Yalom, Irvin D. The Theory and Practice of Group Psychotherapy.
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THE THERAPEUTIC FACTORS IN GROUP THERAPY

How does group therapy help patients? If we can answer this seemingly naïve question with some measure of precision and certainty, we shall have at our disposal a central organizing principle by which to approach the most vexing and controversial problems of psychotherapy. Once identified, the crucial aspects of the change process will constitute a rational basis upon which the therapist may base tactics and strategy.

I suggest that therapeutic change is an enormously complex process and occurs through an intricate interplay of various guided human experiences, which I shall refer to as "therapeutic factors." There is considerable advantage in approaching the complex through the simple, the total phenomenon through its basic component processes; and, accordingly, I shall begin by describing and discussing these elemental factors.

From my viewpoint, natural lines of cleavage divide the therapeutic experience into eleven primary factors:

1. Instillation of hope,
2. Universality,
3. Imparting of information,
4. Altruism,
5. The corrective recapitulation of the primary family group,
6. Development of socializing techniques,
7. Imitative behavior,
8. Interpersonal learning,
9. Group cohesiveness,

10. Catharsis,
11. Existential factors.

In the rest of this chapter, I shall discuss the first seven factors. I consider interpersonal learning and group cohesiveness so important and complex that I have treated them separately in the next two chapters. Existential factors are discussed in chapter 4, where they are best understood in the context of other material presented there. Catharsis is intricately interwoven with other therapeutic factors and will also be discussed in chapter 4. Keep in mind that, though I discuss these factors singly, the discriminations are arbitrary and, to a large extent, the factors are interdependent: they neither occur nor function separately.

Moreover, these factors may represent different parts of the change process; some factors refer to actual mechanisms of change, whereas others may be more accurately described as conditions for change. Though the same therapeutic factors operate in every type of therapy group, their interplay and differential importance can vary widely from group to group. Furthermore, patients in the same group may be benefited by widely differing clusters of therapeutic factors. At its core, therapy is a deeply human experience, and, consequently, there are an infinite number of pathways through the therapeutic process. (I discuss all of these issues more fully in chapter 4.)

The inventory of therapeutic factors I propose issues from my clinical experience, from the experience of other therapists, from the views of the successfully treated group patient, and from relevant systematic research. None of these sources of conviction is beyond doubt, however; neither group members nor group leaders are entirely objective, and our research methodology is both crude and often inapplicable.

From the group therapists we obtain a variegated and internally inconsistent inventory of therapeutic factors (see chapter 4). Therapists are by no means disinterested or unbiased observers. They have invested considerable time and energy in mastering a certain therapeutic approach, and their answers will be largely determined by their particular school of conviction. Even among therapists who share the same ideology and speak the same language, there may be no consensus about why patients improve. In research on encounter groups, my colleagues and I learned that many successful group leaders attributed their success to factors that were quite irrelevant to the therapy process: for example, the "hot seat" technique, or nonverbal exercises, or the direct impact of a therapist's own person (see chapter 16).[1] But that does not surprise us; the history of psychotherapy abounds in healers

who were effective, but not for the reasons they supposed. At other times we therapists throw up our hands in bewilderment. Who has not had a patient who made vast improvement for reasons entirely obscure to us?

From the group therapy patients at the end of a course of treatment we can obtain data concerning those therapeutic factors that they consider most and least helpful; or, during therapy, they can supply evaluations of the significant aspects of each group meeting. For these purposes an interview or a variety of data-collecting approaches may be employed. Yet we know the patients' evaluations will be subjective. Will they not, perhaps, focus primarily on superficial factors and neglect some profound healing forces which may be beyond their awareness? Will their responses not be influenced by a variety of factors difficult to control? For example, their views may be distorted by the nature of their relationship to the therapist or to the group. (One team of researchers demonstrated that when patients were interviewed four years after the conclusion of therapy, they were far more apt to comment on unhelpful or harmful aspects of their group experience than when interviewed immediately at its termination.)[2]

Research has also shown, for example, that the therapeutic factors valued by patients may differ greatly from the factors cited by their therapists or by group observers.[3] Furthermore, many factors influence the patient's evaluation of the therapeutic factors: for example, the length of time in treatment and the level of a patient's functioning,[4] the type of group (that is, whether outpatient, inpatient, day hospital, brief therapy),[5] the age and the diagnosis of a patient,[6] and the ideology of the group leader.[7] Another factor that complicates the search for common therapeutic factors is the extent to which different group patients perceive and experience the same event in different ways.[8] Any given experience may be important or helpful to some members and inconsequential or even harmful to others.

Despite these limitations, patient reports are a rich and relatively untapped source of information. After all, it is *their* experience, theirs alone, and the further we move from the patient's experience, the more inferential are our conclusions. To be sure, there are aspects of the process of change that operate outside of a patient's awareness, but it does not follow that we should disregard what patients *do* say. It is my experience that the richness and the accuracy of a patient's report is largely determined by the mode of inquiry. The more the questioner can enter into the experiential world of the patient, the more lucid and meaningful does the report of the therapy experience become. To the

degree that the therapist is able to suppress personal bias, he or she becomes the ideal questioner: the therapist is trusted and, more than anyone else, understands the inner world of the patient.

In addition to therapists' views and patients' reports, there is yet a third important method of evaluating the therapeutic factors: the systematic research approach. The most common research strategy is to correlate a series of in-therapy variables with ultimate patient outcome in therapy. By discovering which variables are significantly related to successful outcome, one can establish a reasonable base from which to begin to delineate the therapeutic factors. However, the research approach is not beyond reproach. There are many inherent problems: the measurement of outcome is itself a methodological morass, and the selection and measurement of the in-therapy variables are equally problematic. (Generally the accuracy of the measurement is directly proportional to the triviality of the variable. It is easy, for example, to measure the number of words spoken by each patient but extraordinarily difficult to measure the meaningfulness of insight.)

I have drawn from all these methods to derive the therapeutic factors discussed in this book. I do not present these factors as definitive; rather, I offer them as provisional guidelines which may be tested and perhaps expanded by other clinical researchers. For my part, I am satisfied that they derive from the best available evidence and constitute the basis of an effective approach to therapy.

Instillation of Hope

The instillation and maintenance of hope is crucial in all of the psychotherapies: not only is hope required to keep the patient in therapy so that other therapeutic factors may take effect, but faith in a treatment mode can in itself be therapeutically effective. Several research inquiries have demonstrated that high expectation of help before therapy is significantly correlated with positive therapy outcome.[9] Consider also the massive data documenting the efficacy of faith healing and placebo treatment—therapies mediated entirely through hope and conviction.

Therapy groups invariably contain individuals who are at different points along a coping-collapse continuum. Patients have continual contact with group members who have improved in the group and often encounter patients who have had problems very similar to their own and have coped with them more effectively. I have often heard patients

remark at the end of their therapy how important it was for them to have observed the improvement of others. Group therapists should by no means be above exploiting this factor by periodically calling attention to the improvement that members have made. If I receive, let us say, Christmas cards from members who have recently terminated the group, I shamelessly share with the current group all the positive changes they describe. Therapy group members themselves often proffer spontaneous testimonials when new, skeptical members enter the group.

Research substantiates that it is also vitally important that therapists believe in themselves and in the efficacy of their group.[10] I sincerely believe that I am able to help every motivated patient who is willing to work in the group for at least six months. In my initial individual meetings with patients, I share this conviction with them and attempt to imbue them with my optimism.

Many of the self-help groups that have emerged in the past decade (for example, Compassionate Friends [bereaved parents], THEOS [widows], or Mended Heart [heart surgery patients]) place heavy emphasis on the instillation of hope.[11] A major part of Recovery, Inc., and Alcoholics Anonymous meetings is dedicated to testimonials. Recovery, Inc., members give accounts of potentially stressful incidents in which they avoided tension by the application of Recovery, Inc., methods. Successful Alcoholics Anonymous members tell their stories of downfall and salvation at each meeting. One of the great strengths of Alcoholics Anonymous is the fact that the leaders are all ex-alcoholics—living inspirations to the others. Many substance-abuse treatment programs mobilize hope in patients by using recovered drug addicts as group leaders. The members develop a strong conviction that they can be best understood by someone who has trod the same path as they and who has found the way back.

Universality

Many patients enter therapy with the disquieting thought that they are unique in their wretchedness, that they alone have certain frightening or unacceptable problems, thoughts, impulses, and fantasies. There is a core of truth in this notion, since many patients have had an unusual constellation of life stresses and are periodically flooded by material that is usually unconscious. A patient's sense of uniqueness is often heightened by social isolation; because of interpersonal difficulties, opportuni-

ties for frank and candid consensual validation in an intimate relationship are often not available to patients. In the therapy group, especially in the early stages, the disconfirmation of a patient's feelings of uniqueness is a powerful source of relief. After hearing other members disclose concerns similar to their own, patients report feeling more in touch with the world and describe the process as a "welcome to the human race" experience. Simply put, the phenomenon finds expression in the cliché, "We're all in the same boat," or perhaps more cynically, "Misery loves company."

There is no human deed or thought that is fully outside the experience of other people. I have heard group members reveal such acts as incest, burglary, embezzlement, murder, attempted suicide, and fantasies of an even more desperate nature; invariably, I have observed other group members reach out and embrace these very acts as within the realm of their own possibilities. Long ago Freud noted that the staunchest taboos (against patricide and incest) were constructed precisely because these very impulses are part of the human being's deepest nature.

Nor is this form of aid limited to group therapy. Universality plays a role in individual therapy also, although in that format less of an opportunity for consensual validation exists. Once I reviewed with a patient his 600-hour experience in individual analysis with another therapist. When I inquired about his recollection of the most significant event in his therapy, he recalled an incident when he was profoundly distressed about his feelings toward his mother. Despite strong concurrent positive sentiments, he was beset with death wishes for her so that he might inherit a sizable estate. His analyst, at one point, commented simply, "That seems to be the way we're built." That artless statement offered considerable relief and furthermore enabled the patient to explore his ambivalence in great depth.

Despite the complexity of human problems, certain common denominators are clearly evident; and the members of a therapy group are not long in perceiving their similarities. An example is illustrative: for many years I asked members* of T-groups (see chapter 16) to engage in a "top secret" task. The group members are asked to write, anonymously, on a slip of paper their top secret—the one thing they would be most disinclined to share with the group.† The secrets prove to be

*Nonpatients—primarily medical students, psychiatric residents, nurses, psychiatric technicians, and Peace Corps volunteers.

†There are several methods of employing this data in the work of the group. One technique that has proved effective is to collect the anonymous secrets and redistribute

startlingly similar, with a couple of major themes predominating. The most common secret is a deep conviction of basic inadequacy—a feeling that if others really knew the person, they would discover his or her incompetence and see through his or her intellectual bluff. Next in frequency is a deep sense of interpersonal alienation. Individuals report that they do not or cannot really care for or love another person. The third most frequent category is some variety of sexual secret, often a dread of homosexual inclinations. These chief concerns, in nonpatients, are qualitatively the same in individuals seeking professional help, who become labeled as patients. Almost invariably, patients experience deep concern about their sense of worth and their ability to relate to others.

Some specialized groups composed of individuals for whom secrecy has been an especially important and isolating factor place a particularly great emphasis on universality. For example, short-term structured groups for bulimic patients build into their protocol a strong requirement for self-disclosure, especially disclosure about attitudes toward body image and detailed accounts of each patient's eating and purging practices. With rare exceptions, patients express great relief at discovering that they are not alone and that others share the same dilemmas and life experiences.[12]

Universality, like the other therapeutic factors, cannot be appreciated separately. As patients perceive their similarity to others and share their deepest concerns, they benefit further from the accompanying catharsis and from ultimate acceptance (see chapter 3 on group cohesiveness) by other members.

Imparting Information

Under the general rubric of imparting information, I include didactic instruction about mental health, mental illness, and general psychodynamics given by the therapists, as well as advice, suggestions, or direct guidance about life problems offered either by the therapist or by other patients. Generally, when therapists or patients retrospectively examine their experience in interactional group therapy, they do not highly value didactic information or advice.

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them to the members, each one receiving another's secret. Each member is then asked to read the secret aloud and to reveal how he or she would feel if harboring such a secret. This method usually proves to be a valuable demonstration of universality, empathy, and the ability of others to understand.

DIDACTIC INSTRUCTION

Most patients, at the conclusion of successful interactional group therapy, have learned a great deal about psychic functioning, the meaning of symptoms, interpersonal and group dynamics, and the process of psychotherapy. However, the educational process is implicit; most group therapists do not offer explicit didactic instruction in interactional group therapy. There are, however, some group therapy approaches in which formal instruction is an important part of the program. For example, Maxwell Jones, in his early work with large groups, devoted three hours a week to lectures which instructed patients about the structure and function of the central nervous system and the relevance of this material to psychiatric symptoms and disability.[13] J. W. Klapman developed a form of didactic group therapy for outpatients in which he used formal lectures and textbook assignments.[14] L. C. Marsh also organized groups of patients into classes and created a classroom atmosphere by means of lectures, homework, and grading procedures.[15]

Recovery, Inc., is basically organized along didactic lines.[16] This self-help organization was founded in 1937 by the late Abraham Low and, in 1985, had over one thousand operating groups with a regular attendance of over 10,000 individuals. The membership is completely voluntary and includes individuals complaining of any psychological problem. The leaders spring from the membership; and though there is no formal professional guidance, the conduct of the meetings has been highly structured by Dr. Low; parts of his textbook, *Mental Health Through Will Training,* are read aloud and discussed at every meeting.[17] Psychological illness is explained on the basis of a few simple principles which are memorized by the members: for example, the neurotic symptom is distressing but not dangerous; tension intensifies and sustains the symptom and should be avoided; the use of free will is the solution to the nervous patient's dilemmas.

Many other self-help groups strongly emphasize the imparting of information. Groups such as Parents Anonymous, Gamblers Anonymous, Make Today Count (for cancer patients), Parents Without Partners, and Mended Hearts (cardiac surgery patients) encourage the exchange of information among members and often invite experts to address the group.[18]

The recent group therapy literature abounds with descriptions of specialized groups for patients who have some specific disorder or face some definitive life crisis (for example, obesity,[19] adjustment after di-

vorce,[20] chronic pain,[21] sexual dysfunction,[22] rape victims,[23] epilepsy,[24] myocardial infarction,[25] hemodialysis.[26] These groups build in a didactic component and offer explicit instruction about the nature of a patient's illness or life situation. For example, the leaders of a group for primiparous mothers instruct the members about the physiological basis of the physical and psychological changes the latter are undergoing and about the actual mechanics of labor and delivery. The leaders offer anticipatory guidance by helping the members verbalize their fears and then addressing their irrational beliefs systematically by rational, informational means.

D. I. Malamud and S. Machover report an innovative approach organized on a didactic base.[27] They organized "workshops in self-understanding," consisting of approximately twenty patients drawn from a psychiatric clinic waiting list. The workshop aimed to prepare patients for group psychotherapy and consisted of fifteen two-hour sessions which were carefully planned to clarify important reasons for psychological dysfunction as well as methods of self-exploration. The technique was not only successful in preparing patients for further treatment but proved to be effective therapy: at the conclusion of the workshop, many patients felt sufficiently enough improved that no further treatment was required.

My colleagues and I have used an analogous type of anticipatory guidance for psychiatric patients about to enter a frightening situation —the psychotherapy group.[28] By predicting patients' fears, by providing them with a cognitive structure, we helped them to cope more effectively with the initial "culture shock." (This procedure is described in detail in chapter 10.)

Didactic instruction has thus been employed in a variety of fashions in group therapy: to transfer information, to structure the group, to explain the process of illness. Often such instruction functions as the initial binding force in the group until other therapeutic factors become operative. In part, however, explanation and clarification function as effective therapeutic agents in their own right. Human beings have always abhorred uncertainty and through the ages have sought to order the universe by providing explanations, primarily religious or scientific. The explanation of a phenomenon is the first step toward its control. If a volcanic eruption is caused by a displeased volcanic god, then at least there is hope of pleasing and eventually controlling the god. Frieda Fromm-Reichman underscores the role of uncertainty in the production of anxiety.[29] She points out that being aware that one is not one's own helmsman, that one's perceptions and behavior are controlled by

irrational forces, is in itself an important source of anxiety. Jerome Frank, in a study of Americans' reactions to an unfamiliar South Pacific disease (schistosomiasis), demonstrates that secondary anxiety stemming from uncertainty often creates more havoc than the primary disease.[30] Similarly with psychiatric patients: fear and anxiety that stem from uncertainty of the source, meaning, and seriousness of psychiatric symptoms may so compound the total dysphoria that effective exploration becomes vastly more difficult. Thus, didactic instruction, through its provision of structure and explanation, has intrinsic value and deserves a place in our repertoire of therapeutic instruments. (See chapter 5 for a more complete discussion of this issue.)

DIRECT ADVICE

Unlike explicit didactic instruction from the therapist, direct advice from the members occurs without exception in every therapy group. In dynamic interactional therapy groups, it is invariably part of the early life of the group and occurs with such regularity that it can be used to estimate the age of the group. If I observe or hear a tape of a group in which the patients with some regularity say, "I think you ought to . . ." or, "What you should do is . . ." or, "Why don't you . . . ," then I can be reasonably certain either that the group is young or that it is an older group facing some difficulty that has either impeded its development or effected temporary regression. Despite the fact that advice giving is common in early interactional group therapy, I can recall few instances when a specific suggestion concerning some problem was of direct benefit to any patient. Indirectly, however, advice giving serves a purpose; the process, rather than the content of the advice, may be beneficial, since it implies and conveys mutual interest and caring. In other words, what is important is implicit in the very offering of advice. It is seen by the patient as a gift.

Advice-giving or advice-seeking behavior is often an important clue in the elucidation of interpersonal pathology. The patient who, for example, continuously pulls advice and suggestions from others, only to reject it ultimately and frustrate others, is well known to group therapists as the "help-rejecting complainer" or the "yes . . . but" patient (see chapter 13).[31] Other patients may bid for attention and nurturance by asking for suggestions about a problem that either is insoluble or has already been solved. Other patients soak up advice with an unquenchable thirst yet never reciprocate to others equally needy. Some group members are so intent on preserving a high status role in the group or

a facade of cool self-sufficiency that they never ask directly for help; some are effusive in their gratitude; others never acknowledge the gift but take it home, like a bone, to gnaw on privately.

Other types of group, noninteractionally focused, make explicit and effective use of direct suggestions and guidance. For example, behavior-shaping groups, discharge groups (preparing patients for discharge from a hospital), Recovery, Inc., and Alcoholics Anonymous all proffer considerable direct advice. Discharge groups may discuss the events of a patient's trial home visit and offer suggestions for alternative behavior. Alcoholics Anonymous makes use of guidance and slogans: for example, patients are asked to remain abstinent for only the next twenty-four hours, one day at a time. Recovery, Inc., teaches members how to "spot symptoms," how to "erase and retrace," how to "rehearse and reverse," how to apply will power effectively. Researchers studied a behavior-shaping group of male sex offenders and noted not only that advice was common but that it came in several forms: the least effective form of advice was a direct suggestion; the most effective were more systematic operationalized instructions or alternative suggestions about how to achieve a desired goal.[32]

Altruism

There is an old Hasidic story of a rabbi who had a conversation with the Lord about Heaven and Hell. "I will show you Hell," said the Lord, and led the rabbi into a room in the middle of which was a very big round table. The people sitting at it were famished and desperate. In the middle of the table there was an enormous pot of stew, more than enough for everyone. The smell of the stew was delicious and made the rabbi's mouth water. The people around the table were holding spoons with very long handles. Each person found that it was just possible to reach the pot to take a spoonful of the stew, but because the handle of the spoon was longer than anyone's arm, no one could get the food into his mouth. The rabbi saw that their suffering was indeed terrible. "Now I will show you Heaven," said the Lord, and they went into another room, exactly the same as the first. There was the same big round table and the same enormous pot of stew. The people, as before, were equipped with the same long-handled spoons—but here they were well nourished and plump, laughing and talking. At first the rabbi could not understand. "It is simple, but it requires a certain skill," said the Lord. "You see, they have learned to feed each other."

In therapy groups, too, patients receive through giving, not only as part of the reciprocal giving-receiving sequence but also from the intrinsic act of giving. Psychiatric patients beginning therapy are demoralized and possess a deep sense of having nothing of value to offer others. They have long considered themselves as burdens, and the experience of finding that they can be of importance to others is refreshing and boosts self-esteem.

And, of course, patients are enormously helpful to one another in the group therapeutic process. They offer support, reassurance, suggestions, and insight and share similar problems with one another. Not infrequently a patient will listen and absorb observations from another member far more readily than from the group therapist. To many patients, the therapist remains the paid professional; but the other members can be counted upon for spontaneous and truthful reactions and feedback. A patient looking back over the course of therapy invariably credits other members as having been important in his or her improvement—if not for deliberate support and advice, then at least for having been there and permitted the patient to gain self-knowledge through their relationship.

Nor has this therapeutic factor been absent from other psychotherapeutic systems. In primitive cultures, for example, a troubled person is often given the task of preparing a feast or performing some type of service for the community.[33] Altruism plays an important part in the healing process at Catholic shrines such as at Lourdes, where the sick pray not only for themselves but for one another. Warden Duffy of San Quentin Prison is reputed to have claimed that the best way to help a man is to let him help you. People need to feel they are needed. I have known ex-alcoholics who have continued their A.A. contacts for years after they achieved complete sobriety; one worker told me that he had related the story of his downfall and subsequent reclamation at least a thousand times.

This source of help is at first not appreciated. Many patients resist the suggestion of group therapy with the question, "How can the blind lead the blind?" Or, "What can I possibly get from others as confused as I? We'll end up pulling one another down." Such resistance to entering the group is best worked through by exploring a patient's critical self-evaluation. Generally, a patient who deplores the prospect of getting help from other patients is really saying, "I have nothing of value to offer anyone."

There is another, more subtle benefit inherent in the altruistic act. Many patients are immersed in a morbid self-absorption, which takes

the form of obsessive introspection or a teeth-gritting effort to "actualize" oneself. But self-actualization or meaning in life can never be attained via deliberate, self-conscious pursuit. I agree with Victor Frank that these qualities ensue but cannot be successfully pursued: that they are always derivative phenomena which appear on our experiential landscape when we have transcended ourselves, when we have forgotten ourselves in absorption in someone (or something) outside of ourselves.[34] The therapy group implicitly teaches its members that lesson and provides a new counter-solipsistic perspective.

The Corrective Recapitulation of the Primary Family Group

Without exception, patients enter group therapy with the history of a highly unsatisfactory experience in their first and most important group —the primary family. The group resembles a family in many aspects, and many groups are led by a male-female therapy team in a deliberate effort to simulate the parental configuration as closely as possible. Depending upon a patient's assumptive world (shaped to a large degree by early family experience), one interacts with leaders and other members as one may have once interacted with parents and siblings.

There are an infinite variety of patterns: helpless dependence upon the leaders, whom one imbues with unrealistic knowledge and power; blind defiance of the leaders who are thought to block autonomous growth or to strip members of their individuality; an attempt to split the co-therapists and to incite disagreements or rivalry between the two; bitter competition with other members in an effort to accumulate units of attention and caring from the therapists; a search for allies among the other patients in an effort to topple the therapists; or neglect of one's own interests in a seemingly selfless effort to appease or provide for other members.

Obviously, similar phenomena occur in individual therapy. The difference, however, is that the group provides a vastly greater number and array of recapitulative possibilities. In one of my groups, a patient who had been silently pouting for a couple of meetings bemoaned the fact that she was not in one-to-one therapy. The group could not satisfy her needs, and she found herself unable to speak in the meeting, whereas she knew she could speak freely of herself in a private conversation with the therapist or with any one of the members. When

pressed, the patient disclosed her anger that, in a recent meeting, another member had been welcomed warmly upon returning from a vacation. She, too, had recently returned from a vacation, but had not had a similarly warm reception from the group. Furthermore, another patient was praised for offering an important interpretation to a member, whereas she had made a similar statement weeks ago which had gone unnoticed. For some time, too, she had noticed her growing resentment at sharing the group time; she was impatient while waiting for the floor and angry when attention was shifted away from her. All of these experiences obviously had a long history and were deeply rooted in her early relationships with her siblings. Together, they did not constitute a valid criticism for the group therapeutic mode. Quite the contrary: the group format was particularly valuable for her, as it is for many narcissistic patients, since it allowed both her envy and her cravings for attention to surface. In individual therapy these particular conflicts emerge belatedly, if at all; the therapist is always there; the patient is expected to take all the time; there is no other person with whom one must share the therapist or the therapy hour.

What is important, though, is not only that early familial conflicts are relived but that they are relived correctively. Growth-inhibiting relationships must not be permitted to freeze into the rigid, impenetrable system that characterizes many family structures. Instead, fixed roles must be constantly explored and challenged; and ground rules for investigating relationships and testing new behavior must be constantly encouraged. For many patients, then, working out problems with therapists and other members is also working through unfinished business from long ago. (How explicit the working in the past need be is a complex and controversial issue, which I shall address in chapter 5.)

Development of Socializing Techniques

Social learning—the development of basic social skills—is a therapeutic factor that operates in all therapy groups, although the nature of the skills taught and the explicitness of the process vary greatly depending upon the type of group therapy. In some groups—for example, groups preparing long-term hospitalized patients for discharge, or adolescent groups—there may be explicit emphasis on the development of social skills. Role playing may be employed where patients learn to approach prospective employers for a job or adolescent boys learn to invite a girl to a dance.

In dynamic group therapy with ground rules encouraging open feedback, patients may obtain considerable information about maladaptive social behavior. A patient may, for example, learn about a disconcerting tendency to avoid looking at the person with whom he or she is conversing; or about others' impressions of his or her haughty, regal attitude; or about a variety of other social habits which, unbeknownst to the patient, have been undermining his or her social relationships. For individuals lacking intimate relationships, the group often represents the first opportunity for accurate interpersonal feedback. One patient, for example, who obsessively included endless, minute, irrelevant details in his social conversation realized that he did so for the first time in group therapy. For years he had been aware only that other people either avoided or curtailed social contact with him. Obviously, therapy involves far more than the simple recognition and deliberate alteration of social behavior; but, as I shall show in chapter 3, these gains are more than fringe benefits and are often exceedingly instrumental in the initial phases of therapeutic change.

Frequently the senior members of the therapy group acquire highly sophisticated social skills: they are attuned to process (see chapter 6); they have learned how to be helpfully responsive to others; they have acquired methods of conflict resolution; they are less likely to be judgmental and more capable of experiencing and expressing accurate empathy. These skills cannot but help to serve these patients well in future social interactions.

Imitative Behavior

Pipe-smoking therapists often beget pipe-smoking patients. Patients during individual psychotherapy may sit, walk, talk, and even think like their therapists. In groups the imitative process is more diffuse, as patients may model themselves upon aspects of the other group members as well as of the therapist. The importance of imitative behavior in the therapeutic process is difficult to gauge, but social psychological research suggests that therapists may have underestimated its importance. A. Bandura, who has long claimed that social learning cannot be adequately explained on the basis of direct reinforcement, has experimentally demonstrated that imitation is an effective therapeutic force.[35] For example, he has successfully treated a large number of individuals with snake phobias by asking them to observe their therapist handle a snake. In group therapy it is not uncommon for a patient

to benefit by observing the therapy of another patient with a similar problem constellation—a phenomenon generally referred to as "vicarious" or "spectator" therapy.[36] Even if specific imitative behavior is short-lived, it may function to help the individual "unfreeze" by experimenting with new behavior. In fact, it is not uncommon for patients throughout therapy to try on, as it were, bits and pieces of other people and then relinquish them as ill fitting. This process may have solid therapeutic impact; finding out what we are not is progress toward finding out what we are.