THE THERAPIST: WORKING IN THE HERE-AND-NOW

The major difference between an outpatient therapy group that hopes to effect extensive and enduring behavioral and characterological change and such groups as AA, Recovery, Inc., psychoeducational

groups, weight-reduction groups, and cancer support groups is that the therapy group strongly emphasizes the importance of the here-and-now experience.

The here-and-now focus, to be effective, consists of two symbiotic tiers, neither of which has therapeutic power without the other. The first tier is an *experiencing* one: the members live in the here-and-now; they develop strong feelings toward the other group members, the therapist, and the group. These here-and-now feelings become the major discourse of the group. The thrust is ahistoric: *the immediate events in the meeting take precedence over events both in the current outside life and in the distant past of the members.* This focus greatly facilitates the development and emergence of each member's social microcosm. It facilitates feedback, catharsis, meaningful self-disclosure, and acquisition of socializing techniques. The group becomes more vital, and all of the members (not only the one who is working that session) become intensely involved in the meeting.

But the here-and-now focus rapidly reaches the limits of its usefulness without the second tier, which is the *illumination of process.* If the powerful therapeutic factor of interpersonal learning is to be set in motion, the group must recognize, examine, and understand process. It must examine itself; it must study its own transactions; it must transcend pure experience and apply itself to the integration of that experience.

Thus, the effective use of the here-and-now requires two steps: the group lives in the here-and-now, and it also doubles back on itself; it performs a self-reflective loop and examines the here-and-now behavior that has just occurred.

If the group is to be effective, both aspects of the here-and-now are essential. If only the first—the experiencing of the here-and-now—is present, the group experience will still be intense, members will feel deeply involved, emotional expression may be high, and members will finish the group agreeing, "Wow, that was a powerful experience!" Yet it will also prove to be an evanescent experience: members will have no cognitive framework that will permit them to retain the group experience, to generalize from it, and to transfer their learning from the group to situations back home.

If, on the other hand, only the second part of the here-and-now—the

examination of process—is present, then the group loses its liveliness and meaningfulness. It degenerates into a sterile intellectual exercise. This is the error made by overly formal, aloof, rigid therapists. Accordingly, the therapist has two discrete functions in the here-and-now: to steer the group into the here-and-now and to facilitate the self-reflective loop (or process commentary).

Definition of Process

The term *process* has a highly specialized meaning in many fields, including law, anatomy, sociology, anthropology, psychoanalysis, and descriptive psychiatry. In interactional psychotherapy, also, process has a specific technical meaning: it refers to the nature of the relationship between interacting individuals.

It is useful to contrast process with content. Imagine two individuals in a discussion. The content of that discussion consists of the explicit words spoken, the substantive issues, the arguments advanced. The process is an altogether different matter. When we ask about process, we ask, "What do these explicit words, the style of the participants, the nature of the discussion, tell about the interpersonal relationship of the participants?"

Therapists who are process-oriented are concerned not primarily with the verbal content of a patient's utterance, but with the "how" and the "why" of that utterance, especially insofar as the how and the why illuminate aspects of the patient's relationship to other people. Thus, therapists focus on the *metacommunicational* aspects of the message and wonder why, *from the relationship aspect,* a patient makes a statement at a certain time in a certain manner to a certain person.

Metacommunication refers to the communication about the communication. Consider, for example, this transaction: during a lecture, a student raises her hand and asks what the date of Freud's death was. The lecturer replies, "1938," only to have the student inquire, "But, sir, wasn't it 1939?" Obviously the student's motivation was not a quest for information. (A question ain't a question if you know the answer.) The metacommunication? Most likely the student wished to demonstrate her knowledge, or to humiliate the lecturer.

Frequently, in the group therapy setting, the understanding of

process becomes more complex; we search for the process not only behind a simple statement but behind a sequence of statements made by a patient or several patients. The group therapist endeavors to understand what a particular sequence reveals about the relationship between one patient and the other group members, or between clusters or cliques of members, or between the members and the leader, or, finally, between the group as a whole and its primary task.

Some clinical vignettes may further clarify the concept.

Early in the course of a group therapy meeting, Burt, a tenacious, intense, bulldog-faced graduate student, exclaimed to the group in general and to Rose (an unsophisticated, astrologically inclined cosmetologist and mother of four) in particular, "Parenthood is degrading!" This provocative statement elicited considerable response from the group, all of whom possessed parents, and many of whom were parents. The free-for-all that followed consumed the remainder of the group session.

Burt's statement can be viewed strictly in terms of *content.* In fact, this is precisely what occurred in the group; the members engaged Burt in a debate over the virtues versus the dehumanizing aspects of parenthood—a discussion that was affect-laden but intellectualized and brought none of the members closer to their goals in therapy. Subsequently, the group felt discouraged about the meeting and angry with themselves and with Burt for having dissipated a meeting.

On the other hand, the therapist might have considered the process of Burt's statement from any one of a number of perspectives:

1. Why did Burt attack Rose? What was the interpersonal process between them? In fact, the two had had a smoldering conflict for many weeks, and in the previous meeting Rose had wondered why, if Burt was so brilliant, he was still, at the age of thirty-two, a student. Burt had viewed Rose as an inferior being who functioned primarily as a mammary gland; once, when she had been absent, he referred to her as a brood mare.

2. Why was Burt so judgmental and intolerant of nonintellectuals? Why did he always have to maintain his self-esteem by standing on the carcass of a vanquished or humiliated adversary?

3. Assuming that Burt's chief intent was to attack Rose, why did he proceed so indirectly? Is this characteristic of Burt's expression of aggression? Or is it characteristic of Rose that no one dares, for some unclear reason, to attack her directly?

4. Why did Burt, through an obviously provocative and indefensible statement, set himself up for a universal attack by the group? Although the words were different, this was a familiar melody for the group and for Burt, who had on many previous occasions placed himself in this position. Was it possible that Burt was most comfortable when relating to others in this fashion? He once stated that he had always loved a fight; indeed, he glowed with anticipation at the appearance of a quarrel in the group. His early family environment was distinctively a fighting one. Was fighting, then, a form (perhaps the only available form) of involvement for Burt?

5. The process may be considered from the even broader perspective of the entire group. Other relevant events in the life of the group must be considered. For the past two months, the session had been dominated by Kate, a deviant, disruptive, and partially deaf member who had, two weeks previously, dropped out of the group with the face-saving proviso that she would return when she obtained a hearing aid. Was it possible that the group needed a Kate, and that Burt was merely filling the required role of scapegoat? Through its continual climate of conflict, through its willingness to spend an entire session discussing in nonpersonal terms a single theme, was the group avoiding something—possibly an honest discussion of members' feelings concerning Kate's rejection by the group or their guilt or fear of a similar fate? Or were they perhaps avoiding the anticipated perils of self-disclosure and intimacy?

Was the group saying something to the therapist through Burt (and through Kate)? For example, Burt may have been bearing the brunt of an attack really aimed at the co-therapists but displaced from them. The therapists—aloof figures with a proclivity for rabbinical pronouncements—had never been attacked or confronted by the group. Surely there were strong, avoided feelings toward the therapists, which may have been further fanned by their failure to support Kate and by their complicity through inactivity in her departure from the group.

Which one of these many process observations is correct? Which one

could the therapist have employed as an effective intervention? The answer is, of course, that any and all may be correct. They are not mutually exclusive; each views the transaction from a slightly different vantage point. By clarifying each of these in turn, the therapist could have focused the group on many different aspects of its life. Which one, then, should the therapist have chosen?

The therapist's choice should be based on one primary consideration: the needs of the group. Where was the group at that particular time? Had there been too much focus on Burt of late, leaving the other members feeling bored, uninvolved, and excluded? In that case, the therapist might best have wondered aloud what the group was avoiding. The therapist might have reminded the group of previous sessions spent in similar discussions that left them dissatisfied, or might have helped one of the members verbalize this point by inquiring about the member's inactivity or apparent uninvolvement in the discussion. If the group communications had been exceptionally indirect, the therapist might have commented on the indirectness of Burt's attacks or asked the group to help clarify, via feedback, what was happening between Burt and Rose. If, as in this group, an important group event was being strongly avoided (Kate's departure), then it should be pointed out. In short, the therapist must determine what he or she thinks the group needs most at a particular time and help it move in that direction.

In another group, Saul sought therapy because of his deep sense of isolation. He was particularly interested in a group therapeutic experience because of his feeling that he had never been a part of a primary group. Even in his primary family, he had felt himself an outsider. He had been a spectator all his life, pressing his nose against cold windowpanes, gazing longingly at warm, convivial groups within.

At Saul's fourth therapy meeting, another member, Barbara, began the meeting by announcing that she had just broken up with a man who had been very important to her. Barbara's major reason for being in therapy had been her inability to sustain a relationship with a man, and she was profoundly distressed in the meeting. Barbara had an extremely poignant way of describing her pain, and the group was swept along with her feelings. Everyone in the group was very moved; I noted silently that Saul, too, had tears in his eyes.

The group members (with the exception of Saul) did everything in their power to offer Barbara support. They passed Kleenex; they reminded her of all her assets; they reassured Barbara that she had made a wrong choice, that the man was not good enough for her, that she was "lucky to be rid of that jerk."

Suddenly Saul interjected, "I don't like what's going on here in the group today, and I don't like the way it's being led" (a thinly veiled allusion to me, I thought). He went on to explain that the group members had no justification for their criticism of Barbara's ex-boyfriend. They didn't really know what he was like. They could see him only through Barbara's eyes, and probably she was presenting him in a distorted way. (Saul had a personal ax to grind on this matter, having gone through a divorce a couple of years previously. His wife had attended a women's support group, and he had been the "jerk" of that group.)

Saul's comments, of course, changed the entire tone of the meeting. The softness and support disappeared. The room felt cold; the warm bond among the members was broken. Everyone was on edge. I felt justifiably reprimanded. Saul's position was technically correct: the group was probably wrong to condemn Barbara's ex-boyfriend.

So much for the content. Now examine the process of this interaction. First, note that Saul's comment had the effect of putting him outside the group. The rest of the group was caught up in a warm, supportive atmosphere from which he excluded himself. Recall his chief complaint that he was never a member of a group, but always the outsider. The meeting provided an in vivo demonstration of how that came to pass. In his fourth group meeting, Saul had, kamikaze-style, attacked and voluntarily ejected himself from a group he wished to join.

A second issue had to do not with what Saul said but with what he did not say. In the early part of the group, everyone except Saul had made warm supportive statements to Barbara. I had no doubt but that Saul felt supportive of her. The tears in his eyes indicated that. Why had he chosen to be silent? Why did he always choose to respond from his critical self and not from his warmer, more supportive self?

The examination of the process of this interaction led us to some very important issues for Saul. Obviously it was difficult for him to express the softer, affectionate part of himself. He feared being vulnerable and exposing his dependent cravings. He feared losing himself, his precious individuality, by be-

coming a member of a group. Behind the aggressive, ever-vigilant, hard-nosed defender of honesty (honesty of expression of negative but not positive sentiments) there is always the softer, submissive child thirsting for acceptance and love.

In another group, Kevin, an overbearing business executive, opened the meeting by asking the other members—housewives, teachers, clerical workers, and shopkeepers—for help with a problem: he had received "downsizing" orders. He had to cut his staff immediately by 50 percent—to fire twenty out of his staff of forty.

The content of the problem was intriguing, and the group spent forty-five minutes discussing such aspects as justice versus mercy: that is, whether one retains the most competent workers or workers with the largest families or those who would have the greatest difficulty in finding other jobs. Despite the fact that most of the members engaged animatedly in the discussion, which involved important problems in human relations, the therapist strongly felt that the session was unproductive: the members remained in safe territory, and the discussion could have appropriately occurred at a dinner party or any other social gathering. Furthermore, as time passed, it became abundantly clear that Kevin had already spent considerable time thinking through all aspects of this problem, and no one was able to provide him with novel approaches or suggestions.

The continued focus on content was unrewarding and eventually frustrating for the group. The therapists began to wonder about process—what this content revealed about the nature of Kevin's relationship to the other members. As the meeting progressed, Kevin, on two occasions, let slip the amount of his salary (which was more than double that of any other member). In fact, the overall interpersonal effect of Kevin's presentation was to make others aware of his affluence and power.

The process became even more clear when the therapists recalled the previous meetings in which Kevin had attempted, in vain, to establish a special kind of relationship with one of the therapists (he had sought some technical information on psychological testing for personnel). Furthermore, in the preceding meeting, Kevin had been soundly attacked by the group for his fundamentalist religious convictions, which he used to criticize others' behavior but not his own propensity for extramarital affairs and compulsive lying. At that meeting, he had also been termed "thick-skinned" because of his appar-

ent insensitivity to others. One other important aspect of Kevin's group behavior was his dominance; almost invariably, he was the most active, central figure in the group meetings.

With this information about process, a number of alternatives were available. The therapists might have focused on Kevin's bid for prestige, especially following his loss of face in the previous meeting. Phrased in a nonaccusatory manner, a clarification of this sequence might have helped Kevin become aware of his desperate need for the group members to respect and admire him. At the same time, the self-defeating aspects of his behavior could have been pointed out. Despite his efforts to the contrary, the group had come to resent and, at times, even to scorn him. Perhaps, too, Kevin was attempting to disclaim the appellation of thick-skinned by sharing with the group in melodramatic fashion the personal agony he experienced in deciding how to cut his staff. The style of the intervention would have depended on Kevin's degree of defensiveness: if he had seemed particularly brittle or prickly, then the therapists might have underscored how hurt he must have been at the previous meeting. If Kevin had been more open, the therapists might have asked him directly what type of response he would have liked from the others.

Other therapists might have preferred to interrupt the content discussion and ask the group what Kevin's question had to do with last week's session. Still another alternative would be to call attention to an entirely different type of process by reflecting on the group's apparent willingness to permit Kevin to occupy center stage in the group week after week. By encouraging the members to discuss their response to his monopolization, the therapist could have helped the group initiate an exploration of their relationship to Kevin.

Process Focus: The Power Source of the Group

Process focus is not just one of many possible procedural orientations; on the contrary, it is indispensable and a common denominator to all effective interactional groups. One so often hears words to this effect: "No matter what else may be said about experiential groups (therapy groups, encounter groups, and so on), one cannot deny that they are potent—that they offer a compelling experience for participants." Why are these groups potent? Precisely because they encourage process exploration! The process focus is the power cell of the group!

A process focus is the one truly unique feature of the experiential group; after all, there are many socially sanctioned activities in which one can express emotions, help others, give and receive advice, confess and discover similarities between oneself and others. But where else is it permissible, in fact encouraged, to comment, in depth, on here-and-now behavior, on the nature of the immediately current relationship between people? Possibly only in the parent–young child relationship, and even then the flow is unidirectional. The parent, but not the child, is permitted process comments: "Don't look away when I talk to you!"; "Be quiet when someone else is speaking"; "Stop saying, 'I dunno.'"

But process commentary among adults is taboo social behavior; it is considered rude or impertinent. Positive comments about another's immediate behavior often denote a seductive or flirtatious relationship. When an individual comments negatively about another's manners, gestures, speech, physical appearance, we can be certain that the battle is bitter and the possibility of conciliation chancy.

The Therapist's Tasks in the Here-and-Now

In the first stage of the here-and-now focus, the activating phase, the therapist's task is to move the group into the here-and-now. By a variety of techniques, group leaders steer the group members away from discussion of outside material and focus their energy on their relationships with one another. Group therapists expend more time and effort on this task early in the course of the group. As the group progresses, the members come to value the here-and-now and will themselves focus on it and, by a variety of means, encourage their fellow members to do likewise.

It is altogether another matter with the second phase of the here-and-now orientation, process illumination. Forces prevent members from fully sharing that task with the therapist. One who comments on process sets himself or herself apart from the other members and is viewed with suspicion, as "not one of us." When a group member makes observations about what is happening in the group, the others often respond resentfully about the presumptuousness of elevating oneself above the others. If a member comments, for example, that "nothing is

happening today," or that "the group is stuck," or that "no one is self-revealing," or that "there seem to be strong feelings toward the therapist," then that member is courting danger. The response of the other members is predictable. They will challenge the challenging member: "*You* make something happen today," or "you reveal *yourself,*" or "*you* talk about *your* feelings to the therapist." Only the therapist is relatively exempt from that charge. Only the therapist has the right to suggest that others work, or that others reveal themselves, without having to engage personally in the act he or she suggests.

Throughout the life of the group, the members are involved in a struggle for positions in the hierarchy of dominance. At times, the conflict around control and dominance is flagrant; at other times, quiescent. But it never vanishes. Some members strive nakedly for power; others strive subtly; others desire it but are fearful of assertion; others always assume an obsequious, submissive posture. Statements by members that suggest that they place themselves above or outside the group generally evoke responses that emerge from the dominance struggle rather than from consideration of the content of the statement. Even therapists are not entirely immune to evoking this response; some patients are inordinately sensitive to being controlled or manipulated by the therapist. They find themselves in the paradoxical position of applying to the therapist for help and being unable to accept help because all statements by the therapist are viewed through spectacles of distrust. This is a function of the specific pathology of some patients (and it is, of course, good grist for the therapeutic mill). It is not a universal response of the entire group.

The therapist is an *observer-participant* in the group. The observer status affords the objectivity necessary to store information, to make observations about sequences or cyclical patterns of behavior, to connect events that have occurred over long periods of time. Therapists act as the group historian. Only they are permitted to maintain a temporal perspective; only they remain immune from the charge of not being one of the group, of elevating themselves above the others. It is also only the therapists who keep in mind the original goals of the patient and the relationship between these goals and the events that gradually unfold in the group.

Two patients, Tim and Marjorie, had a sexual affair that eventually came to light in the group. The other members reacted in various ways but none so condemnatory nor so vehemently as Diana, a forty-five-year-old nouveau-moralist, who criticized them both for breaking group rules: Tim, for "being too intelligent to act like such a fool," Marjorie for her "irresponsible disregard for her husband and child," and the Lucifer therapist (me) who "just sat there and let it happen." I eventually pointed out that, in her formidable moralistic broadside, some individuals had been obliterated, that the Marjorie and Tim with all their struggles and doubts and fears whom Diana had known for so long had suddenly been replaced by faceless one-dimensional stereotypes. Furthermore, I was the only one to recall, and to remind the group, of the reasons (expressed at the first group meeting) why Diana had sought therapy: namely, that she needed help in dealing with her rage toward a nineteen-year-old, rebellious, sexually awakening daughter who was in the midst of a search for her identity and autonomy! From there it was but a short step for the group, and then for Diana herself, to understand that her conflict with her daughter was being played out in the here-and-now of the group.

There are many occasions when the process is obvious to all the members in the group but they cannot comment on it simply because the situation is too hot: they are too much a part of the interaction to separate themselves from it. In fact, often, even at a distance, the therapist too feels the heat and is wary about naming the beast.

One neophyte therapist, when leading an experiential group of pediatric oncology nurses (a support group intended to help members decrease the stress experienced in their work), learned through collusive glances between members in the first meeting that there was considerable unspoken tension between the young, progressive nurses and the older, conservative nursing supervisors in the group. The therapist felt that the issue, reaching deep into taboo regions of the authority-ridden nursing profession, was too sensitive and potentially explosive to touch. His supervisor assured him that it was too important an issue to leave unexplored and that he should broach it, since it was highly unlikely that anyone else in the group could do what he dared not.

In the next meeting, the therapist broached the issue in a manner that is

almost invariably effective in minimizing defensiveness: he stated his own dilemma about the issue. He told the group that he sensed a hierarchical struggle between the junior nurses and the powerful senior nurses, but that he was hesitant to bring it up lest the younger nurses either deny it or so attack the supervisors that the latter would suffer injury or decide to scuttle the group. His comment was enormously helpful and plunged the group into an open and constructive exploration of a vital issue.

I do not mean that only the leader should make process comments. Other members are entirely capable of performing this function; in fact, there are times when their process observations will be more readily accepted than those of the therapists. What is important is that they not engage in this function for defensive reasons—for example, to avoid the patient role or in any other way to distance themselves from or elevate themselves above the other members.

Thus far in this discussion I have, for pedagogical reasons, overstated two fundamental points that I must now qualify. Those points are: (1) the here-and-now approach is an ahistoric one, and (2) there is a sharp distinction between here-and-now experience and here-and-now process illumination.

Strictly speaking, an ahistoric approach is an impossibility: every process comment refers to an act already belonging to the past. (Sartre once said, "Introspection is retrospection.") Not only does process commentary involve behavior that has just transpired, but it frequently refers to cycles of behavior or repetitive acts that have occurred in the group over weeks or months. Thus, the past events of the therapy group are a part of the here-and-now and an integral part of the data on which process commentary is based.

Often it is helpful to ask patients to review their past experiences in the group. If a patient feels that she is exploited every time she trusts someone or reveals herself, I often inquire about her history of experiencing that feeling in this group. Other patients, depending upon the relevant issues, may be encouraged to discuss such experiences as the times they have felt most close to others, most angry, most accepted, or most ignored.

My qualification of the ahistoric approach goes even further. No

group can maintain a total here-and-now approach. There will be frequent excursions into the "then-and-there"—that is, into personal history and into current life situations. In fact, these excursions are so inevitable that one becomes curious when they do not occur. It is not that the group doesn't deal with the past; it is what is done with the past: the crucial task is not to uncover, to piece together, and to understand the past, *but to use the past for the help it offers in understanding (and changing) the individual's mode of relating to the others in the present.*

Summary

The effective use of the here-and-now focus requires two steps: experience in here-and-now and process illumination. The combination of these two steps imbues an experiential group with compelling potency.

The therapist has different tasks in each step. First, the group must be plunged into the here-and-now experience; second, the group must be helped to understand the process of the here-and-now experience: that is, what the interaction conveys about the nature of the members' relationships to one another.

The first step, here-and-now activation, becomes part of the group norm structure; ultimately the group members will assist the therapist in this chore.

The second step, process illumination, is more difficult. There are powerful injunctions against process commentary in everyday social intercourse which the therapist must overcome. The task of process commentary, to a great extent, remains the responsibility of the therapist and consists, as I will discuss shortly, of a wide and complex range of behavior—from labeling single behavioral acts, to juxtaposing several acts, to combining acts over time into a pattern of behavior, to pointing out the undesirable consequences of a patient's behavioral patterns, to more complex inferential explanations or interpretations about the meaning and motivation of such behavior.

Techniques of Here-and-Now Activation

Each therapist must develop techniques consonant with his or her style. Indeed, therapists have a more important task than mastering a tech-

nique: they must fully comprehend the strategy and theoretical foundations upon which all effective technique must rest.

I suggest that you *think* here-and-now. When you grow accustomed to thinking of the here-and-now, you automatically steer the group into the here-and-now. Sometimes I feel like a shepherd herding a flock into an ever-tightening circle. I head off errant strays—forays into personal historical material, discussions of current life situations, intellectualisms—and guide them back into the circle. Whenever an issue is raised in the group, I think, "How can I relate this to the group's primary task? How can I make it come to life in the here-and-now?" *I am relentless in this effort, and I begin it in the very first meeting of the group.*

Consider a typical first meeting of a group. After a short, awkward pause, the members generally introduce themselves and proceed, often with help from the therapist, to tell something about their life problems, why they have sought therapy, and perhaps, the type of distress they suffer. I generally intervene at some convenient point well into the meeting and remark to the effect that "We've done a great deal here today so far. Each of you has shared a great deal about yourself, your pain, your reasons for seeking help. But I have a hunch that something else is also going on, and that is that you're sizing one another up, each arriving at some impressions of the other, each wondering how you'll fit in with the others. I wonder now if we could spend some time discussing what each of us has come up with thus far." Now this is no subtle, artful, shaping statement: it is a heavy-handed, explicit directive. Yet I find that most groups respond favorably to such clear guidelines.

The therapist moves the focus from outside to inside, from the abstract to the specific, from the generic to the personal. If a patient describes a hostile confrontation with a spouse or roommate, the therapist may, at some point, inquire, "If you were to be angry like that with anyone in the group, with whom would it be?" or "With whom in the group can you foresee getting into the same type of struggle?" If a patient comments that one of his problems is that he lies, or that he stereotypes people, or that he manipulates groups, the therapist may inquire, "What is the main lie you've told in the group thus far?" or "Can you describe the way you've stereotyped some of us?" or "To what extent have you manipulated the group thus far?"

If a patient complains of mysterious flashes of anger or suicidal com-

pulsions, the therapist may urge the patient to signal to the group the very moment such feelings occur during the session, so that the group can track down and relate these experiences to events in the session.

In each of these instances, the therapist can deepen interaction by encouraging further responses from the others. For example, "How do you feel about the perception of your ridiculing him? Can you imagine doing that? Do you, at times, feel judgmental in the group? Does this resonate with feelings that you are indeed influential, angry, too tactful?" Even simple techniques of asking patients to speak directly to one another, to use second-person pronouns ("you") rather than third-person pronouns, and to look at one another are very useful.

Easier said than done! These suggestions are not always heeded. To some patients, they are threatening indeed, and the therapist must here, as always, employ good timing and attempt to experience what the patient is experiencing. Search for methods that lessen the threat. Begin by focusing on positive interaction: "Toward whom in the group do you feel most warm?" "Who in the group is most like you?" or "Obviously, there are some strong vibes, both positive and negative, going on between you and John. I wonder what you most envy about him? And what parts of him do you find most difficult to accept?"

Sometimes it is easier for group members to work in tandem or in small subgroups. For example, if they learn that there is another member with similar fears or concerns, then the subgroup of two (or more) members can, with less threat, discuss their here-and-now concerns.[1]

Using the conditional and subjunctive tenses provides safety and distance and often is miraculously facilitative. I use them frequently when I encounter initial resistance. If, for example, a patient says, "I don't have any response or feelings at all about Mary today. I'm just feeling too numb and withdrawn," I often say something like, "If you were not numb or withdrawn today, what might you feel about Mary?" The patient generally answers readily: the once-removed position affords a refuge and encourages the patient to answer honestly and directly. Similarly, the therapist might inquire, "If you were to be angry at someone in the group, at whom would it be?" or "If you were to go on a date with Albert (another group member), what kind of experience might it be?"

The therapist must often give instruction in the art of requesting and

offering feedback. One important principle to teach patients is to avoid global questions and observations. Questions such as "Am I boring?" or "Do you like me?" are not usually productive. A patient learns a great deal more by asking, "What do I do that causes you to tune out?" "When are you most and least attentive to me?" or "What parts of me or aspects of my behavior do you like least and most?" In the same vein, feedback such as "You're OK," or "a nice guy" is far less useful than "I feel closer to you when you're willing to be honest with your feelings, like in last week's meeting when you said you were attracted to Mary but feared she would scorn you. I feel most distant from you when you're impersonal and start analyzing the meaning of every word said to you, like you did early in the meeting today." (These comments, incidentally, have equal applicability in individual therapy.)

Resistance occurs in many forms. Often it appears in the cunning guise of total equality. Patients, especially in early meetings, often respond to the therapist's here-and-now urgings by claiming that they feel exactly the same toward all the group members: that is, they say that they feel equally warm toward all the members, or no anger toward any, or equally influenced or threatened by all. Do not be misled. Such claims are never true. Guided by your sense of timing, push the inquiry further and help members to differentiate one from the other. Eventually they will disclose that they do have slight differences of feeling toward some of the members. These slight differences are important and are often the vestibule to full interactional participation. I explore the slight differences (no one ever said they had to be enormous); sometimes I suggest that the patient hold up a magnifying glass to these differences and describe what he or she then sees and feels. Often resistance is deeply ingrained, and considerable ingenuity is required, as in the following case study.

Claudia resisted participation on a here-and-now level for months. Keep in mind that resistance is not usually conscious obstinacy but more often stems from sources outside of awareness. Sometimes the here-and-now task is so unfamiliar and uncomfortable to the patient that it is not unlike learning a new language; one has to attend with maximal concentration in order not to slip back into one's habitual remoteness.

Claudia's typical mode of relating to the group was to describe some

pressing current life problem, often one of such crisis proportions that the group members felt trapped. First, they felt compelled to deal immediately with the precise problem Claudia presented; second, they had to tread cautiously because she explicitly informed them that she needed all her resources to cope with the crisis and could not afford to be shaken up by interpersonal confrontation. "Don't push me right now," she might say, "I'm just barely hanging on." Efforts to alter this pattern were unsuccessful, and the group members felt discouraged in dealing with Claudia. They cringed when she brought in problems to the meeting.

One day she opened the group with a typical gambit. After weeks of searching she had obtained a new job, but she was convinced that she was going to fail and be dismissed. The group dutifully, but warily, investigated the situation. The investigation met with many of the familiar, treacherous obstacles that generally block the path of work on outside problems. There seemed to be no objective evidence that Claudia was failing at work. She seemed, if anything, to be trying too hard, working eighty hours a week. The evidence, Claudia insisted, simply could not be appreciated by anyone not there at work with her: the glances of her supervisor, the subtle innuendoes, the air of dissatisfaction toward her, the general ambiance in the office, the failure to live up to her (self-imposed and unrealistic) sales goals. Could Claudia be believed? She was a highly unreliable observer; she always downgraded herself and minimized her accomplishments and strengths.

The therapist moved the entire transaction into the here-and-now by asking, "Claudia, it's hard for us to determine whether you are, in fact, failing at your job. But let me ask you another question: What grade do you think you deserve for your work in the group, and what do each of the others get?"

Claudia, not unexpectedly, awarded herself a "D" and staked her claim for at least eight more years in the group. She awarded all the other members substantially superior grades. The therapist replied by awarding Claudia a "B" for her work in the group and then went on to point out the reasons: her commitment to the group, perfect attendance, willingness to help others, great efforts to work despite anxiety and often disabling depression.

Claudia laughed it off; she tried to brush off the incident as a gag or a therapeutic ploy. But the therapist held firm and insisted that he was entirely serious. Claudia then insisted that the therapist was wrong, and pointed out his many failings in the group (one of which was, ironically, the avoidance of

the here-and-now). However, Claudia's disagreement with the therapist was incompatible with her long-held, frequently voiced, total confidence in the therapist. (Claudia had often invalidated the feedback of other members in the group by claiming that she trusted no one's judgment except the therapist's.)

The intervention was enormously useful and transferred the process of Claudia's evaluation of herself from a secret chamber lined with the distorting mirrors of her self-perception to the open, vital arena of the group. No longer was it necessary for the members to accept Claudia's perception of her boss's glares and subtle innuendoes. The boss (the therapist) was there in the group. The transaction, in its entirety, was entirely visible to the group.

I never cease to be awed by the rich, subterranean lode of data that exists in every group and in every meeting. Beneath each sentiment expressed there are layers of invisible, unvoiced ones. But how to tap these riches? Sometimes after a long silence in a meeting, I express this very thought: "There is so much information that could be valuable to us all today if only we could excavate it. I wonder if we could, each of us, tell the group about some thoughts that occurred to us in this silence, which we thought of saying but didn't." The exercise is more effective, incidentally, if you participate personally, even start it going. For example, "I've been feeling on edge in the silence, wanting to break it, not wanting to waste time, but on the other hand feeling irritated that it always has to be me doing this work for the group." Or, "I've been feeling torn between wanting to get back to the struggle between you and me, Mike. I feel uncomfortable with this much tension and anger, but I don't know yet how to help understand and resolve it."

When I feel there has been a particularly great deal unsaid in a meeting, I have often used, with success, a technique such as this: "It's now six o'clock and we still have half an hour left, but I wonder if you each would imagine that it's already six-thirty and that you're on your way home. What disappointments would you have about the meeting today?"

Many of the observations the therapist makes may be highly inferential. Objective accuracy is not the issue; as long as you persistently direct

the group from the nonrelevant, from the then-and-there, to the here-and-now, you are operationally correct. If a group spends time in an unproductive meeting discussing dull, boring parties, and the therapist wonders aloud if the members are indirectly referring to the present group session, there is no way of determining with any certainty whether they in fact are. Correctness in this instance must be defined relativistically and pragmatically. By shifting the group's attention from then-and-there to here-and-now material, the therapist performs a service to the group—a service that, consistently reinforced, will ultimately result in a cohesive, interactional atmosphere maximally conducive to therapy. Following this model, the effectiveness of an intervention should be gauged by its success in focusing the group on itself.

Often, when activating the group, the therapist performs two simultaneous acts: steers the group into the here-and-now and, at the same time, interrupts the content flow in the group. Not infrequently, some members will resent or feel rejected by the interruption, and the therapist must attend to these feelings for they, too, are part of the here-and-now. This consideration often makes it difficult for the therapist to intervene. Early in our socialization process we learn not to interrupt, not to change the subject abruptly. Furthermore, there are times in the group when everyone seems keenly interested in the topic under discussion. Even though the therapist is certain that the group is not working, it is not easy to buck the group current. Social psychological small group research strongly documents the compelling force of group pressure. To take a stand opposite to the perceived consensus of the group requires considerable courage and conviction.

My experience is that the therapist faced with this type of dilemma can increase the patient's receptivity by expressing both sets of feelings to the group. For example, "Mary, I feel very uncomfortable as you talk. I'm having a couple of strong feelings. One is that you're into something that is very important and painful for you, and the other is that Ben [a new member] has been trying hard to get into the group for the last few meetings and the group seems unwelcoming. This didn't happen when other new members entered the group. Why do you think it's happening now?" Or, "Warren, I had two reactions as you started talking. The first is that I'm delighted you feel comfortable enough now in the group

to participate, but the other is that it's going to be hard for the group to respond to what you're saying because it's very abstract and far removed from you personally. I'd be much more interested in how you've been feeling about the group these past few weeks. Which meetings, which issues, have you been most tuned in to? What reactions have you had to the various members?"

There are, of course, many more activating procedures. But my goal in this chapter is not to offer a compendium of techniques. Quite the contrary. I describe techniques only to illuminate the underlying principle of here-and-now activation. These techniques, or group gimmicks, are servants, not masters. To use them injudiciously, to fill voids, to jazz up the group, to acquiesce to the members' demands that the leader lead, is seductive but not constructive for the group.

Group research offers corroborative evidence. In one group project, the activating techniques (structured exercises) of sixteen different leaders were studied and correlated with outcome.[2] There were two important relevant findings:

1. The more structured exercises the leader used, the more competent did members (at the end of the thirty-hour group) deem the leader to be.
2. The more structured exercises used by the leader, the less positive were the results (measured at a six-month follow-up).

In other words, members desire leaders who lead, who offer considerable structure and guidance. They equate a large number of structured exercises with competence. Yet this is a confusion of form and substance: too much structure, too many activating techniques, is counterproductive.

Overall, group leader activity correlates with outcome in a curvilinear fashion (too much or too little activity led to unsuccessful outcome). Too little leader activity results in a floundering group. Too much activation by a leader results in a dependent group that persists in looking to the leader to supply too much.

Remember that sheer acceleration of interaction is not the purpose of these techniques. The therapist who moves too quickly—using gim-

micks to make interactions, emotional expression, and self-disclosure too easy—misses the whole point. Resistance, fear, guardedness, distrust—in short, everything that impedes the development of satisfying interpersonal relations—must be permitted expression. The goal is to create not a slick-functioning, streamlined social organization, but one that functions well enough and engenders sufficient trust for the unfolding of each member's social microcosm. Working through the resistances to change is the key to the production of change. Thus, the therapist wants to go not around obstacles but through them. Ormont puts it nicely when he points out that though we urge patients to engage deeply in the here-and-now, we expect them to fail, to default on their contract. In fact, we want them to default because we hope, through the nature of their failure, to identify, and ultimately dispel, each member's particular resistances to intimacy—including each member's resistance style (for example, detachment, fighting, diverting, self-absorption, distrust) and each member's underlying fears of intimacy (for example, impulsivity, abandonment, merger, vulnerability).[3]

Techniques of Process Illumination

As soon as patients have been successfully steered into a here-and-now interactional pattern, the group therapist must attend to turning this interaction to therapeutic advantage. This task is complex and consists of several stages:

1. Patients must first recognize what they are doing with other people (ranging from simple acts to complex patterns unfolding over a long time).
2. They must then appreciate the impact of this behavior on others and how it influences others' opinion of them, and consequently the impact of the behavior on their own self-regard.
3. They must decide whether they are satisfied with their habitual interpersonal style.
4. They must exercise the will to change.

Even when therapists have helped patients transform intent into decision and decision into action, their task is not complete. They must

then help solidify change and transfer it from the group setting into patients' larger lives.

Each of these stages may be facilitated by some specific cognitive input by the therapist, and I will describe each step in turn. First, however, I must discuss several prior and basic considerations: How does the therapist recognize process? How can the therapist help the members to assume a process orientation? How can the therapist increase the receptivity of the patient to his or her process commentary?

Recognition of Process

Before therapists can help patients understand process, they themselves must obviously learn to recognize it. The experienced therapist does this naturally and effortlessly, observing the group proceedings from a perspective that permits a continuous view of the process underlying the content of the group discussion. This difference in perspective is the major difference in role between the patient and the therapist in the group.

Consider a group meeting in which a patient, Karen, discloses much heavy, deeply personal material. The group is moved by her account and devotes much time to listening, to helping her elaborate more fully, and to offering her support. The group therapist shares in these activities but entertains many other thoughts as well. For example, the therapist may wonder why, of all the members, it is invariably Karen who reveals first and most. Why does Karen so often put herself in the role of the group patient whom all the members must nurse? Why must she always display herself as vulnerable? And why today? And that last meeting! So much conflict! After such a meeting, one might have expected Karen to be angry. Instead, she shows her throat. Is she avoiding giving expression to her rage?

At the end of a session in another group, Jay, a young, rather fragile patient, had, amid considerable emotional upheaval, revealed that he was gay—his very first step out of the closet. At the next meeting the group urged him to continue. He attempted to do so but, overcome with emotion, blocked and hesitated. Just then, with indecent alacrity, Vicky filled the gap, saying, "Well, if no one else is going to talk, I have a problem."

Vicky, an aggressive forty-year-old cabdriver, who sought therapy because of social loneliness and bitterness, proceeded to discuss in endless detail a complex situation involving an unwelcome visiting aunt. For the experienced, process-oriented therapist, the phrase "I have a problem" is a double entendre. Far more trenchantly than her words, Vicky's behavior says, "I have a problem," and her problem is manifest in her insensitivity to Jay, who, after months of silence, had finally mustered the courage to speak.

It is not easy to tell the beginning therapist how to recognize process; the acquisition of this perspective is one of the major tasks in your education. And it is an interminable task: throughout your career, you learn to penetrate ever more deeply into the substratum of group discourse. This deeper vision increases the keenness of a therapist's interest in the meeting. Generally, beginning students who observe meetings find them far less meaningful, complex, and interesting than does the experienced therapist.

Certain guidelines, though, may facilitate the neophyte therapist's recognition of process. Note the simple nonverbal sense data available.[4] Who chooses to sit where? Which members sit together? Who chooses to sit close to the therapist? Far away? Who sits near the door? Who comes to the meeting on time? Who is habitually late? Who looks at whom when speaking? Do some members, while speaking to another member, look at the therapist? If so, then they are relating not to one another but instead to the therapist through their speech to the others. Who looks at his watch? Who slouches in her seat? Who yawns? Do the members pull their chairs away from the center at the same time as they are verbally professing great interest in the group? Are coats kept on? When in a single meeting or in the sequence of meetings are they removed? How quickly do the group members enter the room? How do they leave it?

Sometimes the process is clarified by attending *not only to what is said but to what is omitted:* the female patient who offers suggestions, advice, or feedback to the male patients but never to the other women in the group; the group that never confronts or questions the therapist; the topics (for example, the taboo trio: sex, money, death) that are never broached; the patient who is never attacked; the one who is never sup-

ported; the one who never supports or inquires—all these omissions are part of the transactional process of the group.

In one group, for example, Sonia stated that she felt others disliked her. When asked who, she selected Eric, a detached, aloof man who habitually related only to those people who could be of use to him. Eric immediately bristled, "Why me? Tell me one thing I've said to you that makes you pick me." Sonia stated, "That's exactly the point. You have no use for me. You've never said anything to me. Not a question, not a greeting. Nothing. I just don't exist for you." Eric, much later, when completing therapy, cited this incident as a particularly powerful and illuminating instruction.

Physiologists commonly study the function of a hormone by removing the endocrine gland that manufactures it and observing the changes in the hormone-deficient organism. Similarly, in group therapy, we may learn a great deal about the role of a particular member by observing the here-and-now process of the group when that member is absent. For example, if the absent member is aggressive and competitive, the group may feel liberated. Other patients, who had felt threatened or restricted in the missing member's presence, may suddenly blossom into activity. If, on the other hand, the group has depended on the missing member to carry the burden of self-disclosure or to coax other members into speaking, then it will feel helpless and threatened when that member is absent. Often this absence elucidates interpersonal feelings that previously were entirely out of the group members' awareness, and the therapist may, with profit, encourage the group to discuss these feelings toward the absent member both at that time and later in his or her presence.

Similarly, a rich supply of data about feelings toward the therapist often emerges in a meeting in which the leader is absent. One leader led an experiential training group of mental health professionals composed of one woman and twelve men. The woman, though she habitually took the chair closest to the door, felt reasonably comfortable in the group until a leaderless meeting was scheduled when the therapist was out of town. At that meeting the group discussed sexual feelings and experiences far more blatantly than ever before, and the woman had terrifying fantasies of the group locking the door and raping her. She

realized how the therapist's presence had offered her safety against fears of unrestrained sexual behavior by the other members and against the emergence of her own sexual fantasies. (She realized, too, the meaning of her occupying the seat nearest the door!)

Search in every possible way to understand the relationship messages in any communication. Look for incongruence between verbal and nonverbal behavior. Be especially curious when there is something arrhythmic about a transaction: when, for example, the intensity of a response seems disproportionate to the stimulus statement; or when a response seems to be off target or to make no sense. At these times look for several possibilities: for example, *parataxic distortion* (the responder is experiencing the sender unrealistically), or *metacommunications* (the responder is responding, accurately, not to the manifest content but to another level of communication), or *displacement* (the responder is reacting not to the current transaction but to feelings stemming from previous transactions).

Common Group Tensions

Remember that certain tensions are always present, to some degree, in every therapy group. Consider, for example, such tensions as the struggle for dominance, the antagonism between mutually supportive feelings and sibling rivalrous ones, between greed and selfless efforts to help the other, between the desire to immerse oneself in the comforting waters of the group and the fear of losing one's precious individuality, between the wish to get better and the wish to stay in the group, between the wish that others improve and the fear of being left behind. Sometimes these tensions are quiescent for months until some event wakens them and they erupt into plain view.

Do not forget these tensions. They are always there, always fueling the hidden motors of group interaction. The knowledge of these tensions often informs the therapist's recognition of process. Consider, for example, one of the most powerful covert sources of group tension: the struggle for dominance. Earlier in this chapter, I described an intervention where the therapist, in an effort to steer a patient into the here-and-now, gave her a grade for her work in the group. The intervention was effective for that particular patient. Yet that was not the end of the

story: there were later repercussions on the rest of the group. In the next meeting, two patients asked the therapist to clarify some remark he had made to them at a previous meeting. The remarks had been so supportive in nature and so straightforwardly phrased that the therapist was puzzled at the request for clarification. Deeper investigation revealed that the two patients, and later others, too, were requesting grades from the therapist.

In another experiential group of mental health professionals at several levels of training, the leader was deeply impressed at the group skills of Stewart, one of the youngest, most inexperienced members. The leader expressed his fantasy that Stewart was a plant, that he could not possibly be just beginning his training, since he conducted himself like a veteran with ten years' group experience. The comment evoked a flood of tensions. It was not easily forgotten by the group and, for months to come, was periodically revived and angrily discussed. With his comment, the therapist placed the kiss of death on Stewart's brow, since thereafter the group systematically challenged and deskilled him. It is likely that the therapist who makes a positive evaluation of one member will evoke feelings of sibling rivalry.

The struggle for dominance fluctuates in intensity throughout the group. It is much in evidence at the beginning of the group as members jockey for position in the pecking order. Once the hierarchy is established, the issue may become quiescent, with periodic flare-ups: for example, when some member, as part of his or her therapeutic work, begins to grow in assertiveness and to challenge the established order.

When new members enter the group, especially aggressive members who do not know their place, who do not respectfully search out and honor the rules of the group, you may be certain that the struggle for dominance will rise to the surface.

In one group a veteran member, Betty, was much threatened by the entrance of a new, aggressive woman, Rena. A few meetings later, when Betty discussed some important material concerning her inability to assert herself, Rena attempted to help by commenting that she, herself, used to be like that, and then she presented various methods she had used to overcome it. Rena reassured Betty that if she continued to talk about it openly in the group she,

too, would gain considerable confidence. Betty's response was silent fury of such magnitude that several meetings passed before she could discuss and work through her feelings. To the uninformed observer, Betty's response would appear puzzling; but in the light of Betty's seniority in the group and Rena's vigorous challenge to that seniority, her response was entirely predictable. She responded not to Rena's manifest offer of help but instead to Rena's metacommunication: "I'm more advanced than you, more mature, more knowledgeable about the process of psychotherapy, and more powerful in this group despite your longer presence here."

Process Commentary: A Theoretical Overview

It is not easy to discuss, in a systematic way, the actual practice of process illumination. How can one propose crisp, basic guidelines for a procedure of such complexity and range, such delicate timing, so many linguistic nuances? I am tempted to beg the question by claiming that herein lies the art of psychotherapy: it will come as you gain experience; you cannot, in a systematic way, come to it. To a degree, I believe this to be so. Yet I also believe that it is possible to blaze crude trails, to provide the clinician with general principles that will accelerate education without limiting the scope of artistry.

The approach I take in this section closely parallels the approach I use to clarify the basic therapeutic factors in group therapy. Here the issue is not how group therapy helps but how process illumination leads to change. The issue is complex and requires considerable attention, but the length of this discussion should not suggest that the interpretive function of the therapist takes precedence over other tasks.

First, let me proceed to view in a dispassionate manner the entire range of interpretive comments. I ask of each the simplistic but basic question, "How does this interpretation, this process-illuminating comment, help a patient to change?" Such an approach, consistently followed, reveals a set of basic operational patterns.

I begin by considering a series of process comments that a therapist made to a male patient over several months of group therapy:

1. You are interrupting me.
2. Your voice is tight, and your fists are clenched.

3. Whenever you talk to me, you take issue with me.

4. When you do that, I feel threatened and sometimes frightened.

5. I think you feel very competitive with me and are trying to devalue me.

6. I've noticed that you've done the same thing with all the men in the group. Even when they try to approach you helpfully, you strike out at them. Consequently, they see you as hostile and threatening.

7. In the three meetings when there were no women present in the group, you were more approachable.

8. I think you're so concerned about your sexual attractiveness to women that you view men only as competitors. You deprive yourself of the opportunity of ever getting close to a man.

9. Even though you always seem to spar with me, there seems to be another side to it. You often stay after the group to have a word with me; you frequently look at me in the group. And there's that dream you described three weeks ago about the two of us fighting and then falling to the ground in an embrace. I think you very much want to be close to me, but somehow you've got closeness and homosexuality entangled and you keep pushing me away.

10. You are lonely here and feel unwanted and uncared for. That rekindles so many of your bad feelings of unworthiness.

11. What's happened in the group now is that you've distanced yourself, estranged yourself, from all the men here. Are you satisfied with that? (Remember that one of your major goals when you started the group was to find out why you haven't had any close men friends and to do something about that.)

Note, first of all, that the comments form a progression: they start with simple observations of single acts and proceed to a description of feelings evoked by an act, to observations about several acts over a period of time, to the juxtaposition of different acts, to speculations about the patient's intentions and motivations, to comments about the unfortunate repercussions of his behavior, to the inclusion of more inferential data (dreams, subtle gestures), to calling attention to the similarity between the patient's behavioral patterns in the here-and-now and in his outside social world.

In this progression, the comments become more inferential. They

begin with sense-data observations and gradually shift to complex generalizations based on sequences of behavior, interpersonal patterns, fantasy, and dream material. As the comments become more complex and more inferential, their author becomes more removed from the other person—in short, more a therapist process-commentator. Members often make some of the earlier statements to one another but rarely make the ones at the end of the sequence.

There is, incidentally, an exceptionally sharp barrier between comments 4 and 5. The first four statements issue from the experience of the commentator. They are the commentator's observations and feelings; the patient can devalue or ignore them but cannot deny them, disagree with them, or take them away from the commentator. The fifth statement ("I think you feel very competitive with me and are trying to devalue me") is much more likely to evoke defensiveness and to close down constructive interactional flow. This genre of comment is intrusive; it is a guess about the other's intention and motivation and is often rejected unless an important trusting, supportive relationship has been previously established. If members in a young group make many "type 5" comments to one another, they are not likely to develop a constructive therapeutic climate.[5]

But how does this series (or any series of process comments) help the patient change? In making these process comments, the group therapist initiates change by escorting the patient through the following sequence:

1. Here is what your behavior is like. Through feedback and later through self-observation, members learn to see themselves as seen by others.

2. Here is how your behavior makes others feel. Members learn about the impact of their behavior on the feelings of other members.

3. Here is how your behavior influences the opinions others have of you. Members learn that, as a result of their behavior, others value them, dislike them, find them unpleasant, respect them, avoid them, and so on.

4. Here is how your behavior influences your opinion of yourself. Building on the information gathered in the first three steps, patients formulate self-evaluations; they make judgments about their self-worth

and their lovability. (Recall Sullivan's aphorism that the self-concept is largely constructed from reflected self-appraisals.)

Once this sequence has been developed and is fully understood by the patient, once patients have a deep understanding that their behavior is not in their own best interests, that relationships to others and to themselves are a result of their own actions, then they have come to a crucial point in therapy: they have entered the antechamber of change. The therapist is now in a position to pose a question that initiates the real crunch of therapy. The question, presented in a number of ways by the therapist but rarely in direct form, is: Are you satisfied with the world you have created? This is what you do to others, to others' opinion of you, and to your opinion of yourself—are you satisfied with your actions?

When the inevitable negative answer arrives, the therapist embarks on a many-layered effort to transform a sense of personal dissatisfaction into a decision to change and then into the act of change. In one way or another, the therapist's interpretive remarks are designed to encourage the act of change. Only a few psychotherapy theoreticians (for example, Otto Rank, Rollo May, Silvano Arieti, Leslie Farber, Allen Wheelis, and myself)[6] include the concept of will in their formulations, yet it is, I believe, implicit in most interpretive systems. I discuss the role of will in psychotherapy in great detail elsewhere, and I refer interested readers to that publication.[7] For now, broad brush strokes are sufficient.

The intrapsychic agency that initiates an act, that transforms intention and decision into action, is will. Will is the primary responsible mover within the individual. Although modern analytic metapsychology has chosen to emphasize the irresponsible movers of our behavior (that is, unconscious motivations and drives),[8] it is difficult to do without the idea of will in our understanding of change. We cannot bypass it under the assumption that it is too nebulous and too elusive, and consequently consign it to the black box of the mental apparatus, to which the therapist has no access.

Knowingly or unknowingly, every therapist assumes that each patient possesses the capacity to change through willful choice. The therapist, using a variety of strategies and tactics, attempts to escort the

patient to a crossroads where he or she can choose, choose willfully in the best interests of his or her own integrity. The therapist's task is not to create will or to infuse it into the patient. That, of course, you cannot do. What you can do is to help remove encumbrances from the bound or stifled will of the patient.

The concept of will provides a useful construct for understanding the procedure of process illumination. The interpretive remarks of the therapist can all be viewed in terms of how they bear on the patient's will. The most common and simplistic therapeutic approach is exhortative: "Your behavior is, as you yourself now know, counter to your best interests. You are not satisfied. This is not what you want for yourself. Damn it, change!"

The expectation that the patient will change is simply an extension of the moral philosophical belief that if one knows the good (that is, what is, in the deepest sense, in one's best interest), one will act accordingly. In the words of St. Thomas Aquinas: "Man, insofar as he acts willfully, acts according to some imagined good."[9] And, indeed, for some individuals this knowledge and this exhortation are sufficient to produce therapeutic change.

However, patients with significant and well-entrenched psychopathology generally need much more than exhortation. The therapist, through interpretive comments, then proceeds to exercise one of several other options that help patients to disencumber their will. The therapist's goal is to guide patients to a point where they accept one, several, or all of the following basic premises:

1. Only I can change the world I have created for myself.
2. There is no danger in change.
3. To attain what I really want, I must change.
4. I can change; I am potent.

Each of these premises, if fully accepted by a patient, can be a powerful stimulant to willful action. Each exerts its influence in a different way. Though I will discuss each in turn, I do not wish to imply a sequential pattern. Each, depending on the need of the patient and the style of the therapist, may be effective independently of the others.

"Only I can change the world I have created for myself."

Behind the simple group therapy sequence I have described (seeing one's own behavior and appreciating its impact on others and on oneself), there is a mighty overarching concept, one whose shadow touches every part of the therapeutic process. That concept is responsibility. Though it is rarely discussed explicitly, it is woven into the fabric of most psychotherapeutic systems. Responsibility has many meanings—legal, religious, ethical. I use it in the sense that a person is "responsible for" by being the "basis of," the "cause of," the "author of" something.

One of the most fascinating aspects of group therapy is that everyone is born again, born together in the group. Each member starts off on an equal footing. In the view of the others (and, if the therapist does a good job, in the view of oneself), each gradually scoops out and shapes a life space in the group. Each member, in the deepest sense of the concept, is responsible for this space and for the sequence of events that will occur to him or her in the group. The patient, having truly come to appreciate this responsibility, must then accept, too, that there is no hope for change unless he or she changes. Others cannot bring change, nor can change bring itself. One is responsible for one's past and present life in the group (as well as in the outside world) and similarly and totally responsible for one's future.

Thus, the therapist helps the patient to understand that the interpersonal world is arranged in a generally predictable and orderly fashion, that it is not that the patient cannot change but that he or she will not change, that the patient bears the responsibility for the creation of his or her world, and therefore the responsibility for its transmutation.

"There is no danger in change."

These efforts may not be enough. The therapist may tug at the therapeutic cord and learn that patients, even after being thus enlightened, still make no significant therapeutic movement. In this case, therapists apply additional therapeutic leverage by helping patients face the paradox of continuing to act contrary to their basic interests. In a number of ways therapists must pose the question, "How come? Why do you continue to defeat yourself?"

A common method of explaining "How come?" is to assume that there are obstacles to the patient's exercising willful choice, obstacles that prevent patients from seriously considering altering their behavior. The presence of the obstacle is generally inferred; the therapist makes an "as if" assumption: "You behave as if you feel there were some considerable danger that would befall you if you were to change. You fear to act otherwise for fear that some calamity will befall you." The therapist helps the patient clarify the nature of the imagined danger, and then proceeds, in several ways, to detoxify, to disconfirm the reality of this danger.

The patient's reason may be enlisted as an ally. The process of identifying and naming the fantasized danger may, in itself, enable one to understand how far removed one's fears are from reality. Another approach is to encourage the patient, in carefully calibrated doses, to commit the dreaded act in the group. The fantasized calamity does not, of course, ensue, and the dread is gradually extinguished.

For example, suppose a patient avoids any aggressive behavior because at a deep level he fears that he has a dammed-up reservoir of homicidal fury and must be constantly vigilant lest he unleash it and eventually face retribution from others. An appropriate therapeutic strategy is to help the patient express aggression in small doses in the group: pique at being interrupted, irritation at members who are habitually late, anger at the therapist for charging him money, and so on. Gradually, the patient is helped to relate openly to the other members and to demythologize himself as a homicidal being. Although the language and the view of human nature are different, this is precisely the same approach to change used in systematic desensitization—a major technique of behavior therapy.

"To attain what I really want, I must change."

Another explanatory approach used by many therapists to deal with a patient who persists in behaving counter to his or her best interests is to consider the payoffs of that patient's behavior. Though the behavior of the patient sabotages many of his or her mature needs and goals, at the same time it satisfies another set of needs and goals. In other words, the patient has conflicting motivations that cannot be simultaneously

satisfied. For example, a male patient may wish to establish mature heterosexual relationships; but at another, often unconscious, level, he may wish to be nurtured, to be cradled endlessly, to assuage castration anxiety by a maternal identification, or, to use an existential vocabulary, to be sheltered from the terrifying freedom of adulthood.

Obviously, the patient cannot satisfy both sets of wishes: he cannot establish an adult heterosexual relationship with a woman if he also says (and much more loudly), "Take care of me, protect me, nurse me, let me be a part of you."

It is important to clarify this paradox for the patient. The therapist tries to help the patient understand the nature of his conflicting desires, to choose between them, to relinquish those that cannot be fulfilled except at enormous cost to his integrity and autonomy. Once the patient realizes what he really wants (as an adult), and that his behavior is designed to fulfill opposing growth-retarding needs, he gradually concludes: To attain what I really want, I must change.

"I can change; I am potent."

Perhaps the major therapeutic approach to the question, "How come?" ("How come you act in ways counter to your best interests?") is to offer explanation, to attribute meaning to the patient's behavior. The therapist says, in effect, "You behave in certain fashions because . . . ," and the "because" clause generally involves motivational factors outside the patient's awareness. It is true that the previous two options I have discussed also proffer explanation but—and I will clarify this shortly—the purpose of the explanation (the nature of the leverage exerted on will) is quite different in each of these approaches.

What type of explanation does the therapist offer the patient? And which explanations are correct, and which incorrect? Which "deep"? Which "superficial"? It is at this juncture that the great metapsychological controversies of the field arise, since the nature of therapists' explanations are a function of the ideological school to which they belong. I think we can sidestep the ideological struggle by keeping a fixed gaze on the function of the interpretation, on the relationship between explanation and the final product: change. After all, our goal is change. Self-knowledge, derepression, analysis of transference, and self-actualization

all are worthwhile, enlightened pursuits; all are related to change, preludes to change, cousins and companions to it; and yet they are not synonymous with change.

Explanation provides a system by which we can order the events in our lives into some coherent and predictable pattern. To name something, to place it into a logical (or paralogical) causal sequence, is to experience it as being under our control. No longer is our behavior or our internal experience frightening, inchoate, out of control; instead, we behave (or have a particular inner experience) because . . . . The "because" offers us mastery (or a sense of mastery that, phenomenologically, is tantamount to mastery). It offers us freedom and effectance. As we move from a position of being motivated by unknown forces to a position of identifying and controlling these forces, we move from a passive, reactive posture to an active, acting, changing posture.

If we accept this basic premise—that a major function of explanation in psychotherapy is to provide the patient with a sense of personal mastery—it follows that the value of an explanation should be measured by this criterion. To the extent that it offers a sense of potency, a causal explanation is valid, correct, or "true." Such a definition of truth is completely relativistic and pragmatic. It argues that no explanatory system has hegemony or exclusive rights, that no system is the correct one.

Therapists may offer the patient any of several interpretations to clarify the same issue; each may be made from a different frame of reference, and each may be "true." Freudian, interpersonal object relations, self psychology, existential, transactional analytic, Jungian, gestalt, transpersonal, cognitive, behavioral explanations—all of these may be true simultaneously. None, despite vehement claims to the contrary, have sole rights to the truth. After all, they are all based on imaginary, as-if structures. They all say, "You are behaving (or feeling) as if such and such a thing were true." The superego, the id, the ego; the archetypes; the masculine protest; the internalized objects; the self object; the grandiose self and the omnipotent object; the parent, child, and adult ego state—none of these really exists. They are all fictions, all psychological constructs created for semantic convenience. They justify their existence only by virtue of their explanatory powers.

Do we therefore abandon our attempts to make precise, thoughtful interpretations? Not at all. We only recognize the purpose and function

of the interpretation. Some may be superior to others, not because they are deeper but because they have more explanatory power, are more credible, provide more mastery, and are therefore more useful. Obviously, interpretations must be tailored to the recipient. In general, they are more effective if they make sense, if they are logically consistent with sound supporting arguments, if they are bolstered by empirical observation, if they are consonant with a patient's frame of reference, if they "feel" right, if they somehow "click" with the internal experience of the patient, and if they can be generalized and applied to many analogous situations in the life of the patient. Higher order interpretations generally offer a novel explanation to the patient for some large pattern of behavior (as opposed to a single trait or act). The novelty of the therapist's explanation stems from his or her unusual frame of reference, which permits an original synthesis of data. Indeed, often the data is material that has been generally overlooked by the patient or is out of his or her awareness.

If pushed, to what extent am I willing to defend this relativistic thesis? When I present this position to students, they respond with such questions as: Does that mean that an astrological explanation is also valid in psychotherapy? These questions make me uneasy, but I have to respond affirmatively. If an astrological or shamanistic or magical explanation enhances a sense of mastery and leads to inner personal change, then it is a valid explanation. There is much evidence from cross-cultural psychiatric research to support this position; the explanation must be consistent with the values and with the frame of reference of the human community in which the patient dwells. In most primitive cultures, it is often only the magical or the religious explanation that is acceptable, and hence valid and effective.[10] Psychoanalytic revisionists make an analogous point and argue that reconstructive attempts to capture historical "truth" are futile; it is far more important to the process of change to construct plausible, meaningful, personal narratives.[11]

An interpretation, even the most elegant one, has no benefit if the patient does not hear it. Therapists should take pains to review their evidence with the patient and present the explanation clearly. (If they cannot, it is likely that the explanation is rickety or that they themselves do not understand it. The reason is not, as has been claimed, that the therapist is speaking directly to the patient's unconscious.)

Do not always expect the patient to accept an interpretation. Sometimes the patient hears the same interpretation many times until one day it seems to "click." Why does it click that one day? Perhaps the patient just came across some corroborating data from new events in the environment or from the surfacing in fantasy or dreams of some previously unconscious material. Sometimes a patient will accept from another member an interpretation that he or she would not accept from the therapist. (Patients are clearly capable of making interpretations as useful as those of the therapists, and members are receptive to these interpretations provided the other member has accepted the patient role and does not offer interpretations to acquire prestige, power, or a favored position with the leader.)

The interpretation will not click until the patient's relationship to the therapist is just right. For example, a patient who feels threatened and competitive with the therapist is unlikely to be helped by any interpretation (except one that clarifies the transference). Even the most thoughtful interpretation will fail because the patient may feel defeated or humiliated by the proof of the therapist's superior perceptivity. An interpretation becomes maximally effective only when it is delivered in a context of acceptance and trust.