There was that law of life, so cruel and so just, that one must grow or else pay more for remaining the same.

—Norman Mailer, *The Deer Park*

Even a neophyte group therapist observing two groups, one having been in existence for three or four sessions and another for several years, would quickly be able to determine which is the older and functionally more mature group. A process has taken place that is the result of what are called group dynamics and group development. In this chapter we will address these two elements, which may be considered the “basic sciences” of group formation and function.

**GROUP DYNAMICS**

*Group dynamics*, a term coined by Kurt Lewin, are the interacting forces that define how the whole group functions. When we refer to group dynamics, we are viewing the group in its totality, and hence our perspective differs from one in which there is a summation of individual personal psychodynamics. A group is similar to a family, in which parents pass on to their children their personal values. This transmission is not always a conscious process because the values are influenced by the subgroups and the
culture to which the family belongs. As children grow, they may have a reciprocal impact upon their parents’ values. Family customs and attitudes evolve as children grow, and their developmental requirements change. Children also influence their parents to change.

Group values and norms also evolve, and changes are observable in how members interact with one another or with the leader, what they find interesting, and what they ignore. Careful observation will show that some ideas are reinforced and others ignored. Members of one group might report many dreams (if the therapist is a person known to have an extensive interest in dream analysis), whereas members from another group might focus on their relationships. The variations are countless, and they represent the norms and culture of the group. The group dynamic perspective explores the group as a social field in which elements of leadership, status, roles, structure, climate, standards, pressure, and communication are in interaction (Forsyth, 1999). We now examine the elements of leadership, culture, and roles as central components in the understanding of group dynamics and processes.

**Leadership**

Leadership can be understood from a social systems perspective as the responsibility for defining the tasks and goals of the group (Skolnick, 1992). Having determined the basic purpose of the group, the therapist defines the structure, time, place, frequency, duration, and size of the meetings. With these elements in mind, member selection and preparation can be made based on the availability of patients who may potentially be able to use the therapeutic processes compatible with the group tasks and goals. From a systems perspective, these tasks can be viewed as managing the external and internal group boundaries.

The leader’s attention to internal group boundaries includes defining the nature of the relationships among members and with the therapist and how members are to proceed in order to achieve their (and the therapist’s) goals. Many of these elements are spelled out in the group agreement (see Chapter 8) and include how communication will take place (in words, not actions) and what level of communications will be addressed (both conscious and unconscious). The boundaries among the members, subgroups, and with the therapist are also defined in order to optimize the therapeutic interactions (i.e., subgrouping among members should be openly discussed). One powerful aspect of the therapist’s “education” of the members is helping them consider their in-group experience as a microcosm of their external lives (Slater, 1966). This phenomenon is also described by Garland (1982), who attempts to have members take the so-called nonproblem (“non-problem” in Garland’s paper) seriously; the term *nonproblem* here refers to members’ reenactment of their problematic relationships within
the group, which may differ from, or replicate, the complaints for which they sought treatment.

The structure of psychodynamic therapy groups, paradoxically, includes both strong direction and nondirection from the leader. Psychodynamic therapists tend to follow the group process rather than initiate it. Initially and throughout, the leader uses real authority in establishing viable therapeutic boundaries and mechanisms. However, within that therapeutic framework, the leader invokes a nondirective leadership role that enhances regressive fantasies and projections. Group leaders become objects of members' fantasies. According to Wilfred R. Bion (see Chapter 2), basic-assumption behavior exists immediately upon entering the group, and if the basic assumption of dependency is active in the group, the leader most likely will be the focus of attention. In a regressed state, members experience and respond to their therapist in polarities: benevolent/malevolent, faultless/flawed, omnipotent/powerless, or omniscient/unknowing. They communicate with the therapist through projective processes, subjecting him/her to powerful feelings such as hate, envy, or love. The therapist's role includes containing and internally processing (metabolizing) these powerful affects in order to use them for therapeutic purposes.

A major role task is management of boundaries. The challenge for the therapist is to create flexible boundaries that can ensure the integrity of the group but are not so loose that structure and safety are sacrificed. Generally there is little negotiation regarding external functions and structure. The therapist initiates the agreements regarding group structure, and the patients accept them as a precondition for group membership. Although external events or situations may result in these agreements changing, it is up to the therapist to effect these changes. Norms and values change as a group matures, and the manner in which members address the group boundaries become more flexible in more advanced groups.

Newton (1973) compares the therapist's tasks to those of a parent, and by extension he views the parental role as an opportunity for particular transference configurations. He asserts that paternal transference is evoked by the therapist's role of managing the external relationships—providing a safe space. Maternal transference is evoked by the internal group tasks—monitoring relationships among members and with the therapist. Thus, the dynamics and structure of the group are conceptualized as influencing the emergence of transference, which is not solely a response to the gender of the clinician.

That the role of leader inevitably invites transference is recognized even in the business world (Maccoby, 2004), where leaders often evoke extremely powerful feelings from their subordinates, not infrequently negative. Leaders must remember that the role is often lonely, and members invariably have mixed and ambivalent feelings about them, just as they do about their parents. Leaders will be neither consistently loved nor hated.
Group Culture and Norms

In the course of time, particular ways of handling conflicts or affects become ingrained within the interactional patterns of groups. Groups develop particular kinds of culture, which help define what individuals can and cannot do as well as how they express themselves or deal with affects.

For example, two groups in their beginning stage may attend to the issues of joining in quite different ways. The members in the first group look to the therapist for solutions to the problems of joining, whereas members in the other talk primarily to one another and ignore the therapist. These represent two differing group cultures; members are negotiating the same tasks of joining and forming a group but are doing so in different ways. The study of a group culture helps the clinician understand the underlying principle by which the members relate to one another, to the therapist, and to the group. It is a way of viewing the organization of the group. Every group develops norms (both conscious and unconscious) regarding appropriate behavior. These norms begin with the expectations of the members and the therapist.

Because the therapist serves as a regulator of the group boundaries and initially defines what is of interest to the group (Astrachan, 1970), s/he is a powerful contributor to group culture. For leaders who focus on the here and now and the affects raised in the therapy room, a description of a childhood event would be a distraction, so soon members would no longer relate childhood events. For therapists who accord a childhood story of metaphorical value, such a memory might throw light on group dynamics in the immediate setting. Such a therapist might delight in hearing such a story from childhood and thereby reinforce the likelihood that other members would share comparable stories from their pasts. For a therapist who values the place of genetic exploration, the childhood story might represent an important piece of personal work for the group member. Because the therapist is a potent initiator of group norms, reinforcement through interest or noninterference serves to communicate and establish appropriate ways of interacting within the group. Often a dichotomy exits between therapists who emphasize transferences to the leader, thereby helping individuals learn of these inner fantasies, and therapists who focus on peer transactions, which highlight the learning of social skills and the giving and receiving of feedback but diminish exploration of the unconscious (Klein & Astrachan, 1971). Groups led by therapists from these different theoretical positions might be equally effective, but they would carry on their work quite differently.

The therapist is not solely responsible for normative behavior and the subsequent group culture. The individuals who constitute the group are constantly changing and altering ways in which norms are expressed. These are not usually major changes, however, because, once established, norms
are rather difficult to alter. In a study of T-groups, Lieberman, Yalom, and Miles (1973) found that the expectations that members brought with them acted as a powerful set of constraints that were unlikely to be reversed in the actual state of affairs. Furthermore, in determining eventual outcome, the impact of the individual upon the group norms is as potent as the leader’s. Recognition of norms and the resultant culture provides another perspective through which the therapist can begin to explore the members’ personalities and to understand differences in group development.

As the group culture develops, forces operate that lead to either cohesion or dispersal. The attractiveness and sense of belonging to a particular culture has been labeled group cohesion (Day, 1981). (This term is akin to the concept of the therapeutic alliance in individual therapy.) The ability of a group to influence behavior and, indeed, for members to identify with its values and goals is, in part, a product of its attractiveness. Unfortunately, group cohesion often has been thought of as a static phenomenon, whereas in truth it is dynamic and changing. What might make a group attractive in a beginning developmental stage (e.g., sharing stories of outside experiences) would be seen as a distraction for a mature group. Implicit in the notion of cohesion is a basic trust that members will not willfully injure other members and that there will be an effort to understand others’ inner world and their interactions. This formulation is the group equivalent to the holding environment in dyadic therapy (Winnicott, 1965). Developmental progress is signaled by members’ capacities to recognize individual differences and idiosyncrasies, a recognition which increases group attractiveness. Patients learn to hear what others are experiencing, even when that differs from their own perceptions. Put simply, a member might ask, “Where else can I go and have emotionally meaningful exchanges in an atmosphere in which I can trust and be trusted?” Deeper progress may be signaled by members’ willingness to recognize individual similarities of attitudes and characteristics that are painful or shameful to recognize in oneself.

**Roles**

In the beginning the only clear function (role) in a therapy group is that of therapist. As groups develop, specialized functions emerge that serve to manage the emotional and work tasks. This emergence of roles was noticed very early by Benne and Sheats (1948), who classified three types of group roles: task roles, maintenance roles, and ego-centered roles. As in business, some individuals have particular talents to fill specific roles that successfully interact with the group culture and norms. Others are “assigned” roles that fail to fulfill their own personal needs but may serve the group (Astrachan, 1970). When the concept of role is used to describe behaviors
in a therapy group, it is important to distinguish between specialized functions within the group itself and characteristic behavioral patterns of a particular individual. The fact that groups often typecast their participants, using personal roles to fill certain group functions, simply confuses the matter further.

Examined from the perspective of the whole group, roles serve both emotional and task functions (Parson, Bales, & Schils, 1953). Some roles seem to facilitate the group effort to work on problems by encouraging exploration of affect or important topics. Others serve to maintain restrictive culture and norms (Benne & Sheats, 1948). A host of specific titles may be assigned to the roles, but basically a group-wide function is being addressed. MacKenzie (1990) condenses the multitude of labels into the following four roles:

1. The **structural** role focuses on understanding the group tasks and is primarily a leadership role. Some individuals who enter treatment with a history of skilled leadership may serve the group effectively, whereas others may demonstrate ineffective (e.g., overly controlling or dominating) leadership. Some members gradually learn how to adopt leadership roles and benefit from these enhanced skills in their lives outside the group.

2. The **sociable** role describes one who is attuned to the quality of feelings in interpersonal relationships. These individuals tend to regulate the amount and kind of affect. For example, group affect can be modified or lessened by certain types of humor and joking. Such functions can facilitate or inhibit group movement. Too much feeling may overwhelm and fragment the group; too little feeling may produce a group that becomes stuck intellectualizing. Members certainly are capable of accurate empathy, labeling emotions, inviting more direct expression of feelings, or accurately understanding the emotional position of the speaker—each of which serves to move the group forward. However, as with all such roles, the individual who characteristically quashes emotions may not serve a welcomed group function and may be forced into another role—that of deviant or scapegoat.

3. The **divergent** role most often is associated with a scapegoat, which is unfortunate because this role serves a very valuable function of providing differing perspectives. This is the oppositional or rebellious person who does not ordinarily comply with group norms or values. In a well-functioning group, it soon becomes apparent that all persons have such affects, and indeed one of the core conflicts of entering a group is that of joining while still maintaining one’s own values. The deviant role serves the therapeutic function of potentially bringing to the fore oppositional, rebellious, or deviant emotions or ideas for examination. It would be a dull and nontherapeutic group indeed if everyone agreed! However, the role carries a danger to the individual, who may be scapegoated and extruded. The
group then loses the potential for examining hidden or “unacceptable” aspects of its membership. For example, the leader may encourage the group’s ability to self-reflect by suggesting that the scapegoat has introduced a topic, although difficult, which may help people see parts of themselves that are experienced as unacceptable. This approach highlights the positive nature of the scapegoat (divergent) role and may have the additional benefit of stimulating self-reflection for the scapegoat, whose character problems tend to draw him or her into that role.

4. The cautionary role is often first identified in the silent person. All of us have secrets and fears that we wish to keep private. From that perspective the function of this role becomes clear. The cautionary member demonstrates the potential humiliation and shame that are possible in any interpersonal encounter. Although the cautionary member is less likely to be scapegoated and extruded than the deviant member, s/he may end up ignored. Attention to the group function being served by this individual may help free members to risk sharing shameful or guilt-ridden aspects of themselves.

It is important to understand that groups might use a particular individual in a specific role, or several individuals might be required to fill the function. In most instances members are drafted to fill roles that are consistent with their personality styles or predilections. For instance, in a situation where intense emotion is present, one or more members may regulate the intensity through joking, direct soothing, or diversion, thereby taking up the sociable role. It is the function that is important, rather than the individual or perhaps even the specific mode. On occasion, under intense affective stimulation and in the absence of a member with the necessary valency, a person might (unconsciously) be called upon to fill a role that is quite alien. This process is labeled “role suction” by Redl (1963) and “role responsiveness” by Sandler (1976). Groups provide a rich forum for members to try out new roles, with an important goal of group therapy being the development of role flexibility in contrast to role rigidity—the typical state of affairs for most individuals.

Members enter a group with their own specific repertoire of roles, which they have used in other life situations. Albert Einstein is reputed to have once mused that “insanity is using the same process repeatedly in the fond hope that the results will be different.” Only rarely are roles generated solely by group processes. One of the purposes of gaining personal historical information is for the therapist and patient to become aware of these stereotypic patterns. However, it is not unusual for an individual to take on a role whose past determinants are unknown to both patient and therapist. When this happens, the opportunity for therapeutic gain is great, because unconscious conflicts are observable in current behavior.
To illustrate the overlap that occurs between groups and individual behaviors, we can consider common types of early group behaviors. Often one or more “hosts” will initiate the introductions and fill up silences. This function may become “assigned” to one person, who will routinely handle affects surrounding newness, beginnings, or silences, or the role may be divided among a few individuals. Individuals who routinely accept the host role may come to this role from a variety of sources. It may be a lifelong pattern of bearing the emotional burden of their families, or it could represent exhibitionistic needs to be the center of attention no matter what the psychic cost, or perhaps a need to be the favorite child in the family. Whatever the derivation of the role, it is generally quite facilitative to the beginning group.

Often some members are essentially mute in the initial meetings. Their silence also is not a new behavior generated specifically for this difficult situation (Gans & Counselman, 2000). Individuals bring out habitual responses of silence to cope with this new stress. Again, the source of this behavior can be quite diverse: It may represent a passive–aggressive position in which the person commands attention through the power of passivity. It may be the youngest sibling once again playing out the role of waiting until last to be fed. It may represent a chronic altruism—an assumption that the needs of others must come first. It may represent a martyr role. Or, of course, it could be the manifestation of terror in this interpersonal arena.

Another subset of behaviors, often labeled as problematic roles, are more directly related to an individual’s character (Benne & Sheats, 1948). These behaviors satisfy individual needs but may be evoked by specific triggers, often unconscious, arising in the group discourse, and they may become a dominant force operating within the group. Individuals who express these roles are viewed negatively, and members often have a strong wish to extrude them from the group. These roles include the monopolizer, the help-rejecting complainer, the naive one, the supplicant, and the playboy. Novice clinicians not uncommonly assume that such behaviors are purely a function of the individual’s own dynamics rather than part of a complicated group dynamic that maintains the problematic behaviors. The therapeutic management of some of these roles is discussed later in this book.

Of course, not every behavioral pattern or role is self-destructive or pathological. At root all such behaviors can be seen as adaptive and as serving some purpose. The therapist needs to discriminate between the useful and adaptive aspects of these roles for the individuals themselves and the potentially destructive and constraining aspects of these roles for the group. The same role can be both healthy and, if pushed to an extreme, pathological. Moreover, the group therapist needs to alternate continually between the group and the individual developmental perspectives (see Chapter 9). A role that may be productive for the group may be constricting for the indi-
vidual, and vice versa. A balance must be struck as to which aspect to explore and in what order so as to maximize the therapeutic effectiveness of the group for all members.

**GROUP DEVELOPMENT**

Understanding the broad outlines of predictable group evolution, complete with the tasks involved in the various stages of that evolution, provides an anchor for the therapist. Just as a knowledgeable individual therapist can gain a deeper understanding of his/her patients' ideas and associations by having an appreciation of the developmental levels and the associated tasks for individuals as they grow, so group therapists are helped by understanding the usual stages of group development. However, groups, like individuals, do not move forward in a linear fashion: They are subject to forward and backward movement. Furthermore, these fluctuations do not take place automatically or by any set timetable.

Not everyone endorses the concept of development within groups. Slavson (1957) attempted to expunge group processes from psychotherapeutic groups; he focused purely on interpersonal interactive processes. Slavson's position represents an effort to transpose classical dyadic psychoanalytic concepts (transference and resistance) into the group psychotherapy settings. By linking group interaction closely to dyadic therapy, Slavson and others (see Wolf & Schwartz, 1962) stressed the continuity of psychodynamic/psychoanalytic concepts. This historic bridge made group therapy acceptable, if not attractive, to the mainstream of the American psychotherapeutic community.

Most of what we know about group development emerged from studies of time-limited, closed-membership groups (Bennis & Shepard, 1956; Tuckman, 1965). Generalization of these ideas to ongoing, open-membership psychotherapy groups has often been done indiscriminately. There is overlap, but the two situations are not identical. For instance, a psychotherapy group has only one actual beginning. Yet, with each addition of one or more new members there is a modified new beginning, usually accompanied by reemergence of themes and modes of relating similar to those at the time of the initial sessions. Moreover, events inside or outside an ongoing group may set off a recrudescence of power struggles characteristic of the second stage of development. The repetition of various developmental stages provides an opportunity to rework previously traversed ground, sometimes in greater depth and with increased insight, and therefore has considerable therapeutic potential.

Group development is a product of the individual members and their interactions among themselves and with the therapist. Accurate assessment of the developmental level of group-wide functioning can aid the therapist.
in assessing the progress patients may be making. For example, less advanced patients may make major gains while working on the early issues of joining, trust building, and belonging to a group. A group of such patients will likely remain at early levels of development for prolonged periods, which would be quite beneficial to that population. Consistent movement to the next level would indicate an important achievement. Patients who have conflicts at a more advanced developmental level often make less therapeutic gain at early levels of group development.

Thus far no schema describing group development has been able to do justice to the complexity of internal fantasies and behavioral transactions that occur when individuals organize and begin to work together in a small group. The tradition of linking individual psychodynamics of oral, anal, and phallic development to similar stages of group development (Savaray, 1975; Gibbard & Hartman, 1973) does not capture the complex phenomena. A somewhat more complete model linking the two fundamental elements present in a successful group—attaining goals and attending to members’ emotional needs—is present in Bion’s model of group functioning. The basic assumption group is one in which the members are responding primarily to their emotional needs. In contrast, the work group is rational and functions to achieve goals. This model is more descriptive than developmental. The group focal conflict model of Whitaker and Lieberman (see Chapter 2) takes into account development in the formulation of restrictive and enabling solutions, which are fueled by conscious and unconscious emotional needs of the members. A more detailed formulation of group stages, which explores particular patient or clinician behaviors that signal developmental shifts, has been formulated by Beck and her colleagues for clinical and research purposes (Beck, Dugo, Eng, & Lewis, 1986; Lewis, Beck, Dugo, & Eng, 2000).

As discussed in Chapter 2, some therapists reify group development and focus on little else. In our view, however, the stages of development are best used as indicators to help the therapist more fully understand what is going on in the group. One stage is not inherently more valuable than another. A common misconception among therapists is that in order to have a “good” group, it is imperative that the group attain and maintain the most advanced developmental level. For many patients this would be asking the impossible. Rather, there should be a reasonable fit between the level of group development and the dynamic issues salient for the members.

Group development can be seen as occurring in four stages: the formative stage (joining and forming the group); the reactive stage (managing concerns about belonging); the mature stage (working maturely toward goals); and the termination stage (separating/terminating). Therapists are wise to remember that the ultimate goals of therapy—greater intrapsychic calm, improved interpersonal functioning, and deepened self-knowledge—can occur during any of these four stages. Keep in mind that these are sche-
matic presentations. Only careful study of the processes and the individuals in each particular group will provide the base for meaningful therapeutic change.

**Stage 1: The Formative Stage**

The overriding characteristic of the formative stage is the members’ unique responses to the emotional and work aspects of group formation. Within expectable variations, members try to orient themselves to the task of learning the ground rules for making group therapy work. Each member will attempt to establish a level of intimacy that has been historically safe, and levels will vary dramatically among members. The themes then revolve around gaining information—asking the leader or inquiring among peers to see if there is an expert on how to make the group work. When such information is not readily forthcoming, which it never is, self-protective mechanisms and reactions to frustration are manifest. The frustration and ambiguity inherent in the task exert a regressive pull upon the members. The emotions stimulated by this situation then dovetail, as all the members struggle to form a group that feels safe enough for them to do their work.

There have been a plethora of contributors to understanding group formation. Yalom (1975) described this first stage as one involving “orientation, hesitant participation, and search for meaning” (p. 303). Hill and Grunner (1972), Fried (1971), and Schutz (1958) have stressed the issue of inclusion. Those espousing a psychoanalytic framework (Bennis & Shepard, 1956) emphasize the dependency aspects in this initial stage. Savaray (1975) likened this early stage to that seen in the childhood progression of oral drives. Day (1981) emphasized both the patients’ dependency needs and their inevitable competition with one another during this initial stage. Slater (1966) suggested that the main concern of the individuals is the fear of being controlled or engulfed by the group, and thus he viewed the deification of the leader as the normative and characteristic response. Common to all the contributors is the notion that a series of expected processes routinely take place in a new group—processes involved in the task of joining and forming a group.

A major task facing patients in a newly formed group or as entrants into an ongoing group is orienting themselves, through trial and error, to see what will be useful and safe. Every member approaches this task with his/her own personal history, developmental needs, and conflicts. Still, there are some common experiences in our culture. Growing up has provided each person with prior experiences in small groups, beginning with the family and then continuing in schools and a host of religious, business, or social institutions. In psychodynamic group therapy, clues regarding how to proceed are purposefully minimized, leaving the members in the emotional position analogous to that of meeting strangers. All the usual
concerns about trust and safety, quite appropriately, are central in the minds of the participants.

When the task at hand includes sharing the most intimate details (and secrets!) of one’s life, the stakes are very high. Revealing these data implies loosening one’s personal boundaries and trusting that they can be reestablished. However, fears are often expressed that boundaries, autonomy, or the “self” will be lost in the group. Joining stimulates each person’s conflicts between, on the one hand, wishes to belong and the implied surrendering of elements of his/her individuality and, on the other, the desire to maintain complete control of him/herself, which carries with it the potential for feeling isolated and alone.

Members’ anxieties are further stimulated by the relatively unstructured, ambiguous situation, creating a situation rife with possibilities to evoke regression. Each member tends to regress to a personally important developmental stage, and his/her response in the group may represent either a successfully or an unsuccessfully completed task. The regression induced in this situation is clinically useful to the therapist in gaining understanding of a member’s manner of managing anxiety.

Although it is expected that patients will regress when they join a group, it should not be expected that all patients will respond to this regression identically. For some this is a time for gaining insight into the nature of their relationship to their parents; many patients respond to joining primarily in terms of feeling dependent, helpless, and confused. Some patients, due to the interpersonal nature of group psychotherapy, turn away from the therapist and approach peers in their efforts to determine the best way to proceed. These patients have often been mislabeled as counterdependent. In fact, such processes typically replicate important aspects of members’ relationships to their parents and demonstrate salient transferential reactions to the therapist. Others regress to developmental stages of fear, self-dissolution, annihilation, or intense desire for merger and engulfment, along with the consequent response of fight–flight behaviors.

The very processes that set regression in motion also contain the seeds for solutions. As noted, Gustafson and Cooper (1979) assert that members enter a group planning a series of tests. These tests, containing both conscious and unconscious elements, revolve around the individual’s anxiety: will s/he again be traumatized by the group, as happened in early childhood or with significant others in the past? Patients are not only testing, they are actively trying to master and resolve earlier conflicts around trust and safety.

Typically, new members look to the therapist to determine how they should proceed, what they should talk about, and what behavior is “good” group behavior. The same information may be sought from peers. Common questions are addressed (though not always overtly): What information is relevant? Are past events significant, or do we just focus on what
happens in the meeting? How do outside relationships fit in with what is happening here? How far can we take these relationships after the therapy hour ends? Am I expected to share all my secrets with these people? These and many other questions generally produce interaction among members, stimulating a variety of opinions and conflicts. Affects are stirred, and how these affects are managed becomes embedded in the group norms as well as providing valuable therapeutic information. Some members may not be ready to face angry encounters and therefore may promote the norm, “Let’s be friendly and not angry.” Others may not be ready to face intimacy and prefer a norm of angry, confrontational exchanges. One individual may fill a sociable role by joking whenever angry feelings are likely to erupt. Another might shift the topic of discussion. Allowing these patterned distractions by the other members indicates that a group norm is operating.

Patients not only ask questions, they also tell about themselves and their experiences. Under the pressure of getting to know one another and the anxiety about how to proceed, patients usually “tell their story” (often demonstrating their difficulty through behavior rather than simply through speech), including informing the group about why they have come and what they hope to gain. This sharing may take the form of a “go-around,” with one member acting as the conductor. Patients experience intense pressure to conform, and seldom will they refuse to tell something about themselves. They might tell about anxiety-laden or frustrating situations they have encountered or are encountering. These stories commonly reveal unconscious metaphors for the individual’s experience of being in the meeting.

Patients reveal themselves both verbally and nonverbally. Many therapists invite members to verbalize their story, but exclusive focus on such verbalization misses significant information about the person that emerges in the manner in which s/he interacts. Members relive their difficulties and demonstrate their maladaptive styles. They reenact rather than recollect. For example, a member might feel envious of the attention received by another member’s particularly engaging story and respond by becoming competitive, destructively envious, or withdrawn. These responses, labeled enactments, often are outside the individual’s awareness, but their presence provides an avenue to gaining self-understanding.

The anxiety and apprehension during the formation stage also represent the first commonly shared experience of the group. Everyone (including the therapist) approaches the unknown with his/her own internal fantasies and mechanisms of defense and mastery. This is particularly true before the first meeting of a new group. Because the reality of the group does not yet exist, there can only be fantasies. The sharing of anxieties represents the first in-group experience of being involved and less isolated; and it represents a beginning step for experientially based group cohesion. For the individual joining an ongoing group, the same is true because the vet-
eran members observe and perceive the new member’s anxiety and are reminded of their own initial anxieties upon entering the group. They also have their own anxieties about meeting a stranger. As those anxieties are shared, a common beginning point is again forged.

An important task that patients need to accomplish is the development of a sense of basic trust in both themselves and others. Slater (1966) observes that groups go through cycles in which members exhibit their conflicts at progressively deeper levels. Trust at each level is necessary before threatening information is revealed. Some individuals with early developmental conflicts may verbalize their distrust and appear to have made gains managing their feelings, only to have another’s absence expose a deeper level of the same anxieties. Members may express their problems verbally or behaviorally. The therapeutic opportunities inherent in the working-through process of these experiences are detailed in Chapter 4.

Members try to determine the optimal anxiety-free way to enter a group. They want to do it “right.” Yet, from the therapist’s vantage point, it is hard to join a group in the “wrong” way, because whatever happens becomes a part of the group history. Whatever a new member does in an attempt to join is clinically relevant because it represents an opportunity for learning. No patient generates totally new behavior just for this situation.

The therapist, acting to help establish the most therapeutic environment, contributes to the process through keeping the group alert to the goals and by attending to members’ and the group-wide emotional climate. For example, the therapist sets the norm that members will be listened to respectfully, that self-disclosure and self-reflection are valued, and that group interactions can be examined to illuminate interpersonal and intrapsychic difficulties. As we discuss in Chapter 5, the therapist’s actions and nonactions are often used by members as behavior models with which they identify. These identifications may lessen anxiety and promote openness and directness as desirable group norms. Such norms become fully established only as they are experientially validated.

The following brief examples illustrate ways in which members of a newly forming group manage and communicate their initial anxieties.

Clinical Example 3.1

A new group met for the first time. Seven of the eight members were present on time, and they began anxiously introducing themselves. They each alluded to how difficult it had been to get to the group on time, some citing work conflicts and others citing traffic problems. About 10 minutes into the group, Allen, the final member, arrived. His entrance was noisy and intrusive, as he stood in the middle of the group and carefully took off his coat, arranged it neatly on the floor beside his chair, and took off his beeper and placed it conspicuously on the floor, as if he
Allen was the youngest—by some 10 years—in his family. He experienced his entrance into the family as an unwelcome intrusion, not only by his siblings but by his parents, who routinely reminded him that he was a “mistake.” His late arrival in the group not only replicated his “late” entrance into his family, it set the stage for the group to respond to him in much the same way as his family had. His entrance was a very important communication about central aspects of his personality.

Clinical Example 3.2

A group that had met for only a few weeks began one meeting with a period of silence. The silence was broken by one member telling about a recent vacation in which he was learning to ski. He had found it a frightening experience, both because of the novelty of the sport for him and because of the various stories he had heard about skiers breaking bones. Moreover, he was quick to point out, the instructor had given them too difficult a slope to begin with, and in general had done such a poor job that many of the class had quit.

This vignette highlights the anxiety of the new group enterprise, adding the specific fear of being injured. The blame for this traumatic experience is placed directly on the instructor’s (therapist’s) shoulders for picking too difficult and dangerous a task and for not instructing them properly in advance. An implicit threat to quit was present. One could imagine a new group getting caught up with such a story and giving advice such as “change instructors” or “choose a less steep hill.” Indeed, advice giving is a characteristic of early group formation. Yet another response from the group might have been for the other members to begin associating to similarly harrowing experiences in their own lives or to comparable times of insufficient instruction or assistance. If the members were particularly insightful, they might see the metaphorical aspects of the story and begin discussing their fears in the group and their concern with the amount of preparation that they were or were not receiving from their therapist.

Depending upon their theoretical orientation, different group therapists might handle this early group vignette quite differently. A therapist who wants the norm to be that members examine only the in-group interactions might point out that the member had taken the focus outside the room. For this therapist the member’s story is a resistance, and s/he would exert pressure for members not to talk about events outside the group itself.

Another therapist, on the other hand, might welcome such a sharing as a metaphor for the patient’s feelings within the group itself, complete with references to the perceived danger of the new venture and questions about
the skill of the leader. Thus the therapist helps set the norm of curiosity about potential deeper meanings of communications, placing out-of-group and in-group events in juxtaposition, with each offering possible elaboration and insight into the other.

A therapist influenced by self psychology might focus on empathizing with the individual’s frightening experience. This approach, which lets the members know that the therapist is listening and trying to understand their experience, thereby contributes to the therapeutic alliance. Such an intervention may not be necessary in many situations, but in early stages may be very helpful. The next step might be linking the story to possible group-wide feelings.

Yet other therapists, still within a psychodynamic frame of reference, might understand the member’s sharing in the manner suggested but decide to make no comment at all. That approach serves to enhance the members’ dependency upon one another for input and sharing. If the discussion felt positive and the members seemed to enjoy the interchange, they might feel more positively about the group, thereby enhancing cohesion. By keeping the overt input of the therapist to a minimum, the opportunities for the patients to make assumptions about the therapist’s point of view, based on their own history and basic assumptions, are enhanced.

The therapist’s role in the formative stage, as in all stages of group development, is to help establish useful norms so that the members feel safe enough to be spontaneous in their participation. In addition, the therapist helps members learn from their feelings, behaviors, reactions, and memories so that they may resolve their interpersonal and intrapsychic difficulties. The therapist and members all contribute to the movement from one stage to the next. The resolution of conflicts over joining is never complete, and a variety of stimuli or stress may reactivate conflicts over belonging. Nevertheless, transition to the second stage becomes manifest when concerns about trust diminish and reactions to belonging are prominent.

**Stage 2: The Reactive Stage**

If in the formative stage the focus was on joining and finding commonalities, in the second stage of group development members are preoccupied with their reactions to belonging to the group. In the reactive stage, the individuality of each person becomes more apparent and important as members try to determine how they can retain or develop their own identities and remain members of a group.

This stage is characterized by members’ emotional outbursts and unevenness of commitment to the group. The norms that arose in the initial stage are now tested and modified. The group agreements will be tested. This is a time when members often arrive late or not at all, threaten to quit or actually do so, or become tardy in payment of their bills. The therapist’s
competence is severely—and at times aggressively—questioned. Emotional-ity is rampant, making it difficult for members to think clearly and rationally; obvious distortions in perception occur, and members experience transactions within the group as controlling, demanding, or otherwise injurious. Anger and sadness, two of the affects most accepted in our culture, are expressed and shared.

Some authors (e.g., Gustafson & Cooper, 1979; MacKenzie, 1994) have suggested that rebellion is characteristic of this stage. Schutz (1958) noted that individuals seem to share a common purpose of maintaining control, and he labeled this stage as one of “power.” Authors (e.g., Savaray, 1975) emphasizing the comparison between group and individual development refer to the anal quality of the transactions during this stage; that is, transactions are characterized by alternating behaviors of withholding and outbursts. Tuckman (1965) succinctly labeled this the “storming” stage.

The tasks of this stage revolve around moving from a sense of “we-ness” to a sense of belongingness that includes “I-ness.” As with the growing child, members often react as if they are saying “Me do it!” Yet, just as with the child, this assertion, however emphatic, should never be interpreted as a wish to no longer belong to the family. Members are freeing themselves from the enthrallment with the therapist and the group. The honeymoon has ended. Early norms are now experienced as rigid and inflexible. Members try to exert their individual mark upon the group by testing how far they can bend, break, or more constructively alter the norms. Other individuals are not seen as having their own needs or wishes but are viewed as exerting control and power. It is during this stage that many patients experience their presenting problems most powerfully within the sessions. This experience is often a painful reality for patients, and therapists frequently hear comments such as, “This group is no different from my family!” or “Why should I stay here? I have as much trouble talking in here as I do in the world outside!” It is important that therapists help patients understand that the change in attitudes about membership during this stage is not only expected but also very helpful for their therapy, because therapy groups are much more effective when individuals are actually experiencing their problems within the group itself.

It is common in this stage for one or more members to abruptly threaten to quit while vigorously complaining either about the therapist or the group for not meeting their expectations. Typical complaints are “This group won’t solve my problems,” “Everything is so superficial—nothing is happening,” or “These people are not at all like me!” Sometimes the therapist is labeled incompetent, uninvolved, or disinterested. These members are not only expressing their own concerns but are also voicing group-wide fears. The threat to quit may represent an expression of the wish to regain control in the face of the affect of helplessness, which is common in this
stage. The disaffected member accuses the others of discussing trivial or irrelevant issues, and the threat to drop out is an effort to control and change the direction of the meeting. Such protests may also represent a test to determine how safe it is to express such feelings. However, these protests may reach such a level of intensity that, for a time, it appears that the group may dissolve.

The reemergence within the therapy of early patterns of relating to others, if observed and examined, represents an opportunity for members to learn a great deal regarding their developmental problems and tasks. There can be very important congruencies between individual development and group development, and the growth potential stimulated in this rebellious/differentiation stage is very important in helping individuals resolve comparable problems in their individual development. Fried (1970) distinguished among various types of anger shown in groups. One type is the anger shown in response to disappointment and hurt. Another, very salient to this developmental stage, is the equivalent to normal assertiveness. A self psychological perspective would include the notion of the group as an unreliable selfobject; that is, the members’ internal image of the whole group is that it will not be available and responsive to understanding their needs (Karterud & Stone, 2003).

Patients’ historical patterns of handling angry feelings, whether originating within themselves or coming from others, are characteristically exposed during this stage. For some patients regressive processes expose deeply buried character problems that were not apparent earlier. These persons may lead destructive processes in the group (Nitsun, 1996).

Not all patients experience or demonstrate overt anger, rebelliousness, or assertiveness. For some the emotional response is withdrawal, passivity, and compliance. Many patients do not have direct access to more active forms of aggression and use passive aggression instead. For these individuals, crucial developmental tasks may be accomplished during this stage as they learn to balance anger and withdrawal with assertiveness and compromise.

Powerful group processes affect individuals in this stage. The rebellion or hostility may be concentrated exclusively in one or two “difficult” individuals, and the remaining members may seem peaceful and even scornful of the troublesome ones. Often the difficult member is the spokesperson for similar affects felt by others, and the therapist must never assume that quieter members do not share the affects verbalized by the more overtly troublesome member. Indeed, the hostility may be increased or aggravated in the rebellious member as the others unconsciously project their feelings into him/her and disown the feelings themselves. This is the commonly observed process of projective identification (Weber, 2005) and reflects how group process is capable of creating difficult members (Gans & Alonso, 1998; Malcus, 1995).
A converse situation arises when the anger is not universally shared. In order to maintain the appearance of togetherness, thereby protecting against retaliation or rejection, angry members try to recruit others to their point of view. Powerful forces for conformity are unleashed under these conditions.

This is also a time of conflict among members. Some of their fighting may be a displacement of anger felt toward the leader, because in our society hostility and assertiveness are more condoned when directed toward peers rather than toward authorities. And some of the fighting may be intended to demonstrate who among the members is the most powerful. Although historically, power struggles generally occurred among men, as gender relations have shifted, women have actively entered into the fray.

Not every group has a volatile storming period, just as not all 2-year-olds display behavior characterized by the phrase “terrible 2s.” Theories of group development offer guidelines based upon common behaviors seen in many groups. But groups go about the tasks involved in development according to the unique mix of individuals, not according to an inexorable set of unvarying steps. If a group were not experiencing the storming stage overtly, its therapist would be mistaken to persist in viewing this absence as a sign of grave dysfunction.

Nonetheless, most groups do seem to move from a stage of sharing information, advice, or opinions to a stage of exploring emotional reactions within the meeting. Members move from a stage of being preoccupied with belonging, of developing we-ness, to being preoccupied with themselves as individuals, competing to have their needs met. In the emotional transactions that occur in this period, members bond to one another in much more authentic ways than had been possible earlier. This bonding is vitally important if groups are to gain maturity, wherein the curative factors are carried predominantly by the membership and not the leader.

The therapist’s tasks in this stage are different than in the formative stage. Not only is the therapist personally challenged, but the entire enterprise is often depreciated as members try to free themselves from what they perceive as the domination and imprisonment of the group. The clinician needs to appreciate that this is a developmental stage and reflects members’ transferences to their experience of restrictive group norms. Norms may be concretized in the image of the group, the leader, or peers.

The therapist must appreciate that fundamentally members are not intent on destroying the group. Rather, they are insistent on protecting their individuality. The group dynamic of using one or more receptive members as carriers of the critical or rebellious feelings creates an atmosphere conducive to group-destructive processes. Indeed, the spokesperson might exhibit considerable courage speaking up (a new behavior), which has been made possible by the emerging group norms and by the therapist’s understanding, accepting stance. Some clinicians might choose to acknowl-
edge the courageous expression (Gans, 2005). The therapeutic task is to avoid the temptation to focus on individual dynamics or transference. Rather, the clinician tries to engage others in expressing feelings carried by the critical or divergent spokesperson. They are thereby helped to re-own disavowed, frightening aspects of themselves.

Clinical Example 3.3

A group of eight members had been meeting for about 3 months. They had proceeded along an expectable path in forming a group, working on trust and openness, and beginning to address intragroup differences. Attendance had been excellent, with members arriving promptly. However, signs of difficulty were emerging, as in each of the two sessions prior to the one to be described a member failed to attend without notice.

On this evening, all members were present, although Joan arrived 10 minutes late. She apologized for her tardiness. Bill, who had missed the preceding session, began by saying that he had attended a golf outing for work. Ruth immediately followed by recounting a recent experience of attending advanced administrative training for her job and getting into conflict with the faculty because of their rigid rules. Several members commiserated with her, and they wondered why she would remain in a job that seemed so controlling and unsatisfactory.

At that point, Hank vociferously complained about the group. He said that all they talked about was superficial things. He complained that the group therapist did nothing to help, and the group seemed to just go in circles. Martha said she had talked with Hank about this after the last two meetings. They had gone for coffee, and she agreed that they seemed to be getting nowhere. Joan said she had been asked to join Martha and Hank, but she had needed to go home.

The therapist wondered if some of the extragroup events described reflected members’ dissatisfaction with the group itself. Perhaps Ruth’s story about the inflexible rules at her conference was a communication about similar feelings about the group.

Ruth replied that she had a lot of feelings about what happened in the group, and that it was very helpful to talk with Hank after the meeting. Another member wondered if Hank was thinking about quitting the group. Hank responded that he didn’t know, but the group was not being helpful.

This vignette illustrates some of the manifestations of a group rebellion. The theme of resentment at what are perceived as strict rules is clearly articulated by Ruth. Hank is more direct about the failure of the group to meet his needs, and indeed he had acted on his dissatisfaction by forming a subgroup with Martha and by maintaining secrecy, clearly altering the group boundary. Joan’s failure to discuss this development in the group points to her collusion in the process.
Other data suggesting that the group was protesting the developing norms of being on time and examining reasons for missing a meeting were apparent in the failure to explore the choices involved in Bill’s decision to go golfing or Joan’s lateness to the session. The potential for Hank to be seen as uncooperative and the “wish” to extrude a troublesome person were both expressed by a member’s inquiry as to whether Hank was going to quit the group. Such a question may represent a projection into Hank of others’ feelings about the group and can be experienced by the therapist as threatening to the integrity of the enterprise. Taken together these individual acts (both active and passive components) represent a more widespread resentment of the group norms, and are members’ expressions of their wish to establish more autonomous “rules of behavior.” The leader needs to remember, however, that the expression of affect, including dissatisfaction with the group agreements, represents an important acceptance of a fundamental group norm of openly talking about all feelings.

**Clinical Example 3.4**

A group of eight members had met for an extended period. They had made progress in their capacity to experience a feeling of belongingness and inclusion, but they had remained stuck in that comfortable stage for many months. The underlying themes of competitiveness between members and concern about the power of the therapist began to emerge initially through a seemingly innocent argument about whether or not a window should be opened! Some members wanted the window opened, whereas others did not; and all seemed quite concerned with the therapist’s opinion in the matter, because they feared his power and did not want to offend or anger him by their actions. In the middle of this debate, which had continued for weeks, as fate would have it, the therapist canceled several meetings in order to fulfill various professional obligations. The therapist, concerned about the number of sessions missed, suggested that the group meet for a double session to replace one of the missed sessions (see Chapter 11 for a discussion of a variety of responses to leader absences). This offer was experienced by the group as an effort at control and domination by the therapist: “You just need our money, Doc!” was the way one irate individual put it. The initial intense rejection of the idea of a double session was mitigated because the group was quite cohesive and members found it pleasant and helpful to meet. Moreover, the members were trying their best to understand their feelings and reactions rather than simply act on them.

In the discussion prior to the proposed double meeting, one member abruptly announced that this was to be his last meeting. “My insurance has been discontinued for some time, and I’ve been thinking about stopping treatment,” he said by way of explanation. In reality, he held a relatively high-paying job, lived alone without undue overhead, and could easily have managed the financial obligations. The remaining members were enraged, but they could neither help him explore the meaning of
this sudden flight nor deter him from actually terminating. One of the primary interpretations the group offered this member was that his sudden desire to leave was directly in response to his feelings about the power and control of the leader.

The theme of power and control was also evident in another way just prior to the double session. The members joked about the extended session, and they explored the need for an intermission, for bringing in food, and for allowing time to feed parking meters (despite the fact that the group met at night, when the meters did not require “feeding”). There was also sufficient feeling of belongingness and togetherness among the remaining members to stimulate curiosity regarding their worries about what might happen in the longer session.

The remaining seven members all appeared on time for the 3-hour session. The meeting was characterized by considerable fear of overinvolvement, which dominated the first 90 minutes (the usual length of the group). Within 5 minutes of the halfway point, one man ostentatiously juggled his coins and left the room to buy a cola. Upon his return two men in succession left the room, announcing they were going to the bathroom. When all the men were back in the room, the group discussed these events, and the exploration clearly showed both conscious and unconscious rebellion by the men who left. As one man said, “I sit through business meetings and sporting events that last 3 hours or more without having to go to the bathroom.” Moreover, the group began to recognize that there was subtle encouragement by the women. One woman, for example, said, “I saw him get those coins, and I hoped he would get up and leave.”

In this instance a change in format provided an opportunity to bring simmering rebelliousness into the open. In the context of the emerging conflicts, this rebellion was not a protest against the loss of a maternal object (the therapist) but rather an opportunity to test one’s power to control one’s fate. The members’ fear of the strength and power of the therapist, along with their wish to take the therapist on, was manifest in their responses to the double session. The terminated member’s rebellion was clearly echoed in the less self-defeating rebellions of the remaining members.

Understanding the members’ behaviors in the context of group development protects against potential scapegoating by both therapist and other members.

For the therapist, experienced or not, this storming stage often brings about a crisis of confidence. The harmonious group that had been such a joy has suddenly become an uncomfortable, affect-laden group that occasionally calls the leader’s credentials into question. The therapist may be intensely impacted by critiques and attacks. S/he may question whether s/he has erred in constructing the group or is an effective clinician. It is important to remember that in most instances, the appearance of these affects
represents a sign of progress, not failure, for the group and the group therapist.

**Stage 3: The Mature Stage**

The mature group is a performing, working entity that appears goal directed. In the schema used here, this next stage represents the apex of group effectiveness. Members interact spontaneously, and they easily carry themes along from session to session. Leadership is shared, and members assume important tasks and emotional leadership roles. Personal growth is indicated by members’ capacities to assume a variety of roles. Strong emotions and seemingly intense conflicts can be tolerated and are not prematurely cut off. There is sufficient flexibility to allow for a shifting focus from intragroup to extragroup to personal or group historical events. Conflict in the group is explored not only from an individual perspective but from that of all members—a true group enterprise.

Descriptions of a mature group reflect various authors’ theoretical perspectives. Bion’s (1960) description of the work group is similar to that of a mature group. Some characteristics of a work group are goal-directedness, an ability of the individuals to cooperate in an activity, and the ability to relate to reality. For Whitaker and Lieberman (1964) group maturity is attained when no focal conflict is evident: “Under these special conditions of safety, the patient may take steps to test the necessity of maintaining his old maladaptive solutions” (p. 166). MacKenzie (1994) emphasizes members’ decreased need for stereotypic and forceful role behavior and the emergence of more “distributed leadership.”

In general systems theory terminology the mature group exhibits a balance between open and closed boundaries (J. E. Durkin, 1981). Boundaries that are too open do not protect the individual sufficiently, and boundaries that are too closed stop the necessary exchanges of information and feeling. H. E. Durkin (1981) maintains that this strictly systems’ point of view is incomplete without adding a psychodynamic understanding of the individual. In an earlier work, contrasting individual psychoanalysis and ordinary living, she suggested that the former almost completely cancels reality and focuses on transference, whereas the latter obscures transference in the reality interchange (H. E. Durkin, 1964). Group therapy falls in the middle, where reality is present but diminished, and transference is present but available for examination. Mature groups for both Durkins are those in which free interaction is made possible by a permissive and safe atmosphere, and this free interaction is the basis for the expression of multiple defenses and transferences, which are then analyzed and understood.

Gustafson et al. (1981), utilizing Mahler, Pine, and Bergman’s (1975) stages of separation and individuation, suggest that a mature group is like the practicing toddler: Members periodically return to the leader for reas-
surance and support, but they can continue to practice on their own and do so with increasing effectiveness. In addition, members’ ability to tolerate differing points of view and conflicting feelings is a sign of a maturing group.

For Day (1981) the mature state is characterized by members’ mutual appreciation of, and trust for, one another. In turn, members gain the flexibility to understand themselves more completely in relation to the other members and the leader; they become able to process, rather than merely experience, transferential relationships. Berman and Weinberg (1998) describe the dynamics of an advanced-stage group along the personal axes of symbolization, internalization, and containment, and along the interpersonal axes of self and self–others development and of differentiation and individuation.

Garland (1982) defines one aspect of a working group as that in which members have become less interested in the problems they entered the group to solve and more interested in the group interactions that were initially viewed as not a problem—the “non-problem” (in Garland’s terminology). Within such an environment patients are able to expand their views of their respective difficulties to include elements of their lives that they did not know were problems but, in fact, are essential in understanding the initial problem. Lewis et al. (2002) suggest that the mature group manifests mutuality, acceptance of others, shared task, emotional leadership, creative work, and individual initiative in an interdependent atmosphere.

With this general review, we can more closely examine some of the indicators of a working group environment.

1. Mature working groups emphasize the intragroup responses and interactions as the primary source of learning and cure. A sense of history develops so that current episodes are linked to prior events, and members become sensitized to repetitive patterns in themselves and other group members.

2. Despite the primacy of in-group interactions, flexibility develops that allows discussion of relevant outside events in the members’ lives. Groups develop the capacity to distinguish between outside events brought into the discussion as resistances and outside events discussed as part of the therapeutic quest. Where possible, members seek to bring such outside material into the group in order to clarify issues. For example, an individual who complains about his interactions with a significant person in his life might be helped to understand his contributions to the problems if members are able to link the outside problem with their in-group awareness of the individual’s behavior.

3. In mature groups the members develop a more collegial relationship with the therapist. The therapist is viewed as an authority and expert, but s/he is demystified and not imbued with magical powers. In other
words a therapeutic alliance has been established that allows for a more realistic appraisal of the leader as well as a more complete conviction that s/he is an ally in the therapeutic venture. Although transference reactions are still cooperative, members are able to help one another gain objectivity on distorted perceptions of the leader and each other.

4. Members have developed confidence in their ability to tolerate anxiety and to examine problems themselves. They no longer look solely to the therapist as the primary source of caring, concern, guidance, and understanding. They have learned that no permanent harm will result from intense affective interactions, and they do not consistently interfere with heated exchanges. The members are more able to trust that it is helpful to share spontaneously the affective responses they experience during the meetings without undue regard for politeness, rationality, or embarrassment. At times individuals remain unable to tolerate specific affects, but such instances are used as opportunities for self-understanding. Members have learned to distinguish between expressing feelings and attacking with intent to hurt.

5. Through repeated experiences members gain a deep understanding of, and appreciation for, one another's strengths and weaknesses. Compassion and tolerance are founded upon the knowledge that unconscious factors operate for everyone and often adversely affect interpersonal relationships. Members in mature groups have also learned that the most abrasive aspects of behavior are often defenses designed to protect against pain, not indications of inherent malice in the individuals in question. Members have an appreciation of the unconscious, even if they do not understand its sources, and they attempt to understand the behavior of their fellow members as well as their own. Similarly, the therapist's strengths and weaknesses can be appreciated or accepted without overwhelmingly intense or prolonged affective swings.

6. Members have learned that interpersonal transactions inevitably involve two distinct components: the interpersonal and the intrapsychic. They know that behavior is not always what it appears to be and that there are personal meanings that might produce particular behaviors. They further appreciate that identical behaviors might have very different meanings for different individuals. Further, members strive in a consistent manner to respond to behaviors from two perspectives: from their own perspective, and from the perspective of the other—that is, from an empathic perspective. In this mature stage not only does the recipient assess his/her own responses, but has the growing capacity to empathize with self and other. Empathy toward the self, somewhat akin to, but not identical with, modifying the critical superego, is an important achievement.

The therapist in the mature group faces new tasks. Using the metaphor of the parent of toddler or adolescent children, the therapist must balance
members’ capacities to experiment and explore without undue interference or intrusion. Moreover, the therapist’s own level of maturity is tested in this stage, not only out of concern for control but out of envy (Stone, 1992a). As members share moments of play or great intimacy, countertransference forces may strain the therapist’s capacity to remain in role.

**Stage 4: The Termination Stage**

Termination, which represents the final stage of group development, is of such significance that it is discussed in detail in Chapter 16. In time-limited groups, the final meetings are completely devoted to the ending of the group. Even in those groups where the members do not seem to speak about the ending of the group, dynamically we must assume that all group content is related to the forthcoming ending. In ongoing psychodynamic groups, the termination stage occurs whenever an individual member decides to terminate membership in the group.

The affects associated with the sense of graduation and saying goodbye to the group are seldom easily managed, either by the departing or the remaining individuals (including the therapist). Terminations are emotionally painful and joyous but never simple. When one or more individuals terminate, in essence a new group is formed. Although it is true that there is a group history and this new group will not take nearly as long to reach a mature stage as a newly forming group, nonetheless much of the process of group development will be revisited.

One vital aspect of the development of group maturity is the successful termination of a member. In the early months, members struggle with their fears that this treatment might not be truly therapeutic. Indeed, the first terminations usually are therapeutic failures—patients who flee the group prematurely. It is often quite a long time before any patient successfully completes the work s/he set out to achieve and leaves with a sense of well-being and accomplishment. It is not unusual that members will refer to such a patient for many years, using that memory as an antidote to doubts and worries about the effectiveness of the group. Mature groups almost invariably have had at least one termination that was perceived as successful by the majority of the members.

New members also become symbols of successful or unsuccessful treatment, because new members fill seats formerly occupied by individuals who have terminated. Groups develop oral legacies whereby history is remembered for a long time. The ways in which various members leave take on powerful meanings for groups. During a period when a number of members leave happy and fulfilled, the sense of confidence and maturity is raised greatly. Perceptions of new members are obscured by the shadows of the members who left before. A new member who happens to fill a seat occupied by a member who left prematurely may be greeted differently
than someone who fills the seat of an honored member who left with work completed. Both situations have their problems. Examination of the impact of terminations on feelings about the replacement member or the group-as-a-whole provides one more opportunity for members to differentiate reality from the affective response. This process contributes considerably to group maturity.

**THE INTERACTION OF GROUP DYNAMICS AND DEVELOPMENTAL STAGES**

Repetitive events may be handled differently at different stages of development. In order for the therapist to maximize learning, it is important for him/her to understand the differences in how groups respond to similar events at different developmental stages. For example, throughout the life of a group, individuals will, from time to time, break the agreement regarding prompt attendance at all meetings. Such breaches are inevitable, but members use those breaches for learning in quite different ways, depending upon the stage of group development.

In the formative stage lateness is often ignored or only cursorily addressed. Commonly, reality reasons are offered to explain the tardiness, and these reasons are quickly accepted by the others. Thus a late member might casually announce, “The bus was late,” or “My boss kept me in a meeting,” or even “I misplaced my car keys.” Such explanations, accompanied by a sincere apology, are usually satisfactory to the others, and the attention of the group moves on to some other subject. These responses are multidetermined. At one level members do not know how to explore or appreciate such behavior. Sometimes members offer advice about how to avoid such situations in the future, but there is little permission in the group to express feelings about such situations. If a member has an intense affective reaction, such as anger, it is usually kept under wraps out of an even more pressing need for acceptance. Furthermore, members at this stage seem to view the lack of condemnation or attack from the therapist as a sign that they, too, should offer no strong response to the tardy member. They are still looking to the therapist for direction about how to behave. Finally, there is a powerful but subtle unconscious pressure not to comment upon breaches in the group boundary, because at this stage of development members may feel a need to employ the same behaviors. The members behave as if no one wants to bolt the door too securely lest they, too, be forced to stay in the group and experience intense emotions.

As members develop a sense of belonging and move to a different stage of development, there is usually increasing pressure to arrive on time as well as to honor the other agreements. Lateness now occurs at the expense of potential censure from one’s peers, and it may represent either a dis-
placed expression of dissatisfaction with the developing group norms or a more direct expression of rebelliousness and assertiveness. Whereas lateness in the forming stage may represent some response to anxiety about joining, such as a fear of being engulfed or becoming dependent, arriving late now represents a move toward individualizing, of fighting for fulfillment of one’s own goals potentially at the expense of the others in the group. Often the rebelliousness begins as an attack on the leader, and this can include overt and covert collusion by the other members. Patients in this mode may pay no more attention to the tardiness than do patients in the earliest stage of development, but in this case the affective tone is quite different. Whereas in the initial stage the nonattention is out of naivete or unwillingness to try to understand a defense that others might want to employ, now the unwillingness is an angry, belligerent struggle with the leader and his/her rules. As one patient angrily expressed it, “Russ comes for 80 minutes. Why focus on the 10 minutes he isn’t here?”

Given that norms are often very rigid during this stage, the affective responses to the perceived or actual tyranny of the group are understandable. A member’s breach of the agreements frequently produces strong emotions, which then are directed either toward the offending member or toward the leader. At the same time, recognition is dawning about the existence of underlying or even unconscious motivation for lateness. No longer will the excuse “I misplaced my keys!” be accepted without question. Following the therapist’s lead, and by now having seen the fruit such inquiries have borne in the past, members begin to explore lateness for hidden meanings. They are freer to communicate emotions, not just thoughts, and they have begun to internalize the curiosity about behavior as a means of learning very important information about themselves and their colleagues. Furthermore, exploration of unconscious feelings is no longer simply an opportunity for humiliation—it is an opportunity for learning.

In mature groups, the members have begun to examine the meaning of breaches of the agreements, both for the individuals who come late or not at all and for themselves. Such behavior is understood as potentially powerful communication. The members may still be enraged by the fact that an individual arrives late or occasionally does not come to the group at all, but they have begun to accept that not all individuals are the same and that absolute conformity is neither just nor fair. Thus members can use such interactions to study both their own expressed and quietly felt responses and concurrently the inner meanings for the latecomer. Finally, members begin to explore the possibilities that such behavior on the part of one individual member is, in fact, a group event. It is commonly observed that lateness and absenteeism tend to increase as a therapist’s vacation approaches, and these breaches of the agreements are indeed a group-wide commentary about the therapist’s impending absence.
Many variations exist regarding the way members respond to tardiness or absences. Common to mature groups, however, is the capacity to establish a norm of viewing behavior as communication and therefore as one more pathway to knowledge. Understanding the multiple determinants of behavior (which would include recognition of processes impacting on the entire group and exploration of the reactions various individuals have to that behavior) becomes a powerful therapeutic tool when the members are attuned to exploring these arenas.

SUMMARY

Group dynamics are ubiquitous. As such, a working knowledge of them is essential to understanding individuals within groups and also whole-group processes. Grasping the centrality of such concepts as leadership, group culture, norms, tasks, and roles prepares clinicians to appreciate group phenomena that are superordinate to the individual. Group dynamics not only result from interactions among participants but have a profound impact upon their behavior and feelings.

The concept of group development is valuable in orienting therapists to a number of processes common to group psychotherapy. Familiarity with the stages of development helps anchor therapists in their work and provides a road map to help them understand what is occurring within their groups.

A great deal of valuable therapeutic work can be accomplished in each stage. Indeed, each stage offers unique opportunities. Further, because groups are dynamic entities composed of living beings, the stages are not rigid and steadfast; rather, they are best considered guidelines, not laws. As groups grow and are confronted with crisis and change, the stage will be revisited regularly.

As development takes place, each group forms its particular culture and norms, which have a major impact upon how the group goes about fulfilling its goal of helping the members solve their problems. The therapist has considerable importance in the evolution of the culture, but the members also contribute greatly. The concept of role is linked with the group’s requirements for building and maintaining its culture as well as the individual’s past habitual methods of handling stress, anxiety, hostility, and positive emotions such as tenderness and affection. Both individual valency and group aspects of role require consideration and frequently can be observed as overlapping within the group.

The developmental stages we have delineated refer specifically to open-ended psychodynamic groups. Time-limited groups go through the same stages, though the stages are compressed. Furthermore, the reality of
a forced ending creates a special emphasis on termination issues. Indeed, most time-limited groups begin making references to the end of the group in the first meeting. Furthermore, from the halfway point in the group until the end, the entire process of the group can usually be understood as stimulated (usually unconsciously) by the approaching end of the group.

To conceptualize a psychodynamic group, select the members, lead the first session, and guide the members toward their goals requires considerable perseverance, courage, tolerance of uncertainty, and skill. Knowledge of, and attention to, group dynamics and development ease that challenge.