CHAPTER 33

CHANGE IN THERAPEUTIC GROUPS

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People have been using groups to accomplish goals since ancient times. Noted group dynamicist Alvin Zander, in tracing the history of groups in society, pointed out that our ancestors protected themselves from dangerous animals, human enemies, and natural disasters by joining together in groups. In ancient Egypt workers combined their efforts to build dams, irrigation systems, and colossal monuments. By 300 B.C. Chinese workers and merchants had formed organized guilds to monitor business practices. The Romans made extensive use of groups, for their armies and their government were organized into various tribunes, legislative bodies, and associations. And, of course, people have traditionally conducted religious services in groups rather than in isolation (Zander, 1985).

This tradition continues today, for most social behavior takes place in a group context. Businesses, governments, educators, administrators, and the armed forces rely on groups to solve problems, create products, formulate standards, and communicate knowledge. Groups, too, have become useful tools in the field of mental health. Springing from such divergent sources as Joseph Hershey Pratt’s 1905 use of groups to ward off depression among patients suffering from tuberculosis, Moreno’s psychodrama and sociometry (1932), Freud’s Group Psychology and the Analysis of Ego (1922), and Lewin’s (1936) training groups (t-groups), groups offer practitioners the means of achieving therapeutic change en masse. Indeed, the fervor and resolve of advocates of group-level interventions prompted Back (1973) to label this perspective a social movement rather than an emerging field.

This chapter explores the utility and dynamics of the therapeutic group. It begins by reviewing extant types of therapeutic groups and their typical characteristics. Next, we raise the question of effectiveness, and rely heavily on previously published reviews as well as on more recent empirical outcome studies to develop an answer. We then catalog the interpersonal processes that are common to many group therapies, making heuristic use of the concept of curative factors (Yalom, 1985). This chapter seeks to draw a general model of group therapy that integrates the clinical litera-
ture on change via group interaction and the social psychological literature on group structure and process.

THE VARIETY OF THERAPEUTIC GROUPS

People join groups to achieve a variety of goals and the vast assortment of currently available therapeutic groups reflects this variability. Traditional therapy groups, such as psychoanalytic or gestalt treatments, remain, but they are only one approach among many. Although the more extreme group interventions requiring marathon sessions or intense emotional stimulation are becoming increasingly rare, these groups have been replaced by a myriad of change-promoting groups. The encounter groups and sensitivity training groups of yesterday have become the jogging clubs, workshops, seminars, and self-help groups of today.

These groups, despite their many forms, generally fit one of three basic categories: group therapy, interpersonal learning groups, and self-help groups (Klein, 1983; Lakin, 1972; Lieberman, 1976; Rudestam, 1982). Like any individual therapy, group therapy is usually conducted by a mental health professional, and it focuses on helping individuals overcome relatively severe psychological and social problems. But unlike individual therapies, group therapies involve treating individuals “in groups, with the group itself constituting an important element in the therapeutic process” (Slavson, 1950, p. 42). Most group therapists tend to be eclectic in their choice of methods. They make use of the transference process to bring issues originating from parental and sibling relationships into the group, they use role-playing, psychodrama, and gestalt experiences, and they analyze events transpiring in the group as well as those outside of it. Many group therapists also rely heavily on principles of behavior therapy, including modeling, behavior rehearsal, and feedback (Holland & Kazaoka, 1988; Rose, 1977, 1983).

Interpersonal learning groups, in contrast, involve attempts to help relatively well-adjusted individuals extend their self-understanding and improve their relationships with others (Forsyth, 1990). These groups spring from an intellectual heritage that can be traced back to Lewin’s “training laboratories” (T-groups), as well as the more humanistically motivated sensitivity training and encounter groups of the 1960s and 1970s (Back, 1973; Lakin, 1972). In contemporary form, however, interpersonal learning groups tend to be much more structured and more behaviorally oriented. Although they are used to achieve a variety of goals from increasing assertiveness and leadership skills to eliminating ineffective listening habits and self-destructive cognitions, most of these interventions involve brief didactic presentations, structured experiential exercises, group discussion of the topic or process under scrutiny, and behavioral rehearsal.

Last, self-help groups are voluntarily formed groups of people who help one another cope with or overcome a common problem. Although drug and food addiction groups like Alcoholics Anonymous (AA) and Weight Watchers are among the best known self-help groups, self-help groups focus on a range of problems. Examples include groups composed of individuals suffering from illness, relatives of the terminally ill or handicapped, people seeking support during a time of life or family crisis, and members of minority groups seeking protection of their social rights. Like AA, many such groups form because the members’ needs are not being met by existing educational, social, or health agencies, and are organized by laypeople (Cole, 1983; Robinson, 1980).

The gulf separating these various forms of therapeutic groups should not be minimized. Yet, despite their uniqueness, all these interventions are similar in that they are all groups. First, they include two or more interdependent individuals who influence one another through social interaction. In some groups (psychoanalytic groups, for example), interactions may center on a leader, but in all these groups influence occurs among members. Second, as groups these therapeutic entities develop structural qualities, including roles, norms, status, and attraction relations. These structures provide an underlying organization for relationships among members and they influence a variety of group processes. Individuals who occupy particular roles, for example, generally perform certain types of behaviors in their groups. In most groups a stable pattern of variations in status and attraction relations can also be discerned, and these patterns have a major impact on member satisfaction. Third, as groups these aggregates of individuals possess some modicum of cohesiveness. In many cases the group develops an identity of its own, and members share a bond of loyalty.
to one another and to the group itself. Fourth, these groups are dynamic in that they change gradually over time. Although different theorists highlight different patterns of change, most agree that groups progress through periods of tentative interaction, conflict, cohesion, productivity, and dissolution (Tuckman, 1965; Tuckman & Jensen, 1977). Last, the groups within these three categories are similar in that they all form for the purpose of facilitating change or adjustment in group members.

**ARE THERAPEUTIC GROUPS THERAPEUTIC?**

The use of groups as agents of change dates back many years, but it was Lewin who stated the "law" of group therapy in its most basic form: "It is easier to change individuals formed into a group than to change any of them separately" (1951, p. 228). In the years since Lewin articulated this hypothesis, researchers have busied themselves with the chore of gathering the evidence needed to evaluate the accuracy of his conjecture. Their efforts offer answers to these questions: (a) Are therapeutic groups effective? and (b) Are some forms of group treatment superior to others?

**Overall Effectiveness of Group Interventions**

Outcome studies of group treatments, although far from unanimous in their support of Lewin's law, are for the most part positive. Two major reviews of the outcome literature published before 1975 ruled in favor of therapeutic groups, although both bemoaned the methodological flaws that undermine the scientific adequacy of the data base (Back, 1974; Meltzoff & Kornreich, 1970). Meltzoff and Kornreich, (1970) for example, were guardedly optimistic about the utility of group therapies as they found that 80% of the methodologically sound studies reported either major or minor benefits for clients, whereas nearly all of the studies that reported no benefit were methodologically flawed.

More recent reviews concur with these initial assessments. Lieberman (1976), Hartman (1979), and Bednar and Kaul (1978), in their general reviews of group outcomes, were positive about current group methods and even more optimistic about future applications. Spitz (1984) presented a generally favorable review of the use of groups with a variety of client populations, including borderline and narcissistic personality disorders, physically ill patients, and chronic psychiatric patients. Kanas (1986), after examining 33 inpatient and 10 outpatient studies dating back to 1950, concluded that group therapy was effective in 67% of the inpatient studies and 80% of the outpatient studies. He also reported that long-term therapy (more than 3 months) was especially useful, as were approaches that focused on interpersonal processes. Lastly, Toseland and Siporin (1986) reviewed over 30 studies that compared individual and group therapies, and concluded that in 25% of these studies the group therapy was significantly more effective than individual therapies. Indeed, Toseland and Siporin argued that group therapy should be the treatment of choice for most clients.

Reviews of experiential groups also are generally positive (Bates & Goodman, 1986; Knapp & Shostrom, 1976). Knapp and Shostrom (1976) found that in those studies that used the Personality Orientation Inventory (POI) to assess outcome, most participants showed a consistent pattern of increased self-actualizing scores. Berman and Zimpfer (1980), in a systematic review of 26 controlled studies of personal growth groups, restricted their analysis to studies that (a) used both pretest and posttest measures, (b) met for at least 10 hours, and (c) had a long-term follow-up (at least 1 month after termination). Summarizing these methodologically superior studies, Berman and Zimpfer concluded that group treatments result in enduring positive changes, particularly at the self-report level.

Studies of the use of group therapies with particular populations also have yielded generally positive results. Kilmann and his colleagues (Sotile & Kilmann, 1977), although initially frustrated by the low quality of the research procedures in studies of group treatments for sexual dysfunctions, eventually concluded that group therapy is an effective means of treating female orgasmic dysfunction and secondary erectile dysfunctional behavior (Mills & Kilmann, 1982). Zimpfer (1987), in his review of 19 studies of group therapy for the elderly, found that group treatments were differentially effective depending on the problems experienced by the client. He concluded that treatments that provide social support and sustain health-promoting actions and attitudes were most effective. Brandsma and Pattison (1985), after reviewing the empirical literature
of experience of the group leaders, as Russell (1978) suggested, but more recent studies provide general confirmation for the equivalency among treatments reported by Lieberman, Yalom, and Miles. Looking first at comparative studies of psychotherapy groups, Gonzalez-Menendez (1985) assigned 40 inpatients to one of three directive psychotherapeutic groups. An informative group emphasized transmitting useful information to subjects, an introspective group stressed self-understanding, and an inspirational group encouraged members to develop health-sustaining behaviors. The informative and inspirational groups were somewhat more effective, but the differences among the three groups were slight.

Falloon (1981) assigned 51 psychiatric outpatients with specific interpersonal skills deficits to either role-rehearsal and modeling behavioral therapy groups or guided discussion group therapy. The role-rehearsal group had fewer dropouts and reported more liking for their groups, but both treatments were effective in changing participants' social skills levels. Coche, Cooper, and Petermann (1984) reported similar results. They assigned 41 psychiatric patients to one of two group therapy procedures: a brief interactive group therapy or a cognitively oriented, problem-solving training group. Both programs were effective, although in somewhat different spheres. The interactive therapy groups resulted in improvements in the interpersonal realm, whereas the problem-solving intervention was more effective in reducing complaints about distress and adjustment.

Turning to experimental studies of assertiveness training, we again see few differences between various types of group approaches. Berah (1981), for example, contrasted massed versus distributed practice in assertiveness training groups. Self-report measures, a role-play test, and peer ratings before, immediately after, and 4 weeks following training all indicated that the subjects improved relative to the controls, but that the mass-practice, distributed-practice, and combined mass and distributed-practice groups were equally effective. Similarly, Sanchez, Lewinsohn, and Larson (1980) compared group assertion training to traditional group psychotherapy for depressed outpatients. Self-report measures indicated that the assertion training was more effective than traditional psychotherapy initially, but differences between the two groups dissipated over time. Markham (1983) studied assertiveness training methods by assigning 45 women to one of three conditions: a behavioral rehearsal group, a group systematic desensitization program, or a control group. Self-report and behavioral measures indicated that individuals in the two treatment groups improved relative to the controls, but the two treatments did not differ significantly from each other on any measure. These effects were still in evidence on a 3-month delayed posttest.

Studies of alcoholism and weight-loss similarly suggest that one group method is as good as another. Knauss, Jeffrey, Knauss, and Harowski (1983) assigned 68 overweight men and women to one of four weight-loss programs: a bibliotherapy effort group, a faded self-management group, a standard self-management group, and a self-management with additional group sessions. Attrition was lower in the group therapy conditions, and all subjects in the various group treatment conditions lost significant amounts of weight. Oei and Jackson (1984) divided 18 problem drinkers into two different therapeutic groups. In both groups the therapist utilized role-playing, modeling, and behavioral rehearsal to stimulate self-understanding, but in one group the therapist also (a) elicited and rewarded all positive self-statements, (b) challenged negative self-statements, and (c) personally self-disclosed. Self-reports and behavioral ratings based on coded videotapes of interpersonal behavior indicated that clients in both groups improved, but that the group with a self-disclosing therapist improved more. Rosenberg and Brian (1986) compared three different group treatments for repeat driving-under-the-influence offenders: a cognitive-behavioral intervention, a rational-emotive approach, and an unstructured insight-oriented therapy. Measures taken after 6 months in the programs indicated all were equally effective. Lastly, Hajek, Belcher, and Stapleton (1985) found that leader-centered groups were less effective than noncentralized groups. They assigned 132 smokers to 14 leader-centered groups and 138 smokers to 14 nondirective groups that emphasized social support and interpersonal pressure against smoking. After 1 year, more individuals in the nondirective groups had quit smoking, particularly if they were members of somewhat larger groups.

Differences among treatments, although rare, have been noted. In an experimental analysis of recently divorced women Graff, Whitehead, and LeCompte (1986) assigned 12 clients to a cognitive-behavioral therapy group, 12 to a supportive-insight group, and 22 to two control groups. Self-
pertaining to group therapy with alcoholics, concluded that group interventions are an effective means of treating alcoholics who require therapeutic treatment.

Not all reviewers are convinced that groups work. Solomon (1982), for example, found that outcome studies that compare individual and group therapy for alcoholism do not recommend one treatment over the other. Parloff and Dies (1977), after reviewing the results of studies of group therapies with a range of client types (schizophrenics, psychoneurotics, juveniles, and adult offenders), concluded that the results are disappointing. Abramowitz (1977) reached a similar conclusion in her review of outcome research on children's activity, behavior modification, play, and verbal therapy groups. Rose, Tolman, and Tallant (1985), although they do not report negative findings about group therapy effectiveness, argued that most investigators do not take group-level process variables into consideration when designing their interventions or their assessments. Also, evidence pertaining to marathon groups is relatively negative (Kilmann & Sotile, 1976).

Negative reviews, however, are the exception; most summaries conclude that therapeutic groups are a useful means of helping individuals deal with psychological difficulties. As Bednar and Kaul (1979) wrote, “Group treatments have been more effective than no treatment, than placebo treatment, or than other accepted forms of psychological treatment” (p. 314). Given the impact of groups in virtually all aspects of our everyday lives, it would be surprising to find that they do not influence individuals in therapeutic settings.

### Comparing Types of Group Therapies

Groups are generally effective, but recently researchers have sought to determine if variations in group technique are differentially effective. The category therapeutic group is extremely broad, for it includes methods that differ greatly in terms of purposes and procedures. A therapeutic group may be designed to accomplish such varied goals as social support (support groups), the improvement of members' social skills (T-groups), an increased insight into one's own emotions and motivations (encounter groups), or it may simply function as arenas for the delivery of traditionally individualistic therapy, including behavioral and psychodynamic therapies (Lakin, 1972; Rudestam, 1982). Groups also conform to no single set of procedures, for some groups are leader centered (psychoanalytic or gestalt groups) whereas others are group-focused (encounter and T-groups), and the group's activities can range from the highly structured (social skill training groups, such as assertiveness-training groups) to the unstructured (encounter groups). Group practitioners also vary greatly in their orientations and techniques, for some focus on emotions with gestalt exercises, others concentrate on the here-and-now of the group's interpersonal process, and others train members to perform certain behaviors through videotaped feedback, behavioral rehearsal, and systematic reinforcement.

Given this diversity in purposes and procedures, one might expect that some types may emerge as more effective than others. Yet, most studies attest to the relative equality of the different types of group therapy. Lieberman, Yalom, and Miles' (1973) classic investigation remains an excellent example of the apparent equivalence of group interventions. This triad investigated the overall impact of a 12-week experiential group on members' adjustment (Lieberman, Yalom, & Miles, 1973; Yalom, 1985; Yalom, Tinklenberg, & Gilula, 1975, cited in Yalom, 1985). Using a pool of 206 Stanford University students who were enrolled for course credit, Lieberman, Yalom, and Miles randomly assigned each person to one of 18 different therapy groups representing 10 theoretical orientations: gestalt, transactional analysis, T-groups, Synanon, Esalen, psychoanalytic, marathon, psychodrama, encounter tape, and encounter. Trained observers coded the group's interactions, with particular attention to the leader's style. Before, during, immediately after, and 6 months following the participation they administered a battery of items assessing group members' self-esteem, attitudes, self-satisfactions, values, satisfaction with friendships, and so on. Measures also were completed by the comebers, the leaders, and by group members' acquaintances.

Somewhat unexpectedly, the project discovered that no one theoretical approach had a monopoly on effectiveness. For example, two separate gestalt groups with different leaders were included in the design, but the members of these two groups evidenced widely discrepant gains. One of the gestalt groups ranked among the most successful in stimulating participant growth, but the other group yielded fewer benefits than all of the groups.

These findings may have resulted from the lack
report measures, which included indices of depression, self-esteem, and neuroticism, indicated both group interventions were effective. A 4-month follow-up, however, indicated that the cognitive-behavioral intervention maintained its effectiveness more than the supportive-insight approach. Beutler, Milton, Schieber, Calvert, and Gaines (1984), too, found some differences among treatments. They randomly assigned 176 patients to a control group or to one of the following three treatment programs: interactive, process-oriented experiential, encounterlike, or behaviorally oriented groups. Beutler found that both the process-oriented and behaviorally oriented groups were effective, but that the experiential group resulted in deterioration among some patients. Lastly, Kivlighan, McGovern, and Corazzini (1984) used similar content and procedures in six therapy groups, but they varied the timing of the delivery of information pertaining to intimacy and expressing anger. As the forming-storming-norming-performing model of group development described by Tuckman (1965) suggests, interventions that matched the group’s stages of development were more effective than mismatched interventions. Kaplan (1982) compared four types of group-oriented approaches with assertiveness training: a behavioral approach, cognitive assertion training, a behavioral-cognitive approach, and a self-awareness approach. The extensive dependent measures, which included self-report measures, a situation test, and two nonobtrusive measures, indicated that all approaches except the self-awareness method were effective. Finkelstein, Wenegrat, and Yalom (1982) in their analysis of est (Erhard seminar training) noted that this large-group change method has a significant group therapy component, but the benefits reported among est graduates result more from expectancy and response sets than from actual psychological change. Lastly, Kilmann and Sotile (1976) argued against the usefulness of marathon groups, and little new research has emerged in support of this technique (cf. Page, 1982, 1983, 1984, 1985).

The Equivalence of Groups and the Dodo’s Verdict

The research reviewed here indicates that certain methods, particularly more radical interventions such as marathon groups, are not particularly effective means of achieving therapeutic change. However, the majority of the more traditional therapeutic groups, including psychodynamic group psychotherapy, support groups, social skills groups, assertiveness training groups, t-groups, Tavistock groups, experiential groups, gestalt groups, and structured groups, facilitate health-sustaining changes in participants. These findings, although somewhat perplexing given the considerable differences among these various interventions, correspond to results obtained in studies of individual therapy. Meta-analytic reviews of one-to-one therapeutic interventions indicate that these treatments are more effective than no treatment at all, but no one approach emerges as more powerful than any other (Smith, Glass, & Miller, 1980). As Luborsky, Singer, and Luborsky (1975) suggested, the verdict of the Dodo bird in Alice’s Adventures in Wonderland seems to apply (Carroll, 1865/1962). At one point in her adventure, Alice and a collection of colorful characters raced against one another. The race was very disorganized, and finally ended when “the Dodo suddenly called out ‘The race is over!’” All the characters then “crowded round it, panting and asking, ‘but who has won?’” The Dodo’s verdict: “Everybody has won and all must have prizes” (p. 45).

Drawing on Stiles, Shapiro, and Elliott’s (1986) analysis of the apparent equivalence of individual therapies, a number of factors can be identified to account for this “no difference” result. First, the various group therapies may be differentially effective, but researchers’ measures may not be sensitive enough to detect these variations. Second, as Kiesler’s (1966) dismissal of the “uniformity myth” suggests, it may be that effectiveness is a complex product of the interaction of groups, therapists, clients, and circumstances. As Paul (1967) stated, the question is not, “Is therapy A more effective than therapy B?” but, “What type of group run by which therapist is effective for this individual with this type of problem?” When researchers ignore the fit between treatment, therapist, client, and problem, the result is global, but undifferentiated, effectiveness. Third, although extant group interventions are based on widely divergent theoretical assumptions, these assumptions may not lead to differences in practice. A leader of a gestalt group and the leader of a psychodynamic group, for example, may each explain their goals and methods in very different theoretical terms, but they may nonetheless rely on identical methods when in their groups.

A fourth plausible explanation remains. This
explanation suggests that despite their heterogeneity in purposes and procedures, therapeutic groups have certain characteristics in common. In all groups the members have the opportunity to learn from others. They can rely on one another for support and guidance. They receive feedback from other group members that is self-sustaining and corrective, and they also gain an audience for their self-disclosures. Might these common aspects of groups and their dynamics account for the therapeutic effects of group interventions? This possibility is examined below.

**SOCIAL PROCESSES IN THERAPEUTIC GROUPS**

Why are therapeutic groups therapeutic? Why, despite their heterogeneity in terms of purposes and procedures, are they generally equivalent in terms of effectiveness? Perhaps the solution to this puzzle lies in the fact that therapeutic groups, as groups, possess certain characteristics in common, and it is these characteristics that may account for their therapeutic impact.

Several theorists have specified the characteristics of therapeutic groups that enhance their effectiveness. Lakin (1972), for example, argued that the successful group must facilitate emotional expression and generate feelings of belongingness, but it must also stimulate interpersonal comparisons and provide members with the opportunity to interact with one another. Similarly, Bednar and Kaul (1978) recommend participation in a “developing social microcosm,” “interpersonal feedback and consensual validation,” and “reciprocal opportunities to be both helpers and helpees in group settings” (p. 781).

Yalom’s interpersonal model of group psychotherapy, however, is by far the most comprehensive and well-researched analysis of why groups work (Yalom, 1975, 1985). Yalom proposed that certain therapeutic, or curative, factors underlie effective psychotherapeutic groups. Some of the factors on Yalom’s list are mechanisms that are responsible for facilitating change, whereas others describe the general group conditions that should be present within effective therapeutic groups. The list includes the installation of hope, universality, imparting of information, altruism, the corrective recapitulation of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential factors. Self-understanding is also a potential candidate for the curative factors list, although Yalom suggests that this factor may be more epiphenomena than mediator of change.

Yalom gleaned these factors from his clinical experience and empirical research. His list, however, is consistent with theoretical analyses of groups in general. Following a tradition established by William Graham Sumner, Charles Horton Cooley, and Kurt Lewin, social psychologists have long argued that groups are the shapers of individuals. Small groups are society’s primary socializing agents, for they provide their members with a particular worldview, and then sustain that view through direct instruction, selective social reinforcement, and corrective social influence as necessary. Individuals, too, sustain their groups by defending them against other groups, by contributing their effort in group activities, and by changing the group when existing norms and forms of activity are antiquated or become maladaptive.

In the following sections, the curative factors in groups from a group dynamics perspective are examined. Where possible, empirical findings are discussed to substantiate the theoretical arguments offered, but in most cases the available evidence is so sparse that many of the ideas discussed are admittedly speculative. Nonetheless, five key processes that undergird change in therapeutic groups are examined below: social comparison, social learning, self-insight, social influence, and social provisions.

**Social Comparison**

In the early 1950s, Leon Festinger suggested that individuals often join groups to obtain information about their social world (1950, 1954). Festinger believed that physical reality rarely provides us with objective standards for the validation of personal opinions, beliefs, or attitudes. Therefore, we often compare our personal viewpoint to the views expressed by others to determine if they are “correct,” “valid,” or “proper.” Festinger called this information-seeking process social comparison.

Through social comparison, members of therapeutic groups gain reassuring information about the nonuniqueness of their problems. Veridical information-seeking—social comparison with similar others in the group convinces members that their problems are more commonplace than they
imagined. Also, the individuals may find reassurance by comparing themselves to others in the group who are experiencing more severe problems or coping less effectively than themselves. This downward social comparison process is likely to occur when we are uncertain of abilities and lack confidence in our beliefs, and hence may serve a protective, adaptive function (Wills, 1981, this volume). Studies of breast cancer patients, for example, indicate that women who compare themselves with superior copers describe their own adjustment in more negative terms. Perhaps as a result of these negative implications, over 60% of the women engaged in downward social comparison by choosing a comparison person who was not coping effectively (Wood, Taylor, & Lichtman, 1985).

Yalom (1985) noted that the act of joining together with people who share a particular problem is, in and of itself, reassuring because it reduces anxiety that emanates from uncertainty: "Fear and anxiety that stem from uncertainty of the source, meaning, and seriousness of psychiatric symptoms may so compendium the total dysphoria that effective exploration becomes vastly more difficult" (p. 12). In support of his speculations, studies of uncertainty and social comparison indicate that individuals seek out other people whenever they feel uncertain of the validity of their attitudes or beliefs. Schachter (1959), for example, found that college women, when confronted by an ambiguous and anxiety-provoking situation, clearly preferred to wait with others, only if these others could provide them with information. Other studies suggest that affiliating individuals, particularly when fearful, interact more, both verbally and nonverbally, and also display withdrawal reactions and controlled nonreactions (Morris, Worchel, Bois, Pearson, Rountree, Samaha, Wachtler, & Wright, 1976). Schachter's studies prompted him to conclude that individuals prefer to face problems in groups rather than alone, because the groups provide members with anxiety-reducing information. As he concluded, "Misery doesn't love just any kind of company, it loves only miserable company" (p. 24).

Social Learning

Theorists have repeatedly underscored the value of groups as arenas for interpersonal learning (Lieberman, 1980; Yalom, 1975). By participating in a group, individuals gain information about themselves, their problems, and their social relationships with others. As Yalom (1985) noted, some of this information is conveyed through direct instruction, as clients trade advice and information and the therapist provides structure and direction. The group also provides members with the opportunity to implicitly gather data concerning their own interpersonal behavior. Interaction in the group setting is social behavior, and so it has implications for self-definition that go beyond the confines of the temporary group situation. Within the social microcosm of the small group, individuals "become aware of the significant aspects of their interpersonal behavior: their strengths, their limitations, their parataxic distortions, and their maladaptive behavior that elicits unwanted responses from others" (Yalom, 1975, p. 40). Through feedback from the group leader and other group members, as well as self-observations formulated within the group setting, individuals gain an increased understanding of their social selves, and this self-understanding provides the basis for changes in cognitions and actions. The value of interpersonal learning is also recognized by group members themselves, for when rating the most valuable aspect of the group experience they tend to emphasize feedback and interpersonal processes: "The group's teaching me about the type of impression I make on others"; "Learning how I come across to others"; and "Other members honestly telling me what they think of me" (Yalom, 1975, p. 79). Of the 12 curative factors noted by Yalom (1985), four of them pertain to social learning: guidance (direct instruction), interpersonal learning via feedback, interpersonal learning by examining relationships with others, and identification with others within the group.

Social learning processes play a role in all types of psychotherapies, but their utility in group settings is particularly noteworthy (Bandura, 1986). Behavioral group therapies, for example, highlight social learning processes by focusing on discrete skills that are modeled and practiced within the group setting (Bellack & Hersen, 1979; Curran, 1977; Galassi & Galassi, 1979). Although such interventions sometimes include structured analyses of participants' self-perceptions, emotions, and perceptions of others, these self-processes are generally tied to specific, identifiable behaviors. Similarly, interpersonal group therapies, like those advocated by Yalom, also stimulate change through social learning. Yalom argues
that by concentrating on events within the group and treating them as the objects of analysis, the “here-and-now” focus gives clients the opportunity to directly observe the social ramifications of their actions. Through feedback from the group leader and other members, clients develop a clearer understanding of their own personal attitudes, values, and characteristics. Thus, the here-and-now focus not only increases self-insight, but also creates new choice points within clients’ behavioral scripts. However, to be certain that these new scripts generalize to nontherapy interactions, some therapy time should be used to bring outside events into the group. As Anderson (1985) and Strong and Claiborn (1982) noted, group therapy is most effective with a here-and-now focus complemented by an excursion into the “then-and-there.”

Self-Insight

Learning about one’s personal and interpersonal characteristics via interaction with others is a particularly important form of social learning that occurs in groups. The need for self-understanding is a prominent motive in human beings, and individuals often seek therapy when they feel that they lack self-insight. Like individual therapies, group interventions promote self-understanding by providing members with feedback from multiple sources, by forcing members to recognize their impact on others, and by giving members the opportunity to reveal hidden aspects of themselves (Luft, 1984).

Achieving self-insight through interaction with others is consistent with symbolic interactionism’s premise that our sense of self is created by our interpretations of the symbolic gestures expressed by others during social interaction (Mead, 1934). Some of these gestures are explicit: a group member may tell another, “You should try to be more sensitive” or “You are always so judgmental, it makes me sick.” Alternatively, this feedback may be implicit, as when individuals’ responses to one another convey information about their perceptions. As Cooley (1902) explained, other people are a mirror that can be used to gain self-understanding: “as we see our face, figure, and dress in the glass, and are interested in them because they are ours ... so we perceive in another’s mind some thought of our appearance, manners, aims, deeds, character, friends, and so on, and are variously affected by it” (p. 231).

Although the self is social in nature, it is hardly a social chameleon. Interpersonal feedback is selectively filtered by the self, with the result that negative feedback or disconfirming feedback is ignored. This self-protective bias, which is often achieved through the use of excuses (Higgins & Snyder, this volume), results in differential sensitivity to positive and negative feedback (Greenwald, 1981; Kivlighan, 1985). For example, in a series of investigations, Jacobs and his colleagues arranged for subjects to participate in a short-term, highly structured “sensitivity” group (Jacobs, 1974). When subjects rated one another on a series of adjectives, Jacobs found that they consistently accepted positive feedback, but consistently rejected negative feedback. This “credibility gap” occurred despite attempts to vary the source of the information (Jacobs, 1974), the sequencing of the information (Davies & Jacobs, 1985; Jacobs, Jacobs, Gatz, & Schaible, 1973; Schaible & Jacobs, 1975), the behavioral and affective focus of the feedback (Jacobs, Jacobs, Cavior, & Feldman, 1973), and the anonymity of the appraisals (Jacobs, Jacobs, Cavior, & Burke, 1974).

Therapeutic groups, however, circumvent these defenses. When several individuals provide similar feedback, the individual is more likely to internalize this information. Also, because the feedback is given in the context of a long-term, reciprocal relation, it cannot be as easily dismissed as biased or subjective. Group leaders, too, often reward members for accepting rather than rejecting feedback, and the setting itself works to intensify self-awareness. The effectiveness and popularity of sensation “games” and simulations in encounter groups possibly stem from their self-focusing qualities.

In sum, a change in self-insight is a key byproduct of therapeutic groups. Even when few changes occur at the behavioral level, changes in self-reported insight are often found in posttherapy reviews (Budman, Demby, Feldstein, & Gold, 1984; Butler, 1977; Ware & Barr, 1977; Ware, Barr, & Boone, 1982). Lieberman et al. (1973), for example, found that most of the gains produced by the group experience were found for self-reported changes in the attitude and value realm, rather than actual behavioral changes. And while Miles (1965) found that executives who participated in National Training Laboratories programs received better ratings by their associates than control group subjects, the participants' self-ratings again revealed much greater change. These and other findings led Gibb (1970, p. 214) to
conclude that participation in sensitivity groups yields changes in "ability to manage feelings, directionality of motivation, attitudes towards the self, attitudes towards others, and interdependence," even when little change in behavior occurs.

Studies of group members' evaluations of the therapeutic experience also attest to the importance of self-insight. Butler and Fuhriman (1983a), in a review of outcome studies that asked group members to rank or rate the importance of these curative factors, found that most group members emphasize three of them as most important: self-understanding, interpersonal learning, and catharsis (Butler & Fuhriman, 1983a; Markovitz & Smith, 1983; Maxmen, 1973, 1978; Rohrbaugh & Bartels, 1975; Rugel & Meyer, 1984; Sherry & Hurley, 1976). When these same researchers (Butler & Fuhriman, 1983b) later asked 91 outpatients from 23 psychotherapy groups to rate these factors, self-understanding, along with catharsis and interpersonal learning, were once more highly valued; and more important, those individuals who profited the most from their therapeutic experience were the ones who most emphasized the impact of increased self-understanding.

Social Influence

Many people have a negative view of social influence. They assume that influence is coercive in some way, that it violates the rights of others to choose freely. This pejorative view of social influence, however, is one sided. Individuals in any group, including a therapeutic group, change their behavior for a variety of reasons (Deutsch & Gerard, 1955; Kelley, 1952). Extreme social pressure may be a factor, but social influence takes many other shapes.

In some cases, individuals change their own personal position when they gain information about others' responses on the issue. This informational influence occurs because other people are a valuable source of information about the social world. As described earlier, social comparison theory notes that one primary reason for joining a group is to gain information about the accuracy of one's own perceptions and beliefs (Festinger, 1954; Goethals & Darley, 1977). If others suggest our views are inaccurate, we sometimes change them. Change also can be caused by normative influence. When a group member feels ashamed for losing her temper and making derogatory statements about the group, strains to disclose an embarrassing personal secret, or tries to give support to a group member who becomes upset, these actions and reactions may reflect the group's norms. At one level, people feel compelled to act in accordance with group norms because a variety of negative consequences could result from nonconformity. Violating group norms can create conflict within the group and can lead to losses in status, to rejection, or even to ostracism. At another level, however, people obey norms in order to fulfill personal expectations about proper behavior. Norms are not simply external constraints but internalized standards; members feel duty bound to adhere to their group's norms because, as loyal members, they accept the legitimacy of the established norms and recognize the importance of supporting these norms.

Change in a group also can result from direct and indirect interpersonal influence. As Strong (1968) argued, therapy is itself a form of persuasive social influence. Clients seek help when they are dissatisfied or frustrated with their current behaviors, but do not feel that they can resolve these problems without assistance. The therapist, therefore, takes the role of the psychological expert who suggests interpretations of the client's experiences and ways to deal with current problems. Interpretations, in the social influence framework, are statements, suggestions, summaries, or questions that offer new ways of viewing the client's problems (Strong & Claiborn, 1982). As a result, therapists who possess certain characteristics that enhance their expertise, attractiveness, and legitimacy (or trustworthiness) influence their clients more strongly (Corrigan, Dell, Lewis, & Schmidt, 1980). These empirical studies also suggest specific techniques that therapists can use to increase the strength of their social influence. For example, professional-looking facilities, displays of credentials, and even manner of dress influence clients' perceptions and may enhance expertise. Group therapists also can increase their expertise by using appropriate (and abstract) psychological terminology, by asking appropriate, thought-provoking questions, and by adopting "an attentive, confident, and reassuring manner" (Corrigan et al., 1980, p. 434). Similarly, Strong (1968, p. 217) offers a number of techniques that therapists can adopt to increase their trustworthiness, including maintaining "a reputation for honesty," adopting a role that is associated with trust (e.g., physician or clergy), and emphasizing one's "sincerity and
openness” and “lack of motivation for personal gain.”

The strength of social influence processes in groups is considerable. Consider, as an example, Crandall’s (1988) recent study of normative, informational, and interpersonal determinants of bulimia. Bulimia tends to run in certain social groups, such as cheerleading squads, dance troupe, sports teams, and sororities (Crago, Yates, Beutler, & Arizmendi, 1985; Garner & Garfinkel, 1980; Squire, 1983). In explanation, Crandall noted that such groups adopt norms that encourage binging and purging. Rather than viewing these actions as abnormal and a threat to health, the sororities that Crandall studied accepted purging as a normal means of controlling one’s weight. He also found indirect evidence of interpersonal influence; to be popular in the group, one had to binge at the rate established by the group’s norms. Also, as time passed, those who did not binge began to binge.

By harnessing these forces to stimulate health-promoting behaviors rather than unhealthy behaviors, the skilled group leader creates internalization rather than merely compliance or imitation. When internalization occurs, the individual “adopts the induced behavior because it is congruent with his value system. He may consider it useful for the solution of a problem or find it congenial to his needs” (Kelman, 1958, p. 53).

Social Provisions

When individuals encounter stressful experiences they require emotional support, advice and guidance, and positive feedback about their value. Across the life span, individuals need to give and receive nurturance. In many situations individuals require information about the nature of the social world and their own personal identities. In some cases the tasks they attempt are so difficult that they would be overwhelmed if they attempted them alone.

The concept of social provisions suggests that group membership is an efficient means of meeting these basic psychological and relational needs (Weiss, 1973, 1974). Across a variety of contexts and cultures, humans tend toward sociality rather than isolation (Mann, 1980). Studies indicate that human infants seem to be predisposed to form strong attachments to others and babies who are deprived of close human contact have higher mortality rates (Ainsworth, 1979; Bowlby, 1980). Even adults are discomfited by protracted periods of social isolation (Zubek, 1973) and most prefer the company of others when threatened or distressed (Rofe, 1984). Sociobiologists, too, suggest that cooperative group life is a more evolutionary stable strategy than competition and individualism (Axelrod & Hamilton, 1981). As a result, individuals may be biologically driven to seek membership in groups, and they experience anxiety when threatened with exclusion from membership (i.e., Baumeister & Tice, 1990; Leary, 1990). As Moreland (1987, p. 104) noted in his theory of social integration, throughout history groups have formed “whenever people become dependent on one another for the satisfaction of their needs.”

The concept of social provisions suggests that therapeutic groups are effective because, as groups, they satisfy certain basic human needs.

The provisions supplied by groups have been described in a variety of ways by researchers and theorists, but the model recently proposed by Shaver and Buhrmester (1983) is particularly parsimonious and comprehensive. Drawing on previous studies of loneliness (Weiss, 1973), social psychological analyses of the bases of society (Toennies, 1887/1961), and leadership in groups (Fiedler, 1978), they suggest that social needs and their corresponding social provisions fall into one of two fundamental categories: psychological intimacy and integrated involvement. The need for psychological intimacy can be met through membership in a group that provides emotional support and nurturance. According to Shaver and Buhrmester, (1983, p. 265), such groups provide members with “affection and warmth; unconditional positive regard; opportunity for self-disclosure and emotional expression; lack of defensiveness, lack of concern for self-presentation; giving and receiving nurturance; security and emotional support.”

Groups that provide members with integrated involvement, in contrast, provide members with “enjoyable and involving activities and projects; social identity and self-definition; [a sense of] being needed for one’s skills; social comparison information; opportunity for power and influence; conditional positive regard; support for one’s beliefs and values” (Shaver & Buhrmester, 1983, p. 265).

Therapeutic groups are effective, in part, because they satisfy one or both of these basic needs. Although intimacy needs are often satisfied by long-term dyadic pairings such as close friendships and love relationships, a highly cohe-
sive therapeutic group also meets these needs. As Yalom (1985) noted, the effective group allows members to give and receive help (altruism), provides them with emotional support and positive feedback (cohesiveness), serves as an audience for self-disclosures and venting of emotions (catharsis), and offers answers to questions of value and meaning (existential factors). An intimate therapeutic group takes the place of the original family group and provides the member with a sense of belonging, protection from harm, and acceptance (recapitulation of the family). Second, group members often give advice to one another and offer new suggestions to problems (guidance). They also demonstrate ways to act (identification) and provide accurate feedback about personal qualities and impact on others (interpersonal learning).

The social provisions offered by group membership suggest that they are effective vehicles for increasing members’ hope regarding future events, for they address the two components of hope identified by Snyder, Anderson, and Irving (this volume). First, a group helps members identify the goals that they wish to achieve. Lewin’s classic studies of level of aspiration in groups, for example, clearly illustrate how groups help individuals set goals that match the capabilities of their members while blocking the formation of goals that will be too easy or too difficult to achieve (Lewin, Dembo, Festinger, & Sears, 1944). Second, groups provide members with the multiple means of achieving these goals. They not only provide individuals with social support, but they also help members develop the interpersonal skills needed to acquire these provisions from groups outside of the therapeutic setting, such as their families and friends (Mallinckrodt, 1989).

THE THERAPEUTIC GROUP QUA GROUP

As therapies go, group therapies are effective. That no one approach to treatment has emerged as particularly potent, however, suggests that their curative effects have more to do with the characteristics of groups per se than with the unique techniques utilized by group therapists.

A group dynamics perspective argues that the therapeutic group, qua group, has a profound impact on its members. Through membership in groups individuals define and confirm their values and beliefs and take on or refine a social identity. When they face uncertain situations, in groups they gain reassuring information about their problems and security in companionship. In groups they learn about relations with others, the type of impressions they make on others, and the way they can relate with others more effectively. In groups, the individual’s most basic needs find satisfaction. These needs may be instinctive, or they may be learned. They may be the end product of early childhood experiences or a reaction to temporary, but stressful, situations. They may reflect our uncertainty about our social world or a desire to achieve important goals. But no matter what their origin or nature, groups offer a means of satisfying these needs.

To close on an editorial note, the preceding analyses of the curative foundations of therapeutic groups are more speculative than they should be. The topic of group processes is one of the oldest and most researched areas within social psychology. The structural properties of groups are now well understood, and recent significant advances have been made in our understanding of leadership, social identity, socialization, and other processes in groups. These advances, however, have not added significantly to our understanding of change-producing groups. Much of the literature on therapeutic groups is devoted to descriptions of new variations on old themes, with little attention paid to the structural and interpersonal factors that mediate the effectiveness of these interventions. The lack of theory and empirical rigor bemoaned by Meltzoff and Kornreich in 1970 and Bednar and Kaul in 1978 remains unexorcized.

Future researchers must move past such basic questions as, “Do groups work?” and “Will this type of group intervention succeed?” to ask “Why do groups work?” They must develop more elaborate conceptualizations of groups that take into account both their change-producing properties and their properties as groups per se. Although daunting, this task requires the integration of recent theoretical developments within group dynamics with analyses of their therapeutic properties. Refinements in theoretical formulations offer very specific hypotheses about the impact of group size, levels of authority, and degree of intimacy or change in groups (Latané, 1981; Mullen, 1985). Recent studies of leadership have succeeded in identifying members’ cognitive and perceptual reactions to leaders, and the impact of these reactions on leadership effectiveness (Lord, 1985).
Studies of decision-making groups reveal the polarizing impact of group discussion on members (Janis, 1982). Moreland and Levine's (1982) model of group socialization describes the predictable sequence of role transitions that occurs as members move through the investigations, socialization, role maintenance, resocialization, and exit phases during their tenure in the group. Although these theoretical developments are not specific to therapeutic groups, they may hold the key for understanding why such groups are effective in promoting change. Because therapeutic groups are groups first and therapeutic groups second, future efforts must build a theoretical context for understanding how therapeutic groups, as groups, promote change.

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