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The currently fashionable practices in the use of groups for changing people present a real dilemma for traditional mental-health practitioners. The constant appearance of new ideas, the burgeoning variety of settings in which people-changing programs occur, and the articulation of goals that resemble but do not completely overlap those espoused in traditional mental-health settings have made it difficult for most to place the newer forms in a proper perspective in relation to the older ones. The litany of new labels— Bioenergetics, Gestalt, Transactional Analysis, Confrontation Therapy, Marathon, Encounter, Sensory Awareness, T-Groups, and so forth— do not constitute a reasonable road map to diminish confusion. The leadership behavior of the proponents of the various positions suggests that some are primarily analytic and interpretive; others see the management of group forces as their distinctive function; still others almost exclusively see their role to be to offer instructional (often nonverbal) exercises. Some among the new breed of people changers believe passionately in the healing qualities of group-generated love; others believe just as passionately in the curative powers of hate, seeing the basic stuff of change as stemming from the experience of primary rage. Some depend solely on talk therapy; others use

music, lights, and clench of human bodies.

An attempt to reduce the confusion by organizing the array of forms and techniques according to the background, education, or professional disciplines of those who purvey group, people-changing services would be of little help. Those who have made themselves available to lead such groups may have been prepared by long years of training in prestigious professional institutions, by participation in a two-week institute, or purely by personal commitment.

Nor would a sense of order stem from examining the location of such activities. Many personal change-oriented groups are to be found in traditional help-giving institutions, such as mental hospitals, schools, or social agencies; some take place in the offices of mental-health practitioners in private practice. Many arc found in growth centers—a new institution specifically formed for conducting such groups. Church basements, dormitories, and living rooms have also become the scene of people-changing groups.

But what of the goals of the groups? Do they not suggest principles of organization into varying types? They may vary all the way from attempts to reduce juvenile delinquency to attempts at reducing weight. Occasionally they may seek only to entertain, to "turn-on," to give experiences in joy. More

frequently they involve instrumental goals of personal change—goals at times couched in language familiar to the mental-health profession, but more often described in terms that appear to go beyond the traditional goals of mental-health professionals.

Albeit there have been some important exceptions, by and large the mental-health profession has responded to these new developments, and to its own attendant confusion, with what can best be described in defense-mechanism language. One fairly typical response has been to deny the relevance of the new forms of group therapeutics for the mental-health field; another, to use verbal aggression when their presence could no longer be ignored. On the other hand, some traditionally trained mental-health practitioners have sought to identify with the aggressor and to internalize, at least partially, the rhetoric and techniques cast forth by the newer apostles.

The present chapter is designed to examine the variety in types of people-changing groups, both new and old. We shall look first at what differences characterize the more extreme examples of new and old forms, then, at some historical and contemporary forces that may explain why, despite the vigorous growth in group technologies, group treatment remains a field beclouded by considerable conceptual fuzziness. Finally, we shall attempt to examine what are the critical practical and theoretical issues that need solution before a truly integrated view of the entire enterprise of

people-changing groups can be achieved.

The "Old" and the "New"

The incredible difficulty and complexity inherent in providing help to one's fellow humans has always produced a multitude of ideas about how best to accomplish this task. Determining the means to help humans overcome their sufferings and frailties can never be solely a scientifically derived decision, for it not only involves questions of technique or efficiency but also confronts us with the ultimate metaphysical questions regarding what is man's disease and what the end point of his quest. What man needs or ought to become are primarily issues of value rather than science. Yet, the practice of psychotherapy must proceed on assumptions regarding the answers to such questions about the ends of life for man. Now, in this arena of choosing among ultimate human values there have been as many answers offered as there have been philosophers to pose the questions. No wonder then that innovation has been rampant in psychotherapy, that the burgeoning of forms has been the rule rather than the exception; no wonder that the push to create distinctive responses to man's complaints has predominated over the effort to build integrative theories of personal change.

Does the variety of activities surrounding the use of groups for people-changing represent useful distinctions, or are they labels much like different

brands of soap that encase the same ingredients? To examine this question more minutely, it may be helpful to visualize an example or two of what superficially appear to be extremely different forms of conducting the people-changing enterprise. To observe the initial session of a traditional group therapy session, for example, would be to experience something like this:

About nine people file into a room slowly, tentatively. Each has seen only one other person in the room before—the therapist, a week earlier in a diagnostic interview. Some appear reluctant, some enthusiastic, but all have come to this first meeting with at least the willingness to go along with the therapist's belief that the group can be useful to them. They sit in a circle, quiet and expectant. Their posture seems anxious. What will go on here? What can go on here? What will the therapist do? Several in the group have had previous psychotherapy. One woman begins the interaction by describing the disappointments she has experienced in previous treatments. A note of desperation and near panic is discernible in the responses of others to her wail of self-negation and helplessness. Sympathetic offerings of similar tales of woe are heard from various people in the room. From time to time the therapist comments, pointing out the fearful expectations of the various group members.

Underneath the "stories" and histories offered by various members, the therapist "hears" the patients asking each other a set of questions only hinted

at in what they are saying. And underneath these questions about others in the room lies still another set having to do with the person himself. Why did you come? What are your hopes? What forms does your "illness" take? Do you feel that this may do me any good at all? Are you as sick as I? Am I as sick as you? How strange, perhaps even insane, is the arrangement whereby I come to a group of neurotics to get better. Above all what is the "doctor" over there planning to do for me? I don't like people—why must I be here? Who are these others and what have I to do with them?

Thus, group therapy begins. The patients begin an experience in treatment that they may understandably feel violates expectations they bring from their experience in other doctor-patient relationships. Often group-therapy patients cannot see what good it will do an unhappy neurotic person to share his "problems" with other neurotic sufferers. Is it enough to reassure him, as some therapists indeed believe, that a "problem shared is a problem helped" or to provide a context founded on the assumption that misery not only loves but is relieved by company? What of the therapist? Will he, by virtue of some rare professional training and intuitive attributes, be able to understand, diagnose, and change the troublesome personality patterns of a lifetime? And, at that, of a roomful of people simultaneously? The therapist obviously expects something useful to come from the interactions of these people, but how does he see the members to be of use to each other when he remains silent and passive so long? What does he expect will happen?

At the other end of the group-treatment continuum we can imagine another group of people temporarily migrating to a growth center. Their arrival is noisier, more buoyant, more playful; they are robed in vacation garb, their talk is free and more reminiscent of the first evening of summer camp than the still, anxious scene of the group-therapy session. They are likely to have a speaking knowledge of Abraham Maslow, C. Rogers, Eric Berne, and F. S. Peris, and of the latest people-changing procedures. They express their desire for change freely and seem eager to get to know one another. They seem hardly able to await the morning's beginning; if some appear a bit anxious, others are enthusiastic about the drama that will unfold. All know in general what they can expect to happen but seem restless to generate the specific emotions and events that will form the content of their shared experience.

What will the leader, whom they have never met, be like? What will he do or expect of them? In the back of their minds is an accumulation of images based on what they have heard from friends and the popular press —images that are mixed with desires to become changed people. Will it work for me? What about the others? Will they really get to know me? Can I trust them? Will they help me?

They do not have long to wait; the leader begins with an explosion of his inner feelings. He may be sleepy this morning, he may not have wanted to

come, he may look around and find the group full of "unattractive people" and "tell it like it is" without pausing. On the other hand, he may express his total positive regard for all and quickly exhibit a readiness to accept any behavior expressed. He may then launch into a set of instructions, perhaps suggesting that "all of you look so ‘up tight’ that we ought to loosen up and begin by playing a childhood game."

The images evoked by these two settings certainly suggest that the people-changing business in our society today has diverse assumptions, allegiances, and expectations to the point that it might appear sheer folly to consider them under the same rubric.

Let us examine the underlying philosophy, technology, goals, and client types of both forms, and determine points of similarity as well as difference that may have become confused and indistinct in much of the current conversation over the relative merits of the "old" versus the "new."

Although the advent of the "newer therapies" has served to magnify the conceptual confusion surrounding the use of groups for people-changing, the origins of the current dilemmas have their roots in the historical development of the field of group psychotherapy. The use of groups for systematically helping individuals in distress is of relatively recent origin in modern mental-health practice. It is perhaps helpful to recall, however, that small groups have

always served as important healing agents; from the beginning of recorded history, group forces have been used to inspire hope, increase morale, offer strong emotional support, induce a sense of serenity and confidence in the benevolence of the universe, thus counteracting many psychic and bodily ills. Religious healers have always relied heavily on group forces, but when healing passed from the priestly to the medical profession, the conscious use of group forces fell into a decline concomitant with the increasing sanctity of the doctor-patient relationship.

The strangeness experienced by many seekers of psychiatric help, when confronted with the help-giving conditions of groups, is the resultant of a complex process affecting both those who seek the help as well as those who give it. The development of psychiatry as an entrenched part of modern medicine was in part predicated on the idea that "scientific medicine" must at all costs distinguish itself from healing that stemmed from nonscientific traditions. Modern Western psychiatry was even more plagued than other branches of medicine with the need to become "scientific." In its beginnings, the medical treatment of psychological problems required, for its legitimization as a branch of medical science, a clear differentiation between its methods and those that preceded it in non-Western societies, where highly developed group-based techniques were used for curing psychological illness within the framework of the family, groups of similar sufferers, the village, or the religious community. This association of "pre-scientific" therapies with

group forms perhaps influenced psychiatry away from utilization of group techniques.

In Western culture, until the recent advent of the new group therapies, it has been expected that personal help will be given by one person—it may be the corner bartender, a personal friend, or a professional such as a lawyer, doctor, or a clergyman—but what is important is the expectation that the context in which it will be rendered will be private, intimate, and exclusive. Even in such congregate bodies as the family or the church, it is generally assumed that personal help will be offered and received in a private, one-to-one relationship, not through the congregate as a whole. The historical roots of modern psychiatry and the general Western cultural context in the first half of the twentieth century in which these roots were dug did not, in other words, create conditions suitable for the flourishing growth of group-based healing technologies.

In the early 1900s, Joseph Pratt, a Boston internist, organized classes for tubercular patients: "The class meeting is a pleasant social hour for members . . . made up as a membership of widely different races and different sexes, they have a common bond in a common disease. A fine spirit of camaraderie has developed. They never discuss their symptoms and are almost invariably in good spirits . . ." Pratt's therapy had many similarities to current-day inspirational group psychotherapy: he hoped to overcome the pessimism of

the patients, to discourage neurotic secondary gains from illness, and to encourage self-confidence.

Isolated individuals in the early 1900s reported similar sets of experiences to those of Pratt. In Europe, Alfred Adler established guidance centers that used group concepts in treating working-class patients. An early and important influence in the development of group psychotherapy was the use of the healing group by Jacob L. Moreno, who is best known for his development of psychodrama. The analogies of Moreno's approach to the healing groups described in anthropological literature are impressive. The patient is provided the opportunity to express himself freely through drama, trying the role of himself or others he feels significantly related to his present problems. In this technique, scenes from the patient's past are often enacted, employing other persons as auxiliary egos who articulate feelings, moods, responses, and so on that may not be evident to the patient himself—a kind of Greek chorus orchestrated by the therapist. The work of Trigant L. Burrows was an important, but unfortunately unrecognized, influence in the use of groups. A psychoanalyst himself, Burrows became dissatisfied with the emphasis psychoanalysis placed on the individual, an emphasis that he felt excluded examination of social forces. In the early twenties, he initiated the use of the group context for the analysis of behavioral disorders in relation to social forces and coined the term "group analysis" to describe the treatment setting.

Thus, the techniques characteristic of current group-treatment practices were clearly evident in the first quarter of the century. The inspirational character of Pratt's groups has many modern counterparts in the self-help movement, such as Alcoholics Anonymous; Recovery, Inc.; and Weight Watchers. The employment of the expressive part of the person through dramatization as part of the curative process forms a major component of many current group methodologies. Finally, the use of the social context provided by the group for analysis via a psychoanalytic framework is still very visible as a major direction in current practice. By and large, however, the efforts of men such as these were isolated efforts: their predominantly pragmatic concerns did not lead them or others to explore the conceptual grounds underlying the use of groups to provide therapeutic benefits.

Rather, the often competing concepts of individual psychotherapy have, oddly enough, been the main source of theory underlying various forms of group treatment in current use, a fact that goes far to explain why the degree of conceptual morass in contemporary theorizing about group-treatment practice is as broad as the degree of disagreement regarding principles of individual psychotherapy. All major schools of psychotherapy (with the exception of the Jungian whose philosophical individualism is antithetical to the use of groups) have generated their counterpart in group psychotherapy. More often than not the counterparts of dyadically generated theories of psychotherapy have had a haphazard growth pattern, developed more out of

necessity and accident than out of systematic theoretical explanation. Individuals trained in the particular school of therapy conduct groups using their fundamental orientation from individual therapy. Often techniques and concepts have been adapted to the multi-person situation with little formal thought given to the consequences that may be generated by the addition of multi-person social forces to the treatment context. The so-called "new therapies" share a similar history. Although some of the newer ideas were generated out of a movement away from a psychoanalytic view of pathology toward more humanistic or existential theories of personality, both the old and the new are similar in that they stem from theories of individual psychotherapy, not from concepts regarding the influence of the group on processes of individual change. Thus, despite a richness of technique and a tenuous commitment to their pragmatic beginnings, both new and old group-treatment forms share a common ailment—an inappropriate, and consequently barren and confusing, conceptual base. The dyadically oriented intellectual legacy of group treatment has produced a macabre scene. The intellectual battles over the competing ideas offered up by various systems of individual psychotherapy are reenacted in the new group arenas without even a pause to ask whether the concepts being questioned even have relevance to groups.

Some Distinctive Aspects of the "New Forms"

A major theme of many of the new forms of personal-growth groups has been a decided move away from defining individuals who need help as patients who are psychologically ill. The boundary lines between what have for nearly a century been defined as the separate provinces of psychiatry, as opposed to educational endeavors, have become so blurred that the newer forms of people-changing groups are not viewed as simply endeavors to aid those who would classically be described as having psychiatric problems. Certainly the ancient stigmas attached to psychiatric problems have been reduced in importance and the old barriers to seeking out help have been considerably lowered. Clinics or psychiatric consultation rooms no longer are the exclusive settings addressed to changing individuals through group participation. Churches, living rooms, and growth centers specially developed to offer people changing have become major settings for people-changing groups. It seems reasonable to suppose that the diversity of groups and the diversity of settings would bring forth many consumers who heretofore had not sought out psychiatric aid. It also seems quite reasonable to assume that such settings would elicit distinctive expectations and individuals entering these newer people-changing settings might hope to achieve goals different from the traditional psychotherapy patients.

Unfortunately, few data are available even to begin to describe the differences produced in people entering a system for help in which one does not define himself as a patient. Some recently developed information,

however (Lieberman, 1973), suggests that perhaps the newer therapies that emphasize growth and the development of human potential may not be attracting a different population from that engaged in psychotherapy. In a survey of 500 users of human potential growth centers, eight out of ten reported they had previous or simultaneous psychotherapy. It appears, in other words, to be the same group of middle-class individuals making up the bulk of private practice psychotherapy in this country who are also the participants in human-potential growth centers. Life-stress scores (Paykel, 1971) of the growth-center participants were significantly higher than Uhlenhuth obtained in a study of a random sample of normal adults (1972), and resembled the levels of high stress characteristic of psychiatric patients. A similar finding was obtained from symptom scales (Symptom Distress Check List [Frank, 1957]); those who were about to go to growth centers again resembled patients and had significantly more symptoms than Uhlenhuth's population. Finally, self-stated goals for attending growth centers emphasized instrumental, help-seeking issues ("to solve some long-term, personal hang-ups, to deal with current life problems," and so forth) rather than the sort of hedonistic or existential goals frequently expressed as the purposes of membership in the newer types of humanistic groups. Thus, although the symbols of growth, of expanding awareness, and so on, surrounding many of the "new" groups for "normals" sound different, it is difficult to evaluate how closely these symbols are incorporated into the

actual, operating functions of the groups. The findings do not support a belief that the newer humanistically oriented groups constitute an alternative pathway for people who would not seek out mental-health settings.

But if the clientele overlap between the new and the old, may they still perhaps be distinguished by the way they go about the business of changing people? What are the unique characteristics of the new forms and what are their contributions to the therapeutic change process? Perhaps the most important technological change characterizing the newer forms is reflected in techniques for *lessening the psychological distance* between the leader and the participant. A variety of methods serve this function. The transparency of the therapist (personal revelations and so forth), the use of warm, informal settings, the emphasis on assuming the stance of a participant, the emphasis that characterizes some of the new forms on diminishing the importance of the expertise of the leader and defining him more nearly as a peer and, finally, the use of physical contact-touching are all devices that seem to be calculated to reduce the psychological distance between the changer and the changing.

Few guides exist to assess the importance of such a change from the traditional patient-therapist relationships. Perhaps all that can be said for sure is that such changes reflect current changes in social mores, which have increasingly moved away from emphasis on the priestly status of healing professionals and other experts. The new forms, having developed more

recently, could be expected to be more sensitive than the old to current cultural expectations.

A third major difference is the use of *highly structured techniques* wherein leaders instruct participants to engage in certain kinds of prescribed behavior or relationships for learning purposes. These prescriptive techniques have been variously labeled games, structured exercises, learning arrangements, mini-experiments, and so forth. They represent highly specific leader-arranged situations that include a set of specific directions for "experimenting" with new or rarely used kinds of behavior. These orders limit the participant's opportunity to choose behavioral alternatives. Some illustrations of these techniques are:

"Form small groups of four people. Take turns introducing yourself nonverbally. Take five minutes to decide how you want to do this. Try to come up with a name for your group."

"Each person think of the most joyous moment of your life and then think of the way to describe it . . . first verbally and then by action."

"Get into contact with your inner self of violence. Have a fantasy fight between your weak self and your strong self. See yourself in a fight. Describe it. Get up and be the weak person."

"Fantasy yourself being shrunk to the size of a pin and enter a trip inside your body. Try to imagine what you smell, feel like. Try to imagine what you find. Travel to any part of your body that you are having a problem with. Try to examine the problem. Now imagine yourself exiting from your body at any point. Okay, open your eyes. Who wants to share a trip?"

Although the use of leader-created learning situations is not unique with the advent of these new technologies (Moreno's psychodrama, for example, clearly antedates them) the wide and extensive application, the diversity, and the prominence of such instructional techniques is, in this sense, a major technological innovation. Some (Argyris, 1967) have been highly critical of this form of leadership and believe it leads to an unproductive learning climate and to unstable gains. Others have claimed that such structured exercises are effective in producing change and are better than letting the group members spend many sessions groping aimlessly and uncertainly for some understanding of the ways in which they habitually behave (Fagan, 1970).

What are the effects of this innovation on learning? A study of eighteen encounter groups that represented ten encounter technologies (Lieberman, 1973) indicated that the use of such exercises was neither the royal road to existential bliss nor a robust means of inducing change in individuals. The evidence suggested that structural exercises are, at best, irrelevant in that

they do not yield markedly different results whether they are used or not; it can be inferred that they are generally less effective than other aspects of leadership in producing positive outcomes. These instructional techniques, however, are highly effective in increasing the esteem of participants for the leader; a leader who uses many exercises is perceived by the members as being more competent and they are more enthusiastic about him and how much they have learned. The use of exercises increases group cohesiveness. These effects of the use of exercises, namely to make leaders feel that they are doing well and members feel close to one another, may account for their widespread popularity, despite the evidence that suggests that they are not powerful tools for inducing learning, growth, or change in individuals.

A fourth distinguishing characteristic of these newer technologies centers around the emphasis on expressivity and emotional experiencing. There has been a decided shift away from the use of the observing ego and the development of cognitive mastery, which is epitomized in more traditional forms of therapy, in favor of experiencing. Many of the techniques described under the headings "the decreasing of psychological distance between the patient and the therapist and the use of prescriptive learning situations" function to inculcate unique and perhaps previously unrecognized interpersonal, inter-psychic, and bodily experiences. Their intention is to generate high levels of intense emotional expression. The newer forms of group treatment appear to be more intense, more active, less silent; much

more appears to be going on.

A uniform reaction particularly of those who practice more traditional forms of group therapy is to compare the intensity and the involvement of participants in the newer forms with the often slower paced, less uniformly intense experiences they have as group therapists. There is no question that the current technologies are potent in the sense that they are capable of generating intense involvement and commitment and often become an emotionally moving experience for the participants.

In the previously cited study of encounter groups, the dominant learning mechanisms associated with the newer technologies (some of which are frequently used in traditional group psychotherapy) were examined in relationship to outcome. The findings with regard to *expressivity* were quite dramatic and unexpected—neither the total amount of expressivity, the importance of it to the participant, nor the context in which expressivity took place was associated with positive outcome. In fact, those who suffered negative outcomes as a consequence of their participation in an encounter group showed significantly more expressivity of a hostile, aggressive kind than those who benefited from participation in the groups. It is important to stress that, in contrast to levels or amount or kind of expressivity, other mechanisms were able to show significant relationships to outcome. Though people may feel good about getting out their feelings and may believe that it is

instrumental in their learning, no evidence yet supports the belief that expressivity per se is specifically associated with differences in individual growth. It should be stressed, however, that the data did not permit a test of the converse hypothesis, non-expressivity. All groups had relatively high levels of expressivity and most participants perceived these experiences as important. There were individual as well as group differences in the amount of expressivity, but the range in the groups studied should be seen as from moderate to very high degrees of expressivity rather than from very low to very high amounts.

Self-disclosure, a mechanism closely related to expressivity and seen by some (Jourard, 1964) as a sine qua non of personal growth, was similarly tested. The findings indicated that the amount or kind of self-disclosure in and of itself did not relate to benefit. Those who benefited from the encounter groups were those who could utilize self-disclosure for cognitive mastery (the ability to place their experience of self-disclosure within some cognitive frame) as well as those who were able to disclose in contexts that proved safe. In other words, self-disclosure itself was not the mechanism that induced learning: how it is related to the participant's intellectual understanding of himself and the conditions under which it takes place appear to make an important difference in its effects on positive change.

The inability of modern man to experience intense emotions may be

seen as a primary diagnosis underlying many of the new techniques in group treatment. The mutilation of this ability has been described by many as at the very core of what is responsible for human problems and the essence of what needs correction—hence, the emphasis on increasing sensory awareness and on the stimulation of physical feelings and emotion-provoking experiences. Analyses of intense emotional experiences of individuals indicated that significant differences in outcome were not related to amount of experience with intense emotions. Indeed, those who benefited from the groups *less frequently* cited intense emotional experiences of a positive (love) type. The findings also indicated that participants who were unchanged by the group experience or who had negative outcomes were significantly more often involved in intense negative emotional experiences than those who benefited. Clearly, the three events that are emphasized by many of the new people-changing endeavors are not mechanisms that appear to have great effectiveness in changing people. This does not mean that they are unimportant. Can one, for example, build an environment for personal learning without a modicum of emotionality and disclosure? Although there is no empirical evidence to answer such a question, it seems reasonable to think not. But such a conjecture is not to be confused with the assumption that the new emphases constitute crucial mechanisms for changing individuals per se.

Although not unique to the newer therapies, the rationale underlying the emphasis on the "here and now" is distinctive in the new technologies.

The theories of Peris and Rogers, as well as of Kurt Lewin, all point to the essentiality of a here-and-now focus as opposed to focus on the personal past or on current interpersonal problems outside the group itself. The position grows out of the view that the group is a social microcosm wherein the behavior of the patients is an accurate representation of their overall interpersonal behavior. In addition, the here and now possesses a sense of immediacy and is an experience shared by all, against which reality checks can readily be applied. What is unique in the newer technologies is the degree of emphasis on this principle: it is used as an "eligibility requirement" against which to test and ban content that does not meet the here-and-now criterion. Yet findings of the encounter-group study suggested that groups obsessed with here-and-now interaction were poorer learning environments, not because the need for historical or genetic material could be established per se, but perhaps because of the anxiety created by such a constraint on the range of interaction.

This is a good illustration of the problems plaguing the newer group forms. Within limits their techniques make sense. Their exuberant militancy, however, has pushed the use of certain techniques to extremes. Structured exercises, for example, can be used successfully to create high levels of cohesiveness in the group, but excessive use of such exercises minimizes group-learning potential.

Finally, the *revamping of time intervals for the enactment of the process* has been an important characteristic of the newer therapies. The traditional group in which strangers met for an hour once or twice a week has been greatly altered. Current practices range from the extremes of forty-eight-hours or more continuous therapeutic marathons to weekend or two-week workshops in which the participants spend eight or so hours a day in their groups. This innovation has called into question the arrangement of time as well as how much time it takes to help people deal with their problems and develop themselves. There is no reason to assume that the traditionally expected long-term participation in a treatment group is a necessary condition for meaningful and stable change to take place. Participants in the encounter group spent a total of thirty hours in the groups. Of the 208 participants, 34 percent made significant alterations in a positive direction; of these 75 percent maintained the originally observed changes when assessed a year later. The fact of the matter is that significant change in a person's life style, his coping strategies, his feelings about self and about others and so forth can be brought about within a limited amount of time.

The creative energy associated with technological innovation is unquestionably impressive. The effectiveness for producing beneficial outcomes of many of these innovations, however, is unfortunately limited. The techniques characteristic of the newer therapies appear to be superbly engineered to provide intense, meaningful, transitory relationships with

others. They probably satisfy a deep hunger in the individual who experiences a sense of social isolation, chronic boredom, or any other symptoms usually associated with the term alienation. Properly used, the new techniques provide an intense, personal experience with others in a responsible manner. They can induce excitement, increase cohesion, and create openness. Such characteristics cannot, however, be claimed to be causally related to personal change. In this sense, the primary effect of the newer technologies rests in their ability to offer involvement and communion. What is of interest even with respect to these outcomes, however, is that they appear to be severely limited in time and space. The feelings of relatedness engendered in the group were found in the encounter study to ebb quickly upon the termination of the experience. The groups are essentially happenings that are salient and significant and meaningful for most of the participants *at the time they take place,* and perhaps accepted by all as being sufficient as such. Unlike many other institutions or settings to which people have turned for communion—most notably the family and church—the new encounter groups exact no pledge to the future as the price of belonging: no permanent commitment to a set of ideas or a set of individuals is required to experience the joy of membership.

In this sense, the technological innovations are unquestionably successful as transitory and temporary, but meaningful, experience with regard to providing people elements of satisfaction sorely missed in many

natural groupings in contemporary social life, but they do not appear to be especially powerful as mechanisms for effecting personal change. Their major import lies not in that they have offered new and powerful means of enhancing therapeutic change but in that they have challenged the assumptions of the traditional forms to which most of us have been accustomed. They contain the potential of an intellectual catalyst for those who would chart out new directions for developing a reasonable science and empirically grounded technology in the people-changing area.

Comparative Effectiveness of Old and New Methodologies

Are there differences between the newer and the older groups in the amount or type of outcomes they are likely to produce? Are the newer forms more effective? Are they likely to change people in ways that are different from changes in the more traditional group therapies? Philosophical distinctions are suggested between the reparative, survival-oriented emphases of the more traditional forms of psychotherapy and the growth or actualization emphases of the newer forms. The image of what man is and what he can become clearly distinguish the two. The need to maximize human potential, as expressed by Maslow, has been a crucial formative influence in the development of the newer therapies, whereas the Freudian image of the far more psychologically limited man has been of more influence in countless clinics that conduct traditional group therapy. Despite these clear

philosophical differences, we have suggested that the clientele of newer forms come as much for reparative reasons as do the clientele of traditional therapeutic endeavors. This, of course, does not directly speak to the issue of outcome.

The question of comparative effectiveness is easier to pose than to answer from empirical data. Lieberman, Yalom, and Miles (1973) compared the overall effectiveness of encounter groups and individual psychotherapy. Sufficient data from group-psychotherapy research were not available in the literature. All of the outcome studies listed by Bergin and Garfield (1971) were used that matched the methodological criteria comparable to the encounter-group study (outcome criteria beyond therapists' ratings and patients' self-perceptions, relatively rigorous methodological design, studies that reported percentage of improvement based upon a complex set of outcome criteria on nonpsychotic patient populations). Percentage of improvement in studies of individual psychotherapy ranged from a low of 33 percent to a high of 87 percent, with a mean of 67 percent and a median of 71 percent. Success rates for the encounter groups ranged from zero to 80 percent with a mean of 33 percent and a median of 33 percent. Although such comparisons are obviously risky because of problems of comparable outcome data, different expectational sets in clients, and so forth, they are instructive in that no evidence exists that suggests that the newer techniques produce results indicative of a breakthrough relative to effectiveness.

The difficulties encountered in attempting to assess relative effectiveness are magnified a hundredfold when trying to determine whether changes that do occur in the newer modalities are distinct from those in the more traditional forms of group therapy. There is no reasonable procedure for assessing the findings from the literature—they are too diverse and do not provide means of comparing types of change. In the encounter groups studied, people were most affected in the areas of values, attitudes, and in the ways they perceived themselves. Value changes were most noticeable: participants emphasized an existential orientation, stressing the values of growth and change and the importance of interpersonal relationships. Those who changed their view of self tended to downgrade agentic motivations and idealize themselves as softer, more lenient persons. Of interest is that no generalized changes were found in how participants perceived the world around them or in their conceptions of significant others. Nor were there generalized changes in participants' life styles or their relationships with people outside the group. Such data suggest that there may be some particular perspectives that could be directly associated with the newer forms of personal change groups. It is likely that comparable data on the more traditional forms of group therapy would yield somewhat different changes in value perspectives or in self-view because the philosophical underpinnings of the older forms are different.

It is not surprising that values and attitudes should show the most

uniform changes: group settings are particularly potent contexts for affecting values and attitudes. It seems reasonable to speculate that changes in such areas would not be as strong in individual psychotherapy when compared to group settings of any kind. There is scant evidence, however, to suggest even the beginning of a framework for understanding the particular effects of the newer techniques compared to the older group techniques, or to examine the question of the particular influence of groups compared to dyads for purposes of individual change. We should be alert to these questions, but the current state of the art offers no empirical data to help answer them.

Responses to the Confusion

Although argument abounds over whether particular group methods lead to destructive chaos or productive growth, it seems unnecessary to document the observation that groups are increasingly being used to heal an ever-larger list of human problems. Whether this expansion expresses some deep need for communion or simply represents the restless quest of unhappy adults for "something different" is a less important question than that of how we can improve the group context as a mechanism for people changing. The simple fact that large numbers of people enter groups for personal change demands work on the question of how to meet their needs in a humane and meaningful way.

The responses of mental-health professionals to the many confusing issues generated by the new forms have followed the general pattern of extremes so characteristic of the reaction pattern of the public at large to people-changing groups. Professionals, like laymen, have run the gamut of responses from "keep them out at any cost, all they do is destructive" to totally "incorporative" behavior. The critical extreme is well documented, but it may be useful to explore the characteristics of "incorporation."

The frequency with which mental-health professionals attend the various and diverse workshops offered to train people in the new treatment forms smacks less of a growth-oriented profession seeking to upgrade its level of operation than of a desperate response to a felt sense of inadequacy. The high degree of personal commitment and emotional intensity generated in clients who have been involved with these newer techniques may also motivate some professionals. At any rate, it is not uncommon for experienced therapists to spend several weeks each year in quest of new answers regarding how to provide more adequate professional service. (This year in Gestalt, next year in Transactional Analysis or some other new form.) "Have you heard about the techniques that X has worked out? I would like to go there next time" are remarks reminiscent of conversations frequently held among mental-health professionals. Although it is difficult to determine, it is likely that such responses are more characteristic of group than individual therapists.

Limitation of Eligibility— A Traditional Response

The problems surrounding eligibility for leadership of personal-change groups appear even more complex than those relating to the practice of individual psychotherapy. The traditional avenues of professional training have been shown to be unlikely to provide answers to the problems of training group leaders, either of the highly professional or almost totally lay variety. In the study of encounter groups, it was found that many highly experienced psychiatrists and clinical psychologists proved to be ineffective; some were frankly destructive, an outcome shown to be related to the particular techniques they employed. General professional training in and of itself is not an antidote for poor group practice. Although there are no systematic data on poor practice in nonprofessional people changers, the "horror stories" told by professionals and participants about casualties incurred by nonprofessionals do little to quiet fears.

Much of the confusion about eligibility for conducting personal-change groups may stem from failure to distinguish between groups and dyads as contexts for therapy. There is no empirical evidence or theoretical reason to assume that the skills acquired through training and practice of dyadic change are transferable to use in group situations. Some therapists are probably better suited for the group context, others for the dyad. Some therapists, for example, in order to develop sensitivity to another human

being, need to know the other person through his history, while other therapists appear more comfortable in being able to achieve a similar understanding simply through seeing how the person behaves. This sort of difference in the personal style of the therapist probably makes for a large difference in effectiveness in a dyad (which emphasizes the former) or a group (which emphasizes the latter in many instances). The assumption of identity of dyadic and group skills is as mythic as the "every man can be a therapist" theme.

Nor are the stresses and strains of the group the same as the stresses and strains of a dyad. The social forces at work in the two modes are different. To assume that one type of training or character unconditionally fits both modes is sloppy thinking.

Thus, to create distinctions between traditional forms of group therapy and the newer treatment group types, based on leader differences in training, serves more to obfuscate than to clarify. The wisdom that has been distilled out of training thousands of therapists for individual psychotherapy has no parallel in the group area. This is, in part, because of the relative newness of the field, but perhaps even more because no one has thought about the issues of eligibility for group leaders with the same intensity as has characterized discussion about eligibility requirements for individual psychotherapists. While the issue of appropriate safeguards for the consumer is not to be

dismissed lightly, there is little evidence that traditional eligibility criteria can predict effective group leaders.

The question of who should lead people-changing groups and how they should be prepared obviously involves many problems. Some derive from basically differing value orientations on how nonprofessionals or para-professionals can make their best contribution to the mental-health enterprise; others may be more purely technological considerations relating to maintenance of control over entry into the business of personal change. Such issues, however, would seem to follow the question of what the leader contributes to the process of change in groups.

Theories of personal change in groups usually give great emphasis to concepts addressed to the relationship of the leader to the collectivity of people to be changed (patients, members, participants). Similar to theories of individual therapy, they emphasize the central importance of the leader or therapist. It is through his actions or abstinence from action that change processes are initiated, set in the right (or wrong) direction. Theorists are often maximally distinguishable by the particular dimensions of the leader-client relationship they emphasize. For some, the core concepts relate to the interpersonal conditions the leader creates between himself and each participant—positive regard, genuineness, and so forth (Rogers, 1970). Others stress the leader's symbolic properties, such as the specific

transference relationships between each individual patient and the leader (or leader surrogate)24 while others stress the symbolic relationship of the leader to the *group as a whole* (Ezriel, 1950; Bion, 1959). Still others, although also stressing the unique relationship of each patient to the leader, emphasize negative rather than positive interaction between and through such devices as the "hot seat" (Perls, 1965) in which the group acts as Greek chorus or background to this primary relationship.

Despite fundamentally different conclusions about what the crucial leader "inputs" are, all these theories agree on the centrality of the leader to the change process. It is he who sets up the learning experience, who makes the interpretations or analyses resistance, who sets the norms, who is the "model," and so on. The specific content of the leader's actions and responsibilities may differ, but the underlying assumption is that the central factor in what changes people is what the leader does or how he expresses himself.

It is quite possible, however, that the leader's behavior, personality, and skill level have taken on mythic proportions as basic causal forces explaining successful personal change in groups. Some obvious factors in the history and development of the use of groups for people changing may have contributed to this view. Theories of group change of individuals naturally have given great prominence to the role of the leader—after all, most of them have been

developed by especially artful practitioners who have often also been highly charismatic individuals. It is understandable that the clinicians who have contributed what little theory there is on changing people through groups might be somewhat myopic and could be easily pardoned if they have overestimated the contribution of the leader (i.e., themselves) to the curative process. No theories of group personal change have been advanced that have developed out of the thinking of patients or experimental psychology (perhaps with the exception of some applications of behavioral modification theory that are used in group contexts). Thus, the assumption of leader centrality found in all theories of group personal change may represent an understandable overestimation on the part of the theorist based on his unique perspective upon the process about which he attempts to theorize.

But what about transference? Could anyone who has ever worked with a people-changing group realistically ignore the magical expectations, distortions, overestimations that are directed toward the person of the leader? No matter what one labels the feelings and thoughts of members toward their leader, it is hard to ignore transference as a central phenomenon common to all people-changing groups. I see no reason to question that the complex, convoluted, supercharged feelings that focus on the person of the therapist do exist. Many would agree that the leader need not do anything more than be there to become enhanced with the aura of a professional—a person capable of giving help, of performing a priestly function. Some have,

however, questioned the generality of the transference concept under other cultural conditions or situations where the social distance or psychological distance between the one who is helped and the helper is lowered. Whether or not transference is a universal product of psychotherapeutic contact, the fact of transference reactions, where indeed they do occur, does not, in and of itself, *demonstrate* that the leader is central to the *curative process.* That supercharged feelings toward the leader are usually generated in a group therapeutic context does not permit one to jump to the conclusion that transference is intrinsically a curative factor in the group context. In other words, no unquestionable cause-effect relationship relative to outcome is demonstrated merely by the evidence that leaders usually become objects of transference.

As a mode that followed the development of dyadic treatment, it is natural that theories of group personal change should have been influenced by images of the obvious control that the therapist exercises in dyadic relationships. Professionalization, the length of time invested in training, the shaip boundaries surrounding the help-giving professions, the distinctive terminologies, the fee structures, and so forth are also conditions that support unexamined adherence to the view that the leader is central, prominent, critical in the curative process. It seems reasonable to think that to the degree that an activity in our society becomes professionalized, so will the role of the professional who conducts that activity become enhanced in the minds both

of the professional and the layman. Consider for a moment the full implications of discovering that most of what helps patients in groups stems from the relationships members have to one another and to processes that are only tangentially related to the behavior and person of the leader. Such a view would in all certainty present difficulties for continued dismissal of questions regarding whether or how much professionalization is necessary.

Thus, many forces exist for creating a mythology surrounding the person of the leader. Journals and professional meetings endlessly encourage debates that support the "prominence" of the therapist or leader through discussions of such issues as what he does, how he does it, when he does it, how he feels, what are his hang-ups, how aware he is, what is his theory, whether he works alone or with a cotherapist, whether "he" is he or she, black or white, kindly or hostile, and so forth.

The empirical findings available in the literature offer little evidence for a reasoned position on the question of how much the therapist or leader contributes to outcome in groups. Some perspective on the question is offered via the analogy from individual psychotherapy relative to the nonspecific treatment or placebo effects. For groups, the analogues to placebo effects are certain events that frequently occur in small face-to-face, intensive groups that can provide experiences that *in themselves* are curative. Because these events occur in concurrence with the presence of a leader, their curative

power is attributed to the leader. (The analogy to "placebo effects" and the special properties of small face-to-face groups should not be taken to imply that the curative mechanisms involved in dyadic and group healing processes are necessarily similar.)

The data available only serve to legitimize raising this question; they are insufficient to answer it. Studies reporting no differences in the effectiveness of naive therapists compared to experienced professionals could be interpreted to mean that the group situation within rather broad limits is useful regardless of the specific behavior of the therapist. Studies in which large outcome differences were found among experienced therapists might, on the other hand, suggest that the behavior of the therapist is critical. If we look closely at these studies, however, an alternate explanation could be offered. Suppose for a moment we make the assumption that the major impact of therapists or leaders is to make people worse. Let us also play with the assumption that there are two major factors operating in therapeutic groups: the intrinsic, beneficial effects of the group itself and the inputs of the leader, most of which are not beneficial. The notion behind these assumptions is to establish an appropriate zero point for assessing the leader's contribution.

In the encounter-group study, leaders who had ten or more years of experience conducting groups were compared to leaderless groups that were

"led" by the peer-tape program (Berzon, 1972). A large variety of outcome measures (including judgments by leaders, data from social network, a large range of instruments to assess coping changes, changes in self-esteem, decision making, and so forth) were developed and composite outcome scores were assigned to each study participant. The sum of these individual scores yielded a weighted score reflecting the overall effects of each group studied. Of the sixteen leaders studied, only four obtained outcome scores that exceeded the mean score of the two tape groups; of the other twelve leaders, some yielded considerably lower outcomes than the tape groups.

While the tape groups, of course, were not leaderless groups in the strictest sense, only a minimal structure was offered to the participants in the tape situation. It seems reasonable to assume that the tape group created conditions reflecting the curative power of the group under minimal leader input. Thus, the finding suggests that groups may have constructive potential without the intervention of a professional leader. It should be easy to see why this interpretation finds little acceptance among professionals. Like the finding that naive therapists did as well as experts, it could be taken to suggest that most therapists are relatively incompetent. This has, in fact, been the usual response of professionals to such "disturbing" findings when they have appeared in the literature. The prestigious backgrounds and professional esteem of the sixteen therapists studied, however, make it hard to argue for the latter interpretation. These men were clearly competent in

executing practices appropriate to their theories of change. They were uneven, however, in the amount of attention they paid or use they made of group forces. Indeed, as already suggested, they may have intervened in ways that obstructed inherent beneficial attributes of the group context.

The study of encounter groups yields further evidence of positive effects of intensive small group experiences that were not attributable to the behavior of the leader. The normative characteristics of the group—the informal, often unarticulated and undiscerned social agreements that regulate behavior of members—were demonstrated in the encounter study to be equal or greater influences on overall outcome scores than leader behavior.

The findings further suggested that leaders contributed a smaller share to establishing the normative structure than would be expected. The ability of participants to identify with the experience of another even without participating in it directly, or to experience similarity between themselves and others in the group, was demonstrated to be a powerful mechanism for inducing individual change. This and other mechanisms of change are stimulated more by the intrinsic characteristics of intensive peer-group experience than by the behavior of the leader. Whether the participant was a deviant in the group or an esteemed, influential member was also demonstrated to account for positive change more than almost any other

elements of the change process.

Findings such as these point to the necessity of initiating debate on the importance of the leader to the group, an assumption that may have thus far served more to confuse than to enlighten. They suggest that documentation of personal improvement through group experience is not sufficient evidence from which to conclude what the therapist or leader contributes to such changes. They suggest, further, that control of leadership "quality" through efforts to upgrade skill levels of leaders will not necessarily lead to more effective utilization of groups. Even highly skilled, effective therapists have not been able to transmit their skills in any orderly way. The models presented by such skilled practitioners frequently emphasize meaningless epiphenomena. They tend to offer generalized suggestions on how to "be like me," rather than to identify specific kinds of behavior that are effective. Perhaps an equal or even more significant implication of such findings is that there may be processes, unique to the group context, that *in and of themselves* induce helpful or growth-producing changes. For all these reasons, the current concern with eligibility requirements or with increasing leadership skill levels via frameworks that explicitly or implicitly derive from dyadic psychotherapy and clinical wisdom seems to circumvent three prior and more crucial questions: (1) What are the proper components of effective training for those who would conduct groups geared toward individual change? (2) Can these components be identified via systematic empirical

processes rather than through less rigorous attempts to distill wisdom from uncontrolled clinical observations? (3) What distinctive properties do groups possess that must be taken into account in *whatever* methods or training designs are developed?

Group Forces as Healing Sources— A Social-Psychological Response

Five properties of groups are particularly important in their influence on the therapeutic experience of the participant: the capacity of the group to develop cohesiveness or a sense of belonging; the capacity of the group to control, reward, and punish behavior; the capacity to define reality for the individual; the capacity to induce and release powerful feelings; and the capacity to provide a contrast for social comparison and feedback. What are the implications of these properties of the group for the induction of productive, psychotherapeutic experiences in the group context?

The capacity of groups to develop cohesiveness reflects the phenomenological experience of communion or belongingness that is usually operationally defined as the attractiveness of the group to its participants. Cohesiveness performs roughly the same function in change groups that positive transference performs in dyadic therapy. Studies of individual psychotherapy in recent years have marshaled evidence that points to the importance of the transference relationship. Truax and Carkhuff (1967) have

shown that patients are more likely to improve with the qualities of positive transference, such as high levels of empathy, non-possessive warmth and genuineness, or feeling liked by the therapist. The group context does not as readily offer the establishment of such relationships between the larger number of members and a single leader. The group property of cohesiveness, however, elicits analogous feelings. A sense of belongingness motivates the participant to stay in the group and to work with it, which mitigates the pains associated with therapeutic exploration. Cohesive groups are ones that offer members almost unconditional acceptance no matter what their history and behavior have been outside of the microcosm that is the group. They offer the support and warmth that encourage risk taking; they provide the psychological glue that permits members to reveal themselves; they provide the bases for public esteem, which has the consequential effect of increasing self-esteem (Yalom, 1970).

Closely associated with and dependent on the level of cohesiveness, is the group's *capacity to control behavior and to provide a system of rewards and punishments.* Groups are microcosms of a larger society; they develop their own cultures and, in large part, their existence depends on special rules and standards they establish as they extend their life. How much one talks, what one talks about, what one doesn't talk about, even "the way" one talks about certain things are all aspects of individual behavior that are subject to the social influences of the group. Such control over individual behavior is a

central property of a group, including a therapy or growth group. The group member is almost inevitably confronted with pressure from others to change his behavior or his views. The need to be in step, to abide by the rules is a powerful factor, inducing conformity in the group. Disregard for the rules brings the possibility of punishment. The ultimate punishment available to a group is the power of exclusion—either psychological or physical. In dyadic therapy, the patient does not fear exclusion if he does not go along with the therapist; he fears loss of the therapist's respect or love. These two very different psychological experiences lead to similar behavior—conformity.

A strong additional force pulling members toward conformity is the group's most prized reward—its *power to offer the authenticating affirmation of one's peers.* The experience of consensual validation appears to be the most salient experience in group therapy, more powerful than the affirmation of the therapist. The power of groups to exact conformity also frequently induces fear in people; there is much evidence that group members fear punishment for nonconformity or departure from the group norms. It is important to remember that the norms that determine what behavior the group will reward or punish are *shared* agreements developed by the group as it establishes its own culture. The member's belief that he has some power to influence the development of norms and standards in a group mitigates, to some extent, his fear of the power of the group to induce conformity.

Groups also have *the capacity to redefine reality for their members.* In dyadic psychotherapy, one of the major roles of the therapist is to attribute meaning to the patient's behavior—to provide *labels* that offer a new view regarding past and present thoughts, feelings, fantasies, transactions with others. Most schools of verbal psychotherapy view insight or *understanding* as a prime effect to be sought for through psychotherapy; developing understanding or insight is, of course, not simply a matter of the therapist labeling or lending meaning, but the labeling process is indispensable to the production of this sought-after state.

Groups exert strong influence on how each member views himself, the group as a whole, and others in the group. Thus, in a group situation, it is not only the leader who has a salient role in providing insight, understanding, or attributing meaning; the social system, the collection of participants also adds to that meaning collectively. The group's capacity to define reality can be found in a dramatic illustration from a group therapy course in which psychiatry residents observed two classmates working as therapists with an ongoing group:

The observers watched from a darkened observation room and discussed the proceedings afterwards with the two therapists. Before the eighth session began, the window blinds were removed for cleaning, so that the patients could see the observers through the one-way mirror. The two

student therapists felt that since all the patients knew they were being observed there was no need to call off the observation. As the patients arrived one by one each looked particularly closely at the large observation mirror and then took his seat. The meeting began with members talking about how difficult it was to communicate with people, "particularly when you couldn't see them—in telephone conversations, etc." They referred to the observers (which they had not done in previous sessions) with statements like "It's uncomfortable.

I don't like being observed because it's one-sided. The observers can see the patients but the patients cannot see the observers." The meeting went on in this vein for about a half hour and then shifted to other topics. After the session, when the two therapists joined the other residents to discuss the session, the observers asked the therapists why they had not intervened and brought some sense of "reality" to the group by pointing out that the observers could be seen for the first time. They answered that the light had shifted and the observers couldn't really be seen. Their belief was so strong that several of us had to accompany them into the therapy room to demonstrate that obviously the group could see the observers—perhaps not every facial gesture, but clearly at least their outlines.

In short, the two therapists, who had entered the session knowing the observers could be seen, and the patients, who collectively upheld as "reality"

the illusion that the observers could not be seen, had redefined reality to meet their own needs.

Another important characteristic of groups is *their capacity to induce powerful feelings.* Emotional contagion was the first phenomenon to interest investigators of groups. G. LeBon, W. McDougall, and Freud pointed out that powerful, primitive affects can be released in groups. Individuals may get carried away and act on feelings without displaying their typical controls. This potential of groups can have either positive or negative effects on personal change. An individual may experience previously denied feelings, not with enduring terror but with acceptance; he may undergo, in other words, the "corrective emotional experience" of finding that the feelings are not overwhelming or that the feared consequences do not occur. Negative effects may occur when an individual is overwhelmed by affect and must defend himself against a group by literal or psychological withdrawal or by the invocation of undesirable psychological defenses. The potential to stimulate emotionality although, again, not peculiar to therapeutic groups, is an important quality of groups that bears directly on the sorts of personal learning or changes that take place in group, people-changing contexts.

The fifth characteristic of groups that is an important influence in therapeutic contexts is the *capacity of the group to provide a context for social comparison.* Group-therapy patients frequently compare their attitudes

toward their parents, husbands, wives, children; their feelings about things that are happening in the group; what makes them sad, happy, guilty, angry; the ways that each typically deals with and expresses anger and affection; and so on. Such comparisons occur naturally and facilitate revision of the patient's identity by suggesting to him new possibilities for feeling, perceiving, and behaving. In a group, members can compare a number of perspectives because different individuals present new vantage points. This inherent property of the group situation perhaps occurs most powerfully in therapeutic social systems where it is expected, often demanded, that members talk about their behavior. Social comparison occurs as an outgrowth.

What do these properties of groups imply for theories of group personal change? As indicated, all too often theoretical developments in this area have stemmed from the translation, with some technical alterations, of principles of dyadic therapy. The existence of group properties implies the need for. a theoretical perspective that takes these properties into account. Although some theorists have initiated their explorations of group therapeutic processes on the premise that groups have special properties, most examples of this orientation are confined to discussions of traditional treatment groups and do not reflect recent developments in the group, people-changing enterprise. A number of theorists (Bach, 1954; Durkin, 1964; Bion, 1959; Ezriel, 1950; Scheidlinger, 1960; Whitaker, 1964) have attempted to take

both group properties and individual dynamics into account in developing a unified theory of group therapy. The role attributed to the therapist in these frameworks is of particular interest. The English school has used the word "conductor" to explain the function of the therapist in the group; American systems-oriented theorists have often labeled the group therapist or leader a social engineer. Both these terms are meant to suggest that the leader's most important function is to help the social system make maximal use of group properties that will induce psychotherapeutic benefits.

A useful way of describing systems-oriented conceptions of group psychotherapy is to distinguish between what have been called therapeutic conditions and therapeutic mechanisms. The former implies the context for change or learning—in the dyad it is the characteristics of the relationship, in the group it is the characteristics of the social system. In both situations the role of the therapist is considered to be to enhance the positive aspects of the condition so that change can occur. This is not the same as saying that the therapeutic relationship is, in itself, therapeutic. It *is* to say that certain events that facilitate growth must happen to the person in treatment. These events are of the sort that were earlier labeled therapeutic mechanisms or mechanisms of change.

Group Change Contexts and Therapeutic Outcomes

These group properties create conditions that engage the group member in a number of activities and concerns that differ from those of the patient in dyadic treatment. In comparison with the latter, the group member gets little practice in reflecting about himself and his interactions with others, in associating about his own feelings, in analyzing dreams, in linking present and past experiences or penetrating covert meanings: he is too busy actively interacting and finding a viable place for himself in the group. However, he gets greater practice than the patient in dyadic treatment in expressing his feelings to peers, in noting the consequences of such expressions, in attempting to understand and empathize with others, in hearing from others about his impact on them, and in comparing himself with others.

Do these differing balances in experience lead to differences in outcome? It is commonly assumed that the group member should end up getting help of much the same order as he would have obtained in a dyadic relationship. It is perhaps helpful to test this assumption against, first, the end state of the person at the close of the change process (symptoms, conflicts, defenses, interpersonal patterns, and the like) and, second, the meta-learning achieved (learning how to approach problems, how to confront and resolve conflicts, and how to cope with anxiety).

Three aspects of the individual's end state are relevant: (1) the symptoms or presenting complaint; (2) the revision of maladaptive patterns,

the relinquishment of neurotic defenses or the resolution of neurotic conflict; and (3) the unsought, ancillary gains. Symptom relief, for example, may be achieved at different rates. (The placebo effect, critical in many instances of rapid symptom relief, seems to us unique to the dyad.) Particular behavior changes or conflict resolutions may be accomplished better by one or the other of the two settings, depending on the nature of the problem, the composition (if a group) and so on. For example, a therapy group whose composition encouraged a patient to maintain an established neurotic pattern might be less effective for the patient than individual therapy. On the other hand, a group that, say, through emotional contagion, led a patient to experience positively a previously feared affect might be more effective than individual therapy.

Finally, the two treatment contexts may be conducive to different ancillary benefits. For example, difficulty in giving to others may be only peripherally related to the person's presenting complaint or core conflicts but, nevertheless, an issue. Since giving to others is often a focal concern in a group, many opportunities appear for each member to note the nature of his anxieties about giving and to try out giving behavior. Thus, changes in giving behavior may occur sooner, or more directly, than in individual therapy. The two contexts may also call attention to different aspects of humanness. In group contexts, members are likely to be struck by the common needs for basic kinship, for sharing with others, among persons who on the surface

appear quite different. They may be impressed both by the difficulties in communicating meaningfully to others and by the profound rewards experienced when such communication proves possible. The dyad, in contrast, does not directly facilitate such experiences.

The differences for meta-learning may be even greater than the differences in end-state outcomes. In any form of treatment the person often adopts a style for approaching problems that reflects the treatment orientation to which he has been exposed. It is not unusual for a patient to emerge from psychoanalysis with an increased tendency to pay attention to his dreams, to deduce emotional meaning from forgetting, to search out unrecognized feelings when he notes inconsistencies in his behavior. A person who has undergone group treatment may be more likely to seek out feedback from others, to make social comparisons, to test out behavior interpersonally.

An appreciation of the intensive positive and negative forces inherent in the face-to-face, social microcosm that is the group-treatment context is perhaps the single most helpful guide toward developing a realistic picture of both the problems and potentials inherent in using groups for people changing. A systems-oriented perspective to people-changing groups must include consideration of some real problems about groups, problems that need solution before the potential of groups can be realized. The three most

critical issues facing the use of groups today have to do with range or applicability, transfer or generalization of in-group learning to the real world the member lives in, and the emotional potency of groups.

Range of Applicability

This refers to the degree of fit between specific procedures and member characteristics. The group people-changing enterprise is strewn with illustrations of extending procedures far beyond their range of applicability. This has been particularly characteristic of the newer group forms that usually begin with a simple set of principles stemming from an overall "diagnosis" that contemporary humans suffer from alienation, lack of integration between body and feelings, inability to express emotions, problems of guilt, and that they have unrealized potential because of these problems. Techniques are then developed, which are considered universally applicable, to relieve those sorts of problems. The proposition that, obviously, not all humans suffer the same upsets would find ready agreement; yet, the increasing appearance of techniques that imply that everyone needs the same kinds of simple corrective experiences has caused the new technologies to be judged inappropriate by those focused on the nuances of personality.

Realistic consideration is gravely needed regarding how various approaches to personal change fit the varied client populations to whom they

are addressed. To assume, for example, that "freeing up," or encouraging expressivity, is a basic need of the constricted white, middle-class client and also the black, ghetto-dwelling client and to conclude, therefore, that the same techniques are operable for both, borders on being an unregulated, omnipotent fantasy. It is also a gross error to assume that the techniques of confrontation, the "leveling" so characteristic of the Synanon model, will have equivalent effects when used with addicts who live in a tightly bounded, residential treatment community and addicts who live "on the street" and experience confrontation techniques only in a once-a-week session. In a similar vein, is it sensible to apply such techniques with equal vigor in suburbia and Synanon, in California and Cornland, Illinois? These are not new problems; they have been mentioned frequently in questioning the universal applicability of traditional treatment modes developed from exclusive experience with middle-class, cognitively oriented populations. Unfortunately, what was learned from attempts to take traditional treatment to the masses has not been remembered in structuring theoretical premises of current people-changing-group ideologies. The various approaches need desperately to consider for whom they are appropriate and for whom they are not and to match techniques to the problems and populations they serve.

Transfer of Learning

The persuasiveness of groups has been so amply demonstrated in

sociological and psychological literature that it needs no amplification here. Because the persuasive power of groups is so great, an illusion that individuals have changed is often created, whereas their alterations of behavior within the group context are simply temporary accommodations to a new referent group, to a different set of norms. The "change," therefore, is often ephemeral because it is more or less a response to the specific group conditions and is dependent on the treatment group for maintenance.

A major, unsolved conceptual requirement in group people changing is to develop not only the techniques but the constructs that will account for how the changes that occur in a group can lead to changes in the member's life outside the group. That lasting change does occur with some frequency is not as important as that it does not occur as frequently as we would like. Yet, no reasonable conceptual system exists to explain the specific relationships between person and group that account for these observed differences in maintenance of change or transfer of learning. How does generalization from the specific context of the treatment group take place? (After all, if the treatment group were identical with normal life little change would probably occur.) Does the inherent persuasiveness of the group situation mean that more attention should be given to providing situations that teach strategies of change and maintenance in the therapy itself? Too often, after participation in the group, the individual faces the external world little prepared to use what he has learned, to try out in the real life the behavior that he has tried out in

the group. Or, just as sad, some individuals emerge from the group ready to try their "new learning," directly and overtly in situations where the response is direct and swift ridicule, exclusion, or similar forms of punishment for nonconformity to the norms of the "outside" group. Treatment groups may be more like "real life" than dyadic relationships with one therapist, but they are certainly not identical with the world outside.

Group Potency

A dilemma inherent in the task of changing people through groups is that of how to capitalize on the potency of the group (its capacity to involve, to commit, and to move people emotionally) in such a way that this capacity will not be accepted as in itself a sufficient end product, a product that, in all likelihood, has been all that has been gained by many of the millions who have tasted the new group roads to growth. How can we employ the power of groups to involve people, to generate their enthusiasm, to exact their commitment, to move them to deep levels of emotionality so that treatment groups or growth groups or whatever they are called will also serve the purpose of helping to resolve the particular brands of human misery that are driving millions to try them out. Encounter-group participants clearly indicate that they come not simply for entertainment; nor are they existentialists searching for greater meaning to life. They are the same people who come knocking at the doors of mental-health clinics and offices of

individual and group therapists. They are people in trouble who come for goal-oriented therapeutic reasons, although the rhetoric of the new forms suggests otherwise. The newer technologies have excelled in adopting old and developing new procedures for creating potent, involving groups. To lead such groups one need not be charismatic (a trait closely associated with group potency); one can effect charisma in himself through use of simple techniques, readily learned from innumerable how-to-do-it manuals. Unfortunately, group potency alone has not been shown to be related to positive outcome.

Conclusion

The question then becomes, how can one relate the potency of groups—which provides a basis for other processes to occur that do effect change and which forms the basis of attraction of the group, so that people will stay and participate and get involved—to the creation of a viable learning environment? It is not enough simply to suggest that the potency of a group is not itself an effective change mechanism and thereby allow oneself to ignore it. In fact, one cannot ignore it. The way that people package their troubles today, the way they see themselves in a change-inducing situation does not permit dependence on the mores of traditional therapy, in which forbearance, patience, inner motivation are stressed. Such expectations of the client do not match "where it's at." It is perhaps an overly generalized view, but I think one

that will become increasingly accurate: group-treatment forms cannot succeed in today's world without approximating the expectations of the members for a potent, moving, emotionally involving experience.

Many dangers lurk in this domain. If therapists and group leaders read potency to mean success, they will err grievously. If they believe they should direct most of their attention to behavior that stimulates group potency, they will have exciting groups, which reward them in a personal sense, but they will not fulfill their function—to provide a setting for growth or change.

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