Group Psychotherapy, Clinical Psychology of

Group psychotherapy is the treatment of psychological, behavioral, emotional, and interpersonal problems in a group context. This article traces the development of group procedures in clinical psychology from its roots as a didactic technique to contemporary psychoanalytic, behavioral and cognitive-behavioral, and interpersonal treatment procedures. These approaches stress different therapeutic mechanisms and methods, but nearly all trace the health-promoting effects of groups to a common set of factors that instill a sense of hope, promote social learning, and induce self-disclosure, emotional expression, and self-insight. Research suggests that group psychotherapy, when properly administered, is as effective as individualized treatment techniques.

1. Approaches to Group Psychotherapy

Group psychotherapy emerged as a means of helping people deal with mental and emotional problems in the early years of the twentieth century. Psychotherapy itself was developing during this period, but most pioneering psychotherapists worked with individual patients only. Some innovators, however, applied their basic change principles in group settings, as did some therapists who turned to groups for didactic purposes or because their patient load demanded a massed approach to treatment. These group applications were often confined to a particular psychiatric facility or clinic, but in time they became more dispersed as other mental health professionals heard of and made use of the group methods. These early psychotherapy sessions involved treating individuals ‘in groups, with the group itself constituting an important element in the therapeutic process’ (Slavson 1950, p. 42).

Group psychotherapy is used currently to treat a variety of problems, including addiction, thought disorders, depression, eating disorders, and personality disorder. Group psychotherapists are usually credentialed mental health professionals and their patients tend to be suffering from diagnosed clinical conditions. The methods used by group psychotherapists are as varied as individual approaches to therapy. Psychoanalysis, psychodrama, systems theory, object relations, existential, Gestalt, and humanistic are just a few of the general orientations adopted by group psychotherapists, who tend to be more eclectic than nongroup therapists in their approaches to treatment. Most approaches, however, fall into one of three basic categories: psychoanalytic, behavioral and cognitive-behavioral, and interpersonal (Forsyth and Corazzini 2000).

1.1 Psychoanalytic Group Psychotherapy

Psychoanalytic group psychotherapy draws on Freud’s (1922) conceptualization of the causes of dysfunction and his recommendations regarding the most effective way to treat those dysfunctions (see Psychoanalysis in Clinical Psychology). The analyst, through such traditional analytic methods as free association, interpretation, and the dissection of transference processes, creates a powerful relationship with the client who then gains insight into unresolved conflicts. The psychoanalytic group psychotherapist, however, exploits the group situation to stimulate self-insight, transference, and the cathartic release of unconscious anxieties. In most cases the therapist acts
as the authority in the group and works with each patient in turn. This rotation gives each patient the opportunity to experience the benefits of one-on-one psychotherapy, but also gives them the opportunity to gain from the analysis of co-members' psychological and emotional difficulties. The group setting, as a recapitulation of a family grouping, also provides more opportunities to work through problems that result from early family conflicts. Just as individual therapy usually stimulates parental transference, group psychoanalysis stimulates sibling transference. Indeed, some experts suggest that Freud’s Vienna Circle—ostensibly a study group formed by Freud and his students to discuss theories of adjustment—was a form of group psychotherapy (Roth 1993).

Psychoanalytic group psychotherapists diverge on one key aspect of the process. Some stress the importance of the individual in the group. This approach argues that the therapist should stress individual-level processes in treatment, and avoid spending valuable treatment time exploring the dynamics of the therapeutic group. Others, in contrast, integrate the treatment of the individual with the analysis of the group itself. The group-as-a-whole approach, which can be traced to Bion, Rickman, and Foulkes’s work at the Northfield Military Hospital in England, is a sterling example of this approach. Although group-as-a-whole therapists embrace psychoanalytic assumptions of unconscious motivations, personality conflicts, and transference, they make use of the tension between the group and the individual to promote growth and development. Bion, for example, stressed the analysis of defense mechanisms used by groups to cope with ego threats, uncertainties, and anxieties. He believed that these strategies are rooted in dependence, for the group members engage in collective projective identification as they struggle to avoid blame for their problems by shifting responsibility from themselves to the therapist. Bion assumed that rapid and lasting adaptive change could be achieved by helping group members understand both individual and collective defensive processes that unfold in their group session, and his work provided the basis for the Tavistock Institute of Human Relations (Harrison 2000).

1.2 Cognitive–Behavioral Therapy Groups

Cognitive and cognitive-behavior psychotherapists, rather than searching for the cause of the problematic behavior in unseen unconscious conflicts or interpersonal transactions, base their interventions on principles derived from learning theories (Dobson et al. 2000) (see Dialectical Behavior Therapy; Cognitive Therapy). They identify and quantify desirable cognitions and behaviors that will be encouraged and undesirable cognitions and behaviors that will be extinguished, and then modify these behaviors through cognitive restructuring, self-instructional training, and problem-solving instruction. Cognitive-behavioral therapy groups use these principles with two or more individuals (Rose 1993). Cognitive–behavioral group therapy is generally both structured and problem-focused. Pretreatment assessments identify a patient’s current level of functioning, and interventions are calibrated to fit the patient’s level of functioning and targeted outcomes. The therapeutic interventions usually use a constellation of behavioral procedures, including modeling, rehearsal, and feedback.

1.3 Interpersonal Group Psychotherapy

Many group psychotherapists not only exploit the social processes that occur in groups during treatment, but they also trace psychological disturbances back to social sources—particularly interactions with friends, relatives, and acquaintances. Interpersonal theorists assume that behavior results from individuals failures to take note of, and correct, cognitive and behavioral tendencies that disrupt their relationships with other people (see Interpersonal Psychotherapy).

Many group therapists, recognizing the interpersonal bases of psychological problems, use the group setting to help members examine their interpersonal behavior. Yalom’s (1995) interpersonal group psychotherapy (also called interactive group psychotherapy), for example, stresses the ‘here-and-now’ of the group’s interaction over the analysis of events and experiences that occur outside of the group (the ‘then-and-there’). Members may spend some time, especially early in the group’s life span, discussing problems they are facing at home or work, but Yalom feels that much of this discussion will be futile since members’ characterize such events inaccurately. Yalom instead recommends that members focus on interactions within the group, with each member eventually responding to one another as they do to others in their lives. The group thus becomes a ‘social microcosm,’ giving members true insight into the causes of the personal problems.

2. Therapeutic Factors in Groups

Group psychotherapy is based on the Lewin’s law of psychological change: ‘It is easier to change individuals formed into a group than to change any of them separately’ (Lewin 1951, p. 228). But what aspects of the group promote positive change? A common-factors perspective on group therapy suggests that various types of group psychotherapies, despite their many differences, share some common properties, and these commonalities may be responsible for their effectiveness. A psychodynamic therapist uses different techniques than a cognitive-
behavior or interpersonal therapist, but these various formats share mechanisms that promote change and sustain well-being. Yalom (1995) terms these shared qualities curative factors, and his list includes the installation of hope, universality, the imparting of information, altruism, the corrective recapitulation of the primary family group, the development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential factors.

2.1 Social Motivation in Group Psychotherapy

Groups, by their very nature, satisfy a range of basic human social motives. Although individuals who are suffering from some behavioral or psychological problem may not find ‘safety in numbers,’ they can find ‘reassurance in numbers.’ When they assemble in a therapeutic group they quickly realize that the situation they face is shared by others. Yalom (1995) calls this realization universality, for patients realize that they have not been singled out to bear some extraordinary misfortune; rather, the problem they face is a universal one.

Therapeutic groups also capitalize on social comparison processes to stimulate growth and adjustment. Social comparison occurs when individuals spontaneously compare themselves to other people around them. This comparative process does not occur in individualistic therapies, for patients can only imagine how they are coping relative to others. In groups, in contrast, patients learn, both directly and indirectly, about one another’s functioning. These comparative data yield two useful consequences. First, comparison provides patients with a baseline to calibrate their own level of functioning and determine where they stand along the ‘coping vs. collapsing’ continuum (Yalom 1995). They may learn, through downward social comparison—comparing themselves to those in the group who are performing poorly—that their own situation is not so bleak as they originally assumed. Second, this comparison can increase their sense of optimism about reaching an improved level of functioning. Yalom (1995) terms this process the installation of hope. Whereas individuals facing unpleasant circumstances alone may feel discouraged and pessimistic, when group members recognize that others are improving their motivational levels.

2.2 Interpersonal Learning

Much of the learning that occurs during psychotherapy is social in nature. Under the guidance of the therapist, patients explore and gain insight into sources of anxiety, they identify and practice behaviors that they can use to cope with sources of stress, and they acquire the skills they need to interact with others. The therapist models the behaviors they want clients to adopt, and shape their behaviors through feedback and selective reinforcement. When therapy is delivered in a group context, however, the sources of social learning are multiplied. Group psychotherapy necessarily involves patients interacting with other patients, and so it sets up opportunities for interpersonal learning among patients. Some therapists purposely minimize the impact of the group on the individual patients, but most group therapists exploit these social processes to promote change.

Yalom (1995) argues that much of the curative power of a group springs from such social processes as imparting of information from one person to another (guidance), the development of socializing techniques, imitative behavior, and interpersonal learning. For example, the exchange of information among participants was one of the first purposes of groups, for the earliest group therapies were primarily didactic in nature, with psychotherapists lecturing to large groups of patients about mental and physical health. Interpersonal learning also occurs indirectly, as group members monitor their impact on the other people within their group, and the psychotherapist helps them draw conclusions about their maladaptive interpersonal tendencies. Group members also gain from simple observation of others. By watching others’ emotional displays, problem-solving behaviors, coping strategies, and interpersonal maneuverings, patients acquire adaptive social skills.

2.3 Emotional Experiences and Group Development

Groups set the stage for strong emotional experiences for members. As therapeutic groups develop over time, members become closely connected to each other emotionally, developing bonds of friendship that are as strong as any they experience in nontherapeutic relationships. Members also report a strong level of identification with the group, with the result that they are more willing to accept the group’s influence.

The range of emotions experienced depends on the group’s stage of development. Early in the group interactions tend to be superficial, but in time conflicts tend to surface. In most groups, these conflicts between members and the group therapist give way to the development of cohesion. This progression of emotional experience, although characterized in a variety of ways, generally follows the forming, storming, norming, performing, and adjourning pattern identified by Tuckman (Tuckman and Jensen 1977). During the forming stage members are uncertain how to behave, and do not trust one another enough to disclose personal information or to admit they need help. During the storming stage group members often find themselves in conflict over the purpose of the group, and they may withdraw from the group and the therapist. In groups where the leader takes a non-directive orientation, this conflict stage focuses on the leader’s failure to ‘take charge’ of the interactions.
During the next phase, norming, the group becomes more cohesive, as norms and standards emerge that dictate how each session will unfold. This stage makes the performing stage possible, where group members engage earnestly in the exchange of information that will help them achieve their therapeutic goals. In time, members must deal with issues of termination as the group adjourns. This movement from one stage to another is therapeutic, so much so that a group that does not move through these stages may not benefit its members (Yalom 1995).

2.4 Self Processes in Therapeutic Groups

All group psychotherapies stress the value of groups as vehicles of self-understanding and self-efficacy. Although group members may initially be reluctant to disclose any information about themselves in the relatively public group setting, as they develop stronger bonds of trust their disclosures change from superficial to substantial. Group members also report feeling gains in self-efficacy as they help others in their group with their problems.

Members particularly value the self-insights they achieve in groups. In interpersonal therapy, in particular, patients often act in the therapeutic group as they do in other social contexts, so much so that the behaviors that caused them interpersonal difficulties erode their relationships within the group. When their fellow group members and therapist call their attention to the parallel, patients experience greater insights into their own motives and emotions. In many cases, as Freud’s analysis of groups suggests, these tendencies can be traced to early childhood experiences in the family of socialization.

3. The Effectiveness of Group Psychotherapy

When they were initially proposed, skeptics questioned the wisdom of putting people who are suffering from psychological problems together in one group. How, they asked, could troubled individuals be expected to cope in a group when they had failed individually? And how could the therapist guide the therapeutic process in a group, given the subtle nuances that pervade one-to-one therapies? In time, however, the method gained widespread acceptance as therapists added group sessions, either supplementing or completely replacing their individual sessions.

But do members leave the group better adjusted than when they entered? Meltzoff and Kornreich (1970) were guardedly optimistic about the utility of group therapies because 80 percent 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. Bednar and Kaul (1994) were guardedly positive, although they questioned the quality of the outcome research in group psychotherapy. Meta-analytic reviews also suggest that group approaches are as effective as individual methods (e.g., Fuhriman and Burlingame 1994). Fuhriman and Burlingame (1994), for example, reviewed 700 group therapy studies and seven meta-analytic studies before concluding that group methods are effective treatments for a wide variety of psychological problems. Similarly, Faith et al. (1995), in a meta-analytic review of 63 studies of sensitivity training, concluded that these groups generally led to increases in self-actualization and self-esteem and improved interpersonal relations. They noted that these effects increased in larger groups, when the groups met for longer periods of time, and when the measures focused on behavioral outcomes rather than self-reported ones. McRoberts et al. (1998) found that group therapies were more effective with clients (a) who were not diagnosed clinically, (b) suffering from substance abuse problems and/or chemical dependencies, and (c) who attended 10 or fewer sessions. Older studies—those conducted prior to 1980—were more likely to favor group over individual approaches.

This positive conclusion, however, requires some qualification. First, the empirical evidence is not definitive. Whereas a number of reviews are positive, others conclude that group therapy is not as potent as individual therapy. Second, the changes brought about by group experiences may be more perceptual than behavioral. Group members frequently report achieving major insights into their behavior and are positive about the gains they have achieved, but objective indices of outcome are more contradictory. Self-reported insight is also related to actual improvements in adjustment. Third, as Bednar and Kaul (1994) note, a participant may decide to leave the group before they have benefited in any way, and in rare cases patients are significantly harmed by the group experience. Last, far more data of better quality are needed to settle the question of efficacy. As Forsyth and Corazzini (2000, p. 325) conclude, the ‘use of varied and undocumented therapeutic methods, with different types of clients, by therapists who differ in skills and experiences, in studies that too frequently lack valid measures and adequate controls, make it difficult to draw firm conclusions.’

Group psychotherapy’s empirically supported usefulness is reason enough for its continued growth, but the approach will also prosper as health maintenance organizations require, and patients increasingly seek, group-level treatment methods. Group psychotherapy is an efficient therapy, for a single therapist can treat more than one individual at a time—a characteristic that is considered very valuable in healthcare systems that seek to minimize costs without cutting quality. But group approaches may also become more popular as clients seek out supportive, stimulating environments for achieving personal change. Indeed, the
increasing popularity of self-help groups signals the need for treatments that take advantage of groups for promoting adjustment. Although the use of groups in business and educational settings was once considered innovative, individuals now expect to learn and work in group contexts. These experiences, combined with a growing collectivism in cultures that were once primarily individualistic, should heighten awareness of groups as a means of treatment.

See also: Cognitive Therapy; Group Processes, Social Psychology of; Groups in Special Environments; Interpersonal Psychotherapy; Psychoanalysis in Clinical Psychology; Psychological Treatment, Effectiveness of; Therapist–Patient Relationship

Bibliography


D. R. Forsyth

Groups in Special Environments

1. Introduction

‘Special’ environments include those that require extraordinary facilities for human survival, as well as those that temporarily pose dangers because of disaster, accident, or violent conflict. Also known as ‘extreme and unusual environments’ (EUEs), they have always engaged high public interest. Since the 1950s, social scientists have begun the systematic study of how people react in and are affected by experiences in hazardous habitats. These include life-support capsules (under water, in space, near the Poles, on offshore oilrigs), natural and industrial cataclysms, combat zones, refugee and concentration camps.

To date, most of the research emphasis has been on the ways in which people react to their experience (Wilson et al. 1988), on methods for preventing, minimizing, or treating negative outcomes (Holland and Curtis 1998), and on how individuals are selected and trained for some special environments, such as space and submarine missions (e.g., Santy 1994). Methods used in these efforts have included some experiments; but the emphasis has been on simulation and analogue studies, questionnaires, interviews, and the content analysis of archival materials.

Although researchers have focused on the individual, the behavior of human beings in special environments is to a great extent the story of groups. Solitary individuals have found themselves in such situations, sometimes by accident (shipwrecked mariners, sole survivors of other disasters) and sometimes on purpose (aboriginal youths on spirit quests, solo mountaineers, hermits, single-handed sailors, early astronauts, and adventurers of various sorts); but the modal inhabitants of EUEs are not alone.

Many aspects of the environment itself strongly influence group relations and behavior. Some of these are: the dangers involved, life-support equipment, duration of the stay, deviation from accustomed physical parameters (temperature, humidity, air quality and pressure, gravity, noise, crowding, comfort, the availability of food and water, and shelter), remoteness from home, the possibility of communication with one’s family and the parent organization, medical care, and rescue if needed. Whether the group is caught up in an extreme environment unwillingly, by accident or superior force, or has volunteered, and its motives for volunteering (excitement, prestige, patriotism, curiosity, money, altruism) are also significant.

Last, it is useful to distinguish between organized