From its primitive beginnings as a healing agency, modern group psychotherapy has experienced impressive expansion as an effective treatment modality recognized the world over. Its first major growth spurt occurred during World War II when military psychiatrists were forced by the large numbers of psychological casualties to resort to group intervention. The American community mental health center movement of the 1960's added further impetus for the use of group measures because of the urgent need to serve large numbers of people with limited staffs. Currently, as approaches range from clinical therapy groups to derivative preventive and supportive interventions reaching out to virtually all human services, group psychotherapy plays a major role in the country's move toward managed health care.

Recounting the history of how small groups have been used for purposes of healing has been viewed by some as pointless and boring as well. I think otherwise. Let me explain and begin with a quote from Johnson and Johnson's book: Cooperation and Competition. Theory and Practice (1989).

From the moment we are born to the moment we die, relationships are the core of our existence. We are conceived within relationships, are born into relationships, live our lives within relationships (p. 107).

I consider it fair to extend the term "relationship" to refer to group relationships, for intimate relationships entail a sense of a shared identity, separate "I" identities turned into a "We" identity.

The history of group therapy is the history of a movement in which past history is continuous with the present—a path leading to the experience of identity. In other words, paraphrasing Erik Erikson, group psychotherapy today is at once a product of what it has been and what it will become tomorrow.

Group therapy's precursors were folk healers, troubadours and prophets who knew the power inherent in group relationships, and who used them to promote in people a sense of well-being and an acceptance of behavioral change. In a similar vein, some authors have considered the Greek healing temples, such as that of Epidaurus (600 B.C.-200 A.D.), the famed sermons by religious leaders from the Sermon on the Mount, to the Tantras and Mantras of the East, Anton Mesmer's Parisian "animal magnetism" sessions of 1776, as well as the Marquis de Sade's theatricals—all have been labeled as precursors of modern group therapy (Janet, 1925).

Thus, in an extended sense, when Joseph Pratt (1906), a compassionate Boston internist (not mental health worker) used the group medium in 1905, to help his poor tubercular patients cope with their then incurable chronic disease, he was following in the tradition of the healers of old. Pratt's didactic approach, soon revealed broader therapeutic potentials, which he seized upon explicitly two decades later to treat psychosomatic problems as well (Pratt, 1945). Edward Lazell (1921), a psychiatrist, adapted Pratt's "class" method, to work with schizophrenic patients at St. Elizabeth's Hospital in Washington, D.C. He used group discussions along psychoanalytic lines, together with supportive lectures. About a decade later, L. Cody March (1931), a minister who became a psychiatrist, developed a group approach with inpatients using both inspiration and exhortation. Both Marsh and Lazell subsequently pioneered the use of outpatient groups, of milieu

Correspondence regarding this article should be addressed to Saul Scheidlinger, 715 Bleeker Avenue, Mamaroneck, NY 10543.
methods and of psychoeducational groups for hospital personnel.

Independently of these developments, Alfred Adler, Freud's erstwhile collaborator, had utilized as early as 1921, in his Viennese child guidance clinics, a "collective therapy" with adults and with children. His student, Rudolf Dreikurs (1932) brought these group methods with him to America, founding an Adlerian "school" of group therapy in Chicago, which specialized in the field of education, working with children's and with parent's groups.

In the mid-1920's, Trigant Burrow (1927), one of the founders of the American Psychoanalytic Association, replaced the couch with small network-kind of groups which included the patient's family members and mental health professionals. Termed "group analysis," his new technique focused on contemporaneous social interactions instead of the traditional Freudian stress on intrapsychic phenomena. When Burrow, a former chemist, became preoccupied with the intricate physiological reactions of group members and called his approach "phyloanalysis," he lost some of his psychoanalyst supporters, including Sigmund Freud, whom he had known personally (Scheidlinger, 1986). He was eventually even forced to leave the American Psychoanalytic Association.

Among group therapy's pioneers, Jacob L. Moreno, the founder of psychodrama, had the longest career. It ranged from his European beginnings in 1908 (only three years after Joseph Pratt's "classes"), to his death in 1974, a total of 66 years. While still a young man, he experimented in Vienna with the "Theatre of Spontaneity" and with sociodrama. Moreno was very critical of Freud's psychoanalysis because of its major reliance on intrapsychic processes, in contrast to his own preference for spontaneity and on overt action in human behavior (1950). Beyond the limited scope of psychodrama, a treatment modality, Moreno's contributions also extended to such broader fields of study as sociometry and sociatriy. Many of his ideas were recognizable in the later American Gestalt, Existential and Encounter group approaches.

Early Models of Group Treatment in the United States (1930–1945)

During this period, a number of psychoanalysts began to apply Freudian principles systematically to group work in psychiatric hospitals. Louis Wender (1940), worked with small patient groups, differentiating his approach from the earlier didactic approaches of Pratt, Lazell, and Marsh. Wender delineated family transference manifestations in his groups, using also the techniques of interpretation and of working through. Paul Schilder (1936), a well-known psychoanalyst, was also an early believer in the value of group treatment. As a significant contributor to the psychoanalytic literature, and as a Research Professor of Psychiatry at New York University's School of Medicine, Schilder lent considerable prestige to the fledgling group therapy field. (As will be noted later, his wife, Loretta Bender, pioneered with children's groups in the same context.)

While Wender, Schilder, and Moreno were psychiatrists, S. R. Slavson, the acknowledged leader of the dominant American, psychoanalytically-geared group therapy movement was an educator who became a self-taught psychotherapist. His initial work in the development of group therapy for children in the mid-1930's will be described separately. He followed two decades later, with important contributions to the group treatment of adolescents and of adults (1964). Soon after, he proceeded to develop models for parent groups, for group work with delinquents and for inpatients.

Fritz Redl, a psychoanalyst and Viennese student of August Aichhorn's, introduced diagnostic children's groups soon after his arrival in the U.S. (1942), and thereafter made many seminal contributions to group work with severely ego-disturbed children and adolescents in residential settings (1952). He also wrote about psychoanalytic group psychology and propagated the acceptance of group therapy among his psychoanalytic colleagues (1950).

Impressed by Wender's and Schilder's work, Alexander Wolf developed a new psychoanalytic model for adult outpatient groups in the 1930's. He offered a derivative of free association, including the interpretation of dreams, of transference, and of resistance. Eschewing attention to group-level manifestations, Alexander Wolf and his collaborator, Emanuel Schwartz, also advocated a controversial innovation of alternate group sessions, convened without the presence of the therapist (Wolf & Schwartz, 1962).

Group Therapy's Growth During World War II (1945–1960)

World War II served as a prime impetus for a dramatic rise in the use of group therapy. Faced
with a large number of psychiatric casualties, military psychiatrists were forced to use group treatment methods through sheer necessity. Accordingly, the American and British military hospitals became the spawning grounds for a number of later authorities in group psychotherapy. William C. Menninger, America’s Chief of Military Psychiatry, considered the use of group therapy during World War II, as one of his branch’s major contributions to civilian psychiatry (1946).

Given this expansion, the two major group therapy organizations founded by Moreno and Slavson, respectively, came into being during the war years, in 1942. Moreno’s American Society for Group Psychotherapy and Psychodrama was designed as an interest group, attracting social scientists and clinicians as members. In contrast, at Slavson’s insistence, the American Group Psychotherapy Association chose a more restrictive route, as a clinical organization for mental health professionals only. Moreno and Slavson maintained a profound influence on these respective organizations, including their separate conferences and publications, well into the 1950’s. The open and personal rivalry between these two brilliant and zealous exponents of the group therapy movement which even reached international dimensions, is regrettable. Its intensity is difficult to fathom. It is also tragic that, notwithstanding their uniquely prolific contributions, their books translated into many languages, they both remain relatively unrecognized after their deaths. The only difference worth noting here, is that the American Group Psychotherapy Association which Slavson had founded, has survived as the largest and most respected professional organization of group therapists. This was made possible only by the shedding of its “partisan” image and by becoming a truly pluralistic organization, attracting group therapists of all ideological persuasions under its umbrella (Scheidlinger, 1991). It even became a facilitative force in helping to shape the 30 national organizations of the International Association of Group Psychotherapy into a vibrant democratic entity.

During the 1960’s, psychotherapy, including group psychotherapy, was beset by unprecedented squabbles, as claims for hegemony emerged from competing schools of thought. Within group therapy, in addition to the early ideological struggles among the psychoanalytic adherents to the Freudian, Adlerian, and neo-Freudian camps of Karen Horney and Harry Stack Sullivan, there were numerous, competing new therapies, among them Transactional Analysis, Person-Centered, Rational-Emotive, and Existential. Transactional Analysis (Berne, 1961) and Gestalt Therapy (Perls, 1969) emerged in group contexts, but the other approaches soon began to extend their initial concepts of individual therapy to the group medium (Corsini, 1973).

The expanding group psychotherapy literature of the day, showed the applicability of group treatment to a wide range of practice settings, including general and psychiatric hospitals, outpatient clinics, and rehabilitation programs, including correctional institutions. The patient populations were broad in scope, ranging from children and adolescents to adults with varied psychological dysfunctions, among them homosexuals and the mentally retarded.

As might be expected, an early, persistent theme entailed the claim that group therapy was a valid form of clinical practice. Once this was established, a stream of writings sought to merge group therapy with Freudian psychoanalysis, given the latter’s dominant position in the contemporary mental health field. Along with such theoretical productions, went publications that dealt with such clinical practice topics as differential criteria for suitability, homogeneous versus heterogeneous groups, combined and conjoint group therapy, and the handling of patient dropouts.

The rapid development of group practice modalities after World War II, comprised clinical outpatient groups and their derivatives such as psychosocial educational groups, so-called T-Groups and Human Development groups, together with Self-Help and Mutual-Help groups in the community. Regrettably, the mental health literature and the public media, tended to favor the generic term “group therapy” for all of these approaches. This lumping together failed to recognize the important fact, that all people-helping groups are not the same, either conceptually or clinically (Scheidlinger, 1982). For example, their potent motivational factors notwithstanding, groups such as Alcoholics Anonymous, or other self-help groups established for people with chronic medical conditions or with social maladies, are not group therapy in the sense of a professional practice model.

The Community Mental Health Center Movement and Group Therapy

The social legislation of the John F. Kennedy years with its Community Mental Health Center
Act of 1963, had a profound influence on group psychotherapy (Peck, 1963). The numerous community mental health centers that sprung up across the country to meet the mental health needs of all citizens, had to rely heavily on group therapy and allied techniques.

The reality of the need for technical and conceptual changes in the programs of the new community mental health centers, led to experimentation with new group service models. Accordingly, the earlier, predominant psychoanalytic treatment groups that had stressed long-term intrapsychic restructuring, and were most appropriate for middle-class clients, yielded to short-term modalities focused on more limited goals of enhanced ego-functioning and social competence.

In addition, modified group measures that did not require rigorous group therapy training, such as psychoeducational, recreational, and occupational methods, including art and dance therapy, were welcomed in these programs. Fortunately, the gradual demise of most of the original community mental health center programs did not affect the status of group therapy, for its methods had by now joined the mainstream of the broader currents of mental health.

The youth revolt kindled by the Vietnam War in the 1960's gave rise to numerous nontraditional group intervention models that functioned under nonprofessional auspices. Among the best known were the Encounter and the Transcendental Meditation groups. Carl Rogers referred to Encounter groups as "...perhaps the most significant social invention of the century (1968, p. 16). Producing a few motion pictures and even a popular best-seller (Schutz, 1967), the Encounter group movement both challenged and embarrassed the professional group work field because many psychologically-vulnerable people flocked to these commercial undertakings, resulting in a number of emotional breakdowns (Parloff, 1970). A united protest by the official mental health professional organizations succeeded in effecting a discontinuation of at least the most serious abuses. Informed consent, the screening of participants, and the employment of trained group leaders became new requirements.

Group Therapy with Children and Adolescents

As was noted earlier, S. R. Slavson began his career by founding activity therapy groups for children in the 1930's (Slavson, 1943). The child clinicians of the day welcomed these new groups because they found it uniquely difficult to engage elementary school age children in one-to-one talking sessions, given the latter's marked difficulty in communicating feelings. Even as these outpatient groups were being created, Loretta Bender (the wife of Paul Schilder), began to work with inpatient children's groups at New York's Bellevue Hospital. She also pioneered in the planful use of children's cathartic expression in groups in general (Bender, 1937) as well as through puppet shows (Bender & Woltman, 1936).

Virginia Axline's (1947) model of play group therapy followed a direction different from Slavson's psychoanalytic approach. She employed the principles of Carl Rogers' Non-directive Therapy with children's groups. With the emergence of behavioral therapy in the 1960's, this method also began to find application in child group therapy (Rose, 1972). When Slavson's most frequently employed nonverbal method of activity group therapy proved to be unsuitable for reaching more seriously disturbed youths, modified versions which relied on greater structure, coupled with verbal therapist interventions, were introduced (Frank, 1983). An up-to-date picture of clinical child group therapy was recently offered by Schamess (1993).

There has been an unprecedented growth in short-term psychoeducational and so-called focus groups in the nation's schools. Their themes range from parental divorce, substance abuse, and skills training, to AIDS prevention (Jaffe & Kalman, 1991). Short-term diagnostic groups have also been introduced in clinics to help clarify newly referred patients' pathology. Liebowitz and Kernberg (1986) described one such program which was designed to ascertain children's behavioral patterns, thus serving as a basis for appropriate treatment planning.

Residential schools for children have relied on the use of group modalities from the beginning, ranging from milieu models to therapy, socialization or recreational groups (Konopka, 1970).

Given adolescents' well-known propensity for peer group involvement, group therapy has often been viewed as the treatment of choice for this population. Because most youths do not enter treatment willingly, they often prefer a group context which permits greater distance from the mistrusted adult "shrink," as well as support from other group members. Younger teenagers (about 10–14), who tend to be especially threatened by
authority figures and by internal and external pressures, were found to require same-gender groups, where activities and games are used, as well as discussion periods (Aronson & Scheidlinger, 1994). Co-educational talking groups for older adolescents have been found very successful, given well-trained therapists who possess the personality attributes required to work with disturbed youths. A sense of humor, coupled with a special stamina to withstand the frequent provocations and resistances inherent in such work, have been listed as prerequisites (Sugar, 1986).

Betty Gabriel, a collaborator of Slavson’s, was the first American to employ talking groups with adolescents (Rachman & Raubolt, 1984). She was followed by Slavson himself, by Ackerman, Rachman and by many others.

Given the fact that adolescent mental health has recently been portrayed as being in a “state of crisis” (Children’s Defense Fund, 1992), a great variety of preventive and reparative group modalities for teenagers have come into being, in clinical settings, in schools and in human service organizations. Not unlike the earlier-noted efforts with children, high schools have employed short-term psychoeducational or focus groups to address such issues as substance abuse, sexuality and, especially, anger control.

Group Treatment Models for Adults

Following World War II, group therapy with adults found ready application in outpatient clinics, in private offices, in hospitals, in family service agencies, and even in prisons. Reflecting trends in individual therapy, group therapists also conducted their groups within the lines of their theoretical framework. The predominant Freudian approach and that of psychodrama were soon joined by neo-Freudian methods such as Sullivanian, Horneyan, and Kohutian. Following are brief summaries of the best-known additional models of group psychotherapy.

Yalom’s Interpersonal Group Therapy based on Sullivanian principles had gained in popularity in recent years with four editions of his best-selling book (1994) appearing. In contrast to the Freudians’ primary preoccupation with intrapsychic conflicts and their origins, Yalom’s focus is on correcting here-and-now interpersonal relationships. The group session becomes for him a laboratory for the expression and understanding of such problems as mistrust, anger, and dependency. He has elaborated, as well, on assumed therapeutic factors in group therapy, among them universality, instillation of hope, corrective emotional experience, modeling, and promotion of self-awareness.

The Freudian Psychodynamic Model of Group Therapy promoted by most of the earlier pioneers—Wender, Schilder and Slavson—in the 1930’s, continues to hold a large proportion of the older practitioners of group therapy to this day. In distinction from the interpersonalists, such as Yalom, Freudian practitioners place major emphasis on eliciting and interpreting derivatives of unconscious conflicts through the manifestations of transferences (member to therapist and member to member), of dreams, and of resistances. The main elements of the Freudian approach are the fostering of a therapeutic regression and the re-construction of genetic connections (Rutan & Stone, 1993). However, there is no unanimity of thought among these proponents of the Freudian psychodynamic model about the importance ascribed to structural theory (ego, id, superego), to group dynamics manifestations, to basic drive theory or object relations theory, or to the role of the actual therapeutic relationship (Kauff, 1979; Tuttman, 1986).

More specifically, the ideological ferment within psychoanalysis of the last two decades, depicted by Greenberg and Mitchell (1983), has effected the emergence of three distinct, yet related, theoretical camps within the field of psychodynamic group psychotherapy. 1) Object Relations (Kibel, 1991; Tuttman, 1990). 2) Self Psychology (Bacal, 1985; Stone, 1992), and 3) Social Systems (Group-as-whole) (Bion, 1959; Ganzarain, 1977). As might be expected, the object relations approach stresses the reactivation of internalized interpersonal conflicts in the group which is viewed as a “holding environment.” Self-psychology practitioners address the enhancement of the patients’ deficient self-esteem through empathy and the internalization of therapist qualities. In the social systems model, shared unconscious fantasies are elicited with the aim of clarifying the group members’ role in the group transactions, with special attention to individual-group and fantasy-reality boundaries.

The time for a comprehensive psychodynamic group therapy theory is obviously not at hand. In the words of Klein, Bernard, and Singer (1992), “Each theory speaks to an aspect of those clinical realities that is vitally important, but none holds an exclusive view of the ‘truth,’ a situation that
is consistent with the state of knowledge in group psychotherapy” p. 400.

Redecision Therapy was developed by Mary and Robert Goulding (1979) combining elements of the newer therapies that have come into being during the turbulent 1960’s. Among them is Transactional Analysis, whose theory of ego states (child, parent, and adult) and of “games,” transactions and scripts (Berne, 1961), used together with Gestalt Therapy’s “chair techniques” (Perls, 1969), evokes emotional awareness and change. The major elements of Redecision Therapy include the following: group members re-examine power and responsibility for their lives, the group’s nurturing environment promotes mature decisions for behavioral change, the group therapist models ways of living and being, errors in patients’ thinking and behavior are confronted. Gestalt techniques are used for the expression of feelings, and group maintenance rules are enforced.

Existential Group Psychotherapy contains both, concepts of existential philosophy and those of therapies. Mullan (1992) claimed that in this method, change flows from the authentic group experience as well as from the therapist’s confrontations. The process of self-examination includes the group therapist, who joins in the exploration of existential meanings of such phenomena as death, illness, dread, and failure. Patients are brought to the threshold of their self-knowledge so that they can subsequently arrive on their own, at responsible choices.

Behavioral Group Therapy emerged during recent years as an effective way of treating a variety of maladaptive conditions, ranging from autism to phobias, in a group context (Shaffer & Galinsky, 1974). Except for Ellis’ Group Rational-Emotive and Cognitive-Behavior Therapy (1992) to be discussed later, there are very few comprehensive models of such treatment. Instead, there are numerous reports in the Behavior Modification literature of utilizing the group setting for the systematic application of explicit procedures to change individual patients’ problem behavior. The common, underlying assumption shared by these diverse reports, is that pathological behavior is learned behavior and thus subject to modification of the conditions which serve to maintain it (Stolz, Wienckowsky, & Brown, 1975). After prolonged and stormy debates, wherein psychodynamic and humanistic practitioners had accused behaviorists of a dehumanizing effort at mind-control (Rogers & Skinner, 1956), there has emerged a gratifying recent trend of trying to effect a productive integration of these approaches (Messer, 1986). Some of the concepts of behavior modification have since then also been mainstreamed into various aspects of group treatment such as “positive reinforcement” or “modeling” in outpatient group psychotherapy, as well as the “token economy” in residential treatment (Ayllon & Azrin, 1968). Group Rational-Emotive and Cognitive-Behavior Therapy (Ellis, 1992) is anchored in Ellis’ theory that people tend to create their own psychological problems by exaggerated expectations from others and by commands to themselves. In addition to a great variety of action-oriented and emotive techniques, Ellis also employs traditional behavioral techniques such as desensitization, reinforcement, skills training, and relapse prevention.

In a recent contribution, Rose (1993) summarized the contemporary trends in cognitive-behavioral group psychotherapy. He regretted that the method’s practitioners had failed until the 1980’s, to include the “group dimension” in their work. In describing his own approach, he stressed the importance of cognitive restructuring which he defined as a “. . . process of identifying and evaluating one’s own cognitions, recognizing the deleterious effects of maladaptive cognitions and replacing them with appropriate cognitions” (p. 211). In addition to the utilization of special exercises where peer reinforcement, feedback, and role-modeling were employed, he placed special stress on techniques which were designed to facilitate the transfer of behavioral change from the treatment situation to the patients’ real world.

It is noteworthy, that most cognitive-behavioral therapy groups are short-term (rarely over 12 sessions) and are designed to isolate and then to eliminate the specific maladaptive behaviors through the use of explicitly designed techniques. The multifarious theoretical and technical positions described—mere samples of those existing in contemporary group psychotherapy for adults—invite bewilderment for anyone trying to categorize the principal dimensions of the group treatment modality. As Dies (1992) noted, “There remains much controversy and uncertainty about the most fruitful ways to distinguish among prevailing models of group treatment” (p. 2). And yet, the present state of affairs represents an improvement over earlier decades where competing schools of thought were involved in unprece-
dented fights for hegemony, not excluding *ad hominem* attacks among the theories' proponents.

Fortunately, the recent search for pragmatism, for specificity, and for cost-effectiveness in the broader health care enterprise, has caused most experienced group therapists to abandon monothemeering in favor of pluralism (Scheidlinger, 1991). This movement has been facilitated by research findings from the broader field of psychotherapy in which experienced practitioners, however divergent their theories, achieved similar outcomes. With those findings came the realization that the commonalities in the various methods were more impressive than the differences (Strupp, 1978).

**Group Treatment of the Elderly**

The first references to group work with the elderly appeared in 1950 (Geller). The early papers dealt almost exclusively with the use of groups in institutions. With the "graying of America," the broadened mental health literature of the 1960's and 1970's began to depict group interventions for noninstitutionalized senior citizens as well. Largely anecdotal in nature, the reports were diversified, dealing with groups for the well-functioning elderly, for those in life "cri ses" such as widowhood or retirement, and for those with physical and emotional disabilities. It was found that impaired older persons responded well to behavioral interventions aimed at anxiety and pain reduction and at social skills training (Lago & Hoffman, 1978).

As MacLennan noted (1988), in deciding on the most appropriate group for an elderly patient, four factors need to be considered. The patient's self-image, the age specificity of the presenting problem, the theoretical focus and group goals of potential modalities, and practical options.

Psychodynamic practitioners differ in opinion about the advisability of insight-geared groups for the aged. Most of the writings appear to favor using supportive, psychoeducational, expressive (such as art or dance), or recreational group formats. Except among severely disabled elderly people, group workers have been impressed by the readiness of most elderly persons to join groups, if only as an antidote to loneliness.

**The Role of Psychologists in Group Psychotherapy’s Development**

As was true with individual psychotherapy, most early practitioners of group psychotherapy in America were psychiatrists. Accordingly, among the pioneers, whom I named earlier, only S. R. Slavson was not a psychiatrist. He was so imbued, however, with the idea of psychiatry’s superiority, that he managed to have all 12 of the American Group Psychotherapy Association’s early presidents, to be psychiatrists! (This was after his own tenure as the first president in 1942). It was over three decades after the organization’s founding, that Henriette Glatzer, a psychologist and woman, was finally elected president in 1976. Not surprisingly, following Slavson, the first three editors of the *International Journal of Group Psychotherapy* were also psychiatrists. In order to attract more psychiatrists to the fledgling association, Slavson also persuaded the Board of Directors to offer psychiatrists special inducements for joining. Ironically, at the present time, the A.G.P.A. has a special Task Force devoted to attracting psychiatrists again to its ranks. Social workers constitute a majority of the current membership of over 5000, with only about 1200 psychologists or about 28%, as members.

During and after World War II, psychologists began to be increasingly drawn to the practice of group therapy as a consequence of their service in the military medical corps and later in the Veteran’s Administration. Thus, many psychologists were involved in the pioneering group therapy research undertaking by Powdermaker and Frank (1953). (Frank is both a psychiatrist and a psychologist.) As for group therapy training centers, in addition to an institute founded by Moreno in the 1930’s to train psychodramatists, the Postgraduate Center for Psychotherapy in New York, offered group therapy training in a psychodynamic frame, beginning in 1957. Under the leadership of Asya L. Kadis, a psychologist, this group therapy training program had attracted an outstanding faculty comprising mostly psychologists, among them such recognized authorities as Marvin Aronson, Helen Durkin, Samuel Flowerman, Edrita Fried, Henriette T. Glatzer, Zanvel Liff, Bernard F. Riess, Emanual K. Schwartz, and Charles Winick (Aronson, 1974).

A recent publication entitled *Classics in Group Psychotherapy* (MacKenzie, 1992), which contains seminal reprinted articles drawn by interdisciplinary peer review from the group therapy literature, beginning with a piece by Joseph Pratt, America’s first professional group therapist, can serve as a gauge of the growth in the number and quality of group therapy writings by psycholo-
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While the earliest period from 1905–1951 had contributions by psychiatrists only (with the exception of one article by Kurt Lewin, a social psychologist) during the years 1952–1967, six of the 10 pieces were authored or co-authored by psychologists. In the last phase, 1968–1981 only two of the eight contributions were by psychiatrists. Five were written by psychologists with one article having a psychologist as a co-author. These numbers speak for themselves.

Given these impressive trends as well as the estimate by Vanden Bos and Stapp (1983) that about 30% of psychology health service providers regularly utilized group therapy with their patients, it is puzzling, to say the least, that official organizations and publications of clinical psychologists failed to recognize group therapy as an important part of the psychotherapeutic enterprise. I can only guess that this was due to the fact that today’s leaders in clinical psychology had not been exposed to group therapy in their training.

Ethical Issues in Group Psychotherapy

It is of historical interest that the question of the group therapist’s ethics, except for casual mention of confidentiality, has not appeared in the literature, until relatively recently. Thus, it took the American Group Psychotherapy Association many years to address this theme directly through the development of Guidelines for the ethical conduct of its members. The tacit assumption had been that group therapists were already bound by the ethical requirements of their respective professions such as psychiatry, psychology, social work, and nursing. It was forgotten that group treatment was special where the co-presence of a number of people with disparate personal problems, coupled with the frequent intense emotional arousal in therapy groups, contained the potential for deleterious effects. Lakin (1985) elaborated on the major ethical dilemmas faced by group practitioners, including informed consent, confidentiality, and rules of conduct, in the group context. He warned appropriately against the misuse of group games and of “warm-up” exercises, and, especially against undertaking leadership roles without appropriate training, credentials, and supervision. Roback, Ochoa, Block, and Purdon (1992) dealt more recently with the issue of confidentiality in clinical groups. The newly initiated National Registry of Certified Group Psychotherapists should help in the prevention of such abuses.

In line with the need for informed consent, it is current practice to prepare prospective group members for the group experience through one or more preliminary individual sessions where the treatment “contract” is clarified, misconceptions and anxieties are addressed, and, above all, an initial “therapeutic alliance” is established. Taylor and Gazda (1991) considered it unethical in combined therapy to bring up material from one-to-one sessions to the group without explicit patient consent.

Research

After decades of benign neglect in some quarters and of well-meaning, yet very unsophisticated stabs at empirical inquiries in others, there has been a gratifying spurt in solid group therapy research in recent years. An early volume by Roback, Abramowitz, and Strassberg (1979) brought together group research articles prior to the 1970’s. In addition, some initial findings in the 1970’s that the “new” group formats such as Encounter and Self-Help groups produced beneficial results (Bednar & Kaul, 1978; Lieberman & Borman, 1979), were followed by comprehensive meta-analytic studies by Smith, Glass, and Miller (1980) which concluded that group therapy was as effective as individual treatment, in the alleviation of psychological problems. To compound this, Toseland and Siporin (1988) reported that in one quarter of comparative studies which they reviewed, group therapy was found to be more effective than individual treatment. These encouraging results notwithstanding, Dies (1986) and Piper (1993) reviewed the remaining conceptual and methodological pitfalls which still stand in the way of a full understanding of group treatments. In addition to the difficulty of establishing the link between specific patient characteristics and the particular kind of group intervention, there remains the broader, still unanswered challenge by Kaul and Bednar (1986) that group therapy researchers focus on their field’s special “fringe benefit”—why and how the group process works, when compared to other modalities.

Researchers in group therapy have addressed themselves primarily to work with adults. Empirical investigations of child and adolescent group therapy have been rare. What there has been, has consisted mainly of clinical reports in which the authors conveyed their impressions of treatment outcomes. However, most of these reports, whether based on group work in outpatient clin-
ics, on hospital wards, or in schools, convey a conviction about the value of the group modality in the treatment of maladjusted youths. It is ironic that this optimism of the clinicians' was not shared by researchers, who claimed that the prevalent impressionistic reports failed to demonstrate the effectiveness of child group psychotherapy (Rutter, 1983). Dies and Riester (1986) noted some exceptions to this discouraging picture, citing more sophisticated research designs in recent studies of successful children's groups.

The situation of research in the realm of adolescent group psychotherapy is similar (Azima & Dies, 1989). Luckily, more recent work suggests growing research rigor coupled with a trend to compare group therapy outcomes with those of other modalities, instead of untreated control groups.

In a subsequent contribution, Kazdin (1991) reviewed the outcome evidence of psychotherapy for children and adolescents. Although he did not, regrettably, separate group treatment from other modalities, his general findings suggest that any kind of psychotherapy is effective with dysfunctional children. However, there does appear to be unanimous research support for the unique value of group approaches in treating adolescent victims of sex abuse (Green, 1993; Mandell & Damon, 1989).

Among the controversial practice issues that still call for research scrutiny is that of co-therapy. While many authorities in the field, such as Slavson, Foulkes, Ezriel, and Bion, do not even mention co-therapy in their writings, many group practitioners, especially the younger ones, strongly prefer to use a co-leader for their groups. Pending research, most senior clinicians, cognizant of the special complications inherent in the introduction of a leader subgroup into an already complex group context, employ co-therapy only if it is specifically indicated—for instance, with an especially difficult group or a situation in which a novice leader needs a role model (Davis & Lohr, 1971). There is also, of course, the basic economic issue that with single leaders, two groups can be run in the same time frame, instead of one.

In general, given the fact that the very survival of group psychotherapy as a recognized treatment modality will depend on the integration of research and practice, more accelerated work in this sphere is bound to emerge. The advent of managed health care, with its emphasis on accountability, will at least force clinicians to continue to demonstrate the cost-effectiveness of their group methods.

A Look at the Future

Despite the uncertain future facing America's health services, it is very likely that the phenomenon of acceptance that group psychotherapy has experienced during the last two decades will continue. As reported by Dies (1992) during the five-year span from 1977–1981 alone, publications on group treatments appeared in over 400 different journals. Furthermore, in the U.S., about eight journals and four professional organizations are currently devoted exclusively to group therapy.

Comprehensive surveys reveal that at least one-half of all inpatient settings in America, use group treatments. These numbers are bound to grow with the continuing documentation of the effectiveness of such interventions (Leszcz, 1985). As for outpatient services, the use of group methods has expanded from traditional multi-service clinics to virtually all human service facilities and organizations, from schools to general hospitals, to thousands of indigenous self-help groups in the community. As for the latter, the 12-step approach of Alcoholics Anonymous has become a general blueprint for a great variety of modified outpatient and inpatient groups for the treatment of all kinds of substance abuse among adolescents and adults. The unprecedented growth of self-help and mutual aid groups, generally, encompassing between 9–12 million Americans (Lieberman, 1990), is likely to increase as traditional mental health services become less affordable. There might be room here, for future group therapists' roles as consultants and trainers, notwithstanding the self-help movement's initial mistrust, if not hostility, to inputs by professionals (Jacobs & Goodman, 1989).

Group work programs addressed to medical patients have a rosy future (Ulman, 1993). The first book devoted to group work with specialized medical populations (e.g., renal, spinal cord, burn patients) was published by Roback (1984). David Spiegel's support groups (Spiegel et al., 1989) for women with serious breast cancer, which were even featured on public television, raised the intriguing possibility of group interventions exerting a beneficial effect on group members' immune systems. Beyond these hopeful signs are promising findings in the preventive realm, where Cummings and Vanden Bos (1981)
documented that psychotherapy addressed to stress reduction, reduces the emergence of medical symptomatology.

In the years to come, the heretofore underserved categories of children and of the elderly, categories found to be especially responsive to group influences, will require additional work. In the instance of children, there are the sobering facts that about 8 million are currently in need of mental health services (Roberts, 1994), and—even more awesome—that children without adequate peer relationships (which group treatment supplies) “... are seriously at risk not only for future social maladjustment, but also delinquency, school drop-out and psychopathology” (Horowitz, Boardman, & Redlener, 1994, p. 86).

On the general health scene, given the push for cost containment, calls for pragmatism, integration, and clarification will be the order of the day.

There is some indication that third party payers have already begun to show interest in the use of short-term group therapy as a way to cut costs (Budman & Gurman, 1988). Furthermore, more recent research studies of short-term group treatment point to definite cost-cutting advantages when these modalities were employed (Rosenberg & Zimet, 1995).

Jerome Frank (1992), predicted that “... the powerful therapeutic properties of group methods, coupled with their relative economy will eventually lead them to become treatments of choice for most persons suffering from psychologically-caused distress and disability. Individual therapy will be reserved for those few for whom it has specific advantages” (p. VII). Tempering, Frank’s overly optimistic prophecy, I will be satisfied when policy-makers and administrators, as a first step, accept group therapy as a cost-effective and successful modality, worthy to be considered on an equal basis with other treatments for all patients. Preference should be given, however, to group therapy where people have been found to be especially responsive to group influence such as those devoid of social skills, people bent on denial and projection, sufferers from abuse and life “crises,” all children and adolescents, as well as the elderly.

References


