THE THEORY AND PRACTICE OF GROUP PSYCHOTHERAPY

FOURTH EDITION

IRVIN D. YALOM

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PREFACE

Since group therapy was first introduced in the 1940s, it has undergone a series of adaptations to meet the changing face of clinical practice. As new clinical syndromes, settings, and theoretical approaches have emerged (and sometimes vanished), so too have corresponding variants of group therapy. The multiplicity of forms is so evident today that it is best not to speak of group therapy but of the many group therapies. Eating-disorders groups, cancer support groups, groups for victims of sexual abuse, for AIDS patients, for the confused elderly, for individuals disabled by panic disorders or obsessive-compulsive symptoms, for patients with chronic schizophrenia, for adult children of alcoholics, for parents of sexually abused children, for male batterers, for the divorced, for the bereaved, for disturbed families, for married couples, for patients with myocardial infarct, paraplegia, diabetic blindness, renal failure, bone marrow transplant—all of these are forms of group therapy.

The settings of group therapy are also diverse: a group for chronically or acutely psychotic patients on a stark hospital ward is group therapy and so, too, is a group of relatively well functioning individuals with neurotic or characterological disorders meeting in a psychotherapist's well-appointed private office.

And the technical styles are bewilderingly different: gestalt, brief therapy groups, supportive-expressive, cognitive-behavioral, psychoanalytic, psychoeducational, dynamic-interactional, psychodrama—these, and many more, are all group therapy.

The family gathering of group therapies is swollen even more by the presence of distant relatives, groups that are cousin to therapy groups: experiential

classroom training groups (or process groups) and the numerous self-help (or mutual support) groups like Alcoholics Anonymous (and numerous other twelve-step recovery groups), Adult Survivors of Incest, Sex Addicts Anonymous, Parents of Murdered Children, Overeaters Anonymous, and Recovery, Inc. Though these groups are not formal therapy groups, they are very often *therapeutic* and straddle the blurred borders between personal growth, support, education, and therapy (see chapter 16 for a full discussion of this topic).

How, then, to write a single book that addresses *all* these group therapies? The strategy I chose twenty-five years ago when I wrote the first edition of this book seems sound to me still. As my first step, I attempted to introduce order by separating "front" from "core" in each of the group therapies. The *front* consists of the trappings, the form, the techniques, the specialized language, and the aura surrounding each of the ideological schools; the *core* consists of those aspects of the experience that are intrinsic to the therapeutic process—that is, the *bare-boned mechanisms of change.*

Disregard the "front," consider only the actual mechanisms of effecting change in the patient, and we find that these mechanisms are limited in number and remarkably similar across groups. Therapy groups with similar goals that appear totally different in external form may rely on identical mechanisms of change. In the first and second editions of this book, influenced by the positivistic zeitgeist surrounding the developing psychotherapies, I referred to these mechanisms of change as "curative factors." I have been educated and humbled by the passing years and I know now that the harvest of psychotherapy is not *cure*—surely, in our field, that is an illusion—but instead change or growth. Hence, yielding to the dictates of reality, I have rechristened the "curative factors" as "therapeutic factors."

The therapeutic factors constitute the central organizing principle of this book. I begin with a detailed discussion of eleven therapeutic factors and from there proceed to describe a psychotherapeutic approach based on these factors.

But which types of groups to discuss? The array of group therapies is now so vast that it is not possible to address each type of group separately: for example, a review of the recent research literature (excluding the clinical literature) for group therapy of only one syndrome (eating disorders) lists 120 references,[1] and a similar research review for one group modality (brief group therapy) lists over 230 recent studies.[2] How then to proceed? My strategy in this book is to center my discussion around a prototypic type of group therapy and *then to offer a set of principles that will enable the student to modify this fundamental group model to fit any specialized clinical situation.*

My prototypic model is the intensive, heterogeneously composed, outpatient psychotherapy group with its ambitious goals of both symptomatic relief and characterological change. Why focus on this particular form of group therapy? After all, the contemporary therapy scene, so driven by economic factors,

is dominated by homogeneous, symptom-oriented groups that meet for briefer periods and have more narrow and limited goals. The answer is that long-term group therapy has been around since the 1940s and has accumulated a great body of knowledge from both empirical research and thoughtful clinical observation. This intensive and ambitious form of therapy is demanding of both patient and therapist. The therapeutic strategies and techniques required to lead such a group are sophisticated and complex. However, *once students master them and understand how to modify them to fit specialized therapy situations, they will be in a position to fashion a group therapy that will be effective for any clinical population in any setting.*

The great majority of my readers are clinicians, and I intend this text to be of immediate clinical relevance. I also believe, however, that it is imperative that clinicians remain conversant with the world of research: even if one does not personally engage in research, one must know how to evaluate the research of others. Accordingly, I review and rely heavily upon relevant clinical and basic social and psychological research. While searching through library stacks during the writing of this book, I often browsed in antiquated psychiatric texts. How unsettling it is to realize that the devotees of therapy through venesection, starvation, purgation, and trephination were obviously clinicians of high intelligence, dedication, and integrity. The same may be said of the former generation of therapists who advocated hydrotherapy, rest cures, lobotomy, and insulin coma. Their texts are as well written, their optimism as unbridled, and their reported results as impressive as those of contemporary practitioners.

Many other patient-care fields have left us far behind because they have applied the principles of the scientific method. Without a rigorous research base, the psychotherapists of today who are enthusiastic about current treatment modes are tragically similar to the hydrotherapists of yesterday. As long as it does not use scientific rigor to test basic principles and treatment outcome, the field remains at the mercy of passing fashions. Therefore, whenever possible, I have attempted to base my approach upon rigorous relevant research and to call attention to areas in which further research seems especially necessary and feasible. Some areas (for example, preparation for group therapy or group dropouts) have been successfully studied, while others (for example, "working through" or countertransference) have been virtually untouched by research. Naturally the relevant chapters reflect this distribution of research emphasis: some chapters may appear, to clinicians, to stress research too heavily, while other chapters may appear, to research-minded colleagues, to lack rigor.

Let us not expect more of psychotherapy research than it can deliver. Will psychotherapy research effect a rapid major change in therapy practice? Very unlikely! Why? Resistance, for one thing. Complex systems of therapy with

adherents who have spent many years in training and apprenticeship and who cling stubbornly to tradition will change slowly and only in the face of very substantial evidence. Furthermore, front-line therapists faced with suffering patients obviously cannot wait for science. Also, keep in mind the economics of research. The marketplace controls the focus of research. If managed-care economics dictates a massive swing to brief, symptom-oriented therapy, then research projects focusing on the process of long-term therapy—even in the face of heavy clinical consensus about the importance of such research—will not be funded. And there is one last consideration: unlike the physical sciences, many aspects of psychotherapy inherently defy quantification. Psychotherapy is both art and science; research findings may ultimately shape the broad contours of practice, but the human encounter at the center of therapy will always be a deeply subjective, nonquantifiable experience.

One of the most important underlying assumptions in this text is that interpersonal interaction is crucial in group therapy. The truly potent therapy group first provides an arena for patients to interact freely with others, then helps them to identify and understand what goes wrong in their interactions, and ultimately enables them to change those maladaptive patterns. I believe that groups resting *solely* on other assumptions, such as psycho-educational or cognitive-behavioral principles, fail to reap the full therapeutic harvest of group therapy. Each of these forms of group therapy can, in my view, be made even more effective by incorporating a focus on interpersonal process.

This point needs emphasis: it has great relevance for the future of clinical practice. The advent of managed care will ultimately result in increased use of therapy groups. But, in their quest for efficiency, brevity, and accountability, managed-care decision makers may make the mistake of deciding or decreeing that some distinct orientations (brief, cognitive-behavioral, symptom-focused) are more efficient because their approach encompasses a series of steps consistent with other efficient medical approaches: the setting of explicit, limited goals; the measuring of goal attainment at regular, frequent intervals; a highly specific treatment plan; and a replicable, uniform, manual-driven, highly structured therapy with a precise protocol for each session.

But do not mistake the *appearance* of efficiency for true effectiveness. Later in this text I will discuss, in depth, the extent and the nature of the interactional focus and its potency in bringing about significant character and interpersonal changes. But what about the more modest goal of managed care: relief of presenting symptoms? Though the prevailing belief is that the cognitive-behavioral or skills-training mode is more efficient in producing symptomatic relief, *there is no research evidence to support that claim.* There have been only a few good studies (using random assignment of patients and rigorously controlled methodology) comparing the outcomes of the brief, systematic cognitive-behavioral approach (which omits a focus on interaction) with an

equally brief, less systematic, more humanistic and interactive approach. These have involved a number of symptoms in diverse clinical populations (HIV-infected persons, alcoholics, depressed college students, depressed adults, incest victims, and those with various eating disorders). In each project both methods have proved effective in the alleviation of specific targeted symptoms; not one experiment has demonstrated a significant difference in outcome between the two.[3]

It was with some reluctance that I undertook the considerable task of revising this text. For the most part, I remain satisfied with the theoretical foundations and the technical approach to group therapy as delineated in the third edition. Yet age spares few books, and the third edition was beginning to show its seams. At my last reading, it seemed awash with dated or anachronistic allusions. Furthermore, the field has changed: managed care, like it or not, has arrived and set up housekeeping; a new diagnostic system (DSM-IV) has appeared; a decade of clinical and research literature needed to be reviewed and assimilated into the text; new types of groups have sprung up and others have passed away. Problem-specific brief therapy groups are growing more frequent, and I have made a special effort throughout to address the particular issues germane to these groups. Furthermore, my notebooks were bulging with new clinical observations and illustrations from the great many group meetings I have led since the publication of the last edition.

The first four chapters discuss eleven therapeutic factors. Chapter 1 covers instillation of hope, universality, imparting information, altruism, the corrective recapitulation of the primary family group, the development of socializing techniques, and imitative behavior. Chapters 2 and 3 present the more complex and powerful factors of interpersonal learning and cohesiveness. Chapter 4 discusses two final therapeutic factors, catharsis and existential factors, and then attempts a synthesis by addressing the comparative importance and the interdependence of all eleven therapeutic factors.

The next two chapters address the work of the therapist. Chapter 5 discusses the tasks of the group therapist—especially those of shaping a therapeutic group culture and of harnessing the group interaction for therapeutic benefit. I emphasize, in chapter 6, that the therapist must both activate the here-and-now (that is, plunge the group into its own experience) and illuminate the meaning of the here-and-now experience.

If chapters 5 and 6 address what the therapist must *do*, then chapter 7 addresses how the therapist must *be*. It explicates the therapist's role and the therapist's use of self by focusing on two fundamental issues: transference and transparency. In previous editions, I felt compelled to encourage therapist restraint: many therapists were still so influenced by the encounter group movement that they, too frequently and too extensively, "let it all hang out."

Times have changed. In this edition, I feel compelled to discourage therapists from practicing too defensively. Many contemporary therapists, threatened by the encroachment of the legal profession into the field (a result of the irresponsibility and misconduct of some therapists, coupled with a runaway, greedy malpractice industry), have grown too conservative and cautious in their use of self in psychotherapy.

Chapters 8 through 14 present a chronological view of the therapy group and emphasize group phenomena and the therapist's techniques that are relevant to each stage. Chapters 8 and 9 (on patient selection and group composition) have been revised to include DSM-IV implications, to make them more relevant to contemporary group therapy practice, and to include new research data on group therapy attendance, dropouts, and outcome. Chapter 10 discusses the practical realities of beginning a group, includes a lengthy new section on brief group therapy, and presents much new important research on the preparation of the patient for group therapy.

Chapter 11 addresses the early stages of the therapy group and includes new material on dealing with the therapy dropout. Chapter 12 deals with phenomena encountered in the mature phase of the group therapy work: subgrouping, conflict, self-disclosure, and termination. I have reorganized the discussion of problem patients in chapter 13, to include a section on the "characterologically difficult patient" (schizoid, narcissistic, and borderline), which reflects changes in both DSM-IV and self-psychology theory. Chapter 14, on specialized techniques of the therapist, contains a new section on the important format of combined (individual and group) therapy, as well as discussions of conjoint therapy, co-therapy, leaderless meetings, dreams, videotaping, and structured exercises, and on the use of the written summary in group therapy.

Chapter 15, on the specialized therapy group, addresses the many new groups that have emerged to deal with specialized clinical syndromes or specialized clinical situations. It presents the principles used to modify traditional group therapy technique in order to design a group to meet the needs of other specialized clinical situations and populations. These principles are illustrated by an in-depth description of the most common (and most challenging) specialized therapy group—the acute psychiatric inpatient group.

Chapter 16, on the encounter group, presented the single greatest challenge for this revision. Because the encounter group *qua* encounter group has faded from contemporary culture, I considered deleting the chapter entirely. However, several factors argue against this: the historical and research value of encounter groups, the use of encounter groups (also known as process groups, T-groups, or experiential training groups) in group psychotherapy education, and the fact that more people than ever are attending groups that use aspects of encounter group technology (a recent survey concludes that four out of ten

adult Americans regularly attend a small group).[4] Hence I have been persuaded to retain this chapter but to shorten it and adapt it to contemporary group therapy practice.

Chapter 17, on the training of group therapists, has been altered to reflect changes in educational requirements and teaching techniques in student education.

Excessively overweight volumes tend to gravitate to the "reference book" shelves. In the hope that this book avoid that fate, I have resisted lengthening it. Since much new material has been added, I have had the painful task of cutting older sections and citations. (I left my writing desk daily with fingers stained by the blood of many condemned passages.) To increase readability, I have consigned almost all details and critiques of research method to footnotes or to notes at the end of the book.

I am grateful to Stanford University for providing the academic freedom and the research accoutrements necessary to accomplish this work. To Jerome Frank, my thanks for having introduced me to group therapy and for having offered a model of integrity, curiosity, and dedication. Many have assisted me in this revision: my son Victor Yalom, Ph.D., helped me at many stages and took a primary responsibility in reviewing, updating, and synthesizing the research for chapters 3 and 4; Professor Molyn Leszcz of the University of Toronto ably reviewed and critiqued the entire manuscript; my daughter-in-law, Tracy LaRue, acted as my primary research assistant and, along with Caroline Constantz, was my main liaison with the library; Morton Lieberman offered many substantive suggestions, particularly regarding chapter 16; my son Benjamin Yalom and Charlene Son offered formidable computer and modem backup. Many others offered valuable suggestions for parts of the manuscript: Robert Dies, Martel Bryant, Alan Sklar, Donald Ehrman, Robert Lipgar, Jordan Litvak, Christine Kieffer, Simon Budman, Michael Weiss, Hillel Swiller, Barbara August, Saul Tutman, Priscilla Kauff, Dustin Nichols, and students attending my group therapy classes at Stanford. To all, my gratitude.

THE THEORY AND PRACTICE OF GROUP PSYCHOTHERAPY

CONTENTS

CHAPTER 1

The Therapeutic Factors

How does group therapy help patients? A naive question. But if we can answer it with some measure of precision and certainty, we will 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 process of change will constitute a rational basis upon which the therapist may base tactics and strategy.

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

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

1. Instillation of hope
2. Universality
3. Imparting 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 will 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.

The distinctions among these factors are arbitrary; though I discuss them singly, they are interdependent and neither occur nor function separately. Moreover, these factors may represent different parts of the change process: some factors (for example, universality) refer to something the patient learns; some (for example, development of socializing techniques) refer to changes in behavior; others (for example, cohesiveness) may be more accurately described as preconditions 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 benefit from widely differing clusters of therapeutic factors.

Keeping in mind that the therapeutic factors are arbitrary constructs, we can view them as providing a cognitive map for the student-reader. This grouping of the therapeutic factors is not set in cement: other clinicians and researchers have arrived at a different, and also arbitrary, cluster of factors. No explanatory system can encompass all of therapy. At its core, the therapy process is infinitely complex, and there is no end to the number of pathways through the experience. (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 is beyond doubt, however; neither group members nor group leaders are entirely objective, and our research methodology is often crude and inapplicable.

From the group therapists we obtain a variegated and internally inconsistent inventory of therapeutic factors (see chapter 4). Therapists, by no means disinterested or unbiased observers, have invested considerable time and energy in mastering a certain therapeutic approach. Their answers will be determined largely 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 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