Psychotherapy with Psychotherapists

Group Psychotherapy for Group Therapists

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GROUP PSYCHOTHERAPY FOR GROUP THERAPISTS

Erich Coché, Ph.D.

After conducting psychotherapy groups in one's own personal style, a therapist is confronted by three main dangers. Although most therapists are aware of these to some degree and have developed their own ways of dealing with them, they are still worth noting because of their potential detrimental effects on therapy groups.[1] This chapter advocates the use of a therapy group for therapists as a method of preventing or coping with the following dangers:

1. With increasing years of experience, many therapists begin to nurture the belief that they have already found the answers to all the problems a group can possibly present. Responding to those problems, they can reach back into their fund of accumulated experience and apply those techniques that have served them well in past years. This, however, causes some therapists to become blasé and stereotypic in their response patterns.

2. Many experienced therapists tend to forget how anxiety arousing a group can be to a participant, how hard it is sometimes to disclose personally troublesome material to a group of peers, and how frightening situations can be as, for instance, the first session, when one is not "in the driver's seat." A group for therapists can refresh those memories and give the therapist a renewed understanding of the feelings of the participants.

3. As time goes on, group therapists tend to become less aware of their own power in a group. I have seen professionals ascribe enormous powers to someone who by all other indicators was their peer, but was now treated as more than that because he or she was assigned the group leader role. Groups tend to invest almost mystical powers in their leaders. Thus, a group magnifies the impact of a leader's utterances for better or worse. There is much potential for healing in such a powerful position, but there is as much seduction for abuse and even more potential for harmful effects if the leader either is unaware of this power or denies its existence. Participation in a group for advanced therapists can reinforce the lesson the therapist needs to keep in mind if power is to be used to the advantage of the patient seeking help.

Continuing education is not limited to cognitive subject matter but can also apply to affective-experiential learning. Some therapists' blind spots develop long after their training, and intermittent intensive group experiences can provide refreshing new impulses for introspection and personal change, which in turn have a salutary effect on the therapist's work. Professionals who have participated in the psychodynamic process groups at the annual institutes of the American Group Psychotherapy Association have repeatedly expressed how profoundly they have been affected by these groups (Coché, Dies, & Albrecht, 1982). Here, too, the learning acquired was seen not only as beneficial to one's work with clients, but also as personally meaningful and growth producing.

In this chapter, I discuss first the rationales that have been advanced in favor of group psychotherapy for psychotherapists. The central section discusses the issues, problems, and choices inherent in the conduct of groups for group therapists. Finally, there is some discussion of the application of concepts of this chapter to therapy groups for beginning group therapists.

RATIONALES FOR THERAPY GROUPS FOR THERAPISTS

Being in the Patient Role

As already mentioned, participation in a therapy group gives the group therapist first-hand knowledge of some of the anxieties, joys, and frustrations that any group therapy patient experiences. Patients are naturally anxious when a group works out its leadership problems. Going through such group events and feeling the pangs of anxiety very directly provides healthy reminders that can enhance the degree and the accuracy of a group therapist's empathy upon return to the groups he or she is leading.

Isomorphism

Group therapy supervisors who conduct training groups for students or for advanced therapists are frequently surprised by the regularity with which similar issues appear both in the supervisory groups and in the groups their

candidates are leading. A principle of isomorphism is often invoked, but is frequently treated as if it were something mysterious and inexplicable. On reflection, however, it becomes rather simple and perfectly logical that this phenomenon should occur. First of all, groups are groups. They proceed with a reasonable degree of regularity from one developmental stage to another, as has been described by many authors (Thelen, 1954; Bennis & Shepard, 1956; Beck, 1981; Beck & Peters, 1981). Regardless of the particular schema one follows, it is likely that very similar types of occurrences develop, depending on the stage a group is in.

Secondly, it is likely that a therapist who leads a group has certain personal and interpersonal issues that will be evoked in some form in the groups he or she is leading as well as the one he or she is participating in. For example, group therapists who have unresolved authority conflicts are likely to focus excessively on this issue in the groups they lead. It is equally likely that they will make this a major issue in the groups in which they participate. Whatever the core conflict may be (such as authority, dependency, or intimacy), it usually does not matter what side of the drama one is on. I have seen therapists switch back and forth in the roles of rebel and dictator from one group to the other, spending considerable amounts of time on the activity, and blatantly seducing other members of either group into playing the contrapuntal role.

Common Therapeutic Advantages

If the group for therapists is indeed a psychotherapy group (as opposed to a seminar), it is likely also to have all the therapeutic elements of any psychotherapy group: among other benefits, it provides its patients with feedback on their behaviors and can help in removing blind spots and in improving communications skills. Most of all, such a therapy group can help its participants to work out some of their own problems that otherwise might be foisted onto their present or future clients. In this regard, group therapy has a distinct advantage over individual therapy because it allows the therapist, the other group members, and the leader of the group to observe the behavior of the member in a group situation.

ISSUES IN THE CONDUCT OF GROUP THERAPY FOR GROUP THERAPISTS

Some practical and theoretical issues must be confronted when one conducts group therapy for psychotherapists. In generating this list of issues, and in formulating some of the answers, I am relying mostly on my personal experiences gathered by participating in and leading such groups.[2]

The following sections address many problems to be faced when designing a group therapeutic experience for therapists. The problems have been organized into three major clusters:

1. Issues that create or enhance resistance among the participants,
2. Issues of format and design that should be addressed before starting the group,
3. Problems typical of all therapy groups, but perhaps exacerbated in groups designed for therapists.

RESISTANCE

Resistance is the central problem for the leader and the group (I. Berger, 1969). Being in a group is always somewhat anxiety arousing, and self-disclosure is difficult for most people under normal circumstances. However, when this is happening to an already established professional within the framework of a therapeutic group, it is likely to create formidable barriers to self-exploration. Resistance in such a group stems from many sources, some of which are elucidated later in this chapter. Overcoming resistance is frequently the overriding goal and ultimate sign of success for this type of group.

Resistance can take many forms, the most frequent and obvious ones being prolonged silences, excessive intellectualization, lateness, absences, or over-talkativeness. More subtle forms of resistance, like the squelching of enthusiasm of more active members, can often go unnoticed for quite a while, but once detected and discussed are often more easily overcome than

the more dramatic symptoms.

A Group of Therapists

Since groups of group therapists consist of mental health professionals, there is a constant danger that everyone in the group will want to be the therapist, and no one will want to play the patient role. These groups can develop superb levels of sophistication in making interpretations for one another, but have trouble finding volunteers to be the recipients of their ministrations. Thus, as Yalom (1975) pointed out, intellectualization is likely to be so commonplace as to make true therapeutic work extremely difficult. It is also quite likely that there will be at least two or three members in the group who will finally become very tired of the constant intellectualization and will take considerable interpersonal risk in order to move the group forward. In this sense, the therapist in the patient role can be both a source of resistance and a force to overcome it.

Institutional Embeddedness

Another set of problems arises out of the fact that many groups for therapists are assembled from within an institution. Frequently the group is part of a special experience organized for members of the staff. The members' familiarity with each other and the conflict created by the multiple role relationships of being colleague and cotrainee can increase resistance

considerably, as illustrated by examples below.

Confidentiality

In most psychotherapy groups, members are understandably concerned that their self-disclosures remain confidential. This becomes even more an issue when the members are also working with one another and with colleagues who do not belong to the group. Concerns about confidentiality frequently determine the content of the first few sessions. Setting rules in this regard may become the first decision-making activity within a new group, and dependency issues can come to a head at this juncture when the group demands that the leader establish clear standards from the outset, and the leader responds by telling the group that it should solve this problem itself and create its own norms and regulations. Thus, many groups for therapists "get going" around the confidentiality issue., Usually, they find a satisfactory solution, but until they do, and if they do not, they can become so concerned over possible violations of confidentiality that this issue itself becomes a major point of resistance and can severely hamper the process of the group.

Hierarchical Structure

It is not uncommon for groups of therapists to comprise members of different levels within the organizational hierarchy of their institution. This too can become a point of resistance; superiors may feel greatly inhibited in

front of the people who work for them; the latter, in turn, may resist involvement because they are afraid to look foolish or weak in the eyes of their superiors. Occasionally, the lower-ranking members will become hyperexpressive, exerting excessive amounts of energy in order to impress their bosses. Where such phenomena occur, they need to be dealt with. Given a skillful leader and a modicum of trust within the group these problems can be overcome and lead to better understanding between the participants.

Of course, hierarchy and institution-related problems can be avoided altogether if group therapists choose to participate in stranger groups convened outside of their organization.

FORMAT CHOICES

The person who organizes a therapeutic experience for group therapists is well advised to consider a number of choices carefully before beginning. Owing to prior experiences, he or she may have a preference for a certain way of conducting such a group, but the many complex issues that tend to arise frequently require differentiated, thoughtful answers for which there may be no prior models. In this section, some choices are detailed.

Group Therapists Only or a Mixed Group

Seeking a group experience outside of one's own institution and circle of acquaintances prevents many of the problems just mentioned. Furthermore, one needs to ask whether the therapy experience is likely to be more genuine and more therapeutic if the therapist is a member of a group of therapists, or in a group with other patients who are not mental health professionals. Certainly there is less likelihood that the kind of intellectualization mentioned earlier will develop in the latter type of group. However, there is a danger that fellow group members may see the mental health professional as another therapist and treat him or her accordingly. Conversely, the professional who is a patient in such a group may enjoy the special status. Most groups, fortunately, only show such preferential treatment for a brief time. After that, they are likely to insist that the therapist-patient become a fellow patient regardless of his or her status in the "outside world". As Dies has pointed out (1983), another problem arises if the therapist who participates in a genuine group has no actual symptoms —in contrast to the rest of the group members. This is likely to further enhance his or her special role.

At the point at which the group begins to work on its leadership and authority problems, the mental health professional who is a patient in a group with lay people is likely to take on a special role. He or she may become a substitute for the leader and be attacked merely because the group is not quite ready to attack the group leader, but does want to begin working

on the authority issues with which they need to deal. It is up to the leader to be cognizant of this development and to prevent such substitute whipping through the appropriate interpretations. This, too, is frequently made more difficult because the actual behaviors that the professional in the group had been showing may have played right into the prejudices and hostilities generated by the professional status.

Participating in a group consisting solely of other group therapists prevents this particular dynamic. It is certainly a viable choice and one long encouraged by the American Group Psychotherapy Association (AGPA) at its annual institutes. Likewise, there are many group therapy possibilities set up "for therapists only" by the affiliate societies of AGPA and by institutions around the country.

Therapy or Process Group

The literature on the training of group therapists is replete with debates on whether the experiential part of training should be a true psychotherapy group or a "process" group. This same question must be faced by the therapist seeking a group experience. Some authors (Sadock & Kaplan, 1971; Woody, 1971) insist that only a therapy group can provide all the benefits of a therapeutic experience, but others believe that any group that studies its own processes is beneficial (Garwood, 1967; Lakin, Lieberman, & Whitaker,

1969). AGPA, in its model training regulations (1978), makes the distinction between the two types of groups and declares a clear preference in favor of the therapy group for the training of group psychotherapists.

The fact that both types of groups are mentioned in AGPA guidelines does not mean that there is much clarity about the differences between the two. The list of distinguishing features described in Table 1 is meant as an aid in clarifying the demarcation. I realize that some of my colleagues will disagree and that most of the differences are matters only of degree and not of substance. Some process groups are, in fact, quite individual-focused, and some therapy groups are almost entirely group-focused. Nevertheless, the differences described in Table 1 are useful as theoretical points of departure. They can also be used in formulating a contract between a leader and prospective group members.

Whichever form of group experience one chooses, there still appears to be an ethical imperative to be clear about the chosen format. It causes great resentment and fear if one promises participants a group-process study group and then turns it into a traditional psychotherapy group. Although either version is likely to be beneficial to its members, the group that has a clear contract from the outset about its goals and its parameters will ultimately be more successful.

Table 1: Distinguishing features of the two types of groups for therapists

Group Aspect	Group Therapy	Group Process Experience
Goal	Amelioration of personal pathology	Affective and cognitive learning about group dynamics
Intervention focus	More individual	More group-as-a-whole
Composition	Therapists only or together with nontherapists	All therapists (or trainees)
Self-concept of members	Patients	Students, participants
Cognitive component (lectures, readings, etc.)	Absent	Present

Closed- or Open-Ended?

If learning about group dynamics is one of the more prominent goals in choosing a therapeutic experience, it is desirable to work with closed-ended groups. They offer the participants a better view of the developmental stages within the life of the group. The formation and changes of norms and roles over time can be observed better if the timeframe of the group has been set from the beginning. However, being in a closed-ended group may not be very realistic in light of the fact that most therapists conduct open-ended groups in private practice and clinic and hospital settings. The disruption of the natural flow of group dynamics caused by periodic terminations of old

members and assimilations of new ones is part of the process with which the leader has to cope. Participating in such a group provides the members with an experience closest to that of the patients dealt with in their own work.

Intervention Foci

Borriello (1979) describes three types of interventions a group therapist can choose to make while working with a group. An interpretation can be focused on: the group as a whole, the interpersonal interaction between two members, or the personality and personal problems of one member. Depending on the focus chosen most often, the group will take on a specific quality. Although most group therapists use a combination of approaches, some are so group-focused that they will never make a person-centered interpretation, whereas others are person-centered to the point where the therapy is essentially an individual therapy conducted in the presence of others.

Whichever focus one chooses, it appears important to make these choices knowingly and with some forethought rather than merely to "roll with the punches" and come up with whatever interpretation seems to be called for at the moment. The preferred focus of the leader determines the type of group experience the participants will ultimately have. Thus, for the group therapist seeking an experience for himself or herself, it is worth

knowing the intervention preference of the potential leader.

There is no overall rule as to which intervention focus is best for a group of psychotherapists. The group-as-a-whole approach tends to provide a greater amount of learning of group dynamics and generally reduces resistance among the participants to a more bearable level. However, just as a psychotherapy group can be legitimate and effective if conducted at a personal intervention level, the same can be true for a group for professionals.

Structured Exercises

The understanding of group dynamics can often be enhanced considerably by structured exercises as proposed by Pfeiffer and Jones (1971). Used at the right moment, the group can learn a great deal about its own issues and its own internal structure through a sociogram or communication exercise. However, such exercises require some risk-taking behavior on the part of the leader. There is always a chance that an exercise will backfire, that it will demonstrate something totally different from what one had planned, that it will disturb the group and increase resistance, or that it will become a source of embarrassment. Despite these risks, exercises are valuable and provide a considerable increase in learning. Interminable intellectual discussions can effectively be cut short by a drastic visible demonstration of

a major group issue. The sociometric pattern on the wall may be the picture worth a thousand words.

Instrumentation

Using research instruments during the course of a therapy group can have an effect similar to that of a structured exercise. Dies (1980) offered a sampling of available instruments that can be used for this purpose. It includes tools like the Hill Interaction Matrix-B (Hill, 1977), the Group Atmosphere Scale (Silbergeld et al., 1975), and the Interaction Process Analysis (Bales, 1950). There are two additions to his list that I have used with some success in groups that I have led:

1. The Group Climate Questionnaire, Short Form (GCQ-S), by K. R. MacKenzie (1981). This instrument has shown itself to be an excellent, quick indicator of the mood and atmosphere in a group. It is sensitive to changes in group climate, which can then be reported back to the group, stimulating more discussion of its own developmental stage and possible resistances.

2. The DEST Test, by J. Durkin (1981). This instrument is closely tied in with the theory of group development and group roles proposed by Beck (1981). It focuses on roles taken by people in a group. It gives members an opportunity to see how their perceptions of themselves fit with the group's perception of them. It also permits insights into overrepresentation or underrepresentation of certain prototypal roles within a group.

The introduction of research instruments not only enhances the group's understanding of its progress and current issues. It also imparts a certain attitude towards research. Group therapy and practice are then no longer seen as antithetical to each other—as some therapists seem to think—but are presented as complementary: good group research enhances the practice of group therapy by making it more effective; the practice of group psychotherapy conversely helps to specify questions worth asking and worth answering through research.

Further, introducing research instruments can teach the group that research is easy to conduct and can move a group forward in great strides. It can thus, by acquainting group therapists with available group research methods, bridge the gap between practice and research (Coché & Dies, 1981).

A Forum for Supervision

Some leaders of groups for therapists encourage their members to discuss problems they are encountering in the groups they are leading. Although this is a legitimate use of group time, one should decide in advance if one wants to run a group with this as part of the agenda. There is certainly a danger that such discussions lead to much intellectualization and an elegant effort on everybody's part to stay away from the dynamics of one's own

group by describing those of another one. The choice needs to be made on the basis of the needs of the members, their other resources for supervision, and the constraints of the institutional setting.

Intermittent Restructuring

The groups that my coworkers and I have led underwent constant changes in the format used. Human beings can be amazingly creative in the ways in which they resist a task once they feel unsafe. Because our groups for therapists took place in an institutional setting and consisted of people who were also working with one another, concerns about confidentiality and hierarchical issues were natural and at times caused much anxiety. We therefore had to reshape our style of working, the requirements and the constraints we placed on the group, and the way in which we combined cognitive and experiential learning in a process of continual readjustment. At times, we could trust that the group's own process and the need of the members to learn would take care of excessive resistances. At other times, however, a purposeful and even forceful intervention from the group leaders was necessary. Without such intervention, the group was occasionally in danger of becoming stale or nonproductive. Frequently, absences, latenesses, or outright complaints were indicators that something needed to be done to get things back on the right track.

COMMON GROUP THERAPEUTIC ISSUES

Groups for therapists present problems that are not genuinely different from problems found in any group. However, they can take on a special quality or be exacerbated by the fact that the members are group therapists.

Subgroupings

In any therapy group there will be times when one faction forms a coalition against another. Such coalitions can be on the basis of gender, race, or other demographic features, but more frequently, they are based on disagreements over the direction the group "should" take. In groups of therapists, the fact that the members may come from different mental health disciplines or different buildings within the institution can lead to the formation of coalitions, which in turn may insist on specific directions toward which they want to push the group. The group leader may have certain allegiances, too, and will at times collude with one of the factions or at least be identified as one of "them." A multidisciplinary coleader team is a great protection against this pitfall. Otherwise, the interventions and interpretations that must be made to move the group out of its factional disputes need to be made more often, more skillfully, and perhaps more forcefully.

Dependency

Dependency is one of the stages described by Bennis and Shepard (1956) in which a group can remain stuck while avoiding work. Although this phase is quite natural, particularly for beginning groups, it can become more poignant and more difficult to overcome in a therapy group for clinicians. Having so much at stake in terms of their professional status and their acceptance within the group, members are understandably frightened and therefore likely to lean on the leaders not merely for direction for the group but also for precepts and guidance for their own within-the-group behavior and the setting of group norms. Here the leader has a fertile field for meaningful and well-placed interpretations that can move the group forward, heighten self-awareness, and provide growth experiences for the members to enable them to take more responsibility for the life of their group and for their own lives as well.

Scapegoating

Beck (1981) describes scapegoating in detail. This role, like all others, develops in the interchange between the role-bearer and the group. He considers the scapegoat to be one of the prime moving figures within the group, not only an object of dislike and derision, but also the representative of a disliked out-group. This phenomenon can frequently be observed in groups of therapists, too. If one of the departments within an institution is represented by only one person in the group, and all the others have more

than one representative, it is possible for that person to be chosen as the first target. Scapegoats tend to contribute to this process by frequently showing behaviors that irritate other group members even though they may actually be very much in the interest of group progress. Occasionally the leader may have to intervene in order to prevent the actual ejection of such a member. Most often, however, a few specific group-as-a-whole interpretations can help the group get out of its attack mode. At times, one other group member will become tired of excessive focusing on the scapegoat and shift to a more fruitful direction.

Between-Session Activities

Interaction among group members between sessions has been the subject of some debate in the group psychotherapy literature (Yalom, 1975; Kaplan & Sadock, 1983). Although these authors warn against such contacts and suggest that groups have rules prohibiting them, many therapists feel that anything goes as long as it is discussible. In an institution where people have to work with each other and also interact in such places as cafeterias and snack bars, a prohibition against between-session contact would be ludicrous. However, some such contacts can cause severe problems for the group. Members may get together to work out differences between them that arose in a group session and thus deprive the group of an important dynamic. Worse than that, they may get together in order to discuss the

pathology of a member who is not party to this discussion. When such behavior becomes group knowledge, it is likely to greatly upset the other members and to lead to the formulation of a group norm prohibiting extra-group contact, which may be impossible to enforce. The leader of such a group experience is well advised to be clear about his or her own preference in this matter and the rationale for a decision. I am most comfortable with allowing members to interact between sessions with the proviso that they discuss their interactions in the group and stay away from extensive discussions of absent members. Also, I prefer to work with groups that clearly articulate their norms.

Acting Out

The above mentioned between-session activities, and occasional lapses in confidentiality or sexual activities between members, are the most common forms of serious acting out, yet they are rather rare in groups of clinicians. More commonly, acting out will take the more subtle forms of innuendo, sarcasm, or excessive silences. When these occur, they are signs that something is wrong in the group and has not been dealt with directly. At that point some attention to the developmental phase of the group is indicated. Group-as-a-whole interventions that focus on the developmental issue rather than the form of the acting out are most likely to be effective in moving the group forward and in squelching the undesired behavior.

An event that occurred in a group of professionals I co-led a few years ago may serve as an example. The group was quite clearly stuck in a developmental phase called "disenchantment" (Bennis & Shepard, 1956). It seemed unable to move on to the next phase, which would have entailed more interdependence and intimacy between the members. At that point, two women in the group spent an evening at the home of one of them, discussing the group and its problems at length, thereby violating a norm this group had set. When they confessed their behavior in the next session, they were at first chastised for their "acting out." The group then, however, with little help from their leaders, began to see that these women had achieved the degree of intimacy and mutual trust the group was longing for. Observing this was the impetus the group needed to stop stalling and to move on to the next stage.

In groups of professionals the danger of acting out is rivaled by the pernicious habit of some members of labeling too many behaviors as "acting out" or "inappropriate." I have learned to watch these words as indicators that a group may be engaged in very rigid norm setting and enforcing. Frequently it is not the whole group but only one particular member who is creating a powerful position for himself or herself by becoming the legislator and guardian of the group norms.

To make matters worse, the behaviors marked as "acting out" are often

either innocuous or actually desirable: for example, self-disclosures or expressions of affect. Labeling them as "inappropriate" causes considerable fear and inhibition, leading to interminable silences, bland intellectualizations, and other symptoms of a group in trouble. The leader of a group of therapists, therefore, needs to be particularly watchful in the normative phase of a group.

GROUP THERAPY FOR THE NOVICE GROUP THERAPIST

This chapter has dealt mostly with the issues involved in the conduct of group therapy for the experienced practitioner. The following section sheds some light on problems encountered in groups for therapy trainees.

The training of group therapists has been a subject of great interest in the group therapy literature. In 1980, Dies found 200 published articles on this topic, plus several reviews. Although a plethora of different teaching modes has been proposed so far, most authors and reviewers (Coché, 1977; and Dies, 1980, for examples) recommend some type of group experience as the crucial ingredient of a comprehensive training program. Group psychotherapy for the aspiring therapist has been advocated by many (M. Berger, 1969; Sadock & Kaplan, 1971; Berman, 1975; Shapiro, 1978). As early as 1947, Samuel Hadden, a past president of AGPA, proposed group therapy sessions as a way of introducing novices to therapy. The response

from his (medical) students was enthusiastic. They considered this step as revolutionary, "like coming off the benches and standing next to the surgeon during the operation" (Hadden, 1982).

The endorsement of group therapy for future group therapists has grown continually since then and is now part of the model training program proposed by AGPA (1978), which lists as one of the desired requirements "Participation as a patient in group psychotherapy for a minimum of 120 hours of which a maximum of 30 hours in a group process experience may be substituted."

However, endorsement of participation in therapy groups for beginning group leaders has never been unanimous and still is not. M. Berger's (1969) article extolling the advantages of groups for group therapists was quickly followed by an article by I. Berger (1969) pointing out many of the difficulties and problems involved in such an undertaking. Shapiro (1978) voices similar concerns, many of which are addressed in this chapter.

Similarities to Groups for Advanced Therapists

Most of the issues described in the preceding pages also pertain to group trainees. Resistance is likely to be just as high as or even higher than in the advanced groups, institutional embeddedness is a major problem, and the

first few sessions are likely to focus on the confidentiality problem. Furthermore, groups of novices are even more prone to develop extreme degrees of dependency and to use extraneous material as a means of avoiding within-group concerns.

Intermittent restructuring of the group format is even more necessary in groups for trainees. The resistances can take so many forms that creativity has to be one of the leader's prime attributes lest the group stagnate and the members stop learning and growing.

Grades and Evaluations

One aspect that sets trainees' groups apart from groups in which accomplished practitioners get together is that in a training program it may be expected that the group leaders will grade the students on their degree or manner of participation in the group. This may be a requirement of the residency or doctoral program.

Concurring with Berman's (1975) and Shapiro's (1978) warnings, I have always eschewed this practice. In the process groups I have led, I have insisted that no grades be required on the members' degree or type of participation. Resistance is enough of a problem; the threat of an ultimate evaluation based on how one "performs" in group would in all likelihood destroy the affective as well as cognitive learning. And to demand self-

disclosure from participants under the threat of a negative evaluation is ethically questionable.

Sometimes, even though the leaders may not write a formal evaluation, their membership on the faculty of the residency or doctoral program can still arouse much concern among the group participants. A workable solution to this problem may be the hiring of a group leader who is not a member of the institutional faculty (Berman, 1975; Shapiro, 1978).

Student Role

Many novices in group therapy are already advanced members of their mental health profession and therefore reluctant to assume the role of a student again. Directly or in more subtle ways, they demand to be treated with special consideration for their status, or they are lax in their handling of such homework assignments as reading or keeping logs. This in turn can cause considerable resentment from lower-ranking members of the group and can add to the tension in the room.

In one of our groups the presence of a high-ranking member of the institutional hierarchy created precisely this problem. Though outwardly denying that she wanted any kind of special consideration, she was so tardy in completing assignments that her actions belied her words. When she began to miss sessions because important committee meetings "made it

impossible to attend the group" it was pointed out to her that she was in fact choosing the institutional committee over the group. This, together with a discussion of the role-conflicts involved, changed her manner of participation considerably and relieved much of the tension and anger felt by the junior participants.

Integration of Cognitive and Experiential Learning

Ever since the trailblazing article by M. Berger (1969), there have been numerous proposals on how to combine the didactic and experiential aspects of the learning to be imparted to future group therapists (Dies, 1980; Gazda, 1975; Bascue, 1978). In our groups at Friends Hospital, we tried a variety of approaches. At one time, we alternated between cognitive and process sessions. Another time, we set an a priori schedule of six theoretical sessions to be followed by six process sessions, alternating for 42 sessions. In more recent years we used a format in which the group would run for 75 minutes, after which 15 minutes were spent on discussing what went on in the session itself. This was combined with a list of suggested readings.

Another method tried was assigning homework, specifically the writing of a one- or two-page log about each session. This would then be read later by the leader and provide information on members' perceptions of their group. From this the leader could derive hints on trouble spots in the

group or about theoretical topics worth pursuing. The disadvantage was that if a problem emerged in a group, the writing, reading, and returning of the log would entail a two-week lag, often causing complicated communication difficulties.

Whatever format we used, the group was always able to abuse it for resistance purposes, a danger already pointed out by I. Berger (1969). Sometimes groups would spend all their time in meaningful and self-disclosing interactions at the expense of their cognitive learning. They would do so purposefully, in order to avoid more intellectual tasks including studying the assigned readings. Other groups would spend their time in esoteric, theoretical discussions, obviously to avoid having to deal with some difficult interpersonal problems within the group. Whenever such excesses were observed, the leaders usually needed to intervene, but were frequently assisted by those members of the group who themselves had become uncomfortable with the imbalance.

Learning Leadership Behaviors

One of the greatest advantages of a therapy group for trainees is that the fledgling therapists learn a large variety of leadership behaviors merely by watching the modeling of their leader. Beginning therapists rarely choose their preferred mode of psychotherapy by making conscious choices

between analytic, rational-emotive, or other therapeutic modalities on the basis of their readings. More often these choices are the result of emulating an inspiring preceptor.

In the life of a group the leader has to deal with many situations not discussed in textbooks. Observing a therapist at work provides the student with an armamentarium of available responses when situations occur in their own groups. For example, I have had long discussions with graduate students in clinical psychology about the advisability of self-disclosure of personal data by a group leader to his or her group. In observing the students at work, I found that their actual self-disclosing behavior was determined much more by the style of their model therapist, who frequently was the leader of their process group, than by weighty debates they had heard or been involved in.

Discovery of Personal Problems

It is possible that in the course of a process group the leader will discover serious personal problems in one member. These can be so severe that one has to question whether this person is fit to be a therapist. Because the group is part of a training program, the emotional impairment of a trainee cannot be taken lightly. The fact that most of these groups work under a contract of confidentiality prevents the therapist from handling the problem

directly with the training director and this creates a complicated ethical dilemma. However, there are a few possible solutions. First, it is likely that the trainee is also being observed by a number of other supervisors and trainers. If the disturbance is serious enough, it is likely to be visible to these people, who are not bound by a confidentiality rule. Secondly, the group leader frequently has a special relationship of trust and respect with the trainee and can make a recommendation for personal therapy in such a way that the trainee will follow up on it instead of becoming defensive and indignant. Thirdly, if participation in the group is truly voluntary, most trainees who already have doubts regarding their emotional stability usually will prefer not to participate in such a group. Thus, their pathology will most likely become evident in the process of being supervised for their therapeutic work rather than in the group.

Prior Experience

Since the 1970s, when growth groups were proliferating, many training programs in psychology and social work have been including process groups in their curricula. Thus, many individuals joining a therapists' group have had some prior experience in a process group. That is frequently more of a burden than a help, because members carry their preconceived notions as to "what a group should be about" into the new group and try to foist the norms and expectations from prior groups onto the present group. This in

turn causes stiff resistance from those who have had different or anxiety-arousing past experiences. The other members who have had no prior experience at all tend to find the sudden injunction to "let it all hang out" rather frightening.

Voluntariness

The fact that the group members are also members of a training program sometimes means that they have only limited choice over whether to attend. Depending on the particular program, there may be either a direct injunction that participation in the group is a prerequisite to graduating from the program; or participation is said to be voluntary, but there is a clear understanding that nonparticipation will be frowned upon by those in power. Finally, there are programs in which the participation is truly voluntary and where trainees who choose not to join the group can still enjoy all the rights and privileges of their training program without any reprisals. It has been our experience that this kind of freedom not only allows potentially shaky members to stay out of the group but also sets a very positive tone for the group, in that everybody knows that all are involved because they want to be there, and they can truly invest their energy in making the most of it.

SOME FINAL CONSIDERATIONS

In recent years, group psychotherapy research has shown with increasing clarity that group therapists not only can do much for the amelioration of human suffering but also can do harm, especially if they are using their groups for the pursuit of personal gain (Hartley, Roback, & Abramovitz, 1979). An experiential group for therapists can help teachers and leaders to detect potentially harmful persons. It can occasionally help the student to change in a desirable direction or it can stimulate his or her supervisors to redirect the career path of the potentially harmful therapist into a more innocuous, nontherapeutic direction, thus saving some future patients from possible iatrogenic disturbances.

An experiential group for therapists can also impart ethical standards through teaching and modeling (Gazda, 1975). This is yet another argument for conducting such groups.

Although it is my conviction that self-study groups for therapy trainees are desirable and truly help in making novice group therapists more effective and more responsible in the work they do, there is unfortunately no research to prove this point. There are some—albeit conflicting—data available on the effects of personal therapy for individual therapists (Strupp, 1955; Holt & Luborsky, 1958; Peebles, 1980; other chapters in this book), but no such information appears currently available on the effects of group therapy for group therapists. We have reached a stage now in which a

generation of new group therapists has been trained in programs that included an experiential component, and we still do not know with any reasonable degree of reliability whether this experiential part is as valuable as we have come to believe. It is hoped that researchers will find the courage and the funding to investigate whether group therapists who had an experiential component in their training are indeed better equipped than group therapists who did not. Until then, we have to assume the superiority of such training on faith, random observation, and personal experience.

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EDITOR'S COMMENTARY
WHEN THE GROUP IS THE MEDIUM

Florence Kaslow Ph.D.

In this chapter, Erich Coché discusses group therapy for group therapist trainees and advanced practitioners. He looks at the difference between process groups and didactic groups, indicating that whichever modality is the preference, it should be clearly stated in the contract with the group. Throughout, he argues persuasively for maximum clarity in the working out of objectives and rules governing group behavior. Given that therapy groups are often made up of people who work together within the same institution, he suggests that issues surrounding confidentiality and feelings about someone's status in the institution hierarchy are quite marked. These, plus institutional embeddedness, need to be discussed openly so that everyone can achieve some degree of comfort with them. It stands to reason that concerns about authority, confidentiality, and loss of privacy would be more marked within the institutional context, because group members are likely to know each other professionally and be concerned about their reputations if they engage in too much personal disclosure. He does not deal with groups of therapists who come together who do not work in the same setting—there might be some important differences such as less concern for what is happening in the institution.

He highlights the importance of people having a choice whether or not to belong. Where participation is mandatory, it is likely to have an impact on increasing the level of resistance. Another concern he raises, and justly, is that of trainees in a program who are required to have a group experience and be given a grade for this. This is an issue with which I struggled for many years when I taught a group therapy course in a graduate school psychology program. If one is teaching group therapy didactically, using the groups the students are leading as the content for analysis of process, the students are likely to press for a group experience with one another. Conversely, if one shifts into leading a group-therapy group, some students are likely to assert that they were not told in the catalogue that this would be part of the experience, and they resent it. Universities must make clear before the student comes into the program whether the group therapy will be taught as a process group experience or as a content-oriented course.

In training programs we do not suggest that students should learn individual therapy by being in individual therapy with the instructor. They learn content of the therapy process, bring in a case they are doing for classroom discussion and critique, or take it to a supervisor. Perhaps the same principles should apply to the learning of group therapy.

There are numerous ethical questions raised. For any institution to make participation in a therapy experience mandatory is almost a

contradiction in terms. To participate in group therapy can be both a personal responsibility and a privilege. What are the responsibilities of the group leader if he or she realizes that a member of the group is severely disturbed? If the person is a trainee, is there an obligation to report this to the teaching institution? If the person is a member of an agency staff, what responsibility does the leader carry for accountability to the agency—especially if he or she, too, is a member of the staff? Coché indicates that the dysfunctional patterns will probably be picked up by another member of the faculty who does not have a relationship that entails privileged communication with a member of the group. I think the issue is more complex than that. A therapist has a responsibility not only to a group member but also to the patients, current and future, this person is likely to serve. Therefore, the therapist must at least seriously consider recommending to this person that he or she seek intensive individual therapy and suggest that perhaps at this time being a therapist might be counterindicated.

As Coché indicates, we need a great deal more research on the efficacy of therapy groups as a training technique for learning group therapy. Also, the entire field could use some research baseline for determining the effects on trainees of telling them that they should be in individual therapy and that perhaps they should put their work as a therapist temporarily on hold until they get some of their own dilemmas straightened out. The legal

ramifications are manifold and need serious consideration.

Group therapy is certainly a medium that provides a sense of belonging, a multidimensional reflection of how others see the self, and a chance to do some critical self-searching within the context of a group experience. Confidentiality and institutional hierarchy issues as Coché casts them are in many ways related to the boundary issues raised by other authors in this book.

1. Most of the experiences that form the basis of this chapter were gathered while I was on the staff of Friends Hospital in Philadelphia.

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