Psychotherapeutic Change through the Group Process

Dorothy Stock Whitaker
& Morton A. Lieberman

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Preface

This book presents a theory about the relation between the properties of groups and therapeutic change. Our purpose is to develop a view of groups which accounts for the diversity, complexity, and fluidity of the group situation—a view which examines the group in depth, attending not only to overt events, but also to covert aspects of the situation; not only to manifest behaviors, but to underlying motivations; not only to the cognitive, rational aspects of the group, but to the intense affect which may be generated under conditions of group interaction; not merely to the group or merely to the individual, but to the individual *in* the group and to the group as the context for personal experience and change. We address ourselves to both the theoretician and the practitioner. To the theoretician we suggest a way of looking at groups which, although developed with reference to therapy groups, has relevance for other types of groups. To the practicing group therapist we suggest that the group forces are a potent element in determining the nature of the patient's therapeutic experience, that the group can work for good or ill, and that the therapist who is in touch with group forces is in an optimal position to utilize the group situation for maximum therapeutic benefit.

We shall proceed by presenting and discussing a series of propositions about the functioning of the group and its meaning for the therapeutic process and the therapist's role. Clinical examples have been selected which most adequately and succinctly clarify successive propositions.

Though this book is not a report of research, much of the thinking presented here was initially explored in research studies. Separate investigations considered the ways in which patients and therapists viewed group events, the nature of deviation, and the development of group standards; factors associated with therapeutic improvement and therapeutic failure; and characteristic concerns of early sessions. These, plus several discussions of theory and methodology, have been published separately.

Our working procedure has been to study intensively a relatively small number of groups, depending upon careful observation of natural groups rather than upon laboratory experimentation. That is, we have chosen to undertake detailed, microscopic analyses rather than large-scale data collection; we have studied natural groups which existed for a relatively long time rather than short-term groups especially set up under laboratory conditions. Our over-all attempt has been to understand the processes of therapy groups in all their clinical richness and intricacy and yet to impose a scientific discipline and control on our analyses. This has meant a continuing attempt to develop appropriate analytic procedures so that clinical analyses can be as firmly rooted as possible in concrete data and reproducible methods.

Our investigations of therapy groups have been conducted in two settings: the Veterans Administration Research Hospital in Chicago and the Department of Psychiatry at The University of Chicago. From 1955 to 1957, while at the Veterans Administration Hospital, we concentrated on short-term groups of hospitalized veterans. Most typically, these patients were suffering from acute states of anxiety or crippling character problems. A certain number were recovering from schizophrenic episodes, but only a few were frankly psychotic. With the move to The University of Chicago in 1957, it became possible to study both adolescent and adult long-term outpatient groups. One of these, a group of late-adolescent patients, was studied intensively throughout its eighty-seven–session life. Excluded from our study are groups composed of patients with specialized problems such as alcoholism, narcotics addiction, or delinquency. In addition to the groups which we conducted, we had the opportunity to observe or study a number of groups conducted by colleagues. This has made it possible for us to become

familiar with a broad range of therapeutic styles and theoretical positions.

Prior to the studies on therapy groups, which began in 1955, we both participated in a series of investigations on non-therapy (task and training) groups, under the general direction of Herbert A. Thelen. A continuing association with the National Training Laboratories has provided invaluable experience with non-therapeutic groups. Such experiences have helped us to place our work in context and to test the applicability of our thinking about therapy groups to other types of groups.

The work of W. R. Bion and the work of Thomas French have been most important in influencing our thinking about groups. Bion's series of papers, "Experiences in Groups," suggested ways of conceptualizing group events in terms of shared covert needs and motivations and emphasized the importance of both cognitive and emotional aspects of group functioning.[1] French's concept of the "focal conflict," developed for application to individual psychoanalytic sessions and dreams, suggested a theoretical approach to groups which could do justice to the varied aspects of the situation and yet organize and conceptualize group events in concise terms.[2] The approach originally inspired by French has been extended and developed in some detail and now forms the core of our view of the group psychological process.

Among those who have personally participated in and contributed to this work, we wish to mention first Prof. Herbert A. Thelen, who introduced us to the study of small-group interaction. It was in his laboratory that we participated in a number of studies of small task and training groups, struggling with problems of research design and methodology and attempting to understand the individual in terms of the group and the group in terms of the individual. Dr. Roy M. Whitman played a major role by introducing us to therapeutic groups and by participating in exploratory studies in applying focal-conflict theory to group interaction. Drs. Thomas French and Philip F. D. Seitz participated in a series of seminars in which group-therapy protocols were studied in an attempt to test the feasibility of conceptualizing group events in focal-conflict terms. Since 1957, we have benefited from the help of a number of research assistants and colleagues: Charles Van Buskirk, Joanne Holden, Margaret Nuttall, Robert Williams, and June

[1] *Experiences in Groups, and Other Papers* (New York and London: Basic Books, Inc., and Tavistock Publications, 1961).

[2] *The Integration of Behavior,* I, II (Chicago: University of Chicago Press, 1952).

Strain. We have observed or studied groups conducted by Drs. Robert S. Daniels, Robert Drye, Marie Duncan, Martin Lakin, Herbert Lessow, Robert F. McFarland, George G. Meyer, Valerie Raulinitis, Roy M. Whitman, and Mary Wicks; Joanne Holden; and Anthony Vattano. Several persons read all or portions of the first draft of this manuscript and provided truly invaluable help in sharpening, condensing, and organizing the material in the book. We are most grateful to Jerome D. Frank, William E. Henry, Joanne Holden, Irving L. Janis, and Philip F. D. Seitz. Ann Welch, Carol Ramey, Sharon Forrest, and Linda Putnam worked intrepidly in typing and preparing the manuscript.

Finally, we are most grateful to the National Institute of Mental Health, which has provided financial support for our research efforts from 1955 to the present.[3] It has been this support which has enabled us to explore, to test, and finally to summarize in this book our thinking about the group-therapeutic processes.

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Table of Contents

PREFACE *vii*

PART I: THE GROUP PROCESSES: THE CONTEXT OF THERAPY *1*

1. Problem and Purposes *3*
2. A Focal-Conflict Model *14*
3. Equilibrium and Change *41*
4. Group Themes *63*
5. Group Culture *95*
6. Development of the Group *116*

PART II: THE INDIVIDUAL'S THERAPEUTIC EXPERIENCE *141*

7. The Patient's Experience *143*
8. The Therapeutic Process *161*

PART III: THE THERAPIST'S CONTRIBUTION *187*

9. Strategy, Position, and Power *189*
10. General Policy *204*
11. Influence through Participation *216*

PERSPECTIVE *239*

12. Other Theories *241*
13. The Threat and Promise of the Group *285*

BIBLIOGRAPHY *294*

INDEX *301*

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I

The Group Processes: The Context of Therapy

Arguments about "existence" may seem metaphysical in nature and may therefore not be expected to be brought up in empirical sciences. Actually, opinions about existence or nonexistence are quite common in the empirical sciences and have greatly influenced scientific development in a positive and a negative way. Labeling something as "nonexisting" is equivalent to declaring it "out of bounds" for the scientist. Attributing "existence" to an item automatically makes it a duty of the scientist to consider this item as an object of research; it includes the necessity of considering its properties as "facts" which cannot be neglected in a total system of theories; finally, it implies that the terms with which one refers to the items are acceptable as scientific "concepts" (rather than as "mere words").

—Kurt Lewin

1 Problem and Purposes

Processes characteristic of the group as a whole are an intrinsic and inevitable aspect of all groups no matter what their size or function. In a therapy group, group processes not only "exist," but are a major factor influencing the nature of each patient's therapeutic experience. The manner in which each patient contributes to, participates in, and is affected by the group processes determines to a considerable degree whether he will profit from his group therapy experience, be untouched by it, or be harmed by it. The therapist can influence the character and development of the group and thereby influence the individual's therapeutic experience. It is, therefore, important that the therapist have some understanding of the group processes and their meaning for the therapeutic process.

As this over-all statement of our position suggests, we regard the group processes which emerge in therapy groups as worthy of serious and careful investigation. To paraphrase Kurt Lewin, we shall attribute "existence" to these group processes and shall systematically discuss their character, their relevance to the therapeutic experience, and their implications for the therapist's role.

Two questions may be asked about group processes in therapy groups. The first is whether such

processes can be observed; the second is whether and in what manner group processes are relevant to the therapeutic progress of individual patients. In our view, the first question is no longer an issue, but the second is both crucial and unresolved.

Although it is now generally accepted that any small face-to-face group, including a therapy group, can be described in terms of its characteristics as a social system, this was not always so. During the 1920's, concepts such as "group mind" or "group unconscious" were matters of controversy in social psychology. Such terms are no longer in general use, not because they have no meaningful elements, but because the phenomena to which they refer are now better understood and no longer need to be discussed in such mystical terms. Although social psychologists no longer talk about the group mind, they do talk about group goals, atmosphere, sociometric structure, or communication pattern. These are characteristics or properties of the group as a whole. They derive from the interaction of the members in lawful ways, yet constitute attributes of the group as a system.

Historically, the factor which probably contributed more than any other to the resolution of these early issues was the development of relevant methodology. Until appropriate techniques were available, there were no means for exploring group phenomena. Pioneer work by Lewin, S. E. Asch, and others paved the way for the controlled observation of groups and the experimental manipulation and examination of group variables.[1] Evidence accumulated to show that small face-to-face groups can be described in terms of properties belonging to the group as a whole. That is, many diverse phenomena can be understood if the group is conceptualized as a social system comprised of elements which have a lawful relation to one another. Such elements can be shown to operate in a variety of groups independently of the specific membership of the group. Furthermore, such total group characteristics have been shown to have an important impact on the behavior of individual members.

The crucial question for group therapists is no longer whether the therapy group can be described in terms of such variables as atmosphere, cohesion, communication patterns, roles, standards, and the like. Rather, the issue is whether regarding the group in these terms is of any use to the therapist in the light of his primary goal, contributing to the personal growth of the patient. To state this more formally, the real question is whether and in what manner characteristics of the therapy group as a social system are relevant to the therapeutic process.

In the literature on group therapy, one finds a range of positions on this issue. Group processes are variously regarded as factors to be

utilized, overcome, or ignored. One position is that, although therapy groups may be described in terms of the "dynamics of the group," group dynamics are detrimental to the therapeutic aim. Perhaps the most articulate proponent of this point of view is S. R. Slavson:

> Thus, even the most common group dynamics described are not permitted to operate, for it is the task of the therapist . . . to uncover the underlying, most often the hostile feelings, from which reactions flow. Thus, dynamics in therapy groups are "nipped in the bud" as it were, for just as soon as responses are analyzed and related to their emotional sources, they no longer operate. . . . Thus, *the therapeutic aim in its very nature is antagonistic to group formation and group dynamics.*[2]

Wolf and Schwartz are even more strongly convinced that attention to group-level processes in therapy groups is likely to defeat the therapeutic goal; they regard group processes as inherently destructive to the individual.[3] Nathan Locke suggests that the characteristics of the group are a side issue; a similar position is advanced by Helen Durkin, who suggests that, although forces exist which may be described as belonging to the group as a whole, they tend to be irrelevant to the therapeutic work of the group.[4]

In sharp contrast to these positions are the views put forth by such group therapists as S. H. Foulkes, W. R. Bion, George Bach, Henry Ezriel, and Jerome D. Frank.[5] Although they differ in many respects, these writers share the view that group processes are central to the therapeutic process.

Bion views the group as the vital instrument of therapy which must be properly utilized and exploited by the therapist: ". . . [W]e are not concerned to give individual treatment in public, but to draw attention to the actual experiences of the group, and . . . the way in which the group and individual deal with the individual." And, later:

> This point is critical; if the psychiatrist can manage boldly to use the group instead of spending his time more or less unconsciously apologizing for its presence, he will find that the immediate difficulties produced are more than neutralized by the advantages of a proper use of his medium.[6]

The stand which one takes on this general issue may depend in part on underlying assumptions about the character of therapy and the nature of emotional illness. Most group therapists recognize important differences between therapy conducted in a group and therapy conducted in a two-person situation. However, the curative model—as-

sumptions about what it is in the treatment situation that helps the patient—is usually translated rather directly from individual to group psychotherapy. For example, the exploration of transference relationships and interpretations of resistance by means similar to those used in individual therapy may be seen as the heart of the treatment. Given such a position, it might seem to follow that attention to total group processes is foreign, useless, or even harmful to these essential therapeutic maneuvers. The way in which the therapist defines emotional illness is also a factor. Slavson's model is essentially an intrapersonal one in which psychotherapy is aimed at freeing the patient from his neurotic inhibitions and problems. Foulkes, on the other hand, is inclined to see emotional illness as rooted in disturbed interpersonal relationships:

> We conceive all illness as occurring and originating within a complex of interpersonal relationships. Group psychotherapy is an attempt to treat the total network of disturbance either at the point of origin in the root—or primary—group, or, through placing the disturbed individual under conditions of transference, in a group of strangers or proxy group.[7]

In our view, the eventual resolution of these issues will not require a choice between irreconcilable alternatives—either the psychoanalytic or the group dynamic explanation. Rather, what is required is an understanding of the manner in which group processes, individual processes, and therapeutic processes exist in complex relationships. We do not see group processes as either consistently constructive or consistently destructive to therapeutic goals. Rather, our position is that they have no such universal and unilateral impact. Depending on their character, group processes may sometimes facilitate therapy. Sometimes they may interfere. The real questions are how and when the therapist can use them to produce useful therapeutic experiences. In order to answer these questions, it is necessary to examine group-level aspects of therapy groups in some detail to determine their impact on the individual and the therapeutic process.

One might wonder why it is that group therapists have not turned to social psychology for an understanding of group processes in therapy groups.[8] We believe it is not because the concepts developed by social psychologists cannot be applied to therapy groups, but because many of the concepts seem irrelevant to the therapeutic process or of only academic interest because they deal with variables which the therapist cannot influence. The social psychologist who studies groups usually does so in order to understand certain properties of the group or rela-

tionships among certain properties. He may be interested in the problem-solving process, the decision-making process, the distribution of power in the group, or the communication pattern. Although such phenomena can be observed in therapy groups, they are likely to be of little interest to the group therapist because they seem so removed from his primary interest—therapeutic change in the individual. Even when the social psychologist focuses on the impact of group variables on the individual, he is likely to be interested in such variables as sense of achievement, changes in attitude or judgment, and so on. Although these are attributes of the individual, they are related only indirectly to the kind of change in which the group therapist is interested.

The group therapist may also feel that the work of the social psychologist has little practical importance because many of the variables cannot be manipulated in the group therapeutic setting. For purposes of experimentation and study, the social psychologist may, for example, open or close certain channels of communication or distribute relevant information unevenly among the group members. Such manipulations are outside the tradition of group therapy and, in general, are inconsistent with his goals.

What is required is a theory of group processes relevant to the task and goals of psychotherapy. To be useful to the group therapist, a theory of group functioning must focus on factors which bear on the therapeutic process and which are subject to the influence of the practicing therapist. We assume that the therapeutic process—that which must occur within the individual if positive personal change is to take place—is essentially the same no matter what the therapeutic setting. The corrective emotional experience, sometimes accompanied by insight, is regarded as fundamental to therapeutic change. A useful theory of group therapy must, then, examine the manner in which this therapeutic process occurs in the special milieu of the group. The group processes form the context of therapy. The group situation is in constant flux, and the individual in a continuously shifting position with relation to group forces. Under certain group conditions, potentially useful experiences may occur. Under others, anti-therapeutic experiences take place. Thus, it becomes important to identify the character of the group context in order to understand its impact on the individual.

The list of variables which the group therapist can influence is a brief one: the size and composition of the group, the physical setting and the frequency of the sessions, the kind of outside individual contacts (if any) he provides for each of the patients, and his own participation during the group sessions. A useful theory of group therapy

should aid the therapist in selecting the techniques and situations which are most likely to help the patients. Of the variables which the therapist can control, his own participation—what he says and when he says it—seems the most crucial. And in order to study the impact of the therapist's participation, it is necessary to understand the character and impact of his interventions in the context of the fluctuating group situation.

For several reasons, then, a theory about group therapy must establish a way of conceptualizing the changing group situation. This situation is important because it is the background against which to examine the therapist's participation, the patients' participation, and the shifting meaning of the group experience for each patient. The following appear to be significant questions:

1. What kinds of emotional issues emerge in therapy groups; how are these expressed and handled?

2. How can one conceptualize the diverse and shifting events of a single therapy session?

3. What are the long-term developmental characteristics of a therapy group?

4. In what ways does the past history of a therapy group affect its current operation?

5. What are the relationships among personality, individual behavior, and the character of the group?

6. What is the impact of the group on the patient's experience: which group conditions contribute to personal growth and which interfere?

7. How does the group therapist contribute to the patient's therapeutic experience?

We shall present a series of propositions which attempt to deal in detail with these and related questions. Part I deals primarily with the character of the group process and is directed to questions 1, 2, 3, and 4; it defines the character of the group therapeutic milieu. Because the group's only constant feature is change, our efforts are directed to understanding the pattern of diversity and the order in change. In Chapter 2, we suggest a view of group events which perceives the diverse elements of the group situation in relation to shared, covert, af-

fective issues. Crucial affective issues and shared conflicts develop to which the patients direct coping efforts. Chapters 3 and 4 are devoted to understanding continuity and change in the group process—first in a single group session and then in a series of sessions linked by the same theme or shared emotional concern. Chapter 5 considers the issue of the group's culture—the unique and usually implicit standards, practices, and values which develop in each group and which, in our view, can have both limiting and enabling effects on the therapeutic experience. Chapter 6 returns to the problem of change, taking a long-range view and considering the over-all developmental characteristics of the group. Both theme (Chapter 4) and culture (Chapter 5) are basic to our view of group development, for we emphasize the recurrence of basic affective issues and themes under broadening cultural conditions. Part I, then, attempts to formulate the character of the group processes in ways which we think are important for understanding the context of therapy. Although we do not consider, except by implication, the relevance of the group processes for the therapeutic process or the therapist's role, this part of the book lays the essential groundwork for the discussion which follows.

Part II considers the individual's experience in the group, particularly the impact of the group processes on the therapeutic experience. This section is directed to questions 5 and 6. In it, we discuss the individual's neurotic dilemma on entering the group, the manner in which he experiences the group situation, and the motives which underlie his behavior in the specific setting (Chapter 7). In Chapter 8, there is a more specific discussion of the therapeutic process—the kinds of experiences which the patient must undergo if positive therapeutic change is to take place and the various ways in which the group processes may affect the individual. In this chapter, we consider the specifics of the therapeutic experience, attempting to delineate the various positions in which the patient may find himself with regard to group forces and to define the group conditions under which positive therapeutic, as opposed to damaging, experiences are likely to occur.

Part III focuses on the manner in which the therapist can contribute to the therapeutic process. The previous sections have defined the character of the group processes and their impact on the individual's therapeutic experience; this section takes up the issue of what the therapist can do to direct the group situation in order to maximize its therapeutic potential. We begin, in Chapter 9, with a consideration of the therapist's strategy, position, and power in the group. Here we attempt to differentiate and compare the therapist's position and in-

fluence with that of the patients and the group therapist's position and influence with that of the therapist in a two-person relationship. We also describe a general strategy by which the therapist concentrates on group processes and on the individual in the context of group processes. This strategy, which we endorse, is contrasted with another which focuses more exclusively on the individual patient and tends to disregard group forces. Chapters 10 and 11 deal more specifically with the therapist's role. Chapter 10 discusses decisions about composition and over-all policy, considered in the light of the character of group processes and the potential impact of the group on each patient. Chapter 11 considers the therapist's participation during the group sessions and concentrates on the ways in which the therapist can work toward establishing potentially beneficial group conditions and can forestall or minimize the establishment of destructive group conditions.

This presentation is directed primarily to group therapists, and all of the illustrative material is drawn from therapy groups. Yet we believe that the view of group functioning which is presented here is relevant to other kinds of groups as well. Part I, particularly, can be read as a general theory of group processes. Certain sections of Part II are also relevant to non-therapeutic groups—for example, the discussions about covert motivational factors which mediate personality, behavior, and social context and about the group conditions under which the individual experiences comfort or threat. In Part III, the material on the therapist's position and power in the group applies, with some modifications, to the position and the power of any group leader. Our discussion of the therapist's strategy, decisions, and tactics is specifically directed toward the goals of the group therapist, which are different from the goals of the leader of a problem-solving group or the head of an organization. But the fundamental point—that a leader operates within the context of group forces and utilizes them in ways which are consistent with certain goals—holds not only for therapy groups, but for other face-to-face problem-solving groups and larger organizations. In this volume, we do not spell out these additional applications systematically, although we occasionally point to other groups for purposes of contrast.

Parts I, II, and III are a statement and elaboration of theory. We have added a final section—"Perspective"—which attempts to place our work in the context of other theoretical views and considers some general issues of theory development. Chapter 12 reviews a series of theoretical questions to which group therapists have addressed themselves and attempts to contrast our thinking with that of others. Chaper 13 reviews the power and potential of the group. Here, we ac-

knowledge the potency of emotional forces which may be released under group conditions and attempt to examine the threat of group forces to the integrity of the individual personality and the promise which the group holds for personal growth and change.

Notes

[1] Kurt Lewin, "Frontiers in Group Dynamics: Concept, Method, and Reality in Social Science: Social Equilibria and Social Change," *Human Relations,* I (1947), 5–41; *idem, Field Theory in Social Science* (New York: Harper & Brothers, 1951); S. E. Asch, "Effects of Group Pressure upon the Modification and Distortion of Judgments," in *Groups, Leadership and Men: Research in Human Relations,* ed. H. Guetzkow (Pittsburgh: Carnegie Press, 1951).

[2] S. R. Slavson, "Are There 'Group Dynamics' in Therapy Groups?" *International Journal of Group Psychotherapy,* VII (1957), 144–145.

[3] Alexander Wolf and Emanuel K. Schwartz, *Psychoanalysis in Groups* (New York: Grune and Stratton, 1962).

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[5] S. H. Foulkes, "Group Analytic Dynamics with Specific Reference to Psychoanalytic Concepts," *International Journal of Group Psychotherapy,* VII (1957), 40–52; *idem,* "Group Process and the Individual in the Therapeutic Group," *British Journal of Medical Psychology,* 34 (1961), 23–31; *idem, Introduction to Group-Analytic Psychotherapy* (New York: Grune and Stratton, 1949); *idem,* "Psychotherapy 1961," *British Journal of Medical Psychology,* 34 (1961), 91–102; *idem,* "The Application of Group Concepts to the Treatment of the Individual in the

Group," in Bertrand Stokvis (ed.), *Sources of Conflict in Contemporary Group Psychotherapy* ("Topical Problems of Psychotherapy," Vol. II [New York and Basel: S. Karger, 1960]), pp. 1–15; S. H. Foulkes and E. J. Anthony, *Group Psychotherapy: The Psychoanalytic Approach* (Baltimore: Penguin Books, 1957); W. R. Bion, *Experiences in Groups, and Other Papers* (New York and London: Basic Books, Inc., and Tavistock Publications, 1961); *idem,* "Group Dynamics: A Re-View," *International Journal of Psychoanalysis,* 33 (1952), 235–247; George Bach, *Intensive Group Psychotherapy* (New York: Ronald Press, 1954); Henry Ezriel, "A Psychoanalytic Approach to Group Treatment," *British Journal of Medical Psychology,* 23 (1950), 59–64; *idem,* "A Psychoanalytic Approach to the Treatment of Patients in Groups," *Journal of Mental Science,* XCVI (1950), 774–779; *idem,* "Experimentation Within the Psychoanalytic Session," *British Journal for the Philosophy of Science,* 7 (1956), 29–48; *idem,* "Reply to Mr. Spilsbury," *British Journal for the Philosophy of Science,* 7 (1956), 342–347; *idem,* "The Role of Transference in Psycho-Analytic and Other Approaches to Group Treatment," *Acta Psychotherapeutica,* 7 (1959) Supplement, 101–116; J. D. Frank, "Some Aspects of Cohesiveness and Conflict in Psychiatric Out-Patient Groups," *Johns Hopkins Hospital Bulletin,* 101 (1957), 224–231; *idem,* "Some Values of Conflict in Therapeutic Groups," *Group Psychotherapy,* 8 (1955), 142–151; J. D. Frank and Eduard Ascher, "Corrective Emotional Experiences in Group Therapy," *American Journal of Psychiatry,* 108 (1951), 126–131; J. D. Frank, Eduard Ascher, Joseph B. Margolin, Helen Nash, Anthony R. Stone, and Edith J. Varon, "Behavioral Patterns in Early Meetings of Therapeutic Groups," *American Journal of Psychiatry,* 108 (1952), 771–778; J. D. Frank, "Some Determinants, Manifestations, and Effects of Cohesiveness in the Therapy Groups," *International Journal of Group Psychotherapy,* 7 (1957), 53–63; J. D. Frank, Joseph B. Margolin, Helen Nash, Anthony R. Stone, Edith J. Varon, and Eduard Ascher, "Two Behavior Patterns in Therapeutic Groups and Their Apparent Motivation," *Human Relations,* III (1952), 289–317; Florence Powdermaker and J. D. Frank, *Group Psychotherapy* (Cambridge: Harvard University Press, 1953).

[6] W. R. Bion, *Experiences in Groups, and Other Papers,* pp. 80–81.

[7] S. H. Foulkes, "Group Analytic Dynamics with Specific Reference to Psychoanalytic Concepts," p. 42.

[8] George Bach has undertaken the only systematic review of the relevance of social psychological research and concepts to group therapy in his book, *Intensive Group Psychotherapy.*

2

A Focal-Conflict Model

In any therapy group in which the therapist does not control the content or the procedure, a session is likely to take the following form. As the patients gather, there is a period of unofficial talk—perhaps about some event from the preceding session, perhaps about an experience that someone has had since the last meeting, or perhaps about some neutral outside happening. Several conversations may go on at once, with the patients talking in pairs or threes; one or two may be silent. The conversation may be general. The atmosphere might suggest depression, tension, distance, or casual friendliness. Then at some signal—perhaps the closing of a door, the arrival of the therapist, or simply the clock indicating that the starting time has arrived—the session "begins."

After a pause or a longer silence, an initial comment is made. It may reflect some personal concern, some reaction to the previous session, or some reference to the current situation. The speaker may direct his comment to the therapist, to another patient, or to the entire group. The initial comment is followed by another which may or may not appear related to the first one. If it seems related, it may be a response to the topic just introduced, or it may be stimulated by the emotion of the original state-

ment and have little to do with the content. It may be a response to some relationship established earlier in the group's history. Comment follows comment, and a conversation develops. There is some coherence to this conversation, so that the group can be described as talking "about" something. Occasionally the conversation may become disjointed. There may be abrupt shifts in topic, lapses into silence, and illogical elements. The mood may shift, and the rhythm and pace of the discussion may vary. Some patients may talk a great deal, others very little. From time to time, the therapist may enter the discussion, directing his remarks to one person or to the group in general. He may comment about the mood of the group, the character of the interaction, or a problem of a patient.

Some comments get "lost" in the group, as if no one hears them; others are built upon and form the predominant topics and themes. The patients may express such emotions as anger, delight, suspicion, nervousness, or superiority. Some feelings and attitudes are expressed in words; others come through in non-verbal behavior. Certain patterns may emerge in terms of who dominates, who is silent, who talks to whom, and who expresses what feelings. After about an hour of complex interaction, the therapist will signal that the time is up, and the group will disperse. It will meet a few days later for another session.

What has happened? We assume that the diversity observed during a group-therapy session is apparent rather than real and that the many different elements of the session "hang together" in relation to some underlying issue. For example, the first session of an inpatient group was marked by long tense silences, brief staccato periods in which the patients compared notes about physical ills but seemed careful to avoid references to psychological worries, and an animated period in which the patients discussed the architecture of the hospital and wondered whether it was well designed and built on solid ground. On the surface these elements are diverse and unrelated, but they gain a certain coherence if one assumes that they all refer to some shared underlying uneasiness about having been placed in a group and a shared concern about the competence and strength of the therapist. As another example, a group of patients which had been meeting for some time were told that the sessions were to be interrupted for the therapist's vacation. They warmly wished him a good time, ignored him for the rest of the session, and turned to an older member for information about college admission procedures and policies about "dumping" students after the end of the first year. Again, these elements gain coherence if one assumes that they all refer to shared underlying feelings about the impending separation from the therapist.

In this view, the observable elements of the session constitute the manifest material. These elements include not only content, but also non-verbal behaviors, mood, pace, sequence, and participation pattern. Thus, an animated period in which everyone joins the discussion is an element of the session, as is a period of desultory conversation or a period of sober but ritualistic "work" on one patient's problems. A seating pattern in which the chairs on either side of the therapist are left vacant is an element of the session, as is a seating pattern in which male and female patients take chairs on opposite sides of the room. Non-verbal behaviors—looking only at the floor when speaking, directing oneself exclusively to the therapist, or directly engaging one another—are also important elements.

We assume that a subsurface level exists in all groups, but is hardest to detect in groups in which the manifest content is itself relatively coherent and internally consistent. When a group is talking about something, one might assume that this is all that is happening. In the brief illustrations just presented, one group was talking about architecture, and the other about college policies. Yet, even when the group situation consists of a conversation which is coherent in itself, we assume that another level of meaning also exists, for, even in such a group, breaks and shifts occur in the topic under discussion. There are reversals and non-verbal accompaniments, suggesting that to assume that only a conversation is going on is to miss an important aspect of the situation. In therapy groups, covert levels are most apparent in groups of sicker patients, where there is less capacity to maintain coherence on an overt, public level. However, even in non-therapeutic groups, one can observe the same phenomenon.[1]

The covert meaning of the manifest material is not likely to be within the patients' awareness. From the patients' point of view, the conversation *is* about architecture or college admission policies. But an observer is in a position to grasp the underlying issue. Once he "sees" the core issue, aspects of the session which might on the surface appear diverse, contradictory, or meaningless gain coherence and meaning.

This view assumes that the successive manifest elements of the session are linked associatively[2] and that they refer to feelings experienced in the here-and-now situation. Whatever is said in the group is seen as being elicited not only by the strictly internal concerns of the individual, but by the interpersonal situation in which he finds himself. Of all the personal issues, worries, impulses, and concerns which a patient *might* express during a group session, what he actually expresses is elicited by the character of the situation. Moreover, a comment is likely to include a number of elements and is responded to

selectively by others. An individual may make a comment which includes a half-dozen elements. As the others listen to an individual's highly personal contribution, they will respond to certain aspects and ignore others. The aspects which are picked up and built upon are in some way relevant to the other patients and gradually become an emerging shared concern. As this suggests, the group-relevant aspect of an individual's comment is defined by the manner in which the other patients react to it. To cite an example, in an inpatient group a patient told a story about a man who had been misunderstood when he used the word "intimate." It was known that this was a personal concern of this patient, who was always apologizing for his sexual thoughts. However, the comments by other patients elaborated on the "misunderstood" aspect of his comment and ignored the "intimate" aspect. We therefore assume that being misunderstood was the shared concern and that the issue of intimacy was not a common concern.

We assume that the content of the session, no matter how seemingly remote, refers to here-and-now relationships and feelings in the group. The patients who worry about the competence of the architect and the strength of the building are really worrying about the competence and strength of the therapist. The patients who complain about college administrators who "dump" their students after the first year are really expressing resentment toward the therapist. The same is true for elements of the session other than the manifest content. Non-verbal behavior, such as a seating arrangement in which male and female patients sit on opposite sides of the room, might reflect concern about heterosexual contact in the group. A participation pattern in which one patient is allowed to dominate might mean that the others are using him to protect themselves from having to participate.

Our point of view is similar to that of Henry Ezriel, who uses the term "common group tension" to refer to the covert, shared aspect of the group process:

> The manifest content of discussions in groups may embrace practically any topic. They may talk about astronomy, philosophy, politics or even psychology; but it is one of the essential assumptions for psychoanalytic work with groups that, whatever the manifest content may be, there always develops rapidly an *underlying* common group problem, a *common group tension* of which the group is not aware but which determines its behaviour. . . . In the beginning of each session there is always some probing when some member of the group, who seems to feel a particular urge to speak, broaches one subject or another. Often a remark made by one member is not taken up by anybody, apparently because nobody can fit it into what is unconsciously at the back of his or her mind. If, on the other hand, it can be fitted

> in . . . if it "clicks" with the unconscious phantasy of another member, and then perhaps with that of a third, then gradually the subject catches on and becomes *the* unconsciously determined topic of the group. . . .[8]

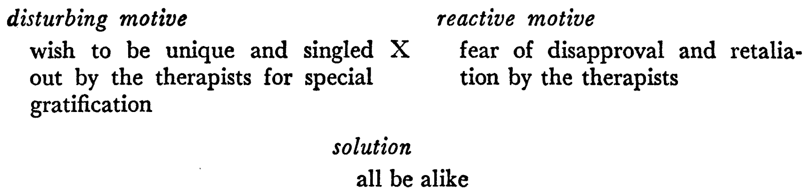
The view of the group situation developed so far is summarized in Proposition 1.

Proposition 1	*Successive individual behaviors are linked associatively and refer to a common underlying concern about the here-and-now situation.*

We view the covert, shared aspects of the group in terms of forces and counterforces, particularly those involving the shared impulses, wishes, hopes, and fears of the patients. For example, in a session presented in detail later in this chapter, there emerged scattered clues that many of the patients in the group wished to be unique and to have a special, close relationship with the therapists. At the same time, there was awareness that the other patients would not permit this and then, more strongly, fear that the therapists would punish them or retaliate in some way. As the session went on, the patients seemed to search for things that they had in common, finally agreeing that they were all alike in some surface traits. Such a session can be understood in light of the force of the wish to have a uniquely gratifying relationship with the therapist and the counterforce of the fear of retaliation. The wish and the fear constitute opposing forces: the fear prevents the wish from being expressed directly or perhaps even recognized. The wish cannot be pursued actively or thoroughly satisfied. At the same time, the wish cannot quite be given up and keeps the fear in the foreground. This situation creates tension in the group. The patients are beset with strong, conflicting feelings and impulses which are, at best, only dimly perceived. Strong impulses are exerting pressure, yet the patients can neither express nor recognize them. Under such circumstances, the patients attempt to find some way of dealing with their conflicting wishes and fears. In the above illustration, the search for things in common and the final agreement that everyone is alike can be seen as an attempt to allay their fears. It is as if the patients were saying, "Don't punish me; I didn't ask the therapist for anything special." Of course, such a solution cannot really be satisfying, since it involves renouncing the wish. It might temporarily reduce anxiety, however.

In attempting to describe the covert, shared aspects of the group's life, we have adopted a theoretical language which utilizes the key terms "group focal conflict," "disturbing motive," "reactive motive,"

and "solution."[4] The events of a group-therapy session are conceptualized in terms of a slowly emerging, shared covert conflict consisting of two elements—a disturbing motive (a wish) and a reactive motive (a fear). These two elements constitute the group focal conflict. The term "group focal conflict" summarizes the key features of this view of groups, indicating that the disturbing and reactive motives conflict, pervade the group as a whole, and are core issues engaging the energies of the patients. Concomitant with the group focal conflict, one sees various attempts to find a solution. A group solution represents a compromise between the opposing forces; it is primarily directed to alleviating reactive fears but also attempts to maximize gratification of the disturbing motive. Thus the group session just described could be summarized in the following diagram. This form, which will appear throughout the book to summarize group situations in focal-conflict terms, uses the symbol "X" to indicate "opposed by" or "in conflict with."



This conceptualization of the character of the underlying shared concerns can be stated in the following two propositions.

Proposition 2	*The sequence of diverse events which occur in a group can be conceptualized as a common, covert conflict (the group focal conflict) which consists of an impulse or wish (the disturbing motive) opposed by an associated fear (the reactive motive). Both aspects of the group focal conflict refer to the current setting.*
Proposition 3	*When confronted with a group focal conflict, the patients direct efforts toward establishing a solution which will reduce anxiety by alleviating the reactive fears and, at the same time, satisfy to the maximum possible degree the disturbing impulse.*

No two group sessions are exactly alike in the group focal conflict which emerges. Even when similar feelings are involved, they are expressed in unique imagery. The solution may also vary in the manner in which it copes with the patients' fears and in the extent to which it satisfies and expresses the disturbing motive. The following examples illustrate some of the variations.

In an outpatient group of schizoid young men, there were a number of symbolically expressed indications of resentment toward the therapist because of his failure to provide direction. For example, the patients shared complaints about the local library: the filing system was chaotic, nothing was labeled, and the librarians were of no help. At the same time, the patients hinted at fears of abandonment and fears of possible angry reactions from the therapist. One patient reported an early memory in which he pitted his will against that of his mother, who threatened to leave if he did not comply with her wishes.

The patients also reported that, following the previous meeting, they had discussed matters and decided to talk and talk rather than to ask the therapist questions. In this way, they expressed thinly veiled anger toward the therapist, as well as compliance with the therapist's implied demand that they, not he, provide direction. This session was summarized as follows:

disturbing motive		*reactive motive*
resentment toward the therapist	X	fear of abandonment and of the therapist's angry reaction

solution
band together to express angry compliance

Focal conflicts in which the disturbing motive involves covert, shared resentment toward the therapist are, of course, not uncommon. Such feelings are expressed in many ways, depending on the character and composition of the group. For example, in an inpatient group of schizophrenic patients, the following occurred:

> Bill responded to Lester's account of his problem by saying, "I have a similar problem. When you have legal problems, you go to authorities, and they don't want to give you any help." He mentioned having "done wrong with" a girl, then told about a friend who had been given the electric chair for robbery. He corrected himself, "No, it must have been for something more serious than that." He again complained that whenever he went for help, "There's no satisfaction." Larry agreed: "He is right—you can't get protection."

In an outpatient neurotic group, similar feelings were expressed in different terms:

> There was some agreement that the trouble with officers in the Army was that they always expected their men to do things that they were frightened to do themselves. Jerry said that the officers "learned never to turn their backs on their men," and Tom said he actually knew of a case in which an officer had been killed by one of his own men during a battle. The man was never found out or punished because it was assumed the officer had been killed by the enemy.

In another group, composed of nonpsychotic patients, the members drew on shared hospital experiences in order to express anger toward the therapist over presumed deprivation:

> There were shared complaints about the patients' cafeteria, especially about having to stand in line for so long. Bert told of being too late for dessert because the cafeteria had run out, but George said, "It's not that they don't have it; they don't want to give it to you." Others said they got enough food, but it was always cold. Grover said that his "big gripe" was with the clothing room and told of an experience in which the clerk was so slow and disinterested that he had had to forego part of his week-end pass.

Sometimes a precipitating event which activates a particular focal conflict can be identified. For example, in an inpatient group of patients with psychosomatic complaints, one patient, with great difficulty and misgiving, confessed his long-time fear of being followed and attacked. Between this session and the next, one of the other patients in the group approached this patient from behind, tapped him on the shoulder, and "teased" him by saying, "Hey, somebody's following you." Clearly, this was the precipitating event for what happened in the next session. The victim of this "joke," after some false starts and prodding from the others, appealed to the therapist: "What do you think of a fellow who hurts another fellow with things that are said here? Don't you think that shouldn't be allowed?" He, as well as the others, was quite reluctant to mention names but persisted in pressuring the therapist to censure such behavior. The meeting was summarized in the following focal-conflict terms:

precipitating event

between sessions, a violation by one patient of an implicit group standard