CHAPTER 15

GROUPS AS CHANGE AGENTS

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This chapter is dedicated to the memory of John Corrazinni, who died unexpectedly in October of 1999. With his passing, we have lost not only a wonderful person but a precious resource—a superb combination of psychotherapist and academician. His legacy is the cadre of students who are better therapists because of their time with Jack.

The Center Therapy Group had been meeting in a counseling center, which was located in an urban university, for the past three years. Membership had changed during that period as new members joined and mature members departed, but at the present time eleven individuals were attending regularly. They reported a range of psychological problems, including difficulties in establishing intimate relationships, confusion about their sexual identities, mood and thought disturbances, and problems relating to members of their families. Ann, for example, had been sexually abused by her father and would emotionally abuse her husband. When she told her mother about the abuse, her mother abandoned her in favor of her father. John came to therapy seeking the skills he needed to establish an intimate relationship with a woman. He had dropped out of college and spent some time in the military, but now he was back to finish his degree requirements. Gene had a very close, protective relationship with his mother. He held women, in general, in very high regard, and was reluctant to achieve independence from his mother. Bob had been sexually abused by both his mother and her girlfriend. He had a great deal of difficulty calling it to mind. Linda suffered from esteem problems, resulting in part from conflict with her mother who criticized her constantly. Linda often dressed in black with fishnet stockings, depicting the hated role of the "slut" that had been given her by her mother. Barry came from an abusive family. He protected himself by deflecting onto his brother the abuse his father might give to him. He and Ann identified with each other in the group. Carl was gay and immature. In addition to several developmental issues, he dealt with the deaths of many friends from AIDS. Jerome lacked self-confidence and talked about settling for romantic partners who were less than what he wanted but would not reject him.

These eleven members of the Center Therapy Group were guided in their therapeutic journey by three mental health professionals. One therapist, a male, had worked as the group's leader during its entire three-year history. A woman cotherapist had been with the group for two years and an intern had been working in the group for several months. These therapists actively orchestrated the content and direction of the hour-long weekly sessions, shifting the group's attention to various concerns shared by the members.

The Center Therapy Group helped most of its members with their problems. Some individuals dropped out of the group before achieving the change they sought, but many more underwent substantial growth and experienced improved psychological adjustment during their tenure in the group. Why? What powerful interpersonal dynamics does the group therapist harness to promote adjustment and beneficial change in members? This chapter examines these questions by scrutinizing both professionally guided groups used to sustain well-being and mental health (e.g., psychotherapy groups, training groups) as well as spontaneous, grassroots groups that also provide members with psychological sustenance (e.g.,

self-help groups, support groups). We consider the history of group approaches and the forms they currently take before appraising their overall utility.

Varieties of Change-Promoting Groups

That a group can be used as a change-promoting agent is not a new idea. Throughout history, personal change often has been achieved through social mechanisms rather than individualistic, asocial processes. Ettin (1992), for example, argues persuasively that the groups used by Socrates and described in the Dialogues—where he examined important philosophical and value issues through guided discussion and questioning—differ little from educational and training groups used today. Marsh (1935, p. 382) similarly suggests that most religious movements that developed around charismatic leaders were therapeutic in nature, for devotees were "partly seekers for knowledge, but they were also seekers for emotional help." Such groups were "a form of group therapy as well as a form of education."

The types of groups that are most numerous today—the therapy group, the interpersonal learning group, and the self-help group—emerged in their contemporary forms between 1910 and 1950. During this period, psychotherapy itself emerged as a means of helping people deal with mental and emotional problems. In some cases, physicians, psychiatrists, psychologists, and other mental health practitioners applied these basic change principles in group settings. These applications often began as local, setting-specific methods but evolved into more general, widely dispersed treatment procedures.

Early Group Therapists

Although the precise point of origin, that first group formed by a mental health professional and that focused on therapeutic goals, is much debated, most sources trace the systematic use of groups as agents of therapeutic change back to 1905 and Joseph Hersey Pratt's group approach to treating patients suffering from tuberculosis. Pratt, a physician with a background in psychology and theology, arranged for patients to gather in groups so that he could give them instruction in personal hygiene. He turned to the group format because it was so efficient: "I originally brought the patients together as a group simply with the idea that it would save my time" (Pratt, 1922, p. 403). But he soon recognized that group-level processes were contributing to the success of his treatments; accordingly, he gradually put less stress on the informational aspects of the groups and increased their interpersonal dynamics. Many of the groups developed tendencies seen in modern-day self-help groups, including sharing of information among members, encouraging testimonial sessions by veteran members, and robust cohesiveness. Pratt refined his methods to focus more on psychological gains, and expanded his groups to include people who suffered from other physical illnesses (e.g., diabetes) and psychological disturbances. By the 1930s he was leading "Thought Control Classes" with individuals who were suffering from nervous disorders (Pratt, 1922).

Pratt was not the only practitioner experimenting with groups during this period. Psychiatrist Edward Lazell, for example, felt that progress in individual therapy sessions would be faster if he delivered information to patients about common psychosexual developmental issues in a group format. So, he gathered his patients together—many of whom were suffering from substantial thought disorders—for lectures on such topics as fear of death, inferiority feelings, narcissism, and overcompensation (Lazell, 1921). At about this same time, Cody Marsh, who most sources describe as a "minister turned psychiatrist" (e.g., Ettin, 1992; Scheidlinger, 1993), was stressing the interpersonal dynamics of groups over the informational content he provided to the group members. He believed that psychological problems weren't rooted in psychosexual problems or biochemical imbalances, but in difficulties in one's interpersonal relations. He summed up his approach with the slogan "By the crowd they have been broken, by the crowd they shall be healed" (Marsh, 1933, p. 407). Marsh also anticipated milieu therapies by opening up his sessions to all members of the community.

A number of early psychoanalytically oriented therapists also turned to group techniques, either in part or exclusively. Kanzer (1983) even goes so far as to suggest that Freud's famous Viennese Circle, which met from 1901 to 1907, was, in some respects, a therapy group. The explicit purpose of the group was to explore and refine Freud's ideas regarding therapy and the nature of personality, but many of the members experienced deep personal change as a result of their participation in the group. The group was an extremely turbulent one, however, and Roth

(1993) suggests that Freud's leadership style and close control over the group process undermined the group's therapeutic value. Indeed, the group ended with the rebellion of Adler, who went on to establish group-centered treatment methods with families and with unrelated patients. He and his colleagues (most notably, Dreikurs, 1959) called this method "Collective Therapy," which stressed self-insight by observing one's interactions with other people.

Trigant Burrow (1927), though trained as a psychoanalyst and a founding member of the American Psychoanalytic Association, also rejected individual analysis in favor of a group approach. He argued that most psychological disorders could be traced back to social relationships rather than intrapsychic turmoil. As such, individual psychoanalysis was artificial because it cut the patient off from contact with other people. He guided his groups in an exploration of the meaning behind any interpersonal processes that occurred in the groups, and has been credited with such concepts as group analysis, group-as-a-whole, and the development of the here-and-now approach with colleague Hans Syz (Rosenbaum, 1963).

Slavson, Moreno, and Legitimization of Group Approaches

Group approaches to change in various mental health facilities were used more and more routinely in the years before and after World War II. Publications describing group methods, with such titles as "Group psychotherapy: A study of its application" (Wender, 1940), "The psychoanalysis of groups" (Wolf, 1949), "Results and problems of group psychotherapy in severe neurosis" (Schilder, 1939), and "Group activities in a children's ward as methods of psychotherapy" (Bender, 1937) signaled the growing acceptance of the method by professionals and the lay public. (Ettin [1992], Kibel [1992], and Rosenbaum [1965] provide extensive histories of the development of group therapy.)

Samuel Slavson and Jacob Moreno were two of the most vocal advocates of group therapy during this period of growth and legitimization. Slavson initially used a group approach with adolescents who were isolated from their peers or suffered from poor relations with their parents. His small, eight- to ten-person *activity groups* met for two hours under the watchful eye of a permissive, nondirective therapist. The activities included art projects, crafts, cooking, and interactive games, but the children were permitted to set their own agendas, even to the point of withdrawing from the group's activities altogether. Slavson noted that such groups could be very boisterous and even violent initially, but that over time group structures developed and interactions became routinized. Slavson, who drew on psychoanalytic theory, believed that submersion in such a group increased self-worth, impulse control, and insight: "The new feeling of security they have found in the special group is applied to other life situations, and their egos are further strengthened and their feelings about themselves become more positive and wholesome" (Slavson, 1950, p. 43).

With adults, Slavson practiced what he called *analytic group therapy*, which emphasized interviews of the patients by the therapist and group discussion. These sessions were conducted much like individual psychoanalytic therapy, stressing transference, catharsis, ego-strengthening, insight, and reality testing, but with these advantages: the presence of people with similar problems helped members speak more freely about their difficulties; supportive friendships developed; and the group helped members deal with the transference problems causing tension between the patient and therapist.

Slavson is responsible for many advances in the use of therapeutic groups, including the founding of the American Group Psychotherapy Association in 1942 and the *International Journal of Group Psychotherapy* in 1951. He has also been credited with coining the phrase *group dynamics*, although he explicitly discounted the relevance of group-level processes in his analytic therapy groups. Unlike his predecessors, Slavson stressed individual functioning and considered the group to be a catalyst only. When in groups, an individual's hidden concerns often surface, allowing the therapist to recognize them quickly and then confront them. The group's dynamics, however, were largely irrelevant to Slavson.

The latter view contrasts sharply with Jacob Moreno's. Moreno conducted therapeutic groups perhaps as early as 1910, and he used the term *group therapy* in print in 1932. Moreno believed that the interpersonal relations that developed in groups provided the therapist with unique insights into each member's personality and proclivities, and that by taking on roles the members become more flexible in their behavioral orientations. He made his sessions experientially powerful by developing psychodrama techniques. Dur-

ing psychodrama sessions, the group members reenacted specific turbulent episodes from group members' lives or events that happened within the group. Moreno believed that psychodrama's emphasis on physical action was more involving than passive discussion, and that the drama itself helped members overcome their reluctance to discuss critical issues (Kipper, 1978; Sacks, 1993). Moreno also developed sociometry to aid him in the analysis of the interpersonal relations linking group members and founded a journal with that name in 1938 (now titled *Social Psychology Quarterly*).

Contemporary Practices

Years ago, practitioners questioned the relative value of group approaches and relied on them only when circumstances made individual approaches impossible. But this view eventually gave way as group approaches emerged as appropriate treatments for a variety of problems, including addiction, thought disorders, depression, eating disorders, and personality disorders (Kaplan & Sadock, 1993; Long, 1998; Spira, 1997). Therapists who traditionally used only dyadic, one-on-one methods added group sessions, either supplementing or completely replacing their individual sessions. Not only did these therapists draw on the earlier work of such pioneers as Marsh, Burrow, Moreno, and Slavson, but they also integrated these approaches with their personal, and often eclectic, approach to treatment. Extensive reviews of the field by Brabender and Fallon (1993), Dies (1992), Ettin (1992), Kaplan and Sadock (1993), Spira (1997), and Yalom (1995) identify an array of approaches, including psychoanalytic, systems, object relations, problem-solving, educative, interpersonal, developmental, transactional, existential, Gestalt, humanistic, and cognitive-behavioral methods. We consider some of these contemporary methods next, after noting that this review is far from exhaustive. Indeed, the variety of contemporary group approaches is enormous.

Psychoanalytic Groups

Psychoanalysis, by tradition, is an individual treatment modality. The analyst, through directives, free association, interpretation, and transference, creates a powerful relationship with the client, who then gains insight into unresolved conflicts. But in *Group Psychology and the Analysis of Ego*, Freud (1922) explained a person's willingness to submit to the authority of a leader in terms of transference processes: Individuals accept their group leaders as authority figures, and other group members come to take the place of siblings. Group membership becomes an unconscious means of regaining the security of the family, and the emotional ties that bind members to their groups are like the ties that bind children to their family (Kohut, 1984).

Psychoanalysis in groups exploits these transference mechanisms to promote change in members. The therapist becomes the central authority in such groups, and usually relies on the traditional tools of the analyst as he or she directs the session and summarizes the group's efforts. By shifting attention from one patient to the next during the course of a single group session, members change their roles during the session—sometimes acting as the patient seeking help, at other times the observer of another's problems, and on occasion the helper who gives counsel to a fellow group member. This rotation gives patients an opportunity to observe others' responses to situations that are similar to their own, and also to observe the dynamic interplay between the authority and their "sibling." Although individual therapy usually stimulates parental transference, during group psychoanalysis sibling transference also occurs. Members may find themselves reacting to one another inappropriately, but their actions, when examined more closely, may parallel the way they treated a brother or a sister when they were young (Day, 1981; Kutash & Wolf, 1993; Rutan & Stone, 1993).

Freudian principles permeate most group approaches. Rare is the therapist who does not deal with transference processes, the interpretation of fantasies or dreams, familial tensions, and other latent conflicts. Treatments generally divaricate, however, in their emphasis on individual versus group processes. Many analysts agree with Slavson by stressing the importance of the individual in the group, rather than the group itself. Wolf (1949), for example, called his approach "psychoanalysis *in* groups" rather than "psychoanalysis *of* groups," and argued against spending too much time considering dynamic relationships within the group. Those who adopt this view suggest that the term *group psychotherapy* is a "misnomer for a technique that, although conducted in a group, is designed to aid an individual patient; it is a treatment of ailing individual patients in a group setting, not a treatment of ailing groups, because only individual patients have intrapsychic dynamics" (Kutash & Wolf, 1993,

p. 126; see, too, Kibel & Stein, 1981; Slavson, 1957; Wolf & Schwartz, 1962).

The group-as-a-whole approach reaches a very different conclusion. Although these approaches embrace psychoanalytic assumptions of unconscious motivations, personality conflicts, and transference, they strive to integrate the treatment of the individual with the analysis of the group-as-a-whole. Rather than ignoring the tension between individuality and group membership, the group-as-a-whole approaches capitalize on these tensions to promote growth and development. This approach is rooted in the work of Foulkes (1964) and Bion (1961), who argued that psychological problems are always interpersonal ones. Bion maintained that just as individuals rely on defense mechanisms to cope with ego threats, groups use strategies to cope with uncertainties and anxieties. Many of these strategies are rooted in dependence, for the group members engage in collective projective identification in an attempt to transfer responsibility for their problems from themselves to the leader. Groups also engage in fight-or-flight reactions and often concentrate their attention on pairs of members within the group, in a process Bion called *basic assumption pairing*. Bion felt that group members gain tremendous insights into both individual and collective defensive processes by examining these ubiquitous, but essentially maladaptive, processes. His work provided the basis for the Tavistock Institute of Human Relations (Ettin, Cohen, & Fidler, 1997; Horwitz, 1993).

Cognitive-Behavioral and Behavioral Therapy Groups

Cognitive-behavioral and behavioral approaches, which have emerged as influential and effective treatment methods in recent decades (e.g., Ingram, Kendall, & Chen, 1991), provide the theoretical and technical basis for some group therapies. These approaches do not focus on unconscious conflicts, interpersonal transactions, or group-as-a-whole dynamics, but instead assume that symptomatic thoughts and behaviors can be controlled through careful application of learning principles (Skinner, 1953, 1971). Behavior therapies tend to focus more on explicit, observable behaviors, such as social or relationship skills. Cognitive-behavioral approaches, such as Ellis's (1973) rational-emotive therapy, Meichenbaum's (1977) cognitive-behavior modification, and Beck's (1976) cognitive therapy, focus on changing cognitive processes. Beck, for example, helps individuals overcome mood disorders by training them to recognize and eliminate such errors in thinking as overgeneralizing, catastrophizing, blaming oneself, and black–white thinking.

These approaches often are used in one-on-one settings, but they also can be applied in group settings (Flowers, 1979; Hollander & Kazaoka, 1988; Rose, 1993). Behavioral therapists tend to be more active within their groups, and the groups themselves are usually more structured. The goals and methods of the group are clearly described to participants, who may go through a period of pregroup training. During this period a staunch behaviorist—one who stresses objective measurement of symptoms before, during, and after treatment—would identify the specific behaviors and cognitions that will be modified and devise the means of assessing them. Clients also may watch videotaped examples of group therapy sessions, with the deliberate intention of creating change-enhancing expectancies and the identification of specific therapeutic goals (Higginbotham, West, & Forsyth, 1988). At this point the therapist also might ask the patients to sign a behavioral contract that describes in objective terms the goals the group members are trying to achieve.

During treatment, therapists rely on a number of behavioral methods, including modeling, rehearsal, and feedback. The group leaders may engage in a one-minute conversation with each other, videotape the interaction, and then play it back to the group while identifying the nonverbal and verbal behaviors that made the conversation flow smoothly. During rehearsal, group members practice particular skills themselves, either with one another or through role-playing exercises. These practice sessions can be videotaped and played back to the group so the participants can see precisely what they are doing correctly and what aspects of their behavior need improvement. This feedback phase involves not only reassurance and praise from the leaders but also support from the other group members (Bellack & Hersen, 1979; Curran, 1977; Galassi & Galassi, 1979).

Interpersonal Group Psychotherapy

Irvin D. Yalom, in his well-received *The Theory and Practice of Group Psychotherapy* (1995), describes his interpersonal approach to treatment. This approach assumes that because most problems, such as depression, anxiety, and personality

disorders, can be traced back to social sources, then social sources can be used to provide relief (Kiesler, 1991). Yalom's (1995) interpersonal group psychotherapy (also called interactive group psychotherapy) uses the group as a *social microcosm* where members respond to one another in ways that are characteristic of their interpersonal tendencies outside of the group. Therapy groups, as groups, display a full array of group dynamics, including social influence, structure, conflict, and development. The therapist takes advantage of the group's dynamics to help members learn about how they influence others, and how others influence them. Members do not discuss problems they are facing at home or work, but instead focus on interpersonal experiences within the group: the *here-and-now* rather than the *then-and-there*. When, for example, two members begin criticizing each other, a client uses powerful influence tactics, or another refuses to get involved in the group's meetings, therapists prompt group members to examine and explain the members' interaction (Yalom, 1995).

Yalom's interpersonal model is unique in its emphasis on identifying, and exploiting, curative factors in groups. In examining group methods, Yalom distinguishes the *front* from the *core*. A therapeutic method's front includes its procedures, techniques, and nuances: a Gestalt therapist uses different techniques than a psychoanalyst, who in turns acts very differently from a cognitive-behavior therapist. But beneath these various fronts, Yalom finds a shared core of mechanisms that promote change and sustain well-being. He terms these shared core qualities *curative factors*, and his list includes the installation of hope, universality, the imparting of information, altruism, the corrective recapitulation of the primary family group, the development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential factors. Some of the factors on Yalom's list are mechanisms that are responsible for facilitating change, whereas others describe the general group conditions that should be present within effective groups.

Interpersonal Learning Groups

Lakin (1972), in his insightful review of types of change-promoting groups, draws a distinction between therapeutic groups and learning groups. Therapeutic groups, as described earlier, are typically led by a mental health professional, and patients are suffering from diagnosed clinical conditions. Participants in learning groups, in contrast, seek to become more aware of, and skilled at, interpersonal relationships. Learning groups are often considered "therapy for normals." Lakin also discusses expressive groups, in which participants strive to express their emotions more completely. Expressive groups are relatively rare.

Analyses of the roots of interpersonal learning groups generally began with Kurt Lewin (1936). Indeed, it was Lewin who stated the basic law of change in groups: "It is easier to change individuals formed into a group than to change any of them separately" (1951, p. 228). Lewin believed that, in many cases, groups and organizations fail because their members aren't trained in human relations. He therefore recommended close examination of group experiences to give people a deeper understanding of themselves and their group's dynamics. Other theorists expanded on this basic idea, and by 1965 the human potential movement was in high gear (Back, 1973; Gazda & Brooks, 1985; Lakin, 1972). Varieties included T groups, encounter groups, and structured training groups.

Training Groups (T Groups)

Although groups have long been used to help members explore their relationships with others and their interpersonal skills, contemporary use of learning groups can be traced to a workshop held on the campus of the State Teachers College in Connecticut in 1946 (Benne, 1964). The procedures used in the workshops were designed by Kenneth Benne, Leland Bradford, and Ronald Lippitt. Kurt Lewin and his students were on hand to document their effectiveness. The trainers had planned to rely on relatively unstructured group discussions in their teaching, but during an evening review session, the organizers realized that much more could be gained if members could review the processes that were occurring within their discussion groups. This discovery is generally credited to Kurt Lewin, who permitted the trainees to sit in on the review sessions even though the researchers were discussing the trainees' behaviors. Lippitt (interviewed by Back 1973, pp. 8–9) describes this unique event as follows:

> And on this particular night, three of the trainees, three school teachers who hadn't gone home that evening, stuck their heads in the door and asked if they could come in, sit, and observe and listen, and Kurt (Lewin

> was rather embarrassed, and we all were expecting him to say no, but he didn't, he said, "Yes, sure, come in and sit down." And we went right ahead as though they weren't there, and pretty soon one of them was mentioned and her behavior was described and discussed, and the trainee and the researcher had somewhat different observations, perceptions of what had happened, and she became very agitated and said that wasn't the way it happened at all, and she gave her perception. And Lewin got quite excited about this additional data and put it on the board to theorize it, and later on in the evening the same thing happened in relation to one of the other two. . . . And the next night the whole fifty were there and were every night, and so it became the most significant training event of the day as this feedback and review of process of events that had gone on during the work sessions of the day.

This serendipitous discovery prompted Lewin's students and the trainers to stress the importance of group process analysis when they created a curriculum for use in a time-limited residential community located in Bethel, Maine (Bradford, Gibb, & Benne, 1964). The training setting was termed a laboratory because the experiences were stimulating, experimental, but drawn from theoretical analyses relevant to behavior change. The laboratory, which was initially sponsored by the National Education Association, the Research Center for Group Dynamics, and the Office of Naval Research (ONR), assumed skills are most easily acquired by actually experiencing human relations. Hence, they were termed training groups, or T groups. As one advocate of group training explained, "The training laboratory is a special environment in which they learn new things about themselves. . . . It is a kind of emotional re-education" (Marrow, 1964, p. 25). After Lewin's death in 1947, his colleagues organized the National Training Laboratory (NTL), and during the last 50 years, thousands of educators, executives, and leaders have participated in its programs (Bednar & Kaul, 1979; Burke & Day, 1986; R. E. Kaplan, 1979).

Structured Training Groups

In NTL groups, the activities of trainees are carefully planned, but much of the time is spent in open-ended group meetings. These groups include a facilitator or trainer who acts primarily as a catalyst for discussion rather than as director of the group. In most cases, the group members experience considerable conflict during the first few days of a session as members grapple with situational ambiguity and they pressure the trainer for leadership support. This ambiguity is built into the curriculum, however, for it shifts responsibility for structuring, understanding, and controlling the group's activities to the participants. During this period, the members reveal their preferred interaction styles to others, and they learn to disclose their feelings honestly, gain conflict-reduction skills, and find enjoyment from working in collaborative relationships.

Structured learning groups, in contrast, are planned interventions that focus on a specific interpersonal problem or skill. Integrating behavioral therapies with interpersonal learning, the group leaders identify specific learning outcomes before the sessions. They then develop behaviorally focused exercises that will help members practice these targeted skills. If the session deals with problems with communication, members may be split into pairs, and the pairs then practice sending messages using only nonverbal channels. During assertiveness training, group members might practice saying no to one another's requests. In a leadership training seminar, group members may be asked to role-play various leadership styles in a small group. These exercises are similar in that they actively involve the group members in the learning process.

Thousands of local and national institutes use structured learning groups in their seminars and workshops. Although the formats for these structured experiences differ substantially, most include (a) an orientation session in which the leader, usually in a lecture format, reviews the critical issues and focuses members on the exercise's goals; (b) an experiential phase during which the group members complete a highly structured exercise; (c) a debriefing phase when the group discusses the experience, with the leader providing interpretations and guidance; and (d) an application phase when the group members use their newfound knowledge to enhance their relationships at work and home (Forsyth, 1999).

Growth Groups

During the 1950s and 1960s, a version of the T group emerged that focused explicitly on enhancing positive emotions and the quality of one's relations. As the purpose of the training shifted

from learning about various group processes to enhancing spontaneity, personal growth, and sensitivity to others, a new label developed for such groups: sensitivity training, or encounters (Johnson, 1988; Lieberman, 1994).

Moreno first discussed the concept of an encounter in his 1914 *Invitation to an Encounter* (Moreno, 1953, p. 7), but the technique did not gain momentum until political and social changes increased the value placed on empathy, emotional understanding, and close interpersonal relations. Carl Rogers's client-centered methods, although often used in both individual and group therapies, initially provided the foundation for growth groups. Drawing on Rogers's self-psychology, these methods assumed that members too often experience self-rejection because their needs for approval and love are rarely satisfied. To minimize expected rejection from others, people tend to keep their interpersonal relations relatively superficial. Encounter groups help members restore their trust in their own feelings, their acceptance of their personal qualities, and promote openness in interactions with others. During sessions members are encouraged to open up to one another by displaying their inner emotions, thoughts, and worries, and the group coordinator stresses mutual understanding by modeling empathy and unconditional positive regard. In most groups, leaders make use of experiential exercises that help members express intense feelings of anger, caring, loneliness, and helplessness. Stripped of defensiveness and facades, Rogers believed, group members would encounter each other *authentically.*

Large Group Awareness Training (LGAT)

Back (1973) calls the rise of growth groups in the 1960s and 1970s a social movement: a deliberate, relatively organized attempt to achieve a change in a social system. But the movement has matured in recent years, and in doing so has changed from a social movement into a social movement *organization.* Social movement organizations still strive to achieve change, but they have lost their local, parochial flavor. Like any organization they have clearly defined goals, rational planning, and bureaucratic leadership structures (Snow & Oliver, 1995).

These organizations, which Lieberman (1994) calls LGATs (Large Group Awareness Training), include EST, FORUM, and Lifespring. Their members seek to improve their overall level of satisfaction and interpersonal rela tions, but instead of joining a local encounte group, they become members of these large orga nizations. Lieberman notes that these organiza tions use methods that combine aspects of struc tured training groups and encounter group: Lifespring, for example, uses music, role-pla exercises, lectures, and guided group interactio in an attempt to increase self-awareness, self confidence, positive thinking, and skilled interac tion with others. Lieberman suggests that at lea 1.3 million Americans have taken part in LGA sessions.

Self-Help Groups

Self-help groups (SHGs) existed long befor practitioners began to make use of groups fc therapeutic purposes. Because SHGs are volur tary associations that form spontaneously whe individuals who share a common problem meet t exchange information and social support, they ar rarely formally documented in the literature o groups. SHGs, which are also known as mutu support groups, likely have primordial origins.

The variety of self-help groups is enormou SHGs exist for nearly every major medical, psy chological, or stress-related problem, includin groups for sufferers of heart disease, cancer, live disease, and AIDs; groups for people who provid care for those suffering from chronic disease, il ness, and disability; groups to help people ove come addictions to alcohol and other substance groups for children of parents overcome by ac dictions to alcohol and other substances; an groups for a variety of problems in living, such a groups for helping people with money or tim management problems. These groups differ fro each other in many ways, but most are sel governing, with members rather than experts c mental health professionals determining activ ties. They also tend to stress the importance c treating all members fairly and giving everyor an opportunity to express their viewpoints. Th members face a common predicament, problen or concern, so they are "psychologically bonde by the compelling similarity of member cor cerns" (Jacobs & Goodman, 1989, p. 537). The groups all stress the importance of reciproc helping, for members are supposed to both giv help to others as well as receive it from other SHGs usually charge little in the way of fees, ar they form because the members' needs are n being met by existing educational, social, c health agencies.

Self-help groups are growing in terms of numbers and members, with perhaps as many as 8 million people in the United States alone belonging to such groups (Christensen & Jacobson, 1994; Goodman & Jacobs, 1994; Jacobs & Goodman, 1989). Jacobs and Goodman explain the rise of SHGs in terms of the erosion of the family, increase in the number of people still living with significant diseases, erosion of confidence in care providers, lack of mental health services, increased faith in the value of social support as a buffer against stress, and increased media attention provided by TV docudramas. Jacobs and Goodman feel that self-help groups will continue to increase, and that they will eventually take a large portion of the mental health dollar away from more traditional approaches.

The best-known self-help group, Alcoholics Anonymous, can be traced back to a specific individual and date of origin: Bill Wilson and 1935. Wilson, a confirmed alcoholic, relapsed many times before, he claims, he had a profound, mystical experience forcing a recognition of his powerlessness over his alcoholism but also his oneness with the universe. To explain the experience, he examined the writings of psychologists William James and Carl Jung, and eventually concluded that such experiences could be triggered by periods of negativity, depression, and helplessness. Wilson built AA around this spiritual experience, and required that members submit to a larger force and abandon their sense of individuality by remaining anonymous. Wilson then connected with a small group-based primitive spiritual group, the Oxford Group Movement, and his friend, physician, and fellow alcoholic William D. Silkworth. The result was a system of behavioral change that stressed self-examination, admitting past wrongs, rebuilding relationships and making amends, and reliance on and helping others.

Wilson's program formed the basis of Alcoholics Anonymous (AA), which became an international organization with millions of members. Despite AA's size, change is still achieved through local chapters of alcoholics who meet regularly to review their success in maintaining sobriety. AA assumes that alcoholism is a disease and that it has no cure. Individuals must remain abstinent, and social drinking is not considered an option. Many of the rituals and structures of AA are designed to prevent drinking, often through mutual support and providing positive examples. AA also makes the goal of sobriety attainable by requiring members to concentrate on not drinking each day, rather than consider long-range methods for controlling their drinking.

AA groups are ubiquitous yet rarely scrutinized by researchers. They have been spared this scrutiny, in part, because their anonymity makes study complex for investigators. Moreover, AA tends to be value-laden in its approach to treating alcoholism, and hardnosed researchers often avoid studying such groups. But, as Miller (1995) notes, AA is one of the most widely used methods for treating addictions.

Sources of Change in Groups

The members of the Center Therapy Group all experienced benefits from their membership. Before treatment they were troubled by feelings of low self-esteem, depression, misgivings about their ability to relate effectively to others, and a variety of specific behavioral and psychological problems. These problems had, however, abated as the group reached its scheduled dissolution. Why? What processes were at work within the group that helped the members improve their psychological functioning?

We preface our analysis of these issues by looking more closely at the processes that operated within a typical session of the Center Therapy Group. The transcript excerpts a longer session, and is a concrete illustration of the psychological and interpersonal processes that lie at the foundation of group approaches to treatment. In this particular session eight members were present, and the discussion focused on family and interpersonal relations.

Bob: I saw my girl friend the other day. She was waiting to talk to me. To reach closure about our relationship.

Gene: Do you feel bad about the breakup? Do you feel responsible?

Bob: I think it is over. I don't feel complete but I don't think there is any chance we can work it out.

Male therapist: One of the themes of this group has been no hope; passivity.

Bob: It affects everything. You want to be in the middle, but you stand on the outside.

Male therapist: Like in here, too?

Bob: Yah! You know what's going on in here but I feel so stupid. My mind is so cluttered. This applies to everything. Like I'm hiding behind a wall.

Male therapist: There is this "reluctance" or

"passivity" in the group. It's more than one person's issue.

John: I feel like this all the time. Like there is a governor in me. I'd like to be full throttle. I'm not alive because of that. I need to apologize for not being here for several weeks and to you, Jill [female leader], especially.

John then explained why he could not attend group. John had not attended the Center Therapy Group since the group's co-leader, Jill, had confronted him.

John: I feel bad about this.

Male therapist: Any chance if you were free, there would still be some reluctance about coming to therapy?

John: Yes, some fear.

Male therapist: Fear of what?

John: The woman in red. [Jill wore a red dress that day.]

Male therapist: But what is so intimidating about her?

John: I don't know.

Male therapist: Maybe someone in the group can help. Is anyone else afraid of Jill?

John: I just feel overwhelmed.

Male therapist: Are there any other women in the group that have the same effect on you?

John: I feel like all women have some affect on me, but it is not as intense.

After some probing as to what it was about Jill, John admitted he was romantically attracted to her.

Male therapist: Can you tell the group how you are feeling right now?

John: I'm really feeling very anxious.

Gene: I'm the opposite. I have a harder time dealing with guys. My friends in high school were women. I'm not afraid of her.

Male therapist: You'd rather sit next to her.

Ann: I'm totally intimidated by her. It's like she is the totally complete package. She's pretty, smart, and carries herself well.

Male therapist: You relate better with men than you do with other women.

Ann: Yes, but I also relate better to Linda [another female group member]. Thank God that she is here. Jill is just too together. I'd like to be like her. To carry myself like that.

John: I've been clobbered in my relationships with women. What would a slob like me do in a relationship with a woman like Jill?

Male therapist: So you have feelings for her. Yet you wonder what chance a slob like you would have with a woman like her.

Co-therapist: I [Jill] have noticed you. I said you are attractive and I feel you haven't heard me.

John: I have trouble with trust. I've been clobbered so often.

Male therapist: Let's get some other reactions.

Jerome: I see her as the ideal mother. She listens and is insightful. My mom doesn't listen.

Barry: She's not perfect. She doesn't talk enough. She doesn't have enough milk for me.

Linda: I had to defend myself from my mother. She called me a slut. I'm intimidated by this whole thing. I don't feel close to my mother.

Intern: I wonder if you're afraid if Jill or I will judge you?

Linda: Yes, I am.

Male therapist: What would it take you to see Jill or other women as women who are different from those that you have known?

Ann: Women's relationships are different. They are very powerful. You tell other women your soul. I don't know what men talk about. Probably cars or something. Women want deep connections. If another woman knows your stuff, they could really hurt you.

Linda: My mother betrayed me.

Male therapist: You used quiet to take care of yourself. Your passivity has been positive. Where are some of the others in the group with these issues?

Gene: I'm comfortable with my mother. I want to hear more from my dad [pointing to the male group leader sitting in the circle opposite to him]. My mother is always right. Women know everything. I just want to hear more from my dad. Women have played a very powerful role in my life; you need to take what they say. For example, when I told my mother I was in group therapy, she asked if the group was talking about her yet. I told her no. But one month later we were talking about her. See, they know.

Male therapist: And when your girlfriend said she was going to commit suicide if you left her . . .

Gene: She tried to. Women are magnificent. They have all the right answers and everything you need.

Male therapist: You can't be who you are without their support; you're beholden to them. Isn't that right, Bob?

Bob: I don't know. I sort of blanked out. I'm feeling confused [*Bob begins to cry*]. My thoughts are all jumbled; I can't make them out.

Jerome: I want to see women as equal instead of up here [*points to a place over his head*].

Barry: But it's weird. I feel like this woman thing is going to fix me. This is my salvation. Women just don't have enough milk for me.

Gene: I didn't date in high school. They kept me at their control. They let me be their friend, but not their boyfriend. No one gave me a chance.

Male therapist: You felt used.

Linda: Guys only wanted me for sex.

Intern: How did that make you feel?

Linda: Shitty!

Carl: They are the ones that are sluts. I like you and I don't want to have sex with you.

Male therapist: We've been talking about how moms have often been inadequate in our lives. That they haven't been enough in some cases. Bob, if Jill could help you right now, what would you want from her?

Bob: She reminds me of my mom's best friend.

Male therapist: Is she a nice person?

Bob: Yes, but she likes to sleep around. I do see her as a mother figure, too.

Male therapist: That has to be very confusing.

Bob: Yes.

Male therapist: I wouldn't know how to relate to her. What do you do with all of this, Jill? Bob says you're not enough and others are afraid of you. I wonder what they are going to do?

The group ended with a number of members stating what they wanted to do in future sessions.

Linda: I'd like to hear more about your feelings, Jill.

Ann: I'd like to hear about how not to be so judgmental.

This session of the Center Therapy Group is consistent with prior analysis of the therapeutic mechanisms that operate in groups. It hints at the processes identified by Lakin (1972), who argued that the successful group must facilitate emotional expression and feelings of belongingness, but it also must stimulate interpersonal comparisons and provide members with an interaction forum. The session also underscores Bednar and Kaul's (1978) concept of a "developing social microcosm," "interpersonal feedback and consensual validation," and "reciprocal opportunities to be both helpers and helpees in group settings" (p. 781). Yalom's (1995) curative factors, which were noted earlier, can also be detected in the session (e.g., Butler & Fuhriman, 1983a, 1983b; Crouch, Bloch, & Wanlass, 1994; Markovitz & Smith, 1983; Maxmen, 1973, 1978; Rohrbaugh & Bartels, 1975; Rugel & Myer, 1984; Sherry & Hurley, 1976; Yalom, 1995; Yalom & Vinogradov, 1993). Yalom gleaned these factors from his clinical experience and empirical research, but the list is generally consistent with theoretical analyses of groups in general (Forsyth, 1996). Table 15.1 summarizes some of these change-promoting factors, and we discuss them next.

Universality and Hope

One of the first, and most fundamental, sources of psychological sustenance in groups is a sense of shared calamity and misfortune. Even Pratt (1922), although originally only interested in using groups to reach a larger number of patients, was struck by they way his discouraged, pessimistic patients became hopeful and optimistic in their groups. When group members first join their groups they often feel that their problems are unique ones, but by comparing themselves to others in the group they come to recognize the *universality* of the problems they face. This idea is consistent with such phrases as "strength in numbers," "we are all in the same boat," and "we are not alone."

The sense of universality is a consequence of social comparison processes that naturally occur in groups. When individuals feel threatened or confused, they often affiliate with others. Schachter's (1959) classic study of women waiting to receive electric shocks, for example, confirmed the tendency people have to seek group membership in times of stress. Through affiliation, people secure social support, but they also can acquire information about their condition from other group members. Indeed, when people are with others who face similar problems or troubling events, they feel better in terms of self-esteem and mood than when they are with dissimilar people (Frable, Platt, & Hoey, 1998). Many groups—and self-help groups in particular—encourage social comparisons through rituals and traditions. Everyone at an AA meeting, for example, publicly states, "I am an alcoholic," and this ritual reassures each participant that his or her problems are shared by others.

Groups also provide members with targets for both downward social comparison and up-

TABLE 15.1 Factors that Promote Change in Groups

Factor	Definition	Meaning to Member
Universality	Recognition of shared problems, reduced sense of uniqueness	We all have problems.
Hope	Increased sense of optimism from seeing others improve	If other members can change, so can I.
Vicarious Learning	Developing social skills by watching others	Seeing others talk about their problems inspired me to talk, too.
Interpersonal Learning	Developing social skills by interacting with others	I'm learning to get along better with other people.
Guidance	Accepting advice and suggestions from the group members	People in the group give me good suggestions.
Cohesion	Feeling accepted by others	The group accepts me and understands me.
Self-disclosure	Revealing personal information to others	I feel better for sharing things I've kept secret for too long.
Catharsis	Releasing pent-up emotions	It feels good to get things off my chest.
Altruism	Increase sense of efficacy from helping others	Helping other people has given me more self-respect.
Insight	Gaining a deeper understanding of oneself	I've learned a lot about myself.

Source: D. R. Forsyth, *Group dynamics* (3rd ed.). Pacific Grove, Ca: Brooks/Cole, (1999).

ward social comparison. Most individuals, when given a choice, make comparisons that will provide them with reassuring as well as accurate information. By comparing themselves with someone who is experiencing even more severe hardships than themselves or someone who is not coping with problems effectively (downward social comparison), members' sense of victimization decreases and their overall sense of self-esteem increases (Gibbons & Gerrard, 1989; Wood, Taylor, & Lichtman, 1985). And when they compare themselves to people who are coping effectively with their problems, the upward social comparison helps members identify ways to improve their own situation (Buunk, 1995; Taylor & Lobel, 1989). Although such *supercopers* may threaten members by drawing their attention to their own limitations, they also reassure members that their problems can be overcome. In general, although contact with such people is reassuring, direct comparison with them is not (Taylor & Lobel, 1989).

Snyder and his colleagues believe that people's sense of hope is one of the best predictors of their mental health and adjustment. Individuals who are hopeful can identify many ways to reach their goals (pathways) and are also relatively confident that they can carry out the actions that are necessary to reach their goals (agency). Hope, in Snyder's model, is more then just a sense of confidence or task persistence. Rather it is an enhanced motivational state that is sustained by clearly identified goals, pathway thoughts, and a sense of agency (Klausner, Snyder, & Cheavens, in press; Snyder, 1994; Snyder, Cheavens, & Sympson, 1997; see also Snyder, Ilardi, Michael, & Cheavens, this volume).

Klausner, Snyder, and Cheavens (in press) confirmed the value of a hope-based group intervention in a study of outpatients receiving antidepressant treatment at a geriatric center. These patients met for 11 weeks in groups that stressed individualized goal formulation and training in both pathway and agency thinking. By the end of treatment the subjects' levels of depression had dropped significantly, and the change was greater than that shown by a second set of patients who participated in a control group. Worthington, Hight, Ripley, Perrone, Kurusu, and Jones (1997) also verified the value of raising group members' sense of hope in a study of marital enrichment programs. These researchers, to offset the pessimism felt by many married people about their chances of avoiding divorce, developed a hope-enrichment therapy that stressed the components of Snyder's hope model. Clients were encouraged

to take the initiative in improving their relationship and they were taught specific behaviors they could use to accomplish this goal. Trained couples had higher relationship satisfaction and better interaction skills than couples in a control condition.

Social Learning

Most theorists, when comparing group approaches to individuals ones, underscore the value of groups as arenas for interpersonal learning (Lieberman, 1980; Yalom, 1975, 1995). In groups, individuals gain information about themselves, their problems, and social relationships with others. They "become aware of the significant aspects of their interpersonal behavior: their strengths, their limitations, their parataxic distortions, and their maladaptive behavior that elicits unwanted responses from others" (Yalom, 1975, p. 40).

Of the 10 curative factors in Table 15.1, vicarious learning, interpersonal learning, and guidance (direct instruction) are most closely related to social learning processes. Unlike strict behavioral approaches that assume only actions followed by positive reinforcers are learned, social learning theory maintains that people can acquire new attitudes and behaviors by observing others' actions (Bandura, 1977). When a therapist carefully coaxes a member into expressing her pent-up hostility, observing group members learn how they can express emotions that they have been suppressing. Group leaders also can model desirable behaviors by treating the group members in positive ways and avoiding behaviors that are undesirable (Dies, 1994). Coleaders can model social interactions that the group members considered difficult or anxiety provoking. The leaders can then help the group members perform these same behaviors through the use of role-play procedures. Groups that use explicit modeling methods show greater improvement than groups that only discuss the problematic behaviors (Falloon, Lindley, McDonald, & Marks, 1977).

Groups also promote change by providing members with feedback about their personal and interpersonal qualities. When interacting with others in a supportive group setting, members receive direct feedback from the other group members about their qualities. The individual who is lonely because he alienates everyone by acting rudely may be told, "You should try to be more sensitive" or "You are always so judgmental, it makes me sick." Some groups exchange so much evaluative information that members withdraw from the group rather than face the barrage of negative feedback (Scheuble, Dixon, Levy, & Kagan-Moore, 1987). Most group leaders, however, are careful to monitor the exchange of information between members so that individuals learn the information they need to change in positive ways.

Interpersonal learning also occurs indirectly, as group members implicitly monitor their impact on the other people within their group, and draw conclusions about their own qualities from others' reactions to them—other group members become, metaphorically, a mirror for self-understanding (Cooley, 1902). A group member may begin to think she has good social skills if the group always responds positively each time she contributes to the group discussion. Another member may decide he is irritating if, each time he interacts in the group, the rest of the members respond with anger and hostility. This indirect feedback helps members perceive themselves more accurately. Individuals who are socially withdrawn, for example, tend to evaluate their social skills negatively even though their fellow group members view them positively (Christensen & Kashy, 1998). Individuals also tend to rate themselves as more anxious than others do (Marcus & Wilson, 1996). Extended contact with others in a group setting may repair these negative perceptions.

Interpersonal learning also occurs as members become recipients, willing or not, of the advice and guidance of both the leader and the other group members. When researchers analyzed recordings of therapy sessions, they discovered that therapists respond to clients at several levels. They provide information and guidance, ask a variety of questions, repeat and paraphrase the client's statements, confront the client's interpretations of problems, offer their own interpretation of the causes of client's problems, and express their approval of and support for the client (Hill, Helms, Tichenor, Spiegel, O'Grady, & Perry, 1988).

Although most would agree that the therapist should guide the group, experts disagree when discussing *how much* guidance a leader should provide. On the one hand, many clinicians advocate the leader-centered approaches typical of psychoanalytic, Gestalt, and behavioral groups. In such groups, the leader is the central figure. He or she guides the course of the interaction, assigns various tasks to the group members, and oc-

cupies the center of the centralized communication network. In some instances, the group members may not even communicate with one another but only with the group leader. In contrast, other therapists advocate a nondirective style of leadership in which all group members communicate with one another. These group-oriented approaches, which are typified by encounters or T groups, encourage the analysis of the group's processes, sometimes with the therapist/leader facilitating the process, but other times providing no direction whatsoever.

Studies of groups indicate that both directive and nondirective leaders are effective agents of change so long as they are caring, help members interpret the cause of their problems, keep the group on course, and meet the members' socioemotional needs (Lieberman, Yalom, & Miles, 1973). Moreover, just as effective leaders in organizational settings sometimes vary their interventions to fit the situation, so do effective leaders in therapeutic settings shift their methods as the group matures. During the early stages of treatment, members may respond better to a task-oriented leader, whereas in the later stages, a socioemotional leader may be more helpful (Kivlighan, 1997).

Several studies suggest that groups with two leaders are more effective than groups with only one leader. Co-leadership eases the burdens put on the group's leader. The two leaders can lend support to each other and also can offer the group members their combined knowledge, insight, and experience. Also, male/female teams may be particularly beneficial because they offer a fuller perspective on gender issues, and serve as models of positive but nonromantic heterosexual relationships. The advantages of co-leadership, however, are lost if the leaders are unequal in status or engage in power struggles during group sessions (Thune, Manderscheid, & Silbergeld, 1981).

Cohesion and Development

Cohesion may not be a sufficient condition for effective groups, but it may be a necessary one (Yalom, 1985). Without cohesion, feedback would not be accepted, norms would never develop, and groups could not retain their members. In emphasizing the value of highly cohesive groups, Yalom and his colleagues join a long line of researchers who have reached similar conclusions. As early as 1951, Dorwin Cartwright suggested that if groups were to be used as change agents, the members should have a strong sense of group identity and belonging or otherwise the group would not exert sufficient influence over them. Others, too, have noted that the "cotherapeutic influence of peers" in the therapy group requires group cohesion (Bach, 1954, p. 348; Frank, 1957; Goldstein, Heller, & Sechrest, 1966).

Cohesive groups, in general, tend to provide healthier environments than noncohesive groups, at least at the psychological level. Because people in cohesive groups respond to one another in a more positive fashion than members of noncohesive groups, people experience less anxiety and tension in such groups (Myers, 1962; Shaw & Shaw, 1962). Studies conducted in industrial work groups, for example, indicate that employees reported less anxiety and nervousness when they worked in cohesive groups (Seashore, 1954). Investigations of therapeutic groups routinely find that the members improve their overall level of adjustment when their group is a cohesive one (Marziali, Munroe-Blum, & McCleary, 1997), perhaps because they are stronger sources of social support (Posluszny, Hyman, & Baum, 1998). People also cope more effectively with stress when they are in cohesive groups (Bowers, Weaver, & Morgan, 1996; Zaccaro, Gualtieri, & Minionis, 1995). Membership in a cohesive group can prove problematic for some members, however, if they become too dependent (Forsyth & Elliott, 1999).

Cohesion likely influences the curative impact of a group by increasing the psychological intensity of the therapeutic experience. People in cohesive groups more readily accept the group's goals, decisions, and norms. Furthermore, pressures to conform are greater in cohesive groups, and an individual's resistance to these pressures is weaker (Back, 1951). When the group norms emphasize the value of cooperation and agreement among members, members of highly cohesive groups avoid disagreement more than members of noncohesive groups (Courtwright, 1978). Members of cohesive groups also sometimes react very negatively when a group member goes against the group consensus, and they take harsh measures to bring dissenters into line (Schachter, 1951).

A group's cohesiveness fluctuates over time, depending on its longevity, membership stability, and stage of development. Even when the group's task is a therapeutic one, time is needed to achieve cohesiveness. In one study, investigators

observed and coded the behaviors displayed by adolescents in a program of behavioral change. These groups did not immediately start to work on self-development issues, nor did the group members try to help one another. Rather, the groups first moved through orientation, conflict, and cohesion-building stages before they began to make therapeutic progress (Hill & Gruner, 1973).

Other studies also suggest that the success of the group depends to a large extent on its movement through stages of development. Although the stages receive various labels from various theorists, many accept the five emphasized by Tuckman (1965): forming, storming, norming, performing, and adjourning. During the forming stage, individual members are seeking to understand their relationship to the newly formed group and strive to establish clear intermember relations. During the storming stage, group members often find themselves in conflict over status and group goals and, in consequence, hostility, disruption, and uncertainty dominate group discussions. During the next phase, norming, the group strives to develop a group structure that increases cohesiveness and harmony. The performing stage is typified by a focus on group productivity and decision making. Last, when the group fulfills its goals, it reaches its final stage of development, adjourning. If a group does not move through these stages, its members will not be able to benefit from the experience (MacKenzie, 1994, 1996; Yalom, 1995).

Dennis Kivlighan and his colleagues studied the impact of group development on therapeutic outcomes by matching interventions to the developmental maturity of the group. Group members were given structured help in expressing either anger or intimacy before either the fourth or ninth group session of their therapy. The information dealing with anger clarified the value of anger as a natural part of group participation and provided suggestions for communicating it. In contrast, the information dealing with intimacy clarified the value of intimacy in groups and provided suggestions for its appropriate expression toward others. As anticipated, when the interventions were matched to the most appropriate developmental stage—for example, group members received the information on anger during the storming phase (session four) or the information on intimacy during the norming phase (session nine)—the subjects displayed more comfort in dealing with intimacy, more appropriate expressions of intimacy and anger, fewer inappropriate expressions of intimacy, and more congruence between self-ratings and other ratings of interpersonal style (Kivlighan, McGovern, & Corazzini, 1984).

Disclosure and Catharsis

Groups become more unified the more the members engage in self-disclosure: the sharing of personal, intimate information with others (Corey & Corey, 1992; Leichtentritt & Shechtman, 1998). When groups first convene, members usually focus on superficial topics and avoid saying anything too personal or provocative. In this orientation stage, members try to form a general impression of each other and make a good impression themselves. In the exploratory affective stage, members discuss their personal attitudes and opinions, but avoid intimate topics. This stage is often followed by the affective stage, when a few topics remain taboo. When the group reaches the final stage, stable exchange, all personal feelings are shared (Altman & Taylor, 1973).

Self-disclosure can be a challenge for some individuals. Individuals experiencing personality and psychological disturbances, for example, often disclose the wrong sorts of information at the wrong time (McGuire & Leak, 1980). Men and boys, too, generally are more reserved in their rate of self-disclosure (Brooks, 1996; Kilmartin, 1994; Shechtman, 1994). In consequence, therapists sometimes must take special steps to induce the male members of therapy groups to share personal information about themselves, including modeling disclosure and the incorporation of disclosure rituals in groups (Horne, Jolliff, & Roth, 1996).

Self-disclosure and cohesion are reciprocally related. Each new self-disclosure deepens the group's relationship intimacy, and this increased closeness then makes further self-disclosures possible (Kaul & Bednar, 1986; Roark & Sharah, 1989; Tschuschke & Dies, 1994). By sharing information about themselves, members are expressing their trust in the group and signaling their commitment to the therapeutic process (Rempel, Holmes, & Zanna, 1985). Self-disclosure of troubling, worrisome thoughts also reduces the discloser's level of tension and stress. Individuals who keep their problems secret, but continually ruminate about them, display signs of physiological and psychological distress. On the other hand, individuals who have the opportunity

to disclose these troubling thoughts are healthier and happier (Pennebaker, 1990).

Members also can vent strong emotions in groups. The group offers members the opportunity to express strong emotions that they cannot express in any other circumstances; this catharsis might ease their level of anxiety. Emotional release has been identified by some as a great benefit of groups, but others suggest that "blowing off steam" may actually heighten members' psychological distress and upset (see Ormont, 1984).

Altruism

The group's leader is not the only source of help available to group members. In some instances, fellow group members can draw on their own experience to offer insights and advice to one another. This mutual assistance provides benefits for both parties. Even though the group's leader, and not the group members, is the official expert in the group, people often are more willing to accept help from people who are similar to them (Wills & DePaulo, 1991). The helper, too, "feels a sense of being needed and helpful; can forget self in favor of another group member; and recognizes the desire to do something for another group member" (Crouch et al., 1994, p. 285). Mutual assistance teaches group members the social skills that are essential to psychological well-being (Ferencik, 1992).

Mutual assistance is particularly important in self-help groups. Mended Hearts, a support group that deals with psychological consequences of open-heart surgery, tells members that "you are not completely mended until you help mend others" (Lieberman, 1993, p. 297). AA groups formalize and structure helping in the twelve-step procedures. Newcomers to the group are paired with sponsors, who meet regularly with the new member outside of the regular group meetings.

Insight

Individuals' perceptions of their personal qualities are generally accurate. Individuals who think of themselves as assertive tend to be viewed that way by others, just as warm, outgoing individuals are viewed as friendly and approachable (Kenny, Kieffer, Smith, Ceplenski, & Kulo, 1996; Levesque, 1997). In some cases, however, individuals' self-perceptions are inaccurate (Andersen, 1984). Individuals may believe that they are unattractive, socially unskilled, or friendly, when in fact they are attractive, interpersonally competent, or hostile.

Groups promote self-understanding by exposing members to unknown areas of the self. Although people are not particularly open to feedback about their attributes—especially their negative ones—when several individuals provide the same feedback, they are more likely to internalize this information (Jacobs, 1974; Kivlighan, 1985). Also, when the feedback is given in the context of a long-term, reciprocal relation, it cannot be dismissed so easily as being biased or subjective. Group leaders, too, often reward members for accepting rather than rejecting feedback, thus making the setting itself work to intensify self-awareness. In a supportive, accepting group, members can reveal hidden aspects of themselves, and therefore feel more open and honest in their relationships. Finally, Luft (1984) maintains that even qualities that are unknown both to the individual and to others can emerge and be recognized during group interactions.

Studies of group members' evaluations of the therapeutic experience also attest to the importance of self-insight. When participants in therapeutic groups were asked to identify events that took place in their groups that helped them the most, they stressed universality, interpersonal learning, cohesion (belonging), and insight. During later sessions they stressed interpersonal learning even more, but universality became less important (Kivlighan & Mullison, 1988; Kivlighan, Multon, & Brossart, 1996). Other studies that asked group members to rank or rate the importance of these curative factors generally found that group members emphasize self-understanding, interpersonal learning, and catharsis (Butler & Fuhriman, 1983a; Markovitz & Smith, 1983; Maxmen, 1973, 1978; Rohrbaugh & Bartels, 1975; Rugel & Meyer, 1984). In general, individuals who stress the value of self-understanding tend to benefit the most from participation in a therapeutic group (Butler & Fuhriman, 1983b).

The Effectiveness of Groups

Groups are used in a wide variety of settings to help individuals achieve personal change. This increasing reliance on groups is due, in part, to an increased concern for both cost and efficiency in an era of managed care that favors methods that can deliver effective services to more individuals at less cost (Hellman, Budd, Borysenko, McClelland, & Benson, 1990; MacKenzie, 1997).

But how effective are groups as treatment vehicles?

As with studies of individual therapies, calibrating the positive benefits of treatment has been difficult and controversial. Reviewers, after sifting through hundreds of studies evaluating the effectiveness of group interventions, rejected many as so methodologically flawed that they yielded no information (Bednar & Kaul, 1978, 1979, 1994; Burlingame, Kircher, & Taylor, 1994; Fuhriman & Burlingame, 1994; Kaul & Bednar, 1986). Groups are even more difficult to study than individuals, and so studies of their effectiveness often suffer from fatal flaws in design and execution. The use of varied and undocumented therapeutic methods, with different types of clients, by therapists who differ in skills and experience, in studies that too frequently lack valid measures and inadequate controls, make it difficult to draw firm conclusions. But those studies that do use valid methods, although far from unanimous in their support of group approaches, are for the most part positive.

Reviews of Group Outcomes

Most narrative reviews of the outcome literature are favorable, although they usually bemoan the methodological flaws that undermine the scientific adequacy of the database (Back, 1974; Meltzoff & Kornreich, 1970). Meltzoff and Kornreich, for example, were guardedly optimistic about the utility of group therapies because 80% of the methodologically sound studies reported either major or minor benefits for clients, whereas nearly all of the studies that reported no benefit were methodologically flawed. Bednar and Kaul's comprehensive and long-term monitoring of group methods are guardedly positive, although they continue to lament the lack of rigor in research (Bednar & Kaul, 1978, 1979, 1994; Kaul & Bednar, 1986). In like fashion Kanas (1986) examined 33 inpatient and 10 outpatient studies dating back to 1950 and concluded that group therapy was effective in 67% of the inpatient studies and 80% of the outpatient studies. He also reported that long-term therapy (more than three months) was especially useful, as were approaches that focused on interpersonal processes. Toseland and Siporin (1986) reviewed over 30 studies that compared individual and group therapies, and concluded that in 25% of these studies, the group therapy was significantly more effective than individual. Spitz (1984) presented a generally favorable review of the use of groups with a variety of client populations, including borderline and narcissistic personality disorders, physically ill patients, and chronic psychiatric patients.

Reviews of experiential groups also are generally positive (Bates & Goodman, 1986; Knapp & Shostrom, 1976; Smith, 1975, 1980). Knapp and Shostrom found that in those studies that used the Personality Orientation Inventory (POI) to assess outcome, most participants showed a consistent pattern of increased self-actualizing scores. Berman and Zimpfer (1980), in a systematic review of 26 controlled studies of personal growth groups, restricted their analysis to studies that (a) used both pretest and posttest measures, (b) met for at least 10 hours, and (c) had a long-term follow-up (at least one month after termination). Summarizing these methodologically superior studies, Berman and Zimpfer concluded that group treatments result in enduring positive changes, particularly at the self-report level.

Studies of the use of group therapies with particular populations also have yielded generally positive results. Kilmann and his colleagues (Sotile & Kilmann, 1977), although initially frustrated by the low quality of the research procedures in studies of group treatments for sexual dysfunctions, concluded that group therapy is an effective means of treating female orgasmic dysfunction and behavioral secondary erectile dysfunction (Mills & Kilmann, 1982). Zimpfer (1987), in his review of 19 studies of group therapy for the elderly, found that group treatments were differentially effective depending on the problems experienced by the client. He concluded that treatments that provide social support and sustain health-promoting actions and attitudes were most effective. Brandsma and Pattison (1985) and Flores (1997), after reviewing the empirical literature pertaining to group therapy with alcoholics, concluded that group interventions are an effective means of treating alcoholics who require therapeutic treatment.

The effectiveness of groups also can be gleaned from a methodologically questionable but empirically intriguing study of 4,000 individuals who responded to a *Consumer Reports* (1995) questionnaire concerning mental health services (see also Ingram, Hayes & Scott, this volume). This survey's conclusions are obviously limited by sampling biases and the reliance on client's self-reports (Seligman, 1995, 1996). The results, however, provide a strong confirmation of clients'

satisfaction with psychological treatments, in general, and group methods, in particular. Nearly one-third of the sample reported membership in a treatment group, often in combination with individual or medical treatments. These individuals rated the experience positively, and felt that groups "seemed to help" (*Consumer Reports*, 1995, p. 738). AA received particularly positive evaluations in this study, described as "overwhelming approval." The analysis suggests that the benefits of AA may result from a dosage effect, because members are required to attend a meeting every day for the first 90 days of treatment, and then three meetings a week after that. This level of treatment far surpasses the treatment frequencies of most other therapies.

Meta-Analytic Reviews

Researchers have conducted enough studies of group and individual approaches to permit reviewers to carry out meta-analytic reviews of prior work (Davis, Olmsted, Rockert, Marques, & Dolhanty, 1997; Fuhriman & Burlingame, 1994; Hoag & Burlingame, 1997; Robinson, Berman, & Neimeyer, 1990; Shapiro & Shapiro, 1982; Smith, Glass, & Miller, 1980; Tillitski, 1990). These quantitative reviews, like the qualitative narrative reviews, generally suggest that group approaches are equivalent in effectiveness to individual approaches. For example, Smith, Glass, and Miller (1980), in their precedent-setting review of therapeutic treatments, found that individual and group treatments were roughly equivalent in terms of effectiveness. Miller and Berman (1983) discovered that cognitive-behavioral treatments were more effective than other methods, irrespective of whether they were carried out in an individual or a group format. Similarly, Addie Fuhriman and Gary M. Burlingame (1994), after reviewing 700 group therapy studies and seven meta-analytic reviews of prior research, concluded that group methods are effective treatments for a wide variety of psychological problems.

McRoberts, Burlingame, and Hoag (1998) also discovered that both individual and group approaches are effective in their meta-analytic review of 23 studies that directly compared individual and group treatment methods. These investigators examined a large number of other treatment and procedural variables that past researchers identified as key determinants of outcome, including theoretical orientation of the therapy use, treatment stardardization, dosage, number of sessions, diagnosis of client, therapist gender and experience, and the presence of a cotherapist. The only factors that covaried significantly with outcome were client diagnosis, number of treatment sessions, and the year in which the study was conducted. Individual therapies tended to be more effective than group therapies when clients were classified using a formal diagnostic system, but group approaches were more effective when clients had "circumscribed symptomology" such as chemical dependencies and job-related stress. Group approaches also were more effective when clients were seen only briefly. When respondents attended only 10 or fewer sessions, group treatments were superior to individual ones. As for the year in which the study was conducted, studies conducted prior to 1980 favored groups, those conducted between 1981 and 1987 favored neither type, and those conducted after 1987 favored individual approaches. Other variables, such as the theoretical orientation of the therapist or type of group intervention, were unrelated to outcome.

Faith, Wong, and Carpenter (1995), in a meta-analytic review of sensitivity-training studies, also confirm the value of such groups. They searched for studies that utilized one of the following methods: T group, encounter group, marathon group, experiential training group, sensitivity training, enhancement training, empathy training, microcounseling, or human relations training. They did not include studies that were conducted in organizational or industrial settings, or ones that were specifically forms of group psychotherapy or cognitive-behavioral therapy. After examining the 63 studies that met their criteria, they concluded that these groups generally led to increases in self-actualization and self-esteem, and improved interpersonal relations. They noted that these effects increased in larger groups, when the groups met for longer periods of time, and when the measures focused on behavioral outcomes rather than self-reported ones. Burke and Day's (1986) analysis of the long-term effectiveness of T groups in organization-development interventions reached similar conclusions.

Comparisons of Group Therapies

McRoberts, Burlingame, and Hoag (1998) are not the only researchers who failed to distinguish between effective and ineffective types of group therapies. Group approaches conform to no single set of procedures, for some groups are leader-

centered (psychoanalytic or Gestalt groups), whereas others are group-focused (encounter and T groups), and the group's activities can range from the highly structured (social skill training groups, such as assertiveness-training groups) to the unstructured (encounter groups). Group practitioners also vary greatly in their orientations and techniques; some focus on emotions with Gestalt exercises, others concentrate on the here-and-now of the group's interpersonal process, and others train members to perform certain behaviors through videotaped feedback, behavioral rehearsal, and systematic reinforcement.

In spite of this diversity, most studies attest to the relative equality of the different types of group therapy. Lieberman, Yalom, and Miles, for example, investigated the overall impact of a twelve-week experiential group on members' adjustment (Yalom, 1985; Lieberman, Yalom, & Miles, 1973). Using a pool of 206 Stanford University students who were enrolled for course credit, Lieberman, Yalom, and Miles randomly assigned each person to one of 18 different therapy groups representing 10 theoretical orientations: Gestalt, transactional analysis, T groups, Synanon, Esalen, psychoanalytic, marathon, psychodrama, encounter tape, and encounter. Trained observers coded the group's interactions, with particular attention to the leader's style. Before, during, immediately after, and six months following the participation they administered a battery of items assessing group members' self-esteem, attitudes, self-satisfactions, values, satisfaction with friendships, and so on. Measures also were completed by the co-members, the leaders, and by group members' acquaintances.

Somewhat unexpectedly, the project discovered that no one theoretical approach had a monopoly on effectiveness. For example, two separate Gestalt groups with different leaders were included in the design, but the members of these two groups evidenced widely discrepant gains. One of the Gestalt groups ranked among the most successful in stimulating participant growth, but the other group yielded fewer benefits than all of the groups. These findings may have resulted from the lack of experience of the group leaders, as Russell (1978) suggests, but more recent studies provide general confirmation for the equivalency among treatments reported by Lieberman, Yalom, and Miles (Berah, 1981; Coche, Cooper, & Petermann, 1984; Falloon, 1981; Gonzalez-Menendez, 1985; Hajek, Belcher, & Stapleton, 1985; Knauss, Jeffrey, Knauss, & Harowski, 1983; Markham, 1985; Rosenberg & Brian, 1986; Sanchez, Lewinsohn, & Larson, 1980; Weinstein & Rossini, 1998; cf. Graff, Whitehead, & LeCompte, 1986; Kaplan, 1982).

Forsyth (1991) draws on Stiles, Shapiro, and Elliott's (1986) analysis of the apparent equivalence of individual therapies to account for this "no difference" result. First, the various group therapies may be differentially effective, but researchers' measures may not be sensitive enough to detect these variations. Second, as Kiesler's (1966) dismissal of the *uniformity myth* suggests, it may be that effectiveness is a complex product of the interaction of groups, therapists, clients, and circumstances. As Paul (1967) stated, the question isn't "Is Therapy A more effective than Therapy B?" but "What type of group run by which therapist is effective for this individual with this type of problem?" When researchers ignore the fit between treatment, therapist, client, and problem, the result is global, but undifferentiated, effectiveness. Third, although extant group interventions are based on widely divergent theoretical assumptions, these assumptions may not lead to differences in practice. A leader of a Gestalt group and the leader of a psychodynamic group, for example, may each explain their goals and methods in very different theoretical terms, but they may nonetheless rely on identical methods when in their groups. Last, as Yalom's (1995) concept of curative factors suggests, all groups—as groups—may promote change no matter what their specific qualities because they often generate curative processes.

Qualifications and Uncertainties

The available evidence pertaining to therapeutic outcomes of groups supports Bednar and Kaul's conclusion: the "accumulated evidence indicates that group treatments have been more effective than no treatment, than placebo or nonspecific treatments, or than other recognized psychological treatments, at least under some circumstances" (Bednar & Kaul, 1994, p. 632).

This positive conclusion, however, requires some qualification. First, and most important, the empirical evidence is not definitive. Whereas a number of reviews are positive, others conclude that group therapy is not as potent as individual therapy (e.g., Abramowitz, 1977; Dush, Hirt, & Schroeder, 1983; Engels & Vermey, 1997; Kilman & Stotile, 1976; Nietzel, Russel, Hemmings, & Gretter, 1987; Parloff & Dies, 1977; Solomon,

1982; Stanton & Shadish, 1997). Solomon, for example, found that outcome studies that compare individual and group therapy for alcoholism treatment do not recommend one treatment over the other. Parloff and Dies, after reviewing the results of studies of group therapies with a range of client types (schizophrenics, psychoneurotics, juveniles and adult offenders), concluded that the results are disappointing. Abramowitz reaches a similar conclusion in her review of outcome research on children's activity, behavior modification, play, and verbal therapy groups. Also, evidence pertaining to marathon groups is relatively negative (Kilmann & Stotile, 1976).

Second, the changes brought about by group experiences *may* be more perceptual than behavioral. Bednar and Kaul (1979), after culling the studies of change in groups that were methodologically flawed, concluded that most studies had reported changes only on self-report data, rather than behavioral data. Reviews of experiential groups also generally find stronger evidence of perceptual changes than of behavioral changes (Bates & Goodman, 1986; Berman & Zimpfer, 1980; Budman, Demby, Feldstein, & Gold, 1984; Ware, Barr, & Boone, 1982). Faith, Wong, and Carpenter (1995), however, did not confirm this tendency in their recent review.

Third, in some cases, groups can do more harm than good for participants. As Bednar and Kaul (1979) note, a participant may decide to leave the group before he or she has benefited in any way; such an individual is usually labeled a premature termination, or dropout (Holmes, 1983). A casualty, in contrast, is significantly harmed by the group experience. A casualty might, for example, commit suicide as a result of the group experience, require individual therapy to correct harm caused by the group, or report continued deteriorations in adjustment over the course of the group. The number of casualties reported in studies has ranged from none among 94 participants in a human-relations training lab followed up after five months (Smith, 1975, 1980) to a high of 8% of the participants in a study of 17 encounter groups (Lieberman, Yalom, & Miles, 1973). A relatively high casualty rate (18%) was obtained in one study of 50 married couples who participated in marathon encounter groups, but this rate was inflated by the problems the couples were experiencing before entering the group (Doherty, Lester, & Leigh, 1986). No evidence is available concerning the rate of casualties in self-help groups, but statistics maintained by the NTL indicate that 25 individuals who participated in the program prior to 1974 experienced a severe psychological reaction (Back, 1974). This number is less than 0.2% of the participants. Casualties can be minimized by limiting conflict during sessions and making certain that the group atmosphere is supportive, nonevaluative, and nonthreatening (Mitchell & Mitchell, 1984; Scheuble et al., 1987).

The Future of Group Approaches to Change

Groups are not all benefit without cost. Groups can demand great investment of time and energy from their members. While groups provide social support, they also are the source of considerable stress for their members. Groups, too, can socialize members in ways that are not healthy and set social identity processes in motion that increase conflict between groups (Forsyth & Elliott, 1999).

Their checkered impact in no way, however, detracts from their significance in shaping mental health. Groups are essential to human life. Groups help their members define and confirm their values, beliefs, and identities. When an individual is beset by problems and uncertainties, groups offer reassurance, security, support, and assistance. Groups are places where people can learn new social skills, and discover things about themselves and others. Groups, too, can produce changes in members when other approaches have failed. Both researchers and mental health professionals who understand groups agree with Lewin's law: "It is easier to change individuals formed into a group than individuals who are alone" (1951, p. 228).

Practitioners have not yet fully exploited the power of groups, however, and researchers have only begun to explain the dynamic interrelationship between a group and its members. Even though therapeutic applications that utilize a group setting (group therapy) and the scientific field devoted to the analysis of groups in general (group dynamics) always have been intertwined, this shared ancestry has yet to inform fully the scientific analysis or the therapeutic application of change methods in group contexts (Forsyth, 1997; Forsyth & Strong, 1986).

This research–practice gap should be closed if the science and practice of groups is to evolve

and grow stronger, and this integration should focus on several levels of integration (Forsyth & Leary, 1991, 1997). Curriculum and training procedures should nurture the scholar's interest in groups in general and therapy groups in particular. Changes in graduate school training that could reduce this insularity include (a) a requirement for studying "real groups" (including families and therapy groups) in social psychology, (b) revision of curriculum to focus on more group topics (e.g., leadership, group structure), (c) updating of textbooks to include clinical topics, and (d) the revision of group-practice texts to include a more defensible foundation in theory and also research in group dynamics (Steenbarger & Budman, 1996).

The gap also should be closed at the professional and practice level. Curiously, when psychology emerged as a mental health field after World War II, many of its central practitioners were academicians who specialized in the study of group processes: Lewin was the prime example of an individual who prospered in the science and in the practice of groups. Over time, however, the professional identity of researchers and therapists diverged until now their shared roots are nearly unrecognizable. Even though group researchers and group therapists likely share many foundational assumptions—both recognize the causal power of a group and have seen the change that it can produce—they likely adopt differing views about the nature of science, and how our understanding of groups can be furthered best. The founding of new organizations, such as Division 49 of the American Psychological Association (Group Psychology and Group Psychotherapy), and the publication of texts and journals that integrate research and practice strive to restore this lost link.

Our understanding of groups as change agents has expanded considerably in the years since Pratt convened his first fledgling groups, but much work remains to be done. Those who study groups and make use of them to promote change agree that groups are essential to human life. Through membership in groups, we define and confirm our values and beliefs and take on or refine a social identity. When we face uncertain situations, in groups we gain reassuring information about our problems and security in companionship. In groups we learn about relations with others, the type of impressions we make on others, and the way we can relate with others more effectively. Given their central importance, we must accept the charge of developing more elaborate conceptualizations of groups that take into account both their change-producing properties and their properties as groups *per se*.

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