THE ROLE OF THE GROUP IN THE INDUCTION OF THERAPEUTIC CHANGE[1]

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Psychotherapy can be regarded as a social influence situation in which the patient's relationship to the therapist is the primary vehicle for the production of therapeutic change. In individual psychotherapy, the situation is so arranged as to maximize the probability that the patient's interactions with the therapist will facilitate desirable changes in his attitudes, values, and action-tendencies. In group psychotherapy, the patient's relationships to his fellow-patients and to the group as a whole become additional vehicles for the production of therapeutic change. In choosing between group and individual therapy, one has to keep in mind, of course, that while the patient-group relationship may serve to strengthen forces toward change, it may also bring certain counterforces into play, thus reducing the potentiality for change contained in the dyadic relationship. Whether or not group therapy seems to be indicated, given these competing forces, will depend on the characteristics of the patient, the nature of his problems, and the current status of his general treatment program. Group therapy will be resorted to when there is reason to believe that the combination of therapist and group will make for a more effective influence situation and facilitate the occurrence of the particular changes that are desired.

My use of the term "social influence" does not carry any value connotations whatsoever. It will become clear, as I proceed, that I use the term very broadly to refer to any change in a person's behavior that is induced by another individual or a group. The induction may take many forms: for example, the influencing agent may exert pressure, offer suggestions, attempt persuasion, serve as a model, or make available new information; all of these would be subsumed under the term "social influence," without ignoring, of course, the importance of the qualitative differences between

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them. In describing psychotherapy as a social influence situation, then, my purpose is not at all to expose it as a manipulative process. Rather, it is my purpose to make it accessible to a social-psychological analysis of influence processes, based on theoretical and empirical exploration of a variety of laboratory and field situations. While psychotherapy constitutes a very unique kind of interaction situation, it is nevertheless continuous with other social situations in which changes in behavior and personality are induced. An application to this situation of some of the concepts that have been developed in the study of other influence situations may, therefore, provide a different perspective for viewing psychotherapy and perhaps offer some new insights.

A Framework for the Analysis of Social Influence

Specifically, I would like to apply to the therapy situation a theoretical framework for the analysis of social influence with which I have been working over the last few years (Kelman, 1961). This framework has generated a number of specific hypotheses that have been tested experimentally (e.g., Kelman, 1958); and it has also been used in the interpretation of attitude changes found in an intensive field situation (Bailyn and Kelman, 1962). The starting point of this framework is a distinction between three processes whereby influence can be accepted: compliance, identification, and internalization.

Compliance can be said to occur when an individual accepts influence from another person or from a group in order to attain a favorable reaction from the other, that is, to gain a specific reward or avoid a specific punishment controlled by the other, or to gain approval or avoid disapproval from him. Identification can be said to occur when an individual accepts influence from another person or a group in order to establish or maintain a satisfying self-defining relationship to the other. In contrast to compliance, identification is not primarily concerned with producing a particular effect in the other. Rather, accepting influence through identification is a way of establishing or maintaining a desired relationship to the other, as well as the self-definition that is anchored in this relationship. By accepting influence, the person is able to see himself as similar to the other (as in classical identification) or to see himself as enacting a role reciprocal to that of the other. Finally, internalization can be said to occur when an individual accepts influence in order to maintain the congruence of his actions and beliefs with his value system. Here it is the content of the induced behavior and its relation to the person's value system that are intrinsically satisfying.

Each of these three processes is characterized by a distinct set of antecedent conditions and a distinct set of consequents. These are summarized in Table 1. Very briefly, on the antecedent side, it is proposed that three qualitative aspects of the influence situation will determine which process is likely to result: (1) the basis for the importance of the induction, i.e., the nature of the predominant motivational orientation that is activated in the influence situation; (2) the source of power of the influencing agent, i.e., the particular characteristics that enable him to affect the person's goal achievement; and (3) the manner of achieving prepotency of the induced response, i.e., the particular induction techniques that are used (deliberately or otherwise) to make the desired behavior stand out in preference to other alternatives. Thus, compliance is likely to result if the individual's primary concern in the influence situation is with the social effect of his behavior; if the influencing agent's power is based largely on his means-control (i.e., his ability to supply or withhold material or psychological resources on which the person's goal achievement depends); and

Table 1*

Summary of the Distinctions Between the Three Processes

	Compliance	*Identification*	*Internalization*
Antecedents:			
1. Basis for the *importance of the induction*	Concern with social effect of behavior	Concern with social anchorage of behavior	Concern with value congruence of behavior
2. Source of *power of the influencing agent*	Means control	Attractiveness	Credibility
3. Manner of achieving *prepotency of the induced response*	Limitation of choice behavior	Delineation of role requirements	Reorganization of means-ends framework
Consequents:			
1. Conditions of performance of induced response	Surveillance by influencing agent	Salience of relationship to agent	Relevance of values to issue
2. Conditions of change and extinction of induced response	Changed perception of conditions for social rewards	Changed perception of conditions for satisfying self-defining relationships	Changed perception of conditions for value maximization
3. Type of behavior system in which induced response is embedded	External demands of a specific setting	Expectations defining a specific role	Person's value system

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if the induction techniques are designed to limit the individual's choice behavior. Identification is likely to result if the individual is primarily concerned, in this situation, with the social anchorage of his behavior; if the influencing agent's power is based largely on his attractiveness (i.e., his possession of qualities that make a continued relationship to him particularly desirable); and if the induction techniques serve to delineate the requirements of the role relationship in which the person's self-definition is anchored (for example, if they delineate the expectations of a relevant reference group). Internalization is likely to result if the individual's primary concern in the influence situation is with the value congruence of his behavior; if the influencing agent's power is based largely on his credibility (i.e., his expertness and trustworthiness); and if the induction techniques are designed to reorganize the person's means-ends framework, his conception of the paths toward maximization of his values.

On the consequent side, the framework proposes that the changes produced by each of the three processes tend to be of a different nature. The crucial difference in nature of change between the three processes is in the conditions under which the newly acquired behavior is likely to manifest itself. Behavior accepted through compliance will tend to manifest itself only under conditions of surveillance by the influencing agent, i.e., only when the person's behavior is observable (directly or indirectly) by the agent. The manifestation of identification-based behavior does not depend on observability by the influencing agent, but it does depend on the salience of the person's relationship to the agent. That is, the behavior is likely to manifest itself only in situations that are in some way or other associated with the individual or group from whom the behavior was originally adopted. Thus, whether or not the behavior is manifested will depend on the role that the individual takes at any given moment in time. While surveillance is irrelevant, identification-based behavior is designed to meet the other's expectations for the person's own role performance. The behavior, therefore, remains tied to the external source and dependent upon social support. It is not integrated with the individual's value system, but rather tends to be isolated from the rest of his values, to remain encapsulated. In contrast, behavior accepted through internalization depends neither on surveillance nor on salience but tends to manifest itself whenever the values on which it is based are relevant to the issue at hand. Behavior adopted through internalization is in some way, rational or otherwise, integrated with the individual's existing values. It becomes part of a personal system, as distinguished from a system of social-role expectations. It becomes independent of the original source and, because of the resulting interplay with other parts of the person's value system, it tends to be more idiosyncratic, more flexible, and more complex. This does not imply complete consistency, nor does it mean that the behavior will occur every time it is relevant to the situation. Internalized responses will, however, at least come into play whenever their content is relevant and will contribute to the final behavioral outcome, along with competing value considerations and situational demands.

I hope that this brief review is sufficient to give the flavor of the three processes of influence. Clearly, the ultimate aim of therapy, at least of insight therapy, is the development of new attitudes, new self-images, and new patterns of interpersonal relationships at the level of internalization. However, as I shall attempt to show, all three processes are typically involved in the therapeutic interaction, and all three are necessary to the production of therapeutic change. Even when internalized change takes place at the conclusion of therapy, compliance and identification serve as ancillary processes: changes at these other levels represent preliminary steps that make internalization possible. Sometimes, as shall be discussed below, changes produced in therapy may not proceed to internalization but remain fixated at the level of compliance and identification.

Changes Within and Outside of the Therapy Situation

Before spelling out the way in which the three processes enter into the production of therapeutic change, I would like to make a further distinction between two phases of behavior change to which the therapeutic relationship must address itself. Very simply, these are changes in the patient's behavior *within* the therapy situation and changes in the patient's behavior *outside* of the therapy situation (cf. Kelman, 1952).

First, the therapist and the group have to exert influence on the patient's behavior within the therapy situation in order to be certain that the patient will engage in the therapeutic process and thus open himself up to the therapeutic potential of the situation. The model of the therapy situation that I have in mind here is that of a situation so set up that the patient is both freed and forced to overcome his resistances and to think and talk about things he ordinarily avoids; the greater freedom allows him to *experience* certain feelings in the therapy situation and to express these feelings as he experiences them; as he engages in this process, corrective emotional experiences in the therapy situation become possible, i.e., experiences marked by the simultaneous occurrence of intense feelings and the examination of these feelings. To make the occurrence of this process possible and likely, the therapist and the group must influence the patient to shed his resistances, to allow himself to experience certain threatening feelings, to express these feelings as he experiences them, and to examine them as he expresses them. In short, they must induce changes in the

patient's behavior within the therapy situation so that he will increasingly meet the requirements of the therapeutic process.

But, obviously, changes in the patient's behavior within the therapy situation are not enough. To be effective, therapy must produce changes in the patient's behavior outside of therapy, in his daily life and in his interactions with the people that form his customary milieu. The therapy situation itself helps to unfreeze existing attitudes and behavior patterns and to extend the patient's repertory, to bring out new behaviors and emotional experiences around which new insights can be built. But the pay-off of such corrective emotional experiences comes when the insights derived from them are transferred to real life. Thus, there is a second phase of behavior change to which the therapist and the group must address themselves: they have to exert influence on the patient's behavior outside of the therapy situation. This must be done in order to make certain that he will apply the therapeutic insights to those situations in which his actions are self-defeating, his perceptions distorted, and his interpersonal relationships unrewarding.

According to the usual model of therapy, the therapist does not intervene in the patient's real life situation in any direct way. The only point at which he enters into the patient's life is during the therapeutic interactions themselves. Nevertheless, therapist and group do exert influence on the patient's real-life behavior by encouraging him (implicitly or explicitly) to try out new patterns, by providing him with a frame of reference for analyzing his own behavior, and by reviewing with him some of his attempts to apply therapeutic learnings to his interactions outside. I am speaking here of ways of influencing the patient's outside behavior while he is still in therapy. Needless to say, if therapy has been successful, its effects will continue to manifest themselves after it has been terminated, as the person applies both the process and the insights he derived from therapy to more and more of his life experiences. This would presumably happen to the extent that internalization has taken place. My concern at the moment, however, is not with these self-activated changes in the patient's behavior that represent the aftermath of effective therapy but with the direct influence on the patient's behavior outside of the therapy situation *while therapy is still in progress*. While most therapists do concern themselves with extra-therapy behavior, there are differences in how much they emphasize it and how explicit they are about it. In some therapeutic approaches, the emphasis is placed entirely on the interaction in the therapy situation proper. Real-life matters are regarded as almost irrelevant. In other approaches, there are deliberate attempts to bring in real-life experiences, to encourage transfer from what happens in therapy to what happens outside (e.g., to encourage the patient to try out new behaviors), to review the patient's

attempts to apply new insights—in short, to use the therapeutic situation as a *deliberate* training facility for real life.

It should be noted that these two phases of change may also represent competing demands. The very features of the therapeutic situation and of the techniques employed by the therapist that are most conducive to unfreezing old behavior and "getting out" new behavior *during* the therapy sessions may, at the same time, interfere with the generalization of this behavior. For example, the more isolated the therapy situation is from real life, the more it is structured as a playful situation which "doesn't really count," the more likely it is that the patient will feel free to experience and express emotions that he finds too threatening in the outside world. By the same token, however, it will be more difficult to generalize what he learns in this situation to real life, where the threatening features are present in full force and where everything does count. Similarly, to the extent that the therapist encourages a view of the therapy situation as the predominant focus of the patient's life, to the requirements of which all other life requirements must be subordinated while therapy is in progress, he will increase the power of the therapeutic situation for controlling the patient's behavior within it. This kind of emphasis may prevent a diffusion of transference, a premature acting-out in real-life contexts, or an escape from the analysis of the person's own neurotic problems to an examination of the reality problems of his environment. At the same time, however, by keeping the therapy situation "pure," one reduces its power to induce changes in the patient's behavior outside of therapy. Thus, a major challenge in all forms of psychotherapy is to find the proper balance between forces toward change in within-therapy behavior and forces toward change in extra-therapy behavior. In this connection, there may be some interesting differences between group and individual therapy. Group therapy may be less powerful in the unfreezing of old behavior and the "getting out" of new behavior, but it may be more powerful in the generalization of therapeutic insights to real life. I would not want to push this proposition too far, without considerable qualification, but it may represent one major dimension of difference.

I would like to propose that compliance, identification, and internalization play a part in each of the two phases of behavior change with which therapy is concerned, i.e., changes within and changes outside of the therapy situation, and contribute to the achievement of a therapeutic effect. In the remainder of this paper, I shall try to show how each process enters into the induction of therapeutic change. Looking first at the patient's behavior within the therapy situation, I shall take the three processes in order and, for each, discuss (1) what type of patient behavior, relevant to a therapeutic outcome, is induced by that particular process; (2) what the

therapist's role is in the induction of this particular behavior; and (3) what the group's role is in the induction of this behavior, i.e., how it may reinforce (or possibly reduce) the therapeutic potential of the situation. I shall then proceed to present a parallel analysis of the patient's behavior outside of the therapy situation.

I should mention here my assumption that, even in group therapy, the therapist is of necessity the primary influencing agent, although the group can make some powerful and unique contributions to the process.

Influence Directed to Behavior within the Therapy Situation

The influence attempts directed to the patient's behavior within the therapy situation are summarized in Table 2. It is proposed that three types of patient behavior have to be induced within the therapy situation in order to facilitate therapeutic change, and that these correspond, in the main, to the three processes of influence.

Table 2

Types of Influence Involved in the Production of Therapeutic Change

A. Processes of Influence Directed to the Patient's Behavior *Within* the Therapy Situation

	Type of patient behavior induced by this process	*Therapist's role in the induction of this behavior*	*Group's role in the induction of this behavior*
Compliance	Engagement in the therapeutic work (obeying the "basic rule")	Trainer	Sanctioning agents
Identification	Commitment to the therapeutic situation	Accepting, permissive, expert listener	Facilitating agents; comparison reference group
Internalization	Occurrence of corrective emotional experiences	Transference object	Interaction objects; role reciprocators

1. *Engagement in the Therapeutic Work.*

If the therapeutic business is to be transacted effectively, the patient must engage in the therapeutic work. He must be trained, as it were, to produce some kinds of behavior and to eschew others in the therapy situation. If he fails to do so, he does not provide the necessary openings for therapeutic interventions and makes it impossible for corrective experiences to emerge. Thus, in analytically oriented therapy, the patient must

allow himself to experience certain feelings despite strong resistances to them and he must express these feelings; he must be trained to talk, to free-associate, to obey the "basic rule."

Almost invariably some degree of compliance is necessary at this stage of therapy. The patient, of course, brings a certain amount of self-activated motivation to the situation, based on his desire to benefit from therapy. Nevertheless, the resistances to engaging in the therapeutic work are so strong that some extraneous motivation has to be brought into play, at least at the beginning. This motivation derives from the patient's desire for the therapist's approval and the avoidance of his disapproval. The patient's concern with a favorable reaction from the therapist constitutes a potent force in overcoming his strong resistances and getting him to proceed with the therapeutic work.

The therapist's role in this part of the process is essentially that of a *trainer,* who responds to the patient's productions in such a way as to increase the probability that what he considers therapeutically relevant material will emerge. Analysts and particularly nondirective therapists would not like to think of themselves as engaging in such deliberate training. But they do—and in fact have to—train the patient, even if they are unaware of it. The therapist often, in subtle ways, directs the patient; he approves of some things and disapproves of others. The patient picks this up and tailors his subsequent productions accordingly. For example, in analytic therapy, the therapist makes the patient uncomfortable about his resistances by confronting him with them, interpreting them, etc., until they gradually become less frequent. Also, he encourages certain kinds of contents, in contrast to other kinds, by responding to them, showing interest in them, and building interpretations around them. Patients learn to give the therapist what he seems to want. In nondirective therapy, the therapist shows approval by reflecting, reacting to a particular line, and picking up some contents while neglecting others. The research on verbal conditioning (cf. Greenspoon, 1955; Krasner, 1958) has shown that in *nontherapeutic* situations, individuals are responsive to slight cues of approval, such as the sound of "mm-hm." Since the therapist's reactions are so much more important to the patient and since the patient finds himself in a relatively ambiguous situation in which he is searching for guidelines for his behavior, it seems more than reasonable to assume that he will be sensitive to subtle cues of approval or disapproval emanating from the therapist. The work of Murray (1954, 1956) is consistent with this assumption.

I do not for a moment want to equate this part of the process with the therapeutic process as a whole. My view of therapy, as should be clear from everything I have said and will say, is completely inconsistent with the

notion that it is all "just a matter of verbal conditioning." I am only proposing that the kind of training I have described, which is based primarily on the therapist's ability to supply or withhold approval in this ambiguous, anxiety-laden, and delicate interpersonal situation, represents an essential step which mediates therapeutic change. Inducing the patient to experience feelings and to talk about them is a prerequisite for the occurrence of therapeutically relevant events. Moreover, inducing the patient to talk about the particular contents and in the particular language that are required by the therapist's theory provides the terms within which this particular therapist can become useful to the patient. While compliance, then, is strictly a mediating step, it may happen that a patient becomes fixated at that level, i.e., that he adopts the language overtly and superficially and does not go beyond that. He says all the right words, even though they do not correspond to his actual feelings and are not used in an attempt to develop more appropriate labels for his behavior. Typically, this represents an elaborate form of resistance to the therapeutic process rather than a way of bringing it forward. By complying with the letter rather than the spirit of the therapist's requests, the patient avoids real engagement in the situation. Overcompliance, as a matter of fact, may represent a form of hostility.

Turning to group therapy, in what way does the group contribute to this part of the therapeutic process, to inducing the individual group member to engage in the therapeutic work? The group members can serve as additional *sanctioning agents* who can apply various kinds of pressure on the individual patient to conform to the requirements of the situation and engage in the therapeutic work. If the requirements to express one's feelings, to say what is on one's mind, etc., are adopted as part of the group's norms, the training process that I have described can be considerably reinforced and speeded up. The group has powerful techniques at its disposal for controlling the behavior of individual members and maximizing their conformity. Desirable behavior can be rewarded by praise, encouragement, support, or by giving the individual visible signs that he is a valued member of the group and that his status is secure and may, in fact, be enhanced. Undesirable (nonconforming) behavior can be discouraged by direct criticism, ridicule, ostracism, loss in status, and other signs of rejection. Small-group studies, both in the laboratory and in industrial settings, have provided demonstrations of the group's power to control member behavior through the selective application of encouragement and pressure. This clearly represents a potentially powerful source of influence.

A group's ability to induce compliance to its norms depends on its control over resources that are important to the individual. In the case of therapy groups, the resources that are at stake are not of a material but of a psychological nature. A member will be likely to comply with the group's

demands to the extent that he depends on this particular group as a source of acceptance and approval. It can be assumed that for most patients this dependence will be rather high for two reasons: first, because they are likely to be low in self-esteem and thus need external support to bolster it; second, because they are likely to lack close interpersonal relationships and involvements in rewarding group interactions. For many patients the therapy group may fulfill a unique function, not by virtue of the therapeutic process that it sets in motion, but simply by virtue of the sustained and meaningful social relationships that it makes possible for them, thus filling a void in their daily lives. It can be assumed that the group's control over this particular type of patient will be especially strong. One might also predict that this type of patient would be most likely to remain fixated at the level of compliance. To the extent that remaining a member in good standing of this group and obtaining immediate satisfactions that derive from group membership satisfy major needs for him, he may be both more motivated to protect his status in the group and less motivated to get deeply involved in the therapeutic process itself: he already has what he most wants, provided the group continues to accept him.

The group's ability to induce compliance also depends, of course, on some of the characteristics of the group. For example, if the group has built up the sanctioning function by actively encouraging and approving conforming behavior and actively discouraging and punishing nonconformity to its norms, its means-control over the individual member will be stronger. Means-control depends not only on the extent to which the group controls important resources, but also on the perceived probability that it will use this control to insure compliance. A group that actively uses this sanctioning function can make an important contribution to the therapeutic business by inducing the patient to engage in the therapeutic work. It must be kept in mind, however, that the group's power in this regard is a double-edged sword. It can be used for the furtherance of the therapeutic process, but it can conceivably also be used for resistance to it. In experimental and industrial groups it has been found that group pressure can be very effective in inducing members to conform to a particular standard of productivity. This, however, may take the form of increasing *or decreasing* an individual's level of productivity, depending on the particular nature of the group standard (Coch and French, 1948; Schachter et al., 1951; Berkowitz, 1954). Similarly, in group therapy, if group norms develop that encourage resistance to the therapeutic process, the group may strengthen antitherapeutic forces. Frank (1957) points out that this is unlikely to happen, because the therapist himself is the only stable source of norms for the group. Be that as it may, it is still necessary for the therapist to concern himself with the nature of the group norms that develop. He cannot leave this

entirely to chance, but must bring his unique influence to bear in such a way that the group norms will support engagement in the therapeutic work rather than resistance to it.

2. *Commitment to the Therapeutic Situation*

The sanctions applied by the therapist and the group may be powerful instruments in inducing the patient to conform to the therapeutic norms, but their effectiveness depends on the patient's motivation to remain in therapy. If this motivation is low, then he will simply remove himself from the situation as soon as the level of anxiety created by the experience and disclosure of his feelings becomes too high. If the patient, then, is to continue in therapy long enough so that he can get to the point of having corrective emotional experiences, he must develop a commitment to the therapeutic situation as one that is potentially beneficial to him and for which it is worth making certain sacrifices. This attitude of commitment is particularly essential since, for most patients, therapy is a strange and ambiguous situation, which violates many of their initial expectations and whose benefits are by no means clear to them. Even under the best of circumstances, it takes some time for any beneficial effects to become apparent, and the patient needs this sense of commitment to sustain him in the interim.

There is another sense in which commitment to the therapeutic situation is essential. The patient must come to view it not only as a situation which is beneficial to him in the long run, but also as one that is safe for him in the "short run." When he is asked to conform to the therapeutic norms by exposing himself and expressing his feelings without censorship, he is placed in a very difficult situation. He runs the risk of criticism, rejection, and condemnation after he has divested himself of his defenses and laid himself bare before others. If the patient is to feel free to engage in the therapeutic process and talk about himself, then he must regard the situation as one in which he is safe from attack and condemnation and in which he can afford to relax his customary protective mechanisms. In short, then, if the patient is to engage himself in the therapeutic process and open himself to the possibility of therapeutic experiences, he must develop a commitment to the situation: an attitude of trust and a willingness to accept its terms, based on his conviction that he will be protected in this situation and that he will benefit from it.

These attitudes to the therapeutic situation, I propose, are induced primarily through the process of identification with the therapist. A patient typically establishes a relationship to the therapist that provides him with a more satisfying self-definition than the one with which he entered

therapy. Through his relationship to the therapist, the patient's self-esteem is enhanced: he comes to see himself as a person who is worthy of attention and acceptance. Moreover, as a consequence of this relationship, he gradually loses his sense of hopelessness about his fate and sees himself as a person who is successfully moving toward a resolution of his conflicts. It is as part of this satisfying self-defining relationship to the therapist that the patient's commitment to the therapy situation as a whole develops. Trust in the therapy situation and acceptance of its terms represent the expectations that circumscribe the patient's role in this reciprocal relationship. To the extent that the patient wishes to maintain this relationship, he will tend to adopt the attitudes expected for his role within it. Freud's (1950) concept of the conscious component of positive transference refers, essentially, to this process of commitment to the therapy situation through identification with the therapist.

The therapist's contribution to this process consists in offering the patient a relationship that will enhance his self-esteem and his feeling of hope. He accomplishes this largely by adopting, as his part of this reciprocal relationship, the role of an *accepting, permissive, expert listener.* Most schools of therapy stress that an essential part of the therapist's role is to communicate to the patient a full understanding and unconditional acceptance of him. Regardless of what the patient may reveal about himself, the therapist does not judge or condemn him. Rogerian therapy places primary emphasis on the attitude of acceptance conveyed by the therapist and regards it as not only a necessary, but actually a sufficient, condition for therapeutic change (Rogers, 1957). In analytically oriented therapy, the emphasis is not so much on acceptance of the patient as a person as it is on permissiveness in the sense of reassurance that no feeling the patient might express and no revelation he might make will lead the therapist to condemn or reject him (cf. Menninger, 1958). Despite differences in emphasis, most schools of therapy do view some form of acceptance as a necessary part of the therapeutic relationship, as Fiedler's (1950a and 1950b) research tends to demonstrate. This aspect of the therapist's role, which tends to enhance the patient's self-esteem and provide him with a more satisfying self-image, certainly forms part of the basis of the patient's identification with the therapist.

A second feature of the therapist's role, which greatly contributes to inducing a commitment to the therapy situation in the patient, is the therapist's apparent expertness and related characteristics designed to inspire faith in his ability to help the patient. Frank (1959) has provided a most illuminating discussion of the variety of factors that promote this kind of faith in the therapist and of the way in which faith enters into the therapy process. The main point in the present context is that, to the extent that

the therapist inspires faith, the patient's relationship to him reduces his sense of helplessness and enhances his feeling of hope. The resulting identification with the therapist, in turn, increases the patient's commitment to the therapy situation and to his own role requirements within it.

In most forms of therapy, this part of the therapeutic process is regarded as a means to therapeutic experiences, not as an end in itself. In analytically oriented therapy, in particular, positive transference is important only in that it provides motivation for the patient to continue with the therapeutic work despite its painfulness, and in that it creates an atmosphere in which the patient feels safe and free to examine his feelings. As a matter of fact, analysts, like Menninger (1958), stress the necessity of limiting the amount of satisfaction that the patient derives from his relationship to the therapist: it must be sufficient to keep him in the situation, but not so much as to make it an end in itself and thus reduce the patient's motivation to engage in the therapeutic process. Even Rogerians, who put primary emphasis on acceptance, do not regard this as the end of therapy. They merely regard it as the limit of the *therapist's* contribution, but this is only a means to the therapeutic process itself, which is essentially the patient's own responsibility. It often happens, however, that the therapeutic process becomes fixated at the level of identification, that establishing a self-defining relationship to the therapist becomes an end in itself rather than a step that mediates the occurrence of corrective, insight-producing experiences. This is the kind of outcome that is sometimes referred to as a "transference cure," which has similar dynamics to placebo cures and faith healing, as described in detail by Frank (1959, 1961). Such an outcome may, in fact, be quite meaningful therapeutically, depending, of course, on the criteria one uses. The opportunity of establishing a relationship with the therapist—by giving the patient something to hold on to, someone in whom he can have faith, on whom he can depend and on whose acceptance he can count—may help to stabilize the patient's self-concept, provide him with a sense of identity (even if it is a borrowed identity), and thus change the whole balance of his life. Thus, solely on the basis of the relationship to the therapist, without any special insight or working-through, the patient may manifest changes in his self-attitudes and, related to these, an increase in general feeling of comfort and symptomatic relief.

Now let us turn to group therapy and examine the way in which the group contributes to this part of the therapeutic process, to inducing the patient's commitment to the therapy situation and to his own role requirements within it. Other group members serve, in various ways, as *facilitating agents* who make it easier for the individual patient to continue with the therapy process and to take the risks of self-revelation. The patient's relationship to the group typically provides him with a more satisfying self-definition because it enhances his self-esteem and lowers his sense of helplessness. In these respects, the group does not merely reinforce the effects of the therapist but makes certain unique contributions that the one-to-one relationship to the therapist cannot offer.

First, the group can help to overcome the patient's feeling of isolation, which is, of course, a central problem for many neurotic patients. The very feeling of belonging to a group is in itself a source of self-esteem (Frank, 1957), which is further bolstered by the experience of intimacy and support from others. Of particular importance is the fact that this is a group of individuals with similar or related problems (cf. Beck, 1958), which gives the patient the reassuring feeling that his situation is not unique and unprecedented. The presence of shared problems and a common fate increases the likelihood of identification with the group, which in turn increases the patient's commitment to the therapy situation as a whole.

A second contribution of the group to a more favorable self-definition of the individual patient is based on its acceptance of him, despite his "obvious deficiencies, lack of status, and intimate revelations" (Beck, 1958). Needless to say, such acceptance enhances the patient's self-esteem as well as his feeling that he can somehow be reclaimed. While acceptance from the group is not as predictable nor as unconditional as that from the therapist, when it does occur it is likely to have a powerful impact. For here is acceptance not by a professional, who has been trained to take this role and is being paid for it, but by the person's own peers who, despite their deviancy, are more representative of society at large.

A third contribution of the group in the present context is based on the fact that it can serve as a *comparison reference group* for the individual patient, i.e., as a group that he can use as a standard for comparison in evaluating his own fate and his own progress. By comparing himself to others whose situation resembles his own, the patient can gain a certain degree of hope and encouragement. His difficulties seem less devastating when he can use a group of fellow-patients as his reference group, rather than his associates from his daily environment (cf. Beck, 1958). Moreover, as other patients show progress, the patient's optimism about his own situation may (at least up to a point) be enhanced.

In short, by relieving the patient's sense of isolation and deviance, by offering him support and acceptance by his peers, and by providing him with encouraging points of reference, the group can greatly enhance his commitment to the therapy situation. The increased self-esteem and hope generated by his relationship to the group help in motivating him to continue therapy and in freeing him to express himself despite the risks this entails.

The satisfying self-definitions that patients derive from their relation-

ship to the group have not only a direct but also an indirect facilitative effect on their commitment to the therapy situation. These and other satisfactions provided by the group contribute to the general cohesiveness of the group, i.e., "the resultant of all the forces acting on all the members to remain in the group" (Cartwright and Zander, 1960, p. 74). Numerous studies have shown that the greater the cohesiveness of a group, the greater its ability to induce change in the members, not only at the level of public conformity but also at the level of private belief. That is, the more cohesive the group, the more likely are the members to accept the attitudes that it prescribes—which, in the case of therapy groups, would include a favorable attitude to the therapy situation. Among the potential sources of cohesiveness in therapy groups, Frank (1957) mentions the extent to which the group provides direct satisfaction for some of the members' needs and promises future satisfactions, the extent to which members find that they can be mutually helpful to each other, the extent to which the group provides rewards for successful performance, and the extent to which mutual attraction of members develops.

If the group is highly cohesive, there is, of course, the possibility that the individual patient will become committed to the group per se rather than to the therapeutic process. In that case, the patient would remain fixated at the level of identification with the group: that is, the satisfying relationship to the group would become an end in itself rather than a means to further self-examination and insight-producing experiences. As I pointed out earlier, such an outcome may be therapeutically quite meaningful in that it may, by enhancing the patient's self-esteem, restore the balance of his life situation. Typically, however, it would be up to the therapist to make sure that the patient's relationship to the group serves as a spur to the therapeutic process rather than as a substitute for it.

There is another danger inherent in group therapy to which the therapist must always remain alert. The facilitative effect of the group is predicated on the assumption that the group will accept the individual member as he is. If the member is confronted, however, with condemnation and rejection, the experience may be antitherapeutic, his commitment to the therapy situation may be reduced, and he may eventually withdraw from the situation completely. This does not mean that acceptance of others has to be complete. As a matter of fact, there is some experimental evidence (Dittes and Kelley, 1956) to the effect that, under certain circumstances, the member who is not fully accepted in the group is more likely to become committed to its norms than the one whose acceptance is very high. Moreover, criticisms and attacks from the group may on occasion initiate therapeutically useful experiences (Frank, 1955, 1957). There must, however, be an underlying atmosphere of acceptance and support by the group, so that

the patient will not regard an occasional attack as complete rejection, and so that there will be the definite prospect that, as he changes his behavior, acceptance will be restored. It is up to the therapist to foster an atmosphere of mutual acceptance as part of the normative structure of the group and to step in to protect the individual patient when this norm is seriously violated.

3. *Occurrence of Corrective Emotional Experiences*

The experience and expression of feelings in the therapy situation, which are encouraged through deliberate training by the therapist and identification with him, are designed to provide opportunities for the occurrence of "corrective emotional experiences" (Alexander and French, 1946). Such experiences are based on the manifestation, right in the therapy hour, of the distorted, self-defeating, and troubling attitudes that the patient brings to his real-life relationships. The conditions for a corrective emotional experience are present if the feelings the patient experiences when he expresses these attitudes in the therapy situation are as real and intense as they are under usual circumstances. The difference between the therapy situation and other situations is, of course, the fact that in therapy he is able, and in a way forced, to examine these feelings as they occur, which he cannot do in real life. With the help of the therapist, the patient can thus begin to see his attitudes in their true light, he can recognize their distorted and self-defeating aspects, and he can gain some understanding of their origins. Typically, the therapist is able to confront the patient with the inappropriateness of his attitudes by reacting in ways that violate the patient's expectations. A clear disconfirmation of a clear expectation provides the raw material for a re-examination of the patient's unrealistic attitudes and inappropriate feelings.

The essence of a corrective emotional experience is the fact that the patient's examination of his attitudes and behavior patterns occurs simultaneously with their actual manifestation at a real-life level of emotional intensity. He examines his attitudes and behavior while he is still experiencing the relevant feelings, which makes this more than a mere intellectual exercise. The unique value of psychotherapy is that it makes this simultaneous occurrence of real feelings and their examination possible. Outside of therapy, situations in which strong feelings occur are precisely those in which examination of these feelings—stepping aside and observing one's self objectively—is impossible. When a person does examine his behavior objectively, it is generally after he has gained some distance from it and it has been drained of its emotional intensity.

Corrective emotional experiences can form the basis for internalized changes in the patient's conceptions of the self and of interpersonal rela-

tionships. As a result of these experiences, and the therapist's interpretations, the range of information that is available to the patient becomes widened. He gains new insight, a new understanding of the attitudes that he characteristically brings to his interpersonal relationships, of the behavior patterns that result from them, and of the expectations of others' reactions that generally guide him. Out of these new insights, more realistic attitudes and expectations can develop. We can speak of internalized changes here because corrective emotional experiences represent a re-examination of the patient's attitudes and behavior in the light of his own value system. The changes that emerge from such experiences are presumably integrated with his value system: the patient abandons self-defeating attitudes and behavior patterns and, instead, learns to see himself and others and to behave interpersonally in ways that are more likely to maximize his own values.

Sometimes, a series of corrective emotional experiences may lead, not only to changes within an existing value framework, but actually to changes in basic values themselves, that is, the patient may come to adopt new values that are more realistic for him. Ideally, however, even when this happens, there would be some continuity between the new values and his self-system. Values communicated by the therapist would serve as catalysts and models in the re-examination of the patient's values, but the patient would not simply take them over *in toto*. He might adopt the therapist's values in modified form, in ways that meet his own needs, temperament, and life history. It may, of course, happen that a patient simply takes over the values of the therapist. This would be a case of therapy having been fixated at the level of identification. A genuine corrective emotional experience, however, implies a confrontation between the patient's current attitudes and behavior and his own value system. Changes resulting from such an experience should, therefore, be changes at the level of internalization.

As has already been noted, compliance and identification are usually necessary before such corrective experiences can occur. Often, the three processes represent sequential steps in the therapeutic process. The patient starts out by complying: he follows the basic rule and engages in the therapeutic work, at least in part, for short-range rewards at the beginning stages of therapy. Identification then enters in, in two ways: the patient must get some satisfaction out of the relationship to the therapist as such, in order to continue in therapy; and, if the therapeutic situation is to offer some novelty, he must be able to take over the therapist's point of view, at least on an experimental basis. As he continues to engage in the therapeutic process, corrective emotional experiences can occur and internalized changes can be built on them.

The therapist contributes to this part of the therapeutic process by confronting the patient with the distorted and self-defeating character of his attitudes and behavior, by offering interpretations, and in other ways encouraging the patient's examination of himself. There is another important contribution, however, that the therapist makes to this part of the therapeutic process: he is frequently the *object* of a corrective emotional experience. One of the major sources of emotional experiences in therapy is the patient's relationship to the therapist. In the context of this relationship, the patient can feel anger, dependency, anxiety about loss of love, sexual attraction, and a whole host of other emotional reactions. Feelings toward the therapist are the most likely to be experienced at their full intensity because they are immediate and directly related to the present ongoing situation. Thus, these feelings are most likely to form the basis of corrective emotional experiences. Essentially, then, the therapist serves as *transference object,* if we use this term more broadly than in its strictly psychoanalytic meaning. In part, it can be assumed that the patient transfers to the therapist attitudes and feelings that are irrelevant to the present situation, that are merely repetitions of patterns based on childhood relationships or of patterns carried over from the patient's present interpersonal relationships outside of the therapy situation. In part, the patient's attitudes and feelings toward the therapist may represent direct reactions to the therapist as a person or to the role that he enacts. Even though the therapist tries to be neutral, he does reveal his personality and attitudes in some ways, and these may stimulate some of the patient's characteristic patterns. Moreover, neutrality as such is also a definite role which can elicit some of the patient's interpersonal reactions. For example, the patient may interpret the therapist's neutrality as lack of interest and lack of concern for him, and he may proceed to manifest his characteristic patterns for situations thus interpreted. Regardless of whether the patient's emotional reactions to the therapist are based "purely" on transference or whether they are based on the patient's interpretation of the realities of the situation, they reveal some of the patient's characteristic patterns of interpersonal behavior at a realistic level of emotional intensity and thus provide current material for corrective experiences.

In group therapy, the group has a special contribution to make to this part of the therapeutic process. The group situation provides many possibilities for stimulating the patient's habitual interpersonal reactions, which can then be examined and form the basis for corrective emotional experiences (cf. Frank and Ascher, 1951; Beck, 1958). The great advantage of the group over the individual therapist in this regard is that it makes available a wide range of *interaction objects* to the patient, thus increasing the chances that the attitudes and patterns that trouble him in real life

will come into play during the therapy hour. In individual therapy the possibilities are limited. The therapist is only one person, and moreover a person who enacts a very special and unusual role, marked as it is by affective neutrality (Beck, 1958). This does not mean that he fails to arouse emotional reactions, particularly since the opportunity for transference is ever-present, but in the group the opportunities are much more extensive. For one thing, there may be a wide range of social statuses represented: members are likely to vary in sex, age, social class, education, occupation, family position, etc. Thus, there are more opportunities for the patient's unrealistic and inappropriate attitudes to be stimulated in the therapy situation. For example, if a patient has problems in his relations with women, or with authority figures, or with peers, it is likely that these will manifest themselves as he interacts with the group members who represent these statuses. Moreover, the group is likely to represent a range of personality styles, interpersonal patterns of behavior, and general attitudes. Thus, again, it offers many opportunities for stimulating the patient's characteristic reactions. If, for example, his neurotic attitudes are most likely to be aroused when he deals with people who are more aggressive than he is, or more confident than he is, etc., chances are that the group will make such interactions available.

A third reason why there is likely to be more stimulation of habitual patterns in the group situation is that it brings into play a wider range of current issues that generate emotions at a real-life level of intensity. The patient is involved in a real group situation, even though this is an atypical group. This situation, like other group situations, is marked by competition for the leader's attention, struggles for power and status within the group, attempts at saving face and making a good impression, requests for help and offers of help, and so on (cf. Varon, 1953). This range of interpersonal issues with which the group members are constantly concerned is likely to stimulate the patient's characteristic attitudes and behavior patterns at a high level of intensity and make them available for examination. The stimulation provided by the here-and-now issues of group interaction is further enhanced by the fact that these bring into play a variety of informal roles and interpersonal patterns, distributed over the members of the group. This happens partly because these situations elicit characteristic behavior patterns that patients bring to their interpersonal relationships (cf. Frank et al., 1952), and partly because the inherent dynamics of group functioning make some degree of role differentiation necessary. Thus, as any given patient deals with the real and current interpersonal issues activated by the group situation, he is confronted with a range of role behaviors on the part of other group members that can serve to instigate, complement, and reciprocate his own reactions.

In sum, one of the major advantages of group therapy is that it provides numerous opportunities for eliciting affect-laden reactions on which corrective emotional experiences can be based. The group accomplishes this by generating significant current issues around which interactions can occur, and by offering each patient a wide range of interaction objects—varying in social status, characteristic interpersonal behavior, and informal group role—capable of bringing out his habitual attitudes and behavior patterns. Thus, the patient's reactions to a wide variety of interpersonal stimuli become directly available for examination at the very moment that they are occurring. The range of possibilities is further extended by the fact that the patient can have some vicarious corrective emotional experiences by observing the behavior of others and its interpretations and applying these to his own case. While this is clearly not at the same level of emotional intensity as a corrective experience in which he himself is the main actor, his identification with the other patient may give the experience an emotional impact. Such experiences may be useful forerunners to more direct corrective experiences for which the patient may not yet be ready. In the group situation there is, thus, a ready-made mechanism for graduating the intensity of the experience. Furthermore, corrective emotional experiences in a group situation typically involve supporting actors in addition to the main one. While one patient's reactions may be the focus in a given situation, the examination of his reactions may also reveal how others have elicited it and contributed to it. Patient B may thus learn something from patient A's corrective experiences, particularly about his own stimulus value and the effect he has on others.

This leads us to another special contribution that the group can make to the analysis of corrective emotional experiences. When the patient manifests a troublesome interpersonal attitude or behavior pattern, he can be confronted not only with the distorted and self-defeating character of the behavior itself but also with the reactions it elicits in others. In individual therapy, such confrontation is limited. The therapist does not react spontaneously, but tends to remain neutral. He can only inform the patient of the kind of reaction this behavior is likely to elicit in others. In group therapy, the reactions of others are present here and now. They are produced spontaneously by fellow-patients, can be observed directly by the patient and the therapist, and thus constitute part of the experience available for analysis. The other patients can also confirm and support the therapist's interpretations by describing their own reactions to the patient's maneuvers. The patient is thus able to obtain a fuller and more dramatic picture of the nature and meaning of his behavior, since he is immediately confronted with the impact it has on others. For example, he can be shown convincingly that the way he reacts to an offer of help is calculated to alienate

others at a time when he most needs them. Similarly, his distorted perceptions of others can be examined effectively since these others are personally present. For instance, he may act on the assumption that others will disdain him if he reveals too much dependency; this expectation can be refuted by the way others in fact react to him and by the way they describe their own reactions in subsequent examination of the relevant event.

The fact that, in group therapy, the reactions of others are included in the corrective emotional experience not only provides a fuller picture of the patient's characteristic behavior for analysis but also increases the similarity between the event in the therapy hour and the real-life situations in which the patient experiences difficulty. The patient's ability to build on this experience, to relate it to his daily life, to find examples that fit what he has just learned, and to note how his interpersonal behavior in daily life prevents maximization of his values is therefore increased. The process thus initiated may lead to internalized changes in the patient's conceptions of himself and of interpersonal relations that go beyond the therapy situation.

The group's ability to stimulate and enhance the realism of corrective emotional experiences depends, in large part, on the heterogeneity of its composition. The opportunities for such experiences will increase if the members of the group represent a range of social statuses and personality types, thus providing a variety of potential interpersonal stimuli. At the same time, however, there must be enough homogeneity in the group so that it can constitute a reasonably representative social unit. If the cultural backgrounds of the members are extremely varied, it is less likely that complementary patterns will mesh and characteristic reactions will be elicited. Similarly, the reactions of others, who are clearly from a different milieu, do not have as much of an impact on a patient who is confronted with them. In short, then, from the point of view of maximizing opportunities for corrective emotional experiences, there should be as much heterogeneity as possible, within the limits of the range of people with whom the patient is likely to interact in his daily life. Of course, other considerations have to enter into the determination of group composition. From the point of view of increasing the patient's commitment to the therapy situation, as discussed above, a certain degree of homogeneity is necessary: the patient must see the other group members as similar to himself and sharing some of his problems. Here too, however, complete homogeneity is neither necessary nor desirable. Optimally, there should be a communality of fate in some important respects but differences in personality, background, and so on. These requirements can generally be met by including in the same group patients with a variety of neurotic symptoms. Even in those cases, however, in which it is considered desirable to maintain homogeneity of

symptoms because of the special nature of the problems engendered by these symptoms, e.g., in groups of alcoholics, it would be best to aim for heterogeneity in all respects other than the defining symptom.

The group therapist's responsibility with respect to this part of the therapeutic process is to serve, as it were, as the director of the corrective emotional dramas that the patients act out. He must be alert to the interactions between the patients in order to guide them and use them as bases for corrective experiences. In this connection, it is important for the therapist to be sensitive to the dynamics of the group process itself, so that he will be aware of some of the immediate forces that determine the patients' behavior and the here-and-now issues with which they are concerned. Group therapists do not always take into account the character of the group as an actual functioning unit in which meaningful interactions are going on. Yet, these interactions offer some of the best opportunities for insight-producing confrontations.

Influence Directed to Behavior Outside of the Therapy Situation

Changes produced within the therapy situation certainly have an important bearing on the patient's behavior outside. Thus, changes resulting from corrective emotional experiences, insofar as they are internalized changes, should, by their very nature, be generalized to the patient's interpersonal relationships in daily life. Similarly, some of the changes produced by identification with the therapist or the group may go beyond the therapy situation: they may enhance the patient's self-esteem and faith sufficiently to help him through a critical period, at which point his normal coping mechanisms can again come into play. In the course of the therapy situation itself, however, there are also *direct* attempts at exerting influence on the patient's behavior outside of therapy. Here again, all three processes of influence may be involved. This part of the argument is summarized in Table 3. I am proposing that three types of extra-therapy behavior must be induced in the patient during therapy in order to facilitate therapeutic change, and that these correspond, in the main, to the three processes of influence.

1. Experimentation with New Actions

Generalization of therapeutic learnings to the patient's real-life situations requires, first of all, that he experiment with new behaviors. Only as he tries to change his actions in interpersonal situations can he become fully aware of the unrealistic nature of his earlier attitudes and gain the necessary confidence to reorient his characteristic patterns. Such experi-

TABLE 3

Types of Influence Involved in the Production of Therapeutic Change

B. Processes of Influence Directed to the Patient's Behavior *Outside* of the Therapy Situation

	Type of patient behavior induced by this process	*Therapist's role in the induction of this behavior*	*Group's role in the induction of this behavior*
Compliance	Experimentation with new actions	Imaginary interlocutor	Anticipated audience
Identification	Adoption of the therapist's and/or group's standpoint for viewing the self and interpersonal relations	Role model; norm setter	Normative reference group
Internalization	Generalization of therapeutic insights to specific real-life situations	Auxiliary reality tester	Representatives of society

mentation, of course, continues to take place after the patient has terminated therapy, but it is important that it begin while therapy is still in progress. At that point, the patient's experimentation can be based on therapeutic experiences that are still fresh in his mind; it can be brought back to the therapy situation for further review; and it can be carried out under conditions of greater protection, i.e., with the support of the therapist and the group and the assurance that the patient can always turn to them in the event of failure.

Typically, experimentation with new behavior develops out of corrective emotional experiences and represents attempts to generalize new insights to specific real-life situations (see section 3, below). Such experimentation, however, usually does and should begin earlier in the course of therapy. It is sometimes possible to induce a small but significant change in the patient's interpersonal behavior simply by pointing out to him that other actions are possible and socially acceptable and encouraging him to try them. Such changes can occur with very little prior insight, but they can become an important source of subsequent insight: after having tried out the new behavior, the patient will be in a better position to examine the causes for his earlier difficulties and the possibilities for overcoming them. Moreover, such experimentation, if successful, may increase the patient's self-esteem and commitment to the therapy situation as a potentially useful experience. For these reasons, there is therapeutic value in inducing the patient to experiment with new behaviors outside—on a limited, graduated

basis—even during the early stages of therapy. At that time, the induction leans heavily on the side of compliance.

What typically happens is that the patient reviews some of his interpersonal relationships and reveals their troublesome character. As he does so, he may be confronted with explicit or implicit suggestions to change his approach in some of the specific situations that he describes. For example, if he discusses the fact that his mother-in-law constantly criticizes him and he always gets upset by these experiences, he may be told: "Next time your mother-in-law criticizes you, why don't you try to stand up to her?" Or, more likely, the encouragement to try out new behavior will be implicit. For example: "It is interesting that you never stand up to your mother-in-law when she nags at you." Along with these suggestions, the expectation is communicated (again, usually implicitly) that carrying out the suggested experimentation will produce approval by the therapist or the group, and failure to do so, disapproval. Often, the patient will react to this kind of suggestion by committing himself to trying out a new approach. When that happens, he can expect further disapproval for failure to carry out his commitment. The patient's concern with approval and disapproval may, thus, motivate him in part to carry out the suggested behaviors.

The therapist's role in this part of the therapeutic process is that of an *imaginary interlocutor*. When the patient finds himself in real-life interpersonal situations that he has discussed in a therapy session, the therapist tends to be represented as a third party with whom he engages in imaginary conversation. The knowledge that he will have to report his behavior in the next session increases the likelihood that he will live up to the therapist's expectations and to his own commitment to try out new actions. Even when a particular situation has not been specifically discussed with the therapist, the patient's behavior is likely to be influenced by the anticipated reaction of the therapist to the subsequent report of this behavior. A patient may spontaneously experiment with new behavior because (on the basis of earlier statements and reactions by the therapist) he expects the therapist to approve it. Similarly, a patient may refrain from engaging in certain behaviors that he knows or thinks are disapproved by the therapist, because he would rather not be in a position of having to report them. Thus, the requirement of reporting to the therapist everything that happens in the patient's life extends the range of the therapist's surveillance and his training function to events outside of the therapy situation proper.

The group's role with respect to this part of the therapeutic process serves to reinforce that of the therapist. Just as the group can use its sanctioning function to induce conformity within the therapy situation, it can

extend this function, to some degree, to extra-therapy behavior. The group represents, in essence, an *anticipated audience* to whom the patient must report on his behavior outside of therapy. Experimental research by Zimmerman and Bauer (1956) has shown that the way in which people organize and remember experiences is partly determined by the groups to whom they expect to report on these experiences. It seems reasonable to propose, in line with their theoretical notions, that the groups to whom the individual expects to report on his experiences will also influence the very experiences he allows himself to have. In other words, there will at least be some tendency to tailor his experiences so that their report will meet with the approval of the anticipated audience. This mechanism is likely to be operative in group therapy, and thus to increase the likelihood that the patient will experiment with new behaviors that the group has encouraged him to try or that he has reason to believe will meet with the group's approbation. The group's ability to influence the patient in this direction should depend on the very same factors that determine its ability to influence the patient's engagement in the therapeutic work within the therapy situation. There is also the possibility of antitherapeutic effects if the group reinforces defensive ways of handling the patient's real-life difficulties.

To the extent that the patient's changes in his behavior outside of therapy are tied strictly to the approval of the therapist or the group, their effect will be limited. They will tend to persist only as long as direct surveillance by the therapist or the group continues. The expectation, of course, is that this experimentation with new behavior will facilitate and be tied in with subsequent insights.

2. *Adoption of the Therapist's and/or Group's Standpoint*

In the course of therapy, the patient is induced not only to experiment with new behaviors in real life but also to adopt a new frame of reference for viewing his own behavior and his relations with others. Thus, for example, he may accept the assumption that much of his interpersonal behavior is defensive in nature; or that his difficulties originate in his own attitudes rather than in an unfriendly environment; or that he is ineffective because he is caught up in neurotic interactions, not because he has a weak character. As he reacts to various baffling situations in his daily life, which previously he had been unable to understand, he can now bring this new point of view to bear on them. He is now able to see some of his problematic interpersonal patterns in a new light and to formulate them in a new language. Essentially, he has learned a new conceptual scheme or a new ideological system from which he derives hypotheses that he can apply to his behavior outside of therapy. The adoption of some new frame of reference

of this sort is essential if the patient is to have corrective emotional experiences in therapy and to carry over the insights derived from these experiences to his real-life situations. The therapeutically induced viewpoint helps to shake loose his original, and generally unproductive, way of looking at things and makes him aware of new possibilities. Moreover, it provides him with a language in terms of which he can account for what is happening and formulate new insights. It also provides a vehicle for bringing real-life experiences back to the therapeutic hour, where their interpretation can be further discussed and refined. Adoption of this frame of reference, then, is not a therapeutic end in its own right, but it represents an important conceptual tool for developing and communicating about new insights.

Typically, this new frame of reference is originally adopted through the process of identification with the therapist. I have already discussed the bases for identification with the therapist and the way in which such identification produces commitment to the therapy situation, i.e., a taking over of the therapist's attitudes toward the situation. For similar reasons and in a similar manner, the patient gradually tends to adopt the therapist's standpoint in viewing himself and his interpersonal relationships. He takes over the therapist's attitudes, including the therapist's attitudes toward the patient himself, as his own. He thus comes to formulate and judge his own behavior and the behavior of others with whom he interacts in the terms that the therapist would use.

The therapist's obvious function with respect to this part of the therapeutic process is that of a *norm setter:* he communicates the normative expectations that the patient would have to meet (outside of the therapy situation, not only within it), if the patient-therapist relationship is to be maintained. These normative expectations include the adoption, at least on a trial basis, of the therapist's ideological viewpoint. There is, however, a perhaps even more important function that the therapist performs with respect to this part of the process, namely, that of a *role model.* Typically, the therapist is attractive to the patient not simply as a partner in a reciprocal role relationship but also as an object for emulation, since he so clearly possesses all the attributes that the patient himself lacks: recognized status, knowledge about human behavior, control over the current situation, apparent mental health. The patient is motivated to become like the therapist and, in the process, to adopt the therapist's language, attitudes, and values, particularly as they relate to matters of immediate concern. Thus, he takes over the therapist's role and looks at himself and others from its vantage point. In group therapy, of course, there is a ready-made arena where this identification with the therapist can play itself out: the patients can take

on the therapist's role vis-à-vis each other, and in fact they are often helpful to each other in doing so.

Ideally, the adoption of the therapist's standpoint through identification with him represents only a transitional stage in therapy. It is therapeutically very important because the patient must find some new way of looking at things and must have some framework that he can apply to specific situations and in terms of which he can formulate specific new insights. Taking over the therapist's framework represents the only economical solution to this problem during the early stages of therapy. As therapy proceeds, however, and the patient manages to loosen his habitual ways of looking at things and to acquire new insights, he should no longer be dependent on the therapist as an ideological fountainhead. He should be able, at that point, to become more selective with respect to the therapist's standpoint, to accept it not as a total system but as a source of useful hypotheses. He would then modify the therapist's standpoint to suit his own value system; he would accept parts of it and reject others in the light of his own experiences and his attempts to maximize his own values.

Thus, the challenge confronting the therapist is to induce an identification that contains the seeds of its own dissolution. It seems to me that such an outcome is most probable if the emphasis is on encouraging the patient to adopt a certain *process* of looking at himself and the world, rather than a certain set of specific formulations. What should ideally remain from the patient's identification with the therapist is the process of self-examination, based originally on emulation of the therapist—a process that involves splitting his ego and observing his own behavior from the outside, the way the therapist would observe it. Adoption of the therapist's standpoint in that sense would enable the patient to carry on the therapeutic process outside of therapy, even after therapy has been terminated, and would mediate internalized changes as the patient examines his own behavior in specific real-life situations.

It is, of course, possible for the therapeutic relationship to become fixated at the level of identification. The patient may adopt the therapist's values as his own and build a whole philosophy of life on the therapist's standpoint (or at least on his interpretation of the therapist's standpoint). Thus, for example, he may take over psychoanalysis as a total ideology, a way of life, a cause. There are some striking similarities between this type of ideological conversion and some of the effects observed in the "brainwashing" situation where the adoption of "the people's standpoint" and of Marxist ideology are induced (cf. Lifton, 1956; Frank, 1959). Needless to say, there are vast differences in the goals and procedures of the two situations, and ideological conversion in therapy stems largely from the needs

of the patient rather than the wishes of the therapist. Nevertheless, therapists can profit from studying the conditions under which brainwashing occurs and seeing in what parallel ways they may inadvertently be structuring the therapeutic situation so as to make ideological conversion a likely outcome. Generally, the changes produced under these circumstances will persist as long as the patient is able to maintain, in some way, the relationship to the therapist or some substitute for it: the patient may remain in therapy for a long time, or return to it repeatedly; or he may build a substitute into his daily life, for example, by establishing active ties with the mental health movement. As long as these relationships persist, they may lend stability to the patient's self-concept and represent a meaningful, if limited, form of improvement.

The group can contribute to this aspect of the therapeutic process by incorporating the therapist's standpoint—the new frame of reference for seeing one's self and one's interpersonal relationships, induced by the therapist—into its normative structure. To the extent that the patient uses the therapy group as a relevant *"normative" reference group*, he will be motivated to live up to its expectations, not only within the therapy situation but also outside of it, and, accordingly, to adopt the standpoint that the group supports. The likelihood that the patient will identify with the therapy group and that it will serve as an important reference group for him is quite high in view of the group's special contribution to his attainment of a more favorable self-definition, as discussed above. The more cohesive a group becomes, the more likely the patient is to adhere to its norms even in the absence of direct surveillance.

The primary value of the group in the present context, then, is that it can use its considerable power in support of the adoption of the therapist's standpoint. This support may make a great deal of difference, since the therapist's standpoint tends to fly in the face of the conventional norms prevalent in the patient's own social milieu (cf. Beck, 1958); despite strong identification with the therapist, the patient is usually subject to normative pressures to reject his deviant ideology. Under these circumstances, the availability of a reference group that supports and prescribes these norms, even though it is an atypical group as far as society at large is concerned, reduces the conflict engendered by the therapist's standpoint and provides the consensual validation necessary for its adoption. The assumption in all of this is, of course, that the group will develop norms in support of the therapist's standpoint rather than in opposition to it. The latter possibility cannot be completely dismissed, although it is not a likely development. While group members may occasionally support each other in their resistance to the therapist's influence (cf. Bennis, 1961), the group is not likely to develop this resistance into a definite, normatively prescribed standpoint

that opposes the therapist's standpoint. A therapy group of neurotic patients typically lacks the independent power to accomplish this. To induce a particular standpoint, the group would have to be cohesive, but, as Frank (1957, p. 61) points out, the therapy group "can develop cohesiveness only by incorporating the standards of the therapist." Nevertheless, it must be kept in mind that lack of support from the group (even in the absence of a normatively structured opposition) can reduce the therapist's effectiveness. The therapist must, therefore, encourage the group to incorporate his standpoint into its normative structure.

3. *Generalization of Therapeutic Insights to Specific Real-Life Situations*

The ultimate goal of psychotherapy is achieved when the patient generalizes therapeutic insights to specific situations in his daily life. He addresses himself to interpersonal situations in which he has problems, situations in which he is ineffective, self-defeating, and uncomfortable. He examines these situations from the point of view of his own contributions to them, the attitudes and expectations that he brings to them, the elements of distortion and unrealism with which he approaches them, and the kind of interaction patterns in which he typically becomes involved. In this examination, the patient applies the insights he derived from corrective emotional experiences in the therapy situation to the real-life situation with which he is now confronted.

The significance of this part of the process lies in the fact that insights are applied to *specific* situations. That is, the patient does not merely adopt some general formulation about himself and interpersonal relationships which he then carries with him into his real-life situations (which is the part of the process discussed in the preceding section). Rather, he goes a step beyond that and involves himself in a more active and idiosyncratic process, not just taking over and expounding an explanatory system and a language but deliberately applying them in a concrete and unique situation. If this application is to be meaningful, it must be based not merely on the general formulations that the patient has learned but on the specific personal insights that he has had in the course of his therapeutic experiences. Moreover, it must involve a consideration of the special characteristics of the life situation to which the insights are generalized. If the process takes this form, then it represents a continued testing and evaluation of the therapeutic learnings as they are applied to real-life experiences, and probably some modification in them in the light of new data. Any changes produced by this process are likely to be at the level of internalization: they should be independent of the patient's relationship to the therapist and integrated with his own value system.

As has already been mentioned, this is the type of process that should go on after therapy has been terminated; adoption of the process of self-examination is perhaps the most valuable carry-over from therapy to the patient's subsequent daily life. This process, however, begins while the patient is still in therapy. Typically, a corrective emotional experience within the therapy situation itself is followed by an attempt to apply the insights derived from this experience to some of the patient's troublesome relationships outside of therapy. That is, the patient is encouraged to examine some of his real-life relationships in the light of the new insight so that he can gain a better leverage on them. Experimentation with new behavior is often tied to this process. Thus, following a corrective emotional experience, the patient would be encouraged to generalize the insights derived from it to real-life situations and to plan new behavior accordingly. In subsequent therapy sessions, the patient's attempts to apply the new insights and to experiment with new behaviors can be brought back for further review. The generalization of therapeutic insights can be facilitated in the therapy situation itself by reviewing, particularly in the aftermath of a corrective emotional experience, both the patient's current behavior outside of therapy and his attempts at changing his behavior.

The therapist contributes to this part of the therapeutic process by taking the role of an *auxiliary reality tester*. As the patient examines his current behavior outside of therapy, the therapist can help him reality-test by calling attention to the points at which his perceptions and expectations of others are likely to be distorted and by making him aware of the reactions that his behavior is likely to generate in the people with whom he interacts. When the patient plans new behavior outside of therapy, in the light of his new insights, the therapist again can help him reality-test by anticipating the kinds of reactions that his behavior is likely to produce in others. Similarly, when the patient brings back to the therapy session reviews of his attempts at trying out new behavior patterns, the therapist can help in the interpretation of the effects that this behavior produced in others and in the explanation of the reasons for these effects. The therapist's usefulness as an auxiliary reality tester is based on his role of an objective outside observer who is generally wise, knowledgeable about human relations, and familiar with social reality and the prevailing cultural norms. Nevertheless, the therapist's contribution to this part of the process is limited. He can only speak about social reality, indirectly, on the basis of the patient's reports and of his own estimation of the social situations to which these reports refer.

In group therapy, the group is in a unique position to make a special contribution to this aspect of the therapeutic process. The group "is more like society in miniature" (Frank and Ascher, 1951, p. 127). It can facilitate

reality testing by bringing society, to a certain extent, directly into the therapy situation. Despite the fact that the group members are in some sense social deviates themselves, they are, in general, sufficiently close to the cultural norms to serve as adequate *representatives of society*. Thus, as the patient examines his current behavior outside of therapy, he can reality-test his interpretations immediately and directly by turning to his fellow-patients. They can inform him about their probable attitudes and reactions if they had been his partners in the situations about which he is reporting. To the extent that they come from a similar milieu and represent a wide range of social roles within it, they should be able to give him a reasonably accurate picture of the social reality that he faces. In fact, they are more likely to give him an accurate picture than he would obtain in real-life situations, since the therapy group operates in terms of the norm of honestly stating what is on one's mind.

When the patient entertains the possibility of trying out new behavior in the light of his new insights, the group can again be very useful by helping him anticipate the reactions that this behavior is likely to produce in the real world. As representatives of society, they can remind him of the social expectations that circumscribe this behavior; they can point out the unrealistic features of his expectations; and they can inform him whether he underestimates or overestimates the negative effects that the planned actions are likely to produce. The group situation provides the patient with the opportunity to engage in an anticipatory practice session, a dry run of the behavior that he will try out in real life. This allows him to reality-test the new behavior under conditions that are both realistic and protective: failure in this situation is not as devastating as it would be outside, since in the therapy group the patient does not "play for real" and he knows that he is in a supportive environment.

Finally, when the patient brings back to the group reports of his experimentation for subsequent examination, he can again benefit from the group's reaction. In the group situation, there is the opportunity for a fairly realistic re-enactment of the real-life experience that the patient has reported. The other group members can indicate directly how they would have reacted if they had been the other participants in the interaction. As a result, the patient can gain a fuller understanding of the adequacy of his expectations and of the social effects of his new behavior. He can see more clearly and dramatically where he has succeeded and where he has failed.

Conclusion

An analysis of the influence processes involved in group therapy has been presented, and their role in the production of therapeutically relevant

changes in the patient's behavior, both within the therapy situation and outside of it, has been described. The analysis was based on a theoretical framework for the study of social influence in general, which was applied here to the special circumstances of the therapy situation. My assumption throughout was that, even in group therapy, the therapist is and must be the primary influencing agent. I tried to point out, however, that there are a variety of very important, unique, and powerful contributions that the group can make to the production of therapeutic change. At the same time, one must remain aware of the possibility that, under certain circumstances, the group may impede or weaken the therapeutic process. It is up to the therapist to make sure that the potentials for therapeutic change that are inherent in the group are maximized and that its possible antitherapeutic effects are minimized. Moreover, the influence processes that characterize the group situation and the varying potentialities of the group have to be taken into account deliberately in the composition of the group and in the decision, for any given individual, as to whether group therapy is the indicated form of treatment.

The kind of systematic analysis that I have offered here may seem arbitrary in that it makes sharp distinctions between changes inside and outside the therapy situation and between different stages and the influence processes that are relevant to them. Needless to say, I do not assume that these neat separations are possible in the actual situation. They are made only for analytic purposes. I hope that they will prove useful by yielding certain implications for the practice of group therapy. It seems to me that this kind of approach may (1) point to some of the features of the group therapy situation that have to be manipulated in order to strengthen its potential for change; (2) help to locate those features that have potentially antitherapeutic effects; and (3) help to provide some criteria both for the selection of patients who can benefit from this experience and for the composition of therapy groups so as to maximize their ability to produce therapeutic changes.

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