THE TECHNIQUE OF PSYCHOTHERAPY

TECHNIQUES IN GROUP, FAMILY, AND MARITAL THERAPIES

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Group psychotherapy is a valuable and, in some cases, indispensable treatment method. Its historical development and uses in supportive, reeducative, and reconstructive approaches have been amply delineated and some of the important bibliography listed in the respective chapters. Group therapy may be employed both as an adjunctive aid to individual psychotherapy and as a treatment modality in its own right. There are some therapists who claim that not only are the results they obtain with groups equivalent to those of individual treatment, but in many cases even superior to it. Consequently, they dispense with individual therapy, except as an adjunct to a group approach. Other therapists, not so skilled in its use, tend to depreciate the effect and "depth" of group treatment. Among experienced therapists there is a feeling that combined or conjoint group and individual therapy is the treatment of choice. Problems show up in a group setting that never become apparent in a dyadic therapeutic relationship.

Evolving in a group are a number of processes that are intimately bound up with the outcome. Among the most important are the developing group cohesiveness and mutual assistance. What one finds evolving in the group are manifestations of empathy, support, challenge, confrontation, and interpretation; availability of identification models; opportunities for introducing projective identifications; investigative explorations; and a joint sharing of problems.

Needless to say, the specific way that the group is employed; its composition; the degree of activity or passivity of the therapist; the extent of the therapist's directiveness, maneuvers, and kinds of participation; the pursuits sanctioned within and outside the group; and the nature of interpretations will vary with the skill, experience, theoretical bias, and personality of the therapist. For example, some therapists assume an almost completely detached attitude on the assumption that this will dredge up the resentments of the group members, in the wake of which basic inner conflicts will be exposed. Other therapists cast anonymity to the winds and virtually become participating patients in the group, acting-out as enthusiastically as any other member. Both methods in the opinion of their sponsors are promoted as the "best" and even "only way" to do group therapy. Actually, there is no "best" group method; this will

vary with the predilections of the therapist. After blundering through a number of sessions, each therapist will settle down to a procedure that works best for him or her.

Group therapy may be utilized (1) independently, during which both intrapsychic and interpersonal operations are considered; (2) in combination with individual therapy conducted by the same therapist ("combined therapy")—individual sessions deal with the patient's resistances, transferential responses to the therapist, and primary separation anxiety, while group sessions focus chiefly on interpersonal phenomena; (3) in conjunction with individual therapy conducted by another therapist ("conjoint therapy"); and (4) as leaderless groups particularly after formal group therapy has ended (Kline, 1975).

Meetings in independent, combined, conjoint therapy may take place one or two times weekly and, in institutional settings, even daily. They may be supplemented with regularly scheduled meetings that are not attended by the therapist ("coordinated meetings")—the members may congregate before a regular session ("pre-meetings"), after a regular session ("post-meetings"), or at other times at specially designated places ("alternate meetings"). Coordinated meetings enable patients to discuss their feelings about the therapist more freely. They are generally less formal and more spontaneous than regular meetings. Acting-out is more than a casual possibility here, which may or may not prove to be beneficial to the patient. ("Closed groups" maintain a constant membership although new members may be added for special reasons. "Open groups" operate continuously with new members being added as regular members complete therapy and leave the group.)

Treatment in group therapy may be "therapist-centered," in which therapists take a directive and more authoritarian role, moderating member-to-member communication, presenting interpretations, and limiting the patients' intragroup and extragroup activities ("triangular communication"). It may be "group-centered," in which the group operates as the primary authority, therapists functioning in a kind of consultative role. Here peer (sibling) and authority (parental) relationships are considered equally important; rotating leadership is encouraged; there is no interference with the relationships between patients ("circular communication"), which are constantly being broken, restored, and reorganized, the therapists controlling their anxiety about neurotic alliances; or "authority-denying" ("horizontal communication") may occur in which the therapists are on an equal plane with the patients, a structured

relationship between therapists and patients being considered limiting to growth. In the latter case emotional interactions are considered most important; direct experience in the group is encouraged, therapists presenting their own problems to the group ("The group can grow if I grow with them.").

The group therapist, regardless of orientation, must be a good leader, requiring skills above and beyond those of a therapist.

How a therapist conducts a group will be determined

1. By the goals that the therapist sets—supportive, reeducative, or reconstructive.

2. By the constituent members—alcoholics, drug addicts, psychotics, stutterers, delinquents, psychoneurotics, character disorders, patients with heterogeneous problems.

3. By the therapist's training—group dynamics, rehabilitation, behavior therapy, cognitive therapy, existential therapy, psychodrama, psychoanalytically oriented psychotherapy, psychoanalysis.

4. By the therapist's personal ambitions and needs—characterologic and countertransferential.

INFLUENCES OF THE GROUP ON THE INDIVIDUAL

When people gather together in a group, phenomena are mobilized that may have an influence on each individual. One of the effects is an immediate impression of strangeness and embarrassment. This soon gives way to a realization that others present are not too different from oneself in problems, weaknesses, and ways of relating. This encourages one to express oneself openly. The person soon discovers that the group fosters free expression of feelings or attitudes on any subject. There are no social taboos on content usually avoided in everyday interactions. The ability to open up varied forbidden topics, and the recognition that fellow members harbor the same fears and doubts, can be reassuring. Apart from the emotional catharsis experienced, the individual finds that problems can be shared with others without rejection or ridicule. Self-esteem and self-confidence are thereby enhanced. The individual begins to realize that he or she is not a reprehensible person deserving of blame or repudiation. The usual drives through which one achieves status and prestige may receive no sanction in the group. Indeed, they may be dealt with harshly or analyzed in terms of their neurotic components.

Humans are group creatures constantly looking to others for acceptance and validation of their own ideas. One of the most powerful molding influences in any group is the impact of group standards and values. These can have a markedly transforming influence on the personal persuasions by which individuals customarily govern themselves. A gradual incorporation of group convictions and judgments in a cohesive and developed group tends to neutralize self-oriented neurotic needs. The presence of the therapist acts as a safeguard against prevailing group values that are inappropriate. There is some validity in the belief that patients in a group may reinforce each other's rational reactions. This is because they collectively make up the norm from which they individually deviate. This is particularly true in a therapeutic group presided over by a therapist with healthy values; it is not so true in a group left to its own destiny, which so often will be diverted and taken over by a charismatic and power-driven member with qualities of leadership.

Group patterns evolve related to the roles members assume and the ways they perceive themselves; how and when they take over leadership; the specific motives assigned to them by other members; and the existing defensive maneuvers, such as competitiveness, struggles for control, dominance, submissiveness, ingratiation, masochistic devices, aggressiveness, and violence. The fluctuating group interaction is influenced by levels of tension that affect participation, the sharing of ideas, and decision making. Arguments, the taking over of a session by a monopolizer, coming late, absenteeism, and the formation of subgroup clusters manifesting special likings and dislikings raise tensions that stimulate corrective action; however, if tension is too high, it will paralyze action. Extremes of harmony and congeniality will also tend to subdue activity.

A successful solution to an interpersonal problem enables the individual better to extend his success to relationships with people outside the group. It is to be expected that reactions to different members will selectively indulge a full range of prejudices. Displays of awe, infatuation, disgust, anger, hate, and sexual interest may be manifested toward members identified as archaic or vulgar or idealized models. Whereas these feelings are controlled and verbalizations related to them suppressed or repressed in the usual group setting; they are encouraged and even rewarded in the therapeutic group by approval from the therapist. The reactions of the person with whom one is immediately entangled presents opportunities to examine the reasonableness or unreasonableness of one's responses. The individual gradually learns to accept criticism and aggression without falling apart. This is a most crucial

lesson; indeed soon recognized is the fact that aggression and criticism can be either proper or unjustified and that one can differentiate the two and manage responses accordingly.

The effect of interpretations from other group members may be striking. The individual begins to distinguish prejudiced opinions from factual ones, and may then generalize tolerance to the world at large. The fear of becoming violent and in turn being subject to physical attack and humiliation lessen. The group judgment is a moving force that cannot be resisted. Where a number of members share an opinion about an individual or behavior, the effect may be more intense than an interpretation by the therapist. As one patient put it: "If a person in a group calls you a horse, you have a right to be indignant. If a second person in the group calls you a horse, you have a right to be insulted. If a third person in a group calls you a horse, you better look into yourself to see if you are acting like a horse." The group strengthens the individual's ability to express feelings toward the therapist, whether rational or irrational; one may be unable to do this during individual therapy.

One of the most important consequences of being in a group geared toward reconstructive goals is learning how emotional processes operate by observing how other members talk about and solve their problems. Dynamic thinking soon becomes a dominant mode in the group. Immediate symptoms are related to basic adaptational patterns. As these are traced to destructive past conditionings, resistance and transference may be mobilized and explored. In this way the patient begins to think more dynamically about himself or herself, the genetic origins of patterns, their manifestations in his or her present life, and the defensive maneuvers they inspire. Awareness of inner psychological operations is also sharpened through emotional involvements with other group members, through one's own spontaneous discoveries, and through interpretations from fellow members and the therapist. Instead of withdrawing, as in a usual life situation, the patient is encouraged to hold his or her ground and to express and analyze feelings and defenses. It is here that a psychotherapist trained in reconstructive therapy can make the greatest impact on the patient.

ADVANTAGES OF GROUP VERSUS INDIVIDUAL THERAPY

Group therapy has certain advantages over individual treatment. It is capable of registering deep impressions by virtue of the fact that the patient is exposed to the judgments of not one person, but a host

of people. In individual therapy the patient soon learns how to cope with and to neutralize the influence of the therapist. It is much more difficult to do this in a group setting. Change is scored on different levels of the intrapsychic organization. This includes one's system of values, which is altered through percussion of disparate ideologies in the group. It is much easier for the individual to recast one's standards in a setting that is a reflection in miniature of the world than in the isolated confines of the dyadic therapeutic relationship.

Diversified intrapsychic defenses come out toward members of the group with whom the patient plays varying roles. Multiple transferences, both sequential and simultaneous, are readily established. The opportunity to relate in different ways to fellow members enables the individual to work through insights in the direction of change. Thus, if the patient finds it difficult to express him or herself aggressively or assertively, practice with the least threatening member may be in order. Thereafter there may be progressive challenge to others who are more threatening. In individual treatment the therapist may continue to be too powerful a figure to override. Moreover, even though the patient masters fear and guilt, he or she may find it difficult to transfer what has been learned during individual therapy to the environment outside the therapeutic setting.

Within the group the patient feels more protected, both by the therapist and by members with whom alliances have been formed, and he or she may be able to practice new attitudes more propitiously. For example, if Mary Smith has a problem in accepting any aggression and hostility that are directed toward her, the group will offer her the opportunity of exposure to these emotions in graduated doses. She will become more and more tolerant of the resentment extended toward her. She will learn to accept criticism—to reflect on it and to see whether it is justified or not—instead of reacting automatically with indignant or violent responses. Rigid character defenses often yield in group therapy as patients observe their ego-syntonic traits operating in others.

On the other hand, one advantage of individual therapy is that the focus is on the patient's personal problems, which often become diluted in a group setting. With so many other members of the group expressing themselves, it is not always possible for the patient to clarify significant feelings at the time he or she is experiencing them. Individual therapy enables the patient to look into the private world of fantasy and conflict and to explore intrapsychic mechanisms in greater depth. It permits a

concentrated working through of past difficulties developed with parental authorities.

Outlining some of the benefits a patient may derive from group therapy, we may include (1) the opportunity to see that one is not alone in one's suffering and that problems felt to be unique are shared by others; (2) the opportunity to break down one's detachment and tendencies to isolate oneself; (3) the opportunity to correct misconceptions in ideas about human behavior by listening to others and by exposing oneself to the group judgment; (4) the opportunity to observe dynamic processes in other people and to study one's own defenses in clear perspective in relation to a variety of critical situations that develop in the group; (5) the opportunity to modify personal destructive values and deviancies by conforming with the group norm; (6) the opportunity to relieve oneself of tension by expressing feelings and ideas to others openly; (7) the opportunity to gain insight into intrapsychic mechanisms and interpersonal processes, (particularly as multiple and split transferences develop), the group acting as a unit that replicates the family setting and sponsors reenactment of parental and sibling relationships; (8) the opportunity to observe one's reactions to competition and rivalry that are mobilized in the group; (9) the opportunity to learn and to accept constructive criticism; (10) the opportunity to express hostility and to absorb the reactions of others to one's hostility; (11) the opportunity to consume hostility from others and to gauge the reasonableness of one's reactions; (12) the opportunity to translate understanding into direct action and to receive help in resolving resistances to action; (13) the opportunity to gain support and reassurance from the other members when one's adaptive resources are at a breaking point; (14) the opportunity to help others which can be a rewarding experience in itself; (15) the opportunity to work through problems as they precipitate in relationship with others; (16) the opportunity to share difficulties with fellow members; (17) the opportunity to break down social fears and barriers; (18) the opportunity to learn to respect the rights and feelings of others, as well as to stand up to others when necessary; (19) the opportunity to develop new interests and make new friends; (20) the opportunity to perceive one's self-image by seeing a reflection of oneself in other people; (21) the opportunity to develop an affinity with others, with the group supplying identification-models; (22) the opportunity to relate unambivalently and to give as well as to receive; (23) the opportunity to enter into productive social relationships, the group acting as a bridge to the world.

ORGANIZING A GROUP

In organizing a group the therapist will be limited by the patients available. Nevertheless, one should choose patients who are sufficiently advanced in their understanding of themselves to be able to perceive their patterns as they will appear in the group setting. While the clinical diagnosis is not too important, experience shows that the following conditions and patients do poorly in a group; except perhaps when implemented by an experienced group therapist in a homogeneous group within an inpatient setup through supportive or reeducative group methods.

1. Psychopathic personalities and those with poor impulse control
2. Acute depressions and suicidal risks
3. Stutterers
4. True alcoholics
5. Hallucinating patients and those out of contact with reality
6. Patients with marked paranoidal tendencies
7. Hypomanics
8. Patients with a low intelligence

The age difference should preferably not exceed 20 years. Homogeneity in educational background and intelligence is desirable but not imperative. A well-balanced group often contains an "oral-dependent," a "schizoid-withdrawn," a "rigid-compulsive," and perhaps a "provocative" patient, such as one who is in a chronic anxiety state. This variety permits the members to observe a wide assortment of defense mechanisms and to experience tensions they might otherwise evade.

The number of group members may range optimally from 6 to 10. If a therapist feels uncomfortable with a large group, then the size of the group should be reduced. Marital status is relatively unimportant. A balance of males and females in the group allows for an opportunity to project and to experience feelings in relation to both sexes, although acting-out is more likely in a mixed group.

A heterogeneous group in terms of age, sex, and syndrome is most effective for reconstructive goals. A homogeneous group, composed of patients with the same problem, is best for alcoholism, substance abuse, obesity, smoking, sexual problems, insomnia, phobias, depression, delinquency, stuttering, criminality, marital problems, divorce, and geriatric problems, although an occasional person with such problems may do well with and stimulate activity in a hetergeneous group. The goals are both supportive and reeducative. Severely handicapped persons, such as paraplegics, women who have had mastectomies, patients undergoing renal dialyses, and laryngectomized patients, feel unrelated to the norm and do better in homogeneous groups. Adolescents seem to be more responsive in same-sex, same-age groups.

In introducing the matter of group therapy to a prospective member the therapist may explain that a group is being organized for purposes of treatment. Talking over problems or ideas in a group tends to expedite getting well. The patient may then be invited to join with the statement that perhaps a group may facilitate his or her progress. This, if the patient is in individual treatment, may be presented as a "promotion."

One of the problems that plagues neurotic individuals is the loss of a sense of group belongingness. To an extent, it is because they devalue themselves and feel rejected by others; partly it is because they anticipate that their own hostility will be reciprocated. As a consequence of this isolation, they lose identity with people and thus are robbed of a vital source of security. When a suggestion is made that they enter a group, they may imagine that their worst fears will come to pass. They will then pose a number of questions that usually reflect their resistance, and#the therapist will be obliged to answer them.

The following are common questions and suggested replies:

Q. How can other mixed-up people like myself help me?

A. People in a group actually do help each other. They become extremely sensitive and perceptive about problems, and they often may be of considerable service to other members. In the group the person has an opportunity to observe how he or she interacts and to witness the nature of reactions to one. The therapist is present during the sessions to see that it goes along well. It's normal to feel some anxiety the first few

sessions which provide "grist for the mill."

Q. I would be ashamed to bring up my problems to a group of people I don't know.

A. This is understandable. It is not necessary for you to divulge anything you do not wish to talk about. [*Actually this reassurance does not retard the patient from divulging the most intimate problems readily as soon as he or she begins to articulate.]* Without your permission I shall not bring up anything about you or your problems. This is up to you. Most people fear not being able to talk in a group. In reality, being with a group with whom you can be yourself is consoling, not frightening.

Q. What am I supposed to do in the group?

A. There is no need for you to do anything special. You may talk or you may remain silent as you wish. Generally one is not as embarrassed as one would imagine.

Q. Won't these people reveal things about each other outside the group?

A. One of the rules is that no mutual confidences are to be revealed to outsiders. Should this happen (and it rarely does), the person is dropped from the group.

Q. Supposing I meet someone in the group I know?

A. When it happens, it may actually prove to be an advantage. Any problems between two people who know each other can often be worked out.

Q. Won't the problems of the other people rub off on me?

A. Without any reservation I can say, "no." On the contrary, you may gain a great deal from observing how other people face and resolve their troubles. It can be a great educational experience for you.

Q. Do I continue seeing you individually?

A. Generally yes, but we will decide how frequently. Sometimes I may want you to try the group alone, but if that comes up, we can talk about it.

Q. Can I raise any issues I want in the group, even about you?

A. Unless you do, you will not get as much benefit out of the group as you might. It is important to talk about your feelings and ideas in relation to yourself, to outside people, to the group members, and to me. That is, if you wish to do so.

Q. Supposing my feelings are unreasonable?

A. This is why the group is of such value. In life there is very little opportunity to examine the reasonableness or unreasonableness of one's attitudes and responses. The group offers you an opportunity to test your assumptions. In the protected setting of the group a person can express one's ideas and emotions.

The length of a group therapy session is approximately *H* to 2 hours. The frequency of meetings is one to two sessions weekly, with alternate sessions once weekly if desired. The best seating arrangement is in a circle.

There are many advantages in employing cotherapists in a group, provided that problems between them do not prevent their working together. The literature on the subject of cotherapy and the difficulties that can occur between cotherapists that can sabotage their usefulness and destroy the group process are pointed out by J. B. Strauss (1975). Her own study deals with the results of a questionnaire that explores the ways therapists conceptualize their problems and how they try to cope with them. A most interesting finding was the difference of role perceptions of male and female therapists. Many problems can be overcome if the cotherapists meet periodically together with a supervisor whom both respect.

THE OPENING SESSIONS

At the first session the members are introduced by their first names, and the purpose of group discussions is clarified. This will vary with different therapists and different groups. Advanced patients will already have worked through some of their individual resistances in their sessions alone with the therapist. Newer patients may need more explanations in the group setting. The more passive-dependent the patient, the more leadership will be demanded of the therapist. The technique employed during the opening session will be determined by the therapist's orientation and level of anxiety. Many therapists who use the group as an adjunct may assume a very passive role so as to elicit spontaneous reactions from different members for use in later individuals sessions.

Some therapists begin by simply stating that the group offers members an opportunity to talk about their feelings and eventually to understand their individual patterns. It is not necessary for the members

to feel compelled to reveal something that they want to keep to themselves. However, communicating freely will help them to get a better grip on their problems. For instance, each member must have had certain definite feelings about entering the group; he or she may have been embarrassed, upset, or fearful. The therapist may then attempt to elicit these emotions, and, as one member expresses freely, others will join in, leading to a general airing of difficulties shared by all.

Before the close of the first session, some therapists find it advisable to stress the confidential nature of the meetings and to caution that each member is expected not to reveal to others the identity of the members and the subject matter discussed in the group. While no member will have to divulge secrets before he or she is ready, each will be encouraged to relate any incidents involving accidental or planned contacts with other members of the group outside of the sessions. Therapists who strongly believe that acting-out is deleterious will, in all probability, discourage any contact outside of the group. Sexual involvements may be forestalled by fostering verbalization of the patients' feelings and impulses toward each other. Usually the anxiety level drops markedly at the end of the first session, but rises temporarily at the outset of the second session.

During the early stages of treatment some therapists who are anxious to prevent acting-out at any cost will, at first, assume a despotic role that contrasts sharply with their role in individual sessions. Parenthetically, this may lead to more acting-out. They may try to keep patients from exposing painful revelations before the group is ready to support them. On the other hand, free verbal interaction may be encouraged in the group in order to bring out each member's customary facades and defenses.

Later in the course of therapy authority is shared by various members, who are, from time to time, "elevated" and "dethroned" by the group according to its needs. Often individual members in their temporary authority posts may initiate ways of eliciting meaningful material. This may take the form of giving each person an opportunity to express him or herself at each session, or there may be a much more informal arrangement with the members spontaneously expressing what is on their minds at the moment. Actually, by the time emotions are beginning to flow freely within the group, there is no further need for procedural structuring; indeed, this should not be rigidly controlled at any time. The content of discussions will vary greatly, covering current incidents of importance in the lives of each member, dreams, attitudes toward others in the group or toward the therapist, and general areas, such as family

relations, sex, dependency, and competition.

In previous chapters, principles of supportive and reeducative group therapy have been described. In this chapter, principles of group psychotherapy oriented around reconstructive goals are considered. In addition, behavior, experiential, transactional analytic, psychodramatic and role playing, family, and marital (couple) interventions are considered.

LATER SESSIONS

Ezriel (1973) believed that principles of classical individual psychoanalysis could be advantageously adapted to group therapy. Essentially mechanisms of the unconscious are uncovered and their meaning explicated through interpretation. The core of the neurotic process are unconscious need structures that constantly strive for satisfaction through transference reactions and that are dynamically related to resistances. "Here-and-now interpretations" of transference maneuvers with group members does not preclude examination of extratransference projections toward persons outside of the group. However, the therapists must be constantly on the alert for covert transference manifestations that relate directly to them but are being diluted by references to others. Interpretation of transference with the therapist ("the required relationship") brings the patient closer to behavior patterns that the patient has been repudiating ("the avoided relationship") and permits reality testing that can demonstrate that anticipated calamities will not come to pass. Often such experiences enable the patient to make a connection between contemporary life and unresolved infantile conflicts. Unconscious common group tensions lead to the development of a group structure within which each member seeks to express transference needs. The therapist can advantageously analyze the structure of the group as it displays itself in a particular session and designate the roles played by the different members, thus delineating the defense mechanisms displayed by the individual members. Interpretation can thus be both individual-centered and group-centered; ideally the focus is on the two during each session. All activity in the group, as in classical individual analysis, other than interpretation must be assiduously avoided to prevent gratification of transference needs, which, while momentarily tension relieving, keeps basic conflicts alive.

Other authorities, especially in the United States, insist that the classical model is too limiting and

introduce many modifications and active maneuvers such as the structural interventions of Minuchin (1974b). A dynamic viewpoint, nevertheless, is desirable even if nonanalytic methods are employed. It is essential, however, always to attune therapy to the presenting complaints. Where this is not done, one can expect poor results.

As the group becomes integrated and develops an "ego" of its own, members feel free to air intimate vexations. The patient gains more insight into personal difficulties recognizing that many troubles previously believed unique have a common base. The therapist should, therefore, direct energies toward stimulating thinking around universally shared problems, getting responses from other group members even though the subject under consideration is out of the ordinary. The patients may be asked to talk about personal impressions of the role the therapist is playing in the group. Thereafter the group is asked to discuss the verity of each patient's assumptions.

As Grotjahn (1973) has pointed out transference is a most important element of the group experience. He describes three trends in transference: (1) transference to the therapist and central figure (e.g., paternal figure), (2) transference to peers (e.g., sibling), and (3) transference to the group itself (e.g., pregenital mother symbol). These different transference relationships are always present simultaneously, patients treating the group as if it were their own family. In working through transference and defenses dreams are advantageously utilized; but they are utilized in a somewhat different manner than in individual therapy, the group members and the therapist associating directly to the dream especially focusing on the thoughts and feelings it evokes in themselves, without waiting for the associations of the dreamer. In this way the dream becomes a part of group experience. Sometimes the therapist's reactions to a group member may be perceived correctly by a third member and interpreted.

Many therapists practicing individual psychoanalysis contend that group therapy waters down transference reactions, minimizes regressive reactions, and neutralizes emergence of a genuine transference neurosis. Character changes in depth are, therefore, circumvented. Durkin and Glatzer (1973) have elaborated on how a constant focus on process rather than content and how selective exploration of origins of defensive behavior during group therapy can effectively bring forth pre-oedipal as well as oedipal conflicts. Systematic analysis of intragroup transferences may act as a vehicle for successful transference interpretations and can lead to reconstructive personality changes of a deep and

enduring nature.

Of vital importance is the opportunity for the development of multiple transferences during which varying members of the group function as vehicles for the projection of feelings, attitudes, and relationships with important persons in the individual's past existence. Of significance, too, is the fact that the group situation allows for "split transferences"—for example, projection of a "good" mother image on one member (or the therapist or the group as a whole) and of a "bad" image on another.

The basic rule in a group setting is for members individually to express themselves as freely and without restraint as possible. This encourages the disclosure of forbidden or fearsome ideas and impulses without threat of rejection or punishment. The patterns of some individual members usually irritate and upset others in the group, mobilizing tension and stimulating appropriate and inappropriate responses. The monopolizing of most of the session's time and competitiveness for the therapist's attention bring about rapid responses from the other members. Many patients will react to a trait in a member that they despise in themselves, even though they may not be immediately aware of possessing that trait.

Some therapists work even at the start on group resistance. For example, they may believe that mobilization and release of hostility is essential toward the development of positive and cooperative attitudes. The activity they engage in, therefore, is designed to stir up hostility and to facilitate hostile verbalizations. Other therapists try to facilitate the activity of the members as "adjunct therapists." The interactional processes virtually do put the various group members in the role of cotherapists. Under the guidance of the therapist this role can be enhanced. The specific effect of member "cotherapists" may be analytic or it may be more supportive, encouraging, accepting, and empathic, thus providing an important dimension to supplement the work of the therapist. One way to enhance cotherapeutic participation is, even at the start, to analyze motivations of one or more members to stimulate curiosity and communication. The members are invited to put themselves into the place of a member chosen for focus, e.g., to imagine dreaming the same dream as the member and to interpret the meaning.

A patient finds it easier to examine the inner feelings that have been repudiated when sensing that the group and the therapist are supportive. If expressed feelings seem to elicit a sympathetic response

from other members, the ensuing discussion often leads to a lifting of tension and a sharpening awareness of the patient's neurotic patterns. In the kaleidoscopic illuminations of the group each person's vision is broadened by taking advantage of the opportunity to observe and study his or her own and other members' reactions within the group—e.g., manifestations of hostility, fear, suspicion, or sexual feeling—and to relate them to the basic character structure. In this context the difficulties and antagonisms among members may, through analysis of the operative projections, lead to a constructive solution.

Among the therapist's activities are clarifying, structuring, focusing, timing, interpreting individual and group resistances, encouraging group interaction, and clarifying group interrelations. The therapist's ability to accept hostility and criticism from one member paves the way for other members to engage in verbalizing and a working through of their own hostile emotions.

Reactions of the patient occur in complex clusters as a release of feeling within the group is accelerated. Lack of restraint in one group member often results in a similar lack of restraint in the others. A climate that tends to remove repression enables the patient to work toward a better understanding of inner conflicts.

The matter of alternate sessions calls for special attention. Although it is regarded by some as a sanctioned vehicle for acting-out, experience shows that it can provide opportunities for free interaction, testing, and exploring. It enables some patients to speak more freely about their feelings about the therapist and thereby to consolidate their separation from parental authority. It is essential, however, that activities at alternate sessions or elsewhere involving group members with each other be reported at the regular group sessions. Acting-out members should be seen also in individual therapy.

TECHNICAL OPERATIONS OF THE GROUP THERAPIST

The role of the group leader is to catalyze participation of the various members, to maintain an adequate level of tension, to promote decision making and problem solving, to encourage identifications, to foster an interest in the goals to be achieved, and to resolve competitiveness, resentments, and other defenses that block activity. Groups have a tendency to develop many resistances; for instance, the

members form cliques, they come late, they socialize too much, they get frozen into interlocking roles. The therapist has a responsibility to deal with these overt obstructions, as well as with those that are more concealed and come through in acts like passivity, detachment, and ingratiation. The group interactions will permit the therapist to witness how individuals function with others, their enmities, and their alliances.

How the leader communicates to the group will vary with the orientation and personal idiosyncrasies of the leader. Some leaders are mercilessly authoritarian, and they take over firm control, directing the various activities with despotic regulation. Others are so passive that they scarcely make their presence known. There are therapists who conceive of their role as a benevolent authority who grace their subjects with kindly guidance. There are those who insist the the function of the leader is to liberate the affects of patients that cause their paralysis as people. This, they believe, is accomplished best not by interpretation, but by establishing meaningful, deep relationships. Accordingly, a therapist must avoid setting up as a paradigm of health or virtue, one who is falsely objective, which may be merely a cover for the therapist's omnipotence. Some therapists contend that there is no reason why the therapist cannot reveal weaknesses and grow with patients, relating to their strengths. Experience convinces, however, that most therapists will do best in group therapy if they function with some discipline and if they sensitize themselves for counter-transference manifestations, which are more easy to elicit and more difficult to control in a group than in an individual setting since they too may unconsciously experience the group as their personal family. This does not mean that one must keep oneself in a straitjacket and not react to provocations. Expression of anger toward the group when this is justified, without threatening recriminations, may be exactly what the group needs.

There is always a temptation in group therapy to allow the group to indulge in social chatter, in endless mutual analysis, and in the recounting of dreams and personal experiences at length. This interferes with proper interaction in the group. The therapist must constantly remind the members that they are not there to act as professional psychoanalysts, attempting to figure out dynamics and to expound on theory. The best use of their time is in exploring their own immediate reactions. The principle activity of the therapist will be to resolve resistances to talking about feelings regarding one another and to try to break up fixed role behavior patterns.

The specific communicative media will also vary with the training of the therapist and the goals in treatment. A recounting of dreams, and particularly recurrent dreams and nightmares, may be activated by most analytically oriented therapists, as may the reporting of fantasies and daydreams. Interpersonal interaction may be facilitated by encouraging the free association of each patient about the others in what Alexander Wolf (1950) has called "going around." Patients are enjoined to recite whatever comes to their minds about their fellow members, whether logical or not. Free association about the therapist is also invited. Interpretation is an instrumentality considered essential for the proper working-through of pathogenic conflicts.

Other therapist activities include

1. Focusing the conversational theme around pertinent subjects when topics become irrelevant.
2. Creating tension by asking questions and pointing out interactions when there is a slackening of activity in the group.
3. Posing pointed questions to facilitate participation.
4. Dealing with individual and group resistances.
5. Supporting upset members.
6. Encouraging withdrawn members to talk.
7. Interfering with hostile pairings who upset the group with their quarreling.
8. Reminding the group that communication about and understanding of mutual relationships is more important than interpreting dynamics.
9. Managing silence, which tends to mobilize tension in the group.

Role playing and psychodrama may be introduced periodically. They have advantages and liabilities, as may touching (Spotnitz, 1972).

An important aspect of the therapist's function in the group is that of gauging and regulating group tension and anxiety. It is well known that some degree of anxiety is one of the moving forces in therapy facilitating growth and change. But anxiety can also be disorganizing—if too much of it is aroused, the

group cannot function; there is low cohesiveness, and dropouts occur. It is up to the therapist to step in and deal with excessive tension and maintain not a minimal level of tension, but an optimal one. If too little tension exists, a "dead" session may be resuscitated by requesting that the members "go around" associating freely about each other. A group that has settled into pallid social interchanges may also be revived by introducing a new active, disturbed member.

Perhaps the main task of the therapist is to detect resistances of the group as a whole as well as of the individual members. The dealing with resistance will depend on its manifestations and functions. The question is sometimes asked, "Should one share one's feelings with one's patients and act as a 'real' person rather than as a detached observer?" This depends on how it is done and the kind of relationship that the therapist has with the patients. To bring out one's *serious neurotic problems* may destroy the confidence of some group members in the therapist's capacity for objectivity, as well as the ability to help them, and the impair effectiveness of the therapeutic process. On the other hand, to share *feelings and reactions* will reveal the therapist as more human and less omniscient and give the patients confidence to talk more openly about their own anxieties.

As has been mentioned, a huge variety of resistances precipitate out in group therapy. Their dissolution has resulted in many innovative techniques. In a humanistic contribution Livingston (1975) describes two major forms of resistance that block progress in group therapy: contempt and masochism (sadomasochism). These defenses may, through the assumption of a special role on the part of the leader, be broken through in what the author calls the "vulnerable moment." During such intervals a patient allows himself or herself to be open and honest, and through a constructive sharing of an experience with the group and therapist, the patient may score substantial reconstructive gains. Describing how awareness of such readiness for change came about in his own group therapy as a patient, Livingston suggests techniques, some derived from Gestalt therapy, that may facilitate the working-through process.

A particularly insidious and masked form of resistance is acting-out. The initial reaction to a therapeutic group experience is generally a profoundly inspiring one. A good deal of the reaction is marshalled by hope, the patient projecting wishes to be accepted, understood, and loved without qualification. While defenses continue to operate, these are softened by the emotional catharsis that is experienced in verbalizing to strangers and by an idealization that projects onto them. Sooner or later he

or she plummets back to the original defensive baseline as the patient discovers flaws in the idealized images of the group, as criticisms, challenges, and attacks justifiably and unjustifiably are leveled at him or her; and as multiple transference reactions come forth that, unfoundedly, make the group a facsimile of the patient's original family, with some members even sicker than those of the patient's own family. Frustration, disappointment, and even despair are apt to dominate responses, and acting-out may then occur verbally and behaviorally.

In groups conducted by unsophisticated therapists the acting-out dimension may be openly encouraged, the patients being helped or goaded into unrestrained speech and behavior without relating personal responses to underlying motivations. The temporary relief of tension and the pseudo-assertive expostulations are confused with cure. Follow-up almost invariably demonstrates how futile are the results. Many of the members become welded into reciprocal sadomasochistic alliances, and therapy becomes interminable. Others find excuses to leave the group.

The ability of the therapist to establish and to maintain proper communication is the principal means of averting this therapeutic impasse. A. Wolf (1975) illustrates how a therapist may utilize his or her own personality characteristics, for example, solicitude, capacity for healthy engagement, self-discipline, and sheer human decency, to resolve resistances and to enhance interaction. He refers to methods employed by Asya Kadis, which tend to encourage working through rather than acting-out and help foster character restructuring.

The control of acting-out requires a differentiation of acting-out behavior from impulsive and compulsive acts (Spotnitz, 1973). It is generally agreed that there is a greater tendency toward acting-out in group therapy than in individual treatment. A primary function of acting-out, according to Spotnitz, is to avoid experiencing unpleasant emotions, often of preverbal origin, that cannot be tolerated. Action becomes tension alleviating. It often conveys information in a dramatic form to the effect that the individual is unable to verbalize freely. More constructively, it may serve as a means of attempting to master traumatic events, and it may actually help prevent the outbreak of psychosomatic illness or psychosis by discharging tension. However, the validity of acting-out is always justifiably challenged unless it results in reality testing or enables a patient to master a tendency toward resistive emotional action. Under these circumstances the patient's actions may be considered constructive and in some

instances even maturational. If, on the other hand, investigation reveals that emotional action serves as a resistance to communication, it must be therapeutically handled as a form of resistance. Particularly damaging are actions that are destructive to the continuity of the group or to any of its members. Inadequate communication of understanding on the part of the therapist and failure to meet the patient's emotional needs may be responsible for acting-out, which may then take the form of the patient dropping out of the group. Awareness of this contingency may help the therapist deal with such behavior at its inception.

Another type of resistance is encountered on the part of members who refuse to participate in the treatment process. Innovative therapeutic approaches here may cut through the defensive system through the use of videotape recording and playback. R. L. Beck et al. (1975) describe such a program in which dance movement therapy is employed to demonstrate how incongruence between verbal and behavioral communication as a form of resistance may be resolved. Success may sometimes be scored through this approach (whereas traditional therapeutic modes are ineffective) and can lead to a more constructive use of verbal psychotherapy.

Special patients and syndromes may also require innovative methods. The unique personality needs and defenses of adolescents (for example, their lability of affect, their struggle for identity) require an atypical format in the conduct of group psychotherapy. There are differences in respect to activity, depth and content of discussion, and roles taken within the group. Adolescents bring into the group (which influences its Gestalt) the rapidly shifting values of the contemporary social scene and their distinctive reactions to delights and horrors of our modern technological era. Their reactions differ from those of their parents, who were subjected to a different type of social conditioning. Moreover, the ease with which runaways may survive away from home in a commune and participation in the drug culture that surrounds them must be taken into account in any group psychotherapeutic plan. Kraft and Vick (1973) present an approach that acknowledges the pressing need in adolescents for expressions of their identity and creativeness by introducing into the group psychodramatic techniques and artistic activities, such as dance or movement, music, poetry, and various visual stimuli and by employing where indicated auxiliary therapists. Major conflicts of adolescents worked through in the group included individual excessive competitive behavior versus withdrawal tendencies, inadequate outlets for emotional expression versus emotional blocking, growing up toward individual responsibility versus dependency,

and self-identification versus expected role assumption and various breakdowns in defensive operations. This type of group, according to the authors, provides a growth experience for the members, results being reflected in enhanced school performance, better peer relationships, and a general strengthening of ego functioning.

Riess (1973) describes in the conduct of a group of adolescents, or family of the adolescent, a structured "consensus technique" that he believes is ideally suited for diagnostic and therapeutic purposes. In this technique a problem situation in written or oral form is presented to each member who writes out what would be the appropriate outcome or way of action. The members then discuss the "solutions" and are given a limited time to come to a unanimous decision. In the course of the ensuing interactions, individual styles, reactions, and defenses become apparent and relationship problems emerge. The results may be utilized diagnostically. By mobilizing conflict and anxiety, defensive operations precipitate out rapidly, and where the therapist is trained dynamically to deal with defenses, therapy may become catalyzed.

One of the poignant problems of the group therapist is how to deal with "difficult" borderline patients, that is, those who do not respond to the usual tactics or maneuvers during the group session, who are extraordinarily self-involved, sensitive, dissatisfied, and angry. Their impact on the group may be intense and not always constructive, since they attempt to destroy, to monopolize, and to provoke counteraggression from other members. Moreover, they engage in struggles with the group leader that can be disturbing to the latter, to say the least. Pines (1975) has described the dynamics of the "difficult" patient, employing some of the ideas of Foulkes, Kohut, and Kernberg. He makes some useful suggestions on how to manage their reactions and resistances.

Efforts to expedite group therapy and catalyze movement have resulted in therapists' evolving their own unique techniques. Thus, Vassiliou and Vassiliou (1974) employ a transactional method "synallactic collective image technique," which actualizes psychodynamic concepts within the framework of general systems theory. Utilizing artistic creations made by group members (free paintings, doodlings, or scribblings), the participants choose, through majority vote, one creation around which discussion is organized. In this way the members "talk" to each other through a common stimulus. Gradually, as different projections evolve, communalities are compared and a "collective image" of the group emerges

that revolves around a central theme with individual variations. Throughout, the therapist operates actively in a key "catalytic regulatory" role, participating continuously in the group transaction.

Encounter and marathon techniques are capable, through the intense emotional atmosphere that they create, of cutting through defenses and rapidly reaching repressed feelings and impulses rarely accessible through the use of conventional techniques. However, such active procedures are unfortunately utilized by therapists as a means of dealing with their own countertransference. Thus, the sessions may be employed as an outlet for the therapist's hostility, boredom, need for social and physical contact, desire for dramatic "instant insights," and solution of professional and personal identity conflicts. The avoidance by encounter therapists of traditional concepts and practices, such as the analysis of countertransference, is a great liability and accounts for the bulk of negative therapeutic reactions and treatment failures. A. W. Rachman (1975) points out the importance of countertransference analysis and suggests methods of examining countertransference.

Corsini (1973) describes a "behind-the-back" (BTB) technique that may serve a useful purpose for groups of people. The problem in ordinary group therapy is that people find it hard to be honest with one another to their faces. The BTB technique is a stylized and formalized procedure that requires a minimum amount of time on the part of the therapist and is one that a suitable group may utilize. Members of the group are prepared by informing them that the method is designed to help express oneself to others and to learn what others really think of one. They are then asked to volunteer their participation as both patients and therapists. Each member in the present and following sessions is given a half hour to tell his or her story without interruption. At the end of this time the involved patient is requested to sit with his back to the group while each member talks about the "absent" member. This requires 20 to 40 minutes. The absent member is asked to face the group again while the therapist briefly summarizes what has been said. The patient is given about 5 minutes to make a rebuttal, responses being studied by the therapist in terms of denials, agreements, evasions, and other defenses. Then the patient sits in the center of the group exposed to the interrogation of the group. The therapist may interrupt these questions and terminate the session by sending the patient out of the room should emotions become too violent. It is to be expected that the patient will be upset by his inquisition, but this very turmoil causes the patient to unfreeze, better to face up to problems, realizing how he or she impresses others. At the very next session the patient is asked to summarize the meaning of the past session. The

BTB technique is planned to facilitate the release of emotions and to expedite change through altered behavior.

It is sometimes propitious, in the opinion of some therapists, once a dynamic understanding of a patient's emotional problems becomes clear, to expedite change through arranging an appropriate scenario that encourages the patient to act out conflicts in a controlled way. E. E. Mintz

(1974) presents a number of such episodes from her experience with marathon groups. The procedures employed, some of which draw from psychodramatic and Gestalt therapeutic techniques, are bounded only by the imagination and dramatic proclivities of the group leader and participant members. Patients who are vulnerable or resistant to "interpretations" in individual sessions are often, with this technique, better capable of cutting into core problems and facing their difficulties. Moreover, the process stimulates the other group members to open up many personal painful areas for discussion.

Bach (1974) utilizes and describes a technique of aggressive therapeutic group leadership through participating actively in fights that occur between members of marathon groups. He considers neutrality and passive objectivity, the preferred stance of psychoanalysis, a form of alienation and not caring, which violates the intimate participative spirit of the marathon experience. The therapist "attacks" by frank verbal explosions and expressions of frustration, irritation, and indignation justified by what is happening in the group. Such actions may be leveled at a passive cotherapist who refuses to participate actively in the group work, at a whole group of "ground-rule" violators (e.g., people who avoid confronting each other with their feelings), at subgroups (e.g., those who hide in a cozy, pairing maneuver), and at individual members who manifest patterns that interfere with the group experience (e.g., monopolizing, controlling, etc.). Bach provides amusing examples of his "attack therapy," which, though seemingly countertransferentially inspired at times, appear, according to his accounts, to result in a more intimate, experience-sharing communion among the members. He expresses his philosophy of therapy in this way: "We must all relearn how to fight to regain our genuineness. Only after this are we ready to share love."

C. Goldberg (1975), on the other hand, stresses an existential stance and believes that patients can be actively taught skills in interpersonal relationships that can mediate their own and others' loneliness

and despair, and which can probe ubiquitous alienation and existential exhaustion. Toward this end, the group leader actively participates in the group through openness, self-disclosures, display of congruence of feeling, and modeling of behavior. There is a minimization of verbal and nonactive interaction. Interpersonal skills are actively taught through such methods as a deciphering of nonverbal "body language," a listing and checking of one's irrational attitudes and an exposure of one's manipulations and defenses in order to influence situations outside the group and to revise strategies and core attitudes.

Many other group interventions have been described and are contained in the annual overview of group therapy by Wolberg & Schwartz (1973) and Wolberg & Aronson (1974-1983).

SPECIAL PROBLEMS

It can be seen from the previous discussion that some group therapists develop their unique techniques and ways of looking at group phenomena that, while valid for them, may not be sound, plausible, or found useful by every psychotherapist. Experimenting with these procedures and ideas, however, will reveal their value.

The mangement by the therapist of special problems among patients will be essential where they obstruct group interaction. The following are some of these.

The Silent Patient

Behind silence may lurk a variety of dynamisms. Sometimes detached, withdrawn persons may be drawn out by the therapist's asking them a pointed question in relation to what is currently going on in the group: "How do *you* feel about this?" Since the response will be hesitant and unsure, more aggressive patients may attempt to interrupt to take the floor over for themselves. The therapist may block this subterfuge and continue to encourage the reluctant patient to articulate. The patient may also be asked directly to report on any dreams. Sometimes it helps to allot a certain amount of time to each member, say, 5 minutes.

The Monopolizer

The person who attempts to monopolize the session may be manifesting a power struggle with the therapist or a masochistic maneuver to bring on the wrath of the therapist and other group members. The aggressive, narcissistic patient who insists on dominating the session will usually be interrupted by one or more members who resent this takeover. Where this does not occur, the therapist may halt the patient by asking another member what he or she is thinking about or by directing a question at the group as to whether they want the monopolizing patient to carry on all the discussion. The same tactics may apply to an interacting pair who interminably carry on a discussion between themselves.

The Quarreling Dyad

A manifestation of unresolved sibling or parental rivalry is two patients who constantly engage in verbal dogfights. This eventually becomes boring for the rest of the group and may sponsor a withdrawal into fantasy. The best way to deal with this phenomenon is by working toward each participant's tracing of the transferential roots of the enmity in order to recognize how both are projecting unconscious aspects of themselves on each other. This should not be too difficult from their dreams and associations. An interruption by the therapist of uncontrollable outbreaks of bickering is, of course, in order.

Acting-out Patients

Because groups are action oriented, because multiple transferences are set loose, because individuals other than the therapist are available for the discharge of erotic or hostile impulses, because not enough opportunity is given each patient to verbalize, and because upsetting revelations on the part of the group members may set off identical problems in a patient, acting-out can be a disturbing phenomenon in groups. The therapist may caution the members to talk out rather than to act out. The group members may be required to report at a regular session the activities engaged in between members outside the group. The therapist may try to reduce the anxiety level of the group. It is possible that the therapist's own countertransference is encouraging the acting-out. One should be constantly on guard for this. It may be necessary to reorganize the group when too many acting-out members are present. The therapist may insist on acting-out members being simultaneously in individual therapy.

The Private Session in the Group

Some patients will attempt to utilize the group time to get a private session with the therapist. They will look at and direct their conversation to the therapist, ignoring the presence of the group. This reaction is especially common in a patient who was an only child in the family of origin or who wants to be the preferred sibling. When this happens, the therapist may ask the patient to focus remarks on the group, may question the group as to how they feel about the patient's carrying on an intimate discussion with the therapist, may ask other members to associate to the patient's verbalizations, and finally, may suggest that the patient come in for a private session.

The Habitual Latecomer

Drifting into the session after it is under way will mobilize resentment among the members, particularly where it is repetitive. This resistance should be handled as a special problem, requesting the patient to try to understand what is behind this neglectful conduct. The latecomer ultimately may be threatened with removal from the group if he or she does not come on time. This may bring to the surface the resentment toward the group that is expressed in this symptom. The group members should be encouraged to deal with this problem, not just the therapist.

The Patient Who Insists that He or She Is Getting Worse not Better

There are patients who display a negative therapeutic reaction that they are only too eager to communicate to the group. Dependent patients who have been in the group for years, and who cling to it for emotional sustenance, usually join in to complain regarding the ineffectuality of therapy. This can influence the group morale and may be disturbing, especially to new members. The therapist may handle such a reaction by nondefensively citing examples from the progress made by various members of the group to disprove the thesis that therapy does not help and, where applicable, may point out the aim of the complainant to drive certain members (especially new members) out of the group.

The Accessory Therapist

A variety of mechanisms operate in the patient who is trying to replace the therapist. It may be a

protest on the part of a dependent patient to the therapist's passivity. It may be an attempt to undermine the authority of the therapist. It may be a way of seeking favor with the therapist. It may be a gesture to compete with and replace the therapist. Irrespective of its basis, the patient may soon gather about him a group of followers as well as adversaries. The best way to handle this maneuver is to ask the other members what they think is happening, until the therapeutic pretender quiets down. The therapist may also ask the competing patient why he or she feels obliged to "play psychoanalyst."

Mobilizing Activity

Where progress has bogged down and members seem to be in a stalemate, one may stir up activity by (1) asking the group why this is so, (2) introducing psychodrama or role playing, (3) asking a member to talk about the role assumed in the group, then going around the group requesting the other members to comment, (4) asking each member to talk about feelings concerning the two people on either side of him or her, (5) utilizing one or more techniques of encounter or Gestalt therapy, (6) extending the length of a session up to the extent of a marathon session, (7) introducing several new members into the group, (8) determining the nature of the resistance and interpreting it, (9) shifting some old members to a new group, (10) introducing a borderline patient into the group whose anxiety level is high, (11) taking and playing back video tapes of the group in action, (12) pointing out which stimuli in the group release repetitive patterns in each patient and interpreting their ramifications in outside relationships.

When a Therapist Becomes Bored with a Session

In this situation the therapist may ask, "Is anybody else besides me bored with this conversation?"Then the group could explore the basis for such a reaction.

MISCELLANEOUS GROUP APPROACHES

Preintake and Postintake Groups

Preintake groups, which act as a forum for discussion and orientation, are a valuable aspect of clinic functioning where a delay is unavoidable before formal intake. Up to 20 people may attend, and sessions may be given at weekly, bimonthly, and even monthly intervals. Parents of children awaiting intake may

be organized into a group of this type, which may meet for 3 to 6 monthly sessions. Postintake groups may take place before permanent assignment, and meetings may be spaced weekly or up to 1 month apart. Here some therapeutic changes are possible as disturbing problems are introduced and elaborated. These preliminary groups serve as useful means of selecting patients for ongoing group therapy. They are worthy orientation and psychoeducation devices and help prepare and motivate patients for therapy.

Special Age Groups

Group therapy with children is usually of an activity nature. The size of children's groups must be kept below that of adult groups (Geller, 1962). For instance, in the age group up to 6 years, two or three children constitute the total. Both boys and girls can be included. Single-sex groups are (1) from 6 to 8 years, which optimally consist of three to five members; (2) from 8 to 12 years, which may have four to six members; (3) from 12 to 14 years, which may contain six to eight youngsters; and (4) from 14 to 16 years, which have the same number. Mixed-sex groups at the oldest age level are sometimes possible.

Play therapy is the communicative medium up to 12 years of age, the focus being on feelings and conflicts. It is obvious that the ability to communicate is a prerequisite here. Beyond 12 years discussions rather than play constitute the best activity medium. Techniques include analysis of behavior in the group, confrontation, and dream and transference interpretation. Both activity (during which acting-out may be observed) and discussion take place at various intervals. Interventions of the therapist should be such so as not to hamper spontaneity. Discussion is stimulated by the therapist, and silences are always interrupted. Ideally, individual therapy is carried on conjointly with group therapy, particularly at the beginning of treatment.

Group psychotherapy with older people has met with considerable success in maintaining interest and alertness, managing depression, promoting social integration, and enhancing the concept of self in both affective and organic disorders (Goldfarb & Wolk, 1966). Where the goal is reconstructive, oldsters may be mixed with younger people.

Behavior Therapy in Groups

Behavioral techniques (Lazarus 1968; Meacham & Wiesen, 1974; Wolpe, 1969; Liberman, 1970; Fensterheim, 1971) lend themselves admirably to group usage, and results, as well as controlled studies, indicate that behavioral change may be achieved by the employment of methods such as behavioral rehearsal, modeling, discrimination learning, and social reinforcement. The group process itself tends to accelerate behavioral strategies. Homogeneous groups seem to do best, the selection of members being restricted to those who may benefit from the retraining of specific target behaviors. Thus, the control of obesity, shyness, speaking anxiety, insomnia, and phobias (flying insects, mice, closed spaces, etc.) can best be achieved in a group where the participants are focused on the abolition of similar undesirable behaviors. In institutional settings, particularly with psychotic patients, group decision making strategies may be practiced, reinforcement being offered through token economies. Short-term hospitalization for severe obsessive-compulsives, and perhaps alcoholics and drug addicts, treated in special groups of populations with similar maladaptive behaviors can often be a rewarding enterprise (Rachman, S., et al, 1971).

Individually oriented behavioral interventions [see Chapter 51, Techniques in Behavior (Conditioning) Therapy] may be employed alone in a group setting, or in combination with psychodrama, role playing, Gestalt tactics, encounter maneuvers, or formal group therapy procedures (inspirational, educational, or analytic) depending on the training and flexibility of the therapist.

A routine practiced commonly is to see the patient initially in individual therapy to take a history, to explore the problem area in depth as to origin, circumstances under which it is exaggerated, reinforcements it receives as well as secondary gains, and goals to be approached, employing the traditional behavioral analysis. If group therapy is decided on, it is best to introduce the patient into a newly formed group with persons suffering from the same difficulties and who have approximately the same level of intelligence and knowledge of psychological processes. The size of the group varies from 5 to 10 individuals. A cotherapist is valuable and sometimes indispensable as in the treatment of sexual problems. The initial few sessions may be relatively unstructured to help facilitate the group process. The time of sessions varies from 1½ to 3 or 4 hours. During the starting sessions members are encouraged to voice their problems and to define what they would like to achieve in the sessions, the therapist helping

to clarify the goals.

A. P. Goldstein and Wolpe (1971) have outlined the following operations important in group behavioral treatment: feedback, modeling, behavior rehearsal, desensitization, motivational stimulation, and social reinforcement. *Feedback* is provided with confrontation of the reactions of the other members to the patient's own verbalizations and responses. This gives the patient an opportunity to alter these if it is desired. *Modeling* oneself after how others approach and master the desired behavior is an important learning modality. The therapists may engage in role playing or psychodrama to facilitate modeling. *Behavior rehearsal* similarly employs role playing involving the patient directly. Repetition of the process with different members helps solidify appropriate reactions, the patient engaging in role reversal when necessary. Here video playbacks may be important so that patients may see how they come across. Counterconditioning and extinction methods (systematic desensitization, role playing with the introduction of the anxiety-provoking stimulus, encouraging expression of forbidden emotions in the group like anger) eventually lead to *desensitization.* The therapist provides direction and guidelines for appropriate behavior, which with the pressure of the group, helps create *motivation* and *social reinforcement.* Support is provided the patient when necessary. Specific assignments outside the group may be given the patient.

Relaxation methods may be employed in a group for the relief of tension and such symptoms as insomnia. Any of the hypnotic or meditational methods outlined in this volume (q.v.) may be utilized; their impact is catalyzed by implementation in a group atmosphere.

Behavioral tactics are ideally suited for habit disorders related to eating, such as obesity, smoking, gambling, alcoholic over-indulgence, and substance abuse. Members for each group must be chosen who suffer from the same problem and possess adequate motivation to cooperate with the interventions.

Where problems are centered around lack of assertiveness, assertiveness training can be highly effective. Fensterheim (1971) describes his method of dealing with this problem. Groups of 9 or 10 consisting of men and women in approximately the same number, roughly homogeneous as to age, marital status, achievement, education, and socioeconomic status (to enhance modeling) meet *2½* hours once weekly. Seats are arranged in a horseshoe configuration, the opening serving as a stage for role

playing and behavior rehearsal. Sessions are begun by each member reporting on the assignment proposed the previous week. Successes are rewarded with approval by therapist and members. Failures are discussed. On the basis of the report, the assignment for the following week may be formulated. Special problems will evoke discussion by the group. Members are asked to keep their own records of assertive incidents that they indulged in during the past week. Special exercises are employed with role playing depending on problems of individual members, such as talking in a loud voice, behaving unpleasantly, telling an interesting story, expressing a warm feeling toward other group members, practicing progressive expressions of anger (reading a dialogue and portraying an angry role, improvising one's own dialogue, role playing angry scenes and incidents reported by other members, and role playing scenes from one's own life and experience). About 5 to 10 minutes of each session is spent doing these exercises over a 4-month period. Roughly 10 to 15 minutes may be used for systematic group desensitization from a common hierarchy prepared by the group. At the end of each session members formulate their own next assignment or if they are blocked, this is suggested.

Phobias respond remarkably well to group behavioral methods. Here the patient selection must also be homogeneous as in assertive training. Aronson (1974) describes a program that has been successful in 90 percent of his patients completing it. The program is designed for fear of flying (but the ideas can be adapted to other phobias, such as fear of cars, ships, elevators, tunnels, bridges, high places, etc.). Initial individual consultations are geared toward establishing a working relationship with the applicant, and essentially to do a behavioral analysis, although Aronson stresses a dynamic accent. A high degree of motivation is desirable. "How much do you want to get over this fear?" may be asked. At the first session the therapist structures the program (the first five sessions devoted to a discussion of fear of flying; one or two educational briefings with safety experts, pilots, and other air personnel to answer questions; seven to eight sessions on discussion and methods of overcoming the fears). The optional size of the goup is 8 to 12 persons. Meetings are for 1½ hours once weekly. Presession and postsession meetings of ½ hour each without the therapist may be recommended. Pertinent reading materials on air travel and development should be available.

The following rules are delineated, (a) Each member will within the time limitations, be permitted to talk freely about existing fears, (b) At the second session each member is to bring in a drawing depicting the most pleasurable aspect that he or she can imagine about a commercial air flight and a

second drawing depicting the most unpleasant consequences. The individual is also invited to talk about any personal dreams about travel (In recounting such dreams no associations are encouraged nor interpretations made regarding defenses.) (c) The following exercises aimed at anxiety control are introduced.

1. While lying down or seated comfortably on a chair, visualize all the sensations and anxieties you experience while on a plane. Simply visualizing yourself on a plane may make you anxious at first. You may find yourself wanting to avoid thinking about it.' If so, let your mind dwell on pleasant thoughts for a while. As soon as you feel somewhat more relaxed, reenter the fantasy of being anxious on a plane. Focus initially on the least frightening aspects of flight. Gradually allow yourself to visualize more frightening fears. Each time you practice this exercise you will be able to get closer to the dangerous situation and stay with it longer. Do this exercise twice a day for a week (based on Wolpe, 1969).

2. Picture yourself in the *most pleasant* situation you can imagine. Let your mind dwell on this situation as long as possible. Then imagine yourself on a plane. Some of the positive feelings you experienced in your fantasy will come back with you and help allay your anxiety when you next imagine yourself on a plane on the ground or actually flying (based on Perls, 1969).

3. Visualize the most unpleasant situation you can possibly think of—a situation even *more unpleasant* to you than being on a plane. You will find that when you leave this fantasy and imagine yourself flying or actually on a flight, you will experience less anxiety (based on Perls, 1969).

Should any of these exercises stir up anxiety, the members must indicate this to prevent it from getting too deep, (d) Should members start feeling strongly hostile to each other, the therapist encourages verbalization and explains that strong, positive feelings among all group members will be necessary for success, (e) Talking about personal matters other than those related to fears of flying is to be discouraged. (f) After the fourth or fifth session one or two educational sessions are held with local airline representatives to answer technical questions about flying and safety measures, (g) After the eighth session the entire group visits an airport and, if possible, meets in a stationary airliner for about 1 hour. Members talk about their fears every step of the way. Around the tenth and twelfth session the group leader suggests a target date for a short flight. If too much anxiety prevails, this date can be temporarily postponed until the anxiety recedes. The leader must set the time with the airline

representatives and accompany the group. After the flight the group reconvenes to discuss the reactions. (h) Members are encouraged to arrange their own flights and to continue in group therapy for a few sessions thereafter.

Other phobias may be treated in a group setting following this format, introducing whatever modifications are essential considering the nature of the target symptom. Videotaping and playback may be employed, should the therapist possess the apparatus, particularly for role-playing exercises.

Experiential (Encounter and Marathon) Therapy

The group therapy movement has mushroomed out to include a variety of forms. The traditional model, which focused on inspiration, education, and insight acquisition, has been supplemented by groups whose objective is experiential with a wide variety of techniques. Many names have been given to these new arrangements including Gestalt, human relations training, human awareness, leadership training, T-groups, sensitivity therapy, and encounter therapy. The time element (traditionally 90 minutes) has been stretched sometimes to several hours, 12 hours, 24 hours, or several days with time off for sleep (marathon groups). Encounter therapy may be an ongoing process like any other form of group therapy, or it may be brief, from one to a dozen sessions.

A constructive group experience with a small group of people who are educationally on a relatively equal level and who permit themselves to disclose their self-doubts and personal weaknesses can be most liberating to the participants. The fact that one can expose oneself to others and reveal fears and desires of which one is ashamed, without being rejected or ridiculed, can be reassuring and strengthening. The person feels accepted for oneself, with all of the flaws, rather than for the pose presented to the world. Whereas previously the individual may have regarded interpersonal relationships as threatening, they can now embrace a sustaining richness. As communication between the members broadens, they share more and more their hidden secrets and anxieties. They begin to trust and accept themselves as they learn to trust and accept the other participants. Interpersonal confrontations, while temporarily upsetting, may even ultimately bring the individual into contact with repudiated aspects of himself or herself.

By communicating without restraint the members are enabled to learn that other individuals have problems similar to and even more severe than their own. The realization enables them to relax their guards and to open up more with one another. The "encounters" in the group will probably sooner or later release underlying patterns of conflict, such as hostility toward certain members, excessive tendencies to defy and obstruct, inferiority feelings, unrealistic expectations, grandiose boastings, and other maneuvers that have little to do with the immediate group situation but rather are manifestations of fundamental characterologic flaws. Under the guidance of a skilled group leader the encounter group becomes a means through which the members become aware of how they are creating many of their own troubles. By talking things out they are able to correct some of their misperceptions.

Some observers would call this process psychotherapy. We are dealing here with semantics. The effects of the encounter group can be psychotherapeutic, particularly in persons who are ready for change and who already have, perhaps in previous psychotherapeutic experiences, worked through their resistances to change. But psychotherapy, in most cases, is not the achieved objective. What is accomplished is an educational realignment that challenges certain attitudes and teaches the person how to function better in certain situations. If one happens in the course of this education to change a neurotic pattern of behavior, so much the better, but it must be emphasized that psychotherapeutic groups are run differently from encounter groups. They are organized on a long-term basis and focused on neurotic symptoms and intrapsychic processes.

Even though there is some evidence that encounter group experiences may have a therapeutic effect on neurotic personality structure, our observations at the Postgraduate Center for Mental Health indicate that personality changes, when they do occur, are temporary, rapidly disappearing once the participant leaves the encounter group and returns to one's habitual life setting. We have worked with the staffs of various institutional units, including psychiatric clinics, correctional institutions, schools, and a host of professional and nonprofessional organizations. Our delight at "depth" changes brought about by encounter techniques has been generally short-lived when we do follow-up studies after a reasonable time has elapsed. This fact does not depreciate what the encounter group can do for a participant, because in many instances it does alert the individuals to many neurotic shortcomings and motivates them to seek psychotherapy on a more intensive level. Many of our "cured" encounter clients have later asked for thorough psychotherapeutic help, once they have an inkling of their problems.

The usual marathon group exposes group members to constant association of approximately 30 hours, generally in the course of which a 5-hour break is taken. During the first 15 hours of interaction there is a gradual sloughing off of defenses, and, in the last hours, a "feedback" is encouraged in which the therapist enjoins the patients to utilize the understanding of themselves to verbalize or execute certain constructive attitudes or patterns. Highly emotional outbursts are encountered with this intensity of exposure, and corrective emotional experiences seem to occur. The therapist participates actively with the group, expressing his or her own reactions to the members but avoiding interjecting personal needs and problems. A variety of techniques may be employed. For example, at Esalen a combination of theories and methods were used, including Perls' Gestalt therapy, Freud's unconscious motivational ideas. Rolfs structural integration and body balance, Lowen's bioenergetic theory, Moreno's psychodrama. Shutz's encounter tactics, and other sensitivity training methods (Quaytman, 1969). Some of these techniques have more recently been taken over by Erhard Seminars Training (EST).

Experiential therapies are sometimes resorted to by psychotherapists when their patients have reached a stalemate in individual or group therapy. In many cases the specific working on the resistance resolves such blockage of progress without the need for dramatic interventions. However, in spite of this, there are some patients who seem unable to move ahead. Productions dry up, boredom develops, motivation to continue therapy dwindles away. Under these circumstances some therapists have found that referring their patients for encounter therapy or a weekend marathon suddenly opens them up, producing a flood of fresh material to work on, and sponsoring more enthusiasm for continued treatment.

Not too many therapists are qualified to do experiential therapy. Apart from that which may be gained by participation as a patient in encounter groups or in several marathons, it requires a special personality structure of great extraversiveness, spontaneous enthusiasm, and histrionic inventiveness. Sufficient flexibility must exist to permit a rapid switching of tactics and changing of formats to meet individual and group needs. The role of the leader will vary, of course, with the individual. Most therapists view themselves as participant observers who, while admitting and sharing some of their own problems, hold themselves up as models of expected behavior. Emotional stability of the therapist and control of countertransference are under these circumstances vital. The presence of a trained cotherapist is often of value in the service of objectivity. Both therapists who do marathon therapy and patients who receive it are usually enthusiastic. Follow-up studies have been more conservative as to the actual

benefits. The immediate experience may be an intensely moving one, and participants usually believe that they have benefited and are reluctant to end their relationship. They feel that they have acquired a new understanding of themselves. Often they do. But we may anticipate that benefits will not persist unless the environment to which the member returns reinforces the new behaviors and attitudes that have been learned. This is usually not the case, however. One would anticipate that unless some intrapsychic change has occurred, the old defensive balances will usually be restored. It is for this reason that results will be best if the individual continues in individual or group therapy to work on the significance to him or her of the encounter or marathon experience.

It has been the practice, unfortunately, to offer encounters or marathons for unscreened applicants willing to pay the price of admission on the theory that even a bit of confrontation, challenge, and encounter can provide fruitful bounties. Undoubtedly, there are persons who may get a good deal out of an intensive interpersonal experience without formally entering into structured psychotherapy. This does not compensate for the unstable souls, balanced precariously on the razor edge of rationality, who can be damaged by exposure to such groups. There are some patients (usually borderline cases) who cannot tolerate the intense emotional relationships of the marathon experience (Stone, WN, & Tieger, 1971; Yalom & Lieberman, 1971). Such individuals may develop frank psychoses as a result of breakdown of their defenses. Unless the therapist is well trained and does diagnostic interviews on all applicants (which is not often the case), he or she is risking trouble, however infrequent this is reported.

Even where an initial diagnostic study qualifies a person for this type of therapy, difficulties can occur in those with fragile defenses. The task of the leader is to pick out of the group those members who in their speech and behavior are beginning to lose control. Removing such vulnerable persons from the group, temporarily by assigning to them isolated tasks and perhaps giving them supportive reassurance in a brief interview, may permit some of them to reenter the group when their reality sense is restored. The therapist will have to interrupt any challenges or attacks that are levied at such persons, refocusing attention elsewhere.

Generally, the individual entering an experiential or marathon group is instructed in the responsibility that he or she has in the group, the need for physical restraint and abstinence from drugs and alcohol, and the fact that while one's behavior in the group is related to one's life style, that there

may be new and better ways of relating that one can learn. Sometimes a contract is drawn up as to what changes a person desires to achieve. Accordingly, the individual may gauge for oneself how far ahead to move. Emphasis is on the "here-and-now" rather than on the past.

As to encounter techniques, these vary with the inventiveness of the leader. In a small group the members may be asked to "go around" and give their impressions of all the other members, positive and negative. The leader may then say, "Reach out and put your hands on the shoulders of the person next to you. He or she will do likewise. Look into each other's eyes and say whatever comes into your mind." Or, "Hold the hands of the person next to you, and describe what you feel these hands are saying."

Utilizing art materials (crayons, chalk, pastels, etc.), the members may be asked to draw anything that represents how they feel and also how they would like to feel. The group later associates to or discusses these productions. The same may be done with clay or plasticene materials.

Two members may be asked to approach each other in front of the group and to communicate in nonverbal terms, i.e., by touching, gestures, facial expressions, etc. The group then discusses the nature of the communication.

Schutz (1967a) has described a number of "warm-up" and other techniques that may be used. One technique in helping a person give up rigid controls and distrust of others is to encourage him or her to stand with back to the therapist and to shut the eyes and fall straight back with trust that the therapist will surely prevent falling. Patients show many defenses to this maneuver, and the discussion of their fears and other feelings provides a stimulus for elaboration in the group. Later members may try this maneuver with each other when they develop confidence in permitting themselves to fall back.

Many touching maneuvers are employed for the same purpose. One is to invite patients to stretch out on a couch and to have them lifted by many hands and passed along, their bodies being stroked in the process. Associations to this are, as may be imagined, often interesting. In encounter groups, participants often play out their needs, impulses and conflicts not only through "verbal interchanges but also various nonverbal devices such as touching, massaging, holding, hugging, dancing, exercising, playing games, eyeball to eyeballing, acting out dreams and fantasies, etc." (Harper, 1975). Such groups which encourage an unrestrained expression of emotion may be helpful, at least temporarily, for inhibited,

repressed individuals who require peer approval and modeling by a leader who also enjoins them to come forth with their feelings. But they may be harmful to vulnerable individuals who, having let the lid off their emotions, are left with residues of guilt and confusion after the group has disbanded. Dangers come from lack of provision for adequate postsession discussion, clarification, support, and interpretation; from inadequate selection procedures for members; and from inexperienced and untrained leaders who, though high in enthusiasm, are low in therapeutic understanding and sophistication.

Negative outcomes with experiential groups are to be expected in view of the superficial screening of the participants and the large number of untrained leaders who contact these groups with few or no limits on the selection of techniques. It would seem propititious to set up certification and licensure requirements for potential leaders of encounter groups to minimize hazards (Hartley, Roback, & Abramowitz, 1976).

It is to be expected that when people come together for an extended therapeutic experience that hopes are high and that there may be unreasonable expectations of benefit. Despite efforts to control postures and defenses and to substitute for them conventional modes of relating, the facades soon break down, particularly when the individual is criticized and challenged. The close contact, the extended time period of interaction, the developing fatigue, and actual and implied pressures for change all add to the uniqueness of the experience. Intimacies develop that the participant needs to control since subgroups and pairing are strongly discouraged. As the individual realizes the consequence of one's acts for the reactions of others, motivation for change may be increased. This is further augmented by reinforcements that one receives in the form of group approval for any changes that are exhibited. Where patients are not in ongoing groups or individual therapy, it is advisable to schedule a follow-up meeting 3 to 4 weeks later to discuss postmarathon impressions and experiences.

Because many participants have failed to achieve the hoped for relief from alienation, personal growth, and self-realization, the popularity of encounter groups has waned during the past decade.

The literature on encounter (experiential groups) has proliferated since the mid 1960s. The following are recommended: Back (1972), Burton (1969), M. Goodman (1972), Kuehn and Crinella

(1969), E.E. Mintz (1967), Perls (1969), Rabin (1971), C.R. Rogers (1970), M. Rosenbaum (1969), Strean (1971-1972). The list continues to grow. Ample material has in the past been published on marathon therapy. A sampling follows: Bach (1966, 1967a-d), Casriel and Deitch (1968), Dies and Hess (1971), A. Ellis (1970), Gendzel (1970, 1972), J. Mann (1970), Rachman (1969, 1975), Sklar et al. (1970), Spotnitz (1968), Stoller (1967, 1968), Teicher et al. (1974), and Yalom and Lieberman (1971). In recent years interest in marathons has diminished.

Transactional Analytic Groups

Transactional analysis is a highly structured group of procedures, developed by Eric Berne in 1950, that is designed to help people achieve an expanded awareness of their interpersonal operations. It is predicated on the idea that human beings carry within themselves a threefold set of directives that influence their behavior in positive and negative ways. The first group of prescripts are residues of parental conditionings, the individual functioning as if driven by the values and attitudes of the parents. When this happens the "parent" (P) within is said to take over. The second group of regulations are the survival remnants of the "child" (C) and consist of immature promptings and habitudes, parcels of the past. The third group, the "adult" (A), is the logical, grown-up self that mediates a reasonable disposition. These divisions roughly correspond to Freud's superego, id, and ego; indeed, there is much in transactional analysis that parodies traditional dynamic formulations. What is unique and original about the method is the crisp, humorous, provocative language tabs assigned to different patterns that people display in their relationship with each other. This enables some persons, confused by the complex concepts and vernacular of psychoanalysis, to acquire insight into their drives and defenses rapidly, to accept more readily responsibility for them, and to work toward a primacy of the "adult" within themselves. It is little wonder that the volumes *Games People Play* by Berne (1964) and *I'm OK—You're OK* by T. Harris (1967) have stirred the popular imagination, plummeting the books to the top of the best-seller list.

Not all therapists, however, are able to do transactional analysis. What is required is a combination of special traits that include an extremely keen sense of humor, a facility for dramatics, a quick ability to perceive patterns as they come through in the patient's speech and behavior, and a unique capacity to label their use with relevant salty titles.

Treatment in transactional analysis begins with several individual interviews. Patients are instructed in the dynamics of the transactional approach and may be given assigned readings (Berne, 1964; Harris, 1967). A treatment "contract" is drawn up describing the goal of therapy in a specific and clear-cut way, and the patient is introduced to the group. Four overlapping phases of therapy are generally described (Karpman, SB, 1972).

The first phase is structural analysis concerned with understanding and recognizing "ego states," which objectively demonstrate themselves in body attitudes, tone of voice, vocabulary, and effect on others. Only one ego state manifests itself within the person at a time. Thus the individual's "parent" (P) may come through in vocabulary and behavior expressing what is right and wrong and what people should or should not do. The parent can be prejudiced, critical, pompous, and domineering, or nurturing, sympathetic, forgiving, reassuring, smothering, oversolicitous, infantilizing. The "adult" (A) is the "sensible, rational, logical, accurate, factual, objective, neutral, and straight-talking side of the personality." The "child" (C) can be "free," i.e., happy, intuitive, spontaneous, adventurous, and creative; or the child can be "adapted," i.e., showing reactions akin of those of parents like being sulky, frightened, guilty, sad, etc. The patient in the group during the first several weeks is encouraged to identify the ego states within oneself and as they come through in one's behavior toward the others in the group. The patient learns also of "skull transactions" (i.e., the internal dialogue that goes on between the ego states) as well as ways of "getting the trash out of your head" (i.e., the adult decision to start new internal dialogues—"A 'go away' or 'That's my Parent talking' often quickly helps a patient 'divorce the parent' "). Catchy slogans are used to identify and describe attitudes of P, A, and C. Decision making, views of the world, modes of cataloging external information, and even examining resistance to therapy are referred to the separate outlooks of parent, adult, and child.

The second phase of therapy is transactional analysis (TA), which deals with the clarifying and diagraming of conversations with others, as by drawing arrows from one of the ego states of the person to one of the ego states of the other person. One's child may talk to another's child ("fun talk"), or adult to adult ("straight talk"), or parent to child ("helpful talk"). Various combinations can thus exist. In a group a patient's transactions can be drawn on a blackboard. In this way the patient learns the typical "games" that he or she plays with people. Transference is handled as a "typical transaction" and the precedents traced to early family transactions.

The third phase is "game analysis." "Games" are involved transactions of a number of people that lead to a "payoff" unless interrupted. They have social and psychological dimensions. Repetitive patterns and defenses are defined by provocative or humorous titles enabling the individual to accept them as part of the personality without too great anxiety. This is one of the virtues of transactional analysis. It is less apt than other dynamic therapies to set up resistance to the acknowledgment of destructive drives. The individual is more likely to accept the fact that he or she is driven by neurotic drives if these are presented humorously as universal foibles. The patient becomes less defensive and more willing to relinquish them.

One of the four basic positions is taken toward the world: (1) "I'm OK, you're OK," (2) "I'm OK, you're not OK," (3) "I'm not OK, you're OK," (4) "I'm not OK, you're not OK." Games are played for figurative "trading stamps" for the purpose of collecting important prizes. "For instance, a man needing only two more books of 'mad' stamps comes home from work, starts a fight with his wife, collects the two books of 'mad' stamps, and cashes them in at the bar for a justifiable drink." Discussion focuses on developing rapidly an awareness of both social and psychological levels of behavior—not in abstract terms but by recognizing how one utilizes people to perpetuate one's own aims ("payoffs"). Sooner or later, the individual is able to interrupt the games (avoid being "hooked," achieve a "quit point") before they eventuate into his habitual acting-out patterns. Thus a cynical attitude toward the games provides motivation to stop them.

The fourth phase is "script analysis." A script is the individual's life plan evolved in early childhood. A "script matrix" charts the relationship with the parents and the crucial injunctions that have circumscribed the individual's life. The "script story" delineates the patient's life pattern and outlines the predicted end of the script. In the course of exploring the script early memories may be revived. The object of working with scripts is to give up old unwanted ones and "get a new show on the road." " 'Permission' in therapy is given to break the 'witch mother' injunctions. This is followed by a necessary period of up to 6 weeks of protection for the new ego, and this is dependent on the therapist having more potency than the witch parents. Patients gain a final autonomy in therapy and choose their own style of life or even live script free.' " Countertransference is recognized. "The therapist should be alert to detect witch messages in his own script and should not pass these on to his patients."

Transactional analysis for groups at one time attracted a sizable number of therapists, some of whom joined the International Transactional Analysis Association, which held seminars and study groups in many cities. Clinical membership was acquired after 2 years of supervised therapy and a written and oral examination. Publication on the subject has been ample, although interest somewhat has drifted away from transactional analysis during the past few years.

Psychodrama and Role Playing

Moreno (1934, 1946, 1966b) created a useful group therapy method, "psychodrama," which he first introduced in 1925 and that has evolved into a number of clinical methods, including sociodrama, the axiodrama, role playing, and the analytic psychodrama. Many of these have been incorporated into modern Gestalt, encounter, and marathon therapy.

In the hands of a skilled therapist psychodrama is a valuable adjunct in helping patients work through resistances toward translating their insights into action. The initial tactic in the group is the "warm-up" process to facilitate movement. This may take the form of the director (the therapist) insisting that the group remain silent ("cluster warm-up") for a.period. As tension mounts, it will finally be broken by some member expostulating about a problem, the verbalizations drawing a "cluster" of persons around the member. Other members may similarly come forth with feelings and stimulate "clusters" interested in what they are saying. Soon the whole group is brought together around a common theme. The "star" chosen is the person whose personality reflects the problem area most clearly. Another warm-up method is the "chain of association." Here the group spontaneously brings up fears and associations until an engrossing theme evolves. The star chosen is the person who is most concerned with the theme. A third warm-up is initiated by the director ("directed warm-up") who, knowing the problems of the constituent members, announces the theme. A "patient-directed warm-up" is one in which a patient announces to the group the subject with which he or she would like to deal.

The star is groomed for the roles to play with representatives of important people in the patient's past and current life, selected from other group members ("auxiliaries") whose needs for insight preferably fit in with the parts they assume. The director facilitates the working together of the group on their problems, while focusing on one person (the "protagonist"). Among the techniques are (1) "role

reversal," during which a protagonist and auxiliary reverse positions; (2) "the double," another member seconding for and supporting the protagonist; (3) "the soliloquy," characterized by a recitation by the protagonist of self-insights and projections; and (4) "the mirror," auxiliary egos portraying what the protagonist must feel.

By forcing themselves to verbalize and act parts, the members are helped to break through blocks in perceiving, feeling, and acting. Sometimes the therapist (the director) decides which life situations from the patient's history are to be reenacted in order to work at important conflictual foci. A technique often followed is that assumed by "auxiliary egos," who are trained workers or former patients "standing in" for the patient and spontaneously uttering ideas and thoughts that they believe the patient may not yet be able to verbalize, thus helping "to bring his personal and collective drama to life and to correct it" (Moreno, 1966a). As the patient reenacts situations, not only the self role, but also roles of other significant persons in his or her life, such as parents or siblings. The therapist, in the role as "director," may remain silent or inject questions and suggestions. Material elicited during psychodrama is immediately utilized in the presence of the "actor" patient and the group "audience." This technique usually has an emotionally cathartic value, and it may also help the patient understand problems revealed by one's personal actions and thoughts as well as those reflected by other members of the group. By venting feelings and fantasies in the role of actor, the patient often desensitize to inner terrors, achieves hidden wishes, prepares for future contingencies, and otherwise helps to resolve many deeper problems and conflicts. Psychodrama may, instead of being protagonist-centered, i.e., focused on private problems of the patient, be group-centered, concerning itself with problems facing all members of the group.

A valuable function of the auxiliary egos is to represent absentee persons important in the life of the protagonist. Auxiliary egos, thus, are best recruited from those persons present in the group who come from a sociocultural environment similar to that of the patient. The auxiliary egos portray the patient's own internal figures, forcing the patient to face them in reality. In this way the symbolic representatives of the inner life are experienced as real objects with whom the patient has an opportunity to cope. The director enters into the drama that is being portrayed with various instructions and interpretations. Choice or rejection of the auxiliary egos is vested in the protagonist or the director. Since auxiliary egos are representations, they may play any role, any age, either sex, even the part of a dead person whose

memory is still alive in the protagonist. If necessary, and where the protagonist can tolerate it, bodily contact is made between the patient and the auxiliary ego to supply reassurances and to restore aspects of closeness that the protagonist has lacked. Thus, a person who never experienced real "fathering" may get this from the actions of an auxiliary ego.

Props are sometimes used, such as an "auxiliary chair" which may represent an absentee personage. Living or dead family members may be portrayed by several empty chairs around a table, each chair in fantasy being occupied by a different relative. In the dramatic interactions the protagonist may play the role of the relative with whom there is momentary concern by sitting in the special chair and speaking for that person. Sometimes a tall chair is employed to give a protagonist sitting in it a means of assuming a position of superiority. A fantasy prop sometimes used is the "magic shop," in which the shopkeeper dispenses to all the members of the group imaginary items cherished by each in exchange for values and attitudes that are to be identified and surrendered by each member.

Role reversal is a useful technique in psychodrama, two related individuals, for example, taking the role of one another expostulating how they imagine the other feels or portraying the behavior of the other. Where a protagonist is involved emotionally with an absent person, the latter may be portrayed by an auxiliary ego.

Rehearsal of future behavior is an aspect of psychodrama. The protagonist here will play out a situation that necessitates the execution of skills or the conquest of anxiety that is presently felt to be unmastered. Verbalizing inner doubts and fears, and applying oneself to the task of overcoming these, may be helpful in easing one through actions in real life.

The controlled acting-out of fearsome strivings and attitudes helps to expose them to clarification. Thus, obsessive gentleness may be revealed as a defense against the desire to lash out at real or imagined adversaries. A protagonist so burdened may be encouraged to swing away at imagined persons who obstruct. A woman whose spontaneity is crushed may be enabled to dance around the room, liberating herself from inhibitions that block expressive movement. A suicidal person may portray going through the notions of destroying himself in fantasy, thus helping the therapist to discuss openly an impulse that otherwise may be translated into tragic action.

Moreno (1966a) explains the value of psychodrama in these words:

> Because we cannot reach into the mind and see what the individual perceives and feels, psychodrama tries, with the cooperation of the patient, to transfer the mind 'outside' the individual and objectify it within a tangible, controllable universe. ... Its aim is to make total behavior directly visible, observable, and measurable.

In this way, patients are presented "with an opportunity for psychodynamic and sociocultural reintegration."

The psychodramatic technique has given rise to a number of *role-playing methods* that are being applied to education, industry, and other fields. Recognizing that the mere imparting of information does not guarantee its emotional acceptance or its execution into action, role playing is employed as a way of facilitating learning (Peters & Phelan, 1957a,b). As an example, a group of four participants and a group leader may be observed by four observers who sit apart from and in the rear of the participants. Initial interviews of 1 hour with each participant and observer are advantageous to determine motivations, expectations, and important psychopathological manifestations. Preliminary mapping of the procedure considers group combinations, problems to be considered, objectives and desired modes of interaction. A short warm-up period is employed at the beginning of each session to establish rapport. Then the participants are assigned roles in a selected conflict situation. A discussion by the group of the issues involved, with delineation of possible alternative courses of action, is followed by the leader's interpretation of why various participants reacted the way that they did. Repetition of the conflict situation with the same participants gives them an opportunity to try out new adaptive methods and tests their capacities for change. It also fosters reinforcement of a new mental set. At the end of the session the group leader renders ego support in the form of praise for individual contributions and reassurance to lower any mobilized tension or anxiety. Approximately six 1-hour group sessions are followed by individual consultation with each member to determine ongoing reactions. Another series of six group sessions, or more, may be indicated. These procedures, while effectively altering attitudes and promoting skills, may not effectuate significant changes in the basic personality structure. More extensive role-playing tactics have been described by Corsini (1966) that are designed to deal with extensive inner conflicts.

Quality of Change in Group Psychotherapy

One must not be deceived regarding the quality and depth of changes observed among members of a group as a consequence of continued interaction. Changes are dramatic: the attacking and aggressive person becomes quiet and considerate; the dominant individual shows abilities to be submissive; the withdrawn person comes out of a shell and relates flexibly to the other members; the dependent, clinging soul is encouraged to express assertiveness. These effects will become apparent, sooner or later, as products of both group dynamics and the interpretive activities of the therapist and group members. But whether there will be a transfer of learning to the outside world sufficient to influence a better life adaptation is another matter. Often what we find in group therapy (as we witness it also in individual therapy) is that the individual fits the group reactions into a special slot. The role played in the group is disparate from the roles in other situations. The group expects one to behave in certain ways, and one obliges. It offers a shelter from the harsh realities of the external world. One can "be oneself' in the group; but defenses may be checked at the therapist's door, and when leaving the therapist's office or the group at postsessions and alternate sessions, one may reclaim them. Only in this haven of safety can one trust oneself to act differently.

This confounding resistance is testimony to the fact that interpersonal change is not the equivalent of intrapsychic change. The former change may merely reflect the acquisition of a new set of social roles that the individual fastens onto and that enhance the repertoire of patterns. It is like acquiring a new wardrobe to be worn on special occasions. The individual underneath remains the same. From this one must not assume that group therapy is of no real consequence. Intrapsychic changes are possible if the person has the courage appreciably to test the changed assumptions and to apply new learning in the group to the other roles played in life. The therapist has a responsibility here in seeing that the patient does not lock into a comfortable stalemate in the group. The patient may be asked whey there are differences in his or her feelings and behavior inside as compared with those outside the group, and if there has been no change, why not. Sometimes the patient's resistance is a persistence of the desire to recreate the patient's original family in the group, with all the ambivalences that this entails from which the patient refuses to break loose. Supplementary individual sessions may be specifically applied to these questions.

FAMILY THERAPY

Families are composed of units of individuals engaged in continuing interrelationships that significantly influence mutual behaviors. Pathology in one member can have a determining effect on the entire family system, which, in turn, will modulate the degree and form of individual dysfunctions. Therapeutic interventions therefore must concern themselves with the organizational distortions of the family as a system. It follows from this that correction of psychopathology in any one or more members presupposes a restructuring of the family organization, which is, to say the least, a difficult undertaking. At the start of treatment, the therapist is usually confronted with the fact that the family, dysfunctional as it may be, has reached a level of stability (homeostasis) that tends to resist modification. Attempts to alter faulty indigenous communication patterns, or efforts to move family boundaries outwardly toward remedial community resources are apt to be resisted. Family therapy is designed to deal with these rigidities (Gurman & Kniskern, 1981).

Contemporary techniques in family therapy are not uniform even though many of them are implemented under the rubric of presumably standard theories. They are essentially organized within the framework of three schools: structural family therapy, strategic family therapy, and intergenerational family therapy (Steinglass, 1984). Structural family therapy (Minuchin, 1974b; Minuchin & Fishman, 1981) focuses on the behavior of the family during the treatment session, and searches for patterns of alliance between two or more members as well as the firmness of their boundaries. Strategic family therapy emphasizes the symptomatic consequences of bad problem-solving. Homework is often assigned in the form of tasks for the different members, sometimes employing ambigious instructions. Patterns of communication may also be explored (Watzlawick, Weakland et al, 1974; Watzlawick et al, 1967), family problem-solving tactics investigated (Haley, 1976), and certain remedial or paradoxical tasks prescribed (Haley, 1976; Selvini-Palozzoli et al, 1978; Madanes, 1981). Intergenerational family therapy searches for patterns of “fusion” and “differentiation” that are passed along from one generation to another (Bowen, 1976). The theories and techniques of these three schools may seem worlds apart, but the effect on families of all of them can be significant when practiced by skilled and empathic family therapists.

Such practice can become quite involved, necessitating an understanding of individual and group therapy, systems theory, sociology, and group dynamics. During treatment the therapist must skillfully

weave back and forth among the various members as resistance, transference, and defensive manifestations break loose. Countertransference is a fluid phenomenon in the process; identification with one or more the patients in the group commonly occurs. Since the actual difficulties are produced by the behavior of the individuals in the system, the resolution of such difficulties will necessitate changes in the behavior of the persons involved in the disorganizing interactions. This is sometimes referred to as the "interactional" approach in family therapy. Problems are not regarded as the tip of the iceberg, so to speak, emerging from buried inner manifestations, but as the iceberg itself. A good number of the therapeutic interventions are directed at the activities that are being used as "solutions" to control or eliminate undesired behavior. These activities usually sustain and reinforce the difficulty. Since such solutions often serve merely to aggravate the problem, therapy is concentrated on eliminating these futile solutions. New problem-solving methods are encouraged, focused on behavioral alterations rather than intellectual insights. A behavioral change in any member of a system can produce a change in the entire system. Accordingly, treatment may concentrate on the member who is most responsible for bringing about difficulties in the system, although the family as a whole is taken into consideration.

Many models for family therapy exist—and are still developing as psychotherapists of different professions, with varying theoretical viewpoints, evolve modes of working in relation to the needs of families and the structure and function of the agencies through which treatment is being implemented (Sager & Kaplan, 1972). Understandably, therapists have special ways of looking at family pathology and they organize their ideas, as has been pointed out, around favorite systems, such as behavioral family therapy, structural family therapy, psychodynamically oriented family therapy, and systems family therapy. Yet a therapist's clinical operations with families are influenced more by individual style of working with patients and the therapist's own unresolved family problems than by the theories espoused. This results in many different forms of practice that vary in such areas as selection of the unit of intervention (i.e., identified patient and parents, or total immediate family including siblings, extended family, distant relatives, etc.); time allotted to sessions (1 hour to several days [marathon family therapy]); duration of therapy (one session to many months); activity during sessions (listening, supporting, challenging, confronting, guiding, advising, censoring, praising, reassuring, etc.); relative emphasis on insight and behavioral alteration; and employment of adjunctive procedures (videotaping, use of one-way mirrors, role-playing, etc.).

How to manage resistance in family therapy is another area of discrepancy. Families struggle to maintain the homeostasis of a neurotic family system by preserving pathologic ways of relating. A great many of the current writings about family therapy specify contrasting ways of dealing with such resistance, and one is impressed with the lack of agreement for proper management of this disturbing phenomenon.

Sometimes family therapy is undertaken in clinics and family organizations, particularly those dealing with children for the purpose of reducing waiting lists. Under these circumstances therapy may be started even at the first interview as part of the intake and diagnostic process. Sometimes a group of workers visit the family in the home after an intake interview with the family and a diagnostic interview with the child (Hammer & Shapiro, 1965). Visiting the home has certain advantages since the members will demonstrate less defensiveness at home than at the clinic or office, displaying habitual reactions more easily.

Multiple therapists are often employed, circumventing to an extent the countertransference that develops in a one-to-one relationship. Individual therapy may be done concurrently by the different members of the team with selected members of the family (Hammer, 1967). Resistance is also more easily managed when more than one team member approaches a patient from a different perspective. The family facade is then more easily dissolved, and family members are more readily motivated to relate with their inner and latent feelings.

Sundry problems are experienced by therapists when dealing with another therapist who is treating a member within the family group. Disagreements will occur in observation, in emphasis of what is important, in diagnosis, and in the type of intervention best suited for specific situations. Competitiveness between therapists may interfere with their capacity to be objective. They may be offended by disagreements with or criticisms of their operations. There is finally the matter of expense and the finding of qualified professionals who can make their time coincide with that of the therapist. Opportunities are obviously better in a clinic than in a private setting, since fixed staff is available. There is an advantage in doing multiple therapy in a training center since a trainee may gain a great deal working with a more experienced therapist. Constructive collaboration between therapists tends to reinforce the impact of interpretations. It helps the resolution of resistance.

Working with a family group may serve purely as a diagnostic procedure, to spot psychopathology, and to aid in the assignment of therapists to individual family members who most need help. The focus may be on the relationships between parents, parents and children, and parents and grandparents. If a tangible problem exists, this may constitute the area around which explorations are organized. Short-term goals usually deal with a family crisis (Bar-ten, 1971). Long-term goals are fluid and have to be adapted to the needs of the family. The objective, for example, may be to hold the members together in a fragmented family. It may be to help adolescents separate and find their own individuality. Sometimes asking each member of the family "What would you like to see changed in the family?" helps provide a focus. Each member may have a different idea about what should be changed. This will give the therapist valuable clues. At the end of the first session, a statement may be made to the family by the therapist as to what the problem seems to be.

It is vital in family therapy to understand and to respect the cultural background. The therapist must not deviate much from the accepted cultural system since this will offend some of the members and create resistance. Sometimes it is helpful to introduce an individual into the family group as a cotherapist who is part of the same subcultural setting, and who is capable of better translating the family code. This individual must, of course, have had some training at least as a paraprofessional.

Desirable goals of family therapy include resolution of conflicts, improved understanding and communication among family members, enhanced family solidarity, and greater tolerance for and appreciation of individuality (Zuk, 1974). All of these goals may not be achievable. In crisis resolution, for example, the total of one to six sessions, *which is the maximum number* acceptable to many lower-class families, may achieve little other than an overcoming of the immediate emergency. Somewhat more extensive are the objectives of short-term family therapy, which, though of longer duration, still may produce little other than symptom reduction, largely because of the reluctance of the family members to involve themselves in extensive verbal interchange. Middle-class families are more willing to regard therapy as a learning experience and, accordingly, do not set strict time limits on treatment, usually accepting up to 25 to 30 sessions. They are often rewarded with more enduring changes. Sophisticated middle-class and upper middle-class families are generally better disposed to the more extensive goals of long-term therapy, e.g., alteration of values.

It is surprising how much can be done in from 3 to 15 family sessions, but follow-up individual or group therapy may be required. Parents soon begin to realize that problems that have exploded into crises have a long history, the roots of which extend into their own early upbringing. Guilt feelings, defensiveness, indignation, and attacking maneuvers may give way to more rational forms of reaction when even a partial picture of the dynamics unfolds itself.

Individual therapy may be done conjunctively with family therapy or at phases when work on a more intensive level is required. For instance, a husband whose authority is being challenged may require help in mastering his anxiety and in giving him some understanding of what is happening. Or a mother and father may need education regarding the processes that go on during adolescence, which can help them understand and deal with their own rebellious child. The family therapist, accordingly, will need the combined skills of the individual therapist, group therapist, sociologist, educator, and social worker.

A number of ethical issues are involved in doing family therapy (Morrison et al. 1982; Hines & Hare-Mustin, 1978; Sider & Clements, 1982). Among these is the question of whose interest is primary, the individual being seen by the therapist or the family? Maintaining the integrity of the family and its other members may mean sacrificing goals that the individual wants desperately to achieve. For example, where a married man seeks a divorce because of an involvement with another woman, should the therapist encourage this knowing that a family with small children and a handicapped wife, who by herself cannot manage the household, will have to be devastated by the family break-up? Another issue is the matter of confidentiality. Are therapists privileged to reveal information that seems vital for other family members to know? Further questions involve such points as to whether traditional ideas of an ideal family model should be held sacrosanct, whether the same therapist who does family therapy should also see individual members when they need it, how and when to arrange for conferences between outside therapists doing individual therapy with a group member and the family therapist, and whether members should be encouraged to reveal all, some, or no secrets they have concealed.

Doing family therapy is not without its risks, since the neurotic disturbance of one or more members may be the penalty the family is paying for holding itself together. Complementary symbiotic patterns may, when examined and resolved, tend to leave the members without defenses and worse off than

before. A child's rebellion may be the only way that the child can preserve his or her integrity against a neurotic or psychotic parent. To interfere with this show of automony may prevent the child from achieving any kind of self-actualization, resulting in crippling inhibitions. Disorganization of the family structure may be a consequence of insight into the neurotic basis for the existing relationships. Divorce, for example, may enable a woman with colitis to live her life without abdominal pain. But she may find herself, as a result, in empty waters, isolated and burdened with children she may not be able to rear by herself. Her need for her husband may then become painfully apparent. Mindful of these contingencies, it is important to work against the too rapid precipitation of drastic changes in the family structure. It is here that life experience as well as professional experience will stand the therapist in good stead. Intensive individual psychotherapy may have to be employed at points where drastic changes in the life situation are imminent.

Some family therapists insist that the initial consultation include all family members. This is possible where family therapy is specifically requested. Usually one member of the family applies or is sent for help; this will necessitate one or more preliminary interviews prior to involving the entire family. Dealing with the resistence of a family to the securing of help, or of a patient to involving the family will call for skillful explanation and negotiation. All members of the immediate family and important members of the extended family as well as intimate friends are best included at least at the beginning. The therapist must be prepared to deal with explosive anger and accusations, channeling and defusing these to prevent the withdrawal of key members and breakup of treatment before it gets a start.

Great tact is needed in avoiding the show of favoritism since members usually attempt to woo the therapist to their side in the arguments that ensue. A delicate point is how to handle personal "secrets" revealed to the therapist during an individual session, the exposure of which may have an unforseen effect, good or bad, on the family. It is best that the therapist treat the secret as confidential information and that members themselves make the decision when, if ever, to reveal what they dread bringing to light. Another important point is the matter of establishing a verbal contract regarding the areas to be dealt with and the hoped for objectives in order to avoid later misunderstanding. Sessions are usually held once weekly for 1½ to 2 hours. It goes without saying that the goals of selective problem solving will require fewer sessions than those of extensive reconstructive changes in the family members. Video

recording with playback is a strikingly useful tool, and among the techniques is "crossconfrontation," during which a family unit is exposed to tape recorded excerpts demonstrating interactions.

Insofar as actual techniques are concerned (supportive, reeducative, and reconstructive), the existing styles are many even within the same practice models—structural, behavioral, psychodynamic, family systems, strategic, or experiential. An example of one stage of a structure, of diagnostic technique is described by Satir (1964a & b). The total interview consists of seven tasks.

The first task ("Main Problem") involves interviewing each family member separately, starting with the father, then the mother and the children in order of their age. Each is asked to discuss briefly: "What do you think is the main problem in your family?" They are each requested not to discuss their answers with other family members until later. Then the same question is asked of the group as a whole, gathered together in the interviewer's office. They are requested to arrive at some kind of consensus. This will expose the interactions and defenses of the members.

The second task ("Plan Something") is composed of a number of parts: (1) The family as a whole is requested to "plan something to do as a family." This enables the therapist to see how the family approaches joint decisions. (2) Next each parent is requested to plan something with all of the children and then the children to plan something that they can all do together. (3) The father and mother are asked to plan something that they can do as a couple. This reveals data of the operation of family subunits.

The third task ("The Meeting") includes the husband and wife only. The question asked them is, "How, out of all the people in the world, did you two get together?" The role each spouse plays in answering this is noted.

The fourth task ("The Proverb") consists of giving the husband and wife a copy of the proverb, "A rolling stone gathers no moss." Five minutes are devoted to getting the meaning from the couple and coming to a conclusion. They then are asked to call the children in and teach them the meaning of the proverb. This enables the therapist to perceive how the parents operate as peers and then as parents, how they teach things to their children, and how the children react.

The fifth task ("Main Fault and Main Asset") requires that the family sit around a table; then each person is given a blank card on which to write the main fault of the person to the left. The therapist, after stating that this will be done, writes two cards and adds them to the others. These contain the words "too good" and "too weak." The therapist then shuffles the cards and reads out the fault written on the top card. Each person is asked in turn to identify which family member has this fault. This exposes the negative value system of the family and prepares the family for the phase of treatment when the task is assigned to avoid open and direct criticism. Following this, each person is requested to identify his or her own main fault. This is succeeded by the assignment for each person to write on a card what he or she admires most about the person to the left. The therapist also fills out two cards: (1) "always speak clearly" and (2) "always lets you know where you stand." Experience shows that this part of the task, which is most difficult, exposes the positive value system of the family.

The sixth task ("Who is in charge") consists of asking the family, "Who do you think is in charge of the family?" This yields clues regarding how members perceive the leadership structure and their feelings about it.

The seventh task ("Recognition of Resemblance and Difference") requests the husband and wife to identify which of the children is like him or her and which like the other spouse. Then each child is asked which parent he or she believes to resemble most and the similar and the similar and different characteristics possessed in relation to both parents. The parents are also asked how each is like and unlike the other spouse. This points to the family identification processes.

These structured interviews last from 1 to 1½ hours and are employed as research diagnostic, and therapeutic tools. The network of communication patterns forms the basis for therapeutic intervention.

Further active procedures include (1) preparation of a list by each member of what they would like to see changed (this may act as a focus for negotiating a joint decision), (2) asking the family to discuss a recent argument, (3) asking each member to discuss what he likes and dislikes about other members, (4) changing the seating order periodically, (5) using puppets with members talking through them.

Zuk (1971a), Minuchin (1965, 1974b), and Minuchin and Montalvo (1967), have outlined a number of other strategies along structural lines that therapists have found useful. A search is instituted

for alliances and splits in the family, the existing power hierarchies, family modes of conflict management with restoring authority lines, rearranging alliances, and reconstituting normal boundaries. Seating rearrangements and homework tasks are instituted to promote these objectives. Passivity on the part of the therapist will bring few rewards. The idea of allowing a family to engage in a free-for-all squabble often accomplishes nothing more than to encourage greater antagonism between the members. Providing some structure in the session, on the other hand, can be most helpful. This is done by asking specific questions, directing the different members to explore certain areas of feeling, and suggesting what behavior changes should be undertaken. Goals for the family are set by the therapist, at the same time that the family members are encouraged to utilize their own resources in moving toward behavior change. For diagnostic purposes, if the therapist deems that it is appropriate to do so (and that the family will not be lost after the first session), it may be advisable to observe an undirected family in action in order to get a biopsy of the existing pathology and the distorted lines of communication. Once this is done, the therapist will be in a better position to structure, guide, direct, educate, and set goals.

In psychodynamic models insight and self-understanding are the goals of a family therapy with emphasis on the unconscious promotion of patterns of behavior, and the relationship of such patterns to past conditionings. The systems model, such as that of Bowen (1960), stresses the need for differentiation from one's family in order to achieve true identity. The understanding and resolution of relationship triangles that exist within the family is essential. A search for transgenerational transmission of problems is executed in quest of helping the patient achieve self-differentiation. In the strategic model resistance is not bypassed but joined, nondangerous symptoms may paradoxically be encouraged, and unusual home assignments given to the members. In assigning tasks in family therapy, the therapist attempts to alter the existing family system by asking members to engage in unusual activities that are foreign to their customary roles. This entails some risk because the assignments may spark resentment and sabotage. To avoid this, some therapists join the neurotic system by paradoxically emphasizing that for the time being the members must keep things as they are. Then, when the confidence of the family is gained, slow alterations in role are suggested followed by more extensive changes.

In the behavioral model, some therapists find a self-rating check list such as the one by Cautela and Upper (1975) useful as an assessment tool. An effort is made to identify the stimuli that activate

symptoms and problem behaviors. Can these be controlled? How does the patient participate in bringing them on? Further information is occasionally obtained by the patient filling out certain standardization forms (Walsh, 1967, 1968). Observation of the patient in actual situations where problem behaviors occur (with family at home, in phobia mobilizing situations, etc.) may be helpful if this can be arranged. The use of visual imagery to identify cognitive elements associated with problem behaviors has been described by Meichenbaum (1971). The next step is quantification of the problem. The frequency and duration of problem behaviors are charted, recording how often and under what circumstances difficulties occur (Homme, 1965). A man with headaches, for example, is given homework to report the days and times when his headaches appear, the immediate circumstances preceding the onset of headaches, the consequences of his headaches to himself and others around him, and what if anything he does to relieve them. The third step is examining the reinforcing contingencies. Are there any gains the patient derives from symptoms or problem behaviors, like sympathy from those around him, freedom from responsibility, etc. If so, can these reinforcers be supplied by altered activities less destructive to the patient? Is the patient aware of such gains? A woman with periodic fainting spells was brought to the realization that these episodes focused attention on her by her family. Assured regarding their functional nature by the family physician who had been summoned to several such emergencies, the therapist suggested the family show studied neglect after a spell. On the other hand, the members were to lavish attention and praise on the patient when she engaged in constructive family activities. The fourth step is outlining the treatment plan. Once sufficient information is available, a hypothesis is presented to the patient, the treatment plan is formulated, agreement is reached on the focus and goals, and a contract is executed.

In actual family therapy practice several of these models may be combined depending on the kinds of problems that must be treated. The management of socially aggressive children especially constitutes a challenge to parents in our contemporary society. Belligerent and hostile children can stir up trouble for the entire family. A number of approaches have developed dealing with this specific problem; one of the best known being the methods developed by G. R. Patterson and his associates (Patterson & Gullion, 1968; Patterson, 1971; Patterson et al, 1975). A social learning approach teaches families to discover the ways in which they reinforce the disturbed child's behavior and how unwittingly they are taught to respond destructively to the child's provocations, thus adding fuel to the fire. Some techniques include

immediate *isolation* of the child for 3 to 5 minutes (no more) when misbehaving, writing a contract with the child defining desirable and undesirable behaviors and prescribing good behavior that may be swapped for privileges.

Hostility that emerges in family therapy often derails the therapeutic process. How to deal with it is an important technical question. Usually the hostility is directed at a selected member who may be the identified patient or a parent who may be blamed for the events leading to the crisis. Unless hostile interchanges are interrupted, the status quo will tend to remain. One method is to divert the hostility by asking questions related to nonpersonal areas: the housing situation, arrangement of rooms, daily routines, employment, certain historical events, etc. Some therapists, who feel they have a good relationship with the family, sometimes try to focus the hostility on themselves to take it away from the scapegoated member. This may be done by asking: "I wonder if there is something I have done or not done that upsets you. I am suggesting that you are really angry at me." Opening up areas of transference can be highly productive at times, but the therapist must be able to control his or her own countertransference. The best way of dealing with hostility, of course, is to interpret it in terms of the personality needs, and defenses of the attacker. This is possible only after a therapeutic alliance has been established, the family pathology comprehended, and the dynamics of the individual family members understood.

The most difficult problem that the therapist will encounter in family therapy is the need and the determined effort (despite protests avowing a desire for change) to maintain the status quo. Yet there are healthy elements that exist in each family on which the therapist can draw. It is important to emphasize these in therapy rather than the prevailing psychopathology.

Reconstructive family therapy may require sessions for several months or several years, depending on the family pathology and goals. It is often articulated with individual or group reconstructive psychotherapy for family members who need special help. The focus here is on intrapsychic experience. The methodology will vary with the relationship designs and the communication systems. The focus is on transferential reverberations and resistances. During the group session it may become apparent that the "identified patient" is not the one who needs most intensive help. Since the patient may be responding to neurotic provocations from another family member, the latter may be the one who should be seen

individually. The following case-history brings this out:

> The primary patient is a 22-year-old man whose chief symptom is undiluted anxiety that interferes with his functioning. His relationships are highly competitive with males, the patient assuming a submissive self-castigating role. With females the patient detaches, fantasies of sexual engagement inspiring anxiety. At home the family is involved in constant quarreling, the patient engaging principally with his father, complaining that his father is excessively passive, manipulated by his mother, who is extraordinarily demanding of and ambitious for him. The two younger sisters display rebellious and withdrawal tendencies that have not yet become too pathological. In individual sessions the father presents himself as a misunderstood martyr. During the first few family sessions, however, it becomes obvious that he dominates and incessantly criticizes the family, especially the mother. The patient and sisters constantly take pot shots at him for acting too strong and dictatorial. The father responds with the expression that any weakness is inadmissible; it is important to deny illness or fear. This, it soon follows, is a pattern that prevailed in the father's own family. The father's father forced himself to work almost constantly as a duty. He died from a cardiac attack at an early age after refusing to see doctors for what seems to have been anginal pains. The father expresses admiration for his own father's "guts." During this recital the patient slumps in his chair interrupting with deprecatory comments. On questioning, he admits feeling defeated and under attack. Recognizing the father's role in stirring up the family, the father was referred for interviews with a therapist. This resulted in a rapid abatement of the patient's symptoms and a more congenial atmosphere at home.

A multiple family group of several families from the same background and socioeconomic level permits mutual exploration of common problems, the ability to observe difficulties in a more objective light, and the availability of a peer group to whom a family can relate who can help educate and be educated (Laqueur, 1968, 1972). The family code is more likely to become translated by a peer family than by a therapist who may come from a different background.

In reviewing 58 outcome studies of family therapy as compared to alternative treatments (i.e., individual therapy, group therapy, hospitalization, and drug therapy) Kniskern and Gurman (1980) found that 41 (i.e., 70 percent) of the family therapy outcomes were found to be superior, 15 (i.e., 25 percent) were found to be equal, and only two (i.e., 4 percent) were found to be inferior. Many of the primary patients in the studies complained of clinical problems (such as depressions) for which individual psychopathology traditionally is believed implicated. However, the authors, probably with good reason, state that interactional difficulties, such as marital problems, are the most likely conditions to respond best to family and conjoint marital therapy. Compared to such approaches, individual therapy, concurrent marital therapy (where one therapist sees each partner separately), and collaborative marital therapy (where each spouse is seen by different therapists) produce less impressive results. What is interesting, nevertheless, is that individual psychopathological difficulties, other than interactional problems, do respond well to good family therapy methods. Family therapy is

highly desirable because the problems do not start or stop with the patient. The least that can be accomplished is the achievement of better lines of family communication and a softening of scapegoating. Family therapy may be one of the most effective ways of reducing rehospitalization, in addition to safeguarding maintenance medication. Many problem families exist, the members sometimes being entangled in complex interpersonal difficulties that seem impossible to unravel. The untrained therapist is apt to encounter insuperable difficulties with these families. On the other hand, an effective family therapist may accomplish good results impossible to achieve by another method.

MARITAL (COUPLE) THERAPY

Marital therapy is important for a variety of reasons. First, it presents an in vivo scan of the relationship operations of the patient who seeks treatment vis-à-vis the marital partner. From a diagnostic viewpoint this is advantageous because it reduces speculation about the patient's interpersonal psychopathology. Second, it enables enlisting the cooperation of the spouse toward helping the patient execute a therapeutic program for management of severe symptoms by serving in the role of cotherapist. Third, it permits observation of and dealing with emerging anxieties and defenses of the spouse that ordinarily might sabotage the progress being made by the patient. Fourth, it permits a more direct entering into and correction of the communication system of the patient as it displays itself in emotional interchanges. Marriage is a vehicle through which people constantly try to satisfy an assortment of needs and influences. It is often regarded by neurotic people as a way of overcoming defects in their own development and handicaps in their current life situation. The marital partner is therefore cajoled, seduced, or terrorized to perform and is held responsible for any deficiency in projected assignments. This imposes an enormous burden on the healthier of the two spouses since the demands made are usually impossible to fulfill.

On top of it all, the habitual hostilities, anxieties, defenses and coping devices that have plagued the individual since childhood become transferred over to the most conveniently available recipient—the spouse. The expression of such improprieties is complicated by reactive guilt feelings, remorse, and attempts at reparation, which in turn invite attack from the injured spouse, perpetuating the continuing chain of indignation, anger, and counterattack. Couples often get locked into this sadomasochistic circuit. It would seem that the battling partners need each other to act out mutual neurotic needs, which

insidiously may keep the marriage together while serving as a platform for combat. A final neurotic gesture is the blaming of each other for personal shortcomings, mediocrities, failings, and even symptoms. Disillusionment is inevitable unless the spouses are willing to compromise. But where the needs of a marital partner are too insistent and the initial idealization and expectancies are too high, the explosive mixture gradually accumulates until detonated by some (perhaps minor) incident that will tend to blow the marriage apart. One severely neurotic member preying on a more healthy spouse is bad enough, but where both members are working on each other, the atomic stockpile builds up to frightening proportions.

Marriage calls for intricate adjustments. It involves not only dealing with one's personal difficulties but also the normal problems and the irrationalities of one's partner. Because marital adjustment is one of the most difficult and stressful human challenges, it is little wonder that so many people get disturbed under its impact. Problems in marriage and difficulties with a spouse account for almost 50 percent of the reasons why people seek professional help (Martin & Lief, 1973; Sager et al, 1968).

The task of marital therapy is twofold. First, it endeavors to help the patient overcome disturbing symptomatic complaints. Second, it strives to keep a shaky marriage together where there is even a small chance of its success, strengthening the couple's psychological defenses in the process, or, if the marriage cannot be saved, helping the partners separate with a minimum of conflict and bad feeling, particularly where children are involved.

Marital relationships are commonly sabotaged by the emotional defects of one or both partners. Where a marriage has deteriorated and the couple is motivated to work toward its betterment, there is a good chance that with proper treatment the relationship will improve. This does not mean that all marriages can be saved. In some cases the "chemical" combination of the union is irreconcilably explosive. Husband and wife are too much at loggerheads in their ideas, values, and goals to achieve even a reasonable meeting of the minds; or there is a barrenness of love and unabating cruelty toward each other; or sexual incompatibilities exist of too great severity; or there is uncontrollable and continued violence toward the children. Many couples are already virtually separated but still living together interlocked in a marital death grip from which they cannot loosen themselves before coming to therapy. Here the marriage may not be worthy of saving. The goal, as has been mentioned, may be to help the

couple master their guilt and achieve the strength to separate. Generally, however, where couples are not too contentious and are willing to face their feelings and examine their behavior, marital therapy can help a marriage survive.

Marital therapy techniques draw from multiple fields, including psychoanalysis, behavior therapy, family therapy, group therapy, marriage counseling, child therapy, and family casework. Although the objects are the mastery of neurotic suffering and alteration of the relationship between the couple, a hoped-for, and usually serendipitous objective is intrapsychic change, which surprisingly may come about in those with a readiness for such change and relief from the distracting cross-fire between the two spouses. Conceptual schemes for the actual conduct of marital therapy are not unified, but the most successful approaches stress the importance of communication (Watzlawick et al, 1967; Minuchin, 1974) toward effecting changes in the transactional system. A system behavioral approach is particularly helpful, concentrating "on observable behavior and rules of current communication (Bolte, 1970; Hurvitz, 1970; Kotler, 1967; Mangus, 1957) without immediate recourse to a historical 'Why' " (Berman & Lief, 1975).

Greene (1972) has pointed out that the great variations in marital patterns require flexibility in therapeutic techniques. He proposes a "six-C" classification of therapeutic modalities:

I. Supportive Therapy

A. Crisis counseling

II. Intensive Therapy

A. Classic psychoanalytic psychotherapy

B. Collaborative therapy

C. Concurrent therapy

D. Conjoint marital therapy

E. Combined therapies

1. Simple therapy

2. Conjoint family therapy

3. Combined-collaborative therapy

4. Marital group psychotherapy

"Crisis counseling" stresses sociocultural forces in the "here-and-now" situation. The "classic approach" is the usual dyadic one-to-one relationship with both partners seeing separate therapists who do not communicate. The focus here is on the individual's personal difficulties with the marriage as the backdrop. It is used where one partner has severe acting-out problems of which the other partner is unaware (e.g., continuous infidelity or homosexuality), where there is preference for this approach, where one partner refuses to share the therapist, and where spouses have widely divergent goals in terms of the marriage problem. The "collaborative approach" is similarly dyadic, but it sanctions communication between the two therapists by regularly scheduled meetings (Martin & Bird, 1963). The same therapist treats both partners individually in the "concurrent approach," which is aimed at bringing about insight into behavior patterns as they affect each member (Solomon & Greene, 1963). This approach results in the lowest divorce rates. Where strong sibling rivalry attitudes exist, or where there are severe character disorders, psychoses, or paranoid reactions, the concurrent approach cannot be used.

These dyadic methods may be educationally oriented, focused on the marital relationship and on strategies of straightening it out by utilizing a variety of counseling and behavioral techniques. Should it become apparent that the patient has a severe personality or emotional problem being projected into the marital situation, individual psychotherapy may be indicated. In a considerable number of cases the marital equilibrium will be restored, and the spouse will change with the stabilization and better adaptation of the patient. However, where the spouse is incapable of change and the patient is unable to adapt to this impasse, the marriage will continue as a traumatic source for both.

The "conjoint marital approach," which is the most common form (Satir, 1965; Fitzgerald, 1969), is used both for counseling and intensive therapy. Here the partners meet jointly with the therapist at the same session. This approach fosters communication between the partners and brings out more clearly the marital dynamics. With the "combined therapies" (1) the "simple" form combines individual, concurrent,

and conjoint sessions in various arrangements; (2) "conjoint family therapy" includes one or more of the children; (3) the "combined-collaborative" form permits regular meetings of the partners together with the two therapists at the same session; and (4) "marital group therapy" consists of group therapy with four couples and one or two therapists (Blinder & Kirschenbaum, 1967; Framo, 1973).

Thus, there are many ways of working with couples but one of the most popular short-term methods is based on a social learning model and involves no more than 12 to 16 one hour to 1£ hour sessions. (Hahlweg & Jacobson, 1984; Jacobson & Margolin, 1979; Lieberman et al. 1980; Stuart, 1980). Such behavioral marital therapy focuses on securing better communication, relationship, conflict reducing, and problem solving skills through an active, directive approach aided by consistent assigned homework exercises. Usually the therapist sets the agenda with input from the couple regarding progress or difficulties with the homework assignments.

We would make an assumption that if the couple appears for therapy or counseling they are interested in staying together. We would assume also that at one time they had a good relationship. Accordingly, it might be a strategic start in therapy to ask the couple how they originally happened to meet and how they got along at the beginning. From this the history of their difficulties would naturally follow. In recalling the circumstances of their early meeting and the congeniality that existed at one time, it may be possible to get the couple off the track of their bitterness and disillusionment with each other. Many couples forget that they have had a pleasing or happy background at one time, a foundation on which they can repair their present demoralization and wreck of a relationship. Talking about a happier past may give the two partners some hope that they can overcome their bitterness and develop better modes of communication and problem solving.

The actual techniques that are employed will vary with goals in treatment and whether we envisage therapy as solely a means of restoring harmony to the distressed couple or whether structural personality changes in one or both partners are possible. Where deep personality problems exist in one or both of the members, marital therapy, which is a short-term approach, will probably need reinforcement with individual dynamic therapy, since negotiation of differences may prove to be of no avail. Some therapists start with the short-term goal and only later move toward a more intensive process when it becomes obvious that severe personality problems interfere with progress.

In certain cases one member comes for treatment with the presenting complaint of a symptom, such as migraine, depression, agoraphobia or other neurotic disorders even though the true source of stress that provokes the symptom lies in the marital relationship. Indeed, a denial mechanism may exist of such severity that the therapist will have to approach the marital problem obliquely. In most cases however marital stress becomes an important complaint, but the patient may believe that nothing can be done about it since, in the opinion of the patient, the partner refuses to cooperate.

It is rare that marital difficulties are totally one-sided. It is rare, too, that the mate will not come in to see the therapist if the latter handles the situation correctly. The presenting patient may be asked if he or she can convince the mate to come in to see the therapist. The following is from a recording of an interview:

Pt. She's impossible. She won't listen. She says I'm nuts and it's all my doing—the mess we're in. I can't talk to her.

Th. Do you think she would come into see me if you asked her?

Pt. I already asked her to come here with me, and she refused. Frankly, I think it would be a waste of time.

Th. You must have had some hope that coming here would help the situation.

Pt. I suppose I'm looking for magic. I know she won't change.

Th. Would you mind if I telephoned her to come to see me about your problem? I would tell her it will be of help to me in helping you if she could give me an idea of what you're like. *(smiles)* Sometimes this defuses things. She won't feel I'm getting her here to accuse her.

Pt. By all means, maybe she'll come in if you convince her it's all my fault.

Th. I'm sure it isn't, but I'll do my best to ease her into talking things out.

The entire object of getting the mate into the therapist's office is to start a relationship with her or him. By listening with an empathic ear, emphasizing how difficult things must be, the therapist usually can gain confidence. In the case cited the following telephone conversation took place:

Th. Is this Mrs. B?

Mrs. B. Yes.

Th. This is Dr. Wolberg. I hope you will forgive me for calling you. I know it's an imposition. But your husband came in to see me, as you know.

Mrs. B. Yes, I do.

Th. I know it's been extremely difficult for you. But it would help me to help your husband if you could come in and tell me a little bit about him, and about what's happening.

Mrs. B. If I came in, I wouldn't stop talking. *(laughs)*

Th. So much the better, you could give me an idea of him and what has been going on. It must have been very rough.

Mrs. B. I'll be glad to come in.

The interview with Mrs. B went along smoothly, and little difficulty was experienced in starting therapy with the couple.

Unless one of the marital partners is paranoidal or completely unwilling to alter the marriage relationship, it should not be too difficult to convince both members to work with the therapist. The design of therapy will vary with the presenting problems and the preferred style of the therapist. Some therapists begin joint sessions immediately after the initial interview. Others prefer seeing the mate alone to assess the problem before starting joint sessions. It is helpful to ask each partner about the relationship their parents have had with one another. Sometimes just talking about this, patients discover that they are acting out roles patterned after parental models.

Where a marital problem is acknowledged by both partners and they seem willing to do something about it, the couple may be seen together right from the start of therapy. But where denial mechanisms are strong, it may be advantageous for the same therapist to begin individual therapy separately with both spouses, different appointments being given the two (*concurrent marital therapy).* They may not yet be ready for couple therapy, which can be instituted later. Where hostility between the partners is high, and appropriate communication is difficult, the therapist may be able to start a relationship individually with each partner, being wisely careful not to fall into the trap of being used by either against the other. It takes a good deal of ingenuity to do this. The therapist may anticipate competitiveness for attention, desires to be the preferred one, misinterpretations of what the therapist says to support an importunate demand on the part of one spouse, and resentment at the partner and therapist for presumed collaboration. Where the spouse of the patient seeking help refuses to see the therapist, one may try a referral to another professional or suggest that there be a personal selection of a therapist. In such a case the different therapists sometimes may have conferences to exchange information and discuss

developments and plans (*collaborative marital therapy).* Where the spouse absolutely refuses any kind of therapy, treatment may be started with the presenting patient alone (*individual marital therapy),* trying to influence the reluctant partner indirectly.

Assuming that one is finally able to bring the partners together in therapy, the initial session may be initiated by asking each of the partners to discuss why they are coming for help as each sees it. The couple may then be queried as to how they originally met and how they happened to decide to get married or to live together. Whenever the two get into an argument or fire charges at each other, the therapist may interrupt the negative exchanges and get them back to talking about positive things that were or are happening. Some therapists find it helpful to spend at least one session alone with each of the spouses, reviewing the past histories, experiences, and problems of each particularly their relationship with each other, sexual and otherwise. At individual sessions, information may come up that will not readily be exposed in joint sessions. The matter of confidentiality should be stressed. Some therapists rely heavily on questionnaires to fill out such as the "Areas of Change Questionnaire," "Marital Status Inventory," the "Dyadic Adjustment Scale," the "Marital Precounseling Inventory," the "Marital Activities Inventory," and the "Sexual Interaction Inventory" (Wood & Jacobson, 1985), which will help in developing a treatment plan.

We usually find that central to many of the problems of marital couples are difficulties in communication. Behavioral approaches to communication training contain a number of procedures geared toward acquisition of communication skills with provision for feedback instructions and behavioral rehearsal. Dynamically oriented therapists may use these as part of their treatment with marital problems.

During joint sessions the therapist will have observed patterns of communication issuing out of the interaction of the couple, and will be able to offer the couple information about their verbal and nonverbal exchanges (criticisms of one by the other, attacks, praise, protectiveness, etc.) in descriptive terms without interpreting the deeper meaning or motivations for such exchanges (which, of course, can be made in a dynamic approach). Immediate feedback to both partners of provocative and disturbed communication patterns may help break the chain reaction of attack, counterattack or retreat that is characteristic of the couple's verbal interactions. With adequate preparation, video feedback may also be

used with some advantage. In employing feedback the therapist should not lose any opportunity to comment on *positive* communication patterns in the hope of reinforcing these. Thus when a partner praises his or her mate the therapist may say, "I liked the way you complimented (or praised) him (her)."

Generally couples are not fully aware of their abrasive thrusts at each other or their corrosive answers to comments. Following an unjustified verbal blast, the therapist may ask a partner to reconsider what the spouse has said and then to give an alternative response. Sometimes the therapist may model a response, playing the roles of both the husband and the wife to avoid a sense of discrimination or favoritism. Cotherapists, if this is the format, may each play the role of one of the spouses and model communication.

Behavior rehearsal is an important part of the relearning process, in that couples may practice in order to increase their skills of communication. Here the therapist provides instructions and modeling if necessary, giving continuing feedback. A valuable technique is *role reversal,* each spouse taking the role of the other in talking about a special situation. In this way, marital partners may teach each other problem-solving skills.

One of the most common difficulties is the insistent use of aversive control strategies by one or both partners ("If you do that again, I'm going to leave you"). Verbal threats and coercion increase until the only way left to deal with mutual intimidation is by detachment techniques, which cause estrangement from one another, further enhancing conflict. By arriving at some sort of agreement regarding areas of change through discussion, an avenue is opened for problem-solving which can be kept alive and expanded by proper reinforcements. Before changes in behavior can be proposed, however, there must be a clear definition of the problem (Jacobson & Margolin, 1979).

The sessions in a short-term format are generally highly structured and understandably call for a good deal of empathy, flexibility, and playing of many roles. "The therapist serves as a director, sympathizer, teacher, evaluator, instigator, and a juggler balancing these roles while providing perspective and insight as necessary." (Wood & Jacobson, 1985).

It is important to inform a couple that they should expect no immediate improvement in their relationship but after a few sessions devoted to studying the problems, they should *if they cooperate with*

the procedures that will be prescribed, notice that matters between them are taking on a more optimistic turn. In this way, one can forestall the disappointment that follows when magical expectations of immediate change do not come to pass. Generally, some precipitating factor will have brought the marital conflict to a head and the couple will be anxious to talk about it. The discussion, arguments, angry displays, and frustrations that become manifest will be like a biopsy of the basic pathological issues. A therapist who steps into a marital melee will have more than was bargained for, particularly when each of the participants attempts to recruit the therapist as an ally against the other partner. It is here that the therapist may become emotionally involved, being tempted to fulfill the roles of arbiter, judge and high priest, rendering verdicts, making decisions, establishing criteria, and setting values. Personal standards and prejudices will unfailingly impose themselves and the therapist's own unresolved problems will vigorously come to the fore.

A great deal has been written about countertransference in psychotherapy, but in no other area than marital therapy is it apt to be so pronounced, particularly in cases where the therapist's own marriage is a mess. No wiser words have been said than for the marital therapist to look at his or her own marital values before the marriages of others can effectively be dealt with. Even though a therapist has some personal problems, an awareness of these and of how judgment may be warped by certain offensive behaviors or attitudes on the part of the therapist's patients should permit greater objectivity. The therapist therefore should carefully avoid being brought into assuming the role of a referee or judge who decides who is right or who is wrong; or ally with one or the other antagonists. This may be difficult for some therapists to do since it is natural to try to assess blame. A guiding principle in marital therapy is to try to search out and to enhance the strengths of a relationship not the weaknesses. Consequently, the therapist may emphasize positive factors that exist and to remind the couple that their relationship has not always been a bad one. A good deal of time may also have to be spent in talking about existing environmental problems that have initiated or that are sustaining the difficulties between the two.

It is important from the outset not to express any condemnatory attitude toward either partner for behavior or characteristics that they are exhibiting either in the interview or outside. There will be ample opportunity later to interpret what is happening, and this is aimed toward insightful rather than punitive objectives. A woman may resent the role that she believes her husband expects of her as a dutiful wife, and she may respond by being defiant and neglectful. Her husband may counterattack by

detaching himself from her and the family and by impotence. The chasm of misunderstanding grows deeper and deeper until each has accumulated an enormous bag of justifiable grievances. A therapist who takes sides will probably lose both patients. Once the dynamics become clear, the therapist may point out the inevitability of misunderstanding on the basis of the background, upbringing, value systems, and pressures that are being exerted by the partners on each other without laying down strict rules about male and female roles. If the therapist has the confidence of the couple, they will turn to him or her for some constructive guidance, which may be offered without being dictatorial about what should be done. It may be pointed out that difficulties exist in all relationships and that some compromise is always necessary, the ground rules to be negotiated through constructive communication.

Willy-nilly, the therapist will find a role assigned, by both members as an arbiter, guide, and potential ally to justify mutual opinions, disgruntlements, and claims. It takes a good deal of fancy footwork to avoid being maneuvered into a judgmental role. Countertransference is to be expected, and one's ability to detect one's own prejudices and predilections borne out of one's background and experience will help keep the therapeutic situation afloat. There are instances where one mate is manifestly unfair in behavior toward the other, or in liberties assumed, and the therapist may find it difficult to remain neutral. It will take ingenuity to get one mate to alter his or her behavior or to help the other member accept the situation with whatever compromises can be negotiated.

For example, one of my male patients who had married late in life, insisted on staying out late "with the boys" two nights weekly. His wife objected on the basis that she felt neglected and lonesome. At interview it was apparent that she suspected infidelity, which she tried to substantiate on the basis of decreasing frequency of intercourse. I was able to convince her, from my interview with her husband, that staying out late constituted a means by which some husbands maintain their independence which is being threatened by feelings of increasing devotion to their wives. This is what happened in this particular case. The husband, a detached person, had avoided close involvements with women until he met his wife. Thwarting his need for independence would, I hazarded, result in increasing detachment from her as a defense and perhaps a development of impotency. The patient's depression, related to hostility at being challenged and "browbeaten," lifted as his wife recognized the dynamics and accepted her husband's need for greater freedom. Joint sessions during which each partner unburdened themselves and traced their attitudes to past experiences resulted in a firming up of the relationship.

Taking an area in which a desire for change has been expressed, each member may be asked to discuss briefly how he or she believes the issue may be resolved with the object of negotiating an agreement on a suitable solution. Communication and problem-solving skills are studied here. Some therapists provide each of the couples with a checklist and a rating scale to score daily happy and non-pleasing exchanges (Patterson, 1976; Weiss &Cerreto, 1980). These instruments have a therapeutic value in pointing out areas of possible improvement as well as providing the therapist with a means of comparing the appraisals of both members.

All of the foregoing measures are useful in devising a treatment plan that is discussed with the couple and to which the couple can add input. Agreement to abide by the terms of the plan is best obtained to enhance the collaborative effort. To repeat, the therapeutic process focuses on increasing positive and eliminating coercive and aversive exchanges. It is hoped that this will spontaneously be developed and carried through by both members. Any difficulty that emerges offers an opportunity for trouble-shooting to analyze the problem and to provide alternative solutions ("brain storming"). Communication skills are taught by suggestion and modeling and are practiced both during sessions and as part of homework. The ability to accept criticism and to have the courage to avoid responding in kind to a negative remark or act is encouraged.

Contracts may be negotiated to try to help firm up behavioral changes. Contingency contracting which operates on the basis of quid pro quo conciliations plays an important part in marital therapy, particularly in its behaviorally oriented forms. Here couples by negotiation come to a written agreement of what each member has to do in the relationship to produce changes with which both members are in harmony.

In contingency contracts each partner promises to alter some aspect of behavior the other partner finds disagreeable. Contingency contracting is for those in whom verbal resolutions alone are not sufficient to put a restraint on their impulsiveness. The presence of a legal-like document helps to promote compliance with prescribed behaviors. When carried out, positive actions produce reciprocal pleasing responses that act as reinforcers for mutually constructive behaviors. The contract should be specific, spelling out exactly the kind of activities to be executed; otherwise arguments may break out as to meanings of vague expressions. The behavioral changes of each should also be sufficiently equivalent

so that both partners feel they are getting an equal share of benefits.

One must keep in mind that the very behaviors that a spouse grumbles about may subversively be reinforced by certain actions of the offended spouse because such behaviors satisfy unconscious needs or defenses in the latter. Thus, a woman complaining about infrequency of sexual relationships may during the sexual experience act in a disinterested, bored, or sarcastic manner. In this way, she punishes the very behavior she desires to increase. When we investigate why these ambivalent attitudes exist, we may find that, in spite of a surface interest, sexuality is laden with a great deal of fear, guilt, and shame. Or her anger at or disgust with her husband forbids carnal intimacy. Or perhaps there is a prohibitive incestuous barrier to sexual activity. Such dispositions, which have their origin in earlier conditionings, might cause us to anticipate that the wife would be unable to halt her punishing activities even though in the contingency contract she promised to do so. This may actually be the case in instances where underlying needs and defenses are intensely and urgently pressing. On the other hand, even where such tendencies act as negative reinforcers, experience teaches that people can exercise a considerable degree of willful control over inner impulses, and through self-discipline and continuing practice gradually master adverse predispositions. It is, of course, helpful to provide in the contract positive reinforcements of some kind for the control of repugnant reactions. In the case cited, the husband may reward his mate for refraining from her customary reactions with praise and some material or behavioral bounty that is significant to his wife. Where no improvement in the sexual situation occurs, however, it may be necessary to utilize a more psychoanalytically oriented approach aimed at expanding the couple's understanding of their motivations and behavior.

The matter of confidentiality is especially important. The patient is told that information given in private sessions will not be revealed to the other member of the couple. The members may be encouraged to talk freely and not hold anything back, but that is up to them. The therapist will not bring up topics that are taboo unless asked to. This encourages the disclosure of secrets so one can work with what comes out.

It is to be expected that where couples have been living in neurotic symbiosis that an alteration in the accustomed response of one member to the other's provocations will arouse anxieties in one or both members. Resistance will generally take the form of a desire to halt joint sessions. Interpretations of the resistance and the reasons behind it are necessary to keep the couple in therapy.

During sessions one may observe physical movements between husbands and wives that serve as forms of nonverbal communication to convey emotional meanings. These are in the form of approach and separation movements and, at different stages of treatment, seating rearrangements among couples, which may be explored with the object of analyzing the underlying dynamics. In the process one may observe one's own countertransference responses, which one should attempt to understand and to resolve.

While the therapist may make suggestions from time to time, it is vital that patients be made aware of the fact that they must work out their own solutions utilizing their own free will.

There are several impasses that may occur in marital therapy. One of the most difficult is the spouse who has a fixed position about divorce. This usually means that he or she does not want therapy except to try to convince the mate to accept the position. Often the lawyer of one mate may be responsible for this impasse. Another problem is when one member of the couple is in individual therapy with another therapist who differs in philosophy and goals from the marital therapist. Then a conference with the other therapist may be in order. Once contact has been established, coordinated therapy may be essential to break up an impasse. Where the marital breakdown has proceeded to a point of no return, both therapists may encourage utilizing divorce mediation procedures to minimize the trauma on the partners and children.

Important adjuncts to marital therapy are role playing and sexual therapy methods (Masters &Johnson, 1970; Kaplan, 1974). Alger (1967a) illustrates the use of the paradigmatic approach in marital therapy, the goal of which is to imitate a pattern one of the partners displays by acting out a part. Alger (1967b) also employs videotape recordings and playback in couple's sessions. His technique consists of a video recording of the first 15 minutes of a joint marital session, which is immediately played back over a television monitor. The participants may ask to stop the recording at any point to comment on the effect of their behavior on others. Viewing themselves as they talk and interact stimulates a great deal of feeling and expedites communication. Video viewing is now being employed with increasing frequency (Alger &Hogan, 1969; Berger, MM, 1969).

The presence of two therapists (cotherapists) lessens the possibility of exclusive alliances and of a

dyadic impasse (Alger, 1967a; Markowitz, 1967). Each of the therapists may function as an alternate ego for one of the patients aerating ideas and sentiments the patient does not dare express. In this way the patient may gain the strength to face impulses and attitudes on the periphery of awareness. Substantiating the value of cotherapy are four truisms: (1) Two heads are better than one. (A second therapist may be able to illuminate areas missed by the first. Each may be able to correct bias and detect countertransference in the other.) (2) One therapist may support a patient under attack by mate when he or she needs a helping hand. (3) One therapist may engage in confrontation and challenging maneuvers while the other therapist interprets reactions of the patient or supports the latter if necessary. (4) Two therapists lessen the danger of the therapist being utilized as a judge or as a guru who knows and gives all the answers.

A mixed male-female team has advantages in providing opportunities for identification. The disadvantages of cotherapy are competitiveness and friction between the therapists and alliances of one therapist with one patient against the other therapist and the other patient. These may be modified by conferences together or in some cases with a trusted colleague acting in a supervisory capacity. There are advantages and disadvantages in conjoint marriage therapy with a husband-and-wife team (Bellville et al, 1969). The inevitable differences arising between the therapist couple are more volatile and unrepressed than in an unrelated couple and can threaten the therapeutic process. In their resolution, however, they offer the patient couple an opportunity to observe how a well-related couple negotiate differences, make compromises, and adapt themselves to each other's individual way of looking at things. It stands to reason that the therapist couple both must be reasonably adjusted, have an understanding about the therapeutic process, and preferably have been in personal therapy or coupled therapy themselves.

The behavioral approaches described may not be able to help marital difficulties that are too firmly anchored in intrapsychic disturbances. The prescription of tasks and exercises that are intended to influence couples to be less abrasive toward each other, to communicate more constructively, and to foster a balanced relationship will therefore not succeed in those couples whose behavior is intractably motivated by urgent unconscious needs and impelling inner conflicts. For example, if a wife transferentially relates to a husband as if he represents a hateful brother with whom she was in competition during early childhood, she may resent being nice to him and continuously fail in her

therapeutic assignments. A husband who is struggling with a dependency need, idealizing his wife as a mother figure who must love, nurture and take care of him, may be unable to give up acting irresponsibly, resisting the independent role his wife insists he must assume as a condition for more fruitful living together.

We should not minimize the utility of the various persuasive, behavioral, and cognitive techniques practiced to expedite marital congeniality. They can be valuable, but they will miss their mark if one utilizes them while ignoring the enormously important developmentally inspired motivational forces that are constantly maneuvering marital partners to act against their best interests. These more insistently dictate the terms of conduct than any injunctions, maxims, precepts, recipes, prohibitions, and interpretations.

Whether or not the therapist deals with factors of transference or projective identification and utilizes dreams will depend on the training of the therapist, the goals desired, and the level of understanding of both patients. Dramatic results are sometimes obtained where marital partners associate to each other's dreams. This helps them become less defensive with each other. By the same token, transference phenomena brought out into the open as they relate to the therapist and to each other, aired without restraint, will bring forth emotions that with proper interpretation can prove helpful. Sager (1967) points out that it is important for anyone doing marital therapy "to be aware and work through reactions to, and general philosophy regarding, maleness and femaleness, maturity, marriage roles, career, money, relationship to children, and a host of other cathected concepts." Flexibility and tolerance for values other than their own are important assets for marital therapists.

The hope is that change occurring in the office and at home will be generalized to other relationships. Any relapses provide opportunities to anticipate future problems. The couple is requested to search for any cues that can trigger difficulties and to practice dealing with them before trouble precipitates.

In many cases progress is enhanced by couples working together in couple groups. As communication improves and relationship skills consolidate, intervals between sessions are increased. Couple groups may continue for a while without the presence of the therapist. Problems and relapses are

anticipated and ways of managing them are discussed.

Follow-up sessions with the marital partners after therapy are wise to prevent a falling back into the old destructive patterns, the intervals between follow-up visits gradually being increased in the event improved adjustment continues.