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Social Psychological Foundations of Change in Therapeutic Groups

Donelson R. Forsyth

Social psychology and clinical psychology share an interest in change. Rather than assuming that people are static and that psychological systems are immutable, social psychologists track the shifts in social attitudes, actions, values, and beliefs that result from individuals' everyday interactions in their social worlds. Similarly, clinical psychologists examine changes in adjustment, well-being, and dysfunction that are evidenced as people develop psychologically and physically, confront new life circumstances, or react effectively or less adaptively to daily life events.

Social and clinical psychologists also recognize that such changes often result from group-level processes. Cooley, an early social psychologist, noted in 1909 that groups play a primary role in forming the "social nature and ideals of the individual" (p. 29). Subsequent studies of beliefs, values, actions, and attitudes returned again and again to the group as the agent of change, eventually leading Lewin to conclude that "it is usually easier to change individuals formed into a group than to change any one of them separately" (1951, p. 228). Clinical psychologists, too, recognized, if somewhat grudgingly, the influence of groups on members. Freud (1922, p. 1), for example, wrote that individuals cannot be understood if separated from the groups to which they belong: "Individual Psychology is concerned with the individual man and explores the paths by which he seeks to find satisfaction for his instincts; but only rarely and under certain exceptional conditions is Individual Psychology in a position to disregard the relations of this individual to others." Maslow (1937) opined that "every human adult living is a member of a particular cultural group and has the social

norms characteristic of this group" (p. 487). Similarly Laing (1969, pp. 81–82) concluded that "we cannot give an undistorted account of 'a person' without giving an account of his relation with others. Even an account of one person cannot afford to forget that each person is always acting upon others and acted upon by others. The others are there also."

Social psychology and clinical psychology also seek ways to promote change in others. Both fields recognize that change often occurs spontaneously as a result of some life experience, but that in other cases change can be achieved through explicit, intentionally designed interventions. Social psychologists, for example, have long been interested in how people's attitudes are changed by other people. Some of the earliest work in the field concerned explicit attempts to change the beliefs of others, including interventions aimed at making bigoted people less prejudiced, increasing citizens' civic engagement in military efforts, or convincing consumers to purchase one brand over another. In like fashion, clinical psychologists' interest in change reflects a practical concern; far from passive spectators of change, clinical psychologists seek to develop and refine the methods that will promote adaptive, healthy, and desirable change in their clients.

This chapter examines the obvious implication of these three intersecting similarities: the use of groups to achieve therapeutic change. It begins with a brief survey of group-level interventions before asking, What social psychological processes are at work in these groups that provide them with their transformative power? The chapter then concludes by considering the effectiveness of group interventions and ways to further enhance the curative efficacy of groups.

THE USES OF GROUPS TO PROMOTE CHANGE

Most general texts on psychotherapeutic treatments sequester group approaches near the end of the book, sandwiched between sections with titles such as "Alternative Approaches," "Sociocultural Perspectives," "Family Therapy," or "Couples Counseling." Group therapists are sometimes portrayed as innovators, rebels, or even radicals who are willing to take risks in their work. Yet, group therapists are in most respects similar to other mental health practitioners. Rarely do they endorse some unique, unusual, and unproven set of assumptions in their work, but instead they base their approach to change on such traditional psychotherapeutic perspectives as psychodynamic, cognitive-behavioral, and interpersonal/existential orientations (DeLucia-Waack & Kalodner, 2005).

Psychodynamic Group Therapy

Psychoanalysis is, by tradition, conducted in the smallest of all groups: the dyad comprising client and therapist. This method can, however, guide therapeutic practices carried out with larger assemblages. Freud (1922) himself, in his *Group Psychology and the Analysis of Ego*, recognized that groups provide a buffer against psychological threat, and as a result, membership in a cohesive group may promote adjustment: "Where a powerful impetus has been given to group formation neuroses may diminish and at all events temporarily disappear" (p. 124). In *Civilization and Its Discontents* he suggests that although one who is suffering psychologically may be tempted to seek isolation, "there is, indeed, another and better path: that of becoming a member of the human community, and, with the help of a technique

guided by science, going over to the attack against nature and subjecting her to the human will. Then one is working with all for the good of all" (1961, pp. 24–25).

Psychoanalytic group therapy is usually a leader-centered method, for the psychoanalyst actively and obviously organizes, directs, coordinates, supports, and motivates the members' efforts. Rather than encouraging group discussion, traditional group psychoanalysts focus the group's attention on specific members, with this attention shifting from person to person throughout the course of the session. This procedure allows members to act in the role of the client for a time, but also to take on the role of observer of others' attempts to gain insight into the causes of their life difficulties. Groups also stimulate the transference processes that occur, in any case, in therapy. As Freud's (1922) replacement hypothesis suggests, the group can become a surrogate family for members, and the emotions linking members are like the ties that bind siblings together, with the group therapist taking on the role of the primal authority figure. As transference unfolds, the group provides the therapist with the means of exploring the childhood roots of current adult anxieties.

Just as free association provides the therapist with the means of gaining insight into the hidden motivations and conflicts of the ego, so the exchanges among group members provide data for the therapist's exploration of the workings and contents of the conscious and unconscious mind (Langs, 1973). The conversation among the members may, at a superficial level, appear to focus on banalities and pleasantries, but the subliteral text of the conversation carries with it information about unstated and often unrecognized motives and fears. The verbal exchanges among members offer many opportunities to ask "What did you mean by that?" and "Why did you say that?" According to psychoanalytic theory, the answers to these questions reveal the way each person's unconscious motivations and preconceptions influence their perceptions, emotions, and actions (Haskell, 1999). Therapists working one on one with a client tend to rely on dreams and free associations to chart the unconscious mind, whereas group psychodynamic theorists consider the ordinary dialogue of interacting group members to be an alternate route to the unconscious (Weiss, 2006).

Cognitive-Behavioral Therapy Groups

Therapists who question the value of Freudian theories and methods often base their interventions on principles of learning and cognition. Such approaches assume that problematic thoughts and behaviors are acquired through experience, so interventions are based on principles derived from learning theories and the expansion of these theories into cognitive realms. Behavioral and cognitive-behavioral therapies eschew a search into clients' pasts for the ultimate cause of their problems, and instead focus pragmatically on encouraging healthy, desirable cognitions and behaviors (e.g., expressing positive emotions) and discouraging undesirable, harmful cognitions and behaviors (e.g., drinking alcohol).

The earliest group psychotherapies used methods that were simplified versions of cognitive-behavioral interventions. Joseph Hersey Pratt's groundbreaking work with group approaches, for example, stressed teaching and learning rather than interpretation and analysis. He initially used the group format for its efficiency—"I originally brought the patients together as a group simply with the idea that it would save my time" (Pratt, 1922, p. 403)—but he was impressed by the group-level processes that increased patient compliance. Pratt gradually enlarged his focus from physical illness to psychological disorders and took to calling his sessions "Thought Control Classes" (Pratt, 1922). He used psychoeduca-

tional methods, including short lectures and demonstrations, to help clients recognize self-defeating, unhealthy ways of dealing with their illnesses and called on more successful group members to model the ways they were achieving their successes.

Modern behavioral and cognitive-behavioral group therapists focus, as Pratt did, on explicit, observable behaviors, such as social or relationship skills, and the cognitions that sustain these behaviors. Behavioral approaches include systematic desensitization training, behavior modification, and skills training. Cognitive-behavioral approaches, such as rational-emotive therapy, cognitive-behavioral modification, and cognitive therapy, focus on changing cognitive processes (Emmelkamp, 2004; Hollon & Beck, 2004). These therapies were initially developed as one-on-one therapies, but they have been used with great success in groups. McDermut, Miller, and Brown's (2001) meta-analysis of group approaches to the treatment of depression, for example, found that nearly all of the experimental studies that examined group methods included at least one treatment condition that made use of cognitive-behavioral therapy.

Interpersonal (Existential) Therapy Groups

Psychodynamic and cognitive-behavioral methods consider and make use of group processes, but some group therapists focus more squarely on the group and relations among group members as the means for achieving change. This third cluster of group therapies is a very heterogeneous one, containing approaches that differ in many ways from one another but are usually based on principles derived from clinical and personality theories that stress the interpersonal and existential roots of adjustment and disorder (Elliott, Greenberg, & Lietaer, 2004). Humanistic, third-force theories such as Rogers's (1940) person-centered theory, Moreno's (1934) psychodrama, Gestalt methods (Perls, Hefferline, & Goodman, 1951), human potential movement methods such as growth and encounter groups (Lakin, 1972), and Yalom's (1995) interpersonal, or interactive, group psychotherapy assume that individuals are, at core, searching for ways to improve their current functioning and maximize their potentialities. Such approaches are often phenomenological and experiential and underscore the importance of a strong, positive, empathic therapeutic environment for facilitating personal and collective growth.

The humanistic therapist Carl Rogers (1970), for example, traced most dysfunction to a loss of self-worth due to the conditional nature of acceptance by others. Rogers treated people by providing them with unconditional positive regard in an accepting therapeutic group encounter. Rogers thought that groups help members experience their emotions more fully and learn to deal with other people in authentic, open ways (Page, Weiss, & Lietaer, 2002). Similarly Gestaltist Fritz Perls frequently conducted his therapeutic sessions in groups rather than with single individuals. In some cases, Gestalt group therapy is one-to-one Gestalt therapy conducted in a group setting, with members observing one another's "work" but not interacting with each other. More frequently, however, interaction takes place among group members, with the therapist actively orchestrating the events. Many group therapists make use of unstructured interpersonal activities to stimulate members' emotional understanding, but Gestalt therapists generally resist offering interpretations to their patients (Goulding & Goulding, 1979; Greve, 1993).

Psychodrama, developed by Jacob Moreno, also makes use of exercises to stimulate emotional experiences in group members. Moreno (1932) conducted therapeutic groups per-

haps as early as 1910, and he used the term *group therapy* in print in 1932. Moreno believed that the interpersonal relations that developed in groups provide the therapist with unique insights into members' personalities and proclivities and that by taking on roles the members become more flexible in their behavioral orientations. He made his sessions more experientially powerful by developing psychodrama techniques. When role playing, for example, members take on the identity of someone else and act as he or she would in a simulated social situation. Moreno believed that psychodrama's emphasis on physical action was more involving than passive discussion and that the drama itself helped members overcome their reluctance to discuss critical issues (Kipper & Ritchie, 2003; Rawlinson, 2000).

Yalom's (1995) interpersonal group psychotherapy is perhaps the most influential of the interpersonal approaches to groups. Yalom views the group as a social microcosm where individuals gain a profound awareness of how they are coming across to others interpersonally and the disruptive impact of their mistaken assumptions about other people on their relationships (parataxic distortions). Because they respond to one another in ways that are characteristic of their interpersonal tendencies outside of the group, Yalom encourages members to focus on the here and now of their group experience, rather than on problems they may be facing at home or at work. When, for example, one member of a group displays self-contempt and is challenged by another member, or when one member responds actively only to questions asked by the leader rather than other group members, the group can review these tendencies and explore their adaptiveness. As the group grapples with personal conflicts, problems of organization, goal setting, and communication failures, the members reveal their preferred interaction styles to others and to themselves. They also learn to disclose their feelings honestly, gain conflict reduction skills, and find enjoyment from working in collaborative relationships.

Yalom (1995) believes that a number of curative factors underlie change in a variety of group settings: 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. Some of the factors on Yalom's list are mechanisms that facilitate change, whereas others describe the general group conditions that should be present within effective therapeutic groups. Yalom's list, as the section that follows suggests, is consistent with social psychological analyses of the influential processes that occur in groups.

THE SOCIAL PSYCHOLOGICAL BASES OF CHANGE IN THERAPEUTIC GROUPS

What is the best restorative method to help people regain and maintain their mental well-being? A group-level approach offers an answer that is, in some ways, at variance with psychology's traditional emphasis on psychogenic solutions. Asked why an individual is depressed, addicted, or engaged in aberrant actions and how that individual can be helped, psychologists tend to focus their attention on intrapsychic, individualistic processes, such as personality traits, past events, and biological processes. In contrast, a group-level, sociogenic approach complements and enriches the psychogenic perspective. Such an analysis assumes that each person is nested in a hierarchy of increasingly complex and inclusive social aggregates, such as groups, organizations, and communities. The unique qualities of each individ-

ual cannot be ignored, but neither can the processes operating within the groups that enfold the individual members. Here we look again at the personal and interpersonal processes examined earlier in this book—self and identity, self-esteem, self-regulation, self-efficacy, self-awareness, social cognition, and interpersonal relations—and the role therapeutic groups play in shaping these socially and clinically significant processes.

Personal Process in Groups

A group-level analysis of change does not ignore individual-level processes but instead seeks to integrate these processes into a multilevel analysis. This perspective recognizes the reciprocal nature of the individual-to-group connection: Individuals' thoughts, actions, and emotions are shaped by group-level processes, but each member also influences every other member as well as the group as a whole. Social psychologists realize that if one is to understand processes that unfold *between* people in groups, then one must also understand the processes that occur *within* the individuals who are members of the groups.

Self and Identity

Sages throughout history have championed the adaptive value of self-knowledge, and contemporary clinical wisdom similarly urges those who are seeking to strengthen their resilience to stressful life events or enhance their psychological well-being to know themselves thoroughly. But even though people often believe that they can best learn who they are through self-reflection (Sedikides & Skowronski, 1995), a group-level analysis suggests that the self is as much a social creation as an intrapsychic one. To answer questions such as, "What is my personal worth?", "Do people like me?", and "Am I an introvert or an extravert?", one must rely on information provided through interaction with other people.

Psychotherapeutic groups, as groups, thus provide members with information that allows them to construct an answer to the question "Who am I?" In some cases, the group may provide explicit information about one's personal qualities, but it also provides indirect feedback by responding in certain ways. When a person is treated in a certain way by others—if, for example, other people respond as if one is intelligent, friendly, confused, or clumsy—then in time these qualities will be incorporated into the self. When members see themselves acting in a particular way consistently—say, by dominating the group interaction, constantly criticizing others, displaying strong emotions, or expressing concern for others' well-being—then they will, in time, come to realize that they are dominant, critical, emotional, or caring, respectively. Because in most cases members of therapeutic groups are known to one another as individuals rather than as the occupants of a particular social role (e.g., parent, child, boss, or employee), members can no longer attribute their actions to the requirements placed on them by the roles in which they find themselves. Ed may typically blame his gruffness on the demands made by his role as boss and Edwina may think her moodiness is caused by her family, but if Ed is gruff and Edwina is moody in group, then they must consider the possibilities that these qualities are part of who they are.

Members also provide one another with explicit verbal and nonverbal feedback about how they are coming across in the group. John may, in time, realize that he lacks social skills when he finally notices that no one in the group will look him in the eye or sit near him, but

he might also get this message when members criticize him for speaking too harshly and for failing to show concern for others' feelings. Individuals are, in fact, somewhat leery of joining therapeutic groups because they recognize that the group may see them for what they are—and that this accurate appraisal may not match their own sense of self (Ringer, 2002). They may find, however, that as they act in ways that are inconsistent with their original self-conception, their self becomes increasingly complex and, in consequence, stabler (Vickery, Gontkovsky, Wallace, & Caroselli, 2006). A simple view of the self may be just as valid as a complex one, but the advantage of a complex view is this: When people who are high in self-complexity experience a negative event in their life, they can cope by focusing on the more positive aspects of their life. Also, because individuals who are high in self-complexity differentiate between their various self-views, a catastrophe in one arena is less likely to spill over and contaminate their other self-views (Dixon & Baumeister, 1991).

Research does not clearly confirm the mental health benefits of accurate, detailed self-knowledge (Sedikides & Strube, 1997), but members of therapy groups nonetheless believe that groups provide them with self-diagnostic data that are, in themselves, therapeutic. When Kivlighan and his colleagues asked participants in therapeutic groups to identify events that took place in their groups that helped them the most, members most frequently mentioned the feeling that their problems were shared with others (universality), the opportunities to learn interpersonal skills, the group's acceptance of them, and the insight into themselves that they gained from the group experience (Kivlighan & Mullison, 1988; Kivlighan, Multon, & Brossart, 1996). When researchers ask members to rank or rate the importance of various curative factors in the group, usually using the list developed by Yalom (1995), they generally find that group members emphasize self-understanding, interpersonal learning, and catharsis, and that clients rate self-understanding as increasingly important as their therapy progresses. In general, individuals who stress the value of self-understanding tend to benefit the most from participation in a therapeutic group (Butler & Fuhrman, 1983a, 1983b; MacNair-Semands & Lese, 2000; Rugel & Meyer, 1984).

Self-Esteem

Knowing the self may promote better adjustment, but *valuing* the self may be equally essential to psychological well-being (Swann, Chang-Schneider, & Larsen McClarty, 2007). A number of psychological problems, including depression, anxiety, alcohol abuse, masochism, and eating disorders such as bulimia, are rooted in a devalued self. (See Dijkstra, Gibbons, & Buunk, Chapter 11, this volume; Leary & Tate, Chapter 2, this volume.) Individuals suffering from depression, for example, report confusion about identity and purpose in life, a sense of emptiness when they turn their attention toward the self, and strong, unrelenting feelings of worthlessness and inadequacy. They often talk of feeling little self-confidence and how this uncertainty leaves them dependent on, and easily influenced by, other people.

Group therapy offers members a means to regain a sense of self-worth. Self-esteem is linked, at a basic psychological level, to inclusion in stable, clearly defined groups. As Baumeister and Leary's belongingness hypothesis argues, "Human beings have a pervasive drive to form and maintain at least a minimum quantity of lasting, positive, and impactful interpersonal relationships" (1995, p. 497). Just as exclusion from a group can trigger a loss in self-esteem, so can inclusion in a group contribute to more positive feelings of self-worth. Leary and Baumeister's (2000) sociometer model goes so far as to suggest that inclusion in a

group raises self-esteem, since self-esteem is not an index of self-appraisal but a monitor of inclusion in social groups (Leary, Tambor, Terdal, & Downs, 1995).

Groups also raise members' sense of worth by ritualizing the exchange of praise and positive feedback among the members. Group members often exchange corrective, and in some cases negative, feedback, but such exchanges are usually counterbalanced by substantial doses of congratulatory, positive evaluations. The group format also provides members with (1) information about other people's failings and faults, setting the stage for the realization that their problems are not unique but instead universal; (2) the chance to help others, thereby establishing their value to the group and its members; and (3) a range of individuals who can be used as targets of social comparison.

Therapeutic groups also enhance self-esteem by providing members with a positive group-level, or social, identity. Although a psychogenic viewpoint typically stresses the importance of the personal, individualistic aspects of the self, the self includes a social side. This collective identity is based on connections to other people and groups, including roles, memberships, and interpersonal relations. Social psychological researchers have repeatedly found that even though individuals may have qualities that are stigmatized by society (e.g., psychological problems; see Corrigan, Larson, & Kuwabara, Chapter 4, this volume), when these individuals identify strongly with their group, their self-esteem increases rather than decreases (Twenge & Crocker, 2002). Marmarosh and Corazzini (1997) examined the impact of membership in a therapy group on social identity by asking the members of some groups to carry a symbol of their group with them (a group card) at all times. The card was to serve as a reminder that they were valued members of their therapy group and that they should know that their group was with them all the time. Those group members given a group identity card reported greater collective self-esteem and displayed more positive treatment gains than members in a no-card control condition.

Self-Regulation

The capacity to control oneself is considered an essential element of mental health, but self-regulation, for some people, is a difficult, complex, and daunting task (see Doerr & Baumeister, Chapter 5, this volume). Depressed individuals may want to regain a sense of purpose and energy. Obsessive-compulsive individuals may wish to limit their repetitive tendencies. People who abuse alcohol may want to control how much they drink. Socially phobic individuals may hope that they can socialize easily with others. Yet, when these individuals try to control their thoughts, emotions, and actions, they are disappointed in the results and in themselves.

It might seem paradoxical to suggest that individuals can enhance their self-regulation by relying on a group, for *self-regulation* implies control of the self by the self rather than by others (Muraven & Baumeister, 2000, p. 247). Indeed, most theories of self-regulation draw a distinction between goals individuals set for themselves and those that are pressed upon them by outside agents. Therapeutic groups, however, blur the distinction between self and other. For example, Kelman (1963), in his analysis of psychotherapy groups, concluded that group members initially merely comply with the demands of the group and its leader. They may act as the group requires, but when the group's restraint is relaxed, they often revert to their original ways. In time, however, they often begin to identify with the group, and their self-image changes as they take on the behaviors, characteristics, and roles of influential group members. They regulate their actions to reduce the discrepancy between their personal

state and the state required by the group. As members become more firmly embedded in the group, they eventually internalize the group's values, so that their personal beliefs, opinions, and goals become one with the group's standards. Over time, group control is transformed into self-control (Kelman, 2006). Similarly, self-determination theory (SDT; Ryan & Deci, 2000) proposes that goals cannot always be clearly divided into those set by the self for personal reasons and goals that originate outside the self. SDT identifies four types of goals that vary in the degree to which regulation is external to the person or integrated internally: external regulation, introjection (complying, often unknowingly, with the external demand but not fully accepting it as one's own), identification, and integration (integrating requirements that were once externally imposed within the self-system).

Self-Efficacy

Groups are not only the source of the individual's goals, but they also play a major role in generating a sense of efficacy about the behaviors one needs to perform to be successful in reaching those goals. As Maddux and Lewis (1995, p. 37) note, self-efficacy and competence are not sufficient conditions for psychological well-being, but "adjustment is difficult, if not impossible, without such beliefs." Individuals who are high in self-efficacy are likely to view their setbacks as challenges rather than as threats. Instead of focusing on their problems and shortcomings, they focus their efforts on identifying ways to achieve their goals and solve their problems. Those who are low in self-efficacy, in contrast, lose their confidence when facing a challenge and become self-focused rather than task-focused.

Groups contribute to members' sense of self-efficacy by helping them learn the specific skills they are seeking. In therapy groups members can observe the actions of others and learn from those who model healthy ways of dealing with interpersonal situations. Members can also practice and receive feedback about their success in performing specific behaviors, so that in time they should feel that they are capable of performing the actions that they (and their therapist) feel they need to develop. Yalom (1995) refers to this increase in self-efficacy as the "installation of hope," and research confirms that group-derived self-efficacy contributes to well-being, as assessed by measures of life satisfaction, depression, and group-derived hope for the self (Cameron, 1999; Marmarosh, Holtz, & Schottenbauer, 2005). Cheavens, Feldman, Gum, Michael, and Snyder (2006), for example, discovered that members of a short-term therapeutic group that focused directly on members' sense of hope reported more optimism about reaching their goals, as well as reduced anxiety and depression, than did members of a waiting-list control group.

Groups are also a source of *collective efficacy* for members. Unlike esprit de corps or liking for other group members, collective efficacy is the belief that group members can work together effectively to reach the group's goals. Members of a psychotherapy group with collective efficacy are optimistic about their group's specific skills and competencies, and these beliefs should help members maintain a higher level of motivation as they seek to attain their goals (Forsyth, 2010).

Self-Awareness

Most analyses of the self-regulation process suggest that individuals monitor the match between their current state and their desired state and, based on that assessment, then initi-

ate changes in their current state or revise their conception of the desired state to minimize the discrepancy (e.g., Carver & Scheier, 1981). Because increased self-awareness tends to be associated with increased self-regulation and goal attainment, the effectiveness of groups can be traced, in part, to their impact on members' discrepancy-monitoring process. Groups create an audience for individual members and thereby generate increases in self-focus; when people join with others, their self-awareness tends to increase. Group activities also trigger increases in self-awareness; if members engage in role playing, structured awareness activities, or physical activities, they are likely to feel more self-aware. The tendency for groups to trigger increased self-awareness also accounts for some of the negative side effects of therapeutic groups. Since self-focus can exacerbate negative psychological states such as depression, the relationship between positive change and self-focused attention may be curvilinear: To be effective, group members must become self-aware, but this awareness should not be so strong that it engenders social anxiety (Leary & Kowalski, 1995; Leary & Tate, Chapter 2, this volume).

Interpersonal Processes in Groups

Interpersonal theorists suggest that psychological disturbances such as depression, anxiety, and personality disorders can be traced back to relational sources—particularly interactions with peers, coworkers, friends, relatives, and acquaintances (e.g., Sullivan, 1953). Because people's problems stem from their "failure to attend to and correct the self-defeating, interpersonally unsuccessful aspects" of their interpersonal acts (Kiesler, 1991, pp. 443), therapies that focus specifically on groups and social relationships are particularly potent since they highlight the origin of the dysfunction. As noted above, psychotherapeutic groups are thought to profoundly affect the selves of the group members: their self-knowledge, self-esteem, self-efficacy, and self-awareness. But these groups are also interpersonal microcosms, and a skilled therapist can harness the social processes in these groups to help individuals achieve the therapeutic goals they have set for themselves. This assumption is summarized in the mantra of group psychotherapists who take an interpersonal approach to treatment: by the group they have been broken, and by the group they will be healed (Marsh, 1931).

Social Learning in Therapeutic Groups

When clients meet one on one with their therapist, they can discuss problems, identify solutions, and receive support and encouragement. But even in the best of circumstances, this exchange is limited, because only one other person acts as listener, mentor, helper, critic, and advisor. In a group, in contrast, individuals can learn not only from the therapist but also from the other group members. When, for example, a group member who has been struggling to express a feeling or painful thought to the group discloses, at last, this message, other members may learn how they too can put their feelings into words. When the leader of the group gradually helps a member understand his or her angry reaction to another member, those watching this process unfold learn how they can help others resolve interpersonal conflicts. When members treat one another in positive, respectful ways and are rewarded by the group leader for doing so, their actions serve as a model for others (Dies, 1994).

Falloon, Lindley, McDonald, and Marks (1977) confirmed the value of modeling in their study of individuals with marked social skills deficits. Those assigned to a simple group

discussion treatment showed some improvement over time, but not as much as clients who observed their group leaders demonstrate skillful social interaction before role-playing these actions themselves. Groups that used explicit modeling methods showed greater improvement than others, and these changes were stable for all but the clients diagnosed with schizophrenia. These findings, and others, prompted Lambert and Ogles (2004) to identify *modeling* and the *social learning* it facilitates as key factors common to effective therapies.

Guidance and Leadership

Unlike support or self-help groups, psychotherapy groups have a designated leader: the therapist who is charged with guiding the others in their pursuit of improved mental health. Group psychotherapists, as the recognized leaders in their groups, can make use of the power of that role to increase their impact on the individual members, and on their groups as a whole. Given individuals' tendency to recognize the authority of leaders, clients who are unmoved by a therapist who meets with them one on one may, in contrast, comply with therapeutic directives when they are offered by someone who is not just a therapist but also a group leader. Therapists, as group leaders, may also enhance their impact by harnessing group pressure to serve therapeutic purposes.

Even though most would agree that the therapist-leader strives to stimulate a change in the client's behavior, there is little consensus concerning the methods the leader should use to achieve this goal. As in individual therapy (Strupp, 1986), no one technique has emerged as clearly superior to other techniques. Many group therapists, for example, advocate the leader-centered approaches typical of psychoanalytic, Gestalt, and behavioral groups. In such groups, the leader controls the course of the interaction, assigns various tasks to the group members, occupies the center of a centralized communication network, and offers interpretations of the causes of clients' problems. In some instances, group members may communicate with only the group leader and not each other. In contrast, other therapists advocate a nondirective style of leadership in which all group members communicate with one another. These group-oriented approaches encourage the analysis of the group's processes, with the therapist-leader sometimes facilitating process but at other times providing no direction whatsoever. In general, so long as leaders are perceived to be caring, to help members interpret the cause of their problems, to keep the group on course, and to meet the members' relationship needs, the group will prosper (Lieberman & Golant, 2002; Lieberman, Yalom, & Miles, 1973).

Cohesive Groups and Social Support

Psychotherapeutic groups offer members something that groups, in general, offer their members: social support. When people find themselves facing difficult life experiences, they often suffer psychological and physical illness. But members of supportive groups are protected against these negative consequences in some ways (Herbert & Cohen, 1993; Uchino, Cacioppo, & Kiecolt-Glaser, 1996; Wills & Cleary, 1996; Lakey, Chapter 10, this volume). Most people turn to familiar groups such as friendship cliques and family for their social support, but members of therapeutic groups frequently turn to one another and offer help by providing advice, guidance, direction, and emotional support (e.g., LaBarge, Von Dras, & Wingbermuehle, 1998).

Studies of the capacity of therapeutic groups to provide support to members suggest that the more cohesive the group, the more likely its members will feel as though the group serves as a buffer against stress and anxiety (Burlingame, Fuhriman, & Johnson, 2001). Hence, therapists who help the group move through periods of uncertainty and conflict to a stage of cohesion and performance may find that their members gain more from membership (Kivlighan & Mullison, 1988; MacNair-Semands, 2002). A cohesive therapy group functions like a team: The members are engaged in the group and its change-promoting processes. They rarely miss meetings, they take part in the planning of the group's topics and activities, and they may even explicitly mention the group's esprit de corps and sense of camaraderie (Kivlighan & Tarrant, 2001; Ogrodniczuk & Piper, 2003).

Self-Disclosure

Studies of reactions to stressful events suggest that self-disclosure about these events promotes adjustment for a variety of psychological reasons. Disclosing troubling, worrisome thoughts also reduces the discloser's level of tension and stress. Individuals who keep their problems secret but continually ruminate about them display signs of physiological and psychological distress, whereas individuals who have the opportunity to disclose these troubling thoughts are healthier and happier (Pennebaker, 1997; Sloan, Chapter 12, this volume). Speculating, since self-disclosure to a single person (or to an unknown audience) is healthy, then disclosure to a group should be particularly beneficial. When groups first convene, members usually focus on superficial topics and avoid saying anything too personal or provocative; but as cohesion increases, members begin to feel that they can share very personal information with other members. As a result, self-disclosure and cohesion are reciprocally related. Each new self-disclosure deepens the group's intimacy, and this increased closeness then makes further self-disclosures possible (Agazarian, 2001). By sharing information about themselves, members are expressing their trust in the group and signaling their commitment to the therapeutic process. Members can also vent strong emotions in groups, although the value of such emotional venting continues to be debated by researchers, since "blowing off steam" heightens members' psychological distress and degree of upset (Ormont, 1984).

THE EFFECTIVENESS OF GROUP TREATMENTS

Therapeutic groups capitalize on a range of interpersonal processes common to groups, in general, to promote the functioning and adjustment of members. Yet when earlier adopters of this format suggested treating people's psychological problems by having them gather together in a group, this idea was considered radical and risky. History, however, proved the skeptics wrong. Group psychotherapy is currently used to treat all types of psychiatric problems, including addictions, thought disorders, depression, eating disorders, posttraumatic stress disorder, and personality disorders (Barlow, Burlingame, & Fuhriman, 2000; Forsyth & Corazzini, 2000).

But how effective is group psychotherapy? Meta-analytic reviews, including those that code studies for methodological rigor, generally suggest that group approaches are as effective as individual methods. Earlier reviews (e.g., Fuhriman & Burlingame, 1994; Smith & Glass, 1977) found that individual and group treatments were roughly equivalent in terms of

effectiveness, and more recent reviews have confirmed those conclusions (e.g., Burlingame, Fuhrman, & Mosier, 2003; Burlingame & Krogel, 2005; Kösters, Burlingame, Nachtigall, & Strauss, 2006). Burlingame and his colleagues (McRoberts, Burlingame, & Hoag, 1998), in a particularly careful analysis, tracked a number of treatment and procedural variables that past researchers identified as key determinants of therapeutic success, but the only factors that covaried significantly with outcome were client diagnosis, number of treatment sessions, and the year in which the study was conducted. Group therapies were more effective with clients who were not diagnosed clinically, and the more sessions, the better. Studies conducted prior to 1980 were more likely to favor group over individual approaches.

Burlingame, MacKenzie, and Strauss (2004, p. 652), in summarizing the outcome literature on group therapy, conclude that "group psychotherapy is potent enough to be the sole or primary treatment for patients suffering from a psychiatric disorder," but they temper their positive conclusion by noting that group approaches work better for some disorders than for others. In particular, in both outpatient (Burlingame et al., 2003) and inpatient (Kösters et al., 2006) settings, individuals experiencing mood disorders (anxiety, depression) respond better to group psychotherapies than individuals experiencing other types of disorders (e.g., thought and dissociative disorders).

Burlingame and his colleagues (2004) reiterate a conclusion reached by Bednar and Kaul (1979): too little is known about the psychological and social processes that sustain the changes that are produced by group therapy. Do group-level processes such as social influence (informational, normative, and interpersonal), group cohesion, group norms, and social networking operate to shape the structure and function of therapeutic groups? If so, how do these group-level processes combine to influence outcome? Which group-level processes are most responsible for attitudinal and behavioral change, and which are less critical? Researchers have only begun to answer questions pertaining to the factors that mediate the treatment–outcome relationship.

Second, much of the evidence that is available is tainted by methodologically limited procedures. Groups are difficult to study, and so studies of their effectiveness often suffer from fatal flaws in design and execution. Treatment fidelity is difficult to verify, as each treatment session is influenced not only by the therapist but also by the clients themselves. In many cases, too, no attempt is made to measure group-level processes, such as cohesiveness or emerging networks of influence within the group, as researchers' rely only on each individual members' perceptions of these qualities. Researchers, too, often study so few groups that they have problems separating out the effects of the treatment from the unique effects of a particular group or group member on members. It is common, for example, for a researcher to assign one therapy group to the treatment condition and a second therapy group to a control condition. Since this design confounds treatment and group, the relative effectiveness of the treatment cannot be ascertained.

These two significant limitations aside, the available evidence prompts a guardedly optimistic conclusion about the therapeutic use of groups. Groups often exert an unrelenting influence on their members. Nearly all human societies are organized around small groups, and these groups shape their members' psychological adjustment and dysfunction. Given their ubiquity, people generally respond positively when presented with the opportunity to work in a group to achieve mental health goals. Far more research is needed to analyze the nature of the therapeutic group and its impact on members, but given the powerful self-processes and interpersonal processes that such groups instigate and the positive findings

already reported by researchers, groups should be considered a treatment of choice rather than a radical alternative.

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