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A Concise Guide to Group Therapy

Therapeutic Factors

(Yalom – The Theory and Practice of Group Psychotherapy, 5th Edition)

1. Instillation of hope
2. Universality
3. Imparting information
4. Altruism
5. Corrective capitulation of the primary family group
6. Development of socializing techniques
7. Imitative behavior
8. Interpersonal learning
9. Group cohesiveness
10. Catharsis
11. Existential factors

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2 WHAT MAKES GROUP PSYCHOTHERAPY WORK?

Group psychotherapy makes use of specific therapeutic factors. We must identify these specific factors if we are to understand the common ways in which vastly different kinds of groups help members to change. Such a simplifying principle helps us also to understand what happens to different members within the same group.

THE THERAPEUTIC FACTORS

Over the past three decades, a variety of research approaches have been used to answer the question, "What makes group psychotherapy work?"—including the interview and testing of group therapy patients with successful outcomes, as well as questionnaires directed at experienced group therapists and trained observers. From these methods, researchers have identified a number of mechanisms of change in group psychotherapy: the curative or therapeutic factors (1).

There is a high degree of overlap among the various classification systems proposed by different investigators (2–4). Yalom has developed an empirically based, 11-factor inventory of the therapeutic mechanisms operating in group psychotherapy, as follows:

1. Instillation of hope
2. Universality
3. Imparting of information
4. Altruism
5. Development of socializing techniques
6. Imitative behavior
7. Catharsis
8. Corrective recapitulation of the primary family group
9. Existential factors
10. Group cohesiveness
11. Interpersonal learning

INSTILLATION OF HOPE

Faith in a treatment mode is itself therapeutically effective, both when the patient has a high expectation of help and when the therapist believes in the efficacy of the treatment (5, 6). Although the instillation and maintenance of hope are crucial to all of the psychotherapies, this plays a unique role in the group setting.

In every therapy group, there are patients who have improved as well as members who are at a low ebb. Patients often remark at the end of therapy that to have observed the improvement of others offered them great hope for their own improvement. Groups such as Alcoholics Anonymous, which are aimed at alcohol and substance abusers, use the testimonials of ex-alcoholics or recovered addicts to inspire hope in new members. Many of the self-help groups that have emerged in the past decade, such as Compassionate Friends (for bereaved parents) or Mended Heart (for cardiac surgery patients), also place a heavy emphasis on the instillation of hope.

UNIVERSALITY

Many patients go through life with an overwhelming sense of isolation. They are secretly convinced that they are unique in their loneliness or their wretchedness, that they alone have certain unacceptable problems or impulses. Such people are often socially isolated and have few opportunities for frank and candid social interchange. In a therapy group, especially in its early stages, patients experience a powerful sense of relief when they realize they are not alone with their problems.

Some specialized groups, in fact, are focused on helping individuals for whom secrecy has been an especially important and isolating part of life. For example, many short-term structured groups for bulimic patients require open disclosure about attitudes toward body image and detailed accounts about bingeing and purging behavior. As a rule, patients experience great relief as they discover that they are not alone, and that their problems are universal and are shared by other group members.

IMPARTING INFORMATION

The imparting of information occurs in a group whenever a therapist gives didactic instruction to patients about mental or physical functioning, or whenever advice or direct guidance about life problems is offered either by the leader or by other group members. Although long-term interactional groups generally do not value the use of didactic education or advice, other types of groups rely more heavily on advice or instruction.

DIDACTIC INSTRUCTION

Many self-help groups—such as Alcoholics Anonymous, Recovery, Inc., Make Today Count (for cancer patients), Gamblers Anonymous, and the like—emphasize didactic instruction. A text is used, experts are invited to address the group, and members are strongly encouraged to exchange information. Specialized groups aimed at patients with a specific medical or psychological disorder or facing a specific life crisis (for example, obese individuals, rape victims, epileptics, chronic pain patients) build in a didactic component; leaders offer explicit instruction about the nature of the individual's illness or life situation. Therapists leading specialized groups often teach members ways of developing coping mechanisms and implementing stress-reduction or relaxation techniques.

ADVICE-GIVING

Unlike explicit didactic instruction from the therapist, direct advice from the members occurs without exception in every kind of therapy group. Noninteractionally focused groups make explicit and effective use of direct suggestions and guidance from both the leader and other members. For example, behavior-shaping groups, discharge groups (preparing patients for discharge from the 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, while Alcoholics Anonymous and Recovery, Inc. use guidance and directive slogans ("One day at a time" or "Ninety meetings in ninety days"). Research on a behavior-shaping group of male sex offenders noted that the most effective

form of guidance was through systematic operationalized instructions or through alternative suggestions about how to reach a desired goal (7).

In dynamic interactional therapy groups, advice-giving invariably is part of the early life of the group, but is of limited value to the members. Later, when the group as a whole has moved beyond the problem-solving stage and has begun to engage in interactional work, the reappearance of advice-seeking or advice-giving around a given issue suggests that the group is avoiding the work of therapy.

ALTRUISM

In every therapy group, patients become enormously helpful to one another: They share similar problems and they offer each other support, reassurance, suggestions, and insight. To the patient starting therapy who is demoralized and who feels that he or she has nothing of value to offer anyone, the experience of being helpful to other members of the group can be surprisingly rewarding, and is one of the reasons that group therapy so often boosts self-esteem. The therapeutic factor of altruism is unique to group therapy; patients in individual psychotherapy almost never have the experience of being helpful to their psychotherapist.

The altruistic act not only boosts self-esteem, it also distracts patients who spend much of their psychic energy immersed in morbid self-absorption. The patient caught up in ruminations about his or her own psychological woes is suddenly forced to be helpful to someone else. By its very structure, the therapy group fosters the act of aiding others and counters solipsism.

DEVELOPMENT OF SOCIALIZING TECHNIQUES

Social learning—the development of basic social skills— is a therapeutic factor that operates in all psychotherapy groups, although the nature of the skills taught and the explicitness of the process vary greatly depending upon the type of group. In some groups, such as those preparing long-term hospitalized patients for discharge or those for adolescents with behavioral problems, there is explicit emphasis on the development of social skills. Role

playing techniques are often used to prepare patients for job interviews or to teach adolescent boys how to invite a girl to a dance.

In groups that are more interactionally oriented, patients learn about maladaptive social behavior from the honest feedback they offer each other. A patient may, for example, learn about a disconcerting tendency to avoid eye contact during conversation, or about the effect that his or her whispery voice and constantly folded arms has on others, or about a host of other habits which, unbeknownst to the patient, have been undermining his or her social relationships.

IMITATIVE BEHAVIOR

The importance of imitative behavior as a therapeutic factor is difficult to gauge, but social psychological research indicates that psychotherapists underestimate its importance (8). In group therapy, members benefit from observing the therapy of another patient with similar problems, a phenomenon referred to as vicarious learning.

For example, a timid, repressed female member who observes another woman in the group experiment with more extroverted behavior and a more attractive appearance may then, herself, similarly experiment with new methods of grooming and self-presentation. Or an emotionally restricted, lonely male member may begin to imitate another man in the group who has received positive feedback from women members by expressing himself openly and frankly.

CATHARSIS

Catharsis, or the ventilation of emotions, is a complex therapeutic factor that is linked to other processes in a group, particularly universality and cohesiveness. The sheer act of ventilation, by itself, although accompanied by a sense of emotional relief, rarely promotes lasting change for a patient. It is the affective sharing of one's inner world, and then the acceptance by others in the group, that is of paramount importance. To be able to express strong and deep emotions, and yet still be accepted by others,

brings into question one's belief that one is basically repugnant, unacceptable, or unlovable.

Psychotherapy is both an emotional and a corrective experience. In order for change to take place, a patient must first experience something strongly in the group setting and undergo the sense of catharsis accompanying that strong emotional experience. Then the patient must proceed to integrate the cathartic event by understanding the meaning of the event, first, in the context of the group, and second, in the context of his or her outside life. This principle is discussed further in the section on interpersonal learning and the here-and-now focus of group psychotherapy.

CORRECTIVE RECAPITULATION OF THE PRIMARY FAMILY GROUP

Many patients enter group therapy with a history of highly unsatisfactory experiences in their first and most important group: the primary family. Because group therapy offers such a vast array of recapitulative possibilities, patients may begin to interact with leaders or other members as they once interacted with parents and siblings.

A helplessly dependent patient may imbue the leader with unrealistic knowledge and power. A rebellious and defiant individual may regard the therapist as someone who blocks autonomy in the group or who strips members of their individuality. The primitive or chaotic patient might attempt to split the cotherapists or even the entire group, igniting fires of bitter disagreement. The competitive patient will compete with other members for the therapist's attention, or perhaps seek allies in an effort to topple the therapists. And a self-effacing individual may neglect his or her own interests in a seemingly selfless effort to placate or provide for other members. All of these patterns of behavior can represent a recapitulation of early family experiences.

What is of capital importance in interactional group psychotherapy (and to a lesser degree in other group settings that make use of psychological insight) is not only that these kinds of early familial conflicts are re-enacted, but that they are recapitulated correctively. The group leader must not permit these growth-

inhibiting relationships to freeze into the rigid, impenetrable system that characterizes many family structures. Instead, the leader must explore and challenge fixed roles in the group, and continually encourage members to test new behaviors.

EXISTENTIAL FACTORS

An existential approach to the understanding of patients' problems posits that the human being's paramount struggle is with the givens of our existence: death, isolation, freedom, and meaninglessness (9). In certain kinds of psychotherapy groups, particularly those centered around patients with cancer or chronic and life-threatening medical illnesses, or in bereavement groups, these existential givens play a central role in therapy.

Even standard therapy groups have considerable traffic with existential concerns if the group leader is informed and sensitive to these issues. In the course of therapy, members begin to realize that there is a limit to the guidance and support they can receive from others. They may find that the ultimate responsibility for the autonomy of the group and for the conduct of their lives is their own. They learn that, although one can be close to others, there is nonetheless a basic aloneness to existence that cannot be avoided. As they accept some of these issues, they learn to face their limitations with greater candor and courage. In group psychotherapy, the sound and trusting relationship among the members—the basic, intimate encounter—has an intrinsic value as it provides presence and a "being with" in the face of these harsh existential realities.

COHESIVENESS

Group cohesiveness is one of the more complex and absolutely integral features of a successful psychotherapy group. Group cohesiveness refers to the attractiveness that members have for their group and for the other members. The members of a cohesive group are accepting of one another, supportive, and inclined to form meaningful relationships in the group. Research indicates that cohesive groups achieve better therapeutic outcomes (10).

Just as, in individual psychotherapy, it is the relationship

itself between therapist and patient that heals, cohesiveness is the group therapy analog of this therapist–patient relationship. Most psychiatric patients have had an impoverished history of belonging—never before have they been a valuable, integral, participating member of any kind of group, and the sheer successful negotiation of a group therapy experience is, in itself, curative. Furthermore, the social behavior required for members to be esteemed by a cohesive group is also adaptive to the individual in his or her social life outside of the group.

Group cohesiveness also provides conditions of acceptance and understanding. Patients are, under cohesive conditions, more inclined to express and explore themselves, to become aware of and integrate hitherto unacceptable aspects of themselves, and to relate more deeply to others. Cohesiveness in a group favors self-disclosure, risk-taking, and the constructive expression of confrontation and conflict, all phenomena that facilitate successful psychotherapy.

Highly cohesive groups are stable groups with better attendance, active patient commitment and participation, and minimal membership turnover. Some group settings, such as those specializing in a particular problem or disorder (a cancer support group, a group for women law students run by a university health center) will, because of the members' shared problems, develop a great deal of immediate cohesiveness. In other kinds of groups, especially those where membership changes frequently, the leader must actively facilitate the development of this important and pervasive therapeutic factor (see Chapter 7).

■ INTERPERSONAL LEARNING: A COMPLEX AND POWERFUL THERAPEUTIC FACTOR

In group psychotherapy, each member is provided, ready-made, with a unique ensemble of interpersonal interactions to explore. Yet the potent therapeutic factor of interpersonal learning is often overlooked, misapplied, or misunderstood by leaders, perhaps because the understanding and encouragement of interpersonal exploration requires considerable therapist skill and experience. In order to define and understand the use of interpersonal learning in group therapy, we must examine four underlying concepts:

1. The importance of interpersonal relationships
2. The necessity of corrective emotional experiences for successful psychotherapy
3. The group as a social microcosm
4. Learning from behavioral patterns in the social microcosm

THE IMPORTANCE OF INTERPERSONAL RELATIONSHIPS

Interpersonal relationships contribute not only to the development of personality, as we discussed earlier, but to the genesis of psychopathology. Interpersonal interactions can thus be used in therapy both to understand and to treat psychological disturbances.

INTERPERSONAL RELATIONSHIPS AND THE DEVELOPMENT OF PSYCHOPATHOLOGY

Given the prolonged period of helplessness during infancy, the need for interpersonal acceptance and security is as crucial to the survival of the developing child as any basic biological need (11). To ensure and promote this interpersonal acceptance, a developing child accentuates those aspects of his or her behavior that meet with approval or obtain desired ends, and suppresses those aspects that engender punishment or disapproval. The little girl who grows up in a rigid household where the expression of emotion is discouraged, for example, soon learns to squelch her spontaneous feelings in favor of more detached behavior.

Psychopathology arises when interactions with significant others have resulted in fixed distortions that persist into life beyond the period of original shaping—distortions in how one tends to perceive others, distortions in the understanding of one's own needs and the needs of others, distortions in how one reacts to various interpersonal interactions. "There seems to be no agent more effective than another person in bringing a world for oneself alive, or, by a glance, a gesture, or a remark, shriveling up the reality in which one is lodged." (12)

INTERPERSONAL RELATIONSHIPS AND PRESENTING SYMPTOMS

Patients are generally unaware of the importance of interpersonal issues in their clinical condition. They seek treatment for

the alleviation of various troubling symptoms, such as anxiety or depression. The first task of the interpersonally oriented psychotherapist is to concentrate upon the interpersonal pathology which underlies a particular symptom complex; in other words, the therapist translates psychological or psychiatric symptoms into interpersonal language.

Consider, for example, the patient who complains of depression. It is rarely fruitful for the psychotherapist to address "depression" per se. The typical symptom cluster of dysphoric mood and neurovegetative signs does not in and of itself offer a handhold to begin the process of psychotherapeutic change. Instead, the therapist relates to the person who is depressed and ascertains the underlying interpersonal problems that both arise from and exacerbate the depression (problems such as dependency, obsequiousness, inability to express rage, and hypersensitivity to rejection).

Once these maladaptive interpersonal themes have been identified, the therapist has more tangible issues to address. Dependency, rage, obsequiousness, and hypersensitivity will all emerge in the therapeutic relationship and will be accessible to analysis and to change.

CORRECTIVE EMOTIONAL EXPERIENCES

Therapy is an emotional and a corrective experience. Patients must experience something strongly, but they must also understand the implications of that emotional experience. Therapeutic work consists of an alternating sequence of, first, affect evocation and expression, and second, the analysis and understanding of that affect. Franz Alexander introduced the concept of the "corrective emotional experience" in 1946: "The patient, in order to be helped, must undergo a corrective emotional experience suitable to repair the traumatic influence of previous experience (13)."

These two basic principles of individual psychotherapy—the importance of a strong emotional experience and the patient's discovery that his or her reactions are inappropriate—are equally crucial to group psychotherapy. In fact, the group setting offers far more opportunities for the genesis of corrective emotional experiences, as it contains a host of built-in tensions and multiple

interpersonal situations to which the patient must react.

For the interactions inherent in a group setting to be translated into corrective emotional experiences, two fundamental conditions are required:

1. The members must experience the group as sufficiently safe and supportive so that they are willing to express basic differences and tensions.
2. There must be sufficient feedback and honesty of expression to permit effective reality testing.

The corrective emotional experience in group psychotherapy thus has several components, summarized in Table 1.

THE GROUP AS SOCIAL MICROCOSM

A corrective emotional experience can occur in a group when basic tensions and modes of relating are allowed to emerge in a safe and honest environment, followed by examination of (and learning from) the ensuing interpersonal interactions. What makes group psychotherapy an ideal arena for this kind of interpersonal learning is that individual group members create their characteristic interactional tensions and engage in their maladaptive modes of relating to others right there in the group setting. Put another way, the therapy group becomes a social microcosm for each of its members, a microcosm in which each member can then undergo corrective emotional experiences.

TABLE 1. **Components of the Corrective Emotional Experience in Group Psychotherapy**

Features of Group	Process	Result
Safe environment Supportive interactions	Expression of basic tensions and emotions	Affect evocation
Open feedback Honest reactions	Reality testing and examination of each member's emotional experience	Affect integration

Sooner or later (given enough time and freedom, and provided that the group is experienced as safe), each member's underlying interpersonal tensions and distortions begin to emerge. Each person in the group begins to interact with other group members in the same way that he or she interacts with people outside of the group. Patients create in the group the same type of interpersonal world they inhabit on the outside. Competition for attention, struggles for dominance and status, sexual tensions, stereotyped distortions about background and values, all come to light.

The group becomes a laboratory experiment in which interpersonal strengths and weaknesses unfold in miniature. Slowly, but predictably, each individual's interpersonal pathology is displayed before the other group members. Arrogance, impatience, narcissism, grandiosity, sexualization—all such traits eventually surface and become enacted in the confines of the group.

In a group that is encouraged to free-run in a safe, interactionally oriented manner, there is almost no need for members to describe their past or to report present difficulties with relationships in their outside life. As in the clinical vignettes below, patients' group behavior provides far more accurate and immediate data. Individual members begin to act out their specific interpersonal problems before the eyes of everyone in the group and perpetuate their distortions under the collective scrutiny of fellow members. A freely interacting group eventually develops into a social microcosm of each of the members of that group.

CLINICAL VIGNETTES

Elizabeth was an attractive woman who, after her husband's job promotion and transfer, had left a high-powered career and had a baby; she soon entered a severe depression, and felt overwhelmed by pain she couldn't express. She found her life lacking in intimacy, and her outside relationships, including her marriage, felt superficial and unauthentic. In the group, Elizabeth was very popular. She was charming, sensitive, and concerned about everyone. However, she rarely let the group see behind her composed facade and into the depths of her pain and despair. Her great shame about her depression (after all, she was wealthy, privileged,

and "had it so good") and even deeper shame about the childhood of poverty and abuse from which she had risen resulted in her recreating in the group the same type of cordial but distant and unnourishing relationships she had established in her social life and marriage.

Alan joined the group complaining that his life contained no emotional highs or lows, but just a neutral, functional evenness. He had no close friends, and although he was extremely successful professionally, he had a compulsive, competitive, and intimidating attitude in the workplace that kept colleagues at a distance. Although he dated frequently, the thrill of the initial sexual conquest would inevitably pall; a woman he was most interested in had refused to commit to a relationship with him and had left the area, leaving him with a feeling of emptiness. Alan soon recreated this situation in miniature in the therapy group. Although he was an active and articulate member, he devoted himself to establishing a witty but condescending dominance over the women in the group, including the female cotherapist. The female members began to feel belittled and withdrew from him. He also adopted an exceedingly competitive and intimidating stance with the men in the group, and soon all the members began avoiding any meaningful or emotionally-laden interactions with him. Alan quickly succeeded in isolating himself from all fulfilling relationships in the social microcosm of the group, perpetuating his pervasive feeling of emptiness.

Bob was a young, rebellious artist with a delinquent tinge. His outside life was characterized by defiance toward authority and professional status, a defiance that was puerile and ineffective rather than the result of mature assertiveness. He eschewed real competition in his social and work life, and this attitude was seriously hampering his financial and professional success. In the group, he quickly adopted the role of provocateur, and he frequently challenged and prodded members. His relationship with the male cotherapist became especially complex: Bob soon found himself unable to look at the therapist face-to-face, or accept any positive feedback from him. When questioned, Bob would refuse to respond, and at times said he was afraid he would start to cry. This group work began to clarify the other side of Bob's defiance, and gradually he began to understand the counterdependent nature of his rebelliousness: Bob in fact had many dependent yearnings and a strong desire to be cared for, and his fear of those cravings led him to adopt his characteristic defiant attitude both in the group and in his life outside the group.

Because of the wide range of corrective emotional experiences offered in the group setting, the process of group psychotherapy provides the therapist with an extremely powerful tool for change, that of interpersonal learning. This process—in which psychopathology emerges from and is embodied in distorted interpersonal interactions; in which the group becomes a social microcosm as each member displays his or her interpersonal pathology; and in which feedback allows each member to experience, to identify, and to change his or her maladaptive interpersonal behavior—is schematically outlined in the following sequence and summarized in Table 2 (14, 15):

1. Psychopathology and symptomatology emerge from and are perpetuated by maladaptive interpersonal relationships; many of these maladaptive interpersonal relationships are based on distortions that arise from early developmental experiences.

TABLE 2. **Learning from Behavioral Patterns in the Social Microcosm of the Group**

Display of interpersonal pathology
↓
Feedback and self-observation
↓
Sharing reactions
↓
Examining results of sharing reactions
↓
Understanding one's opinion of self
↓
Developing a sense of responsibility for one's presentation of self
↓
Realizing one's power to effect change in presentation of self

2. Given enough time, freedom, and sense of safety, the therapy group evolves into a social microcosm, a miniaturized representation of each member's social universe.
3. A regular interpersonal sequence occurs:

Pathology display: Members display their characteristic maladaptive behavior as tensions and interpersonal interactions in the group emerge.

Feedback and self-observation: Members share observations of each other's behavior, and discover some of their blind spots and interpersonal distortions.

Sharing reactions: Members point out each other's blind spots, and share responses and feelings in reaction to each other's interpersonal behavior.

Result of sharing reactions: Each member begins to have a more objective picture of his or her own behavior and the impact it has on others. Interpersonal distortions become clarified.

One's opinion of self: Each member becomes aware of how his or her own behavior influences the opinions of others and, hence, his or her own self-regard.

Sense of responsibility: As a result of understanding how interpersonal behavior influences one's sense of self-worth, members become more fully aware of responsibility for correcting interpersonal distortions and establishing a healthier interpersonal life.

Realization of one's power to effect change: With the acceptance of responsibility for life's interpersonal dilemmas, each member begins to realize that one can change what one has created.

Degree of affect: The more affectively laden the events in this sequence, the greater is the potential for change. The more that the different steps of interpersonal learning occur as a corrective emotional experience, the more enduring is the experience.

Interpersonal learning is the cardinal mechanism for change in unstructured, longer-term, high-functioning interaction groups. In these settings, in fact, the elements of interpersonal learning are ranked by members as being the most helpful aspect of the group therapy experience (16, 17). Not all therapy groups

concentrate in an explicit manner on interpersonal learning; however, interpersonal interaction, with its rich potential for learning and change, occurs any time a group assembles. It behooves the group therapist of every persuasion to be familiar with these fundamental principles.

■ FORCES WHICH MODIFY THE THERAPEUTIC FACTORS

Group therapy is a forum for change whose form, content, and process varies considerably across groups in different settings with different goals, and within the same group at any given time. In other words, different types of groups make use of different clusters of therapeutic factors, and furthermore, as a group evolves, different sets of factors come into play. Three modifying forces influence the therapeutic mechanisms at work in any given group: the type of group, the stage of therapy, and individual differences among patients.

TYPE OF GROUP

Different kinds of groups make use of different therapeutic factors. When researchers ask members of long-term interactional outpatient groups to identify the most important therapeutic factors in their treatment, they consistently select a constellation of three—interpersonal learning, catharsis, and self-understanding (14). Inpatients, in contrast, identify other mechanisms: the instillation of hope, for example, and the existential factor of assumption of responsibility (18, 19).

Why these differences? For one thing, inpatient groups usually have high member turnover and are quite heterogeneous in clinical composition; patients with greatly differing ego-strength, motivation, goals, and psychopathology meet in the same group for varying lengths of time. Furthermore, psychiatric patients usually enter the hospital in a state of despair, after they have exhausted other available resources. The instillation of hope and the assumption of responsibility are most important for patients in this state. Long-term higher-functioning outpatients, however, are more stable and are motivated to work on more subtle and complex issues of interpersonal functioning and self-knowledge.

Groups that are centered around self-help concepts, such as Alcoholics Anonymous and Recovery, Inc., or specialized support groups, such as Compassionate Friends (for bereaved parents), have a clear and focused agenda. In such groups, an entirely different set of therapeutic factors will be most operative, generally those of universality, guidance, altruism, and cohesiveness (20).

STAGE OF THERAPY

Patients' needs and goals change during the course of psychotherapy, and so do the therapeutic factors which are most helpful to them. In its early stages, an outpatient group is concerned with establishing boundaries and maintaining membership, and factors such as instillation of hope, guidance, and universality dominate.

Other factors, such as altruism and group cohesiveness, are salient in outpatient groups throughout the duration of therapy. Their nature, however, and the manner in which they are manifested, changes dramatically with the stage of the group. Consider altruism, for example. Early in the group, patients manifest altruism by offering suggestions to each other, by asking appropriate questions, and by showing concern and attention. Later, they may be able to express a deeper sharing of emotion and a more genuine sharing.

Cohesiveness is another therapeutic factor whose nature and role in the group changes over time. Initially, group cohesiveness is reflected in group support and acceptance. Later, it facilitates self-disclosure. Ultimately, group cohesiveness makes it possible for members to explore various tensions, such as issues of confrontation and conflict, tensions so essential to interpersonal learning. These in turn foster a different, deeper sense of closeness and group cohesiveness. The longer patients participate in a group, the more they value the therapeutic factors of cohesiveness, self-understanding, and interpersonal interaction (17).

INDIVIDUAL DIFFERENCES AMONG PATIENTS

Each patient in group psychotherapy has his or her own needs, personality style, level of functioning, and psychopathol-

ogy. Each patient finds a different set of therapeutic factors to be beneficial. Higher-functioning patients, for example, value interpersonal learning more than do the lower-functioning patients in the same group. In a study of inpatient groups, both types of patients chose awareness of responsibility and catharsis as helpful elements of group therapy; however, the lower-functioning patients also valued the instillation of hope, whereas higher-functioning patients selected universality, vicarious learning, and interpersonal learning as additional useful experiences (19).

A group experience resembles a therapeutic cafeteria in that many different mechanisms of change are available and each individual patient "chooses" those particular factors best suited to his or her needs and problems. Consider catharsis: The passive, repressed individual benefits from experiencing and expressing strong affect, while someone with impulse dyscontrol profits from self-restraint and an intellectual structuring of the affective experience. Some patients need to develop very basic social skills, while others benefit from the identification and exploration of much subtler interpersonal issues.

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