationships.

For some individuals, disclosure of overtly hostile feelings comes easily in the guise of being “honest.” But they find it more difficult to reveal underlying meta-hostile feelings—feelings of fear, envy, guilt, or sadistic pleasure in vindictive triumph. And how many individuals find it easy to disclose negative feelings but avoid expressing positive ones—feelings of admiration, concern, empathy, physical attraction, or love?

A group member who has just disclosed a great deal faces a moment of vulnerability and requires support from the members and/or the therapist. Regardless of the circumstances, no client should be attacked for making an important self-disclosure. A clinical vignette illustrates this point:

> **Five members were present at a meeting of a year-old group.** (Two members were out of town, and one was ill.) One member, Joel, began the meeting with a long, rambling statement about feeling uncomfortable in a smaller group. Ever since Joel had entered the group, his style of speaking had turned members off. Everyone found it hard to listen to him and longed for him to stop. But no one had really dealt honestly with these vague, unpleasant feelings about him until this meeting, when, after several minutes, Betsy interrupted him. She said, “I’m going to scream—or burst! I can’t contain myself any longer! Joel, I wish you’d stop talking. I can’t bear to listen to you. I don’t know who you’re talking to—maybe the ceiling, maybe the floor, but I know you’re not talking to me. I care about everyone else in this group. I think about them. They mean a lot to me. I hate to say this, but for some reason, Joel, you don’t matter to me.”
>
> Stunned, Joel attempted to understand the reason behind Betsy’s feelings. Other members agreed with Betsy and suggested that Joel never said anything personal. It was all filler, all cotton candy—he never revealed anything important about himself; he never related personally to any of the members of the group. Spurred, and stung, Joel took it upon himself to go around the group and describe his personal feelings toward each of the members.
>
> I (IY) thought that, even though Joel revealed more than he had before, he still remained in comfortable, safe territory. I asked, “Joel, if you were to think about revealing yourself on a 10-point scale, with 1 representing cocktail-party stuff and 10 representing the most you could ever imagine revealing about yourself to another person, how would

you rank what you did in the group over the past ten minutes?" He thought about it for a moment and said he guessed he would give himself a 3 or a 4. I asked, "Joel, what would happen if you were to move it up a rung or two?"

He deliberated for a moment and then said, "If I were to move it up a couple of rungs, I would tell the group that I was an alcoholic."

This was a staggering revelation. Joel had been in the group for a year, and no one else in the group—including me or my co-therapist—had known this. Furthermore, it was vital information. For weeks, Joel had bemoaned the fact that his wife was pregnant and had decided to have an abortion rather than have a child by him. The group was baffled by her behavior and over the weeks had become highly critical of his wife; some members even questioned why Joel stayed in the marriage. The new information that Joel was an alcoholic provided a crucial missing link. Now his wife's behavior made sense!

My initial response was one of anger. I recalled all those futile hours when Joel had led the group on a wild goose chase. I was tempted to exclaim, "Damn it, Joe, all those wasted meetings talking about your wife! Why didn't you tell us this before?" But fortunately, I recognized that this was just the time to bite my tongue! The important thing was not that Joel had withheld this information earlier, but that he had now told us. Rather than being punished for his previous concealment, he should be reinforced for having made a breakthrough. He had been willing to take an enormous risk in the group. The proper technique consisted of supporting Joel and facilitating further horizontal disclosure, that is, ask him to talk more about his experience of disclosure. **<<**

It is not uncommon for members to withhold information, as Joel did, with the result that the group spends time inefficiently. Obviously, this has a number of unfortunate implications, not the least of which is the toll it takes on the self-esteem of the withholding member, who knows he or she is being duplicitous—acting in bad faith toward the other members. Often group leaders do not know the extent to which a member is withholding, but as soon as they begin doing concurrent group and individual (or combined) therapy with the client, they are amazed at how much new information the client reveals.

In Chapter 7 we discussed aspects of group leader self-disclosure. The therapist's transparency, particularly within the here-

and-now, can be an effective way to encourage member self-disclosure.[76] But therapist transparency must always be guided by the principle of deepening the group work and being alert to one's impact on the group. The general who, after making an important tactical decision, goes around wringing his hands and expressing his uncertainty will undercut the morale of his entire command. Similarly, the therapy group leader should obviously not disclose feelings that would undermine the effectiveness of the group, such as impatience with the group, a preoccupation with a client or a group seen earlier in the day, or any of a host of other personal concerns.[77]

TERMINATION

We now return our attention to group development with a focus on the concluding phase of group therapy: termination, a critically important but frequently neglected part of treatment.[78] Group therapy termination is particularly complex: Members may leave because they have achieved their goals, they may drop out prematurely, the entire group may end, the therapist may leave a continuing group, or there may even be traumatic endings, such as in the form of a client suicide. Feelings about termination must be explored from different perspectives: that of the individual member, that of the therapist, and that of the group as a whole.

Even the word *termination* has unfavorable connotations. It is often used in such negative contexts as what we do with an unwanted pregnancy or a poorly performing employee.[79] In contrast, a mutual, planned ending to therapy is a positive, integral part of the therapeutic work that includes a review and consolidation of work done, mourning, and celebration of the commencement of the next phase of life. The ending should be clear and focused—not a petering out. Confronting the end of therapy is a boundary experience, a confrontation with limits.[80] It reminds us of the precious nature of our relationships and the requirement to conclude with as few regrets as possible about work undone, emotions unexpressed, or feelings unstated. In addition, there are clear tasks associated with the ending phase of therapy. These include the consolidation of gains, the resolution of remaining relationship issues, and planning for the future without the group.[81]

When a Client Terminates from the Group

If properly understood and managed, termination can be an important force in the process of change. Throughout, we have emphasized that group therapy is a highly individual process. Each client will enter, participate in, use, and experience the group in a

uniquely personal manner. The end of therapy is no exception.

Only general assumptions about the length and overall goals of therapy may be made. Though third-party insurers decree that most therapy groups be brief and problem oriented, we have presented evidence in Chapter 9 that brief group approaches may effectively offer benefit beyond symptomatic relief alone and can launch important growth for our clients. There is also evidence, however, that therapy is most effective when the end of treatment is collaboratively determined by the client and the therapist, guided by the client's progress and not arbitrarily imposed by a third party.[82] Third-party payers are most interested in what will be most useful for the majority of a large pool of clients. Psychotherapists are less interested in statistics and aggregates of clients than in individual distressed clients in their office. How much therapy is enough? That is not always an easy question to answer. The growing use of measurement-based care (see Chapter 13) can provide client outcome data to assist in guiding these decisions.[83] Although remoralization and recovery from acute distress often occur quickly, a substantial change in character structure generally requires twelve to twenty-four months—or more—of weekly therapy. Clients with chronic depression and a complex interplay of personality difficulties and trauma may require much longer periods in treatment.[84]

The goals of therapy have never been stated more succinctly than by Freud: "To be able to love and to work."[85] Freud believed that therapy should end when there is no prospect for further gains and the individual's pathology has lost its hold. Some theorists would add other goals: the ability to love oneself and to allow oneself to be loved; to be more flexible; to learn to play; to discover and trust one's own values; and to achieve greater self-awareness, greater interpersonal competence, and more mature defenses.[86]

Some group members may achieve a great deal in a few months, whereas others require years of group therapy. Some individuals have far more ambitious goals than others; it would not be an exaggeration to state that some individuals, satisfied with their therapy, terminate it in approximately the same state in which others

begin therapy. Some clients may have highly specific goals in therapy and, because much of their psychopathology is ego-syntonic, choose to limit the amount of change they are willing to undertake. Others may be hampered by important external circumstances in their lives. All therapists have had the experience of helping a client improve to a point at which further change would be countertherapeutic. For example, a client might, with further change, outgrow his or her spouse, such that continued therapy would result in the rupture of a marital relationship unless concomitant changes occurred in the spouse. Without that, the therapist may be well advised to settle for the positive changes that have taken place, even though the personal potential for greater growth is clear.

Termination of professional treatment is but a stage in the individual's course of growth. Clients continue to change, and one important effect of successful therapy is to enable individuals to use their psychotherapeutic resources constructively in their personal environment. Moreover, treatment effects may be time delayed. We have seen many successful clients in long-term follow-up interviews who have not only continued to change after termination but who, after they have left the group, recall an observation or interpretation made by another member or the therapist that only then—months, even years, later—becomes meaningful to them. Others carry the group within them and utilize the adage we noted before—"What would the group say?"—whenever they are challenged in their life.

Setbacks, too, occur after ending therapy. From time to time, successfully treated clients encounter severe stress and need short-term individual help. In addition, members may experience anxiety and depression after leaving a group. A period of mourning is an inevitable part of the termination process. Current loss may evoke memories of earlier losses, which may be so painful that the client truncates the termination work. Indeed, some cannot tolerate the process and will withdraw prematurely with a series of excuses. This must be challenged: the client needs to internalize the positive group experience and the members and leader; without a proper separation process that is worked through, the internalization will be

compromised, and the client's future growth constricted.[87]

Some therapists find that termination from group therapy is less problematic than termination from long-term individual therapy. In the latter, clients often become extremely dependent on the therapeutic situation. Group therapy participants are usually more aware that therapy is not a way of life but a process with a beginning, a middle, and an end. In the open therapy group, there are many living reminders of this therapy sequence. Members see new members enter and improved members graduate, and they observe the therapist beginning the process over and over again to help new members through difficult phases of therapy.

Not infrequently, a group places subtle pressure on a member not to leave because the remaining members will miss that person's presence and contributions. There is no doubt that members who have worked in a therapy group for many months or years acquire interpersonal and group skills that make them particularly valuable to the other members. Therapists, also, may so highly value such a member's contributions that they are slow in encouraging him or her to terminate. Of course, there is no justification for such a posture, and therapists should explore this issue openly as soon as they become aware of it.

Many therapists have noted that a "role suction" operates at such times: once the senior member leaves, another member begins to exercise skills acquired in the group. Therapists, like other members, will feel the loss of departing members, and by expressing their feelings openly can do some valuable modeling for the group, demonstrating that the therapy and the relationships matter, not just to the clients but to them, the therapists, as well. Some socially isolated clients may postpone termination because they have been using the therapy group for social reasons rather than as a means for developing the skills to create a social life for themselves in their home environment. The therapist must help these members focus on transfer of learning and encourage risk-taking outside the group. Others unduly prolong their stay in the group because they hope for some guarantee that they are indeed safe from future difficulties.

They may suggest that they remain in the group for a few more months, until they start a new job, or get married, or graduate from college. If the improvement base seems secure, however, these delays are generally unnecessary. Members must be helped to come to terms with the fact that one can never be certain; one is always vulnerable.

Not infrequently, clients experience a brief recurrence of their original symptomatology, including dismissive or clinging attachment behaviors, shortly before termination.[88] There are times when this regression can serve as a last opportunity to revisit the concerns that led to treatment initially and promote some relapse prevention work. It is helpful to remember that good work in therapy rarely gets undone by the ending process, and the return of old behaviors provides an opportunity for more complete working through and consolidation. Rather than prolong their stay in the group, the therapist should help the clients understand this event for what it is: protest against termination.

> **One group member, three meetings before termination, reexpe**rienced much of the depression and sense of meaninglessness that had brought him into therapy. The symptoms rapidly dissipated with the therapist's interpretation that he was searching for reasons not to leave the group. That evening, the client dreamed that the therapist offered him a place in another group in which he would receive training as a therapist. The client felt that he had duped the therapist into thinking he was better. The dream represents an ingenious stratagem to defeat termination and offers two alternatives: the client goes into another of the therapist's groups, in which he receives training as a therapist, or he has duped the therapist and has not really improved (and thus should continue in the group). Either way, he does not have to terminate. **<<**

Some members improve gradually, subtly, and consistently during their stay in the group. Others improve in dramatic bursts. We have known many members who, though hardworking and committed to the group, made no apparent progress whatsoever for six, twelve, even eighteen months, and then suddenly, in a short period of time, seemed to transform themselves. As we tell our students and

trainees, change is often slow. Do not look for immediate gratification from clients. If your clients build solid, deep therapeutic foundations, change is sure to follow. So often we think of this as just a platitude designed to bolster neophyte therapists' morale. But we must not forget that it is true. Do not sell the ending phase short; the last four to eight sessions are often a time when much of the prior work consolidates and clients evolve from feeling that they are renters of the psychotherapeutic endeavor to owners.

The same staccato pattern of improvement is often true for the group as a whole. Sometimes groups struggle and lumber on for months with no visible change in any member, and then suddenly enter a phase in which everyone seems to get well together. Scott Rutan uses the apt metaphor of building a bridge during a battle.[89] The leader labors mightily to construct the bridge, and may, in the early phases, suffer casualties (dropouts). But once the bridge is in place, it escorts many individuals to a better place.

There are certain clients for whom even a consideration of termination is problematic. These clients are particularly sensitized to abandonment; their self-regard is so low that they consider their illness to be their only currency in their traffic with the therapist and the group. In their minds, growth is associated with dread, since improvement would result in the therapist leaving them. Therefore, they must minimize or conceal progress. Of course, it is not until much later that they discover the key to this paradox: once they truly improve, they will no longer need the therapist!

One useful sign suggesting readiness for termination is that the group becomes less important to the client. One terminating member commented that Mondays (the day of the group meetings) were now like any other day of the week. When she began in the group, she lived for Mondays, with the rest of the days inconsequential wadding between meetings.

The group members are an invaluable resource in helping one another decide about termination, and a unilateral decision made by a member without consulting the other members is often premature. Usually a decision to leave is made jointly by the member, the group,

and the group therapist, with planning in advance to ensure that there is adequate time to do the psychological work of ending. In our open-ended groups, it is common for a client to give notice of termination four to eight sessions in advance.[90] There are times when clients make an abrupt decision to terminate membership in the group immediately. We have often found that such individuals find it difficult to express gratitude and positive feeling; hence they attempt to abbreviate the separation process as much as possible. These clients must be helped to understand and correct their jarring, unsatisfying method of ending relationships. In fact, for some, the dread of ending dictates their whole pattern of avoiding connections and intimacy. To ignore this phase is to neglect an important area of human relations. Ending is, after all, a part of almost every relationship, and throughout one's life one must say good-bye to important people. A meaningful relationship should be honored and concluded with dignity.

Many terminating members attempt to lessen the shock of departure by creating links to the group that they can use in the future. They seek assurances that they may return; they collect the cellphone numbers and email addresses of the other members, "friend" one another on social media, or arrange social meetings to keep themselves informed of important events in the group. These efforts are only to be expected, and yet the therapist must not collude in the denial of termination. On the contrary, you must help the members explore it to its fullest extent. Clients who complete individual therapy may return, but clients who leave the group can never return. They are truly leaving because the group will never be the same group again. It will be irreversibly altered: new members will enter the group; new problems will emerge for discussion; relationships will evolve. The present cannot be frozen; time flows on inexorably. These facts are soon evident to the remaining members. There is no better stimulus than a departing member to encourage the group to deal with issues of loss, separation, death, aging, the rush of time, and the contingencies of existence. Termination is thus more than an extraneous event in the group. It is the microcosmic

representation of some of life's most crucial and painful issues.

The remaining group members will need some sessions to work through their feelings of loss and to deal with many of these issues. The loss of a member provides an unusual work opportunity for individuals sensitized to loss and abandonment. Since they have compatriots sharing their loss, they mourn in a communal setting and witness others encompassing the loss and continuing to grow and thrive.[91]

After a member leaves the group, it is generally wise not to bring in new members without a hiatus of one or more meetings. Not only does this provide time for further working through of the impact of the departure, but it reminds the group that group members are not replaceable with a call to "central intake." A member's departure is often an appropriate time for others to take inventory of their own progress in therapy. Members who entered the group at the same time as the terminating member may feel some pressure to move more quickly. More competitive members may rush toward termination prematurely. Senior members may feel envy or react with shame, experiencing the success of the co-member as a reminder of their own deficiencies and failings. In extreme cases, the envy-ridden group member may seek to devalue and spoil the achievement of the graduating member. Newer members may feel inspired or awed, but doubt whether they will ever be able to achieve what they have just witnessed.

Should the group engage in some form of ritual to mark the termination of a member? Sometimes a member or several members may present a gift to the graduating member or bring coffee and cake to the final meeting. How best to proceed?[92] There are a range of perspectives on this question that reflect the way our models, experiences, and personhood influence our practice. Our perspective is that these rituals are acceptable, perhaps even desirable, as long as they are examined and processed in the group.[93]

We therapists must also look to our own feelings during the termination process, because occasionally we unaccountably and

unnecessarily delay a client's termination. Some perfectionist therapists may unrealistically expect too much change and refuse to accept anything less than total resolution. Moreover, they may lack faith in a client's ability to continue growing after the termination of formal therapy.[94] Other clients bring out Pygmalion pride in us: we find it difficult to part with someone who is, in part, our own creation: saying good-bye to some clients is like saying good-bye to a part of ourselves. Furthermore, it is a permanent good-bye. If we have done our job properly, the client no longer needs us and breaks all contact.

The suicide of a group therapy client is, thankfully, uncommon. However, in the career of a mental health professional and group therapist who may also be supervising group therapy trainees, it does occur. One in two psychiatrists and one in six psychologists will experience a suicide in their practice over time.[95] It is a painful and potentially traumatic event. Although the suicide of one man in a group I (ML) was supervising happened many years ago, I still recall it vividly and its impact lingers with me as well as with the two therapists who led the group, who are now colleagues. The client was depressed, had lost his business, and was going through a divorce as well, but did not manifest despair in the group and appeared to be forward thinking. He ended his life on the filing date for his income taxes.

A client suicide shakes a therapist's foundations and generates feelings of guilt, shame, fear, anger, and incompetence. It can impact how one practices, leading a therapist to avoid higher-risk clients.[96] It is exceptionally challenging to work with group therapy clients who have lost a member to suicide. Sharing this painful news is an urgent imperative but can be complicated ethically and legally because of the disclosure of private client health information. It is advisable to discuss this issue with the privacy officer at one's institution or with the relevant professional oversight committee.

We recommend that you enlist collegial support as you prepare to inform a group about a member's suicide. It is essential to be able to discuss, reflect on, and address your own reactions. Group members' reactions will be intense and will cover the range of

emotions described above. In addition, group members may fear for their own safety and identify with the deceased group member. Anger at the client, at treatment, and at the group therapist is to be expected. The group therapist needs to be able to join the group in grief without becoming paralyzed or frozen. Therapeutic presence and therapeutic containment can stabilize the group, maintain group integrity, promote member safety, and support the members' grieving process. The surviving group members' existential confrontation with mortality may strengthen their commitment to their treatment and safeguard the group from fragmenting into a state of hopelessness and futility.

When the Therapist Departs from the Group

In training programs, it is common practice for trainees to lead a group for six months to a year and then pass it on to a new student as their own training takes them elsewhere. The departure of the group leader is generally a difficult period for the group members, who often respond with repeated absences and threatened departure of their own. It is a time for the departing therapist to attend to any unfinished business he or she has with any of the members. Some members feel that this is their last chance and share hitherto concealed material. Others experience a return of earlier symptoms, as though to say, "See what your departure is doing to me!"[97] Therapists must deal with all of these concerns. The more complete their ending with the group, the greater the potential for an effective transfer of leadership.

The same principles apply in situations in which a more established leader needs to end his leadership owing to a move, an illness, or a professional change. If the group members decide to continue, it is the leader's responsibility to secure new leadership. The transition process takes considerable time and planning, and the new leader must set about as quickly as possible to take over group leadership. One reported approach is for the new leader to meet with all the group members individually in a pregroup format as described in Chapter 9, while the original leader is still meeting with the group.

After the first leader leaves, the new leader begins to meet with the group at the set group time or at a mutually agreed-upon new time.[98]

The departing group leader's denial of loss, particularly when retiring from practice, may lead him or her to underestimate the work and time required for the group to address the loss and anger at ending.[99] At other times, illness or an accident precludes proper planning. To avoid leaving one's group abandoned, therapists should consider writing a professional will. Ann Steiner, a practicing clinical psychologist, has articulately described such a guide. The purpose of such a will is to ensure that you have addressed the continuing care needs of your clients in an ethical fashion. This includes a plan for one's clients to be contacted in the event the therapist is unable to do so and provided with options for care.[100]

When the Whole Group Terminates

Groups terminate for various reasons. Brief therapy groups, of course, have a preset termination date. Often, external circumstances dictate the end of a group: for example, groups in college counseling centers usually run through a semester or two. Open groups often end only when the therapist retires or leaves the area (although the group may continue if there is a co-therapist). Occasionally, a therapist may decide to end a group because the great majority of its members are ready to terminate at approximately the same time.

Often a group avoids the difficult and unpleasant work of termination by denying or ignoring it, and the therapist must keep the task in focus for them.[101] In fact, it is essential for the leader of the brief therapy group to remind the group regularly of the approaching termination and to keep members focused on the attainment of goals. Groups hate to die, and members generally try to avoid the ending. They may, for example, pretend that the group will continue in some other setting—for example, reunions or regularly scheduled social meetings. But the therapist is well advised to confront the group with reality: the end of a group is a real loss. It never really can

be reconvened, and even if relationships are continued in pairs or small fragments of the group, the entire group as the members then know it—in this room, in its present form, with the group leaders—will be gone forever.

The therapist must call attention to maladaptive modes of dealing with the impending termination. Some individuals have always dealt with the pain of separating from those they care about by becoming angry or devaluing the others. Some choose to deny and avoid the issue entirely. If anger or avoidance is extreme—manifested, for example, by tardiness or increased absence—the therapist must confront the group with this behavior. Usually with a mature group, the best approach is direct: reminding the members that it is their group, and they must decide how they want to end it.

Pain over the loss of the group is dealt with in part by a sharing of past experiences. Exciting and meaningful past group events are remembered in the final meetings: members remind one another of the way they were then; personal testimonials are invariably heard. It is important that the therapist not bury the group too early, or the group will limp through ineffective lame-duck sessions. You must find a way to hold the issue of termination before the group and yet help the members keep working until the very last minute. Often it is useful to enquire into members' feelings of regret about any issues not yet addressed.

Some leaders of effective time-limited groups have sought to continue the benefits of the group by helping it move into an ongoing leaderless format. The leader may facilitate the transition by attending the meetings as a consultant at regular but decreasing intervals, such as biweekly or monthly. In our experience, it is particularly desirable to make such arrangements when the group is primarily a support group and constitutes an important part of the members' social lives—for example, groups of elderly clients who, through the death of family members, friends, and acquaintances, are isolated. Others have reported the successful launching of ongoing leaderless groups for men, for women, for AIDS sufferers, for Alzheimer's caregivers, and for the bereaved. Cancer support groups often continue to good effect after the formal duration of the

treatment has concluded.[102]

Keep in mind that the therapist, too, experiences the discomfort of termination. Throughout the final group stage, we can facilitate the group work by disclosing our own feelings. Therapists, as well as members, will miss the group. We are not impervious to feelings of loss and bereavement. We have grown close to the members and we will miss them as they miss us. To us as well as to the client, termination is a jolting reminder of the built-in cruelty of the psychotherapeutic process. Such openness on the part of the therapist invariably makes it easier for the group members to make their good-bye more complete. For us, too, the group has been a place of anguish, conflict, fear, and also great beauty. Some of life's truest and most poignant moments occur in the small and yet limitless microcosm of the therapy group.

Footnotes

i This is the same Ginny with whom I coauthored a book about our psychotherapy: I. Yalom and G. Elkin, *Every Day Gets a Little Closer: A Twice-Told Therapy* (New York: Basic Books, 1975; reissued 1992).

12

The Challenging Group Member

WE HAVE YET TO ENCOUNTER A CLIENT WHO COASTS through therapy like a newly christened ship gliding smoothly into the water. Each group member *must* be a challenge: the success of therapy depends on the members encountering and then mastering fundamental life problems in the here-and-now of the group. Only in that way can therapy be helpful; the clinical challenge is in fact the therapeutic opportunity. Each client's clinical concerns are overdetermined and unique. In light of this, our intent is not to provide a compendium of solutions to all possible problems. Instead we aim to describe a strategy and set of techniques that will enable a therapist to address challenges that arise in the group. The term "challenging group member" is itself problematic because it can narrow our focus and reduce our understanding. Keep in mind that the challenging group member rarely exists in a vacuum but is often an amalgam of several components: the client's own traits and psychodynamics, the group's dynamics, and the client's interactions with co-members and the therapist. By overestimating the contributions of the client's character and underestimating the role of the interpersonal context, we pathologize clients and place them at risk for scapegoating.[1]

At the same time, certain behavioral constellations merit particular attention because of their common occurrence and their utility in explicating therapeutic principles for group leaders. Accordingly, in this chapter, we turn our attention to common problematic clients: the monopolist, the silent client, the boring client, the help-rejecting complainer, the acutely psychotic or bipolar client, the schizoid client,

and the characterologically difficult client (the borderline client and the narcissistic client). Although diagnostic classifications and nomenclature evolve over time, these clinical prototypes seem to persist. These clients often cause serious difficulties when they engage interpersonally with fellow group members, and they will also likely cause therapists to experience strong countertransference reactions. Keep in mind that these group members often direct attention away from their core vulnerabilities as they enact their difficulties rather than explore them.[2]

THE MONOPOLIST

The bête noire of many group therapists is the habitual monopolist, a person who seems compelled to chatter on incessantly. These individuals are anxious if they are silent; if others get the floor, they reinsert themselves through a variety of techniques: rushing in to fill the briefest silence, responding to every statement in the group, continually addressing the problems of other group members with a chorus of "I'm like that, too."

The monopolist may persist in describing conversations with others in endless detail, gossiping, or presenting accounts of online or social media stories that are only slightly relevant to the group.[3] Some monopolists hold the floor by assuming the role of interrogator. One member barraged the group members with so many questions and "observations" that it occluded any opportunity for other members to interact or reflect. Finally, when angrily confronted by co-members about her disruptive effect, she explained that she dreaded silence because it reminded her of the "calm before the storm"—the silence preceding her father's explosive, violent rages.

Some clients who have a dramatic flair monopolize the group by means of the crisis method: they regularly present the group with major life upheavals, which always seem to demand urgent and lengthy attention. The other members are cowed into silence, their problems seeming trivial in comparison. ("It's not easy to interrupt *Game of Thrones*," as one group member put it.)

Although a group may welcome and even encourage the monopolist in the initial meetings, the *effect on the group* is quickly countertherapeutic. The mood soon turns to one of frustration and anger. Other group members are often disinclined to silence a member for fear that they will then be obliged to fill the silence; they anticipate the obvious rejoinder of, "All right, I'll be quiet. You talk." It is not possible to talk easily in a tense, guarded climate. Members who are not particularly assertive may smolder quietly or make indirect hostile forays. Generally, oblique attacks on the monopolist

will only aggravate the problem and fuel a vicious circle. If the monopolist's compulsive speech is an attempt to deal with anxiety, and he or she begins to sense the growing tension and resentment in the group, his or her anxiety rises, and the compulsive tendency to speak only increases.

Unresolved tension arising from this dynamic will eventually wear away at group cohesion and manifest in signs of group disruption such as absenteeism, dropouts, fighting, and divisive subgrouping. When the group does finally confront the monopolist, it often takes the form of an explosive, brutal outburst by a group spokesperson, who then usually receives unanimous support from the other members. We have even witnessed a group giving the spokesperson a round of applause—a sure sign that a problem has been addressed far too late. The monopolist may then sulk, be completely silent for a meeting or two ("See what they do without me?"), or leave the group. In any event, little that is therapeutic has been accomplished for anyone.

How can the therapist interrupt the monopolist in a therapeutically effective fashion? Despite the strongest urge to shout the client down or to silence the client by edict, such an assault has little value (except as a temporary catharsis for the therapist). The client is not helped: no learning has accrued; the dynamics underlying the monopolist's compulsive speech persist and will, without doubt, erupt again in further monopolistic volleys or force the client out of the group. Neither is the group helped; regardless of the circumstances, the others are threatened by the fact that the therapist has silenced one of its members in such a heavy-handed manner. A seed of caution and fear is implanted in each member's mind as they imagine a similar fate befalling them.

Nevertheless, monopolistic behavior must be checked, and generally it is the therapist's task to do so. Although therapists generally do well to wait for the group to handle many other group problems, the monopolistic member is one problem that groups, especially young groups, often cannot handle. Monopolistic clients pose a threat to the group's procedural underpinnings; group members are encouraged to speak, yet this particular member must

be silenced. The therapist must prevent the development of therapy-obstructing norms and at the same time prevent the monopolistic client from committing social suicide. A two-pronged approach is most effective: consider both the monopolizer *and* the group that has allowed itself to be monopolized. This approach reduces the hazard of scapegoating and illuminates the role played by the group in each member's behavior.

From the standpoint of the group, bear in mind that individual and group psychology are inextricably interwoven. No monopolistic client exists in a vacuum: the client always abides in a dynamic equilibrium with a group that permits or encourages such behavior.[4] So the therapist may inquire why the group permits or encourages one member *to carry the burden of the entire meeting*. This inquiry may startle the members, who have perceived themselves only as passive victims of the monopolist. Or we might inquire if others experience the desire to hold everyone's attention by talking through the whole meeting.[5] After the initial protestations are worked through, the group members may benefit from examining their use of the monopolist in avoiding their own disclosures.

Part of the power of group therapy is the way a single group phenomenon may evoke many different reactions. Some group members may be relieved at not having to speak in the group. They may let the monopolist do all the self-disclosure, or appear foolish, or act as a lightning rod for the group members' anger, while they themselves assume little responsibility for the group's therapeutic tasks. Prompted to disclose and discuss their reasons for inactivity, group members' personal commitment to the therapeutic process is often augmented. They may, for example, discuss their fear of asserting themselves, or of harming the monopolist, or of being attacked in retaliation by another member or by the therapist. Or they may wish to avoid seeking the group's attention lest their own neediness or narcissism be exposed. Or they may secretly revel in the monopolist's plight, and enjoy being a member of the victimized and disapproving majority. The disclosure of any of these issues by an uninvolved client signifies greater engagement in therapy.

> **In one group a submissive, chronically depressed woman, Katie,** exploded in an uncharacteristic expletive-filled rage at the monopolistic behavior of another member. As she explored her outburst, Katie quickly recognized that her rage was really inwardly directed, stemming from her own stifling of her own voice, her own passivity, her avoidance of her own emotions. “My outburst was twenty years in the making,” Katie added as she apologized and thanked her startled “antagonist” for crystallizing this awareness. **<<**

The group approach to this problem must be complemented by work with the monopolistic individual. The basic principle is a simple one: you do not want to silence the monopolist; you do not want to hear less from the client—*you want to hear more*. This seeming paradox is resolved when we consider that the monopolist uses compulsive speech for self-concealment. The issues the monopolist presents to the group do not accurately reflect deeply felt personal concerns but are selected for other reasons: to shield, entertain, gain attention, justify a position, present grievances, and so on. The monopolist sacrifices the opportunity for therapy to their insatiable need for attention or control. The essential message to monopolists must be that, through such compulsive speech, they hold the group at arm’s length and prevent others from relating meaningfully to them. You do not reject the monopolist, but instead issue an invitation to the monopolist to engage more fully in the group. If you harbor only the singular goal of silencing the client, then you have, in effect, submitted to your countertransference and abandoned the therapeutic goal; you might as well remove the member from the group.

At times, despite considerable therapist care, the client will continue to hear only the message, “So, you want me to shut up!” Such clients may ultimately leave the group, often in embarrassment or anger. Although this is an unsettling event, the consequences of therapist inactivity are far worse. Though the remaining members may express some regret at the departure of the member, it is not uncommon for them to acknowledge that they were on the verge of leaving themselves had the therapist not intervened.

In addition to their grossly maladaptive interpersonal behavior,

monopolists have a major social sensory impairment. They seem peculiarly unaware both of their interpersonal impact and of the response of others to them. Moreover, they lack the capacity or inclination to empathize with others. These are bread-and-butter issues in group therapy, but only if they can be addressed.

Data from a preliminary study supports this conclusion.[6] Group members and student observers of a series of group sessions of a therapy group were asked to fill out questionnaires at the end of each group meeting. One of the areas explored was group activity. Both the participants and the observers were asked to rank the group members, including themselves, for the total number of words uttered during a meeting. There was excellent reliability in the activity ratings among group members and observers, with two exceptions: (1) the ratings of the therapist's activity by the clients showed large discrepancies (a function of transference); and (2) monopolistic clients placed themselves far lower on the activity rankings than did the other members, who were often unanimous in ranking a monopolist as the most active member in the meeting.

The therapist, then, must help monopolists be self-observant by encouraging the group to provide them with continual empathic feedback about their impact on the others.[7] Relating this feedback to the initial therapy goals of these clients is also helpful. For instance, saying, "You want to get close to people," "You want to be less isolated," or "You want feedback about what goes wrong in your relationships" can help the client see the difficult confrontation as an opportunity. Without this sort of guidance from the leader, the group may provide the feedback in a disjunctive, explosive manner, which only makes the monopolist defensive.

> **In his initial interview, Matthew, who would later become a monopolist** in the group, complained about his relationship with his wife, who, he claimed, often abruptly resorted to such sledgehammer tactics as publicly humiliating him or accusing him of being irresponsible and dishonest in front of his adult children.
>
> Within the first few meetings of the group, a similar sequence unfolded in the social microcosm of the group: because of his

> monopolistic behavior, judgmental attitude, and inability to hear the members' response to him, the group pounded harder and harder, until finally, when he was forced to listen, their sledgehammer message sounded cruel and humiliating. **<<**

Often the therapist must help increase a client's receptivity to feedback. You may have to be forceful and directive, saying, for example, "Charlotte, I think it would be best now for you to stop speaking because I sense there are some important feelings about you in the group that would be very helpful for you to know." You should also help the members disclose their responses to Charlotte rather than their interpretations of her motives. As described earlier, in the sections on feedback and interpersonal learning, it is far more useful and acceptable to offer a statement such as, "When you speak in this fashion I feel…" rather than "You are behaving in this fashion because…" Clients often perceive interpretations about motivations as accusatory, but find it more difficult to reject the validity of others' subjective responses, particularly when echoed by other group members.

Too often in group therapy, we confuse or interchange the concepts of cause, interpersonal manifestation, and response. The *cause* of monopolistic behavior may vary considerably from client to client: some individuals speak in order to control others; some so fear being influenced or penetrated by others that they compulsively defend each of their statements; and some so overvalue their own ideas and observations that they cannot delay and all thoughts must be immediately expressed. Still others are simply desperate for the group's attention. Generally, the cause or actual intent of the monopolist's behavior is not well understood until much later in therapy, and interpretation of the cause may offer little help in the early management of disruptive behavior patterns. It is far more effective to concentrate on the client's *manifestation* of self in the group and on the other members' *response* to his or her behavior. Members must be confronted gently but repeatedly with the paradox that however much they may wish to be accepted and respected by others, they persist in behavior that generates only irritation,

rejection, and frustration. That feedback can be truly impactful and empathetic.[8] A clinical illustration of many of these issues occurred in a therapy group in a psychiatric hospital/prison in which sexual offenders were incarcerated:

> **Walt, who had been in the group for seven weeks, launched into** a familiar, lengthy tribute to the remarkable improvement he had undergone. He described in exquisite detail how he had not understood the damaging effects of his behavior on others, and how now, having achieved such understanding, he was ready to leave the hospital.
>
> The therapist, alert to the group process, observed that some of the members were restless. One softly pounded his fist into his palm, while others slumped back in a posture of indifference and resignation. The therapist intervened by asking the group members about their response to Walt's account. All agreed they had heard it at every meeting—in fact, they had heard Walt speak this way in the very first meeting. Furthermore, they had never heard him talk about anything else and knew him only as a story. The members discussed their irritation with Walt, their reluctance to confront him for fear of seriously injuring him, of losing control of themselves, or of painful retaliation. Some spoke of their hopelessness about ever reaching Walt, and of the fact that he related to them only as stick figures without flesh or depth. Still others noted their terror of speaking and revealing themselves in the group; therefore, they welcomed Walt's monopolization. A few members expressed their total lack of interest or faith in therapy and therefore failed to intercept Walt because of apathy.
>
> Thus, the process was overdetermined: a host of interlocking factors resulted in a dynamic equilibrium of monopolization. By halting the runaway process, and uncovering and working through the underlying factors, the therapist obtained maximum therapeutic benefit from a potentially crippling group phenomenon. Each member moved closer to group involvement. Walt was no longer enabled to participate in a fashion that could not possibly be helpful to him or the group. **<<**

It is essential to guide the monopolistic client into the self-reflective process of therapy. We urge such clients to reflect on the type of response they hoped to receive from the group and then compare that with what actually occurred when they were given feedback. How do they explain that discrepancy? What role did they

play in it? Would they like to change the way they relate to others?

Often monopolistic clients may devalue the importance of the group's reaction to them. They may suggest that the group consists of disturbed people, or protest, "This is the first time something like this has ever happened to me." If the therapist has prevented scapegoating, then this statement is always untrue: the client is in a particularly familiar place. What is different in the group is the presence of norms that permit the others to comment openly on the behavior.

The therapist increases therapeutic leverage by encouraging these clients to examine and discuss interpersonal difficulties in their lives: loneliness, lack of close friends, not being listened to by others, being shunned without reason—all the reasons for which therapy was first sought. Once these are made explicit, the therapist can more convincingly demonstrate to monopolistic clients the importance and relevance of examining their in-group behavior. Good timing is necessary: there is no point in attempting to do this work with a closed, defensive individual in the midst of a firestorm. Repeated, compassionate, and properly timed interventions are required.

THE SILENT CLIENT

The silent member is a less disruptive but often equally challenging problem for the therapist. How concerned should we be? Perhaps the client profits silently. A story, probably apocryphal, that has circulated among group therapists for decades tells of an individual who attended a group for a year without uttering a word. At the end of the fiftieth meeting, he announced to the group that he would not return; his problems had been resolved, he was due to get married the following day, and he wished to express his gratitude to the group for the help they had given him.

Let's examine this issue more closely. Some reticent members may profit from vicariously engaging in treatment through identifying with active members with similar problems. It is possible that changes in behavior and in risk-taking can gradually occur in such a client's relationships outside the group, although the person remains silent and seemingly unchanged in the group. The encounter group study that Morton Lieberman, Matthew Miles, and I (IY) conducted indicated that some of the participants who changed the most seemed to have a particular ability to maximize their learning opportunities in a short-term group (thirty hours) *by engaging vicariously in the group experience of other members*.[9]

In general, though, the evidence indicates that the more active and influential a member is in the group, the more likely it is that he or she will benefit. Research in experiential groups demonstrates that for the vast majority of participants, regardless of what the participants say, *the more words they speak, the greater the positive change in their picture of themselves*.[10] Other research demonstrates that vicarious experience, as contrasted with direct participation, was ineffective in producing either significant change, emotional engagement, or attraction to the group process.[11] A member who is persistently silent also fails to contribute to the work of others, which undermines the cohesion of the group. This silent

member can become an object of projection, seen as sitting in judgment of group members.

There is much clinical consensus that silent members do not profit from the group. Group members who self-disclose very slowly may never catch up to the rest of the group and at best achieve only minimal gains.[12] The greater the verbal participation, the greater the sense of involvement and the more that clients are valued by others and ultimately by themselves. Self-disclosure is not only essential to the development of group cohesion, it is directly correlated to positive therapeutic outcome, as is the client's "work" in therapy. We urge therapists not to be lulled by the legendary story of the silent member who got well. *A silent client is a problem client and rarely benefits significantly from the group.* The hazard is particularly acute in time-limited groups as there is less opportunity for late starters to catch up before the group concludes. Silence, if unchallenged by the therapist or group, may reinforce the client's pathogenic beliefs and assumptions.

Clients may be silent for many reasons. Some may experience a pervasive dread of self-disclosure: every utterance, they feel, may commit them to progressively more disclosure. Others may feel so conflicted about aggression that they cannot undertake the self-assertion inherent in speaking. Some are waiting to be activated and brought to life by an idealized caregiver. Some have lived with no independent voice, and engage in their relationships only through echoing, never initiating. Others, who demand nothing short of perfection in themselves, never speak for fear of falling shamefully short, whereas others attempt to maintain control through a lofty, superior silence. One group member claimed he was silent because his psychotic mother had criticized him for making any noise when chewing his food. Sometimes a client is especially threatened by a particular member in the group and habitually speaks only in the absence of that member. Others participate only in smaller meetings or in alternate (leaderless) meetings. Still others may silently sulk to punish others or to force the group to attend to them.[13] Culture may also play a role for some members in discouraging public emotional

expression and encouraging respectful deference to authority.[14] Clients with a history of trauma may also remain silent and avoid emotional expression as a way of trying to maintain safety and reduce their exposure to traumatic triggers related to anger or attack.[15]

Group dynamics may also play a role. Group anxiety about potential aggression or about the availability of emotional supplies in the group may push a vulnerable member into silence to reduce the tension or competition for attention. Distinguishing between a transient “state” of silence or a more enduring “trait” of silence is therefore quite useful.

The important point, though, is that *silence* is behavior and, like all other behavior in the group, has meaning in the here-and-now as a representative sample of the client’s way of relating to his or her interpersonal world. The therapeutic task, therefore, is not only to change the behavior (that is essential if the client is to remain in the group) but to explore the meaning of the behavior. It may seem a relief to have silent members join one’s group, because they do not immediately seem to place urgent demands on the group leaders. In truth this is a countertherapeutic stance, conveying the sense that silence is welcome, acceptable, and even desirable.

Proper clinical management depends in part on the therapist’s understanding of the dynamics of the silence. A course must be steered between two undesirable outcomes: placing undue pressure on the client, or allowing the client to slide into an extreme isolate role. The therapist may periodically include the silent client by commenting on nonverbal behavior: that is, when, by gesture or demeanor, the client is evincing interest, tension, sadness, boredom, or amusement. Not infrequently, a silent member introduced into an ongoing group will feel awed by the clarity, directness, and insight of more experienced members. It is often helpful for the therapist to point out that many of these admired veteran group members also struggled with silence and self-doubt when they began.[16]

Even if repeated prodding or cajoling is necessary, the therapist should encourage client autonomy and responsibility by repeated

process checks. “Is this a meeting when you want to be prodded?” “How did it feel when Mike put you on the spot?” “Did he go too far?” “Can you let us know when we make you uncomfortable?” “What’s the ideal question we could ask you today to help you come into the group?” “What will it feel like to go home tonight knowing that you took some risks with us?” “What do you think it means to us?” The therapist should seize every opportunity to reinforce the client’s activity and underscore the value of pushing against his or her fears (pointing out, for example, the feelings of relief and accomplishment that follow his risk-taking).[17]

If a client resists all these efforts and maintains a very limited participation even after three months of meetings, our experience has been that the client’s prognosis is poor. The frustrated group will tire of coaxing the silent member. In the face of the group’s disapproval, the client becomes more marginalized and even less likely to participate. Concurrent individual sessions may be useful in helping the client at this time. If this fails, the therapist may need to consider withdrawing the client from the group. Occasionally, entering a second therapy group at a later time may prove profitable, since the client now has the lived experience of the hazards of silence.

THE BORING CLIENT

Rarely does anyone seek therapy because of being boring. Yet, in different garb, the complaint is not uncommon. Clients complain that they never have anything to say to others; that they are left standing alone at parties; that no one ever invites them more than once; that others use them only for sex; that they are inhibited, shy, empty, or bland. Being boring, like being silent or monopolizing, is to be taken seriously. It is an important problem, whether the client explicitly identifies it as such or not.

In the social microcosm of the therapy group, these members re-create their problems and bore the members of the group—and the therapist. The therapist dreads a small meeting in which only two or three boring members are present. If they were to terminate, one imagines they would simply slip away, leaving nary a ripple in the pond.

Boredom is a highly individualized experience. In general, the boring group therapy client is massively inhibited, lacks spontaneity, and never takes risks. Their utterances are always “safe” (and, alas, always predictable). Before speaking, they scan the faces of the other members to determine what is expected of them to say, and they squelch contrary sentiments. Social styles of boring patients may vary: one may be silent, another stilted and hyperrational, another timid and self-effacing, still another dependent, demanding, or pleading. What they share in common is limited access to emotions. Thinking dominates feeling: the cognitive, left hemisphere of the brain dominates the emotional, right hemisphere.[18]

Some boring clients are in fact alexithymic—an affective difficulty stemming from cognitive processing deficits around emotions.[19] The alexithymic client is concrete, lacks imaginative capacity, and focuses on details, not emotional experience. Individual therapy with such clients can be painfully slow and arid. Group therapy alone, or concurrent with individual therapy, may be particularly helpful in promoting emotional expressiveness, because group members will

model how to engage with and express emotions and lend support to others.[20]

The inability to read their own emotional cues also may make these individuals vulnerable to medical and psychosomatic illness.[21] Group therapy, because of its ability to increase emotional awareness and expression, can reduce alexithymia and has been shown to improve medical outcomes, for example in heart disease.[22] Effective group therapy with this population is marked by slow, deliberate expansion of the client's emotional world rather than a sudden transformative breakthrough.

Group leaders and members often work hard to encourage spontaneity in boring clients. They ask such clients to share fantasies about members, to scream, to curse—anything to pry something unpredictable from them.

> **One client, Nora, drove the group to despair with her constant** clichés and self-deprecatory remarks. After many months in the group, her outside life began to change for the better, but each report of success was accompanied by the inevitable self-derogation. She was accepted by an honorary professional society ("That is good," she said, "because it is one club that can't kick me out"); she received her graduate degree ("but I should have finished earlier"); she looked better physically ("shows you what a good sunlamp and make-up can do"); she had been asked out by several new men in her life ("must be slim pickings in the market"); she obtained a good job ("it fell into my lap"); she had had her first orgasm with a man ("give the credit to marijuana").
>
> The group tried to increase Nora's awareness of her self-effacement. An engineer in the group suggested bringing an electric buzzer to ring each time she knocked herself. Another member, Ed, trying to shake Nora into a more spontaneous state, commented on her bra, which he felt could be improved. He said he would bring her a present, a new bra, next session. Sure enough, the following session he arrived with a huge box, which Nora said she would prefer to open at home. So, there it sat, looming in the group and, of course, inhibiting any other topic.
>
> She was finally prevailed upon to open the gift and did so laboriously and with enormous embarrassment. The box contained nothing but Styrofoam stuffing. Ed explained that this was his idea for Nora's new bra: that she should wear no bra at all. Nora promptly thanked him for

the trouble he had taken. The incident launched much work for both members. The group told Nora that, though Ed had humiliated and embarrassed her, she had responded by apologizing to him. She had politely thanked someone who had just given her a gift of precisely nothing! The incident created the first robust spark of self-observation in Nora. She began the next meeting with, "I've just set the world ingratiation record. Last night I received a scam call about money I allegedly owed, and I apologized to the man. I said, 'I'm sorry but you must have the wrong number.'" **<<**

The underlying dynamics of the boring patient vary enormously from individual to individual. Many have a core dependent position and dread rejection and abandonment so much that they are compulsively compliant, eschewing any aggressive remark that might initiate retaliation. They mistakenly confuse healthy self-assertion with aggression, and by refusing to acknowledge their own vitality, desires, spontaneity, interests, and opinions, they bring to pass (by boring others) the very rejection and abandonment they had hoped to forestall.[23]

If you, as the therapist, are bored with a client, your boredom is important information. The therapy of all challenging clients necessitates thoughtful attention to your countertransference. Therapist countertransference is always a source of valuable data about the client, never more so than with those clients whose behavior challenges our therapeutic effectiveness. Managing countertransference effectively is strongly correlated with better clinical success. Any unusual therapist reaction or behavior signals that interpersonal pulls are being generated, and therapists must take care to examine their feelings before responding.[24] Always assume that if you are bored by the member, so are others. You must counter your boredom with curiosity. Ask yourself: "What makes the person boring? When am I most and least bored? How can I find the person—the real, the lively, spontaneous, creative person—within this boring shell?" No urgent "breakthrough" technique is indicated. Since the boring individual is tolerated by the group much better than the abrasive, narcissistic, or monopolistic client, you can take your time.

Lastly, keep in mind that the therapist must take a Socratic posture with these clients. Our task is not to put something *into* the individual but quite the opposite, to let something out that was there all the time. Thus, we do not attempt to *inspirit* boring clients, or inject color, spontaneity, or richness *into* them, but instead to remove the obstacles to free expression of the creative, vital parts they have squelched.

THE HELP-REJECTING COMPLAINER

The help-rejecting complainer, a variant of the monopolist, was first identified and named by my (IY) mentor Jerome Frank in 1952.[25] Since then the behavior pattern has been recognized by many group clinicians, and the term appears frequently in the psychiatric and psychotherapy literature.[26] In this section, we discuss the rare fully developed help-rejecting complainer; however, this pattern of behavior is not a distinct, all-or-nothing clinical syndrome. Individuals may arrive at this style of interaction through various psychological pathways. Some may persistently manifest this behavior in an extreme degree with no external provocation, whereas others may demonstrate only a trace of this pattern. Still others may become help-rejecting complainers only at times of particular stress. Closely associated with help-rejecting complaining is the expression of emotional distress through somatic complaints, often in the form of perplexing, medically unexplainable symptoms.[27]

Help-rejecting complainers (or HRCs) show a distinctive behavioral pattern in the group: they implicitly or explicitly *request* help from the group, by presenting problems or complaints, and then *reject* any help offered. HRCs continually present problems in a manner that makes them appear insurmountable. In groups they often focus wholly on the therapist in a tireless campaign to elicit intervention or advice, and appear oblivious to the group's reaction to them. They base their relationship to the other members along the singular dimension of being more in need of aid than the other members. HRCs rarely show competitiveness in any area—except when another member makes a bid for the therapist's or group's attention by presenting a problem. Then HRCs often attempt to belittle that person's complaints by comparing them unfavorably with their own. They tend to exaggerate their problems and to blame others, often authority figures on whom they depend in some fashion.

When the group and the therapist do respond to the HRC's plea, the entire bewildering configuration takes form as the client rejects the help offered. The rejection is unmistakable, though it may assume many varied and subtle forms: sometimes the advice is rejected overtly; sometimes indirectly; sometimes, while accepted verbally, it is never acted upon; and if it is acted upon, it inevitably fails to improve the member's plight.

The effects on the group are obvious: the other members become irritated, frustrated, and confused. The HRC seems like an unstoppable whirlpool, sucking the group's energy. Faith in the group process suffers as members experience a sense of impotence and despair at making their own needs appreciated by the group. Cohesiveness is undermined as members disengage in frustration.

The *dynamics* that underpin the behavioral pattern of the HRC appear to be an attempt to resolve highly conflicted feelings about dependency. On the one hand, the HRC feels helpless, insignificant, and totally dependent on others, especially the therapist, for a sense of personal worth and security. Any notice or attention from the therapist temporarily enhances the HRC's self-worth. On the other hand, the HRC's dependent position is vastly confounded by a pervasive distrust and enmity toward authority figures. Consumed with need, the HRC turns for help to a figure he or she anticipates will be unwilling or unable to help.

These clients may best be understood through an attachment paradigm. The HRC experiences two forms of attachment insecurity at the same time. The first form is that of individuals who are *anxiously attached*, who seek closeness and reassurance, often exaggerating their distress to ensure that their caregivers will respond to them. The second form is the *avoidant, dismissively attached* individual, who resists and rejects care. The HRC combines these, experiencing both simultaneously in a style referred to as *fearful attachment*. These clients experience care providers as both the sought-after solution and the dreaded source of mistreatment. The interpersonal consequences are enormously frustrating, and therapists may feel they are trying to pick up mercury: whatever they

do misses the mark.[28] What inevitably follows is a vicious cycle of seeking and being disappointed—one that has been spinning for much of the client's life.

The HRC is an exceedingly difficult clinical challenge. Many such clients have won a pyrrhic victory over therapist and group by failing in therapy. This is a loss for all. Any chance at successful treatment is predicated upon the group leader understanding the simultaneous wish the HRC carries for care and the dread of that care being unreliable, hurtful, or destructive. Patiently building a relationship with the HRC is essential, and it is easier to achieve if both the hope and dread can be acknowledged and validated as genuinely felt and not as a client manipulation to defeat the treatment. The HRC solicits advice not only for its potential value but also in order to spurn it. Acknowledging the pain of this bind, of longing for care and simultaneously being unable to use it effectively when offered, may reduce tension in the group and create more space for trust to develop. Although the therapist and the group's advice, guidance, and treatment may be rejected, retaliation merely completes the vicious circle: the anticipation of ill treatment and abandonment that such clients experience is once again realized, and they feel justified in their hostile mistrust; as a result, they are able to affirm once again that no one can ever really understand them.

A nonblaming, nonfaulting therapeutic stance is critically important. Aim to mobilize the major group therapeutic factors in the service of the client. When a cohesive group has been formed, and the client—through universality, identification, and catharsis—has come to value membership in the group, then the therapist can encourage interpersonal learning by continually focusing on feedback and process, in much the same manner as we have described in discussing the monopolistic client. Helping help-rejecting clients see their interpersonal impact on the other members is a key step for them. Coming to examine their characteristic pattern of relationships makes way for them to build safe connections and make different relationship choices.

THE ACUTELY PSYCHOTIC CLIENT

Many groups are designed specifically to work with clients with major mental illnesses. In fact, when one considers groups on psychiatric wards, partial hospitalization units, veterans' hospitals, and aftercare programs, the total number of therapy groups for severely impaired clients is substantial.[29] We will discuss groups composed for hospitalized clients in Chapter 15; for now we will consider the issue of what happens to the course of an interactive therapy group of higher-functioning individuals when one of its member develops an acute psychotic illness during treatment.

The fate of this client, the response of the other members, and the effective options available to the therapist all depend in part on *timing*—that is, *when in the course of the group the psychotic episode occurs*. In general, the members of mature groups in which the client has long occupied a central, valued role are far more likely to be tolerant and effective during the crisis.

In Chapter 8, we emphasized that in the initial screening, the client with severe and persistent mental illness should be excluded from standard outpatient interactional group therapy. Other group modalities are much better suited for these individuals.[30] However, it is common practice to refer clients with apparently stable bipolar disease or other severe mood disorders in remission to interactional group therapy to address the interpersonal consequences of their illness. Combining group work with the care provided by a physician or psychiatrist who is prescribing and managing the client's mood-stabilizing medications can be very effective.

At times, despite cautious screening, an individual decompensates in the early stages of therapy, perhaps because of unanticipated stress from life circumstances, or from the group, or perhaps because of poor adherence to a medication regimen. This always creates substantial problems for the newly formed group—and, of course, for the client, who is likely to slide into a deviant role in the group and eventually terminate treatment, often much the

worse for the experience.

As we have stressed throughout this book, the early stages of the group are a time of great flux and great importance. The young group is easily influenced, and norms that are established early are often exceedingly durable. A compelling sequence of events unfolds as, in a few weeks, an aggregate of anxious, distrustful strangers evolves into an intimate, mutually helpful group. Any event that consumes an inordinate amount of time early on and diverts energy from the tasks of the developmental sequence is potentially destructive to the group. Some of the relevant problems are illustrated by the following clinical example:

> **Sandy was a thirty-seven-year-old housewife who had once, sev**eral years before, suffered a major treatment-resistant depression requiring hospitalization and electroconvulsive therapy. She sought group therapy at the insistence of her individual therapist, who thought that an understanding of her interpersonal relationships would help her to improve her relationship with her husband and overcome her shame and isolation.
>
> In the early meetings of the group, Sandy was an active member. She tended to reveal far more intimate details of her history than the other members. Occasionally, she expressed anger toward another member, and then she engaged in excessively profuse apologies coupled with self-deprecatory remarks. By the sixth meeting, her behavior was becoming quite inappropriate. She discoursed at great length on her son's urinary problems, for example, describing in intricate detail the surgery that had been performed to relieve his urethral stricture. At the following meeting, she noted that the family cat had also developed a blockage of the urinary tract; she then urged the other members to describe their pets.
>
> By her eighth meeting, Sandy was becoming increasingly manic. She behaved irrationally, insulting other members of the group, openly flirting with the men, to the point of stroking their bodies, and finally lapsing into pressured speech, inappropriate laughter, and tears. One of the co-therapists finally escorted her from the group room and took her to the emergency room. She was hospitalized; remained in a manic, psychotic state for a month; and then gradually recovered on a new medication regimen.
>
> The members were obviously extremely uncomfortable during

Sandy's final meeting. Their feelings ranged from bafflement and fright to annoyance. After she was escorted out, some expressed their feelings of guilt, worried that, in some unknown manner, they may have triggered her behavior. Others spoke of their fear of her. One member recalled someone he knew who had become threatening and brandished a gun following a psychotic breakdown.

During the subsequent meeting, one member expressed his conviction that no one could be trusted: even though he had known Sandy for seven weeks, her behavior proved to be totally unpredictable. Others expressed their relief that they were, in comparison, psychologically healthy, and still others, in response to their fears of similarly losing control, employed considerable denial and veered away from discussing these problems. Some expressed a fear that if Sandy returned she would make a shambles of the group. Others expressed their diminished faith in group therapy; one member asked for transcranial magnetic stimulation treatment instead, and another brought in an article from a scientific journal claiming that psychotherapy was ineffective. A loss of faith in the co-therapists and their competence was expressed in one member's dream, where one of the co-therapists was in the hospital and the client rescued him.

Over the next few weeks, all these themes went underground, and the meetings became listless, shallow, and intellectualized. Attendance dwindled, and the group seemed resigned to its own impotence. At the fourteenth meeting, the co-therapists announced that Sandy was improved and would return the following week. A vigorous, heated discussion ensued. The members feared that:

- They would upset Sandy. An intense meeting would make her ill again and, to avoid that, the group would be forced to move slowly and superficially.
- Sandy would be unpredictable. At any point she might lose control and display dangerous, frightening behavior.
- Sandy would, because of her lack of control, be untrustworthy. Nothing in the group would remain confidential.

At the same time, the members expressed considerable anxiety and guilt for wishing to exclude Sandy from the group. Soon, tension and a heavy silence prevailed. The group's extreme reaction persuaded the co-therapists to delay reintroducing Sandy (who continued in concurrent individual treatment) for a few weeks.

When Sandy finally did reenter the group, she was treated as a

fragile object, and the entire group interaction was guarded and defensive. By the twentieth meeting, five of the seven members had dropped out of the group, leaving only Sandy and one other member.

The co-therapists reconstituted the group by adding five new members. It is of interest that, despite the fact that only two of the old members and the co-therapists continued in the reconstituted group, the old group culture persisted—a powerful example of the staying power of norms even in the presence of a limited number of culture-bearers.[31] The group dynamics had locked the group and Sandy into severely restricted roles and functions. Sandy was treated so delicately by even the new members that the group moved slowly, floundering in politeness and social conventionality. Finally, in one group meeting, the co-therapists confronted the issue openly. They discussed their own fears of upsetting Sandy and thrusting her into another psychological decompensation. Only then were the members themselves able to deal with their feelings and fears about her. At that point, the group moved ahead more quickly. Sandy remained in the reconstituted group for a year and made significant improvements in her ability to relate with others and in her self-concept. **<<**

An entirely different situation may arise when an individual who has been an involved, active group member for many months decompensates into a psychotic state. Other members are then primarily concerned for that member rather than for themselves or for the group. Since they have previously known and understood the now acutely ill member, they often react with great concern and interest; the client is less likely to be viewed as a strange and frightening object to be avoided. Stigma regarding mental illness continues to be prominent, even in health care, particularly for trainees.

A colleague and I (IY) observed that medical students assigned for the first time to a psychiatric ward regarded the psychotic patients as extremely dangerous, frightening, unpredictable, and dissimilar to themselves. After five weeks, the students' attitudes had changed considerably: they were less frightened of their patients and realized that psychotic individuals were just confused, deeply anguished human beings, more like themselves than they had previously thought.[32]

Although some members are able to continue relating to a distressed group member, others may experience a personal upheaval and begin to fear that they, too, might lose control, and slide into a similar disturbed state. Hence, the therapist does well to anticipate and express this fear to the others in the group.

When faced with an acutely psychotic client in a group, many therapists revert to a medical model and symbolically dismiss the group by intervening forcefully in a one-to-one fashion. In effect, they say to the group, “This is too serious a problem for you to handle.” Such a maneuver, however, is often antitherapeutic: the client is frightened, and the group infantilized.

It has been our experience that a mature group is perfectly able to deal with the psychiatric emergency and to consider every contingency and take every action that the therapist might have considered.

Consider the following clinical example:

> **In the forty-fifth meeting of a group, Roberta, a forty-three-year-**old divorced woman, arrived a few minutes late in a disheveled, tearful, and obviously disturbed state. Over the previous few weeks, she had gradually been sliding into a depression, but now the process had suddenly accelerated. During the early part of the meeting she wept continuously and expressed feelings of great loneliness and hopelessness as well as an inability to love, hate, or, for that matter, have any deeply felt emotion. She described feeling great detachment from everyone, including the group, and, when prompted, discussed suicidal ruminations.
>
> The group members responded to Roberta with great empathy and concern. They inquired about events during the prior week and helped her discuss two important occurrences that seemed related to the depressive crisis. First, for months she had been saving money for a summer trip to Europe, but she now feared she would not be able to go. During the past week, her seventeen-year-old son had decided to decline a summer camp job, and he refused to search for other jobs. In Roberta’s eyes, this turn of events jeopardized her trip. Second, after months of hesitation, she had decided to attend a dance for divorced middle-aged people, and it proved to be a disaster. No one had asked her to dance, and she had ended the evening consumed with feelings of total worthlessness.

The group helped Roberta explore her relationship with her son, and for the first time she expressed considerable anger at him for his lack of concern for her. With the group's assistance, she attempted to explore and express the limits of her responsibility toward him. It was difficult for Roberta to discuss her experience at the dance because of the shame and humiliation she felt. Two other women in the group, one single and one divorced, empathized deeply with her and shared their experiences and reactions to the scarcity of suitable males. The group also reminded Roberta of the many times during sessions when she had interpreted every minor slight as a total rejection and condemnation.

Finally, after much attention, care, and warmth had been offered her, one of the members pointed out to Roberta that the experience of the dance was being disconfirmed right in the group: several people who knew her well were deeply concerned and involved with her. Roberta rejected this idea by claiming that the group, unlike the dance, was an artificial situation, in which people followed unnatural rules of conduct. The members quickly pointed out that quite the contrary was true: the dance—the contrived congregation of strangers, the attractions based on split-second, skin-deep impressions—was the artificial situation, and the group was the real one. It was in the group that she was more completely known.

Roberta, suffused with feelings of worthlessness, then berated herself for her inability to feel reciprocal warmth and involvement with the group members. One of the members quickly intercepted this maneuver by pointing out that Roberta experienced considerable empathy for the other members, evidenced by her facial expressions and body postures. But then Roberta let her "shoulds" take over and insisted that she should feel more warmth and more love than anyone else. The net effect was that the real feeling she did have was rapidly extinguished by the winds of her impossible self-demands.

In essence, what then transpired was Roberta's gradual recognition of the discrepancy between her public and private esteem. Near the end of the meeting, Roberta burst into tears, and she wept for several minutes. The group members were reluctant to leave but did so once they had convinced themselves that suicide was no longer a serious consideration. Throughout the next week, they maintained an informal vigil, each calling or texting Roberta at least once as she stabilized. The group therapist also followed up with Roberta to ensure that she received urgent care in the form of clinical support and medications. **<<**

A number of important and far-reaching principles emerge from

this illustration. Early in the session, the therapist realized the important dynamics operating in Roberta's depression. Had he chosen to do so, he might have made the appropriate interpretations to allow the client and the group to arrive much more quickly at a cognitive understanding of the problem. But that would have detracted considerably from the meaning and value of the meeting for Roberta as well as for the other members. For one thing, the group would have been deprived of an opportunity to experience its own potency. Every success adds to the group's cohesiveness and enhances the self-regard of each of the members. It is difficult for some therapists to refrain from interpretation, and yet it is essential to learn to sit on your wisdom. There are times when it is foolish to be wise and wise to be silent.

At times, as in this clinical episode, the group will perform the appropriate action; at other times, the group may decide that the therapist must act. But there is a vast difference between a group's hasty decision, stemming from infantile dependence and unrealistic appraisal of the therapist's powers, and a decision based on the members' thorough investigation of the situation and mature appraisal of the therapist's expertise.

This point leads us to an important principle of group dynamics, one substantiated by considerable research: *A group that reaches an autonomous decision based on a thorough exploration of the pertinent problems will employ all of its resources in support of its decision; a group that has a decision thrust upon it is likely to resist that decision and be even less effective in making valid decisions in the future.*[33] Although the acutely ill group member is *the* urgent priority, the group and its members may also have a unique opportunity to deepen their own psychotherapeutic work at the same time.

The implications for group therapy are apparent: members who personally participate in planning a course of action will be more committed to the enactment of the plan. They will, for example, invest themselves more fully in the care of a distressed member if they recognize that it is their problem and not the therapist's alone.

Sharing intense emotional experiences often strengthens ties among group members. The danger to the group occurs when the acutely psychotic client consumes such a massive amount of energy for such a prolonged period that it causes other members either to drop out, to deal with the disturbed individual in a cautious manner, or to ignore the member altogether. These methods never fail to aggravate the problem. In such critical situations, one important option always available to the therapist is to see the acutely disturbed client in individual sessions for the duration of the crisis (an option we will discuss more fully in the discussion of combined therapy; see Chapter 13). However, the group should thoroughly explore the implications and share in the decision to have one member see the therapist separately while also still participating in the group.

What happens if a group member requires hospitalization? In this event, we strongly urge that the group leader visit the client in the hospital.

> **Julia, a thirty-eight-year-old woman, entered group therapy to** address her social isolation and her sense of herself as defective because of her long-standing bipolar disorder. She had been doing well on mood stabilizers, but several months into the group she began to wean herself off her medications, believing that she no longer required them. She soon became progressively paranoid and agitated in the group, and her individual therapist arranged for her admission as an involuntary patient to an acute care psychiatric unit.
>
> I (ML) visited Julia during her month-long hospital admission. She exclaimed at how moved she was by my visiting her and how heartening it was to feel that she was remembered. My visit made her eventual return to the group easier. When she returned, she expressed embarrassment about her behavior when she had been manic, but was grateful that the group had not rejected her. For several months following, Julia referred to the importance of my hospital visit. **<<**

The client with acute bipolar affective disorder is best managed pharmacologically and is not a good candidate for interactionally oriented treatment at this stage. It is obviously unwise to allow the group to invest much energy and time in treatment that has such

little likelihood of effectiveness. There is mounting evidence, however, for the effectiveness of using specific, homogeneous groups to treat clients with bipolar illness. These groups offer psychoeducation about the illness and stress the importance of pharmacotherapy adherence and maintenance of a healthy lifestyle, along with biological daily rhythm and self-regulation routines. Such groups are best employed in conjunction with pharmacotherapy during the maintenance phase of treatment. Substantial benefits from these groups have been demonstrated, including improved pharmacotherapy adherence, reduced mood disturbance, fewer illness relapses, less substance abuse, and improved psychosocial functioning.[34]

THE SCHIZOID CLIENT

Many years ago, in a previous edition of this book, I (IY) began this section with the following sentence: “The schizoid condition, the malady of our times, perhaps accounts for more patients entering therapy than does any other psychopathological configuration.” This no longer rings true. The fashions of mental illness change, and diagnostic criteria and clinical presentations change over time, which is yet another reason why we should approach our diagnostic assumptions with humility. Today, clients more commonly enter treatment because of depression, anxiety, substance abuse, eating disorders, and sequelae of sexual and physical abuse.

It is also worth noting that many individuals diagnosed in the past with schizoid personality might today be diagnosed with Asperger syndrome (AS) or, as it is now reclassified in DSM-5, autism spectrum disorder (ASD). We see an explosive increase in the frequency of the ASD diagnosis.[35] Although the strict diagnostic criteria distinguish the schizoid client from the ASD client, the clinical distinction is less clear-cut for these individuals when we consider their pursuit of group therapy. Clinically, both the schizoid client and the ASD client may present with impaired relationship capacities, social failure, isolation, social awkwardness, misreading of social cues, impediments to empathy, impaired processing of emotions in themselves and others, and a wish for more connection. Group therapies structured for ASD clients are developing slowly but are not yet widely accessible. Therefore, it is not uncommon to have high-functioning ASD individuals referred to interpersonal group therapy.[36]

> **Gene, a twenty-eight-year-old man, arrived for his initial consul**tation for outpatient group therapy with his community caseworker. He had asked the caseworker to attend because he had previously experienced discrimination when pursuing mental health care, having been told he was not suitable for the treatment he sought.
>
> Gene conveyed a sense of social oddness and awkwardness: his eye

contact was poor, and he wore a long bright yellow raincoat throughout the entire consultation. At the same time, he expressed an earnest wish to alleviate his loneliness. He felt that he would benefit from exposure to others interacting normally, rather than being with others who suffered impairments similar to his.

Gene entered an interpersonal psychotherapy group that was time limited, meeting weekly for eight months, and proved to be a regular and reliable participant. He described a lifetime of people avoiding him because they saw him as odd or mentally ill. Now, he was eager to understand how he alienated others and was keen to improve his social skills.

In his early group sessions, he disclosed excessively and indiscriminately about his isolation, his sexual frustration, and his disappointment that others did not appreciate his special abilities. He missed social cues and, if not interrupted by the group leaders, would have talked throughout the entire meeting.

Despite appropriate preparation for the group, he sought to meet members outside the meetings, and the leaders had to reinforce boundaries time and again. Gradually, Gene learned how to share time and to offer help to others. Although the group feedback at times was heavy handed, he listened, and over the course of the group sessions he began to make eye contact, pose more appropriate questions to others, and allow time for people to respond before jumping to the next question. He also assimilated feedback about how his intense gazing at women's bodies made them feel sexually objectified and was "creepy."

The group members treated Gene firmly, respectfully, and affectionately, and ultimately expressed their pleasure in witnessing Gene's interpersonal growth. In the concluding session, Gene told the group this was his first positive experience as a member of any type of group. He also brought in a list of all the lessons he had learned, expressing his deep appreciation to the group members and his intention to build upon what he had learned. **<<**

Even though the schizoid condition is no longer the malady of our times, schizoid individuals are still common visitors to therapy groups. They are emotionally blocked, isolated, and distant and often seek group therapy out of a vague sense that something is missing: they cannot feel, cannot love, cannot play, cannot cry. They are spectators of themselves; they do not inhabit their own bodies; they do not experience their own experience.

No one has described the experiential world of the schizoid individual more vividly than Jean-Paul Sartre in *The Age of Reason*:

> He closed the paper and began to read the special correspondent's dispatch on the front page. Fifty dead and three hundred wounded had already been counted, but that was not the total, there were certainly corpses under the debris. There were thousands of men in France who had not been able to read their paper that morning without feeling a clot of anger rise in their throat, thousands of men who had clenched their fists and muttered: "Swine!" Mathieu clenched his fists and muttered: "Swine!" and felt himself still more guilty. If at least he had been able to discover in himself a trifling emotion that was veritably if modestly alive, conscious of its limits. But no: he was empty, he was confronted by a vast anger, a desperate anger, he saw it and could almost have touched it. But it was inert—if it were to live and find expression and suffer, he must lend it his own body. It was other people's anger. Swine! He clenched his fists, he strode along, but nothing came, the anger remained external to himself. Something was on the threshold of existence, a timorous dawn of anger. At last! But it dwindled and collapsed, he was left in solitude, walking with the measured and decorous gait of a man in a funeral procession in Paris. He wiped his forehead with his handkerchief, and he thought: One can't force one's deeper feelings. Yonder was a terrible and tragic state of affairs that ought to arouse one's deepest emotions. It's no use, the moment will not come.[37]

Schizoid individuals are often in a similar predicament in the therapy group. In virtually every group meeting, they have confirmatory evidence that the nature and intensity of their emotional experience differs considerably from that of the other members. Puzzled at this discrepancy, they may conclude that the other members are melodramatic, excessively labile, phony, overly concerned with trivia, or simply of a different temperament. Eventually, however, schizoid clients, like Sartre's protagonist, Mathieu, begin to wonder about themselves, and begin to suspect that somewhere inside themselves is a vast frozen lake of feeling.

In one way or another, by what they say or do not say, schizoid clients convey this emotional isolation to the other members. In

Chapter 2 we described a male client who could not understand the members' concern about the therapist leaving the group or a member's obsessive fears about her boyfriend being killed. He saw people as interchangeable. He had his need for a minimum daily requirement of affection but had little concern about the source of the affection. He was "bugged" by the departure of a therapist only because it would slow down his therapy; he did not share the grief expressed by other members over the loss of the human being who had been their therapist. A schizoid member in another therapy group, chided by the group because of his lack of empathy toward two highly distressed members, responded, "So, they're hurting. There are millions of people hurting all over the world at this instant. If I let myself feel bad for everyone who is hurting, it would be a full-time occupation."

Most of us get a rush of feelings and then try to comprehend the meaning of the feelings. In schizoid clients, feelings come much later—they are awarded priority according to the dictates of rationality. The group is often keenly aware of discrepancies among a member's words, experiences, and emotional responses. They may read the schizoid member's emotions from postural or behavioral cues. Indeed, such individuals may relate to themselves in a similar way and join into the investigation, commenting, for example, "My heart is beating fast, so I must be frightened," or "My fist is clenched, so I must be mad." In this regard they share a common difficulty with the alexithymic clients described earlier.

The response of the other members is predictable, proceeding from curiosity and puzzlement through disbelief, solicitude, irritation, and frustration. They will repeatedly inquire, "What do you feel about…?" and only much later come to realize that they were demanding that this member quickly learn to speak a foreign language. At first, members become very active in helping to resolve what appears to be a minor affliction, telling schizoid clients what to feel and what *they* would feel if they were in that situation. Eventually, the group members grow weary of the project and frustration sets in; then they redouble their efforts—almost always without noticeable results. Ultimately, they resort to the

sledgehammer approach.

The therapist must avoid joining in the quest for a breakthrough. We have never seen a schizoid client significantly change by virtue of a dramatic incident. Change is a prosaic process of grinding labor, repetitive small steps, and almost imperceptible progress. It is tempting and potentially useful to employ some activating, nonverbal, or gestalt techniques to hasten a client's movement. These approaches may speed up the client's recognition and expression of nascent or repressed feelings. But keep in mind that schizoid clients need more than new skills: they need a new internalized experience of the world of relationships—and that requires time, patience, and perseverance.

In Chapter 6, we described several here-and-now activating techniques that are also useful in work with the schizoid client. Work energetically in the here-and-now. Encourage the client to differentiate among the group members; despite his or her protestations, the client does not feel *precisely* the same way toward everyone in the group. Help such members move into feelings they pass off as inconsequential. When the client admits, "Well, I may feel slightly irritated or slightly hurt," suggest staying with these feelings. You might suggest, "Describe exactly what it is like." Invite the client to imagine what others in the group are feeling. Try to cut off the client's customary methods of dismissal of his or her feelings: "Somehow, you've gotten away from something that seemed important. When you were talking to Julie, I thought you looked near tears. Can you talk about what was going on inside?"[38]

Encourage the client to observe his or her body. Often the client may not experience affect but will be aware of the affective autonomic equivalents: tightness in the stomach, sweating, throat constriction, flushing, and so on. Gradually the group may help the client translate those physical feelings into their psychological meaning.

Therapists must beware of assessing events solely according to their own experiential world. As we have discussed previously, clients may experience the identical event in totally different ways.

An event that is seemingly trivial to the therapist or to one of the group members may be an exceedingly important experience to another member. A slight show of irritation by a restricted schizoid individual may be a major breakthrough for that person. In the group, these individuals, like many others described in this chapter, are high risk and high reward. Those who can manage to continue in the group without becoming discouraged by their inability to change their relationship style quickly are almost certain to profit considerably from the group therapy experience.

THE CHARACTEROLOGICALLY DIFFICULT CLIENT

The final two types of challenging clients in group therapy we shall discuss are the borderline client and the narcissistic client. Clinicians are acutely aware of the prevalence of these personality disorders at large, as they represent between 6 and 13 percent of the general population.[39] These clients are often discussed together in the clinical literature under the rubric of the characterologically difficult—or what were formerly known as cluster B—client.[40] But traditional DSM diagnostic criteria do not do justice to the complexity of these clients, failing to capture their inner psychological experience adequately.[41]

Most characterologically difficult clients have problems with how they perceive and interpret themselves and others, how they function interpersonally, impulsivity, and regulation of affect.[42] Their pathology is thought to be based on serious difficulties in the first few years of life. They lack internal soothing or comforting parental representations: their internal world is inhabited by abandoning, withholding, and disappointing caregiver representations. Often lacking the ability to integrate ambivalent feelings and interpersonal reactions, they split the world into black and white, good and bad, loving and hating, idealizing and devaluing. At any given time they have little recall of feelings other than the powerful ones they feel at that moment. Prominent difficulties include rage, vulnerability to abandonment and to narcissistic injury, and a tendency toward projective identification.[43]

Often the characterologically difficult client has experienced traumatic abuse early in life as well, which further amplifies the challenge in treatment. In some samples the comorbidity of posttraumatic stress disorder (PTSD) and borderline personality disorder exceeds 50 percent. When the traumatic experiences and consequent symptoms—chiefly intrusive reexperiencing of the trauma, avoidance of any reminder of the trauma, and general

hyperarousal—have a profound combined impact on the individual, the term “complex PTSD” is often applied. This term captures the way in which the traumatic events and psychological reactions to these events shape the individual’s personality.[44]

Characterologically difficult clients are prevalent in almost every clinical setting. They are often referred to groups by individual therapists when (1) the transference has grown too intense for dyadic therapy; (2) the client has become so defensively isolated that group interaction is required to engage the client; (3) therapy has proceeded well but a plateau has been reached, and interactive experience is necessary to produce further gains.

The Borderline Client

For decades, psychotherapists have known about a large cluster of individuals who are unusually difficult to treat and who fall in between the major diagnostic criteria of severity of impairment: they are more disorganized than neurotic clients but more integrated than psychotic clients. A thin veneer of integration conceals a primitive personality structure. Under stress, these borderline clients are highly unstable; some develop brief psychotic episodes.

DSM-5 diagnostic criteria for clients with borderline personality disorder note a multiplicity of difficulties centered around a pervasive pattern of instability in the individual’s interpersonal relationships, self-image, affects, and control over impulses.[45] The diagnosis still lacks precision, has unsatisfactory reliability, and often serves as a catchall for a personality disorder that clinicians cannot otherwise diagnose.[46] It will, in all likelihood, undergo further transformation in future classificatory systems.

There is considerable debate about the psychodynamics and the developmental origins of the borderline personality disturbance.[47] This debate is tangential to group therapy practice, however, and need not be discussed here. What is important for the group therapist, as we have stressed throughout this book, is not the elusive and unanswerable question of how one *got to be the way one is*, but the nature of the current forces, both conscious and

unconscious, that influence the way the client relates to others.

There has recently been an explosion of interest in the diagnosis, psychodynamics, and effective therapeutic treatment of the borderline client, including much new literature on group therapy.[48] Group therapists have developed an interest in these clients for two major reasons. First, because borderline personality disorder is difficult to diagnose in a single screening session, many clinicians unintentionally introduce borderline clients into therapy groups consisting of clients functioning at a higher level of integration. Second, there is growing evidence that specialized group therapy is an effective form of treatment for these clients. Some impressive research results have emerged from homogeneous and intensive partial hospitalization programs. These groups offer the borderline individual containment, emotional regulation training, emotional support, and interpersonal learning. They also demand personal accountability in an environment that counters regression and unhealthy intensification of transference reactions. Significant and enduring improvements in mood, psychosocial stability, and self-harm behavior have been reported.[49] The majority of borderline clients, however, are likely to be treated in heterogeneous outpatient groups, and research indicates that these clients highly value their group therapy experience.[50]

Keep in mind that the borderline client's pathology places great demands on the treating therapist, who is often frustrated by the client's inability to make gains in therapy. At times the therapist may experience strong wishes to rescue these clients, even to modify the traditional procedures and boundaries of the therapeutic situation. Many individual therapists suggest group therapy for borderline clients not because these clients work well or easily in therapy groups but because they are so extraordinarily difficult to treat in individual therapy. Therapists often find it difficult to deal with the demands and the primitive anger of the borderline client, particularly since the client so often acts them out (for example, through absence, lateness, drug abuse, or self-harm). Crippling transference and countertransference problems regularly emerge in both

individual and group therapy, but the group setting provides some added capacities: for example, other members may provide their own views of the course of group events, and peer support lessens the borderline client's dependence on the therapist. The borderline client's primitive affects and highly distorted perceptual tendencies greatly influence the course of group therapy and severely tax the resources of the group. The duration of therapy is long: there is considerable clinical consensus that borderline clients require many years of therapy and will generally stay in a group longer than any of the other members.

Separation anxiety and the fear of abandonment play a crucial role in the dynamics of the borderline client. A threatened separation (the therapist's vacation, for example—and sometimes even the end of a session) characteristically evokes severe anxiety and triggers the characteristic defenses of this syndrome: splitting,[i] projective identification, devaluation, and flight.[51]

The therapy group may assuage separation anxiety in two ways. First, one or (preferably) two group therapists are introduced into the client's life, thus shielding the client from the great dysphoria occurring when the individual therapist is unavailable. Second, the group itself becomes a stable entity in the client's life, one that exists even when some of its members are absent. Repeated loss (that is, the termination of members) within the secure continued existence of the group helps these clients come to terms with their extreme sensitivity to loss. The therapy group offers a singular opportunity to mourn the loss of an important relationship in the comforting presence of others who are simultaneously dealing with the same loss. Real relationships can offset the intense hunger the borderline client feels, but in a more mutual, less intense fashion.[52] Once the borderline client develops trust in the group, he or she may serve as a major stabilizing influence. Because borderline clients' separation anxiety is so great and they are so anxious to preserve the continued presence of important figures in their environment, they help keep the group together, often becoming the most faithful attendees and chiding other members for being absent or tardy.

One of the major advantages of a therapy group for the treatment of a borderline client is the powerful reality testing provided by the ongoing stream of feedback and observations from the members. Thus, regression is far less pronounced for these clients in group therapy than in individual therapy. Clients gain the capacity to think about their own and others' inner experience. Making sense of the interpersonal world of the group paves the way to build trust in their capacity to engage the world more fully.[53]

> **Margie, forty-two, was referred to the group by her individual** therapist, who had been unable to make headway with her. Margie's feelings toward her therapist alternated between great rage at him and hunger for him. The intensity of these feelings was so great that little work could be done, and the therapist was on the verge of discontinuing therapy. Placing her in a therapy group was his last resort.

Upon entry into the group, Margie refused to talk for several meetings because she wanted to determine how the group ran. After four meetings in silence, she suddenly unleashed a ferocious attack on one of the group co-leaders, labeling him as cold, powerful, and rejecting. She offered no reasons or data for her comments aside from her gut feeling about him. Furthermore, she expressed contempt for those members of the group who felt affection for him.

Her feelings for the other leader were quite the opposite; she experienced him as soft, warm, and caring. Other members were startled by her black-and-white view of the co-therapists and urged her, unsuccessfully, to work on her great propensity for judgment and anger. Her positive attachment to the one leader contained her sufficiently to permit her to continue in the group—and allowed her to tolerate her intense hostile feelings toward the other leader and to work on other issues in the group—though she continued to snipe intermittently at the hated leader.

A notable change occurred with the "bad" therapist's vacation. When Margie expressed a fantasy of wanting to kill him, or at least to see him suffer, members expressed astonishment at the degree of her rage. Perhaps, one member suggested, she hated him so much because she badly wanted to be closer to him and was convinced it would never happen. This feedback had a dramatic impact on Margie. It touched not only on her feelings about the therapist but also on deep, conflicted feelings about her mother. Gradually, her anger softened, and she

described her longing for a different kind of relationship with the therapist. She expressed sadness also at her isolation in the group and described her wish for more closeness with other members. Some weeks after the return of the “bad” therapist, her anger had diminished sufficiently to work with him in a more productive manner. **<<**

This example illustrates how, in a number of ways, the group therapy situation can reduce intense and crippling transference distortions. First, other members offered different views of the therapist, which ultimately helped Margie correct her distorted views. Second, borderline clients who develop powerful negative transference reactions are able to continue working in the group because they so often develop opposite, positive feelings toward the group members or co-therapist—which is why many clinicians strongly advise a co-therapy format in the group treatment of borderline clients.[54] It is also possible for a client to rest temporarily, to withdraw, or to participate in a less intensified fashion in the therapy group. Such respites from intensity are rarely possible in the one-to-one format.

The work ethic of psychotherapy is often more readily apparent in a group. Individual therapy with borderline clients may be marked by the fragility of the therapeutic alliance and repeated ruptures and emotional storms.[55] Some clients lose sight of the goal of personal change and instead expend their energy in therapy seeking revenge for inflicted pain or demanding gratification from the therapist. Witnessing other members working on therapy goals in the group often supplies them with an important corrective to a derailed therapy.

Since the borderline individual’s core problems lie in the sphere of intimacy, the therapeutic factor of cohesiveness is often of decisive import. If these clients are able to accept the reality testing offered by the group, and if their behavior is not so disruptive as to cast them in a deviant or scapegoat role, then the group may become a holding environment—an enormously important, supportive refuge from the stresses that borderline clients experience in everyday life. Borderline clients’ sense of belonging is augmented by the fact that

they are often a great asset to the therapy group. These individuals have great access to affect, as well as to unconscious needs, fantasies, and fears, and they may loosen up a group and facilitate the therapeutic work of inhibited, constricted individuals. Of course, this can be a double-edged sword. Some group members may be negatively affected by a borderline client's intense rages and negativity, which can undermine the work of co-members who are themselves victims of abuse or trauma.[56]

The borderline client's vulnerability and tendency to distort are so extreme that concurrent or combined individual therapy is often required. Many therapists suggest that the most common reason for treatment failure of borderline clients in therapy groups is the omission of adjunctive individual therapy.[57] If conjoint therapy is used, it is particularly important for the group and the individual therapists to be in ongoing communication. The dangers of splitting are real, and it is important that the client experience the therapists as a solid, integrated team.

The decision to include a borderline client in a group depends on the characteristics of the particular individual being screened rather than on the broad diagnostic category. The therapist has to assess not only a client's ability to tolerate the intensity of the therapy group but also the group's ability to tolerate the demands of that particular client at that point. Most heterogeneous outpatient groups can, at best, manage only one or possibly two borderline individuals. A mature group offers better prospects of therapeutic gains for these challenging clients than does a newly formed, young group. Other major considerations influencing the selection process are the same as those described in Chapter 8. It is particularly important to assess the possibility of the client becoming a deviant in the group. Rigidity of behavioral patterns, especially patterns that antagonize other people, should be scrutinized carefully. Clients who are markedly grandiose, contemptuous, and disdainful are unlikely to have a bright future in a group. It is necessary for a client to have the capacity to tolerate minimal amounts of frustration or criticism without serious acting out. Attention to emotional regulation and affect tolerance

strategies can be very helpful and may augment or preface the interpersonal group work.[58]

The Narcissistic Client

The term *narcissistic* may be used in different ways. It is useful to think about narcissistic clients representing a range and dimension of concerns rather than a narrow diagnostic category.[59] Although there is a formal diagnosis of narcissistic personality disorder, there are many more individuals with narcissistic traits who create characteristic interpersonal problems in the course of group therapy. Here again we see the four key domains of difficulty we noted earlier in this section: perceiving and interpreting self and others, interpersonal function, impulse control, and affect regulation.[60]

Many individuals with narcissistic difficulties present with features of grandiosity, a need for admiration from others, and a lack of empathy. These individuals also tend to have a shallow emotional life, derive little enjoyment from life other than tributes received from others, and tend to depreciate those from whom they expect little narcissistic gratification.[61] Their self-esteem is brittle and easily diminished, often generating outrage at the source of insult. Noah, the self-absorbed group member described in detail in the preceding chapter on the advanced group, exemplifies this clinical presentation and the countertransference elicited.

Appropriate narcissism, a healthy love of oneself, is essential to the development of self-respect and self-confidence. *Excessive* narcissism takes the form of loving oneself to the exclusion of others, of losing sight of the fact that others are sentient beings, that others, too, construct and experience a unique world.

The narcissistic client often has a stormier but more productive course in group than in individual therapy. In fact, the individual format provides so much gratification that the core problem emerges much more slowly: the client's every word, feeling, fantasy, and dream is acknowledged; much is given to and little demanded from the client. In the group, however, the client is expected to share time; to understand, empathize with, and help others; to form

relationships; to be concerned with the feelings of others; to receive constructive but sometimes critical feedback. Narcissistic individuals often feel most alive when on stage: they judge the group's usefulness on the basis of how many minutes of group and therapist time they have obtained at a meeting. They guard their specialness fiercely and often object when anyone points out similarities between themselves and other members. For the same reason, they also object to being included with the other members in group-as-a-whole interpretations.

They may have a negative response to some crucial therapeutic factors—for example, cohesiveness and universality. To belong to a group, to be like others, may be experienced as a homogenizing and diminishing experience. Hence the group experience readily brings the narcissistic client's difficulties in relationships to light. Other members may feel unsympathetic to the narcissistic member because they rarely see the vulnerability and fragility that reside beneath the grandiose and exhibitionistic behavior, a vulnerable core that the narcissistic client often keeps well hidden.[62]

> **Vicky was highly critical of the group format and frequently ex**pressed her preference for the one-to-one therapy format. She often supported her position by citing psychoanalytic literature critical of the group therapy approach. She felt bitter at having to share time in the group. For example, three-fourths of the way through a meeting, the therapist remarked that he perceived Vicky and John to be under much pressure. John had begun in the preceding session to talk about his mounting feelings of worthlessness. They both admitted that they needed and wanted time in the meeting that day. After a moment's awkwardness, John gave way, saying he thought his problem could wait until the next session. Vicky consumed the rest of the meeting, and at the following session she continued where she had left off. When it appeared that she had every intention of using the entire meeting again, one of the members commented that John had been left hanging in the last session. But there was no easy transition, since, as the therapist pointed out, only Vicky could entirely release the group, and she gave no sign of doing so graciously (she had lapsed into a sulking silence).
>
> Nonetheless, the group turned to John, who was in the midst of a major life crisis. John presented his situation, but no good work was

> done. At the very end of the meeting, Vicky began weeping silently. The group members, thinking that she was weeping for John, turned to her. But she was weeping, she said, for all the time that was wasted on John—time that she could have used so much better. What Vicky could not appreciate for at least a year in the group was that this type of incident did not indicate that she would be better off in individual therapy. Quite the contrary: the fact that such difficulties arose in the group was precisely the reason that the group format was especially indicated for her. **<<**

Though narcissistic clients are frustrated by their bids for attention being so often thwarted in the group as well as in their outside life, that very frustration constitutes a major advantage for the group therapeutic mode. Furthermore, the group is catalyzed as well: some members profit from having to take assertive stands against the narcissist's greediness, and members who are too nonassertive may use aspects of the narcissistic client's demanding behavior as modeling.

Another narcissistic patient, Ruth, who sought therapy for her inability to maintain deep relationships, participated in the group in a highly stylized fashion: she insisted on filling the members in every week on the minute details of her life and especially on her relationships with men, her most pressing problem. Many of these details were extraneous, but she was insistent on a thorough recitation (much like the "watch me" phase of early childhood). Aside from watching her, there seemed no way the group could relate to Ruth without making her feel deeply rejected.

Some narcissistic individuals who have a deep sense of specialness and entitlement feel not only that they deserve maximum group attention but also that it should be forthcoming without any effort on their part. They expect the group to care for them, to reach out for them despite the fact that they reach out for no one in return. They expect gifts, surprises, compliments, concern, though they give none. They expect to be able to express anger and scorn but to remain immune from retaliation. They expect to be loved and admired for simply being there. We have seen such expectations especially pronounced in individuals who have been

praised all their lives simply by virtue of their appearance and their presence.[63]

The narcissistic client's lack of awareness of, or empathy for, others in the group is obvious. After several meetings, members begin to note that although the client does personal work in the group, he or she never questions, supports, or assists others. The client may describe his or her own life experiences with great enthusiasm, but is a poor listener and grows bored when others speak. One narcissistic man often fell asleep in the meeting if the issues discussed were not immediately relevant to him. When confronted about his sleeping, he would ask for the group's forbearance because of his long, hard day (even though he was frequently unemployed, a phenomenon he attributed to the failure of potential employers to recognize his unique skills). There are times when it is useful to point out that there is only one relationship in life where one individual can constantly receive without reciprocating to the other—the young infant with his or her mother.

Many therapists distinguish between the *overgratified* narcissistic individual who has an overinflated sense of self and the *undergratified* narcissistic individual, who tends to feel more deprived and enraged, even explosive. The group behavior of the latter is misunderstood by the other members, who interpret the anger as an attack on the group rather than as a last-ditch attempt to defend the otherwise unprotected self. Consequently, undergratified narcissistic individuals are given little nurturance for their unspoken wounds and deficits and are at risk of bolting from the group. It is essential that therapists maintain an empathic connection to these clients and focus on their subjective worlds, particularly when they feel diminished or hurt. Their protestation may well be understood as the persistent hope for care, rather than resignation to despair of submission and compliance. At times, the group leader may even need to advocate for these provocative members and encourage the other members to try to understand their emotional experience.[64]

Recognize your own countertransference and use it to interrupt negative interpersonal cycles. One group member, Rona,

consistently criticized the group members and therapist for “not getting it.” Despite valiant efforts to the contrary, session after session was marked by Rona’s anger and ended with group members feeling invalidated and incompetent. It was only after reflecting on my (ML) fantasy of how the group would be better if Rona were to leave that my awareness crystallized. This was projective identification in action. Rona’s mother had abandoned her at a young age, and upon returning some time later was invalidating toward Rona and hostile to her emotional needs. Rona’s presence made her feel guilty, an emotion the mother rejected wholly. Now Rona was treating us exactly the way her mother had treated her, hoping against hope for a different outcome. As we began to unpack our experience of Rona’s invalidation of the group members, and of me, we were able to restore an empathic link to Rona. Her rejection of us was a window into how she felt with her mother. This deepened our understanding and we signaled that we were not going to respond by rejecting her. As she came to understand that we were sticking by her, she calmed enormously and became more able to take in our care.

> **Sal, a narcissistic man, was insulting, unempathic, and highly** sensitive to even the mildest criticism. In one meeting, he lamented at length that he never received support or compliments from anyone in the group, least of all from the therapists. In fact, he could remember only three positive comments to him in the many group meetings he had attended. One member responded immediately and straightforwardly: “Oh, come on, Sal, get off it. Last week both of the therapists supported you a whole lot. In fact, you get more stroking in this group than anyone else.” Every other member of the group agreed, and they offered several examples of positive comments that had been given to Sal over the past few meetings.
>
> Later in the same meeting, Sal responded to two incidents in a highly maladaptive fashion. Two members were locked in a painful battle over control. Both were shaken and extremely threatened by the degree of anger expressed, both their own and their antagonist’s. Many of the other group members offered observations and support. Sal’s response was that he didn’t know what all the commotion was about; in his view, the two were “jerks” for getting themselves so upset about nothing at

all.

A few minutes later, Farrell, a member who had been very concealed and silent, was pressed to reveal more about herself. With considerable resolve, and for the first time, she disclosed intimate details about a relationship she had recently entered into with a man. She talked about her fear that the relationship would collapse. Moreover, she desperately wanted children, but she had once again started a relationship with a man who made it clear that he did not want children. Many members of the group responded empathically and supportively to her disclosure. Sal was silent, and when called upon he stated that he could see Farrell was having a hard time talking about this, but couldn't understand why, because "it didn't seem like a big-deal revelation." Farrell responded, "Thanks, Sal, that makes me feel great—it makes me want to have nothing to do with you. I'd like to put as much distance as possible between the two of us."

The group's response to Sal in both of these incidents was immediate and direct. The two people he had accused of acting like jerks let him know that they felt demeaned by his remarks. One commented, "If people talk about some problem that you don't have, then you dismiss it as being unimportant or jerky. Look, I don't have the problems that you have about not getting enough compliments from the therapists or other members of the group. It simply is not an issue for me. How would you feel if I called you a jerk every time you complained about that?" **<<**

This meeting illustrates several features of group work with a characterologically difficult client. Sal was inordinately adversarial and had developed an intense and disabling negative transference in several previous attempts in individual therapy. In this session, he expressed distorted perceptions of the therapists (that they had given him only three compliments in dozens of sessions, when in fact they had been strongly and consistently supportive of him). In individual therapy, Sal's distortion might have led to a major impasse, because his transferential distortions were so marked that he did not trust the therapists to provide an accurate view of reality. Therapy groups have a great advantage in the treatment of such clients because, as illustrated in this vignette, group therapists do not have to serve as the sole champions of reality: the other group members assume that role and commonly provide powerful and accurate reality testing to the client.

Sal, like many other narcissistic patients, was overly sensitive to criticism. (Such individuals are emotionally like the hemophiliac patient, who bleeds at the slightest injury and lacks the resources to staunch the flow of blood.)[65] The group members were aware that Sal was highly vulnerable and tolerated criticism poorly. Yet they did not hesitate to challenge him directly and compassionately. Although Sal was wounded in this meeting, as in so many others, he also heard the larger message: the group members took him seriously and respected his ability to take responsibility for his actions. We believe that it is crucially important that a group assume such an honest and direct stance toward these vulnerable clients. Honest and caring confrontation is different from confrontations driven by the wish to retaliate, punish, or humiliate the narcissistic member.[66] Once a group begins to ignore or patronize a narcissistic individual, therapy for that client is certain to fail.

THE MAJOR TASK FOR THE GROUP THERAPIST WORKING WITH ALL of these problematic clients is neither precise diagnosis nor a formulation of early causative dynamics. Whether the diagnosis is borderline or narcissistic personality disorder, the primary issue is the same: the therapeutic management of the highly vulnerable individual in the here-and-now of the therapy group. Group therapy can illuminate interpersonal pathology exceedingly well. It then needs to be matched with sensitive and supportive psychotherapeutic work.

Footnotes

i Splitting is a psychological defense in which the individual separates positive emotions and relationship experiences from negative ones. This results in dramatic and polarizing states and swings from idealizing and loving to devaluing and hating. Ambivalence is severely diminished and the client's world is experienced as black and white.

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Specialized Formats and Procedural Aids

A NUMBER OF IMPORTANT VARIABLES MAY IMPACT THE FAMILIAR group therapy format in which one therapist meets with six to eight members: the client may concurrently be in individual treatment, for example, or may be attending a twelve-step group in addition to the therapy group. The group may also be led by co-therapists instead of one. We shall discuss each of these in this chapter and describe as well some specialized techniques and approaches that may facilitate the course of therapy.

CONCURRENT INDIVIDUAL AND GROUP THERAPY

First, some definitions. *Conjoint therapy* refers to a treatment format in which the client is seen by one therapist in individual therapy and a different therapist (or two, if co-therapists) in group therapy. In *combined therapy*, the client is treated by the *same* therapist simultaneously in individual and group therapy. Little systematic data exists about the added value of concurrent group and individual therapy relative to each delivered alone, although most studies show comparable effectiveness for group and individual therapy.[1] Despite the widespread practice of concurrent individual and group treatment, little research data exist to guide therapists. Therefore, we offer some guidelines and principles that arise from our clinical experience and the literature.[2]

Whenever we integrate two treatment modalities, we must first consider their compatibility. More is not always better! Are the different treatments working at cross-purposes, or do they enhance one another? If compatible, are they complementary, working together by addressing different aspects of the client's therapy needs? Typically, we think of group therapy addressing interpersonal issues in the here-and-now and individual therapy addressing early life dynamics and intrapsychic issues.[3] Integration of these two perspectives may strengthen each modality.

The relative frequencies of the two types of concurrent therapy are unknown, although it is likely that in private practice combined therapy is more commonly employed than conjoint therapy.[4] The opposite appears to be true in institutional and mental health treatment settings.[5] By no means should one consider conjoint and combined therapy to be equivalent. They have exceedingly different features and clinical indications, and we shall discuss them separately.

Conjoint Therapy

We believe that, with some exceptions, conjoint individual therapy is not *essential* to the practice of group therapy. If members are selected with a moderate degree of care, a weekly therapy group is ample therapy and should benefit the great majority of clients. But there are exceptions. The characterologically difficult client, whom we discussed in Chapter 12, frequently needs to be in concurrent individual and group therapy. In fact, the earliest models of concurrent group and individual therapy developed in response to the needs of these challenging clients, and concurrent treatment for these clients has evolved in both dynamically oriented and mentalization-based treatments.[6] Clients with a history of childhood sexual abuse or who have other major issues around shame also often require concurrent therapy.[7] Individual treatment can help clients develop tailored approaches to emotional self-regulation that may help them continue in their group during storms of affect and distress.

Group members frequently go through a severe life crisis (for example, bereavement or divorce) that requires temporary individual therapy support. Some clients are so fragile or blocked by anxiety or fearful of aggression that individual therapy is required to enable them to participate in the group. From time to time, individual therapy is required to prevent a client from dropping out of the group, or to monitor more closely a suicidal or impulsive client.

> **Joan, a young woman with borderline personality disorder partic**ipating in her first therapy group, was considerably threatened by the first few meetings. She felt increasingly alienated because her bizarre fantasy and dream world seemed so far from the experience of the other members. In the fourth meeting, she verbally attacked one of the other members and was attacked in return. For several nights thereafter, she had terrifying nightmares. In one, her mouth turned to blood, an image that appeared to be related to her fear of being verbally aggressive and destructive. In another, she was walking along the beach when a huge wave engulfed her—this related to her fear of losing her boundaries and identity in the group. In a third dream, Joan was held down by several men who guided the therapist's hands as he performed an operation on her brain—obviously related to her fears of

therapy and of the therapist being overpowered by the male members of the group.

Joan's hold on reality grew more tenuous, and it seemed unlikely that she could continue in the group without added support. Concurrent individual therapy with another therapist was arranged, and it helped her to contain her anxiety and remain in the group. **<<**

> Jim was referred to a group by his psychoanalyst, who had treated him for six years and was now terminating analysis.[8] Despite considerable improvement, he still had not mastered the symptom for which he had originally sought treatment: fear of women. He found it difficult even to give direction to his female administrative assistant. In one of his first group meetings, he was made extremely uncomfortable by a woman in the group who complimented him. He stared at the floor for the rest of the session, and afterward called his analyst to say that he wanted to drop out of the group and reenter analysis.

His analyst discussed the situation with the group therapist and agreed to resume individual treatment with Jim on the condition that he return to the group as well. For the next few months, they had an individual session following each group session. The two therapists collaborated well, and the group therapist was able to increase support sufficiently to enable Jim to continue in the group. Within a few months, Jim was able to reach out emotionally to female group members for the first time, and he gradually grew more at ease with women in the real world. **<<**

Thus far, we have considered how individual therapy may facilitate the client's course in group therapy. The reverse is also true: group therapy may be used to augment or facilitate the course of individual therapy.[9] In fact, the majority of clients in conjoint therapy enter the group through referral by their individual therapists. The individual therapist might find a client exceptionally restricted and unable to access the material necessary for productive work. Often the rich, affective interpersonal interaction of a group is marvelously evocative and generates ample data for both individual and group work. At other times, clients have major blind spots that prevent them from accurately or objectively reporting what actually transpires in their lives. One older man was referred to group therapy by his individual therapist because individual therapy was at an

impasse owing to an intense negative paternal transference. The male therapist could say nothing to this client without its being challenged and obsessively picked apart for its inaccuracy or incompleteness. It was a reenactment of the relationship between oppressed son and bullying father, and although both the client and the therapist were aware of this, the client made no real progress until he entered the more democratic, nonhierarchical group environment, where he was able to hear feedback that was free of paternal authority.

Other clients are referred to a therapy group because they have improved in the safe setting of the one-to-one therapy hour, yet have been unable to transfer the learning to outside life. The group setting may serve as a valuable way station for the next stage of therapy: experimentation with new behavior in a low-risk environment, which may effectively disconfirm the client's fantasies of the calamitous consequences of that desired behavior.

Sometimes, in the individual therapy of characterologically difficult clients, severe, irreconcilable problems in the transference may arise. The therapy group may be particularly helpful in diluting the client's intense transference and facilitating reality testing. The individual therapist may also benefit from a deintensification of the countertransference. This is particularly useful in the treatment of clients who use defenses that diffuse personal boundaries, such as splitting and projective identification, or other defenses which may be overwhelming to the therapist. Recall the earlier illustration of George (described in Chapter 2 in the story "Attack First"), whose female individual therapist referred him to conjoint group therapy in response to George's mounting dependence. He had defended against his dependence by aggressively sexualizing their relationship. The group diffused the intensity of his dependence and both treatments progressed well.

In essence, conjoint therapy capitalizes on the presence in treatment of multiple settings, multiple transferences, multiple observers, multiple interpreters, and multiple maturational agents.[10] The group therapist and the individual therapist may function

effectively as peer consultants to one another.

Complications

Along with these advantages of conjoint therapy come a number of complications. When there is a marked difference in the basic approach of the individual therapist and the group therapist, the two therapies may work at cross-purposes, or even become competitive with each other. An overarching sense of a synthesis of the group and individual work is necessary for success.

Not infrequently, individual therapy clients beginning group therapy are discouraged and frustrated by the initial group meetings, which seem to offer less support and special attention than their individual therapy hours. They do not yet appreciate the group as a unique resource that offers new opportunity; instead, they see others as a source of competition and deprivation.[11] Some clients, when attacked or stressed by the group, may defend themselves by unfavorably comparing the group to their individual therapy experience. Such an attack on the group invariably results in further deterioration of the situation.

Another complication of conjoint therapy arises when clients use individual therapy to drain off affect from the group. The client may interact like a sponge in the group, taking in feedback and carrying it away to gnaw on like a bone in the safe respite of the individual therapy hour. Clients may resist working in the group through the pseudo-altruistic rationalization, “I will allow the others to have the group time since I have my own hour.” Another form of resistance is to deal with important material in the opposite setting—to use the group to address the transference to the individual therapist and to use the individual therapy to address reactions to group members. When these patterns are particularly pronounced and resist all other interventions, the therapists, in collaboration, may insist that either the group or the individual therapy be terminated. We have known several clients whose involvement in the group dramatically accelerated when their concurrent individual therapy was stopped.

In our experience, the individual and the group therapeutic

approaches complement each other particularly well if certain conditions are met. There must be a good working collaboration between the individual and group therapists. They must have the client's explicit permission to share all information with each other as they see fit. Conjoint therapy cannot proceed without that agreement in place. It is important that both therapists (and the prescribing psychiatrist or physician, if pharmacotherapy is employed) be equally committed to the idea of conjoint therapy and in agreement about the rationale for the conjoint approach. A referral to a group for conjoint treatment should not be a cover for the sloughing off of clinical responsibility because the individual therapist is paving the way to terminate the treatment of a difficult client.[12] Furthermore, it is essential that the therapists are mutually respectful—regarding both the therapeutic approach and the competence of the other.

A solid relationship between the individual and group therapists may prove essential in addressing the inevitable tensions that arise when clients compare their group and individual therapists, at times idealizing one and devaluing the other. This is a particularly uncomfortable issue for less experienced group therapists working conjointly with more senior individual therapists, whose invisible glowering presence in the group may inhibit group therapists and undermine their confidence. In such a scenario, the group therapist may become concerned about how he or she is being portrayed by the client to the individual therapist.[13] It is exceedingly difficult to be the devalued therapist in a conjoint treatment. The position of the idealized therapist may be easier to bear, but it, too, is precarious.

Thus, the first condition for an effective conjoint therapy experience is that the individual and group therapists have an open, solid, mutually respectful working relationship. The second condition is that the individual therapy must complement the group approach—that is, it must encompass an interpersonal focus. Ideally, it devotes time to an exploration of the client's feelings toward the group members and toward the incidents and themes of the current meetings. Such an exploration can serve to deepen the client's involvement in the group.

Individual therapists who are experienced in group methods may significantly help some clients by coaching them on how to work in a therapy group, and often, this benefits the rest of the group as well. For example, one young man I (IY) was seeing in individual therapy was characteristically suffused with rage. He usually expressed it in explosions toward his wife or as road rage (which had gotten him into several dangerous situations). I referred him to a therapy group, and after a few weeks he reported in his individual hours that he had varying degrees of anger toward many of the group members. When I raised the question of him expressing this in the group, he paled: "No one ever confronts anyone directly in this group—that's not the way this group works.… I would feel awful.… I'd devastate the others.… I couldn't face them again.… I'd be drummed out of the group." We rehearsed how he might confront his anger in the group. Sometimes I role-played how I might talk about it in the group if I were him, and I gave him examples of how to give feedback that would be unlikely to evoke retaliation. For example, "I have a problem I haven't been able to discuss here before. I have a lot of anger. I blow up to my wife and kids and have serious road rage. I'd like help with it here and I'm not sure how to work on it. I wonder if I could start to tackle it by talking about some flashes of anger I feel sometimes in the group meeting." At this point, any group therapist we have ever known would vibrate with pleasure and encourage him to try.

He might then continue, I suggested, by saying, "For example, you, John [one of the other members]: I have tremendous admiration toward you in so many ways, your intelligence, your devotion to the right causes, but nonetheless last week I felt a wave of irritation when you were speaking about your attitude toward the women you date—Was that all me or did others feel that way?" My client took notes during our session and followed my lead, and within a few weeks the group therapist told me it had been a success: not only was this client doing good work, but he had turned the whole group around. The meetings had become more interactional for everyone. Individual therapy can also help the client apply what he or she has learned in the group to new situations and other relationships—for

example, with the individual therapist and with other important figures in the client's social world.

Although it is more common for group therapy to be added to an ongoing individual therapy, the opposite also occurs. The group work can catalyze changes or evoke memories that cause great distress warranting more time and attention than the group may be able to provide.[14] In general, it is best to launch one treatment first and then add the second, if required, rather than start both at once, to avoid confusing or overwhelming the client. Group therapists who recommend the addition of individual treatment to a group member should be alert to the meaning of that recommendation to the other group members and be prepared to discuss it openly.

Combined Therapy

Earlier we said that concurrent therapy is not *essential* to group therapy. We feel the same way about combined therapy, but we also agree with the many clinicians who find that combined therapy can be an exceptionally productive and powerful therapeutic format.

Generally in clinical practice, combined therapy begins with individual therapy. After several weeks or months of individual therapy, therapists place a client into one of their therapy groups—one generally composed entirely of clients who are also in individual therapy with the leader. Homogeneity in this regard—that is, that all the members of the group also be in individual therapy with the group leader—is helpful, but it is not essential. The pressures of everyday practice sometimes result in some clients being in individual therapy with the group leader while one or two are not. Not infrequently, issues of envy may arise in members who do not meet with the group leader individually.

Typically, the client attends one group session and one individual session weekly. Other, more cost-effective variants have been described—for example, a format in which each group member meets for one individual session every few weeks.[15] Although such a format has much to offer, it has a different rationale from combined therapy, in that the occasional meeting is only an adjunct to the

group: it is designed to facilitate norm formation and to optimize the member's use of the group.

In combined therapy, the group is usually open-ended, with clients remaining in both therapies for months, even years. But combined therapy may also involve a time-limited group format. I (IY) have, on many occasions, formed a six-month group of my long-term individual clients. After the group terminates, the clients may continue individual therapy, which has been richly fertilized by group-spawned data. I continue to be impressed by the results of placing my individual clients into a group: almost invariably, therapy is accelerated and enriched.

There is no doubt that combined therapy (as well as conjoint therapy) decreases dropouts.[16] Our informal survey of combined therapy groups—our own and those of supervisees and colleagues—over a period of several years reveals that early dropouts are exceedingly rare. In fact, of the clients who were already established in individual therapy before entering a group led by their individual therapist, *not a single one* dropped out in the first twelve sessions. This finding, of course, contrasts starkly with the high dropout rates for group therapy without concurrent individual therapy. The reasons are obvious. First, therapists know their individual therapy clients very well and can be more accurate in the selection process. Second, the therapists in their individual therapy sessions are able to prevent impending dropouts by addressing and resolving issues that have hindered the client's work in the group.

> **After seven meetings, David, a somewhat obsessional fifty-year-**old confirmed bachelor, was on the verge of dropping out. The group had given him considerable feedback about several annoying characteristics he had: his frequent use of euphemisms; his concealment behind long, boring, repetitious anecdotes; and his persistence in asking distracting and irrelevant questions. Because David seemed untouched by the feedback, the group ultimately backed away and began to "mascot" him—tolerating him in a good-natured fashion, but not taking him seriously.
>
> In an individual session, he lamented being "out of the loop" in the group and questioned whether he should continue. He also mentioned that he had not been wearing his hearing aid to the group, because of

his fear of being ridiculed or stereotyped. Under ordinary circumstances, David would likely have dropped out of the group, but I (IY) could explore in his individual therapy many of the disturbing group events as well as the meaning of his being "out of the loop." It turned out to be a core issue for David. Throughout his childhood and adolescence, he had felt socially shunned, and ultimately he had resigned himself to it. He became a loner and entered a profession (freelance IT consultant) that permitted a solitary, unattached lifestyle.

At my urging, he used his hearing aids in the group and expressed his feelings there of being out of the loop. His self-disclosure—and, even more important, his examination of his own role in putting himself out of the loop—were sufficient to reverse the process and bring him into greater engagement with the group. He remained in combined therapy with much profit for a year. **<<**

This example highlights another advantage of concurrent treatment: the rich and unpredictable interaction in the group commonly opens areas in therapy that might otherwise never have surfaced in the more insular individual format. David never felt "out of the loop" in his individual therapy—after all, I listened to his every word and strove to be present with him continually. Working in combined therapy helps us to realize the limits of our knowledge of our clients based upon individual therapy alone.

> Steven had for years engaged in many extramarital encounters but refused to take safer-sex precautions. In individual therapy I (IY) discussed this with him for months from every possible vantage point. We discussed his grandiosity and sense of immunity from biological law, his selfishness, and his concerns about impotence with a condom. I communicated my concern for him, for his wife, and for his sex partners. I expressed paternal feelings: both sadness at his self-destructiveness and outrage at his selfish behavior. All to no avail. When I placed Steven in a therapy group, he did not discuss his sexual risk-taking behavior, but some relevant experiences occurred.

On a number of occasions, he gave feedback to women members in a cruel, unfeeling manner. Gradually, the group confronted him on this and reflected on his uncaring, even vindictive, attitudes to women. Most of his group work centered on his lack of empathy. Gradually, he learned to enter the experiential worlds of others. The group was time limited (six months), and many months later in individual therapy, when

we again focused in depth on his sexual behavior, Steven recalled, with considerable impact, how the group members had accused him of being uncaring. He was now able to consider his choices in the light of his lack of loving, and only then did his behavioral pattern change. **<<**

> Sam, a man who entered therapy because of his inhibitions and general flatness, encountered his lack of openness and his rigidity far more powerfully in the therapy group than in the individual format. He kept three particularly important secrets from the group: that he had been trained as a therapist and practiced for a few years; that he had retired after inheriting a large fortune; and that he felt superior and held others in contempt. He kept secrets in the group (as he did in his social life), convincing himself that self-revelation would result in greater distance from others: he believed he would be stereotyped in one way or another, and "used," envied, revered, or hated.

After three months of participation in a newly formed group, Sam became painfully aware of how he had re-created in the group the same onlooker role he assumed in his real life. All the members had started together, and all the others had revealed themselves and participated in a personal, uninhibited manner; he alone had chosen to stay outside the circle.

In our individual work, I (IY) urged Sam to reveal himself in the group. In session after session, I felt like a cornerman in a boxing ring exhorting him to take a chance. In fact, as the group meetings went by, I told him that delay was making things much worse. If he waited much longer to tell the group he had been a therapist, he would get a lot of flak when he did. (Sam had been receiving a steady stream of compliments about his perceptivity and sensitivity.)

Finally, Sam took the plunge and revealed his secrets. Immediately, he and the other members began to relate in a more genuine fashion. His disclosure enabled other members to reveal more about themselves. A member who was a student therapist discussed her fear of being judged for making superficial comments; another revealed that she was a closet snob, and a wealthy member revealed his concerns about others' envy. Still others discussed strong, previously hidden feelings about money—including their anger at the therapist's fees.

After the group ended, Sam continued to discuss these interactions in his individual therapy and to take new risks with me as well. The members' acceptance of him after his disclosures was powerfully affirming. Previously, they had accepted him for his helpful insights, but that acceptance meant little to him, because he knew it was rooted in

his bad faith: his false presentation of himself and his concealment of his training, wealth, and personal traits. **<<**

Sam's experience points out some of the inherent pitfalls in combined therapy. For one thing, the role of the therapist changes significantly and increases in complexity. There is something refreshingly simple in leading a group when the leader knows the same thing about each member as everyone else does. But the combined therapist knows so much that life gets complicated. A member once referred to my (IY) role as that of Professor X from Marvel Comics. I knew everything: what members felt toward one another, what they chose to say, and, above all, what they chose to withhold. But this access to information can be a problem.

Group therapists who do not see any of their group clients in individual therapy can be more freewheeling. They can ask for information, take blind guesses, ask broad, general questions, call on members to describe their feelings about another member or some group incident. But the combined therapist knows too much! It becomes awkward to ask questions of members when you know the answer. Consequently, many therapists find that they are less active in groups of their own individual clients than when leading other groups. Another consideration is that when the same therapist provides both the individual and group therapies, client dependence and negative transference and countertransference reactions may even be amplified.

The therapist who provides combined treatment often struggles with the issue of boundaries and confidentiality. (This is also true in conjoint therapy at times when the group therapist has learned from the individual therapist about important feelings or events that their mutual client has not yet addressed in the group.) Is the content of the client's individual therapy the property of the group? It is almost always best to urge clients to bring up group-relevant material in the group. If, for example, in the individual therapy hour, the client brings up angry feelings toward another member, the therapist urges the client to bring these feelings back to the group.

Suppose the client resists? Again, most therapists will pursue the

least intrusive options: first, repeated urging of the client and investigation of the resistance; then focusing on in-group conflict between the two members, even if the conflict is mild; then sending knowing glances to the client; and, the final step, asking the client for permission to introduce the material into the group. Good judgment, of course, must be exercised. No technical rationale justifies humiliating a client. As noted earlier, a promise of absolute therapist confidentiality can rarely be provided without negatively constraining the therapy. Therapists can only promise that they will use their discretion and best professional judgment. Meanwhile, they must work toward helping the client accept the responsibility of bringing forward relevant material from one venue to the other.

The client's shame often blocks disclosure, but this is rarely well addressed by bulldozing through the group member's avoidance.[17] In fact, bringing information from the individual setting to the group without permission may well be an ethical breach on the therapist's part, as it violates client privacy. An added complexity arises when the group is co-led and the client is in individual therapy with one of the co-therapists. Many of these ethical matters emerge from dynamics regarding therapist power and privilege and client autonomy.[18] Whatever the circumstance, informed consent about communication, boundaries, and confidentiality is essential in combined therapy, as noted in Chapter 9.[19]

COMBINING GROUP THERAPY AND TWELVE-STEP GROUPS

An increasingly common form of concurrent therapy is the treatment in group psychotherapy of clients who are also participating in twelve-step groups or other mutual support groups. Historically, antipathy existed between the proponents of these two modalities, each viewing the other competitively and with suspicion.[20] Fortunately, there has been a growing rapprochement and appreciation for how these approaches complement one another. The vast economic costs and psychosocial scope of substance use disorders, which directly impact at least 20 million individuals in the United States at any moment and countless more indirectly; the high comorbidity rates with other psychological problems; the relapsing nature of the illness; and the social context of addiction make group therapy particularly relevant.[21]

Individuals with substance use disorders typically experience disturbances in their relationships at every stage of their illness. First, they have predisposing interpersonal difficulties resulting in emotional pain that they try to ease through substance use; second, they have relational difficulties resulting from the substance use itself; third, they have interpersonal difficulties that complicate the maintenance of sobriety. There is good evidence that group therapy can play an important role in recovery by helping these individuals develop coping skills that sustain sobriety and enhance resilience to relapse.[22] Constructing a new support network together with interpersonal learning is often integral to recovery.[23]

There is also strong evidence that twelve-step groups are both effective and valued by clients.[24] (Alcoholics Anonymous is the most prevalent of the twelve-step groups, but there are over 100 variations, including those for such conditions as drug addiction, gambling, sexual addiction, and overeating.)[i] It is inevitable that some of the many millions of members of AA, who attend one of the

115,000 weekly AA meetings worldwide, will also participate in group psychotherapy.[25]

Group therapy and AA complement one another when certain misunderstandings and obstacles are removed. First, group leaders must become informed about the mechanisms of twelve-step group work and learn to appreciate the inherent wisdom in the twelve-step program as well as the enormous support it offers to those struggling with addiction. Second, it is helpful to see that the models share some features in common: twelve-step groups use familiar group principles regarding bonding and belonging, employ role modeling, and recognize the importance of members developing new and rewarding relationships and gaining a sense of personal effectiveness.[26] Third, there are several common misconceptions held by group therapists and/or by members of AA and similar groups that must be dispelled. These include the notions that:

1. Twelve-step groups are opposed to psychotherapy or medication.
2. Twelve-step groups encourage the abdication of personal responsibility by turning oneself over to a higher power.
3. Twelve-step groups discourage the expression of strong affects.
4. Mainstream group therapy neglects spirituality.
5. Mainstream group therapy is powerful enough to be effective without twelve-step groups.
6. Mainstream group therapy views relationships among twelve-step members and the relationship between sponsor and sponsee as regressive.[27]

Keep in mind that it is difficult to make blanket statements about twelve-step meetings, because meetings are not all the same: there is much variability from group to group. In general, however, there are two apparent major differences between the AA approach and the group therapy approach regarding the core of treatment.

The Twelve Steps of AA rest on the idea that reliance on a "Power greater than ourselves" is the essential component in staying sober. While the concept of "higher power" is left to each member to define for him or herself and the number of explicitly secular and humanistic twelve-step groups is growing, traditional, "old-school" AA focuses heavily on the members' relationship to a higher power clearly defined in the AA Big Book as "God," on surrender to God's will, and on understanding the self in relationship to God.[28] At the same time, however, a fundamental part of what propels change in AA is provision of a social network and fellowship, alternative and sober role models, and support for individual self-efficacy.[29] These mechanisms are all very compatible with interpersonal group therapy.

Group therapy encourages member-to-member interaction, especially in the here-and-now: it is the lifeblood of the group. AA, by contrast, specifically prohibits "crosstalk"—that is, direct interaction between members during a meeting. "Crosstalk" could be any direct inquiry, suggestion, advice, feedback, or criticism. (This, too, is a generalization, however; if one searches, one can find AA groups that engage in considerable interaction—particularly before and after meetings.) The prohibition of "crosstalk" by no means leads to an impersonal meeting, however. AA members have pointed out to us that the knowledge that there will be no judgment or criticism is freeing to members and encourages them to self-disclose deeply. Since there is no designated trained group leader to modulate and process here-and-now interaction, AA's decision to avoid intensive interpersonal interaction makes great sense.

Therapy group leaders introducing an AA member into their therapy group must keep in mind that group feedback will be an unfamiliar concept. Extra time and care should be taken in pregroup preparation sessions to explain this difference between the AA model and the therapy group model. We recommend that group leaders attend some AA meetings and become thoroughly familiar with the Twelve Steps. Demonstrate your respect for the steps and aim to convey to the client that most of the steps have meaning in

the context of the therapy group as well and, if followed, will enhance the work of therapeutic change.

Table 13.1 lists the Twelve Steps and suggests related group therapy themes. We do not suggest a reinterpretation of the Twelve Steps but a loose translation of ideas in the steps into compatible and related interpersonal group concepts. With this framework, group leaders can readily employ a common language that covers both approaches and reinforces the idea that therapy and the recovery process are mutually facilitative.[30]

TABLE 13.1 The Convergence of Twelve-Step and Interpersonal Group Therapy Approaches

The Twelve Steps: 1. We admitted that we were powerless over alcohol and that our lives had become unmanageable.	*Interpersonal Group Psychotherapy*: Relinquish grandiosity and counterdependence. Begin the process of trusting the process and the power of the group.
The Twelve Steps: 2. Came to believe that a Power greater than ourselves could restore us to sanity.	*Interpersonal Group Psychotherapy*: Self-repair through relationships and human connection. Reframe “Power greater than ourselves” into a source of soothing, nurturance, and hope that may replace the reliance on substances.
The Twelve Steps: 3. Made a decision to turn our will and our lives over to the care of God as we understood Him.	*Interpersonal Group Psychotherapy*: Make a leap of trust in the therapy procedure and the goodwill of fellow group members.
The Twelve Steps: 4. Made a searching and fearless moral inventory of ourselves.	*Interpersonal Group Psychotherapy*: Self-discovery. Search within. Learn as much about yourself as possible.
The Twelve Steps: 5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.	*Interpersonal Group Psychotherapy*: Self-disclosure. Share your inner world with others—the experiences that fill you with shame and guilt as well as your

dreams and hopes.

The Twelve Steps: 6. Were entirely ready to have God remove all these defects of character.
Interpersonal Group Psychotherapy: Explore and illuminate, in the here-and-now of the treatment, all destructive interpersonal actions that invite relapses. The task of the group is to help members find the resources within themselves to prepare to take action.

The Twelve Steps: 7. Humbly asked Him to remove our shortcomings.
Interpersonal Group Psychotherapy: Acknowledge interpersonal feelings and behaviors that hinder satisfying relationships. Modify these by experimenting with new behaviors. Request and accept feedback in order to broaden your interpersonal repertoire. Though the group offers the opportunity to work on issues, it is your responsibility to do the work.

The Twelve Steps: 8. Made a list of all persons we had harmed, and became willing to make amends to them all.
Interpersonal Group Psychotherapy: Identify interpersonal injuries you have been responsible for; develop empathy for others' feelings. Try to appreciate the impact of your actions on others and develop the willingness to repair injury.

The Twelve Steps: 9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
Interpersonal Group Psychotherapy: Use the group as a testing ground for the sequence of recognition and repair. Start the ninth-step work by making amends to other group members whom you have in any manner impeded or offended.

The Twelve Steps: 10. Continued to take personal inventory and when we were wrong promptly admit it.
Interpersonal Group Psychotherapy: Internalize the process of self-reflection, assumption of responsibility, and self-revelation. Make these attributes part of your way of being in the therapy group and in your outside life.

The Twelve Steps: 11. Sought through prayer and meditation to improve our conscious contact with God as we understand Him, praying only for knowledge of His will for us and the power to carry that out.
Interpersonal Group Psychotherapy: No direct psychotherapeutic focus, but the therapy group may support mind-calming meditation and spiritual exploration.

The Twelve Steps: 12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to other addicts, and to practice these principles in all our affairs.
Interpersonal Group Psychotherapy: Become actively concerned for others, beginning with your fellow group members. Embracing an altruistic way of being in the world will raise your love and respect for yourself.

Source: Adapted from R. Matano and I. Yalom, “Approaches to Chemical Dependency: Chemical Dependency and Interactive Group Therapy: A Synthesis,” *International Journal of Group Psychotherapy* 41 (1991): 269–93. “The 12 Steps of AA,” Alcohol.org, www.alcohol.org/alcoholics-anonymous.

CO-THERAPY

Some group therapists choose to meet alone with a group, but the great majority prefer to work with a co-therapist.[31] Indeed, the practice of co-therapy far outstrips the small amount of research evaluating its added clinical benefits. Although co-therapy adds some complexity, cohesion is not compromised in groups led by good co-therapy teams. One large head-to-head comparison of single vs. co-therapy leadership reported significant added clinical benefits for adolescents treated in co-therapy-led groups.[32] Our own clinical experience has taught us that co-therapy presents both special advantages and potential hazards.

First, consider the advantages, both for the therapists and the clients. Co-therapists complement and support each other. Together, they have greater cognitive and observational range, and with their dual points of view they may generate more hunches and more strategies. When one therapist, for example, is intensively involved with one member, the co-therapist may be far more aware of the remaining members' responses to the interchange and in a good position to broaden the range of the interaction and exploration. When one leader's empathy and mentalization capacity falls short, the other can maintain the focus essential for the group.[33] And do not underestimate the sheer instrumental value of being able to take vacations, knowing that the group will continue to meet with your colleague. For forty years, I (ML) have co-led a group every Wednesday night with a psychiatry resident, and I greatly value the added flexibility co-therapy has provided.

Because clients differ so much among themselves in their reactions to each of the co-therapists and to the co-therapists' relationship, co-therapy also catalyzes transferential reactions and makes the nature of distortions more evident. In groups where strong therapist countertransference reactions occur or when personal identification with one's clients is likely (for example, groups for

clients with HIV or cancer, or trauma groups), the supportive function of co-therapy becomes particularly important for both clients and therapists.[34] I (ML) vividly recall the last group meeting that Mary, a member of a group for women with advanced breast cancer, was able to attend. She knew she was dying and spoke about her family, her appreciation for the group, and what she valued in her life. My mother was very ill with cancer at the same time and I found myself emotionally overwhelmed and unable to regain my therapeutic composure. My co-therapist recognized this and facilitated the meeting effectively and then helped me debrief after the session.

Many clinicians have long believed that a male-female co-therapist team may have unique advantages. The image of the group as the primary family may be more strongly evoked; many fantasies and misconceptions about the relationship between the two therapists arise and may profitably be explored. Many clients benefit from the model of a male-female pair working together with mutual respect and inclusiveness, without the destructive competition, mutual derogation, exploitation, or pervasive sexual subtext they may associate with male-female pairings. For victims of early trauma and sexual abuse, a male-female co-therapy team provides an opportunity to address issues of mistrust, abuse of power, and helplessness. Clients from cultures in which men are dominant and women are subservient may experience a co-therapy team of a strong, competent woman and a tender, competent man as uniquely facilitative.[35] It is also important to note that gender roles are changing rapidly in society, and male and female gender stereotypes are less and less relevant. In well-functioning co-therapy teams, roles are fluid, not rigid.

From our observations of over two hundred therapy groups led by neophyte therapists, we consider the co-therapy format to have special advantages for the beginning therapist. Many students consider co-leading a group to be one of their most effective and professionally impactful learning encounters. Where else in the training curriculum do two therapists have the opportunity to participate simultaneously in the same therapy experience with the

same supervision?[36] For one thing, the presence of a co-therapist reduces therapist anxiety and permits neophyte therapists to be more objective in understanding the meeting. In the postmeeting rehash, the co-therapists can provide valuable feedback about each other's behavior. Similarly, co-therapists may aid each other in the identification and working-through of countertransference reactions toward various members.

It is especially difficult for beginning therapists to maintain objectivity in the face of massive group pressure. Weathering a group attack and helping a group make constructive use of it is one of the more unpleasant and difficult chores for neophyte therapists. When you are under the gun, you may feel too threatened either to clarify the attack or to encourage further attack without appearing defensive or condescending. There is nothing more squelching than an individual under fire saying, "It's really great that you're attacking me. Keep it going!" A co-therapist may prove invaluable here in helping the members continue to express their anger at the other therapist and ultimately to examine the source and meaning of that anger.

Whether co-therapists should openly disagree with each other during a group session is an issue of some controversy. We have generally found co-therapist disagreement unhelpful to the group in the first few meetings. The group is not yet stable or cohesive enough to tolerate such divisiveness in their leadership. Later, however, therapist disagreement may contribute greatly to therapy. In one study, I (IY) asked twenty clients who had concluded long-term group therapy about the effects of co-therapist disagreement on the course of the group and on their own therapy.[37] They were unanimous in their judgment that it was beneficial. For many it was a model-setting experience: they observed individuals whom they respected disagree openly and resolve their differences with dignity and tact.

Consider a clinical example:

> **During a group meeting, my co-leader, a resident, asked me (ML)** why I seemed so quick to jump in with support whenever one of the

men, Rob, received critical feedback. The question caught me off guard. I commented first that I had not noticed that until she drew it to my attention. I then invited feedback from others in the group, who agreed with her observation. It soon became clear to me that I was indeed overly protective of Rob, and I commented that although he had made substantial gains in controlling his anger and explosiveness, I still regarded him as fragile and I felt I needed to protect him from overreacting. Rob thanked me and my co-leader for our openness and added that, although he may have needed extra care in the past, he no longer did at this point. **<<**

In this way, group members experience therapists as human beings who, despite their imperfections, are genuinely attempting to help the members. Such a humanization process is inimical to irrational stereotyping, and clients learn to differentiate others according to their individual attributes rather than their roles. If group members wrestle with issues around power, status, race, or privilege, they may project these issues onto the co-therapy relationship. This may evoke co-therapist tension and rivalry. A respectful, transparent, in-group discussion between the two collaborative therapists can be very constructive. Unfortunately, co-therapists take far too little advantage of this wonderful modeling opportunity. Research into communicational patterns in therapy groups shows exceedingly few therapist-to-therapist remarks.[38]

Although some clients are made uncomfortable by disagreements between co-therapists, which may echo earlier parental conflict, for the most part it strengthens the honesty and the potency of the group. The principles of therapist transparency are critical in this context. As you disclose, be sure that your intent in doing so is therapeutic and that the impact of what you say aligns with that intent. We have observed many stagnant groups spring to life when the two therapists differentiated themselves as individuals.

The disadvantages of the co-therapy format flow from problems in the relationship between the two co-therapists. How the co-therapy goes, so goes the group. That is one of the main criticisms of the use of co-therapy outside of training environments.[39] Why add another relationship (and one that drains professional resources) to the

already interpersonally complex group environment?[40]

Hence, it is important that co-therapists feel comfortable and open with each other. They must learn to capitalize on each other's strengths: one leader may be more able to nurture and support and the other more able to confront and to tolerate anger. If the co-therapists are competitive, however, and pursue their own brilliant interpretations rather than supporting lines of inquiry the other has begun, the group will be distracted and unsettled. It is also important that co-therapists speak the same professional language. A survey of forty-two co-therapy teams revealed that the most common source of co-therapy dissatisfaction was differing theoretical orientation.[41]

In some training programs, a junior therapist is paired with a senior therapist, a co-therapy format that offers much but is fraught with problems. Senior co-therapists must teach by modeling and encouragement; junior therapists must learn to individuate while avoiding both nonassertiveness and destructive competition. Most important, they must be willing, as equals, to examine their relationship—not only for themselves but as a model for the members. The impact of differences in gender, culture, age, and experience of each co-therapist must be addressed. Over time both therapists should exercise the full range of leadership, unconstricted by stereotypes or group members' projections. A co-therapy team that entrenches the participants in dominant and subordinate roles will, unfortunately, model to the group that it is acceptable to withdraw and accept a submissive position.[42]

> **Our own initial experience of co-therapy together reminds us of** these principles. During my training, Irv invited me (ML) to co-lead an ongoing group of group therapists that he had been leading by himself. It was daunting to enter a group whose members were themselves experienced group leaders. Often a group member would carry the most recent edition of this book—which they had assigned their own students—into the session.
>
> The group clients were exceedingly constrained and deferential to Irv, afraid to challenge one another or speak to the competitiveness they felt. Our hope was that shifting to co-leadership might help mobilize the group and unlock some of the unspoken tensions. For the first several

sessions after my entry, every comment I made landed like a lead balloon in the oppressively quiet group. A bit exasperated, I finally proclaimed that the group members were stuck and afraid to take risks, leaving everything to “Irv, the wizened group leader.”

That seemed to help unlock the group somewhat, and later, in our postgroup discussion, Irv asked me if I was aware of my competitive feelings toward him, adding with humor that he assumed I intended to say, “Irv, the wise group therapist,” not “wizened,” i.e., shriveled. Alas, one cannot lie to one’s unconscious, as my slip of the tongue betrayed, in this instance, to good effect. **<<**

The choice of co-therapist is not to be taken lightly. We have seen many classes of psychotherapists choose co-therapists and have had the opportunity to follow the progress of these groups, and we are convinced that the ultimate success or failure of a group depends largely on the correctness of that choice. If the two therapists are uncomfortable with each other or are closed, rivalrous, or in wide disagreement about style and strategy—and if these differences are not resolvable through supervision—there is little likelihood that their group will develop into an effective work group.[43] Co-leading a group with a hostile or untrusting co-therapist ranks as one of the worst professional experiences a group leader will endure.

Differences in temperament and natural rhythm are inevitable. What is not inevitable, however, is that these differences get locked into place in ways that limit the co-therapists’ roles and functions. Sometimes the group’s feedback can be illuminating and lead to important work, as was the case in a group for male spousal abusers, who questioned why the male co-therapist collected the group fee and the female co-therapist did the “straightening up” after each session.

When consultants or supervisors are called in to assist with a group that is not progressing satisfactorily, they can often offer the greatest service by directing their attention to the relationship between the co-therapists. (This will be discussed further in Chapter 16.) One study of neophyte group leaders noted that the factor common to all trainees who reported a disappointing clinical group experience was unaddressed and unresolved co-therapy tensions.[44]

One frustrated and demoralized co-therapist reported a transparent dream in supervision just after her arrogant but incompetent co-therapist withdrew from the training program. In the dream she was a hockey goalie defending her team's net, and one of her own players (guess who?) kept firing the puck at her.

Co-therapist choices should not be made blindly. Do not agree to co-lead a group with someone you do not know well or do not like. Do not make the choice because of work pressures or an inability to say no to an invitation; it is far too important and too binding a relationship. *You are far better off leading a solo group with good supervision than being locked into an incompatible co-therapy relationship.* You will do well to select a co-therapist toward whom you feel close but who in personal characteristics is dissimilar to you: such complementarity enriches the experience of the group.

Spouses frequently co-lead marital couples' groups. Co-leadership of a long-term interpersonal group, however, requires an unusually mature and stable marital relationship. We advise therapists who are involved in a newly formed romantic relationship with each other not to lead a group together. It is advisable to wait until the relationship has developed stability and permanence. Two former lovers, now estranged, do not make a good co-therapy team.

Characterologically difficult clients who are unable to integrate loving and hateful feelings may project these feelings onto the therapists in a way that ends up "splitting" the co-therapy team. One co-therapist may become the focus of the positive part of the split and is idealized while the other becomes the focus of hateful feelings and is attacked or shunned. Unless this is explored and worked through, it is a recipe for therapeutic failure for the client as well as for co-therapy fracturing.

Some groups divide into two factions, each co-therapist having a "team" of clients with whom he or she has a special relationship. Sometimes this division has its genesis in the relationship the therapist established with those clients before the group began, in prior individual therapy or in consultation. (For this reason, it is advisable that *both* therapists interview all clients, preferably simultaneously, in the pregroup screening. We have seen clients

continue to feel a special bond throughout their entire group therapy course with the member of the co-therapy team who first interviewed them.) Other clients align themselves with one therapist because of his or her personal characteristics, or because they feel a particular therapist is more intelligent, more senior, or more sexually attractive than the other, or more ethnically or personally similar to themselves. Whatever the reasons for the subgrouping, *the process should be noted and openly discussed*.

Discussion time is essential for a co-therapy team. The co-therapy relationship takes time to develop and mature. *Co-therapists must set aside time to talk together and tend to their relationship.*[45] At the very least, they need a few minutes before each meeting to talk about the last session and examine possible issues for that day's meeting, and then fifteen to twenty minutes at the end to debrief and to share their reflections about the meeting and about each other's behavior. If the group is supervised, it is imperative that *both* therapists attend the supervisory session. Many busy clinics, in the name of efficiency and economy, make the serious mistake of not setting aside time for co-therapist discussion. Because of their intense intimate experience in the group, deep and abiding friendships may develop between co-therapists.

DREAMS

The number and types of dreams that group members bring to therapy are largely a function of the therapist's attentiveness to dreams. The therapist's response to the first dreams presented by clients will influence the nature of dreams subsequently presented. The intensive, detailed, personalized investigation of dreams practiced in analytically oriented individual therapy is hardly feasible in group therapy. It would require a disproportionate amount of time to be centered upon one client and would likely be minimally useful to the remaining members, who become mere bystanders.

What useful role, then, can dreams play in group therapy? Usually therapists think of dreams as consisting of both manifest (conscious) and latent (unconscious) content. We suggest that therapists also think about dreams as carrying both intrapsychic and interpersonal dimensions. The dream is the client's intrapsychic creation, but when the client shares it within the group, the dream is transformed into an interpersonal act.[46]

In individual psychodynamic treatment, therapists are usually presented with many dreams. They therefore never strive for complete analysis of all dreams, electing instead to work on aspects of dreams that seem *pertinent to the current phase of therapy*. Therapists may ignore some dreams and ask for extensive associations to others. For example, if a bereaved client brings in a dream full of anger toward her deceased husband as well as heavily disguised symbols relating to sexual identity, the therapist will generally focus upon the former theme and defer the latter. Moreover, the process is self-reinforcing. It is well recognized that clients who are deeply involved in therapy dream or remember dreams compliantly: that is, they produce dreams that are tied to the current thrust of therapy and reinforce the theoretical framework of the therapist ("tag-along" dreams, Freud termed them).

The investigation of certain dreams can accelerate group therapeutic work. Most valuable are group dreams—dreams that

involve the group as an entity—or dreams that reflect the dreamer's feelings toward one or more members of the group. Either of these types may elucidate not only the dreamer's but also other members' concerns that have not previously come fully into consciousness. Some dreams may introduce, in disguised form, material that is conscious but that members have been reluctant to discuss in the group. Hence, inviting all the group members to comment on the dream and associate to it and its impact on them is often productive. It is important also to explore the context of the disclosure of the dream: Why dream or disclose this dream at this particular time? How does exploration of this dream deepen the understanding of the dreamer and of the group?[47]

> **In a meeting just preceding the entry of two new members to the** group, one self-absorbed man, Jeff, reported his first dream to the group after several months of participation. "I am polishing my new BMW to a high sheen. Then, just after I clean the car interior to perfection, seven people dressed as clowns arrive, get into my car carrying all sorts of food, and mess it up. I just stand there watching and fuming."
>
> Both he and the group members presented associations to the dream around an old theme for Jeff—his frustrating pursuit of perfection and need to present a perfect image to the world. The leader's inquiry about "why this dream now?" led to more significant insight. Jeff said that over the past few months he had begun to let the group into his less-than-perfect "interior" world. Perhaps, he said, the dream reflected his fear that the new members coming the next week would not take proper care of his interior. He was not alone in this anxiety: other members also worried that the new members might spoil the group. **<<**

At the twentieth meeting of another group, Sally related this dream:

> **I am walking with my younger sister. As we walk, she grows** smaller and smaller. Finally, I have to carry her. We arrive at the group room, where the members are sitting around sipping tea. I have to show the group my sister. By this time, she is so small she is in a package. I unwrap the package but all that is left of her is a tiny bronze head. **<<**

The investigation of this dream clarified several previously unconscious concerns of the dreamer. Sally had been extraordinarily lonely and immediately became deeply involved in the group—in fact, the group was her only important social contact. At the same time, however, she feared that the group had become *too* important to her. Sally modified herself rapidly to meet group expectations and, in so doing, lost sight of her own needs and identity. The rapidly shrinking sister symbolized herself becoming more infantile, more undifferentiated, and finally inanimate, as she immolated herself in a frantic quest for the group's approval. Perhaps there was anger in the image of the group "sipping tea." Was the group truly working? Did the other members really care about her? The lifeless, diminutive bronzed head—was that what they wanted? Dreams may reflect the state of the dreamer's sense of self and need to be treated with great care and respect as an expression of self and not as a secret message that must be aggressively decoded.[48] Think of the dream as a gift offered by the client to the group and to the therapist; pay careful attention to the group members' emotional responses to the dream.

The following dream illustrates how the therapist may selectively focus on those aspects that further the group work:

> **> My husband locks me out of our grocery store. I am very con**cerned about the perishables spoiling. He gets a job in another store, where he is busy taking out the garbage. He is smiling and enjoying this, though it is clear he is being a fool. There is a young, attractive male clerk there who winks at me, and we go out dancing together. **<<**

This member was a middle-aged woman who was introduced into a group of younger members. From the standpoint of her personal dynamics, the dream was highly meaningful. Her husband, distant and work-oriented, locked her out of his life. She had a strong feeling of her life slipping by unused (the perishables spoiling). At a previous group meeting she had referred to her sexual fantasies as "garbage." She also felt a considerable amount of previously unexpressed anger toward her husband and made him an absurd figure in the dream.

Though there were several tempting dream morsels, the therapist chose to focus on the *group-relevant* themes. The client had many concerns about being excluded from the group: she felt older than the other members, less attractive, and very isolated from them. Accordingly, the therapist focused on the theme of being locked out and on her desire for more attention from others in the group, especially the men (one of whom resembled the winking clerk in the dream).

Dreams often reveal unexpressed group concerns or shed light on group impasses.[49] The following dream illustrates how conscious, but avoided, group material may, through dreams, be brought into the group for examination:

> **> There are two rooms side by side with a mirror in my house. I feel** there is a burglar in the next room. I think I can pull the curtain back and see a person in a black mask stealing my possessions. **<<**

This dream was brought in at the mid-phase of a time-limited therapy group that was observed through a one-way mirror by the therapist's students. Aside from a few comments in the first meeting, the group members had never expressed their feelings about the observers. A discussion of the dream led the group into a valuable and much-needed conversation about the therapist's relationship to the group and to his students. Were the observers "stealing" something from the group? Was the therapist's primary allegiance toward his students, and were the group members merely a means of presenting a good show or demonstration for them?

AUDIOVISUAL TECHNOLOGY

The advent of audiovisual technology seemed a great boon to the practicing group therapist, and early professional group therapy literature reflected an initial wave of tremendous enthusiasm. Video recording was a way to turbocharge feedback to our clients.[50] It was part of our ongoing wish to maximize client learning and augment the direct clinical group work. Later in this chapter we discuss other useful feedback platforms.[51]

In recent years we have seen a steep decline in articles and books about the clinical use of audiovisual technology. It is likely that the current ethos of efficiency is to blame for this reduction, as clinical use of audiovisual equipment is often awkward and time-consuming. What remains yet to be determined is the therapeutic opportunities presented by the growing use of video teleconferencing for group therapy. These sessions are now easily recorded—with client consent, of course—and may have utility in providing direct feedback to group members and therapists as well as in the research on group therapy. Privacy concerns regarding the transmission and storage of video recordings are notable. Nevertheless, this technology still has much potential; at the very least, it merits a brief survey of how it has been used clinically, even if the methodologies seem anachronistic. The use of audiovisual techniques in teaching and in research is more enduring and still prominent.

In earlier approaches some clinicians taped each meeting and used immediate playback (“focused feedback”) of selected sections during the session. Some therapists used an auxiliary therapist whose chief task was to record the group and even to select suitable portions for playback. Other therapists recorded the meeting and devoted the following session to playback and discussion of certain key sections.[52]

Some therapists scheduled an extra playback meeting in which

most of the previous taped session was viewed. Still others used a serial-viewing technique: they videotaped every session and retained short representative segments of each, which they later played back to the group.[53] Some simply made the videos available to clients who wished to come in between meetings to review some segment of the meeting. The videos were also made available for absent members to view the meeting they missed.

Client response depends on the timing of the procedure. Clients will respond differently to the first playback session than to later sessions. In the first playback, clients attend primarily to their own images and are less attentive to their styles of interacting with others or to the process of the group. Our own experience, and that of others, is that group members may have a keen interest in viewing video recordings early in therapy, but once the group becomes cohesive and highly interactive, they rapidly lose interest in the viewing and resent time taken away from the live group meeting.[54] Often a member's long-cherished self-image is radically challenged by the video playback, and after viewing a recording, members may recall previous feedback offered by other members more readily and be more receptive to it. Self-observation is a powerful experience; nothing is as convincing as information one discovers for oneself.

We have on occasion found video recording to be of great value in crisis situations. For example, a man in a group of alcohol-dependent individuals arrived at a meeting intoxicated and proceeded to be monopolistic, insulting, and crude. Heavily intoxicated individuals obviously do not profit from meetings because they are not capable of retaining and integrating the events of the session. This meeting was recorded, however, and a subsequent viewing was enormously helpful to the client. He had been told but until this replay had never really understood how destructive his alcohol use was to himself and others.

On another occasion a different client arrived heavily intoxicated to this group and soon lost consciousness. He lay stretched out on the sofa while the group, encircling him, discussed various courses of action. Some time later, this client viewed the tape and was

profoundly affected. People had often told him that he was killing himself with alcohol, but the sight of himself on video, laid out as if at his funeral, brought his twin brother—who had died of alcoholism—to mind.

In another group, a periodically manic client who had never accepted that her behavior was unusual had an opportunity to view herself in a particularly frenetic, disorganized state.[55] In each of these instances, the video recording provided a powerful self-observatory experience—a necessary first step in the therapeutic process.

Many therapists are reluctant to inflict a video camera on a group. They feel that it will inhibit the group's spontaneity and that the group members will resent the intrusion—though not necessarily overtly. In our experience, the person who experiences the most discomfort is often the therapist. The fear of being exposed and shamed, particularly in supervision, is a leading cause of therapist resistance and must be addressed in supervision.[56]

Clients who are to view the playback are usually receptive to the suggestion of video recording. Of course, they are concerned about confidentiality and need reassurance on this issue. If the video is to be viewed by anyone other than the group members (for example, students, researchers, or supervisors), the therapist must be explicit about the purpose of the viewing and the identity of the viewers and must also obtain written permission from each member with regard to each intended use: clinical, educational, and research. Clients should be full participants in the decision about the secure storage or deletion of the videos.

Video in Teaching

Video recording has proven its value in the teaching of all forms of psychotherapy. Students and supervisors are able to view a session with a minimum of distortion or defensive misrepresentation by the trainee.[57] Important nonverbal aspects of behavior of both students and clients—which may be completely missed in the traditional supervisory format—become available for study. The student-

therapist has a rich opportunity to observe his or her own presentation of self and body language. Frequently what gets missed in traditional supervision is not the students' "mistakes," but the very effective interventions that they employ intuitively without conscious awareness. Confusing aspects of the meeting may be viewed several times until some order appears. Valuable teaching sessions that clearly illustrate basic principles of therapy may be preserved and a teaching video library created. Videos have become a mainstay of training psychotherapists for both clinical practice and for leading manual-based groups in clinical trials, helping to ensure that therapists do not drift from the prescribed model.[58]

Video Recording in Research

The use of videotaping and video recording has also advanced the field significantly by allowing researchers to ensure that the psychotherapy being tested in clinical trials is delivered competently and aligns faithfully with the study protocol.[59] It is no less important in a psychotherapy trial than it is in a drug therapy trial to monitor the treatment delivery and demonstrate that clients received the right kind and right amount of treatment. In pharmacotherapy research, blood-level assays can be used for this purpose. In psychotherapy research, video recordings are an excellent monitoring tool for the same purpose. It is virtually impossible to obtain psychotherapy research funding without a clear and reliable protocol to ensure that the psychotherapy was delivered in the right way across different therapists and different sites in multisite trials.

WRITTEN SUMMARIES

Throughout my practice of group psychotherapy, I (IY) have regularly used the ancillary technique of writing summaries of the groups I have led. At the end of each session, I dictate a detailed summary of the group session and send a copy to each group member.[60] The summary is an editorialized narrative that describes the flow of the session, each member's contribution, my contributions (not only what I said, but also what I wished I had said and what I did say but regretted), and any hunches or questions that occur to me after the session. This summary can be typed or dictated using voice recognition software and then emailed to the group members. Dictation of summaries (two or three single-spaced pages) requires approximately twenty to thirty minutes per group session. It is best done immediately after the session; the longer it is postponed, the longer it will take to complete and the more inaccurate it will be. The sequence of events in the group fades from memory quickly. Do not let even a phone call intervene between the meeting and your completion of the summary. To date, my students, co-therapists, colleagues, and I have written and mailed thousands of group summaries to group members. It is my strong belief that the procedure greatly facilitates therapy.

In these days of economically pressured psychotherapy, however, who can accommodate a task that requires yet another thirty minutes of therapist time and additional administrative support? For that matter, look back through this chapter: Who has time for setting up cameras and selecting portions of video to replay to the group? Who has time for even brief meetings with a co-therapist before and after meetings? Or for conferring with group members' individual therapists? The answer, of course, is that harried therapists must make choices, and often, alas, they must sacrifice some potentially powerful but time-consuming adjuncts to therapy in order to meet the demands of contemporary practice. It is easy to be dismayed by the mountains of record keeping that need to be completed.[61]

Health-care administrators may believe that time can be saved by streamlining therapy—making it slicker, briefer, more uniform. However, therapists sacrifice the very core of therapy if they sacrifice their ingenuity and their ability to respond to unusual clinical situations with creative measures. Hence, even though the practice is not in wide clinical use at present, we continue to describe such techniques as the written summary. We believe it is a potent facilitating technique. Our experience has been that all group therapists willing to try it have found that it enhances the course of group therapy.[62] Moreover, it plays a role in the education of young therapists by helping them use language skillfully.[63] Writing the summary encourages the reflection and deliberate practice that hones our skills as therapists.[64]

The written summary may even do double service as a mechanism for documenting the course of therapy and turning the usually unrewarding and dry process of record keeping into a functional intervention.[65] We are wise to remember that the client's record belongs to the client and can be accessed by the client at any point. In all instances, it is appropriate to write notes expecting that they may be read by the client. Notes should use only first names and provide a transparent, therapeutic, de-pathologizing, considered, and empathic account of the treatment.

My (IY) first experience with the written summary was in individual therapy. A young woman, Ginny, had attended a therapy group for six months but had to terminate because she moved out of town and could not arrange transportation to get to the group on time. Moreover, her inordinate shyness and inhibition had made it difficult for her to participate in the group. Ginny was inhibited in her work as well: a gifted writer, she was crippled by severe writer's block. Furthermore, because of her limited income, she could not afford individual therapy.

I agreed to treat her in individual therapy and waive the fee but with one unusual proviso: after each therapy hour, she had to write an impressionistic, freewheeling summary of the "underground" of the session—that is, what she was really thinking and feeling but had

not verbally expressed. My hope was that the assignment would help penetrate the writing block and encourage greater spontaneity. I agreed to write an equally candid summary. Ginny had a pronounced positive transference. She idealized me in every way, and my hope was that a written summary conveying my honest feelings—pleasure, discouragement, puzzlement, fatigue—would permit her to relate more genuinely to me.

For a year and a half, Ginny and I wrote weekly summaries. We handed them, sealed, to my administrative assistant, and every few months we read each other's summaries. The experiment turned out to be highly successful; Ginny did well in therapy, and the summaries contributed greatly to that success.[ii] I developed sufficient courage from the venture (and courage is needed: it is difficult at first for a therapist to be so self-revealing) to think about adapting the technique to a therapy group. The opportunity soon arose in two groups of alcoholic clients.[66]

My co-therapists and I had attempted to lead these groups in an interactional mode. The groups had gone well, in that the members were interacting openly and productively. However, here-and-now interaction always entails anxiety, and clients with alcohol use disorders are notoriously poor at regulating anxiety. By the eighth meeting, members who had been dry for months were drinking again (or threatening to drink again if they "ever had another meeting like the one last week!"). We hastily sought methods of modulating the anxiety: increased structure, a written agenda for each meeting, video playback, and written summaries distributed after each meeting. The group members considered the written summary to be the most efficacious method by far, and soon it replaced the others.

We believe that the summaries are most valuable if they are honest and straightforward about the process of therapy. They are virtually identical to summaries I (IY) make for my own files (which provide most of the clinical material for my writing) and are based on the assumption that the client is a full collaborator in the therapeutic process—that *psychotherapy is strengthened, not weakened, by demystification*.

The summary serves several functions: it provides understanding of the events of the session; takes note of good (or resistive) sessions; comments on client gains; predicts (and, by doing so, generally prevents) undesirable developments; brings in silent members; increases cohesiveness (by underscoring similarities, caring in the group, and so on); invites new behavior and interactions; provides interpretations (either repetition of interpretations made in the group or new interpretations occurring to the therapist later); and provides hope to the group members, helping them realize that the group is an orderly process and that the therapists have some coherent sense of the group's long-term development. In fact, the summary may be used to augment every one of the group leader's tasks in a group.

Let's look at the functions of the summary. (In the following discussion we cite excerpts from actual summaries.)

Revivification and Continuity

The summary becomes another group contact during the week. The meeting is revivified for the members, and the group is more likely to maintain continuity. In Chapter 5 we stated that groups assume more power if the work is continuous—that is, if themes begun one week are not dropped, but instead explored more deeply, in succeeding meetings. The summary augments this process. Not infrequently, group members begin a meeting by referring to the previous summary—perhaps a theme they wish to explore or a statement with which they disagree.

Understanding Process

The summary helps clients reexperience and understand the important events of a meeting. In Chapter 6, we described the here-and-now as consisting of two phases: *experience* and *the understanding of that experience*. *The summary facilitates the second stage*, the understanding and integration of the affective experience. Sometimes group sessions may be so threatening or unsettling that members close down and move into a defensive,

survival position. Only later (often with the help of the summary) can they review significant events and convert them into constructive learning experiences. The therapist's process commentaries (especially complex ones) delivered in the midst of a melee tend to fall on deaf ears. These same comments, often fine-tuned, repeated in the summary, may be more effective, because the client is able to consider them at length with some distance from the intensity of the initial engagement.

Shaping Group Norms

The summaries may be used to reinforce norms both implicitly and explicitly. The following excerpt reinforces the here-and-now norm:

> Phil's relationship with his boss is very important and difficult for him at this time, and as such is certainly material for the group. However, the members do not know the boss, what he is like, what he is thinking and feeling, and thus are limited in offering help. However, they are beginning to know one another and can be more certain of their own reactions to one another in the group. They can give more accurate feedback about feelings that occur between them rather than trying to guess what the boss may be thinking.

Therapeutic Leverage

The therapist may, in the summary, reinforce risk-taking and focus clients on their primary task, their original purpose in coming to therapy. For example:

> Irene felt hurt at Jim's calling her an observer of life and fell silent for the next forty-five minutes. Later she said she felt clamped up and thought about leaving the group. It is important that Irene keep in mind that her main reason for being in therapy was that she felt estranged from others and unable to create closer, sustained relationships, especially with men. In that context, it is important for her to recognize, understand, and eventually overcome her impulse to clamp up and withdraw as a response to feedback.

Or the therapist may take care to repeat statements by clients

that will offer leverage in the future. To illustrate:

> Nancy began weeping at this point, but when Ed tried to console her, she snapped, “Stop being so kind. I don’t cry because I’m miserable, I cry when I’m pissed off. When you console me or let me off the hook because of my tears, you always stop me from looking at my anger.”

New Thoughts

Often the therapist understands an event only after the fact. On other occasions, the timing is not right for a clarifying remark during a session (there are times when too much cognition might squelch the emotional experience), or there has simply been no time available in the meeting, or a member has been so defensive that he or she would reject any efforts at clarification. The summaries provide the therapist with a second chance to convey such important thoughts.

Transmission of the Therapist’s Temporal Perspective

Far more than any member of the group, the therapist maintains a long-range temporal perspective and is cognizant of changes occurring over many weeks or months, both in the group and in each of the members. There are many times when the sharing of these observations offers hope, support, and meaning for the members. For example:

> Seymour spoke quite openly in the group today about how hurt he was by Jack and Burt switching the topic off him. We [the co-therapists] were struck by the ease and forthrightness with which he was able to discuss these feelings. We can clearly remember his hurt, passive silence in similar situations in the past, and are impressed with how markedly he has changed in his ability to express his feelings openly.

The summaries provide temporal perspective in yet another way. Since the clients almost invariably save the reports, they have a comprehensive account of their progression through the group, which they may refer to with great profit in the future.

Therapist Self-Disclosure

Therapists, in the service of the clients' therapy, may use the summary as a vehicle to disclose personal here-and-now feelings (of puzzlement, of discouragement, of irritation, of pleasure) and their views about the theory and rationale underlying their own behavior in the group. Consider the therapist self-disclosure in these illustrative excerpts:

> We felt very much in a bind with Seymour. He was silent during the meeting. We felt very much that we wanted to bring him into the group and help him talk, especially since we knew that the reason he had dropped out of his previous group was because of his feeling that people were uninterested in what he had to say. On the other hand, today we decided to resist the desire to bring him in because we knew that by continually bringing Seymour into the group, we are infantilizing him, and it will be much better if, sooner or later, he is able to do it by himself.

> Irv had a definite feeling of dissatisfaction with his own behavior in the meeting today. He felt he dominated things too much, that he was too active, too directive. No doubt this is due in large part to his feeling of guilt at having missed the previous two meetings and wanting to make up for it today by giving as much as possible.

Filling Gaps

An obvious and important function of the summary is to fill in gaps for members who miss meetings because of illness, vacation, or any other reason. The summaries keep them abreast of events and enable them to move more quickly back into the group.

New Group Members

The entrance of a new member may also be facilitated by providing summaries of the previous few meetings. I routinely ask new members to read such summaries before attending the first meeting.

General Impressions

We believe the written summary facilitates therapy. Clients have

been unanimous in their positive evaluations: most read and consider the summaries very seriously; many reread them several times; almost all retain them for future use. The client's therapeutic perspective and commitment is deepened; the therapeutic relationship is strengthened; and in our experience no serious negative transference complications or adverse consequences occurred. The dialogue and disagreement about summaries are always helpful and makes this a collaborative process. The intent of the summary should never be to convey a sense of the "last word."

Many therapists have asked us about confidentiality and client privacy. To date we have not encountered problems in this area. Clients are asked to treat the summary with the same degree of confidentiality as they do any event in the group. As an extra precaution, we strongly recommend that therapists use only first names, that they avoid explicit identification of any particularly delicate issue (for example, an extramarital affair), and that they use a secure, agreed upon delivery system. When we first sent out summaries, we mailed them in a plain envelope with no return address. Today, of course, email, with encryption to protect privacy, is an easier alternative.

We suggest this approach to crafting the summary: first try to construct the skeleton of the meeting by recalling the two to four main issues of the meeting. When that is in place, next try to recall the transitions between issues. Then go back to each issue and try to describe each member's contribution to the discussion of each issue. Pay special attention to your own role, including what you said (or didn't say) and what was directed toward you.

Do not be perfectionistic: one cannot recall or remember everything. Do not try to refresh your memory by listening to a tape of a meeting—that would make the task far too time-consuming. Mail it out without proofreading it; clients overlook errors and omissions, or it becomes grist for exploration.

Like any event in the group, the summaries generate differential responses. For example, clients with severe dependency yearnings will cherish every word; those with a severe counterdependent posture will challenge every word, or, occasionally, be unable to

spare the time to read them at all; obsessive clients obsess over the precise meaning of the words; and mistrustful individuals search for hidden meanings. Thus, although the summaries provide a clarifying force, they do not thwart the formation of the distortions whose corrections are intrinsic to therapy.

MONITORING GROUP THERAPY OUTCOME AND PROCESS

Throughout this text we have emphasized that every group leader can be an evidence-based practitioner. One important pathway is for leaders to obtain feedback about how their groups and group members are actually doing. This is referred to as "practice-based evidence" and is a central component of the accountability demanded of our work.[67] Why is this feedback helpful? In the absence of feedback, group therapists must rely only on their clinical impressions. When therapy is progressing well, this is generally sufficient. However, as we have discussed elsewhere, a sizable percentage of our clients will not progress and will drop out of treatment. Both individual and group therapists generally do a poor job of recognizing who among their clients may be at risk of deterioration or dropout. Monitoring outcome and process helps in the earlier detection of problems, lessens negative clinical outcomes, and boosts therapy gains.[68] This burgeoning area of research, enabled by modern technology, enables each group therapist to be, in essence, a clinical scientist.

Two widely used outcome-monitoring systems are the Outcome Questionnaire (OQ-45.2) and the Partners for Change Outcome Management System (PCOMS).[69] Both provide feedback about each member of the group in terms of individual distress, interpersonal relationships, and social function. These systems also offer process measures regarding how each member is experiencing the session. Incorporating the Group Questionnaire (GQ)[70] (referred to in Chapter 3) provides additional feedback to group therapists by measuring the client's experience of relationships within the group. By comparing each member to other group members, therapists can be alerted to members who are out of sync and who may require additional attention. Outcome measurements also provide comparisons to a large pool of psychotherapy clients, and the

trajectory of each group member can be compared to trajectories for thousands of clients. Feedback messages signal that the client is on track (green); may not be on track (yellow); or is clearly off track (red). Feedback is also provided to the group leader regarding what clinical areas may warrant particular attention. Guided by this information, the client who is strongly connected but avoidant of risk-taking may be more assertively challenged. The client who is compliantly attending but emotionally disengaged can similarly be identified.

Feedback can be provided at the individual or group level or aggregated system-wide to get a sense of how therapy groups in a particular organization or setting may be functioning. Clients can complete these questionnaires easily and securely on a range of handheld devices. Ideally these are completed before each session so that the group leaders can review the reports before the meeting. The reports can even facilitate record keeping. Clients can be engaged in providing this feedback if they understand its importance; they can be encouraged to view it as equivalent to getting blood work done to assist their family physician in providing good care. Sharing feedback with clients enhances the therapeutic alliance, builds a sense of partnership about the therapy, and allows for more collaborative and equitable decision-making. Using objective data promotes treatment efficiency and effectiveness.[71]

Pitfalls of Monitoring

Gathering information without using it in therapy will quickly discourage clients from completing the questionnaires in the future. Determining how best to incorporate the feedback into the clinical work requires consideration of timing and should be tailored to an understanding of one's clients, particularly those who may find it easier to signal their distress on a questionnaire than in person. Therapists are sometimes reluctant to make use of this kind of feedback system, finding it intrusive and compromising of their autonomy or the sanctity of therapy. Others may balk at the potential added cost of this kind of monitoring.[72] Some clinicians fear that

getting negative feedback about their effectiveness will lead to punitive institutional responses. Organizational culture and organizational climate play a key role in the proper utilization of this feedback; it is important that the organizational culture supports and enhances clinicians' capacity to do their work effectively. We should aim to create a culture that promotes professional development for group leaders ensuring that both clients and therapists benefit.[73]

STRUCTURED EXERCISES

We use the term *structured exercise* to denote an activity in which a group follows some specific set of directions. It is an experiment carried out in the group, generally suggested by the leader but occasionally by some experienced member. The precise rationale of structured exercises varies, but in general they are intended as accelerating devices to foster engagement or to enhance efficacy.

Structured exercises attempt to speed up the group with warm-up procedures that bypass the hesitant, uneasy first steps of the group; they speed up interaction by assigning individuals tasks that circumvent ritualized, introductory social behavior; and they may help members get in touch quickly with suppressed emotions and unknown parts of themselves, cope with intense affects, or reconnect with their physical and creative selves.[74] In some settings and with some clinical populations, the structured exercise may be the central focus of the meeting. There are a wide range of possible exercises: some common models include action- and activity-oriented groups for the elderly (such as art, dance, and movement groups) that aim to reconnect clients to a sense of effectiveness, competence, and social interaction; structured activity groups for hospitalized psychotic patients; and guided imagery or body awareness after cancer surgery or for victims of trauma.[75] Our group work with women with advanced breast cancer always concluded with an exercise in progressive muscle relaxation and guided imagery.[76] Personal narratives that are authored individually can be shared to good effect in the group treatment of individuals with chronic medical illnesses and HIV.[77]

Mindfulness-based stress reduction (MBSR) groups that teach meditation, deep breathing, and relaxation and focus awareness on members' moment-to-moment state of being are also prominent and have been used to remarkably good effect in the treatment of medical illnesses and anxiety disorders and in the prevention of

relapse in depression.[78] These techniques can also be incorporated as helpful components of broader-based group interventions.

> **Sara, an eighty-two-year-old woman with anxiety and depression** participating in a day hospital for seniors, told her group that she was intensely anxious about attending her granddaughter's wedding five days hence. Getting dressed up and being exposed to a large crowd of people filled her with dread. As she spoke, Sara started to panic, hyperventilate, and cry. While the group therapists tried to be reassuring, Sara's neighbor, an eighty-five-year-old woman, Doris, reached over, grabbed her hand, and lovingly stated: "You know what to do Sara; you know to breathe deeply, focus on your breath, and make yourself feel better. There is nothing to fear; I know how much you want to attend the wedding. I am going to breathe with you right now and I want you to join me. You have practiced this and now we will use it. You are not alone here."
>
> As Doris began to breathe deeply and slowly, others around the group circle joined in. Twelve group members, including the two group leaders, held hands around the circle and echoed Doris's pace of breathing. Sara slowly calmed, regained her composure, and said, "Thank you so much for reminding me of that. It always helps but I forget about it when I start to get anxious. I felt so overwhelmed and alone."
>
> The remainder of the session focused on the sense of effectiveness the group members felt in working together and supporting one of their members. Sara committed to practicing her breathing exercises daily and to making a plan to have a close friend come over before the wedding to help her get ready. She promised to give the group a full report on the wedding, which she subsequently did with much gratitude. **<<**

A structured exercise in interactional groups may require only a few minutes or may consume an entire meeting. It may be predominantly verbal or nonverbal. Generally, the successful structured exercise will generate data that is subsequently discussed. To maximize the impact of the exercise, it must be both experienced and processed. Having the experience without attributing meaning to it, which occurred all too often in the early stages of the encounter group movement, is insufficient.[79] Such

exercises, common in the encounter groups but far less so in the therapy group, might involve the *entire group as a group* (the group may be asked, for example, to build something or to plan an outing); *one member vis-à-vis the group* (the "trust fall," for example, in which one member stands, eyes closed, in the center and falls, allowing the group to catch, support, and then cradle and rock the person); *the entire group as individuals* (members may be asked in turn to give their initial impressions of everyone else in the group); *the entire group as dyads* (the "blind walk," for example, in which the group is broken into dyads and each pair takes a walk with one member blindfolded and led by the other); *one designated dyad* (two members locked in a struggle may be asked to take turns pushing the other to the ground and then lifting him or her up again); or *one designated member* ("switching chairs"—a member may be asked to give voice to two or more conflicting inner roles, moving from one chair to another as he or she assumes one or the other role). Any prescribed exercise that involves physical contact needs to be carefully considered. If the usual boundaries of therapy are to be crossed, notwithstanding clear therapeutic intent, it is essential to obtain informed consent from the group members.

The injudicious use of structured exercises was a miscarriage of the intent of the approaches that spawned these techniques. The initial training group (or T-group) field formulated exercises that were designed to demonstrate principles of group dynamics (both between and within groups) and to accelerate group development. Since the typical T-group met for a sharply limited period of time, the leaders sought methods to speed the group past their initial reserve and ritualized social behavior. Their aim was for members to experience as much as possible of the developmental sequence of the small group. It was not intended to provide therapy.

What does research tell us about the effects of these procedures on the process and outcome of the group? My (IY) encounter group project with Morton Lieberman and Matthew Miles closely studied the impact of the structured exercise.[80] We concluded that leaders who used many exercises were popular with their groups:

immediately after the end of a group, the members regarded these leaders as *more competent, more effective, and more perceptive* than leaders who used these techniques sparingly. *Yet the members of groups that used the most exercises had significantly less favorable outcomes than the members of groups with the fewest exercises.* (The groups with the most exercises had fewer high changers, fewer total positive changers, and more negative changers than the groups that used the exercises more sparingly. Moreover, the high changers from the encounter groups with the most exercises were *less* likely to maintain their changes over time.)

The moral of this study is that *if your goal is to have your group members think you're competent and you know what you're doing, then use an abundance of structured interventions*; in doing so—in leading by providing explicit directions, assuming total executive function—you fulfill the group's fantasies of what a leader should do. However, your group members will *not be improved; in fact, excessive reliance on these techniques renders a group less effective*. Groups that use many structured exercises never deal with several important group themes. Though structured exercises appear to plunge the members quickly into a great degree of expressivity, the *group pays a price for its speed*; it circumvents many group developmental tasks and the group does not develop a sense of autonomy and potency.

This encounter group project also demonstrated that it was not just the leaders' interactions with a member that mediated change. Of even greater importance were many psychosocial forces in the change process: change was heavily influenced by an individual's role in the group (centrality, level of influence, value congruence, and activity) and by characteristics of the group (cohesiveness, climate of high intensity and harmoniousness, and norm structure). In other words, the data failed to support the importance of the leaders' direct therapeutic interaction with each member.

Though these research findings issued from short-term encounter groups that met for a total of thirty hours, they have much relevance for the therapy group. First, consider speed: structured exercises do indeed bypass early, slow stages of group interaction and plunge

members quickly into an expression of positive and negative feelings. Whether or not they accelerate the process of therapy is another question entirely.

In short-term groups—T-groups or very brief therapy groups—it is often legitimate to employ techniques to bypass certain difficult stages, or to help the group move on when it is mired in an impasse. In long-term therapy groups, the process of bypassing is less germane; the leader more often wishes to guide the group *through* anxiety, *through* the impasse or difficult stages, rather than *around* them. Resistance, as we have emphasized throughout this text, is not an impediment to therapy; it is the stuff of therapy.

Yet another reason for urging caution in the use of multiple structured exercises in therapy groups is that leaders who do so run the risk of infantilizing the group. Members of a highly structured, leader-centered group begin to feel that help—all help—emanates from the leader; they await their turn to work with the leader; they deskill themselves; they cease to avail themselves of the help and resources available in the group. They divest themselves of responsibility.

We do not wish to overstate the case against the use of structured exercises. Surely there is a middle ground between allowing the group, on the one hand, to flounder pointlessly in some unproductive sequence and, on the other, assuming a frenetically active, overly structured leadership role. Indeed, that is the conclusion that we reached in the encounter group study. The study demonstrated that an active, executive, managerial leadership style relates to outcome in a curvilinear fashion: that is, *too much structure and too little structure were both negatively correlated with good outcome*. Too much structure created the types of problems discussed above (leader-centered, dependent groups), and too little (a laissez-faire approach) resulted in plodding, unenergetic, high-attrition groups.

The use of structured exercises is common to many types of groups. Many of the techniques we described in Chapter 5, which the leader employs in norm setting, in here-and-now activation, and in process-illumination functions, have a prescriptive quality. (“Who

in the group do you feel closest to?" "Can you look at Mary as you talk to her?" "If you were going to be graded for your work in the group, what grade would you receive?" And so on.)

Every experienced group leader employs some structured exercises. For example, if a group is tense and experiences a silence of a minute or two (a minute's silence feels very long in a group), we often ask for a go-around in which each member says, quickly, what he or she has been feeling or has thought of saying, but did not, during that silence. This simple exercise usually generates much surprising and valuable data.

What is important in the use of structured exercises is the purpose to which they are put. If structured interventions are suggested to help mold an autonomously functioning group, or to steer the group into the here-and-now, or to explicate process, they may be of value. In a brief group therapy format, they may be invaluable tools for focusing the group on its task and plunging it more quickly into that task. If used, they should be properly timed; nothing is as disconcerting as the right idea in the wrong place at the wrong time. It is a mistake to use exercises as emotional space filler —that is, as something interesting to do when the group seems at loose ends.

Nor should a structured exercise be used to generate affect in the group. A properly led therapy group should not need energizing from outside. If there seems to be insufficient energy in the group, if meetings seem listless, if, time and time again, the therapist feels it necessary to inject voltage into the group, there is most likely a significant developmental problem that a reliance on accelerating devices will only compound. What is needed instead is to explore the obstructions, the norm structure, the members' passive posture toward the leader, the relationship of each member to his or her primary task, and so forth. Structured exercises often play a more important role in brief, specialized therapy groups than in the long-term general ambulatory group. In the next chapter, we shall describe uses of structured exercises in a number of specialty therapy groups.

GROUP THERAPY RECORD KEEPING

Every group therapist should be knowledgeable about the specific documentation requirements for their setting. Documentation of therapy must protect client confidentiality and meet a number of objectives: demonstrate that an appropriate standard of care has been provided; describe the process and effectiveness of the treatment; demonstrate the evaluation of clinical risk; facilitate continuity of care by another therapist at a later time, if required; and verify that a billable service has been provided at a certain time and date.

The record belongs to the client and the client may well read it. It should be written with that in mind: the tone should be objective, respectful, balanced, and transparent with regard to the therapist's therapeutic rationale and plan for treatment.[81] We encourage all practitioners to be well informed of the impact of the Health Insurance Portability and Accountability Act (HIPAA) on client privacy and personal health information.[82] An added consideration is the need to protect the private health information of other group members when documenting the care provided to each individual group member.

For these purposes many recommend that the group therapist keep a combined or dual record: a group record and a separate file for each individual member.[83] If written group summaries are used, they should be included in the group record. For students, the group record may also serve as the group *process notes* that will be reviewed in supervision. The group record should note attendance, major group themes, the state of group cohesion, prominent interactions, transference and countertransference, what was engaged and what was avoided, and anticipations of what will need to be addressed in the next session. The group therapist should *always, without fail*, review this record immediately before the following meeting.

In addition, a personal chart or record must be kept for each individual client. These serve as the client's personal progress notes and include initial goals, symptoms, safety concerns (if any), engagement with the psychotherapy process, and achievement of therapy goals. Email exchanges between therapists and clients are also typically considered part of the clients' individual clinical records and should be retained. The personal record pertains to each individual client, and the therapist must make certain that personal information or identifying details of other group members is not divulged in the individual chart. The group record pertains to the entire group. Whereas the group record should be made after each group meeting, the individual progress notes can be made at less frequent but regular intervals, with more frequent entries as the clinical situation warrants. Treatment teams in inpatient or intensive outpatient settings may require added record keeping. In all situations, secure storage of all clinical records is essential.

Footnotes

i Newer non-twelve-step peer support groups are also developing that use social learning approaches, such as the SMART Recovery and Women for Sobriety models.

ii I learned a great deal about psychotherapy from this experiment. For one thing, it brought home to me the *Rashomon*-like nature of the therapeutic venture. The client and I had extraordinarily different perspectives of the hours we shared. All my marvelous interpretations? She never even heard them! Instead, Ginny heard, and valued, very different parts of the therapy hour: the deeply human exchanges; the fleeting, supportive, accepting glances; the brief moments of real intimacy. The exchange of summaries also provided interesting instruction about psychotherapy, and I used the summaries in my teaching. Several years later Ginny and I decided to write a prologue and an afterword and publish the summaries as a book, the royalties from which we would share equally. See I. Yalom and G. Elkin, *Every Day Gets a Little Closer: A Twice-Told Therapy* (New York: Basic Books, 1974; reissued 1992).

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Online Psychotherapy Groups

BY FAR THIS IS THE SHORTEST AND THE YOUNGEST CHAPTER in the book. Shortly before the publication of the sixth edition we encountered a sudden explosion of a new way to deliver group psychotherapy.[1] In an extremely short period of time, literally within a matter of a few weeks in early 2020, the COVID-19 pandemic changed the practice of group psychotherapy, shifting face-to-face groups to online group therapy.[2] This new format, which we will refer to as video-teleconferencing (VTC) group therapy, has sustained group therapy during the many months of physical distancing necessitated by the pandemic. Though we have much yet to learn, there is sufficient scientific literature and accrued clinical wisdom to date to articulate some principles for group leaders running VTC groups. It is dicey to predict the future, but we fully expect VTC groups to be part of our field long after the COVID-19 pandemic recedes. In the following discussion we will describe what is unique about VTC groups and what is consistent with our previous discussion about group psychotherapy practice.

Much about VTC groups is the same as in face-to-face groups—time, size, duration, and focus—but the group members meet on a screen rather than live in an office. Participants are able to see one another onscreen even though they are many miles apart. The trajectory of change has been dramatic, and many group therapists have taken a rapid and deep dive into this work. Some therapists have noted the change from *group circle* to *group screen* is as profound as the change from the *couch* to the *group circle* in the

early days of group therapy.[3] Overall, VTC groups have maintained group therapy continuity and access to care, but not without substantial growing pains.

VTC GROUPS: EARLY FINDINGS

VTC groups were used prior to the COVID-19 pandemic and there is evidence that group therapy can be effective in this format. Brief, well-designed, well-planned VTC groups have reported outcomes comparable to in-person group therapy, notwithstanding some initial hesitation on the part of both clients and therapists. VTC treatment has been used to provide group cognitive-behavioral therapy (CBT-G) for depression, cognitive-processing group treatment for veterans with PTSD, groups for dementia caregivers and for cancer patients to address psychological distress, as well as treatment for a range of other clinical populations.[4] Although some clients and therapists have initially found this new format to present challenges, support and training readily offset initial misgivings.[5]

What is evident at this early point? Client satisfaction appears to be good. Participants have reported feeling less alone, better informed, and well supported. Groups had high participation rates, low dropout rates, and excellent completion rates. Group cohesion measures in VTC groups do appear to be less strong than in traditional face-to-face group therapy, but not to the degree that therapeutic outcomes are compromised.[6] Client privacy concerns were not prominent even before COVID-19, when VTC was done on older technical platforms that were less secure and less HIPAA compliant than the ones now available. The number of platforms has expanded exponentially, and developers are now paying greater attention to the security of client health information. The rapidly expanding use of VTC has increased these concerns and alerted practitioners and clients alike to privacy issues that will need to be addressed through the development of even better online platforms.

ALTHOUGH THE ISSUE HAS NOT BEEN DEEPLY STUDIED TO DATE, it appears that VTC groups utilize all the familiar group therapeutic factors.[7] No doubt as we gain more clinical experience with VTC, we may need to

develop new ways to conceptualize group cohesion, group dynamics, and group process in VTC groups. Research is understandably limited at this early point, but it will no doubt emerge over the years to come. We also need to understand how starting a VTC group by design, as opposed to transitioning to one from an in-person group out of necessity, impacts a group's functioning.

The rapid and forced transition to VTC groups generated a range of reactions, including feelings of loss and upheaval among participants, and these feelings colored their experience in therapy. The transition was also associated with widespread anxiety about the physical, economic, and psychosocial upheaval precipitated by the COVID-19 pandemic. Although therapists are growing more comfortable with the technology, many are still uneasy about relying on the Internet to deliver care.[8] We have all had frustrating encounters with problematic Internet connections that are distractions from the work of the group.

GUIDELINES FOR GROUP PSYCHOTHERAPISTS

Ethical guidelines require therapists to practice only in those areas in which they are competent. For the VTC group therapist, that includes competence in using the VTC technology. The group leader's administrative tasks have always included responsibility for securing a safe, stable, secure environment for the group. Now it also entails managing the VTC technological platform.[9] It can be challenging enough to organize a group within the bricks and mortar of one's own familiar office or institution. Consider then how much more difficult it can be to establish a workable group environment that now includes nine group members each calling in from their home, office, or car.

VTC therapists must obtain written, informed consent to employ the VTC platform. In doing so, they must clarify the nature of the contract, including the limits of their ability to be responsive to clinical emergencies when therapy is delivered online. Since the client and therapist may be at great physical distance, the therapist must make a clear backup plan with clients to ensure client safety and access to emergency care. Hence, access to all group members' phone numbers is essential. Moreover, the therapist and client may encounter problems with their Internet connections, and a phone connection can be a useful back-up plan. Group members may need some instruction in how to use the platform. An important point is how clients wish to name and identify themselves online. Attention to this detail can protect against inadvertent privacy breaches. We have seen group members unpleasantly surprised to see their family name on the screen, for example. Even learning what kind of lighting is best or how to position oneself with the camera requires discussion and experimentation to enhance the video quality.

As VTC grows in popularity, professional guidelines for the effective and ethical practice of online care will undergo development and revision.[10] Practitioners should be aware of their respective professional association and jurisdictional licensure requirements. In

all instances it is essential to ensure a HIPAA-compliant platform.

A common question, for example, is whether a professional in one state can treat a client in another state in which the therapist is not licensed. What if the treatment begins in one state, and then the client moves to another state and wishes to continue in therapy? Which ethical priority should guide the therapist's decision—continuity of care, or licensing jurisdiction issues? This is a widening gray area and requires federal attention to match legislation with contemporary practice patterns.[11]

Informing clients about group participation during pregroup preparation now needs to include instruction about using the online platform and articulating each member's responsibility to protect one another's privacy. Group members must also appreciate that privacy and confidentiality are harder to ensure online even with a secure platform. There may be other people in a client's home who may overhear the group, for example—a problem that even the best software cannot prevent. The online group leader must emphasize that group members participate without intrusions and distractions from their personal setting.

The boundaries protecting the group may come under pressure in the online world, and addressing these issues with the most up-to-date technical information is essential. For example, meetings should be password protected, and participants should never share their passwords with others. Participants should not connect to the session using unsecured WiFi—for example, from a coffee shop or hotel room. Meeting information should never be posted on social media. Screen-sharing, recording, and file-transfer features should be disabled. Finally, be sure to use the most up-to-date version of your VTC software, as security patches may help prevent problems. As VTC therapy becomes more common, these recommendations will evolve, so it is important to stay well informed.

Despite all your precautions, some clients may not like the VTC option. In our early VTC experience we had one group member refuse to switch to the VTC group because it required participating from her home, and this threatened her ability to separate the group

from her personal life. Another client asked for a leave from his group, lamenting the loss of the *inner sanctum* of the group room and the opportunity it offered to discuss deeply personal issues. He felt that meeting online, with his family nearby in his small home, would strip him of his sense of privacy and safety.

VTC GROUP CHALLENGES AND OPPORTUNITIES

In addition to the unique challenges VTC groups face, they must also confront many of the same challenges as in-person groups: building group cohesion, creating constructive group norms, and addressing antigroup behavior, unhealthy group pressures, and scapegoating.[12] We anticipate that there may be an increase in dropouts as a result of the transition to VTC, and there are reports of long-running groups withering in reaction to the shift. For vulnerable clients who experience emotional dysregulation, some of the technical difficulties of VTC may be almost too much for them to contain. For example, having a group member's Internet connection fail in the midst of deep emotional work is particularly disturbing.

VTC groups simultaneously reduce and increase members' access to information about one another. Group members and therapists lose access to nonverbal communication and may feel constrained by seeing only faces onscreen. Moreover, one cannot establish meaningful eye contact in VTC, particularly when the screen displays a gallery view with thumbnails of six or eight participants. One cannot tell who is looking at whom in the group, and on a computer screen it is virtually impossible to convey a calming, comforting, empathic response nonverbally. Scanning the group members to detect signs of engagement or distress is similarly difficult. At times, the audio and visual functions may be out of synchrony, adding a further sense of disjunction. These VTC drawbacks can be quite disheartening; some group therapists have described the limitations as equivalent to "working with one hand tied behind their back." Adding this layer of uncertainty, unfamiliarity, and apprehension to the process may amplify therapist countertransference.[13]

Are there positive offsets to these potential losses? Undoubtedly, the answer is yes. Group members are now "invited" into each other's homes. This can add texture to the relationships between group members. Each member's personal life, pets, and art and

furnishings are better illuminated to the group.[14] The image of a member's child coming onscreen and sitting on his or her parent's lap may be worth a thousand words. Keep in mind that everything is grist for the mill in a group meeting, including an exploration of what is being brought into the group's purview. Conversely, a member's failure to protect the group session from intrusion and distraction will require exploration.

Some therapists and group members report very positive experiences in online groups. They believe that VTC groups are effective and efficient, especially as they sidestep hassles with commuting to a meeting place and finding a parking place, or having to take public transit. Members who travel may still attend when they are out of town. Some group members experience a heightened intensity, depth, and focus in VTC groups. Indeed, some clients feel *more comfortable* in VTC groups than when meeting in person and are more willing to take interpersonal risks.[15] The interpersonal distance created by the online setting may serve a facilitating and protective function. Shame and the fear of judgment may be reduced.

Keep in mind that the normal warm-up to the group—walking to the meeting or sitting in the waiting room and chatting with other members—is absent. Some leaders actively encourage a deeper focus on engagement in the meeting and ask members to turn their full attention to the group, closing out the external world for the time of the session.

Leading a VTC group is different from leading an in-person group and requires flexibility, adaptability, and a spirit of openness to its potential, as illustrated in the following description.

> **In one of the first sessions after abruptly transitioning from an** ongoing in-person group to VTC as a result of the COVID-19 pandemic, Harold, a sixty-five-year-old retired teacher, became quite emotionally expressive. In uncharacteristic fashion, he was moved to tears talking about the impact of the pandemic. He was fearful for the health of his family and the mounting sense of loss of the familiar around him.
>
> It had been an emotionally charged session. The impact of isolation

and the threat of illness and death had shaken us all. It appeared as though Harold was carrying much of the emotional vulnerability we had all been feeling in the group. The group members longed for our familiar in-person meeting, but we realized that the video session at least enabled us to meet. It was the best we could do at this time.

The meeting was made more difficult by some Internet access problems that forced another group member, Sue, to come in and out of the meeting. This disruption distressed her and added to our feelings of vulnerability and helplessness in securing our sense of connection. In response, another member of the group, Sam, said that if we had been in the group together as we normally were, he would have offered Harold and Sue a comforting hug. That was no longer an option in a VTC meeting.

I (ML) joined in expressing disappointment that we could not meet in person, but suggested that we could fully harvest the warmth and caring in Sam‘s offer. I added that our session had been filled with a sense of the preciousness of our emotional connections to one another. We were doing as well as we could with VTC, and I hoped for a return to our familiar face-to-face meetings. But it was clear that our connection to one another mattered enormously—even more now, with the physical distancing required of us at that moment, than previously. We could not predict when we could meet in person again, but we could continue to make excellent use of the group. **<<**

Experience to date suggests that VTC therapists need to be more active than traditional in-person group leaders, checking in frequently with individual clients and the group as a whole. The group therapist’s attention to group process is perhaps even more important in VTC than in traditional group therapy because it is so easy to miss meaningful and subtle group and client information. Co-therapists will need to develop new ways of connecting with one another as well in order to offset the loss of their familiar communication expressed through a raised brow, a smile, or a quiet glance over to one another. With less access to nonverbal communication, greater therapist transparency may also be required to deepen and sustain engagement.[16]

Similarly, all group members need to be as open as possible in communicating their reactions to one another and to the group.

Active inquiry of what group members are feeling physically in their bodies may be helpful in offsetting the lack of VTC access to members' nonverbal communication and body language. It is worth noting one unexpected technological benefit of the VTC group: group members can hear one another better, as the audio in VTC groups can be easily amplified.

CONCERN HAS BEEN NOTED REGARDING THE COGNITIVE DEMANDS that VTC places on participants, and particularly group leaders. It can be exhausting to look for an extended period of time at a VTC session with seven or eight members. The gallery view shows all participants at one time, but in a constricted and limited fashion. Although we see each other's faces, our brains are searching, even hungering, for more, for the nonverbal emotional cues that we seek in normal interaction that are not readily accessible online.[17] Some clients also balk at seeing themselves onscreen, and it heightens their self-consciousness. Participation is easier at times if members shut off their own self-view. This issue, too, of course, warrants exploration.

We are in early days of VTC in the provision of mental health care, and so there are no doubt important age and generational considerations in preferences for how therapy is accessed and how these preferences will change in the future. To some skeptics, it may be a surprise to see technology increasing rather than decreasing human engagement. In our view, it represents a contemporary route to meaningful connection, and it is an irreplaceable resource when traditional in-person group work is not possible.[18]

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Specialized Therapy Groups

GROUP THERAPY METHODS HAVE PROVED TO BE SO USEFUL IN so many different clinical settings that it is no longer correct to speak of group therapy. Instead, we must refer to the group *therapies*. Even a cursory survey of professional journals shows that the number and scope of the group therapies are expanding dramatically. This is true for both face-to-face groups and for the explosion of online groups. The Internet, as noted, now makes it possible for almost any individual dealing with any malady or life challenge to find and join a suitable group.[1]

Clinical necessity sparks clinical innovation. This is particularly evident in college counseling centers.[2] On campuses across North America, counselors tailor groups to help students with a wide array of concerns: eating disorders, social anxiety, developmental challenges, separation anxiety, depression, nonsuicidal self-injury disorder (NSSID), attention deficit hyperactivity disorder (ADHD), autism spectrum disorder (ASD), diabetes, chronic fatigue, and issues around substance abuse, sexual abuse and trauma, writing blocks, gender identity and sexual orientation, communication skills, assertiveness training, stress management, and the effects of racism and discrimination. These are just a few of the commonly offered groups. The groups are often brief, delivered in modules of four to twelve sessions to fit within the academic semester.

Beyond the college campus we can find an even greater range of groups. Clinical applications are growing by the day as we respond to the many individuals seeking care for psychological, medical, and

social distress. Many groups are homogeneous for particular conditions, responding to members' needs for belonging, destigmatization, and coping strategies. There are groups for survivors of incest and sexual trauma, for people with HIV/AIDS, for clients with eating disorders or panic disorder, for the suicidal, for parents of sexually abused children, for compulsive gamblers and sex addicts, for alcoholics, for children of alcoholics, for women with postpartum depression, for sexually dysfunctional men, and for sexually dysfunctional gay men. There are groups for survivors of divorce, for children and spouses of people with Alzheimer's, for male batterers, for mothers of drug addicts, for families of the mentally ill, for depressed older women, for angry adolescent boys, for survivors of terrorist attacks, for children of Holocaust survivors, for women with breast cancer, for dialysis patients, for people with multiple sclerosis, for the deaf and hard of hearing, for people with developmental disabilities, for transgendered individuals, for people with borderline personality disorder, for irritable bowel (IBS) sufferers, for amputees, for college dropouts, for people who have had a myocardial infarction or a stroke, for parents of adopted children, for bereaved spouses and parents, for the dying, for refugees and asylum seekers, and for many, many others.[3]

Obviously, no single text could address each of these specialized groups. Nor, even if it were possible, would it constitute an intelligent training approach. Does any sensible teacher of zoology, to take one example, undertake to teach anatomy by having the students memorize the structures of each subspecies separately? Of course not. Instead, the teacher teaches basic and *general principles* of form, structure, and function and then proceeds to teach the anatomy of a *prototypical* primal specimen that serves as a template for all others. Remember those biology dissection laboratories?

The extension of this analogy to group therapy is obvious. The group therapist must first master fundamental group therapy theory and obtain a deep understanding of a prototypical therapy group. But which group therapy best represents the original common ancestor? If there is an ancestral group therapy, it is the *interpersonal*

outpatient group therapy described in this book. It was the first group therapy, and over the past seventy years it has been the subject of a great deal of systematic research and has stimulated an imposing body of professional literature containing the observations and conclusions of thoughtful clinicians and researchers.

Now that you have come this far in this text and are familiar with the fundamental principles and techniques of the prototypical therapy group, you are ready for the next step: *the adaptation of basic group therapy principles to any specialized clinical situation*. That step is the goal of this chapter. First, we describe the basic principles that allow the group therapy fundamentals to be adapted to different clinical situations, and then we present two distinct clinical illustrations—the adaptation of group therapy for the acute psychiatric inpatient ward, and the widespread use of groups for clients coping with a variety of medical illnesses. The chapter ends with a discussion of important developments in group therapy: structured group therapies, self-help and support groups, and online psychotherapy groups.

MODIFICATIONS FOR SPECIALIZED CLINICAL SITUATIONS: BASIC STEPS

To design a specialized therapy group, we suggest the following four steps: (1) assess the clinical situation; (2) formulate appropriate clinical goals; (3) modify traditional techniques to fit with the new clinical situation and the new set of clinical goals; (4) evaluate the effectiveness of your changes.

Assessment of the Clinical Situation

It is important to examine all the clinical factors that will bear on the therapy group. Take care to differentiate the *intrinsic* limiting factors (akin to computer hardware) from the *extrinsic* factors (akin to software). The intrinsic ones are built into the clinical situation and cannot be changed—for example, mandatory attendance for clients on legal probation, the prescribed duration of group treatment in a clinic, or frequent absences because of medical hospitalizations in an ambulatory cancer support group.

The extrinsic limiting factors are arbitrary and within the power of the therapist to change—for example, an inpatient ward may have a policy of rotating the group leadership so that each group session has a different leader, or an incest survivors group may traditionally open with a long "check-in" (which may consume most of the meeting) in which each member recounts the important events of the week.

In a sense, the message of the AA serenity prayer has relevance here: therapists must accept that which they *cannot* change (intrinsic factors); change that which *can* be changed (extrinsic factors), if necessary; and be wise enough to know the difference. Keep in mind that as therapists gain experience, they often find that more and more of the factors that seemed to be intrinsic are actually extrinsic —and can be changed. For example, by educating the program's or institution's decision-makers about the rationale and effectiveness of group therapy, it is possible to create a more favorable atmosphere

for the therapy group.[4] That is often the first task in creating successful group therapies.

Formulation of Goals

When you have a clear view of the clinical facts—number of clients, length of therapy, duration and frequency of group meetings, clinical focus, type and severity of pathology, availability of co-leadership—your next step is to construct a reasonable set of clinical goals.

You may not like the clinical situation. You may feel hampered by the many intrinsic restraints that prevent you from leading the ideal group. But do not wear yourself out by protesting an immutable situation. Better to light a candle than to curse the darkness! With proper modification of goals and technique, you will always be able to offer some form of help.

We cannot overemphasize the importance of setting clear and achievable goals. Nothing will so inevitably ensure failure as inappropriate goals. The goals of the interpersonal outpatient group we describe in this book are ambitious: to offer symptomatic relief *and* to change character structure. If you attempt to apply these same goals to, say, a group of young adults recently diagnosed with a first episode of schizophrenia, you will rapidly become a therapeutic nihilist and stamp yourself and group therapy as ineffective or even harmful. An allied principle: do not underestimate the broad impact of groups with tailored and circumscribed goals.

It is imperative that you shape a set of goals *appropriate to the clinical situation and achievable in the available time frame*. The goals must be clear not only to the therapists but to participants as well. In our discussion of group preparation in Chapter 9, we emphasized the importance of enlisting the client as a full collaborator in treatment. You facilitate collaboration by making explicit the goals and the group task and by linking the two: that is, by making it clear to the members how the work of the therapy group will help them attain those goals.

In time-limited, specialized groups, the goals must be tailored to the capacity and potential of the group members. It is important that

the group be a success experience: clients enter therapy often feeling defeated and demoralized, and the last thing they need is another failure. In the discussion of the inpatient group in this chapter, we shall give a detailed example of this process of goal setting.

Modification of Technique

When you are clear about the clinical conditions and appropriate, realizable goals, you must next consider the implications of these conditions and goals for your therapeutic technique. In this step, it is important to consider the therapeutic factors and to determine which ones will play the greatest role in the achievement of the goals. It is a phase of disciplined experimentation in which you alter technique, style, and, if necessary, the basic form of the group to adapt to the clinical situation and new goals of therapy. Keep in mind as well that despite the unique clinical populations addressed and the group modifications required, your understanding of the core principles of group therapy process and of group leadership is an invaluable asset.[5]

To provide a brief hypothetical example, suppose you are asked to lead a group in an area that is unfamiliar to you. Say, for example, that a large network of family doctors asks you to lead a brief group for men who have suffered heart attacks. The men are often depressed and resist cardiac rehabilitation.[6] Your overriding goal is to help these men become able and motivated to participate in their own rehabilitation.

During your screening interviews (never skip that step), you develop some additional goals: you discover that some clients are negligent about taking their medication and that all of them suffer from severe social isolation and pervasive feelings of hopelessness and meaninglessness. They feel compromised as men, and many dread their next heart attack. So, given the additional goals of working on these issues, how do you modify standard group techniques to achieve them most efficiently?

First, you must assiduously monitor the fluctuations and intensity

of their depression. You might ask members to fill in a brief depression scale each week. Or you could begin each meeting with a *brief* check-in focused on isolation and mood. Because of their discouragement and social isolation, you may wish to *encourage* rather than discourage extragroup contact among the members, perhaps even mandating a certain number of phone calls, texts, or email messages from clients to therapists and between clients each week. You may decide to encourage an additional coffee hour after the meeting or between meetings. Or you may address both the isolation and the sense of uselessness by tapping the therapeutic factor of altruism—for example, by experimenting with a "buddy system," in which new members are assigned to one of the more experienced members, who serves as a mentor. The experienced member would check in with the new member during the week to make sure he is taking his medication and participating in rehab. The veteran member can "sponsor" the new member in the group session, making sure he gets sufficient time and attention.

There is no better antidote to isolation than deep therapeutic engagement in the group; thus you must strive to create positive here-and-now interactions in each meeting. Focusing on the members' immediate value to one another can work wonders. Instilling hope is critical for these men, and to facilitate this you may choose to include some clients in the group who have already regained their self-efficacy and ability to function in the world.

Shame about physical disability is also an isolating force. The therapist might wish to counteract this shame through physical contact—for example, asking members to join hands at the end of meetings for a brief guided meditation. In an ideal situation, you may launch a support group that will evolve, after the group therapy ends, into a freestanding self-help group for which you act as consultant.

It is clear from this example that therapists must know a good deal about the special problems of the clients in their group. This is true for each clinical population; there is no all-purpose formula. Therapists must do their homework, immersing themselves in the specific clinical area, in order to understand the unique problems and

dynamics that are likely to develop during the course of the group.[7]

For instance, therapists leading interpersonal groups of clients with *alcohol abuse* must expect to deal with issues surrounding sobriety, AA attendance, sneak drinking, deception, emotional dependency, deficiencies in the ability to regulate anxiety, and a proclivity to act out.[8]

Bereavement groups must often focus on guilt (for not having done more, loved more, been a better spouse), on loneliness, on major life decisions, on life regrets, on adapting to a new, unpalatable life role, on feeling like a "fifth wheel" with old friends, and on the need to "let go" of the dead spouse despite the pain that is entailed. (Many widows and widowers feel that building a new life would signify a betrayal of their dead spouse.) These groups must also focus on issues around dating (and the ensuing guilt), and if the therapist is skillful, on personal growth.

Retirement groups must address such themes as recurrent losses, increased dependency, loss of one's social role, the need for new sources of validation for one's sense of self-worth, diminished income and expectancies, relinquishment of a sense of continued ascendancy, late life developmental tasks, and shifts in one's spousal relationship as a result of more time shared together.[9]

Groups for *burdened family caregivers* of individuals with Alzheimer's disease must focus on the experience of loss and on the horrific experience of caring for spouses or parents who are but a shell of their former selves, unable to acknowledge their caregivers' efforts or even identify them by name. They focus also on caregivers' isolation, on their strategies for coping with their burden, and the guilt they feel for wanting (or achieving) some emancipation from this burden. These groups may involve role playing of difficult caregiving scenarios, perhaps using trained actors (standardized patients) as the individuals with dementia to build skills for managing difficult, oppositional, or aggressive behavior. And importantly, these groups will provide validation and recognition of the caregivers' efforts and personhood.[10]

Groups for *health-care workers* dealing with the stresses of

providing care in a pandemic create opportunities for members to identify their chief concerns. These could include adequate access to resources to care for their patients, fear for their own safety, access to personal protective equipment, moral distress in not being able to provide care according to their professional and personal standards, and grief and loss. The groups would work to build safety for their members, foster social support, educate about coping strategies, restore a sense of efficacy, and promote hope for the future.[11]

Groups for psychological trauma would likely address a range of concerns, perhaps through a sequence of different group tasks. Building safety, trust, and security would be important at first. Being together with others who have experienced a similar trauma and learning about the impact of trauma on the mind and body can reduce feelings of isolation and confusion. Later these groups might use structured behavioral interventions, such as deep breathing or imagery, to treat specific trauma symptoms. Next, they might address how trauma has altered members' basic beliefs and assumptions about the world. If the trauma was caused by sexual abuse, these groups would ideally be gender-specific in the earlier stage of work. Later, a mixed-gender group may be necessary to complete the process of the client's reentry into the posttrauma world.[12]

Or, if the traumatized clients were refugees escaping war and violence, the leaders would need to modify the approach to provide sensitive, culturally attuned care. Any psychoeducational materials would need to be translated into the requisite language of the participants and adapted to the clients' varying levels of mental health literacy. You might employ more nonverbal behavioral interventions that require less use of language. An example would be teaching parents how to play with their young children in ways that promote security, communication, and mastery of fear. Strengthening individual families increases, in turn, the sense of security of the larger community.[13]

In summary, to develop a specialized therapy group, we recommend taking the following steps:

1. *Assess the clinical setting.* Determine the immutable clinical restraints.
2. *Formulate goals.* Develop goals that are appropriate and achievable within the existing clinical restraints.
3. *Modify traditional technique.* Retain the basic principles and therapeutic factors of group therapy, but alter the techniques to achieve the specified goals: therapists must adapt to the clinical situation and the dynamics of the special clinical population.
4. *Evaluate your work.* Study and attempt to improve your work.

These steps are clear but too aseptic to be of immediate clinical usefulness. We shall illustrate the entire sequence in detail by describing the development of a therapy group for the acute psychiatric inpatient ward.

We focus on an acute inpatient therapy group for two reasons. First, it offers a particularly clear opportunity to demonstrate many principles of strategic and technical adaptation. The clinical challenge is severe: *The acute inpatient setting is so inhospitable to group therapy that radical modifications of technique are required.* Second, this particular example may have value to many readers since the inpatient group is a common specialized group: therapy groups are led on most acute psychiatric wards. This is true even in this era of ever briefer hospital stays. Inpatient psychiatric care appears to be increasing in prevalence as well, often as a result of inadequate community-based care for clients.[14] Clients value the social and relationship opportunities on their inpatient units, yet in many units they spend a staggering amount of time idle and socially disconnected.[15] Group therapy can address these relationship needs. For many clients, it is their first therapeutic group exposure; hence it behooves us to make it a constructive experience. And it is significantly impactful on overall clinical outcomes. Group therapy in inpatient settings also improves staff morale and increases the providers' sense of purpose.[16] As any staff member can easily

perceive, group therapy is far more humane and effective than “beds and meds” as a treatment philosophy.

THE ACUTE INPATIENT THERAPY GROUP

The Clinical Setting

The outpatient group that we describe throughout this book is freestanding; all important negotiations occur between the group therapist(s) and the seven or eight group members. Not so for the inpatient group! When you lead an inpatient group, the first clinical fact of life you must face is that your group is never an independent, freestanding entity. It always has a complex relationship to the inpatient ward in which it is ensconced. What happens between members in the *small* therapy group reverberates with what transpires within the *large* group of the unit and institution.[17]

The inpatient group's effectiveness, often its very existence, is heavily dependent upon administrative engagement and backing. It is important to distinguish between types of inpatient groups: ward community meetings, group activities and *programming*, and group *therapy*. All of these are important, but they have very different goals as well as different training and leadership requirements.[18] Some groups exist at the interface, such as watching a well-selected film and discussing its relevance regarding recognition and communication of clients' feelings and social relationships.[19] If the ward medical director and the clinical nursing coordinator are not convinced that the group therapy approach is effective, they are unlikely to lend support and may undermine the prestige of the therapy groups in many ways: for example, they may not assign staff members to group leader positions on a regular schedule, they may ask less experienced staff members to lead the group, or they may not provide supervision or even schedule group sessions at a functional, consistent time. Therapy groups under such conditions are rendered ineffective. The group leaders are unsupported and rapidly grow demoralized. Meetings are scheduled irregularly and are often disrupted by members being yanked out for individual sessions or for a variety of other hospital appointments.

Is this state of affairs an *intrinsic, immutable* problem? Absolutely not! Rather, it is an *extrinsic, attitudinal* problem and stems from a number of sources, especially the professional education of the ward administrators. Many psychiatric training programs and nursing schools do not offer a comprehensive curriculum in group therapy (and virtually no programs offer sound instruction in inpatient group psychotherapy). It is completely understandable that ward directors decline to invest ward resources and energy into a treatment program about which they have little knowledge and in which they have no faith. Interprofessional tensions may also play a role: Is group therapy leadership valued, or considered a low-status activity? Which disciplines are entrusted to provide psychotherapy? The small therapy group must not be used as a battleground upon which professional interests are contested.

Without a potent psychosocial therapeutic intervention, inpatient wards rely only on medication, and the work of the staff is reduced to custodial care. We believe that inpatient care can be improved through greater clinical engagement. Copious research demonstrates the effectiveness of inpatient group therapy.[20]

A well-functioning group program can permeate and benefit the milieu as a whole, and the small group should be seen as a resource to the system as a whole.[21] By combining training, supervision, and regular, measurement-based feedback to clinicians about their inpatient group work, a large US behavioral health care network, providing care to thirteen thousand clients annually, transformed clinical care. They demonstrated the following: significant improvements in clinical outcomes, significant improvements in client satisfaction, significant reductions in aggression and critical incidents, and significantly improved staff morale.[22] Such is the power of properly led group therapy.

In addition to these extrinsic, programmatic problems, the acute inpatient ward poses several major *intrinsic* problems for the group therapist. There are several particularly challenging problems that must be faced by every inpatient group therapist.

Rapid Client Turnover. The duration of psychiatric hospitalization

has shortened inexorably. On many wards, hospital stays range from a few days to a week or two. This means, of course, that the composition of the small therapy group will be highly unstable. In different inpatient settings we have led groups that have met three to five times a week for many years, and these groups have rarely had the same set of members for two consecutive meetings—almost never for three.

This appears to be an immutable situation. The group therapist has little influence on ward admission and discharge policy. In fact, more and more commonly, discharge decisions are based on economic and system pressures rather than individual clinical concerns. Staff members feel overburdened and stretched. The high-pressure, revolving-door inpatient unit is here to stay, and even as the door opens and shuts ever faster, clinicians must continue to keep primary focus on the client's treatment, doing as much as they can within the imposed constraints.[23] But we also must not create added staff demand without providing commensurate support.

Heterogeneity of Psychopathology. In Chapter 8, we stressed the importance of composing a group thoughtfully and of avoiding members who will fail to fit in with the group, and to selecting members with roughly the same amount of ego strength. How, then, to lead a group in which one has almost no control over the membership, a group in which there may be floridly psychotic individuals sitting side by side with higher-functioning, better-integrated members?

In addition to the major confounding factors of rapid client turnover and the range of psychopathology, several other intrinsic clinical factors exert significant influence on the functioning of an inpatient psychotherapy group, including time limitations, group boundaries, and unique group leader challenges.

Time Limitations. The therapist's time is very limited. Generally, there is no time to see a client in a pregroup interview to establish a relationship, let alone a therapeutic alliance, and to prepare the person for the group. There is little time to integrate new members into the group, to address endings (someone terminates the group

almost every meeting), to work through issues that arise in the group, or to focus on transfer of learning.

Group Boundaries. Group boundaries in inpatient settings are often blurred. Members are generally in other groups on the ward with some or many of the same members. Extragroup socializing is the rule rather than the exception: clients spend their entire day together. The boundaries of confidentiality are similarly blurred. There can be no true confidentiality in the small inpatient group: clients often share important small group events with others on the ward, and staff members freely share information with one another during rounds, nursing reports, and staff meetings. It is therefore imperative that the inpatient small group boundary of confidentiality be elastic and encompass the entire ward staff rather than being confined to any one group within that ward. Otherwise the small group becomes disconnected from the unit. Negotiating and managing these boundaries is a key group leader task.[24]

Challenges for the Group Leader. The role of inpatient group leaders is complex because they may be involved with clients throughout the day in other roles. Their attendance may often be often erratic. Group leaders are frequently psychiatric nurses who, because of the necessity of weekend, evening, and night coverage, are on a rotating schedule and often cannot be present at the group for several consecutive meetings.

Therapist autonomy is limited in other ways as well. For example, just as therapists have only limited control over group composition, they rarely have a choice about co-therapists, who are usually assigned on the basis of the rotation schedule. Inpatient group therapists usually feel more exposed than their outpatient colleagues. Difficulties in the group will be readily known by all on the unit. Lastly, the harried pace of the acute inpatient ward leaves little opportunity for supervision, or even for a postmeeting discussion between co-therapists.

Formulation of Goals

Once you have grasped these clinical facts of life of the inpatient

therapy group and differentiated intrinsic from extrinsic factors, it is time to ask this question: *Given the many confounding intrinsic factors that influence (and hobble) the course of the inpatient group, what can the group accomplish?* What are reasonable and attainable goals?

Let us start by noting that the goals of the acute inpatient group are *distinct from those of acute inpatient hospitalization*. The goal of the group is not to resolve a psychotic episode, not to regulate a client with mania, not to diminish hallucinations or delusions, not to resolve a deep depression. Inpatient groups can do none of these things.

So much for what the inpatient group cannot do. What *can* it offer? We will describe six achievable goals.

1. Engage clients in the therapeutic process.
2. Demonstrate to clients that talking helps.
3. Help clients identify and spot problems.
4. Decrease clients' isolation.
5. Provide opportunities for clients to help others.
6. Reduce ward tensions and hospital-related anxiety.

1. *Engage clients in the therapeutic process.*

The contemporary pattern of acute psychiatric hospitalization—brief but repeated admissions to psychiatric wards in general hospitals—can be more effective than longer hospitalization only if the inpatient stay is followed by adequate aftercare treatment. There is good evidence that group therapy is a particularly efficacious mode of aftercare treatment.[25]

A primary goal of inpatient group therapy emerges from these findings—namely, to engage the client in a process that he or she perceives as constructive and supportive and will wish to continue after discharge from the hospital.

2. *Demonstrate to clients that talking helps.*

The inpatient therapy group helps clients learn that talking about their problems is helpful. They learn that there is relief to be gained in sharing pain and in being heard, understood, and accepted by others. From listening to others, members also learn that others suffer from the same types of disabling distress as they do, that one is not unique in one's suffering.

> **In an inpatient therapy group, Sally, an agitated woman with par**anoid delusions, demanded to know why her roommate, Rose, had asked her to play Ping-Pong on the unit table. Sally declared that she loved Ping-Pong, but how could Rose know that? Sally was concerned that Rose was able to read her mind and that Rose was stealing ideas from her brain. Rose responded that she had no knowledge of Sally's thinking—it was an innocent request to pass the time. That message needed to be repeated and reinforced, and Sally eventually replied, "Then does that mean you cannot read my thoughts? I was so scared of that." **<<**

3. ***Help clients identify problems.***

The duration of therapy in the inpatient therapy group is far too brief to allow clients to work through problems. But participation in the group can efficiently help clients spot problems that they may work on effectively in ongoing individual therapy, both during their hospital stay and in their post-discharge therapy. By providing a discrete focus and direction for therapy, which clients value highly, inpatient groups increase the efficiency of other therapies.[26]

It is important that the group identify client problems that are circumscribed and malleable (not problems such as chronic unhappiness, depression, or suicidality, all of which are too generalized to offer a discrete handhold for therapy). The group is most adept at helping members identify problems in their mode of relating to other people. It offers the ideal arena *to learn about maladaptive interpersonal behavior*. Emily's story is a good illustration of this point:

> **Emily was an extremely isolated young woman who was admitted** to the inpatient unit because of depression. She complained that she always called others to arrange social engagements but never received

invitations, and she had no close girlfriends who sought her out. Her dates with men always turned into one-night stands. She attempted to please them by going to bed with them, but they never called for a second date. People seemed to forget her as soon as they met her. During the three group meetings she attended, the group gave her consistent feedback about the fact that she was always pleasant and always wore a gracious smile and always seemed to say what she thought would be pleasing to others. In this process, however, people soon lost track of who Emily was. What were her own desires and feelings? Her need to be eternally pleasing had a serious negative consequence: people found her uninteresting and inaccessible.

A dramatic example occurred in her second meeting, when I (IY) forgot her name and apologized to her. Her response was, “That’s all right, I don’t mind.” I suggested that the fact that she didn’t mind was probably one of the reasons I had forgotten her name. In other words, had she been the type of person who would have minded or made her needs more overt, then most likely I would have remembered her name. In her three group meetings, Emily had identified a major problem that had far-reaching consequences for her relationships: her tendency to submerge herself in a desperate but self-defeating attempt to capture the affection of others. **<<**

4. ***Decrease clients’ isolation.***

The inpatient group can help break down the isolation that exists between members. The group is a laboratory exercise intended to sharpen communication skills: the better the communication, the less the isolation. It helps individuals share with one another, permits them to obtain feedback about how others perceive them, and helps them discover their blind spots.

Decreasing isolation between group members has two distinct payoffs. First, improved communication skills will help clients in their relationships with others outside the hospital. Virtually everyone who is admitted in crisis to an inpatient ward suffers from a breakdown or an absence of important supportive relationships with others. If the client is able to transfer communication skills from the group to his or her outside life, then the group will have fulfilled a very important goal.

A second payoff is evident in the client’s behavior on the ward: as

isolation decreases, the client becomes increasingly able to use the therapeutic resources available, including relationships with other patients.[27]

> **Jack, a man with chronic schizophrenia, reluctantly attended his** first meeting on the inpatient ward. He told the group that his guardian angel, who regularly transmitted messages to him through the TV, advised him to be very cautious about talking with anyone on the unit or in the group. I (ML) welcomed Jack to the meeting, acknowledged his caution, and noted that in telling us about his guardian angel, he was informing us about his need for both safety and for connection. He relaxed notably when I commented that I hoped that he would see that the group and the ward were intended to be safe for him and for all participants: we all could benefit from feeling that there was someone out there looking out for us. Mary, admitted for depression marked by feelings of worthlessness and ineffectiveness, then asked Jack if they could eat together that evening. She had noticed his isolation and wanted him to feel more comfortable. She added that she was pushing herself hard to engage more and was taking a risk now. Jack responded positively, saying, “We can sit together, but don’t expect me to talk yet.” **<<**

5. ***Provide opportunities for clients to help others.***

This goal, the therapeutic factor of altruism, is closely related to the previous one. Clients are not just helped by their peers; they are also helped by the knowledge that they themselves have been useful to others. Clients generally enter psychiatric hospitals in a state of profound demoralization. They feel that not only can they not help themselves, but they have nothing to offer others. The experience of being valuable to other ward members is enormously affirming to one’s sense of self-worth. Mary’s response to Jack in the last vignette is an illustration of that process.

6. ***Reduce ward tensions and hospital-related anxiety.***

The process of psychiatric hospitalization can be intensely anxiety provoking. Many clients experience great shame and are concerned about stigmatization and the effects of hospitalization on their jobs and friendships. Many are distressed by events on the ward—not

only the bizarre and frightening behavior of very ill clients, but also the evident staff tensions.

Many of these secondary sources of tension compound the client's primary dysphoria and must be addressed in therapy. Inpatient group therapy (as well as the larger, unit-wide community meeting) provides a forum in which clients can air these issues, and often they are reassured simply from learning that other members share these concerns. They can learn, for example, that their roommates are not hostile or intentionally rejecting them, but preoccupied and fearful. One man who had been quite frightening on the unit while in an agitated manic state came to inpatient group therapy to apologize for his threatening behavior when he had been psychotic. He was mortified and wanted to tell us that such behavior was not typical of him. We have seen variations on the same theme many times. For this man, the experience was also a powerful reminder to adhere to his medication regimen.

Modifying Technique

We have now accomplished the first two steps of designing a group for the contemporary inpatient ward: (1) assessing the clinical setting, including identifying the intrinsic clinical facts of life on the unit, and (2) formulating an appropriate and realistic set of goals. Now we are ready to turn to the third step: designing a clinical strategy and technique that provides support, education, and the acquisition of communication, coping, and life skills.[28]

The Therapist's Time Frame. In the conventional outpatient therapy group we have described earlier in this text, the therapist's time frame is many weeks or months, sometimes years. Therapists must be patient, must build cohesiveness over many sessions, and work through issues repetitively from meeting to meeting. The inpatient group therapist faces an entirely different situation: the group composition changes almost every day, and the duration of therapy for members is often very brief—indeed, many attend the group for only a single session.

Hence the inpatient group therapist must adopt a *radically*

shortened time frame. Perhaps there will be continuity from one meeting to the next, and perhaps there will be culture-bearers who will be present in several consecutive meetings, but do not count on it. It is best to assume that *your group will last for only a single session*, and you must strive to offer something useful for as many participants as possible during that session.

Efficiency and Activity. The single-session time frame demands *efficiency*. You have no time to allow issues to build, to let things develop in the group and slowly work them through. You have no time to waste; you have only a single opportunity to engage the clients, and you must not squander it. There is no place in inpatient group therapy for the passive, reflective group therapist. You must activate the group by calling on, supporting, and interacting personally with members. This increased level of activity requires a major shift in technique for the therapist who has been trained in long-term group therapy, but it is an absolutely essential modification of technique. Though leading inpatient group therapy is often more challenging than leading outpatient open-ended groups, all too often little attention is paid to the training, development, and supervision of the inpatient group therapist.[29]

Keep in mind that one of the major goals of the inpatient therapy group is to *engage clients in a therapeutic process they will wish to continue* after leaving the hospital. Thus, it is imperative that the therapist create in the group an atmosphere that members experience as supportive, positive, and constructive. Members must feel safe, understood, and accepted.

The inpatient therapy group is not the place for confrontation, for criticism, or for the expression and examination of intense anger. There will often be members in the group who are conning or manipulative and who may need powerful confrontation, but it is far better to let them pass unchallenged than to run the risk of making the group feel unsafe to the vast majority of participants. Recognizing group process and group dynamics is no less important in the inpatient setting than in the open-ended, longer-term group, but there is a difference: in the inpatient group, you use your

understanding to make the group safe and supportive rather than to deepen exploration.[30]

Group leaders need to recognize and incorporate both the needs of the group and the needs of the individual into their intervention. Consider, for example, Jared, an angry man with bipolar disorder who arrived at the group the day after being forcibly restrained and secluded by unit staff. He had earlier threatened to harm a nurse who refused his request for a pass off the ward. Jared obstinately sat silently outside of the circle with his back to the group members. Addressing Jared's behavior was essential—it was too threatening to ignore—but it was also potentially inflammatory to engage Jared against his evident wish. The group leader chose to acknowledge Jared's presence, noting that it likely was hard for Jared to come to the group after the tensions of the night before. He was welcome to participate more fully if he chose, but if not, just coming was welcomed. Though Jared maintained his silent posture, the group was liberated and able to proceed.

In the long-term outpatient group, therapists provide support both directly and indirectly: *direct* support through personal engagement, empathic listening, and understanding, expressed in accepting glances, nods, and gestures; *indirect* support by building a cohesive group that then becomes a powerful agent of support.

Inpatient group therapists must learn to offer support quickly and directly. Support is not something that therapists reflexively provide. Therapists are often trained to become sniffers of pathology, experts in the detection of weaknesses, and often hold themselves back from engaging in basic supportive behavior with their clients.

Support may be offered in myriad ways. The most direct, the most valued by clients, and the most often overlooked by professional therapists is a gentle acknowledgment of the members' efforts, intentions, strengths, positive contributions, and risks.[31] If, to take an obvious example, one member states that he finds another member in the group very wise or very warm, it is important that this member be supported for the risk he has taken. You may wonder whether he has previously been able to express his admiration of another so

openly and note, if appropriate, that this is reflective of real progress for him in the group. Or, suppose you note that several members have been more self-disclosing after one particular member took a risk and revealed delicate and important material—then openly comment on it! Do not assume that members automatically realize that their disclosures have helped others take risks. Identify and reinforce the adaptive parts of the client's presentation.[32]

Try to emphasize the positive rather than the negative aspects of a defensive posture. Consider, for example, members who persist in playing assistant therapist. Do not confront them by challenging their refusal to work on personal issues; instead offer positive comments about how helpful they have been to others and then gently comment on their unselfishness and reluctance to ask for something personal from the group. It is the rare individual who resists the therapist's suggestion that he or she needs to learn to be more selfish and to ask for more from others.

The therapist also can help members obtain support from the group. Some clients, for example, obtain very little support from the others because they characteristically present themselves in a highly objectionable fashion. A self-centered member who incessantly ruminates about a somatic condition will rapidly exhaust the patience of any group. When the leader spots such behavior, it is important to intervene quickly before animosity and rejection have time to well up and the client commits social suicide. The leader may try any number of tactics—for example, directly instructing the client about other modes of behaving in the group, or assigning the client the task of introducing new members into the group, giving feedback to other members, or attempting to guess and express what each person's evaluation of the group is that day.

> **Consider a woman who talked incessantly about her many surgical** procedures. It became clear to me (IY) from listening to this woman's description of her life situation that she felt she had given everything to her children and family and had received nothing in return. I suggested that when she talked about her surgical procedures, she was really saying, "I have some needs, too, but I have trouble asking for them. My

talking about my surgery is a way of asking, 'Pay some attention to me.'"

Over the course of three sessions, she agreed with my formulation and gave me permission, whenever she talked about her surgery, to translate that into the real message, "Pay more attention to me." When she explicitly requested help, the members responded to her positively, in contrast to their negative response to the endless recitation of her litany of somatic complaints.[33] **<<**

Another approach to support is to make certain the group feels safe by anticipating and avoiding conflict whenever possible. If clients are irritable or want to learn to be more assertive or to challenge others, it is best to channel that work onto yourself: you are, let us hope, in a far better position to handle criticism than are the group members.

The inpatient group is not the place for intensification of affect or hostility. If two members are engaged in conflict, it is best to intervene quickly and to search for positive aspects of the conflict. For example, keep in mind that sparks often fly between two individuals because of the group phenomenon of *mirroring*: one sees aspects of oneself (especially negative aspects) in another, and dislikes that person because of what one dislikes in oneself.[34] Thus, you can deflect conflict by asking individuals to discuss the various ways in which they resemble their adversary. Can they put themselves into the shoes of the other and speculate on what their adversary might be feeling? In this way you may turn tension into empathy.

There are many other conflict-avoiding strategies. *Envy* is often an integral part of interpersonal conflict, and it can be constructive to ask adversaries to talk about those aspects of each other that they admire or envy. Role switching is sometimes a useful technique: ask adversaries to switch places and present the other's point of view. An effective technique is to remind the group that opponents generally prove to be very helpful to each other, whereas those who are indifferent rarely help each other grow.

One reason some members experience the group as unsafe is

that they fear things will go too far and that the group may coerce them to lose control—to say, think, or feel things that will result in interpersonal catastrophe. You can help these members feel safe in the group by encouraging them to exercise control over their own participation. Check in with members repeatedly by asking questions: “Do you feel we’re pushing you too hard?” or “Is this too uncomfortable for you?” or “Do you think you’ve revealed too much of yourself today?” Make small engagement contracts along the way.

In groups of more disturbed, regressed clients, group leaders must provide even more direct support. Find the latent human core beneath the manifest psychotic symptoms. Examine the behavior of the severely regressed client and find in it some positive aspect: support the mute member for staying the whole session, compliment the member who leaves early for having stayed twenty minutes, support the member who arrives late for having shown up, support inactive members for having paid attention throughout the meeting. If members try to give advice, even inappropriate advice, reward them for their intention to help. If statements are unintelligible or bizarre, label them as attempts to communicate. One group member, Jake, hospitalized because of a psychotic decompensation, angrily blurted out in the group that he intended to get Satan to rain “hellfire and brimstone upon this God-forsaken hospital.” Group members withdrew into apprehensive silence. I (ML) wondered aloud what had provoked this angry explosion. Another member commented that Jake had been agitated since his discharge planning meeting. Jake then said that he did not want to go to the hostel that was recommended. He wanted to go back to his boardinghouse because it was safer from theft and assault. That was something everyone in the group could understand and support. Finding the underlying and understandable human concern brought Jake and the group members back together—a far better situation than isolating Jake because of his bizarre behavior.

The Here-and-Now Focus of the Inpatient Group

Throughout this text, we have repeatedly emphasized the

importance of here-and-now interaction in the group therapeutic process. We have stressed that work in the here-and-now is the heart of the group therapeutic process, the power cell that energizes the therapy group. Yet when we visit inpatient wards, we find that groups rarely focus on here-and-now interaction. Such avoidance of the here-and-now is, in our view, precisely the reason so many inpatient groups are ineffective.

If the inpatient group does not focus on the here-and-now, what other options are there? Most inpatient groups adopt a then-and-there focus in which members, following the therapist's cues, take turns presenting their "back-home problems"—those that brought them into the hospital—while the rest of the group attempts to address those problems with exhortations and advice. This approach to inpatient group therapy *is the least effective way to lead a therapy group* and almost invariably sentences the group to failure.

The problems that brought a person into the hospital are complex and overwhelming. They have generally foiled the best efforts of skilled mental health professionals and will, without question, stump the therapy group members. The then-and-there focus has many other disadvantages as well. For one thing, it results in highly inequitable time sharing. If much or all of a meeting is devoted to one member, many of the remaining members will feel ignored or bored. Unlike outpatient group members, they cannot even bank on the idea that they have credit in the group—that is, that the group owes them time and attention. Since they will most likely soon be discharged or find themselves in a group composed of completely different members, they are left clutching worthless IOUs.

Some inpatient groups focus on *ward problems*—ward tensions, staff-client conflict, housekeeping disputes, access to smoking or passes, and so on. Generally, this is also an unsatisfactory use of the therapy group. In any therapy group meeting, only a few members and one or two staff members will be present. There is no quorum for meaningful discussion. A much better arena for dealing with ward problems and ward business is the community meeting, in which all clients and staff are present.[35]

Other inpatient groups focus on one or more common themes—for example, suicidal ideation, the experience of hospitalization and treatment, symptoms such as hallucinations, or drug side effects. Such meetings may be of value to some but rarely to all members. Often such meetings serve primarily to dispense information that could easily be provided to clients in other formats. *It is not the most effective way of using the inherent power of the small group.*

The clinical circumstances of the inpatient group do not make the here-and-now focus any less important or less advisable. In fact, *the here-and-now focus is as effective in inpatient as in outpatient therapy*. However, the clinical conditions of inpatient work demand modifications in technique. As we mentioned earlier, there is too little time to work through interpersonal issues. Instead, you must help clients spot interpersonal problems and reinforce interpersonal strengths while encouraging them to attend ongoing post-hospital treatment where they can pursue and work through the interpersonal issues they have identified in the group.

The most important point to be made about the use of the here-and-now in inpatient groups is already implicit in the foregoing discussion of support. We cannot emphasize too heavily that the here-and-now is *not synonymous with conflict, confrontation, and critical feedback*. We are certain that it is because of this erroneous assumption that so few inpatient group therapists capitalize on the value of here-and-now interaction.

Conflict is only one—and by no means the most important—facet of here-and-now interaction. The here-and-now focus helps members learn many invaluable interpersonal skills: how to communicate more clearly, get closer to others, and express positive feelings; how to become aware of personal mannerisms that push people away; and how to listen, offer support, reveal oneself, and form friendships.

The inpatient group therapist must pay special attention to the issue of the relevance of the here-and-now. All the members of an inpatient group are in crisis. All are preoccupied with their life problems and immobilized by dysphoria or confusion. Unlike many outpatient group members who are interested in self-exploration, in

personal growth, and in improving their ability to cope with crisis, inpatients are in a survival mode, and unlikely to readily apprehend the relevance of the here-and-now focus for their problems.

Therefore, the therapist must provide explicit instruction about its relevance. We begin each group meeting with a brief orientation in which we emphasize that, though individuals may enter the hospital for different reasons, everyone in the group can benefit from examining how he or she relates to other people. Everyone can be helped by learning how to get more out of relationships with others. We focus on relationships in group therapy because *that is what group therapy does best*. In the group, there are other members and one or two mental health experts who are willing to provide feedback about how they relate to others in the group. We always acknowledge that members have important and painful problems other than interpersonal ones, but note that these problems need to be addressed in other therapeutic modalities: in individual therapy, in social work interviews, in couples or marital therapy, and/or with medication or other biological treatments.

Modes of Structure

In acute inpatient group work, regardless of model, there is no place for the nondirective group therapist. The group leader serves as an essential and stabilizing anchor for the group participants. You are a chief agent of any semblance of cohesion that the group will experience. The great majority of clients on an inpatient ward are confused, frightened, and disorganized; they crave structure and stability. Consider the experience of individuals newly admitted to the psychiatric unit: they are surrounded by other troubled, irrational clients; their mental acuity may be dulled by medication; they are introduced to many staff members who, because they are on a complex rotating schedule, may not appear to have consistent patterns of attendance; and they are being exposed, sometimes for the first time, to a wide array of treatments and treaters.

Often the first step to acquiring internal structure is exposure to a clearly perceived externally imposed structure. In a study of

debriefing interviews with recently discharged inpatients, the overwhelming majority expressed a preference for *group leaders who provided an active structure for the group*.[36] They appreciated a therapist who provided crystal-clear direction for the procedure of the group, who actively invited members to participate, who assured equal distribution of time, and who reminded the group of its basic group task and direction. The research and clinical literature strongly agree that such leaders obtain superior clinical results.[37]

Spatial and Temporal Boundaries

A secure space and time for the inpatient group should be considered sacrosanct. The ideal physical arrangement for an inpatient therapy group, as for any type of group, is *a circle of members meeting in an appropriately sized room with a closed door and comfortable seating*. It sounds simple, yet the physical plan of many wards makes these basic requirements difficult to meet. The failure to secure the group boundaries compromises group integrity and cohesiveness and in turn compromises the work of the group; it is far preferable to find some secure, safe, and reliable space, even if it means meeting off the ward (provided it is safe to do so).

Structure is also provided by *temporal stability*. The ideal meeting begins with all members present and punctual, and runs with no interruptions until its conclusion. It is difficult to approximate these conditions in an inpatient setting for several reasons: disorganized clients arrive late because they forget the time and place of the meeting; members may be called out for some medical or therapy appointment; members with a limited attention span may ask to leave early; heavily medicated members may fall asleep during a session and interrupt the group flow; and agitated or panicked patients may bolt from the group. Ward administration may advocate for an open-door policy to maximize client attendance even if that undermines the group boundaries.

Therapists must intervene in every way possible to provide maximum stability. You should urge the unit administration to declare the group time inviolable, so that group members cannot be called

out of the group for *any* reason (not because the group is the most important therapy on the unit, but because these disruptions undermine it, and group therapy, by its nature, has little logistical flexibility). You may ask the staff members to remind disorganized clients about the group meeting and escort them into the room. It should be the ward staff's responsibility, not the group leaders' alone, to ensure that inpatients attend. And, of course, the group therapists should always model promptness. Be wary of your colleagues at the hospital using the phrase "your group." It is not your group; it is the ward's group led by you and it must be embedded in the unit structure and supported by the team.

The problem of bolters—members who run out of a group meeting—can be approached in several ways. First, clients are made more anxious if they perceive that they will not be permitted to leave the room. Therefore, it is best simply to express the hope that they can stay for the whole meeting. If they cannot, suggest that they return the next session, when they feel more settled. The member who attempts to leave the room in midsession cannot, of course, be physically blocked, but there are other options. You may reframe the situation in a way that provides a rationale for putting up with the discomfort of staying: for example, in the case of a person who has stated that he or she often flees from uncomfortable situations and is resolved to change that pattern, you might recall that resolution. You may comment, "Eleanor, it's clear that you're feeling very uncomfortable now. I know you want to leave the room, but I remember you saying just the other day that you've always isolated yourself when you felt bad and that you want to try to find ways to reach out to others. I wonder if this might not be a good time to work on that by simply trying extra hard to stay in the meeting today?" You may decrease Eleanor's anxiety by suggesting that she simply be an observer for the rest of the session, or you may suggest that she change her seat to a place that feels more comfortable to her. You may validate her distress and endorse her courage in coming for as much of the meeting as possible. Reduce the client's sense of failure.

Groups may be made more stable by a policy that prohibits

latecomers from entering the group session once the door is closed, perhaps after a five-minute grace period. Employing such a policy poses an ethical dilemma in balancing inclusivity and protecting the group's boundaries. It may need to be discussed with the leadership of the ward. This policy may create resentment in clients who arrive late, but it also conveys that you value the group time and work and that you want to get the maximum amount of uninterrupted work each session. Interviews with discharged inpatients highlight that they resent interruptions and approve of the therapists' efforts to ensure stability.[38]

Therapist Style

The therapist also contributes greatly to the sense of structure through personal style and therapeutic presence. Confused or frightened clients are reassured by therapists who are firm, explicit, and decisive, yet who, at the same time are open about the reasons for their actions. Judicious therapist transparency, as we have discussed earlier (see Chapter 7), can reduce client anxiety and help them make sense of the experience of the group. Inpatient groups are disrupted repeatedly by major in-group events. Members are often too stressed and vulnerable to deal effectively with such events and are reassured if therapists act decisively and firmly. If, for example, a manic member veers out of control and monopolizes the group's time, you must intervene and prevent that member from obstructing the group's work in that session. You may, for example, tell the member that it is time to be quiet and to work on listening to others, or, if the member is unable to exercise any control, you may escort him or her from the room, inviting him to return when he is feeling more settled.

Generally, it is excellent modeling for therapists to talk about the dilemma they face and their ambivalent feelings in such a situation. You may, for example, share both your conviction that you have made the proper move for the welfare of the entire group *and* your great discomfort at assuming an authoritarian pose. Everyone in the group will be watching you and the manner in which you deal with

such tensions. Keep in mind the principles of nonshaming and nonblaming, even in the context of firm limit setting. Conversely, you may interrupt a detached and irrelevant discourse by reminding the group members of their task regarding interpersonal support and communication. Don't hesitate in that spirit to be directive when it is necessary to maintain the group's therapeutic focus.

Group Session Protocol

One of the most potent ways of providing structure is to build a *consistent, explicit sequence* into each session. This is a radical departure from traditional outpatient group therapy technique, but in specialized groups it makes for the most efficient use of a limited number of sessions, as we shall see later when we examine cognitive-behavioral therapy groups. In the inpatient group, a structured protocol for each session increases efficiency and also ameliorates anxiety and confusion in severely ill participants. We recommend that rapid-turnover inpatient groups take the following form:

1. *The first few minutes.* The therapist provides explicit structure for the group and prepares the group members for therapy. (Shortly, we will describe a model group in which we offer a verbatim example of a preparatory statement.)
2. *Definition of the task.* The therapist attempts to determine the most profitable direction for the group to take in a particular session. Do not make the error of plunging in great depth into the first issue raised by a member, for in so doing you may miss other potentially productive agendas. You may determine the task in several ways. You may, for example, simply listen to get a feel of the urgent issues present that day. Or you may provide some structured exercise that will permit you to ascertain the most valuable direction for the group to take that day. Your inpatient colleagues may inform you of critical events that may affect the group members.
3. *Filling the task.* Once you have a broad view of the potentially

fertile issues for a session, you attempt, in the main body of the meeting, to address these issues, involving as many members as possible in the group session.

4. *Summing up.* The last few minutes is the summing-up period. You indicate that the work phase is over, and you devote the remaining time to a review and analysis of the meeting. This is the self-reflective loop of the here-and-now in which you attempt to clarify, in the most lucid possible language, the interaction that occurred in the session. You may also wish to do some final mopping up: You may inquire about any jagged edges or ruffled feelings that members may take out of the session, or ask the members, both the active and the silent ones, about their experience and evaluation of the meeting.

Disadvantages of Structure

Earlier in this text we remonstrated against excessive structure. For example, in discussing the setting of norms, we urged that therapists strive to make the group as autonomous and as responsible for its own functioning as possible. As noted in Chapter 13, empirical research demonstrates that leaders who provide excessive structure may be positively evaluated by their members, but their groups fail to have positive outcomes.[39] The golden mean prevails: *Too much or too little leader structuring is detrimental to growth.*

Thus, we face a dilemma. In many brief, specialized groups, we must provide structure; but if we provide too much, our group members will not learn to use their own resources. This is a major problem for the inpatient group therapist, who must, for all the reasons we have described, structure the group and yet avoid infantilizing its members.

There is a way out of this dilemma—a way so important that it constitutes a fundamental principle of therapy technique in many specialized groups. *The leader must structure the group so as to encourage each member's autonomous functioning.* The following illustration of an inpatient group will clarify this apparent paradox.

A Working Model

In this section we describe in some detail a model for the inpatient group. It is best suited for those clients able to utilize a verbal format. Those who are less able to participate may make better use of group activities and group programming that engage clients in safe and accessible tasks. The highly successful and impactful implementation of this specific model across a large behavioral health network in the United States is notable. It began in an inner-city hospital treating indigent and marginalized psychiatric patients with an average length of stay of five days. Building upon this initial success, the model was used in the training of sixty group therapists caring for over thirteen thousand psychiatrically ill individuals annually. This model has been shown to produce better outcomes, higher client satisfaction, a safer milieu, and improved staff morale.[40]

We suggest this approach for a group that meets three to five times a week for approximately sixty to seventy-five minutes. Briefer time frames of forty-five minutes have been employed with smaller numbers of group participants. This model is described in greater detail in an earlier text, *Inpatient Group Psychotherapy*.[41]

1. Orientation and Preparation: three to five minutes
2. Personal Agenda Setting: twenty to thirty minutes
3. Agenda Filling: twenty to thirty-five minutes
4. Review: ten minutes

1. Orientation and Preparation. The preparation of clients for the therapy group is just as important in inpatient settings as it is in outpatient group therapy. The time frame, of course, is radically different. Instead of spending twenty to thirty minutes preparing an individual for group therapy during an individual session, the inpatient group therapist must accomplish such preparation for all members in the first few minutes of the inpatient group session. We suggest that the leader begin every meeting with a simple and brief introductory statement that includes a description of the ground rules

(time and duration of meeting, need for punctuality), a clear exposition of the purpose of the group, and an outline of the basic procedure of the group, including the sequence of the meeting. The following is a typical preparatory statement:

I'm Irv Yalom and this is Mary Clark. We'll co-lead this afternoon therapy group, which meets daily at two o'clock for one hour and fifteen minutes. The purpose of this group is to help members learn more about the way they communicate and relate to others. People come into the hospital with many different kinds of important problems, but one thing that most individuals have in common here is some unhappiness about the way some of their important relationships are going.

There are, of course, many other urgent problems that people have, but those are best worked on in some of your other forms of therapy. What this kind of group does best of all is to help people understand more about their relationships with others. One of the ways we can work best is to focus on the relationships that exist between the people in this room. The better you learn to communicate with each of the people here, the better it will become with people in your outside life. Other groups on our unit may emphasize other approaches and goals.

(If applicable you may add: *It's important to know that observers are present almost every day to watch the group through this one-way mirror.* [Here, point toward the mirror and also toward the microphone, if appropriate, in an attempt to orient the group members as clearly as possible to the spatial surroundings.] *The observers are professional mental health workers, often medical or nursing students, or other members of the ward staff. In the last ten minutes of the group these observers will join us and share their observations with us.*)

We begin our meetings by going around the group and checking with each person and asking each to say something about the kinds of problems they're having in their lives that they'd like to try to work on in the group. That should take fifteen to thirty minutes. It is very hard to come up with an agenda during your first meetings. But don't sweat it. We will help you with it. That's our job. After that, we then

try to work together on as many of these problems as possible. Near the end of the meeting, the group leaders will discuss together how the meeting has been and any observers will join us at that point. [If there are no observers, then the group co-therapists use this time as form of rehash but with the group participants present]. *Then, in the last few minutes, we check in with everyone here about how they size up the meeting and about the leftover feelings that should be looked at before the group ends. We don't always get to each agenda fully each meeting, but we will do our best. Hopefully we can pick it up at the next meeting, and you may find also that you can work on it between sessions with your nurse or doctor or other supports.*

Note the basic components of this preparation: (1) a description of the ground rules; (2) a statement of the purpose and goals of the group; (3) a description of the procedure of the group (including the precise structure of the meeting). Some inpatient therapists suggest that this preparation can be partly communicated outside of the group and should be even more detailed and explicit by, for example, including a discussion of blind spots, supportive and constructive feedback (providing illustrative examples), and the concept of the social microcosm.[42] Written preparation handouts can be distributed in advance to each client on the unit, mindful of the need to have translated versions for ethnoculturally diverse clients.

2. Personal Agenda Setting. The second phase of the group is the formulation of the task. Many group leaders find this the most daunting component of the model. The overriding task of the group is to help members explore and improve their interpersonal relationships. The leaders then assist each member to formulate a brief personal agenda for the meeting. The agenda must be realistic and doable in the group that day. It must focus on interpersonal issues and, if possible, on issues that in some way relate to one or more members in the here-and-now of the group.

Formulating an appropriate agenda is a complex task. Clients need considerable assistance from the therapist, especially in their first couple of meetings. Each group member is, in effect, being

asked to make a personal statement that involves three components: (1) an acknowledgment of the wish to change (2) in some interpersonal domain (3) that has some here-and-now manifestation. Think about this as an evolution from the general to the specific, the impersonal to the personal, and the personal to the interpersonal. “I feel unhappy” evolves into “I feel unhappy because I am isolated,” which evolves into “I want to be better connected,” which evolves into “with another member of the group.” There are innumerable ways clients might begin, but there are only a few core agendas that express the vast majority of client concerns:

- I want to be less isolated.
- I want to get closer to others.
- I want to be more assertive about what I need.
- I want to be a better communicator.
- I want to be a better listener and be less focused on myself.
- I want to not feel bottled up.
- I want to feel more trusting.
- I want specific feedback about how I come across regarding…
- I want to deal with anger more effectively and less destructively.

Having these examples in mind may make it easier for therapists to help clients create a workable focus.

Clients have relatively little difficulty with the first two aspects of the agenda, but most will need considerable help from the therapist in the third domain—framing the agenda in the here-and-now. Fortunately, the third part is less complex than it seems, and the therapist may move any agenda into the here-and-now by mastering only a few basic guidelines.

Consider the following common agenda: “I want to learn to communicate better with others.” The client has already accomplished the first two components of the agenda: (1) he or she has expressed a desire for change (2) in an interpersonal area. All

that remains is to move the agenda into the here-and-now, a step that the therapist can easily facilitate with a comment such as, “Please look around the room. With whom in the group do you communicate well? With whom would you like to improve your communication?”

Another common agenda is the statement, “I’d like to learn to get closer to people.” The therapist’s procedure is the same: Thrust it into the here-and-now by asking, “Who in the group do you feel close to? With whom would you like to feel closer?” Another common agenda is, “I want to be able to express my needs and get them met. I keep my needs and pain hidden inside and keep trying to please everybody.” The therapist can shift that into the here-and-now by asking, “Would you be willing to try to let us know today what you need?” or “What kind of pain do you have? What would you like from us?”

Nota bene, the agenda is generally *not* the reason the client is in the hospital. But, often unbeknownst to the client, the agenda may be an underlying or contributory reason. It is rarely irrelevant. The client may have been hospitalized because of substance abuse, depression, or a suicide attempt. Underlying such behaviors or events, however, there are almost invariably important tensions or disruptions in interpersonal relationships.

Note also that the therapist strives for agendas that are gentle, positive, and nonconfrontational. In the agendas we just cited that deal with communication or closeness, we made sure to inquire first about the positive end of the scale (for example, “With whom in the group do you communicate well?”). That is often a powerful and yet safe way to help members begin to open up.

Many clients offer an agenda that directly addresses anger—for example, “I want to be able to express my rage. The doctors say I turn my anger inward and that causes me to be depressed.” This agenda must be handled with care. You do *not* want clients to express anger at one another, and you must reshape that agenda into a more constructive form.

We have found it helpful to use the following approach: “I believe that anger is often a serious problem because people let it build up

to high levels and then are unable to express it. The release of so much anger would feel like a volcano exploding. It's frightening both to you and to others. It's much more useful in the group to work with *young anger*, before it turns into red anger. I'd like to suggest to you that today you focus on young anger—for example, impatience, frustration, or very minor feelings of annoyance. Would you be willing to express in the group any minor flickerings of impatience or annoyance when they first occur—for example, irritation at the way I lead the group today?"

The agenda exercise has many advantages. For one thing, it is a solution to the paradox that *though structure is necessary it can also be growth inhibiting and infantilizing*. The agenda exercise provides structure for the group, but it simultaneously encourages autonomous behavior on the part of the client. Thus, the agenda encourages members to assume a more active role in their own therapy and to make better use of the group. They learn that straightforward, explicit agendas involving another member of the group will guarantee that they do productive work in the session. An example of a clear, direct, and accessible client statement would be, "I tried to approach Sue earlier today to talk to her, and I have the feeling that she rejected me, wanted nothing to do with me, and I'd like to find out why." Such a clear statement carries the added benefit of potentially reducing interpersonal tensions on the unit, which will also elevate the status of group therapy on the unit.

Some clients have great difficulty stating their needs directly and explicitly. In fact, many enter the hospital because of self-destructive behaviors that are *indirect methods of signifying that they need help*. The agenda task teaches them to state their needs clearly and directly and to ask explicitly for help from others. In fact, for many, *the agenda exercise, rather than any subsequent work in the group meeting, is itself the therapy*. If these clients can broaden their repertoire in asking for help verbally rather than through some nonverbal, self-destructive mode, then the hospitalization will have been very useful.

The agenda exercise also provides a wide-angle view of the group work that may be done that day. The group leader is quickly

able to make an appraisal of what each client is willing to do and whose goals may dovetail with those of others in the group.

The agenda exercise is valuable but cannot immediately be installed in a group. Often a therapy group needs several meetings to catch on to the task and to recognize its usefulness. Personal agenda setting is *not* an exercise that the group members can accomplish on their own: the therapist must be extremely active, persistent, inventive, and often directive to make it work. Once it is established as a group norm however, a group culture will emerge that reinforces this mode of working. You can count on group members passing the model along to the next wave of participants, and your colleagues on the unit can also reinforce it.

If members are extremely resistant, sometimes a suitable agenda is for them to examine why it is so hard to formulate an agenda. Profound resistance or demoralization may be expressed by comments such as, “What difference will it make?” “I don’t have any problems!” “I don’t want to be here at all!” If it is quickly evident that you have no real therapeutic leverage, you may choose to ally with the resistance rather than occupy the group’s time in a futile struggle with the resistant member. You may simply say that it is not uncommon to feel this way on admission to the hospital, and perhaps the next meeting will feel different. You might add that the client may choose to participate at some point in the session. If anything catches his interest, he should speak about it. Remember, the experience should be nonblaming and nonshaming and, as much as possible, a nonfailure experience.

Sometimes if a client cannot articulate an agenda, one can be prescribed that involves listening and then providing feedback to a member the client selects. At other times, it is useful to ask other members to suggest a suitable agenda for a given individual. Recall that the group members often have a great deal of knowledge of one another stemming from the vast amount of time they may have spent together on the ward.

> **Joey, a nineteen-year-old young man, offered an unworkable** agenda: “My dad treats me like a kid.” He could not comprehend the

> agenda concept in his first meeting, and I (IY) asked for suggestions from the other members. There were several excellent ones: “I want to examine why I’m so scared in here,” or, “I want to be less silent in the group.” Ultimately, one member suggested a perfect agenda: “I want to learn what I do that makes my dad treat me like a kid. You guys tell me: Do I act like a kid in this group?” **<<**

Take note of why this was the perfect agenda. It addressed Joey’s stated concern about his father treating him like a kid; it addressed his behavior in the group that had made it difficult for him to use the group; and it focused on the here-and-now in a manner that would undoubtedly result in the group being useful to him.

3. Agenda Filling. Once the personal agenda setting has been completed, the next phase of the group begins. In many ways, this segment of the group resembles any interactionally based group therapy meeting in which members explore and attempt to change maladaptive interpersonal behavior. *But there is one major difference*: therapists have at their disposal agendas for each member of the group, which allows them to focus the work in a more customized and efficient manner. The presumed life span of the inpatient group is only a single session, and the therapist *must* be efficient in order to provide the greatest good for the greatest number of patients.

In our experience, six is the ideal size. But if the group is large—say, twelve members—and if there are new members who require a good bit of time to formulate an agenda, then there may be only thirty minutes in which to fill the twelve agendas. Obviously, work cannot be done on each agenda in each session, and it is important that clients be aware of this possibility. You may tell members explicitly that the personal agenda setting does not constitute a promise that each agenda will be focused on in the group. You may also convey this possibility through conditional language in the agenda formation phase: “If time permits, what would you like to work on today?” It is often helpful to encourage clients to continue their agenda work with their nurse, doctor, or other trusted supports. Even when an agenda may not be filled in that group session, clients report great value in clarifying a focus in the midst of feeling

overwhelmed.[43]

Nonetheless, the efficient and active therapist should be able to work on the majority of agendas in each session. The single most valuable guideline we can offer is to try to fit agendas together so that you work on several at once. If, for example, John's agenda is that he is very isolated and would like some feedback from the members about why it's hard to approach him, then you can fill several agendas simultaneously by calling for feedback for John from members with agendas such as, "I want to learn to express my feelings," "I want to learn how to communicate better to others," or, "I want to learn how to state my opinions clearly."

Similarly, if there's a member in the group who is weeping and highly distressed, why should you, the therapist, be the only one to comfort that individual when you have, sitting in the group, members with the agenda of, "I want to learn to express my feelings," or, "I want to learn how to be closer to other people"? By calling on these members, you stitch several agendas together.

In summary, during the personal agenda setting, the therapist collects commitments from members about certain work they want to do during the meeting. If, for example, one member states that she thinks it would be important for her to learn to take risks in the group, it is wise to store this and, at some appropriate time, call on her to take a risk by, for example, giving feedback or evaluating the meeting. If a member expresses the wish to open up and share his pain with others, it is facilitative to elicit some discrete contract—you may even make a contract for only two or three minutes of sharing—and then make sure that individual gets the time in the group and the opportunity to stop at the allotted time. It is possible, with such contracts, to increase responsibility assumption by asking the client to nominate one or two members to monitor him to ensure he has fulfilled the contract by a certain time in the session. This kind of "maestro-like conducting" may feel heavy-handed to the beginning therapist, but it leads to a more effective inpatient group. Group members generally can distinguish between the leader's helpful facilitation and over-controlling behavior.

4. The End-of-Meeting Review. The final phase of the group meeting signals a formal end to the body of the meeting and consists of review and evaluation. We have often led inpatient groups on a teaching unit and generally had students observing the session through a one-way mirror. We prefer to divide the final phase of the group into two equal segments: a discussion of the meeting by the therapists and observers, followed by the group members' response to this discussion.

In the first segment, therapists and observers (if present) form a small circle in the room and conduct an open analysis of a meeting, just as though there were no group members in the room listening and watching. In this discussion, leaders and observers review the meeting and focus on the group leadership and the experience of each of the members. For example, the leaders may question what they missed, consider what else they might have done in the group, or determine whether they left out certain members. We instruct the discussants to make some comment about each member: the type of agenda formulated, the work done on that agenda, and their guesses about that individual's satisfaction with the group.

Although this group wrap-up format is unorthodox, it is, in our experience, effective. For one thing, it makes constructive use of observers. In the traditional teaching format, student-observers stay invisible and meet with the therapist in a postgroup discussion to which the members do not have access. Members generally resent this observation format and sometimes develop paranoid feelings about being watched. To bring the observers into the group transforms them from an opaque and negative force to a transparent and more positive one. In fact, we have often heard group members express disappointment when no observers are present.

This format requires therapist transparency and is an excellent opportunity to do invaluable modeling. Co-therapists may discuss their dilemmas, concerns, or puzzlement. They may ask the observers for feedback about their behavior. Did, for example, the observers think they were too intrusive or that they put too much pressure on a particular individual? What did the observers think about the relationship between the two leaders?

In the final segment of the review phase, the discussion is thrown open to the members. Generally, this is a time of great animation, since the therapist-observer discussion generates considerable data. There are two directions that the final few minutes can take.

First, the members may respond to the therapist-observer discussion: for example, they may comment on the openness, or lack thereof, of the therapists and observers. They may react to hearing the therapist express doubt or fallibility. They may agree with or challenge the observations that have been made about their experience in the group. This joint rehash invites genuine collaboration. The second direction is for the group members to process and evaluate their own meeting. The therapist may guide a discussion, making such inquiries as: “How did you feel about the meeting today?” “Did you get what you wanted out of it?” “What were your major disappointments with this session?” “If we had another half hour to go, how would you use the time?” The final few minutes are also a time for the therapist to make contact with silent members and inquire about their experience: “Were there times when you wanted to speak in the group?” “What stopped you?” “Had you wanted to be called on, or were you grateful not to have participated?” “If you *had* said something, what would it have been?” (This last question is often remarkably facilitative.)

This last phase of the meeting thus has many functions: review, evaluation, pointing to future directions. It is highly valued by the members.[44] It is also a time for reflection and tying together loose ends before they leave the group session. Because the small group is embedded in the larger milieu, it is wise to make the group as self-contained as possible. It will not enhance your credibility to have the group members empty out for the evening onto the unit in a state of unsettled agitation because of the group.

Your final task is communicating about the group to the team at large. This should be a timely, bidirectional flow of information that promotes integration of care through team meetings and charting. A postgroup debrief by the group leaders at the nursing station with other team members present (who may be curious to know how the

patients they are working with did in the group) provides efficient and timely communication.

A final comment about client boundaries. Clients will inevitably interact with one another outside of the group in an inpatient setting. That is highly desirable—but with the proviso that everyone commit to honoring each person's privacy and treating in-group disclosures with respect on the unit.

GROUPS FOR THE MEDICALLY ILL

Group interventions play an increasingly important role in comprehensive medical care. Given their effectiveness and potential for reducing health-care costs, this trend is likely to continue and expand.[45] The range of approaches used is as broad as the range of conditions addressed. These groups are often homogeneous for and include all the major medical illnesses and concerns that warrant medical care, such as cancer, cardiac disease, obesity, lupus, inflammatory bowel disease, pregnancy, postpartum depression, infertility, transplantation, arthritis, chronic obstructive pulmonary disease (COPD), brain injury, Parkinson's, multiple sclerosis, diabetes, HIV/AIDS, and somatic symptom disorder (SSD).[46] These groups are typically led by mental health experts in collaboration with the medical providers whose support for their patients participation is essential.

There has been a dramatic increase in the use of groups in the integrated medical and psychological treatment of clients with heterogeneous chronic medical illnesses.[47] These groups are held in primary care practices and are often co-led by a primary care physician and a mental health professional. It serves as an effective way to provide follow-up care. Many of the participating clients experience significant psychosocial challenges in addition to their chronic medical illnesses.[48] Group medical visits offer peer support and teach participants about their illnesses and related coping skills in a cost-efficient way. Both medical and psychological clinical outcomes are significantly improved.

Earlier in this chapter we identified several key principles for the adaptation of group therapy: determine the clients' needs, set relevant goals, modify the group to meet those goals, and evaluate outcomes to improve the group's effectiveness. Distinguish between the fixed and the mutable elements that may constrain the group therapy. With medically ill clients there is an additional consideration:

these groups are most valuable for those in need of help and support; they may not be valuable for those who are already coping well.[49]

What psychological needs do the medically ill have? Depression, anxiety, and stress reactions are common consequences of serious medical illness and often amplify the impact of the medical illness.[50] We know, for example, that depression after a heart attack occurs in up to 50 percent of men, significantly elevating the risk of another heart attack.[51] Furthermore, the anxiety and depression accompanying serious medical illness tend to increase health-compromising behaviors such as alcohol use and smoking. They also disrupt compliance with recovery regimens of diet, exercise, medication, and stress reduction.[52]

Ironically, recent advances in medical treatment have created new sources of psychological stress. For instance, many diseases which were formerly fatal can now be managed as long-term chronic illnesses. These lifesaving outcomes bring with them constant worries of recurrence, or the need to adapt to body- or life-altering surgeries.[53] Recent breakthroughs in prevention and early detection similarly may save lives at the cost of increased stress. Genetic testing now plays an important role in medical practice, allowing physicians to compute individual risk of developing such illnesses as Huntington's disease or breast, ovarian, and colon cancer.[54] Yet this knowledge comes with a cost. Large numbers of individuals are tormented by momentous, anxiety-laden decisions. When one learns, for example, of a genetic predisposition to breast cancer, one is faced with numerous questions: Should I have a prophylactic mastectomy? Is it fair for me to get married? To have children? Do I share this information with my siblings, who may prefer not to know? Am I doomed to follow in the footsteps of my mother? Many individuals overestimate their risk and suffer significant emotional distress as a result.[55]

There is also the great psychological stigma attached to many medical illnesses, such as COVID-19, HIV/AIDS, hepatitis C, and

Parkinson's. At a time when individuals are in great need of social support, the shame and stigma of illness can cause social withdrawal and isolation that is both stressful and harmful.[56]

Additionally, seriously ill individuals and their families fear uttering anything that might amplify worry or fear in loved ones. The pressure to "think positive" invites tentativeness in communication, which further increases the affected individual's sense of isolation.[57]

Collaborative, trusting communication between client and doctor is generally associated with greater well-being and better decision-making. Yet many clients, dissatisfied with their relationship with their physicians, feel powerless to improve it. They need assistance in asserting their needs and advocating for their care.[58]

Medical illness confronts us with vulnerability and limits. Illusions that have sustained us and offered comfort are challenged. We lose, for example, the sense that life is under our control; that we are special, immune to natural law; that we have unlimited time, energy, and choice. Serious illness confronts us with death and evokes fundamental existential questions about the meaning of life, transiency, and our place in the universe.[59]

And, of course, the strain of medical illness extends far beyond the person with the illness. Family members and caregivers may suffer significant stress and dysphoria.[60] Groups often play an important role in their support. Consider, to cite one example, the enormous growth in groups for caretakers of individuals with Alzheimer's disease.[61]

General Characteristics

We may categorize the medical groups according to their emphasis:

1. Emotion-based coping—social support, emotional ventilation
2. Problem-based coping—active cognitive and behavioral strategies, psychoeducation, stress reduction techniques
3. Meaning-based coping—increasing existential awareness, realigning life priorities and finding purpose. These three

different foci are readily combined into integrative group models.[62]

Typically, groups for the medically ill are homogeneous for the illness. They are typically brief and run for four to twenty sessions. As we discussed in Chapter 9, brief groups require clear structure and high levels of focused therapist activity. But even in brief, highly structured, manual-guided group interventions, the group leader must attend to group dynamics and group process, managing them effectively so that the group stays on track. The quality of leadership is just as important here as it is in traditional group therapy.[63]

Homogeneous groups tend to jell quickly. Still, the leader must endeavor to engage outliers who resist group involvement. Certain behaviors may need to be tactfully and empathically reframed into a more workable fashion. For example, consider the bombastic, hostile man in a ten-session post-myocardial infarction group who angrily complains about the lack of concern and affection he feels from his sons. Since deep personal work is not part of the group contract, the therapist needs to have constructive methods of addressing such a client's concerns without violating the groups norms. For example, the leader might take a psychoeducational stance and discuss how anger and hostility are noxious to one's cardiac health. The group might address the latent sadness that the anger is masking and invite the man to express those primary emotions more directly. Or others in the group might be asked to share how they cope with anger or with disappointment.

These groups do not emphasize interpersonal learning and the leaders generally avoid strong here-and-now focus. Nonetheless, many of the other therapeutic factors are particularly potent in group therapy with the medically ill. *Universality* is prominent and serves to diminish clients' stigmatization and isolation. *Self-disclosure* of anxiety and fear can generate relief and connection with group members. *Cohesiveness* provides social support directly. Extragroup contact is often encouraged and viewed as a successful outcome, not as resistance to the work of the group. Seeing others cope

effectively with a shared illness *instills hope*, which can take many forms at different stages of the illness: hope for a cure, for courage, for dignity, for comfort, for companionship, or for peace of mind. Generally, members learn coping skills more effectively from the *modeling* of their peers than from experts.[64]

Imparting of information (psychoeducation about one's particular illness and more generally about health-related matters) plays a major role in these groups and comes not only from the leaders but from the exchange of information and advice between members. *Altruism* is strongly evident and contributes to well-being through one's sense of usefulness to others. *Existential factors* are also common, as the group supports its members in confronting the fundamental anxieties of life that we conceal from ourselves until we are forced to address them. Any work in the here-and-now focuses on building support and connection and on reinforcing new and adaptive behaviors, not on deep interpersonal exploration. Benefits from these group interventions emerge from experiencing social support and connection, finding meaning in the face of adversity, and gaining coping skills.[65]

A Prototype Group for Medical Illness

Let's examine a group for women with breast cancer. Breast cancer serves as a compelling illustration for the role of group therapy because of its high prevalence (one in eight women will be diagnosed with breast cancer in their lifetime) and its breadth of concern, ranging from genetic and familial predisposition, to early primary breast cancer (which is often curable), to advanced disease carrying a grave prognosis.[66] The model we describe has subsequently been adapted and used broadly. Related group models used to good effect include cognitive-existential group therapy and meaning-based group therapy.[67]

The Clinical Situation. At the time of the first experimental therapy groups for women with breast cancer in the mid-1970s, women with breast cancer were in serious peril. Surgery was severely deforming and chemotherapy poorly developed. Women whose disease had

metastasized had little hope for survival, were often in great pain, and felt abandoned and isolated. They were reluctant to discuss their despair with family members and friends lest they bring them down into despair as well. Moreover, friends and relatives often avoided them, not knowing how best to speak to them. All this resulted in an ever-increasing isolation. Women with advanced breast cancer often felt guilty: the pop psychology of the day frequently made them feel that they were in some manner responsible for their own disease.[68]

Finally, there was considerable resistance in the medical field to forming a group because of the widespread belief that talking openly about cancer and hearing several women share their pain and fears would only make things worse. It was in this environment that I (IY) first began to work with breast cancer patients.[i]

Goals for the Therapy Group. My primary goal was to reduce isolation and improve coping. I hoped that bringing together several individuals facing the same illness and encouraging them to share their experiences and feelings would create a supportive social network, destigmatize the illness, and help the members share coping strategies. Many of the women's closest friends had dropped away, and I hoped to counter that by committing myself and the group to staying with them—to the death if needed.

Modification of Group Therapy Technique. Mixing women with the better prognosis of primary breast cancer with women with the graver prognosis of metastatic disease undermined cohesion because metastatic disease represented the former subgroup's worst fears. After some experimentation with groups of women with different types and stages of cancer, I concluded that a homogeneous group offered the most support and formed a group of women with metastatic breast cancer that met weekly for ninety minutes. It was an open group with new women joining the group over time, cognizant that others before them had died from the illness.

Support was the most important guiding principle. I wanted each member to experience "presence"—to know others facing the same situation. As one member put it, "I know I'm all alone in my little boat,

but when I look and see the lights on all the other boats in the harbor, I don't feel so alone."

In order to increase the members' sense of personal control, I turned over as much of the direction of the group as possible to the members. They invited each other to speak, to share their experiences, to express the many dark feelings they could not discuss elsewhere. They validated each member's concerns, modeled empathy, attempted to clarify confused feelings, and sought to mobilize the resources available in the membership.

For example, if members described their fear of their physicians and their inability to ask their oncologist questions, I encouraged other members to share the ways *they* had dealt with their physicians. At times, I suggested that a member role-play a meeting with her oncologist. Not infrequently a member invited another group member to accompany her to her medical appointment under the principle that two heads are better than one while under stress. One of the most powerful interventions the women learned was to respond to a rushed appointment with the compellingly simple and effective statement, "Doctor, I know that you are rushed, but if you can give me five more minutes of your time today, it may give me a month's peace of mind." No physician would refuse that request.

Members expressing affect, whatever it might be, was a positive experience in the group: the members had too few opportunities elsewhere to express their feelings. They talked about everything: all their macabre thoughts, their fears of death and oblivion, the sense of meaninglessness, the dilemma of what to tell their children, how to plan their funerals. Such discussions served to detoxify some of these fearsome issues. Expressing emotions almost invariably improved the women's well-being.[69]

I attempted to be always supportive, never confrontational. The here-and-now, if used at all, always focused on positive feelings between members. Members differed greatly in their coping styles. Some members, for example, wanted to know everything about their illness; others preferred not to inquire too deeply. I never challenged behavior that offered comfort, mindful never to tamper with a group

member's coping style unless I had something far superior to offer. Some groups formed cohesion-building rituals, such as a few minutes of hand-holding meditation or guided imagery at the end of meetings.

Unlike traditional therapy groups, the members were encouraged to have extragroup contacts: phone calls, luncheons, and the like, and even occasional death vigils were part of the ongoing process. Some members delivered moving eulogies at the funerals of other members, fulfilling their pledge never to abandon one another. These eulogies repeatedly demonstrated deep understanding and care of one another.

Many members had overcome panic and despair and found something positive emanating from the confrontation with death. Some spoke of entering a golden period in which they prized and valued life more vividly. Some reprioritized their life activities and stopped doing the things they did not wish to do. Instead they turned their attention to the things that mattered most: loving exchanges with family, the beauty of the passing seasons, discovering creative parts of themselves. One woman noted wisely, "Cancer cures psychoneurosis." The petty things that used to agonize her no longer mattered. More than one member said she had become wiser but that it was a pity she had to wait until her body was riddled with cancer before learning how to live. How much she wished her children could learn these lessons while they were healthy. Because of these attitudes, they welcomed student observers rather than resenting them. Having learned something valuable from their encounter with death, they could imbue the final part of life with meaning by passing their accrued wisdom on to others, to students, and to their children and group leaders.

An illustration from a group session (led by ML) highlights this:[70]

> **Kathleen, a sixty-five-year-old woman with advanced disease,** told the group about enjoying a respite from chemotherapy. Her oncologist encouraged her to use this window of relative well-being wisely. Kathleen recognized that she had a very poor prognosis, but she was feeling better at this moment than she had in months. She even

fantasized about taking a last trip to visit her older brother in Ireland. He had a heart condition that prohibited him from traveling to see her, and time was passing for them both.

The group encouraged Kathleen to seize this moment, and she replied that she was obligated to care for her ninety-two-year-old mother-in-law and so could not travel. A sense of resignation fell upon the group until Sue, another group member, jumped in: “Kathleen, you have four adult children in the city. Give them the gift of giving *you* the gift of looking after their grandmother so that you can take this trip.” It was a brilliant intervention; Kathleen thought for a moment and then endorsed it. She quickly arranged a trip to Ireland. She returned after a lovely visit and expressed deep appreciation to the group members for their wisdom and support. She relapsed shortly after her return and died a few weeks later.

After Kathleen’s death, her children sent a note to the group members thanking them for encouraging this final trip. They loved their mother but were frustrated at how hard it was to repay her for her devotion to them. She always put herself last. By supporting this trip, they felt they had reciprocated her love for them. Though they were sad, the trip eased their grief and helped “balance the books a bit better.” **<<**

It is important to note that leading such a group is deeply emotionally demanding, and that co-therapy and supervision are highly recommended. Leaders cannot remain distant, as these issues deeply touch the leaders as well as the group members. There is no “us and them.” We are all fellow travelers facing the same existential threats.[71]

This particular group approach, which is now termed supportive-expressive group therapy (SEGT), has been described in a series of publications.[72] It has been taught to many psycho-oncology professionals for use with a range of cancer patients along the continuum of illness.[73]

This approach has also been used for women with a strong genetic or familial predisposition to develop breast cancer. Reports describe effective homogeneous groups that meet for a course of twelve weekly sessions. The last four meetings may be used as boosters, meeting once monthly for four months, which extends

exposure to the intervention to six months. Central concerns in these groups include coping with life's uncertainty, decisions about prophylactic mastectomy, and shattered illusions of invulnerability. Feelings of loss and grief are prominent, often amplifying the sense of personal risk for breast cancer. Working through these feelings contributes to a better informed, more accurate assessment of one's personal risk.[74]

Effectiveness. Outcome research over the past twenty-five years has demonstrated the effectiveness of these groups. Supportive-expressive group therapy for women at risk of breast cancer, women with primary breast cancer, and women with metastatic disease has consistently been shown to reduce the experience of pain and to improve psychological coping and adaptation. The medical profession's initial apprehensions—that talking about death and dying would make women feel worse or cause them to withdraw from the group—has been thoroughly disconfirmed.[75]

Can groups for cancer patients increase members' survival time?[76] The first controlled study of groups for women with metastatic breast cancer reported longer survival, but several other studies have consistently failed to replicate those first findings. The original reports spurred hope that we could find a psychoneuroimmunological mechanism to account for a psychosocial intervention prolonging life. Subsequent studies have eliminated neither the controversy nor our wish to find survival benefits. It is likely the case that any impact on survival is the result of the group enhancing social support, reducing isolation for those with limited relationships, promoting health equity, and helping vulnerable individuals access and maintain compliance with difficult treatment regimens. All of the studies, however, show significant positive psychological results: less experience of pain, less psychological distress, better quality of life, and even the capacity to grow personally as one faces the trauma of mortal illness. Even if the group intervention does not prolong life, there is little doubt that it can improve the quality of life for its members.[77]

ADAPTATION OF CBT AND IPT TO GROUP THERAPY

In this section we describe two widely used models of brief group therapy. Cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT) were originally constructed, described, and empirically tested in individual therapy.[78] Both are now used as brief group therapy interventions and are accruing good support for their effectiveness.

It is important not to be misled by labels. A review of the current literature on group therapy for women with breast cancer noted that many of the groups identified as CBT were in fact integrative models that synthesized contributions from multiple models.[79] This important finding is by no means the exception: it is often the case that effective, well-conducted therapy of purportedly different ideological models shares much in common. One of the major conclusions of the encounter group study was exactly that: *The behavior of effective therapists resembled that of effective therapists from other ideological schools far more than it did the behavior of other, less effective practitioners of their own school.*[80] Why is this so? Likely it is a result of the effective use of the common and evidence-based factors that predict effectiveness across all therapy models and that we have examined throughout this text.[81] Good group therapists are committed to being helpful to their clients and not wedded to their model's ideology.

Cognitive-Behavioral Group Therapy

Group CBT (CBT-G) initially arose from the search for greater clinical efficiency. Cognitive-behavioral therapists used the group venue to deliver individual CBT to a large number of clients simultaneously. Note this important and fundamental difference: *CBT therapists were using groups to increase the efficiency of delivering CBT to individual clients, not to tap the unique benefits inherent in group therapy that we have emphasized throughout this text.* At first, cognitive-

behavioral therapists had a narrow focus: they wanted to provide psychoeducation and cognitive and behavioral skill training. They used the group as a *setting* to deliver an intervention without harnessing the group as an *agent* of change. What about peer support, universality, instillation of hope, imitative behavior, altruism, destigmatization, social skills training, and interpersonal learning? They were considered merely backdrop benefits. What about the presence of group process, cohesion, or phases of group development? They represented noise in the system, often interfering with the work of delivering CBT; in fact, some CBT therapists initially raised the concern that the group format diluted the power of CBT.[82]

We have now passed into a second generation of more sophisticated CBT-G applications in which the essential elements of group life are being acknowledged. CBT-G therapists are productively utilizing groups to deepen learning and experience. Greater attention to the use of the group therapy factors, the development of group cohesion and early client engagement, and a focus on group leadership style have all increased CBT-G's effectiveness.[83] Group cohesion fosters more risk-taking, deeper task engagement, and reduced shame and avoidance. Relationship building and skill development reinforce one another, and the quality of the group experience contributes substantially to the outcome of the group treatment even in skill-focused groups.[84]

The CBT approach postulates that psychological distress is the result of impaired information-processing and disruption in patterns of social behavioral reinforcement.[85] Although thoughts, feelings, and behaviors are of course interrelated, CBT considers one's thoughts in particular to be central to the process. Often automatic and flying beneath the radar of one's awareness, one's thoughts initiate alterations in mood and behavior. CBT therapists attempt to access and illuminate these thoughts through probing, Socratic questioning, and the encouragement of self-examination and rigorous self-monitoring reaching client core beliefs.

What type of core beliefs are uncovered? Core beliefs fall into two

main categories—relationships and competence: “Am I worth loving?” and “Can I achieve what I need to confirm my worth?” Integrative therapists have noted that core beliefs are often strongly interpersonal at their center.[86] Once these dysfunctional core beliefs (for example, “I am entirely unlovable”) are identified, the next objective of treatment is to restructure them into more adaptive and self-affirming beliefs.

CBT-G has been applied effectively to an array of clinical conditions: acute depression,[87] chronic depression,[88] chronic dysthymia,[89] depression relapse prevention,[90] posttraumatic stress disorder (PTSD),[91] acute stress,[92] eating disorders,[93] insomnia,[94] somatization and hypochondriasis,[95] spousal abuse,[96] panic disorder,[97] obsessive-compulsive disorder,[98] generalized anxiety disorder,[99] social phobia,[100] anger management,[101] schizophrenia (both for negative symptoms, such as apathy and withdrawal, and, positive ones, such as hallucinations),[102] perinatal anxiety,[103] parent-child groups for childhood anxiety,[104] and many other conditions, including medical illnesses.[105]

Substantial and durable benefits have been regularly reported in these applications. Recent generations of CBT-G in which group therapists pay more attention to group cohesion and group process have been found to be no less effective than individual CBT. CBT-G generally does not have a higher rate of premature termination of therapy. Exposure-based group treatment for PTSD, however, does have a greater frequency of dropouts. Exposure-based treatments require clients to gradually approach their trauma-related memories, feelings, or situations, directly or in imagination. Group members are often so overwhelmed by exposure to traumatic memories that a brief format is likely not feasible. Desensitization must be conducted over a considerable period.[106]

The application of CBT in groups varies according to the particular needs of the clients in each type of specialty group, but all share certain well-identified features.[107] CBT-G is typically homogeneous, time limited, and relatively brief, generally with a

course of eight to twenty meetings that last two to three hours.[108] Group CBT emphasizes structure, focus, and acquisition of cognitive and behavioral skills. Therapists assign homework between sessions and make it clear that group members are each accountable for advancing their own therapy. The homework is tailored to the concerns of the individual client. It might involve keeping a log of one's automatic thoughts and how these thoughts relate to mood, or it might involve a behavioral task that challenges avoidance. Gradients of exposure to fearful stimuli can be jointly constructed by the client and group leader and engaged by the client.

The review of the homework is conducted in each group meeting and represents a key difference between group CBT and interactional group therapy: the CBT leader substitutes "cold processing" of the client's at-home functioning for the "hot processing" that typifies interactional group therapy.[109] In other words, the group focuses on clients' descriptions of their at-home functioning rather than on their real-time functioning in the here-and-now interaction.

Measurement of clients' distress and progress through self-report questionnaires is ongoing, providing regular feedback that either supports the therapy or signals the need to realign therapy.

The group CBT therapist makes use of a set of strategies and techniques, in various combinations, that clients employ and then discuss together in the group.[110] These interventions deconstruct the clients' difficulties into workable segments and combat their tendency to generalize, magnify, and distort. For example, clients may be asked to:

- *Record automatic thoughts.* Make overt what is covert; link thoughts to mood and behavior. For example, "I will never be able to meet anyone who will find me attractive; why should I try to date?"
- *Challenge automatic thoughts.* Challenge negative beliefs; identify distortions in thinking; explore the deeper personal

assumptions underlying the automatic thoughts. For example, “How can I actually meet people if I keep refusing invitations to go out for drinks after work?”

- *Monitor mood.* Explore the relationship between mood and thoughts and behaviors. For example, “I think I started to feel lousy when no one invited me for lunch today.”
- *Create an arousal hierarchy.* Rank anxiety-generating situations and gradually confront each one, from easiest to hardest. For example, a client with agoraphobia would rank the places that elicit anxiety from the easiest to the most challenging. Going to church on Sunday morning with a spouse might be at the low end of arousal. Going shopping alone at a new mall at night might be at the high end of arousal. Ultimately, gradual exposure desensitizes the client and extinguishes the anxious and avoidant response.
- *Monitor activity.* Track how time and energy are spent. For example, one might take note of how much time is actually lost to rumination about work competence and how that in turn interferes with completing required tasks.
- *Problem-solve.* Find solutions to everyday problems. Therapists challenge clients’ belief in their inevitable failure by breaking a problem down into instrumental and workable components. For example, clients may be asked how to balance self-care with care for an ill family member.
- *Acquire knowledge through psychoeducation.* This might include, for example, education about the physiology of anxiety or the symptoms of the stress response.
- *Learn relaxation training.* Reduce emotional tension by progressive muscle relaxation, guided imagery, breathing exercises, and meditation. Generally, a meeting or two is devoted to training in these techniques. The objective is to increase the clients’ abilities to step back and reflect on their experience, lessening the tendency to be highly reactive.

- *Perform a risk appraisal.* Clients examine what feels threatening and what resources they have to meet these threats. This might include, for example, examining the client's belief that his panic attack is actually a heart attack and reminding him that he can use deep breathing to settle himself effectively.
- *Employ guided imagery for exposure.* Clients challenge negative attributions about self-worth and the anticipation of rejection that result in avoidance and escape behaviors. They focus instead on constructing positive and healing imagery.
- *Anticipate relapse and create a relapse prevention plan.* Clients identify potential triggers—both external events and internal assumptions—and the core skills they need to respond to these triggers. They plan and practice for the future.

The group CBT treatment of social phobia is representative.[111] Each group consists of five to seven members and meets for twelve sessions of two and a half hours each. Each meeting has a beginning agenda and check-in, a middle working phase, and an end-of-session review. An individual pregroup or postgroup meeting may be used with each member.

The first two group sessions address the clients' automatic thoughts regarding situations that evoke anxiety. For example, a member might state, "If I speak up, I will certainly make a fool of myself and be ridiculed." Skills are then taught to challenge these automatic thoughts and errors in logic. For example: "You assume that you will express yourself poorly, and reach the worst outcome possible. But when you voice your concerns here, others have repeatedly told you that you are clear and articulate."

The middle sessions address each individual's target goals using homework, in-group role simulations, and behavioral exposure to the source of anxiety. The last few sessions consolidate gains and identify future situations that could trigger a relapse. Imagery can be added to deepen the client's exposure to the aversive situation.[112] In

summary, the group leader helps each member to identify dysfunctional thinking, to challenge these thoughts, to restructure thoughts, and to modify behavior.

Group Interpersonal Therapy

Individual interpersonal therapy (IPT), first described by Gerald Klerman, Myrna Weissman and colleagues, has also been adapted for group use.[113] In the same way that CBT views psychological dysfunction as a problem of information processing and behavioral reinforcement, IPT views psychological dysfunction as a problem rooted in one's interpersonal relationships. As the client's social and interpersonal functioning improve, his or her presenting disorder—for example, depression or binge eating—also improves. Interestingly, this can occur with relatively little specific attention to the actual disorder other than psychoeducation about its nature, course, and impact.[114] The improvement in social and interpersonal functioning can have broad positive reverberations that reinforce and sustain improvement in the primary symptoms.

Group IPT (IPT-G) emphasizes the acquisition of interpersonal skills and strategies for dealing with social and interpersonal problems.[115] Group applications of IPT-G emerge from the societal drive toward greater efficiency, but it also recognizes the many therapeutic opportunities group members can provide one another in addressing interpersonal dysfunction. These include reducing social isolation, modeling, destigmatization, and supporting treatment compliance and engagement. The first group IPT application was developed for clients with binge eating disorder, but clinical applications have proliferated since then. IPT-G is now used in the treatment of depression, social phobia, postpartum depression, and psychological trauma, among other clinical foci. It has been used effectively as a stand-alone treatment and has been combined with social rhythm interventions for clients with bipolar disorder in order to help with self-regulation of sleep, activity, and exposure to stimulation. It has proven effective in skills training for depressed adolescents with poor school functioning.[116] IPT-G can be employed

conjointly with pharmacotherapy, either concurrently or sequentially.[117]

IPT-G's relevance and efficacy have also been demonstrated in other cultures, where it has been taught effectively to providers who have little prior psychotherapeutic training.[118] The World Health Organization has published a manual to support the delivery of IPT-G internationally in under-resourced countries where other depression treatments may be inaccessible. IPT-G's relational focus makes it a good match across cultures and with diverse populations. It has even been delivered in environments as challenging as displaced persons camps.[119]

Group IPT closely follows the individual IPT model. A positive, supportive, transparent, and collaborative client-therapist relationship is strongly encouraged. Each client's interpersonal difficulties are ascertained beforehand in an intensive evaluation of relationship patterns. These are categorized into one or two of four main areas: grief and loss, interpersonal disputes, role transitions, or interpersonal sensitivity. Self-report questionnaires and interpersonal inventories may be used to refine the client's focus and to measure progress. The most commonly used self-report measurements address the client's chief areas of distress—mood, trauma, eating behaviors, or interpersonal patterns. One to three goals are identified for each client to help focus the work and to jump-start the group therapy.

A typical course of therapy consists of one or two preliminary individual meetings aimed at building a therapeutic alliance and establishing therapy goals and then eight to twenty-four group meetings of ninety minutes each, with an individual follow-up session three or four months later. Some practitioners also use an individual evaluation meeting after the group has completed half of its sessions. Booster group sessions may be scheduled at regular intervals in the months following the intensive phase of therapy.

The group therapy meeting consists of an initial introduction and orientation phase, a middle working phase, and a final consolidation and review segment.[120] Written group summaries (see Chapter 13)

may be sent to each group member before the next session.

The first phase of the group, in which members present personal goals, helps to catalyze cohesion and universality. Psychoeducation, interpersonal problem solving, advice, and feedback are provided to each client by the group members and the therapist(s). The ideal posture for the therapist is one of active concern, support, and encouragement. Transference issues are managed rather than explored. Clients are encouraged to analyze and clarify their patterns of communication with figures in their environment but not to work through member-to-member tensions.

What are the differences between group IPT and the interactional, interpersonal model described in this text? In the service of briefer therapy and more limited goals, IPT-G generally de-emphasizes both the here-and-now and the group's function as a social microcosm. These modifications reduce interpersonal tensions and the potential for disruptive disagreements. (Such conflicts may be instrumental for far-reaching change but may impede the course of brief therapy.) The group, through its supportive and modeling functions, nonetheless becomes an important social network. In some carefully selected instances, group here-and-now interaction may be judiciously employed and linked to the client's focus and goals, but generally this focus is much less prominent than in the interpersonal group model we have described in this text. As we have noted elsewhere, skillful group leadership regarding an appreciation of group dynamics, group cohesion, group development, and group process play an important role in enhancing effectiveness.[121]

SELF-HELP GROUPS AND ONLINE SUPPORT GROUPS

The number of participants in self-help groups (SHGs) is staggering. To place some perspective on this, a report antedating the huge expansion of Internet support groups reported that over ten million Americans had participated in one of over five hundred thousand self-help groups in the preceding year and twenty-five million Americans had participated in a self-help group sometime in the past. That study focused exclusively on self-help groups that had no professional leadership. But in fact, more than 50 percent of self-help groups have professional leadership of some sort, which means that a truer measure of participation in self-help groups at that time, even by a conservative estimate, was likely twenty million individuals in the previous year and fifty million overall—figures that far exceed the number of people receiving professional mental health care.[122] This trend will only increase in light of consumers' growing self-awareness, self-assertiveness, access to information online, and difficulty in accessing costly professional care.

Group psychotherapists will regularly encounter clients who participate in SHGs and may at times encourage client participation in self-help groups. SHGs exist for virtually every condition and life challenge and are particularly prominent for mental health concerns and substance use disorders.[123] Fortunately, there are many excellent guides and entry points to this vast resource. The National Alliance on Mental Illness (NAMI), for example, each year provides millions of Americans with support, psychoeducation, and online resources by working with five hundred local affiliates. NAMI provides online support groups tailored to particular client concerns. Online self-help clearinghouses such as Mental Health America and the National Mental Health Consumers Self-Help Clearinghouse similarly provide useful guides to the many types of self-help groups available as well as materials, support, and guidance for the development of self-help groups.[124]

SHGs are proliferating rapidly, but they are certainly not new. In fact, we can readily track an arc from the fraternal organizations of the fourteenth century to the online support groups of today.[125] While the means of delivery has changed, the objectives of SHGs have remained consistent. SHGs provide their members with mutual aid and support. This includes a sense of safety and belonging, information sharing, and development of coping strategies. These groups may also help members advocate for change, as exemplified by Mothers Against Drunk Driving (MADD). In such cases, using one's lived experience to help others can lead to feelings of empowerment and a greater sense of self-efficacy.[126]

Evaluation of outcomes is difficult, given that SHG membership is often anonymous and records are unreliable. Nonetheless, some systematic studies attest to the efficacy of these groups. Members value the groups highly (sometimes more so than clients' objective improvement alone would predict) and report improved coping and well-being, greater knowledge of their condition, and reduced use of other health-care services.[127]

SHGs resemble therapy groups in many ways; the quality of peer leadership and the development of group cohesion are critical. SHGs make extensive use of almost all the group therapeutic factors, most prominently, altruism, cohesiveness, universality, imitative behavior, instillation of hope, and catharsis. But there is one important exception: the therapeutic factor of interpersonal learning plays a far less important role in the self-help group than in the therapy group.

Several factors account for the widespread growth of SHGs. They are open and accessible, offering psychological support to anyone who identifies with the group. Ailments that are underrecognized or unaddressed by the professional health-care system are very likely to generate self-help groups, and in these cases the groups are quite reassuring, helping members accept and normalize their malady.[128] Beyond traditional face-to-face SHGs, the Internet promotes connections between isolated individuals who feel unique in their distress. Instead of relying on restricted, perhaps unresponsive local communities, those affected with rare maladies now have access to

support from kindred folks from around the world.

Self-help groups emphasize *internal* rather than *external* expertise. They draw on the resources available within the group rather than those available from external experts, and this shift is empowering. The members' shared experience makes them both peers and credible experts. They become *providers* and *consumers* of support at the same time, benefiting from both roles: their self-worth rises through altruism, and hope is instilled by contact with others who have surmounted similar problems. Active coping strategies enhance functional outcomes.[129]

The presence of a professional leader in the SHG may facilitate deeper disclosures by participants.[130] These findings have led some researchers to call for more active collaboration between professional health-care providers and the self-help movement. There is a risk, however, that professional status may overshadow the SHG members' expertise. In any such collaboration, mutual respect and recognition of the value brought by both peer and professional experts is critical.[131]

Telemental Health Applications

Online mental health platforms include mobile device applications, remote health monitoring, and educational material. Apps and personal devices that provide a stream of personalized feedback about mood and stress aimed at promoting mental health self-awareness and self-care are proliferating daily. Although the feedback these provide is often generic and not individually tailored, there is no question that they can be of benefit.[132]

The early and technologically simpler (but still popular) online groups that first appeared operate either as real-time groups (synchronous chat lines) or asynchronous groups (bulletin boards). In both formats, members have no video contact but communicate by posting written messages. Facebook groups, for instance, are models of both. Groups may be time limited or ongoing; they may be actively managed through a facilitator's comments or questions regarding posts; or they may operate without any professional input.

They may be of varying and even indeterminant size. If there is professional input from moderators, their responsibility is to coordinate and curate participants' messages in ways that maximize the functioning of the group.[133]

An online bulletin board or chat group is a support system that is available 24/7 and allows its members time to rehearse, craft, and fine-tune their narrative.[134] That is the good news, and the impact is often profound and positive. The less good news, at times, is that the lack of boundaries may foster regressive online behaviors. Despite its manifest appearance as a kind of therapy group, an online chat group or bulletin board group can be a *very large* group in cyberspace shaped by large group dynamics and forces. This may include the expression of emotionally powerful, at times unconscious social and cultural forces regarding race, identity, diversity, authority, and inclusion. Participants only know one another through their limited posts, and without deeper interpersonal knowledge, assumptions and projections can easily mount.[135] This may encourage posting of attacking or inflammatory responses. Some professional input can reduce the risk of destructive and damaging posts.

A study of 103 participants in an online peer support group message board for depression found that many of the members of the group valued it highly, spending at least five hours engaged with the group online over the preceding two weeks to post messages and respond to others' posts. Benefits of participation included emotional support and tips about depression treatments. High users of the message board were more likely to experience resolution of their depression. More than 80 percent of the participants also continued to receive in-person professional care. They saw the online group as a supportive adjunct to, rather than as a substitute for, traditional care.[136] One participant's account of her experience describes many of the unique benefits of the online support group:

> **I find online message boards to be a very supportive community in** the absence of a "real" community support group. I am more likely to

> interact with the online community than I am with people face to face. This allows me to be honest and open about what is really going on with me. There are lots of shame and self-esteem issues involved in depression, and the anonymity of the online message board is very effective in relieving some of the anxiety associated with "group therapy" or even individual therapy. I am not stating that it is a replacement for professional assistance, but it has been very supportive and helped motivate me to be more active in my own recovery program.[137] **<<**

Posting messages as the vehicle for communication has the serendipitous benefit of facilitating research, as every communication can be examined. An analysis of postings in groups for women with breast cancer demonstrated that members of groups that had trained moderators were more likely to express distressing emotions than members of groups without moderators. Greater emotional expression by participants was associated with reduced depression.[138] The moderator, generally a mental health expert, requires skill in facilitation and in activating, containing, and exploring strong emotions. This appears to be as important in online support groups as in face-to-face groups.[139]

Internet support group participants describe many other unique advantages. Individuals, for example, who are unable to attend face-to-face meetings, because of geographic distance, cost, physical disability, infirmity, or the dearth of professionals in their communities, are now able to participate in a self-help or therapy group.[140] Patients with stigmatizing ailments or social anxiety may prefer the relative anonymity of an Internet support group. These groups promote health equity by enhancing access to care. For many people in search of help, an Internet support group is the equivalent of putting a toe in the water in preparation for full immersion in some other therapy endeavor; for others, it is a definitive treatment. Intimacy itself is being redefined favorably in online terms. Haim Weinberg has coined the term "E-ntimacy" to describe the intimacy that online platforms generate.[141]

Footnotes

i For a full description of the first group I led for cancer patients, see “Travels with Paula” in *Momma and the Meaning of Life* (New York: HarperCollins, 1999), 15–53.

- 16 -

Training the Group Therapist

GROUP THERAPY IS A CURIOUS PLANT IN THE GARDEN OF THE psychotherapies. It is hardy: the best available research consistently reports that group therapy is as effective and robust as individual therapy. It also represents a remarkably efficient use of therapist resources.[1] It is a Triple E therapy: effective, equivalent to individual therapy, and efficient. Yet it needs constant tending; its perennial fate is to be periodically choked by the same old weeds: prejudices and judgments that it is "superficial," "dangerous," or "second-rate—to be used only when individual therapy is unavailable or unaffordable." We hope the American Psychological Association's 2018 recognition of group psychotherapy as a designated psychology specialty will alter the landscape, elevating group therapy practice and training to the status it warrants.[2]

Clients and many mental health professionals continue to underrate and to fear group therapy, and unfortunately those very same attitudes adversely influence group therapy training programs.[3] Why? Perhaps because group therapy cannot cleanse itself of the anti-intellectual taint of the antiquated encounter group movement. Perhaps it is because we all wish to be the special and singular object of attention that individual therapy promises. Perhaps because many of our clients have found groups to be their life *problem*, not the *solution*. Perhaps many of us prefer to avoid the anxiety inherent in the role of the group leader: greater public exposure of oneself as a therapist, less sense of control, fear of being overwhelmed by the group, too much clinical material to

synthesize. Perhaps, too, it is because groups evoke for us unpleasant personal memories of earlier peer group experiences.

The moment demands a whole new generation of well-trained group psychotherapists, and it behooves us to pay careful attention to their education. Training is a lifelong endeavor. Time and experience are not sufficient: deliberate attention to ongoing learning and to feedback on one's work are required for group therapists to grow and develop.[4]

In this chapter, we present our views about group therapy training, not only in terms of specific training recommendations but also in the form of an underlying philosophy of training. The approach to group therapy described in this book is based on a synthesis of extensive clinical experience and the best available research evidence. Similar principles apply to the education of group therapists.

Most training programs for mental health professionals focus on individual therapy and do not provide group therapy training, or offer it only as an elective part of the program. In fact, it is not unusual for students to be given excellent individual therapy supervision and then, early in their program, to be asked to lead therapy groups with no specialized guidance whatsoever. Many program directors apparently expect, naïvely, that students will be able somehow to translate their individual therapy training into group therapy skills without meaningful group experience and training. This practice not only invites ineffective group leadership but causes students to devalue the group therapy enterprise.[5] The same process occurs in many clinical work settings. Despite group therapy practice being more complex than individual therapy, therapists are routinely thrown into the work without adequate training, and with discouraging results.[6]

Neophyte group therapists make predictable errors, and without strategies to address these errors, replication of them is likely. Good training helps the developing group therapist to appreciate the complexity of the group and to reflect on the "big picture" of what is happening regarding group process, dynamics, and development.

Errors of omission tend to be more prominent than errors of commission in the practice of the beginning group therapist.[7]

It is essential that mental health training programs appreciate the need for rigorous, well-organized group therapy training and offer programs that match the needs of trainees and their clients. Both the American Group Psychotherapy Association (AGPA) and the American Counseling Association (ACA) have established minimum training standards for group therapy certification that can serve as a template for training. For example, the AGPA's International Board for Certification of Group Psychotherapists (IBCGP) requires a minimum of fifteen hours of didactic training, three hundred hours of group therapy leadership, and seventy-five hours of group therapy supervision with a group therapist who has met the standards of certification.[8] These are the expectations for recognition as a Certified Group Psychotherapist (CGP). Many international organizations have set training standards as well and in addition insist on personal group therapy as a component of core training.[9] For many group therapists, experiential training at intensive institutes offered at conferences serves a similar purpose: a personal group experience greatly enhances one's effectiveness as a group therapist.

Health-care economics force us to recognize that one-to-one psychotherapy cannot possibly meet the pressing mental health needs of the public. Health insurers forecast rapid growth in the use of group therapy, particularly in structured and time-limited groups.[10] We believe strongly that psychotherapy training programs that do not acknowledge this and do not expect students to become as fully proficient in group as in individual therapy are failing to meet their responsibilities to the field and to their students.

While we cannot hope to offer a definitive blueprint for a universal training program, we shall, in the following section, discuss the four major components that we consider essential to a comprehensive training program beyond the didactic: observation of experienced group therapists at work, close clinical supervision of students' maiden groups, a personal group experience, and personal

psychotherapeutic work.

OBSERVATION OF EXPERIENCED CLINICIANS

Though it is exceedingly uncommon for students to observe a senior clinician doing individual therapy, the more public nature of group therapy makes it possible for trainees to observe directly. Student therapists derive enormous benefit from watching an experienced group practitioner at work.[11] At first, experienced clinicians may feel considerable discomfort while being observed; but once they have taken the plunge, the process becomes comfortable as well as rewarding for all: students, therapists, and group members.[12] In one study, trainees who observed ongoing group therapy described it as their most impactful training experience. They reported learning about group leadership and group dynamics as well as how to bear the strong emotions generated by group therapy.[13]

The format of observation depends, of course, on the physical facilities. We prefer having our students observe our group work through a one-way mirror, but if students' schedules do not permit them to be present for a ninety-minute group and a postgroup discussion, the group can be videotaped (with client consent) and reviewed at a later time. However, observation is more alive in the moment, noting as well there is a significant difference between live observation through a one-way mirror and being physically present in the group room. If there are only one or two observers, they may sit in the group room outside of the circle without unduly distracting the members. In this model, observers sit silently and decline to respond to any questions group members may pose to them.

Regardless of the format used, the group members must be fully informed about the presence of observers and their purpose. In every instance, observers should be held to the same standard of professionalism regarding confidentiality and ethical conduct as the therapists.[14] A clear observers' contract protects both the clinical and learning environments. If a trainee recognizes or knows a group member, that individual is not permitted to observe.

I (ML) once faced the situation of having a group member, Donna, recognize a student entering the observation room as someone she knew from her neighborhood. Donna was furious at me for this apparent violation and I was flummoxed. Through the one-way mirror, I asked the observer in apparent violation to leave the viewing room immediately, only to learn afterward, in our rehash, that the observer had an identical twin whom Donna knew. My credibility in making that improbable explanation the next week was strained, but ultimately survived intact.

Clients may initially protest feeling like “specimens” when being observed but generally this feeling soon evaporates. We remind clients that observation is necessary for training, that we were trained in that fashion, and that their willingness to permit observers will ultimately be beneficial to the student observers’ clients in the future.

The total length of students’ observation time is generally determined by service and training rotations. If there is sufficient program flexibility, we suggest that observation continue for at least six to ten sessions, which generally provides a sufficient period of time for changes to occur in group development, in interactional patterns, and in perceivable client growth.

The postmeeting discussion is an absolute necessity in training, and there is no better time for the group leaders/teachers to meet with student observers than immediately after the meeting. We prefer to meet for thirty to forty-five minutes, and we use the time in a variety of ways: obtaining the students’ observations, answering their questions about underlying reasons for our interventions, and using the clinical material as a springboard for discussion of fundamental principles of group therapy. Although some introductory didactic sessions are useful, we find that much of the material presented in this book can be best discussed with students when appropriate clinical material arises in an observed group. Theory becomes so much more alive when it is immediately relevant.

The relationship between observers, the group, and the group therapists is important. There will be times when observers may be critical and faulting. The repeated questions of “Why didn’t you…?”

may create discomfort for the therapists, but also models openness to learning and feedback. Not infrequently, observers complain of boredom, and therapists may feel some pressure to increase the group's entertainment quotient. Our experience is that, in general, *boredom is inversely related to experience*. As students gain experience and sophistication, they come increasingly to appreciate the many subtle, fascinating layers underlying every transaction.

The observation group has a process of its own that may reverberate with themes in the group. Observers may identify with the therapist, or with certain characteristics of the clients that, if explored in the debriefing session, may provide an opportunity to explore such themes as empathy, countertransference, and projective identification. At times, observers develop strong attachments to group members and may express the wish that they were in the group as participants. One observer was so disturbed when one group member verbally attacked another that he shared a fantasy of coming into the group and accosting the offending group member. This admission led to a rich discussion of how to manage intense affects and countertransference.

Group members respond to being observed by students in a range of ways. Like any group event, the different responses resemble a projective test. If all members face the same situation (that is, being observed by students), why do some respond with anger, others with suspicion, and still others with pleasure, even exhilaration? Why such different responses to a common stimulus? The answer, of course, is that *each member has a different inner world*, and the differing responses facilitate examination of each inner world.

Nonetheless, for the majority of clients, observation is an intrusion. Sometimes the observers may serve as a lightning rod for anxiety arising from other concerns. For example, one group I (ML) led had been observed consistently but suddenly became preoccupied with the observers, growing convinced that they were mocking and ridiculing the members. A group member reported encountering someone in the washroom before the group who smirked at him, and he was convinced this person was an observer.

The group members demanded that the observers be brought into the group room to account for themselves. The group's reaction was so intense that I began to wonder if there had been some breach of trust. As we continued to examine the source of this intensity, it became apparent that the group members were in fact projecting their apprehensions onto the observers. There were impending changes in the group—two senior members had left, and two new additions to the group were imminent—and the real issue was whether the *new additions* would value the group or deride the process and the members.

Though the most a leader can generally expect from clients is a grudging acceptance of the observers' presence, there are methods of turning the students' observations to therapeutic advantage. We remind the group that the observers' perspectives are valuable to us as the leaders; if appropriate, we may cite some helpful comments observers made after the previous meeting. Some of the observers' comments may also be incorporated into the written summary of the meeting.

Another, more daring strategy is to invite the group members to be present at the observers' postmeeting discussion. In Chapter 15 we discussed a model of an inpatient group that regularly included a ten-minute observers' discussion that the group members observed.[15] I (IY) have used a similar format for outpatient groups. I invite members and observers to switch rooms at the end of a meeting so that the clients can view the observers' and co-therapists' postgroup discussion through the one-way mirror. My only proviso is that the entire group elect to attend: if only some members attend, the process may be divisive and impede the development of cohesiveness. A significant time commitment is required: forty-five minutes of postgroup discussion after a ninety-minute group therapy session make for a long afternoon or evening. This format has interesting implications for teaching. It teaches students how to be constructively transparent, and it conveys a sense of respect for the client as a full ally in the therapeutic process.

A further benefit is that boredom in the observation room

absolutely vanishes: students, knowing they will later take part in the meeting, become more engaged in the process.

A useful adjunct teaching tool may be a group videotape designed to illustrate important aspects of leader technique and group dynamics. We recommend use of three videotape programs—one for outpatient groups, one for inpatients, and one based upon *The Schopenhauer Cure*.[16]

CLINICAL SUPERVISION

Supervision is a sine qua non in the education of the group therapist. This book describes our approach to therapy and delineates principles of technique that emerge from the empirical roots of group therapy. But the laborious working-through process that constitutes the bulk of therapy cannot be thoroughly depicted in a text. An infinite number of situations arise, each of which may require a rich, imaginative approach. It is precisely at these points that a supervisor makes a valuable and unique contribution to a student therapist's education. Because of its central importance in training, supervision has become a major focus of attention in the psychotherapy literature.[17]

We can conceive of the tasks of psychotherapy supervision as threefold: normative, formative, and restorative. The *normative* elements include setting the stage administratively and practically for the trainee's clinical work, supervision, and evaluation. The *formative* elements include guiding the trainee session to session in the principles that link theory and practice. The *restorative* elements include supporting the trainee in the face of the challenges of the clinical work: bearing strong emotion, dealing with countertransference, fostering remoralization, and promoting trainee wellness.[18]

We want our trainees to learn not only how to be effective group therapists but also how to take care of themselves professionally. The work we do is difficult: extensive exposure to the traumatic experiences of our clients can generate feelings of vicarious traumatization. Psychotherapist burnout—the triad of feeling exhausted, disengaged, and ineffective—is a growing concern in our field. Prevention, in the form of engaging in self-care, setting appropriate limits, maintaining collegial connectedness, and redefining professionalism to include personal balance, is preferable to downstream efforts at recovery. Burnout damages the provider

and in turn compromises good clinical care.[19]

What are the characteristics of effective supervision? Supervision first requires the establishment of a *supervisory alliance* that conveys to the student the ambiance and value of the *therapeutic alliance*. This encompasses student and supervisor agreement regarding the goals, tasks, and nature of the supervision relationship. Supervision not only conveys technical expertise and theoretical knowledge but also models and transmits the profession's values and ethics. Accordingly, supervisors must strive for congruence: they should treat their students with the same respect and care that the student should provide to clients. If we want our trainees to treat their clients with respect, compassion, and dignity, then that is how we must treat our trainees.[20] Training is enhanced when the *hidden* curriculum aligns with the *manifest* curriculum.

The supervisor should focus on the professional and clinical development of the trainee and be alert to any blocks—either from lack of knowledge or from countertransference—that the trainee encounters. A fine balance must be maintained between training and therapy. Anne Alonso suggests that the supervisor should listen like a clinician but speak like a teacher, never crossing the boundary into therapizing the supervisee.[21]

The most effective supervisors are able to tune in to the trainee, track the trainee's central concerns, capture the essence of the trainee's narrative, guide the trainee through clinical dilemmas, and demonstrate personal concern and support. Supervision that is unduly critical, shaming, or closed to the trainee's principal concerns will not only fail educationally but also dispirit the trainee. The effective supervisor pays careful attention to any emotional reactions to the supervisee's clinical presentation and uses that as data to deepen his or her understanding of the supervisee and of the clients being presented in supervision.[22]

How personal and transparent should the supervisor be? The same principles we described for the group therapist in Chapter 7 apply here. The supervisor must be able to identify his or her motivation and the likely impact of personal disclosure in

supervision. By revealing their own experiences and clinical challenges, supervisors reduce the power hierarchy and help the trainee see that there is no shame in not having all the answers. What's more, such a revealing and nondefensive stance will influence the type of clinical material the trainee will bring to supervision. If we expect our clients to accept their imperfections without crushing shame, the principle of acceptance must be echoed in the supervision of the group therapist.

Supervisees report that judicious supervisor disclosure promotes a sense of collegiality and reduces the hierarchy of the relationship.[23] I (ML) have at times found it helpful to describe my tendency to avoid aggression, for example. Being the child of Holocaust survivors, I learned from a young age to reduce interpersonal tensions. In my therapy practice I am careful not to enact that avoidance. This supervisory disclosure has been helpful in addressing the difference between the components of countertransference that can be attributed to our client's impact on us (objective) and that which we bring into our work with our clients (subjective). A cardinal task of psychotherapy training is developing the trainee's capacity to become self-aware of countertransference, to be able to recognize it, and to harness its therapeutic power.[24]

Leading a first group is a highly threatening experience for the neophyte group therapist. Until the therapist appreciates how to harness the group forces constructively, he or she may be in a state of *group shock*, overwhelmed by the clinical material, the public exposure of his or her abilities, and the fear of the group failing to launch. Even conducting psychoeducational groups, with their clear content and structure, can be inordinately challenging to the neophyte.[25] In a study of neophyte trainees, researchers compared trainees who had positive and negative group therapy training experiences. Both groups reported high degrees of apprehension and strong, distressing emotional reactions early in the work. One variable distinguished the two groups: the quality of the supervision. Those reporting greater satisfaction with their supervision were far more likely to feel positive about their subsequent group therapy

experience than those reporting less satisfaction.[26]

In another study, my (IY) colleagues and I examined twelve nonprofessionally trained leaders of groups in a psychiatric hospital. Half received ongoing supervision as well as an intensive training course in group leadership; the others received neither. Observers—who did not know which therapists received supervision and which did not—rated the therapists at the beginning of their groups and again six months later. The results indicated not only that the trained therapists had improved, but that the untrained therapists *were less skilled at the end of the period than they had been at the beginning*.[27] Sheer experience, apparently, is not enough. Without ongoing supervision and evaluation, *original errors may be reinforced by simple repetition*: trainees may lose therapeutic confidence, shrink their range of interventions, and become less effective.

Supervision may be even more important for the neophyte group therapist than for the budding individual therapist because of the inherent stress in the group leader role. We have had many trainees report anxiety-laden dreams just before commencing their first group experience. These are filled with images about being out of control or confronting some threatening group situation. Because they arise so frequently, we routinely inquire about such dreams to depathologize initial trainee anxiety.

It is not only the neophyte who benefits from the support and reflective space that supervision provides. I (ML) was shaken by an experience I had several years ago. It took place in a demonstration group I led at a conference.

> **A woman volunteered to join a demonstration group I was leading** only to use time in the group to roundly criticize my teaching and group leadership earlier in the day. She left virtually no part of me untouched by her attack. I was overcome with feelings of vulnerability and shame and was acutely aware of the irony that I was to be honored the next day with an award for outstanding contributions to our field.
>
> My task in the demonstration group was to protect this individual from being scapegoated by the other group members, who jumped to my defense. Identifying why she would seek to participate in this group at

all remained a puzzle to me in the limited time we had, but it was certainly a signal that more was at play than met the eye. I was affected by her attack, not the least part of which was its public nature, which is of course what happens for our group trainees.

An intervention by a colleague in the audience was very helpful. He texted me after the session, telling me that he had some interesting information to share with me. He, too, was puzzled by this attack, and he approached this woman afterward and inquired why she had been so upset and critical. That led to a conversation about her learning difficulties. It seemed that she was upset that I had used an academic approach to teaching in the morning, rather than being entirely experiential. Because of a learning disability, such academic presentations were "deadening" to her. She elaborated to my colleague that because of her learning disability, she had felt humiliated in every course of study and had completed her training only with significant learning accommodations. He asked her whether she had ever protested this before so powerfully, to which she replied, "Never until today."

That information helped settle me enormously. It underscored that she had seized an opportunity to do something she had not been able to risk doing in the past. By not rebuking her in the group, I allowed her to feel safe enough to protest—and perhaps to offset her usual feeling of failure by projecting that onto me.

What struck me was that I was an experienced clinician with many years of practice and was on the cusp that week of receiving a significant honor, yet my sense of myself as a therapist and my understanding of my work was roiled by her attack. What was very helpful to me in regaining my equanimity was talking with a trusted colleague who saw what I did not. It was fortunate that in this instance he had additional information regarding "the backstory."

Supervision often provides that backstory. The supervisor is able to see things beneath what is manifest that the trainee does not yet appreciate. **<<**

A few practical recommendations may be helpful. First, supervision should be well established before the first group, both to attend to the selection and preparation tasks of group leadership and to address therapist apprehension about starting the group. *One supervisory hour per group therapy session* is, in our experience, the optimal ratio. It can be logistically challenging to find time for the

group, for the co-therapists' postgroup discussion, and for supervision, but it is wise to hold the supervisory session soon after the group session, preferably the following day. Some supervisors observe the last segment of each meeting and hold the supervisory session immediately thereafter. At the very least, the supervisor must observe one or two sessions at the beginning of supervision and, if possible, an occasional session throughout the year; this enables the supervisor to affix names to faces and also to sample the affective climate of the group.

An added benefit of live observation is that even the most committed trainees will miss important material in their process notes. We have often had the experience of writing five pages of notes while observing a group segment that might be reported by our supervisees in thirty seconds. The move to competency-based health-care provider education demands even greater direct observation of our trainees and the provision of tailored feedback.[28] Video recordings may serve this purpose as well (audio recordings, too, though far less satisfactorily).

If too much time elapses between the group meeting and the supervisory session, the events of the group fade; in this case, students are well advised to make detailed postgroup process notes. Therapists develop their own styles of note taking. Our preference is to record up to three major themes for each session. For example: (1) Joaquin's distress at losing his job and the group's efforts to offer support; (2) Sharita's anger at the men in the group; (3) Annabelle's feelings of inferiority and of not being accepted by the group.

Once this basic framework is in place, other vital data can be added: the transition between themes, each member's contribution to each of the themes, and therapist interventions and feelings about the meeting as a whole and toward each of the members. Other supervisors suggest that students pay special attention to *choice points*—a series of critical points in the meeting where action was required of the therapist. Still others make use of client feedback obtained from questionnaires distributed at the end of a group session (see Chapter 13 regarding monitoring of outcome and

process).[29]

A ninety-minute group session provides a wealth of material. If trainees present a narrative of the meeting and discuss each member's verbal and nonverbal contribution as well as the trainees' own participation and reactions toward each of the group members, there should be more than enough important material to occupy the supervisory hour. If the trainee quickly runs out of material, or if the supervisor has to scratch hard to learn the events of the meeting, something has gone seriously wrong in the supervisory process. At such times a supervisor would do well to examine his or her relationship with the trainee. Is the student guarded, distrustful, or fearful of being exposed to scrutiny, perhaps more invested in protecting his or her self-esteem than in learning?[30]

The supervisory session is no less a microcosm than is the therapy group. The supervisor should be able to obtain much information about the therapist's behavior in a therapy group by attending to the therapist's behavior in supervision. (Sometimes this phenomenon is referred to as the "parallel process" in supervision.) Important emotions that are felt in any component of the group-therapist-supervisor system are likely to be expressed throughout that system and can be addressed productively in supervision.[31]

If students lead groups as co-therapy teams (and, as Chapter 13 explains, we recommend that format for neophyte therapists), a process focus in the supervisory hour is particularly rich. It is likely that the relationship of the two co-therapists in the supervisory hour parallels their relationship during the therapy group meetings. Supervisors should attend to such issues as the degree of openness and trust during the supervisory hour. Who reports the events of the meeting? Who defers to whom? Do the co-leaders report two bewilderingly different views of the group? Is there much competition for the supervisor's attention? The relationship between co-therapists is of crucial importance for the therapy group, and the supervisor is maximally effective by focusing attention on this relationship.

In the ongoing work, the supervisor must explore the student's

verbal and nonverbal interventions and check that they help establish useful group norms. At the same time, the supervisor must avoid making the student so self-conscious that spontaneity is stunted.

Most supervisors will at times tell a supervisee what they themselves would have said at some juncture of the group. It is not uncommon, however, for student therapists to mimic the supervisor's comments at an inappropriate spot in the following group meeting and then begin the next supervisory session with: "I did what you said, but…" Thus, when we tell a student what we might have said, we often preface our comments with, "Don't say this at the next meeting, but here's one way you might have responded…" But at some pivotal points, it can be very helpful to suggest a particular intervention. Here, too, a delicate balance needs to be maintained. Although we are often explicit in supervision about the *principles* that underpin our interventions, supervision should rarely be prescriptive and never heavy-handed.

Supervision Groups

Many supervisors have, to good effect, expanded the supervisory hour into a continuous case seminar for several trainees, with the group leaders taking turns presenting their group to the entire supervision group. Since it takes time to assimilate data about all the members of a group, we prefer that one group be presented for several weeks before moving on to another. In this format, three to four groups can be followed throughout the year. In our experience this works best with more advanced supervisees.

There are several benefits to providing group therapy supervision in a group format. For one thing, it may be possible for a skillful supervisor to focus on the interaction and the group dynamics of the supervisory group. The participants' self-reflection on the supervision group can be very instructive in illuminating the dynamics of the therapy groups. The supervisees' lived experience of risk-taking, of belonging (or not), of feeling shamed or silenced, become powerful portals into the clinical work. Another benefit of group supervision is

the presence of peer support, which helps to normalize the developmental challenges of leading therapy groups. The impact of group cohesion and the holding, containing function of the group can also be brought to life.[32]

Furthermore, accounts of colleagues' experiences, conceptualizations, and techniques expose trainees to a greater range of group therapy phenomena and broaden their empathic awareness. Trainees also have the opportunity to think like a supervisor or consultant, a skill that will be useful at other points in their careers.[33] Feedback about one's clinical work is often a delicate process. Supervision groups teach members to communicate authentically, respectfully, and empathically.

A group supervision format may also encourage subsequent participation in a peer supervision group by demonstrating the value of peer supervision, consultation, and support.[34] The supervision group should not, however, transform itself into a personal growth or therapy group—*that* group experience involves a substantially different set of norms and expectations.

A Multicultural Orientation and Supervision

Some recent supervision innovations have made good use of the Internet to offer supervision to practitioners living in isolated or distant locales. Facilitated online supervision groups now occur routinely, bringing together trainees from around the world.[35] This approach has been a mainstay of training within the Yalom Institute in China. This program, led by Ruthellen Josselson, PhD, and me (ML), has provided ongoing supervision, with translation, of course, to scores of Chinese mental health professionals and trainees.[36] Culture plays a crucial role both in training and in psychotherapy. Attitudes about self-expression, emotional expression, and authority are different in the West than in many other parts of the world.

Among the initial challenges we faced in providing training in China was the tendency for our students (and their clients) to defer to authority, to seek conferred wisdom, and to comply without

assertion or protest. Therapy and supervision were very top-down, much less collaborative than in the West, and required our constant attention to the impact of cultural norms and expectations on our work together. Even these statements, however, are less true now than when we began our work there ten years ago, reflecting the large cultural shifts rapidly occurring in today's world.

One of the key messages in supervision and training of psychotherapists and group therapists is this: *Understanding culture is central.* Therapist multicultural orientation is strongly correlated with significantly better clinical outcomes. The hallmarks of culturally resonant care include *cultural humility*, the therapist's openness to new learning without presumption or disrespect; *cultural comfort*, the therapist's examination of his or her thoughts and feelings regarding the client's cultural identities or culturally focused material in therapy; and *cultural opportunity*, seizing opportunity to discuss cultural issues.[37]

Within our psychotherapy groups these issues become even more important. Not only is discrimination corrosive to mental health, but the social microcosm of the group provides a unique arena for *difficult dialogues* about race and privilege that are not often possible in other settings. This is challenging work, fraught with the hazards of unintended adverse events arising from microaggressions that invalidate, diminish, or *otherize* group members based upon cultural stereotypes. But the group also has the potential to promote healing more broadly in our society and to disrupt the intergenerational transmission of race-based trauma. It is essential work, and the experience of our trainees in supervision will shape their capacity to do this work well. Both a safe space and a brave space need to be preserved in our groups.[38]

A GROUP EXPERIENCE FOR TRAINEES

For decades, a group experiential component was widely accepted as an integral part of training. Across a range of disciplines, this is much less so today. Although they are still prominent in many psychiatry training programs, some surveys show an overall decline in these training opportunities—part of the de-emphasis on psychological and psychotherapeutic treatments in psychiatry training programs.[39] We believe strongly that these training group experiences offer many types of learning not available elsewhere. Members are able to learn at an emotional level what they may previously have known only intellectually. They experience the power of the group—power both to wound and to heal. They learn how important it is to be accepted by the group; what self-disclosure really entails; how difficult it is to reveal your secret world, your fantasies, your feelings of vulnerability, hostility, and tenderness. They learn to appreciate their own strengths as well as their weaknesses. They learn about their own preferred role in the group, about their habitual countertransference responses, and about group-as-a-whole and system issues that lurk in the background of the meetings. They learn about group process and the hazards of oversimplified explanations. Perhaps most striking of all, they learn about the role of the leader by becoming aware of their own dependency and their own often unrealistic appraisal of the leader's power and knowledge.[40] These are the reasons why this form of training continues to be so popular in continuing professional development.

Even experienced practitioners who are being trained in a new model of group therapy benefit greatly when an experiential affective component is added to their didactic training. Personal participation is the most vital way to teach and to learn group process. That is the approach I (ML) and colleagues used in training a national network of group therapists in a multisite trial of supportive-expressive group

therapy for women with metastatic breast cancer.[41]

The most common model is a group composed of other trainees and referred to by any number of terms (T-group, support group, process group, experiential training group, and so on). This may be a short-term group, lasting perhaps a dozen sessions, or an intensive one- or two-day experience. The model we recommend is a process group that meets for sixty to ninety minutes each week for a year.

We have led groups of mental health trainees for over thirty years and, without exception, have found these groups to be highly valuable educationally. Indeed, many psychotherapy students, when reviewing their training programs, have rated their group as the single most valuable experience in their curriculum. A group experience with one's peers has a great deal to recommend it: members not only learn how to lead a group but also, if the group is led properly, bond with each other. Relationships and communication within the trainee class improve, enriching the entire educational experience. Students always learn a great deal from their peers, and any efforts that potentiate that process increase the value of the program. The group can also play an important role in promoting therapist wellness and self-care.

> **In a T-group of psychiatry residents, an older male resident asked** an attractive, aloof, younger female resident, Tiffany, why she appeared so distant. Much to his surprise, she welcomed his overture and acknowledged that she knew she had a reputation as "The Ice Queen." She added that she was isolated and lonely in the residency and hoped to lessen the aura of detachment she conveyed to others. She then disclosed that "the residency is particularly challenging for me because of all the suicidal patients I am caring for; and because my father, also a physician, took his own life after abusing narcotics for some time prior to his death. No one—not my colleagues nor my supervisors—knows that. This is the first I am speaking of it."
>
> I (ML) paused and checked in with Tiffany to determine how the pace and depth of disclosure felt. Through her tears, she responded that she felt relief and an unburdening. The group was very supportive, thanked her for her courage and trust, and then dove into a deep and meaningful discussion of physician mental health and why suicide rates were so high in the profession. They determined that the least they

could offer one another in the residency was a lessening of that isolation and toxic self-reliance. **<<**

Are there also disadvantages to a group experience? One often hears storm warnings about the possible destructive effects of staff or trainee experiential groups. These are by and large urban myths, and in our experience the warnings are based on irrational premises: for example, that enormous amounts of destructive hostility ensue once a group unlocks suppressive floodgates, or that groups precipitate an enormous invasion of privacy as forced confessionals are wrung one by one from each of the hapless trainees. We know now that responsibly led groups that are clear about norms and boundaries facilitate communication and constructive working relationships.

Should Training Groups Be Voluntary?

An experiential group is always more effective if the participants engage voluntarily and view it not only as a training exercise but as an opportunity for personal growth. Indeed, we prefer that trainees begin such a group with an explicit formulation of what they want to obtain from the experience personally as well as professionally. To this end, it is important that the group be introduced and described to the trainees in such a way that they consider it to be consonant with their personal and professional goals. We prefer to frame the group within the students' training career by asking them to project themselves into the field of the future. It is, after all, highly probable that mental health practitioners will spend an increasing amount of their time in professional groups—both as members and leaders of treatment teams. Their clients will be in groups as well. To be effective in this role, clinicians of the future will simply have to know their way around groups. They will have to learn how groups work and how they themselves work in groups.

Once an experiential group is introduced as a regular part of a training program, and once the faculty develops confidence in the group as a valuable training adjunct, there is little difficulty in selling it to incoming trainees. Still, programs differ on whether to make the

group optional or mandatory. Our experience is that if a group is presented properly, the trainees not only look forward to it with anticipation but experience strong disappointment if for some reason the opportunity for a group experience is withheld.

Nadiya Sunderji, Jan Malat, and I (ML) reviewed several years of data from evaluations of our annual intensive experiential group day model. In this model, sixty to eighty residents meet in groups of eight to ten participants for the day with an experienced leader. Although residents were required to attend twice in the four years of residency, many of them went beyond the requirement. It is a safe learning experience, and the evaluations are uniformly positive. For the study, participants reported that they were much more self-disclosing than they expected to be and that feedback from peers was more valuable than they anticipated. We consistently receive feedback that the day has much personal significance as well as professional value.[42] Participants reported the following benefits:

- Gaining firsthand experience as a group participant
- Appreciating the patient's perspective
- Understanding the difficulty of self-disclosure
- Learning about themselves in a safe setting
- Learning more about their colleagues and making a better connection with them
- Learning about group process and group facilitation techniques
- Improving their skills as group leaders

Who Should Lead Student Experiential Groups?

Directors of training programs should select the leaders for trainee groups with great care. For one thing, the group experience is an extraordinarily influential event in the students' training career; the leader will often serve as an important role model for the trainees and therefore should have extensive clinical and group experience and the highest possible professional standards. The overriding criteria are, of course, the personal qualities and skill of the leader; a

much lesser consideration is the leader's professional discipline.

We believe that a training group led by a leader skilled in the interactional group therapy model provides the best educational experience.[43] Supporting this view is a study of 434 professionals who participated in two-day American Group Psychotherapy Association training groups. Process-oriented groups that emphasized here-and-now interaction resulted in significantly greater learning about leadership and peer relations than groups that were more didactic or structured. The members felt they profited most from an atmosphere in which leaders supported participants, demonstrated techniques, and facilitated an atmosphere in which members supported one another, revealed personal feelings, and took personal risks.[44]

Is the Training Group a Therapy Group?

This is a vexing question. In training groups of professionals, no other issue is so often used in the service of group resistance. It is wise for leaders to present their views about training versus therapy at the outset of the group. We begin by asking that the members make certain commitments to the group. Each member should be aware of the requirements for membership: a willingness to invest oneself emotionally in the group, to disclose feelings about oneself and the other members, and to explore areas in which one would like to make personal changes.

There is a useful distinction to be made between a therapy group and a therapeutic group. *A training group, though it is not a therapy group, is therapeutic in that it offers the opportunity to learn about oneself.* By no means, though, is each member expected to do extensive therapeutic work.

The basic contract of the group, in fact, its *raison d'être*, is training, not therapy. To a great extent, these goals overlap: a leader can offer no better group therapy training than that of an effective therapeutic group. Furthermore, every intensive group experience contains within it great therapeutic potential: members cannot engage in effective interaction, cannot fully assume the role of a

group member, cannot get feedback about their interpersonal styles and their blind spots, without some therapeutic spin-off. Yet that is different from a therapy group that assembles for the purpose of accomplishing extensive therapeutic change for each member of the group.

Leader Technique

The leader of a training group of mental health professionals has a demanding job: he or she not only must be a role model, by shaping and conducting an effective group, but must also make certain modifications in technique to deal with the specific educational needs of the group members. Leading these groups can be stressful for the group facilitators. They are exposed to the scrutiny of the group participants (who may also be evaluating the leader's effectiveness) and may dread a group that becomes defensively avoidant and boring, or, worse yet, a group that becomes unsafe for the trainees.

Nevertheless, our suggestions for leaders of training groups do not deviate from the guidelines for leading groups we have outlined throughout this book. For example, the leader is well advised to retain an interactional, here-and-now focus. It is an error to allow the group to move into a supervisory format where members describe problems they confront in their clinical work: such discussion should be the province of the supervisory hour. Whenever a group is engaged in discourse that can be held equally well in another formal setting, it is failing to capitalize on its unique properties and achieve its full potential. Instead, members can discuss these work-related problems in more profitable, group-relevant ways. For example, they might discuss how it would feel to be the client of a particular member. The group is also an excellent place for two members who happen to work together as co-leaders to work on their relationship.

There are many ways for a leader to use the members' professional experience in the service of the group work. In a therapy group, the expression and integration of affect and the recognition of here-and-now process are essential but secondary considerations to the primary goal of promoting individual therapeutic

change. In a training group of mental health professionals, the reverse is true. There will be many times when the T-group leader will seize an opportunity for explication and teaching that a group therapist would seize for deeper emotional exploration. This rebalancing of emotional activation and cognitive integration is one of two key modifications we have found useful.

The second modification focuses on leader transparency. We are much more likely to show our thinking in these groups. We are also unusually self-disclosing—in effect, we give the members more on us than we have on them. In so doing, we model openness and communicate how unlikely it would be for us to adopt a judgmental stance toward them. Leader transparency offered in the service of training lowers the perceived stakes for the participants by normalizing their concerns.

For example, we have often made transparent statements to the training group in the following vein: “The group has been very slow moving today. When I inquired, you told me that you felt ‘lazy’ or that it was too soon after lunch to work. If you were the leader of a group and heard this, what would you make of it? What would you do?” Or, “Not only are Joanie and Stewart refusing to work on their differences, but others are lining up behind them. What are the options available to me as a leader today?” In a training group, we are inclined, much more than in a therapy group, to explicate group process. In therapy groups, if there is no therapeutic advantage in clarifying group process, we see no reason to do so. In training groups, there is always the superordinate goal of education.

Often process commentary combined with a view from the leader’s seat is particularly useful. For example:

> **Let me tell you what I (IY) felt today as a group leader. A half hour** ago I felt uncomfortable with the massive encouragement and support everyone was giving Tom. This has happened before, and though it was reassuring, I haven’t felt it was really helpful to Tom. I was tempted to intervene by inquiring about Tom’s tendency to pull this behavior from the group, but I chose not to—partly because I’ve gotten so much flak lately for being nonsupportive. So, I remained silent. I think I made the right choice, since it seems to me that the meeting developed into a

very productive one, with some of you getting deeply into your feelings of needing care and support. How do the rest of you see what's happened today? **<<**

In a particularly helpful essay, Mark Aveline, an experienced leader of training groups, suggests that the leader has five main tasks:

1. Containment of anxiety through exploration of sources of anxiety in the group and provision of anxiety-relieving group structure
2. Establishment of a therapeutic atmosphere in the group by shaping norms of support, acceptance, and group autonomy
3. Establishing appropriate goals that can be addressed in the time available
4. Moderating the pace so that the group moves neither too fast nor too slowly, so that members do not engage in forced or damaging self-disclosure
5. Ending well[45]

PERSONAL PSYCHOTHERAPY

A training group rarely suffices to provide all the personal self-exploration a student therapist requires. Few would dispute that personal psychotherapy is necessary for the maturation of the group therapist, and the field at large has long considered personal therapy an indispensable element of personal and professional development. The role of personal psychotherapy for psychotherapists has spawned many studies and surveys.[46]

A large, early survey of 318 practicing psychologists indicated that 70 percent had entered therapy during their training—often more than one type of therapy: 63 percent in individual therapy (mean = 100 hours); 24 percent in group therapy (mean = 76 hours); 36 percent in couples therapy (mean = 37 hours). What factors influenced the decision to enter therapy? Psychologists were more likely to engage in therapy if they had an earlier therapy experience in their training, if they were dynamically oriented in their practice, and if their practice involved significant amounts of psychotherapy.[47] In another survey, over half of psychotherapists entered personal psychotherapy after their training, and over 90 percent reported considerable personal and professional benefit from the experience.[48]

What about more recent studies? A national survey of 600 nonmedical psychotherapists reported that 85 percent engaged in personal psychotherapy and 90 percent of those who did reported benefits. Top motivations for treatment were relationship distress, depression, pursuit of self-understanding, and dealing with stress or anxiety. Enduring lessons that emerged from personal therapy included the importance of therapist reliability, skill, and empathy. These are the hallmarks of good psychotherapy.

Surveys of psychiatry residents provide another perspective.[49] A survey of 400 Canadian psychiatry residents reported that 43 percent pursued therapy while in training. They were motivated by

the desire for personal growth, self-understanding, and professional development; one-third sought care because of mental health concerns. The personal and professional impacts were very positive. A comparable US study showed a lower and declining participation rate of 26.5 percent. Here, too, the motivations were a mix of personal need and professional development. Program directors are largely supportive and encouraging of their residents pursuing psychotherapy, but time and cost persist as barriers to access.[50]

The survey methodology can only inform us of so much due to variable response rates, yet consistent findings emerge: Respondents have great interest in personal therapy and report clear benefit from their therapy. Without doubt, the training environment influences the pursuit of personal therapy among trainees, and more should be done to facilitate that pursuit. It is a grave concern that American psychiatrists today are so much less likely to pursue personal therapy than was the case for the prior generation.[51]

We both consider our personal psychotherapy experiences during our residencies to be an important part of our training as therapists. Moreover, in later years, I (IY) reentered therapy with therapists of various persuasions, including Gestalt, behavioral, and existential. We urge every student entering the field not only to seek out personal therapy but to do so more than once during their careers—different life stages evoke different issues to be explored. The emergence of personal discomfort is an opportunity for greater self-exploration that will ultimately make us better therapists.[52]

Both the challenge and the richness of our work lies in our ability to use ourselves as therapeutic agents. Our tools are largely our models and ourselves. Our self-knowledge plays an instrumental role in every aspect of therapy. An inability to perceive our countertransference responses, to recognize our personal distortions and blind spots, or to use our own feelings and fantasies in our work will severely limit our effectiveness.

If you lack insight into your own motivations, you may, for example, avoid conflict in the group because of your proclivity to mute your feelings; or you may unduly encourage confrontation in a

search for aliveness in yourself. You may be overeager to prove yourself or to make consistently brilliant interpretations, and thereby disempower the group. You may fear intimacy and prevent open expression of feelings by offering premature interpretations—or do the opposite: overemphasize feelings, make too few explanatory comments, and overstimulate clients, so that they are left in agitated turmoil. You may so need acceptance that you are unable to challenge the group and, like the members, get swept along by the prevailing group current. You may be so devastated by an attack on yourself and so unclear about your presentation of self as to be unable to distinguish the realistic from the transference aspects of the attack.

There is another excellent reason to recommend personal therapy for all psychotherapists. It is an excellent resource for maintaining wellness and reducing the risk of burnout.[53]

Several training programs have historically encouraged their candidates to participate as bona fide members in a therapy group led by a senior clinician and composed of nonprofessionals seeking personal therapy.[54] Advocates of such programs point out the many advantages to being a real member of a therapy group. There is less sibling rivalry than in a group of one's peers, less need to perform, less defensiveness, and less concern about being judged.

Experience as a full member of a bona fide therapy group is invaluable, and we encourage all trainees to seek such therapy. Unfortunately, the right group can be hard to find. Advocates of personal group therapy for trainees hail from large metropolitan areas (New York, London, Toronto, Geneva). But in smaller urban areas, the availability of personal group therapy is limited. There are simply not enough groups that meet the proper criteria—that is, an ongoing, high-functioning group led by a senior clinician with an eclectic dynamic approach (who, incidentally, is neither a personal nor a professional associate of the trainee).

The use of online groups (see Chapter 14) creates new opportunities for therapists and trainees to join and participate regardless of their location. The online format adds insulation that

allows therapists to feel less professionally exposed to colleagues in their local community. The growth of good, reliable, HIPAA-compliant VTC platforms will foster much greater use of this format.

There is one other method of obtaining both group therapy training and personal psychotherapy. For several years, I (IY) led a therapy group for practicing psychotherapists. In fact, for one year, this was a group that we led as co-therapists during ML's fellowship at Stanford University. It was a straightforward therapy group, not a training group. Admission to the group was predicated on the need and the wish for personal therapy, and members were charged standard therapy group fees. Naturally, in the course of their therapy, the members—most but not all of whom are also group therapists—learn a great deal about the group therapy process.

SUMMARY

The training experiences we have described—observation of an experienced clinician, clinical supervision in group therapy, experiential group participation, and personal therapy—constitute, in our view, the minimum essential components of a program to train group therapists. These build atop a comprehensive education in the theory and underpinnings of group therapy. We recommend that observation, personal therapy, and the experiential group begin very early in the training program, to be followed in a few months by the formation of a group and ongoing supervision. We feel it is wise for trainees to have a clinical experience in which they deal with basic group and interactional dynamics in traditional group therapy before they begin to work with goal-limited groups of highly specialized client populations or with one of the new specialized therapy approaches.

Training is, of course, a lifelong process. Every discipline sets expectations for continuing professional development. We feel strongly that this should not be a perfunctory undertaking, but should reflect a deep commitment to deliberate practice. It is important as well that clinicians maintain contact with colleagues, either informally or through professional organizations such as the American Group Psychotherapy Association (AGPA) or the Association for Specialists in Group Work. For growth to continue, ongoing input is required. Many formats for continued education exist, including reading, working with different co-therapists, teaching, participating in professional workshops, webinars, and having informal discussions with colleagues. Postgraduate personal group experiences are a regenerative process for many. The AGPA offers two-day experiential groups led by highly experienced group leaders at its annual institute, which regularly precedes its annual meeting. Follow-up surveys attest to the value—both professional and personal—of these groups.[55] Many of the AGPA's local affiliate societies offer similar opportunities.

Another format is for practicing therapists to form leaderless support groups. Though, until recently, there has been little in the literature on support groups of mental health professionals, I (IY) can personally attest to their value. For over thirty years I have benefited enormously from membership in a group of ten therapists of my own age and level of experience that meets for ninety minutes every other week. As time went by, several members of the group aged and died, and new members were introduced into the group. Currently, I am the oldest member. Our group has evolved a clear consensus of expectations, goals, and norms to ensure that we stay on track and address our personal issues and our own group process.[56] I have greatly benefited from the work of this group, and I recommend such a group to all mental health practitioners.

BEYOND TECHNIQUE

The group therapy training program has the task of teaching students not only *how to do* but also *how to learn*. What clinical educators must not convey is a rigid certainty in either our techniques or our underlying assumptions about therapeutic change; the field is far too complex and pluralistic for disciples of unwavering faith. To this end, we believe it is most important that we teach and model a basic research orientation to this work—meaning an open, self-critical, inquiring attitude toward clinical and research evidence. As we have noted earlier, experience alone does not confer effectiveness. Rather, it is what we do with that experience that influences our professional growth.

Recent developments in psychotherapy research underscore this principle. We can all be evidence-based group therapists regardless of our theoretical models. Ultimately, it is the therapist more than the model that produces benefits. We believe the effective therapist is characterized by these key elements: the ability to form strong therapeutic relationships across a range of clients; strong interpersonal skills; professional humility and self-reflection; and a dedication to learning and refining one's craft.[57]

Appendix

SAMPLE:

Group Therapy Information and Guidelines for Clients

Your group will begin on: _____
The location of the group is: _____
Your group therapists are: _____ and _____
We can be reached at: _____

THIS HANDOUT OUTLINES WHAT TO EXPECT AND HOW TO GET the most from your group therapy experience.

YOU ARE MAKING A VERY GOOD DECISION IN BEGINNING GROUP therapy. Group therapy has a long, proven record as a highly effective psychotherapy. Most clients find group therapy as helpful as individual therapy. For some it may even be more effective, particularly when social support and learning about interpersonal relationships are important objectives of treatment. The vast majority of individuals who participate in group therapy benefit from it substantially. Although group therapy is generally highly supportive, you may find it challenging at times.

SOME GOALS OF GROUP PSYCHOTHERAPY

Many individuals seeking group therapy feel isolated and dissatisfied in their life situation. They may have difficulties establishing and maintaining close, mutually gratifying, and meaningful relationships with others. Frequently they are interested in learning more about how they relate to others.

Group therapy offers an opportunity to:

- Receive and offer support and feedback
- Improve interpersonal relationships and communication
- Experiment with new interpersonal behaviors
- Talk honestly and directly about feelings
- Gain insight and understanding into one's thoughts, feelings, and behaviors by looking at relationship patterns both inside and outside the group
- Gain understanding of the thoughts, feelings, and behaviors of others
- Improve self-confidence, self-image, and self-esteem
- Start a process of personal change inside the group which can be carried into one's outside life

CONFIDENTIALITY

Everything we discuss in group psychotherapy must be treated with the utmost respect and confidentiality. It is an essential part of creating a safe, reliable therapeutic experience.

Therapists

Group therapists pledge to maintain complete confidentiality except in one situation: when there is an immediate risk of serious harm to a group member or to someone else. Confidentiality is a central aspect of ethical professional conduct.

If you are in concurrent treatment with another therapist, we request your permission to communicate with your individual therapist at regular intervals. Your therapists are your allies, and it is important for your therapy that they communicate with one another.

Group Members

Confidentiality is similarly expected of all group members. This commitment is essential to develop trust within the group. Most individuals in therapy prefer to keep the therapy a private place and refrain from any discussions about it with others. If, however, in discussions with friends or family, you wish at some point to refer to your group therapy, you should speak only about your own experience, not about any other member's experience. Never mention any other member's name or say anything that might inadvertently identify any group member.

WHAT DO YOU DO IN THE GROUP? HOW ARE YOU EXPECTED TO BEHAVE?

There is no prescribed agenda for each session. Participants are encouraged to talk about any personal or relationship issues relevant to the problems and goals that led them to therapy.

Participants are encouraged to offer support, to ask questions, to wonder about things said or not said, and to share associations and thoughts. Much emphasis will be placed on examining the relationships between members in the “here-and-now.” Members will often be asked to share their impressions of one another—their thoughts, fears, and positive feelings. The more we work in the here-and-now of the group, the more effective we will be.

Disclosure about oneself is necessary for one to profit from group therapy, but members should choose to disclose at their own pace.

In order to construct a therapeutic group environment, we ask that members always try to say things to other members in a way that is constructive. Helpful feedback focuses on what is happening in the here-and-now. This kind of direct feedback and engagement is novel: rarely in our culture do individuals speak so honestly and directly. Though it may feel risky at first, it will likely also feel deeply engaging and meaningful.

Direct advice-giving from group members and therapists is not generally useful. Neither are general discussions of such topics as sports or politics helpful unless there is something about a current event that has particular relevance to one’s personal or interpersonal issues.

Although you are likely to develop strong connections to group members, the therapy group is not a place to make friends. Think of it as a social laboratory—a place in which you acquire the skills to develop meaningful and satisfying relationships. In fact, therapy groups (unlike support or social groups) do not encourage social contact with other members outside the group. An outside relationship with another member or members generally impedes

therapy!

Your primary task in the therapy group is to explore fully your relationships with each and every member of the group. At first, that may seem puzzling or unrelated to the reasons you sought therapy. But it begins to make sense when you consider the fact that the group is a social microcosm—that is, the problems you experience in your social life will invariably emerge in your relationships *within* the group. Therefore, by exploring and understanding all aspects of your relationships with other members and then transferring this knowledge to your outside life you begin the process of developing more satisfying relationships.

If, however, you develop a close relationship with another member (or members) outside the group, you may be reluctant to share all your feelings about that relationship *within* the group. Why? Because that friendship may mean so much that you may be reluctant to say anything that might jeopardize it in any way. When openness and honesty are compromised, therapy grinds to a halt!

Therefore, it is best that members who meet outside the group (by chance or design) or have online contact share all relevant information about that with the group. Any type of secrecy about relationships slows down the work of therapy. At times members develop strong feelings toward other members. We encourage members to discuss these feelings, whether they are positive feelings or negative ones such as irritation or disappointment. Throughout, group members are expected to talk about feelings without acting on their feelings.

GROUP THERAPISTS

Your group therapists are not going to “run the show.” They will act more as participants/facilitators than as instructors. Therapy is most productive when it is a collaborative and shared enterprise. Keep in mind that the input from other members is often as important as—or even more important than—the therapists’ comments. The therapists may make observations about group interactions and behavior or about what particular individuals say or do in the group. They might also comment on progress or obstructions within the group.

When you have something to say to the group therapists, we hope that, as much as possible, you do so in the group sessions. However, if there is something urgent you must discuss with the group therapists outside of group, between sessions, this can be arranged. In such cases, it is useful to bring that back to the next group meeting. Even relevant material from your individual or couples’ therapy with another therapist should be shared. We hope there will be no issue you cannot talk about within the group. At the same time, we recognize that trust develops only over time and that some personal disclosures will be made only when you feel sufficiently safe in the group.

INITIAL LENGTH OF TRIAL PERIOD OR COMMITMENT

Group therapy does not generally show immediate positive benefit to its participants. Because of this fact, participants sometimes find themselves wanting to leave therapy early on if it becomes stressful for them. We ask that you suspend your early judgment of the group's possible benefits and continue to attend and to talk about the stresses involved and your doubts about group therapy.

We ask that you make an initial commitment to attend and participate in your therapy group for at least twelve sessions. By then you will have a clearer sense of the potential helpfulness of the group.

ATTENDANCE AND GROUP COHESION

The group works most effectively if the group is cohesive, reliable, and predictable. Regular attendance is a key part of that, so we request that you make it a priority in your schedule. Regular attendance and active participation in the meetings are important ways to demonstrate respect for and value the work of each member. Similarly, it is important to arrive on time to each session. If you know you are going to be late or absent, we ask that you notify the group therapists ahead of time as soon as possible so that they can let the group know at the beginning of the session.

We ask that you also inform the group of your vacation plans well ahead of time, if possible. The group therapists will do the same.

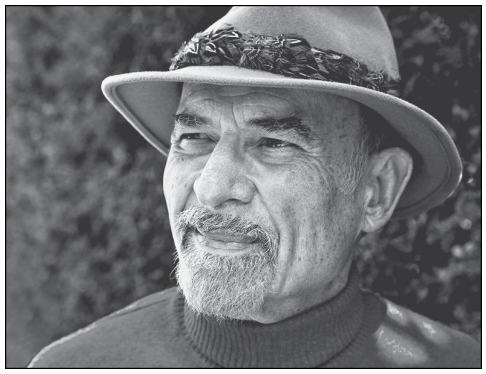
There may be times when the group is the last place you want to be because of the uncomfortable feelings it may bring up. In our experience these times may in fact be unusually productive opportunities to do the work of psychotherapy. In the same vein, you can anticipate that some of the difficulties that you have experienced in your life will express themselves in the group. Don’t be discouraged by this. It is in fact a great opportunity, because it means that you and the group members are tackling the important issues that concern you.

You have decided to begin a process of giving and receiving support and working toward needed changes in your personal and interpersonal life. We look forward to the opportunity of working together with you in this group.

ONLINE GROUPS

If your group will be meeting online, please take additional note of the following guidelines:

- Your group will be using a secure and private online platform for video-teleconferencing.
- It is important to note that even the most secure online platforms are vulnerable to privacy breaches.
- By attending the group you are consenting to participation in this format.
- Every precaution will be taken to ensure your and the group's confidentiality and privacy. We ask that you attend the group from a private location; use only your first name for identification; ensure access to WiFi or data that will support video-teleconferencing; and provide a phone number where you can be reached in the event that the WiFi fails or you need to be reached in an emergency.



CREDIT: REID YALOM

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Notes

CHAPTER 1: THE THERAPEUTIC FACTORS

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CHAPTER 2: INTERPERSONAL LEARNING

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informs the group leader about clients' actual and potential maladaptive transactions in therapy. Moreover, this information can be used to help group therapists maintain a therapeutic perspective in the presence of the strong interpersonal pulls affecting others or themselves. Once therapists recognize the interpersonal impact of each client's behavior, they can more readily understand their own countertransference, and ultimately they can provide more accurate and useful feedback.

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CHAPTER 3: GROUP COHESIVENESS

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1. How often do you think your group should meet?
2. How well do you like the group you are in?
3. If most of the members of your group decided to dissolve the group by leaving, would you like an opportunity to dissuade them?
4. Do you feel that working with the group you are in will enable you to attain most of your goals in therapy?
5. If you could replace members of your group with other ideal group members, how many would you exchange (exclusive of group therapists)?
6. To what degree do you feel that you are included by the group in the group’s activities?
7. How do you feel about your participation in, and contribution to, the group work?
8. What do you feel about the length of the group meeting?
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CHAPTER 4: THE THERAPEUTIC FACTORS: AN INTEGRATION

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5. An alternative method of assessing therapeutic factors is the “critical incident” approach used by my colleagues and me in a large encounter group study. (M. Lieberman, I. Yalom, and M. Miles, *Encounter Groups: First Facts* [New York: Basic Books, 1973]) and by Bloch and Crouch (*Therapeutic Factors in Group Psychotherapy*). In this method, clients are asked to recall the most critical event of the therapy session, and the responses are then coded by trained raters into appropriate categories. The following are examples of studies using critical incident methodology: S. Bloch and J. Reibstein, “Perceptions by Patients and Therapists of Therapeutic Factors in Group Psychotherapy,” *British Journal of Psychiatry* 137 (1980): 274–78. D. Kivlighan and D. Mullison, “Participants’ Perception of Therapeutic Factors in Group Counseling: The Role of Interpersonal Style and Stage of Group Development,” *Small Group Behavior* 19 (1988): 452–68. D. Kivlighan and D. Goldfine, “Endorsement of Therapeutic Factors as a Function of Stage of Group Development and Participant Interpersonal Attitudes,” *Journal of Counseling Psychology* 38 (1991): 150–58. G. Mushet, G. Whalan, and R. Power, “In-patients’ Views of the Helpful Aspects of Group Psychotherapy: Impact of Therapeutic Style and Treatment Setting,” *British Journal of Medical Psychology* 62 (1989): 135–41. Mörtl and Von Wietersheim, “Client Experiences of Helpful Factors.” M. Fontao and E. Mergenthaler, “Therapeutic Factors and Language Patterns in Group Therapy Application of Computer-Assisted Text Analysis to the Examination of Microprocesses in Group Therapy: Preliminary Findings,” *Psychotherapy Research* 18 (2008): 345–54. K. Lese and R. McNair-Semands, “The Therapeutic Factor Inventory: Development of a Scale,” *Group* 24 (2000): 303–17.

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11. K. Lese and R. McNair-Semands, “The Therapeutic Factors Inventory: Development of a Scale,” *Group* 24 (2000): 303–17. I. Yalom, J. Tinklenberg, and M. Gilula, “Curative Factors in Group Therapy,” unpublished study, Department of Psychiatry, Stanford University, 1968.

12. Spurred by the large data pool of the NIMH Treatment of Depression Collaborative Research Program, individual psychotherapy researchers have used a method similar to the Q-sort discussed in detail in this chapter: they developed a one-hundred-item scale, the Psychotherapy Process Q Set (PQS), which is completed by trained raters evaluating session recordings at sessions 4 and 12 of a sixteen-session treatment. The PQS evaluates the therapy, therapist, and therapy relationship on a range of process criteria. Analysis of the one hundred items produces a core of therapeutic factors. Successful therapies, including interpersonal therapy and cognitive-behavioral therapy, were similar in that both treatments created a relationship in which clients developed a positive sense of self and very strong positive regard for their therapist. J. Ablon and E. Jones, “Psychotherapy Process in the National Institute of Mental Health Treatment of Depression Collaborative Research Program,” *Journal of Consulting and Clinical Psychology* 67 (1999): 64–75. Lese and McNair-Semands (“Therapeutic Factors Inventory”) developed the group therapy Therapeutic Factors Inventory (TFI), a self-report instrument. The TFI, which builds on the original therapeutic factor Q-sort, demonstrates promise as a research tool with empirically acceptable levels of internal consistency and test-retest reliability. Subsequent research has worked to refine the TFI into a smaller number of higher-order therapeutic factors. G. Tasca, C. Cabrera, E. Kristjansson, R. MacNair-Semands, A. Joyce, and J. Ogrodniczuk, “The

Therapeutic Factor Inventory-8: Using Item Response Theory to Create a Brief Scale for Continuous Process Monitoring for Group Psychotherapy," *Psychotherapy Research* 26 (2016): 131–45.

13. Yalom et al., "Curative Factors in Group Therapy."

14. There were four checks to ensure that our sample was a successfully treated one: (1) the therapists' evaluation; (2) the length of treatment (previous research in the same clinic demonstrated that group members who remained in therapy for that length of time had an extremely high rate of improvement [I. Yalom et al., "Prediction of Improvement in Group Therapy," *Archives of General Psychiatry* 17 (1967): 158–68]); (3) the investigators' independent interview ratings of improvement on a thirteen-point scale in four areas: symptoms, functioning, interpersonal relationships, and self-concept; and (4) the members' self-rating on the same scale.

15. The number in each of the seven piles thus approaches a normal distribution curve and facilitates statistical assessment. For more about the Q-sort technique, see J. Block, *The Q-Sort Method in Personality Assessment and Psychiatric Research* (Springfield, IL: Charles C. Thomas, 1961). S. Freedman and J. Hurley, "Perceptions of Helpfulness and Behavior in Groups," *Group* 4 (1980): 51–58. M. Rohrbaugh and B. Bartels, "Participants' Perceptions of 'Curative Factors' in Therapy and Growth Groups," *Small Group Behavior* 6 (1975): 430–56. B. Corder, L. Whiteside, and T. Haizlip, "A Study of Curative Factors in Group Psychotherapy with Adolescents," *International Journal of Group Psychotherapy* 31 (1981): 345–54. D. Kivlighan, J. Miles, and J. Paquin, "TFs in Group Counselling: Asking New Questions," in Conyne, *Oxford Handbook of Group Counselling*, 121–36. D. Kivlighan and S. Holmes, "The Importance of Therapeutic Factors: A Typology of Therapeutic Factors Studies," in *Handbook of Group Counseling and Psychotherapy*, ed. J. DeLucia-Waack, D. Gerrity, C. Kalodner, and M. Riva (Thousand Oaks, CA: Sage Publications, 2004), 23–36. M. Stone, C. Lewis, and A. Beck, "The Structure of Yalom's Curative Factor Scale," presented at the American Psychological Association Convention, Washington, DC, 1992. Tasca et al. ("Therapeutic Factor Inventory-8") evaluated 621 clients' responses to the Therapeutic Factor Inventory and used item response theory to shrink the number of therapeutic factors and reduce the impact of social desirability on clients' responses. Their work realigns the therapeutic factors into four overarching ones in an effort to construct a higher order understanding of therapeutic mechanisms. These are: social learning, secure emotional expression, instillation of hope, and awareness of relational impact. This classification shows good internal consistency and predictive value re outcome. L. Greene, S. Barlow, and F. Kaklauskas, "Therapeutic Factors," in *Core Principles of Group Psychotherapy: An Integrated Theory, Research, and Practice Training Manual*, ed. F. Kaklauskas and L. Greene (New York: Routledge, 2019), 56–70. A. Joyce, G. Tasca, R. MacNair-Semands, and J. Ogrodniczuk, "Factor Structure and Validity of the Therapeutic Factors Inventory-Short Form," *Group Dynamics Theory Research and Practice* 15 (2011): 201–19.

16. Freedman and Hurley ("Perceptions of Helpfulness") studied twenty-eight subjects in three fifty-hour sensitivity-training groups. Seven of the ten items selected as most helpful by these subjects were among the ten I listed. The subjects in Freedman and Hurley's study placed three new items (21, 23, and 24 in table 4.1) into the top ten. These items are all interpersonal output items, and it is entirely consistent that members of a sensitivity group that explicitly focused on modifying interpersonal behavior should value these items. B. Corder, L. Whiteside, and T. Haizlip ("A Study of Curative Factors in Group Psychotherapy") studied sixteen adolescents from four different groups in different clinical settings, both

outpatient and inpatient. The youths did not highly value the adults' top-ranked item (insight), but their next four highest items were identical to those the adults had chosen. Overall, they valued the therapeutic factors of universality and cohesiveness more highly than the adults did. R. Marcovitz and J. Smith ("Patients' Perceptions of Curative Factors in Short-Term Group Psychotherapy," *International Journal of Group Psychotherapy* 33 [1983]: 21–37) studied thirty high-functioning inpatients who attended group psychotherapy in a psychiatric hospital. Only three of the top ten items in their study corresponded to our results, but their method was different: they asked patients to rate items from 1 to 60, rather than using the Q-sort technique of sorting into piles from most helpful to least helpful. Their subjects' top selected item was item 60 (*Ultimately taking responsibility for my own life*). When condensed into the rankings of overall therapeutic factors, their results were quite similar to ours, with five of the top six factors the same; their subjects ranked altruism third, notably higher than the outpatient sample did. Rohrbaugh and Bartels ("Participants' Perceptions of 'Curative Factors'") studied seventy-two individuals in both psychiatric settings and growth groups. Their results were also consistent with our original Q-sort study: interpersonal learning (both input and output), catharsis, cohesiveness, and insight were the most valued factors, and guidance, family reenactment, and identification were least valued.

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findings of these projects are consistent with the studies of the therapeutic factor in the abbreviated Q-sort.

18. Lieberman, Yalom, and Miles, *Encounter Groups*. Freedman and Hurley, “Perceptions of Helpfulness.” Kivlighan and Goldfine, “Endorsement of Therapeutic Factors.”

19. MacKenzie, “Therapeutic Factors in Group Psychotherapy.”

20. P. Dierick and G. Lietaer, “Client Perception of Therapeutic Factors in Group Psychotherapy and Growth Groups: An Empirically-Based Hierarchical Model,” *International Journal of Group Psychotherapy* 58 (2008): 203–30.

21. Greene et al., “Therapeutic Factors.” S. Barlow, *Specialty Competencies in Group Psychology* (New York: Oxford University Press, 2013). Stone et al., “Structure of Yalom’s Curative Factor Scale.” J. Krogel et al., “The Group Questionnaire: A Clinical and Empirically Derived Measure of Group Relationship,” *Psychotherapy Research* 23 (2013): 344–54. We can see in many of these therapeutic factor models the three domains captured by the Group Questionnaire—Positive Bond, Negative Relationship, and Positive Work.

22. S. Holmes and D. Kivlighan, “Comparison of Therapeutic Factors in Group and Individual Treatment Process,” *Journal of Counseling Psychology* 47 (2000): 478–84. Bridges, “Activating the Corrective Emotional Experience.” D. Kivlighan, “Three Important Clinical Processes in Individual and Group Interpersonal Psychotherapy Sessions,” *Psychotherapy (Chic)* 51 (2014): 20–24.

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25. A. Pascual-Leone and N. Yeryomenko, “The Client ‘Experiencing’ Scale as a Predictor of Treatment Outcomes: A Meta-Analysis on Psychotherapy Process,” *Psychotherapy Research* 27 (2017): 653–65. H. Levitt, A. Pomerville, and I. Surace, “A Qualitative Meta-Analysis Examining Clients’ Experiences of Psychotherapy: A New Agenda,” *Psychological Bulletin* 142 (2016): 801–30.

26. Freedman and Hurley, “Perceptions of Helpfulness.”

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33. Rohrbaugh and Bartels, “Participants’ Perceptions of ‘Curative Factors.’”

34. J. Flowers and C. Booraem, “The Frequency and Effect on Outcome of Different

Types of Interpretation in Psychodynamic and Cognitive-Behavioral Group Psychotherapy," *International Journal of Group Psychotherapy* 40 (990): 203–14. L. Johansson and A. Werbart, "Patients' Views of Therapeutic Action in Psychoanalytic Group Psychotherapy," *Group Analysis* 42 (2009): 120–42.

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39. Maslow, "Need to Know."

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52. Randall, "Curative Factor Ratings."

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1. Acceptance (group cohesiveness)
2. Universalization (universality)
3. Reality testing (includes elements of recapitulation of the priMona family and of interpersonal learning)
4. Altruism
5. Transference (includes elements of interpersonal learning, group cohesiveness, and imitative behavior)
6. Spectator therapy (imitative behavior)
7. Interaction (includes elements of interpersonal learning and cohesiveness)
8. Intellectualization (includes elements of imparting information)
9. Ventilation (catharsis)

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1. The precontemplation stage (no recognition that a problem exists)
2. The contemplation stage (some recognition of the problem but with ambivalence about doing something about it)
3. The preparation stage (a desire to change but a lack of knowledge about how to do so)
4. The action stage (actual behavioral shifts)
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CHAPTER 7: THE THERAPIST: TRANSFERENCE AND TRANSPARENCY

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CHAPTER 8: SELECTING CLIENTS AND COMPOSING GROUPS

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psychologically minded than continuers. They also tended to have greater psychiatric symptomatology and greater intensity of target symptoms. McCallum et al., “Dropping Out from Short-Term Group Therapy.” A study of Veterans Administration ambulatory groups found that dropouts had less capacity to withstand stress, less desire for empathy, less ability to achieve emotional rapport, and a lower Wechsler verbal scale IQ and came from a lower socioeconomic class. Rosenzweig and Folman, “Patient and Therapist Variables.” Many other studies have reported that dropouts (from any psychotherapeutic format) are disproportionately high among the lower socioeconomic class. R. Klein and R. Carroll, “Patient Characteristics and Attendance Patterns in Outpatient Group Psychotherapy,” *International Journal of Group Psychotherapy* 36, no. 1 (1986): 115–132. H. Roback and M. Smith, “Patient Attrition in Dynamically Oriented Treatment Groups,” *American Journal of Psychiatry* 144 (1987): 426–43. Grotjahn studied his long-term analytic groups and noted that, over a six-year period, 43 group members (35 percent) dropped out within the first 12 months of therapy. He felt that, in retrospect, approximately 40 percent of the dropouts were predictable. They fell into three categories: (1) clients with diagnoses of manifest or threatening psychotic breakdowns; (2) clients who used the group for crisis resolution and dropped out when the emergency had passed; (3) highly schizoid, sensitive, isolated individuals who needed more careful, intensive preparation for group therapy. Grotjahn, “Learning from Dropout Patients.” Nash and his coworkers studied 30 group therapy clients in a university outpatient clinic. The 17 dropouts (three or fewer meetings) differed significantly from the 13 continuers in several respects: they were more socially ineffective, experienced their illness as progressive and urgent, or were high deniers who terminated therapy as their denial crumbled in the face of confrontation by the group. Nash et al., “Some Factors.” MacNair and colleagues also studied two large groupings of clients treated at a university counseling service in 16-session interactional interpersonal group therapy. This study of 155 and 310 clients, respectively, over several years employed the Group Therapy Questionnaire (GTQ) to evaluate the group members. Dropouts and poor attenders could be predicted by the following characteristics: anger, hostility and argumentativeness, social inhibition, substance abuse, and somatization. MacNair and Corazzini, “Clinical Factors Influencing Group Therapy Dropout.” In contrast, prior experience in some form of psychotherapy was a protective variable. MacNair-Semands, “Predicting Attendance and Expectations.” This latter finding echoes an earlier report that demonstrated that dropouts were much more likely to be individuals who were in group therapy for their first time. Stone and Rutan, “Duration of Treatment.” Tasca and colleagues studied 102 clients in an intensive group therapy day hospital program and reported that dropouts were predicted by the combined presence of reduced psychological-mindedness and chronicity of problems. High degrees of psychological-mindedness offset the negative impact of illness chronicity on treatment completion. G. Tasca et al., “Treatment Completion and Outcome in a Partial Hospitalization Program: Interaction Among Patient Variables,” *Psychotherapy Research* 9 (1999): 232–47. Dropout rates for 139 clients participating in 12-session group therapy for complicated grief were 23 percent (regardless of whether they were in an interpretive or a supportive model of group therapy). Dropouts experienced far less positive emotion in the early sessions and were less compatible with, and less important to, the group. The therapists reported that they had less emotional investment in these clients from the outset of therapy. McCallum et al., “Early Process and Dropping Out.” The phenomenon of very early therapist divestment and antipathy to the clients who ultimately drop out has been reported by others as well. L. Lothstein, “The Group Psychotherapy Dropout Phenomenon Revisited,” *American Journal of Psychiatry* 135 (1978): 1492–95. O. Stiwne, “Group

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CHAPTER 9: CREATING THE GROUP

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CHAPTER 10: IN THE BEGINNING

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CHAPTER 11: THE ADVANCED GROUP

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CHAPTER 12: THE CHALLENGING GROUP MEMBER

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CHAPTER 13: SPECIALIZED FORMATS AND PROCEDURAL AIDS

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CHAPTER 14: ONLINE PSYCHOTHERAPY GROUPS

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17. In the following discussion, we draw heavily from I. Yalom, *Inpatient Group Psychotherapy* (New York: Basic Books, 1983), where interested readers may find more in-depth discussion. Although this model was developed for the inpatient ward, it has been modified and adapted to many other settings, including partial hospitalization groups and intensive two- to three-week programs for substance abusers. (In Chapter 9, we discuss a particularly common major group therapy modification, the time-limited, brief, closed therapy group.) See also Bernard et al., "Clinical Practice Guidelines"; Leszcz and Kobos, "Evidence-Based Group Psychotherapy"; E. Hopper and H. Weinberg, eds., *The Social Unconscious in Persons, Groups, and Societies*, vol. 1, *Mainly Theory* (London: Karnac Books, 2011).

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CHAPTER 16: TRAINING THE GROUP THERAPIST

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