

Whitaker, D.S & Lieberman, M.A. (1964) A Focal-Conflict Model in *Psychotherapy through the Group Process*, pp 14 – 40, Aldine Press, Chicago.

A Focal- Conflict Model

In any therapy group in which the therapist does not control the content or the procedure, a session is likely to take the following form. As the patients gather, there is a period of unofficial talk—perhaps about some event from the preceding session, perhaps about an experience that someone has had since the last meeting, or perhaps about some neutral outside happening. Several conversations may go on at once, with the patients talking in pairs or threes; one or two may be silent. The conversation may be general. The atmosphere might suggest depression, tension, distance, or casual friendliness. Then at some signal—perhaps the closing of a door, the arrival of the therapist, or simply the clock indicating that the starting time has arrived—the session “begins.”

After a pause or a longer silence, an initial comment is made. It may reflect some personal concern, some reaction to the previous session, or some reference to the current situation. The speaker may direct his comment to the therapist, to another patient, or to the entire group. The initial comment is followed by another which may or may not appear related to the first one. If it seems related, it may be a response to the topic just introduced, or it may be stimulated by the emotion of the original state-

ment and have little to do with the content. It may be a response to some relationship established earlier in the group's history. Comment follows comment, and a conversation develops. There is some coherence to this conversation, so that the group can be described as talking "about" something. Occasionally the conversation may become disjointed. There may be abrupt shifts in topic, lapses into silence, and illogical elements. The mood may shift, and the rhythm and pace of the discussion may vary. Some patients may talk a great deal, others very little. From time to time, the therapist may enter the discussion, directing his remarks to one person or to the group in general. He may comment about the mood of the group, the character of the interaction, or a problem of a patient.

Some comments get "lost" in the group, as if no one hears them; others are built upon and form the predominant topics and themes. The patients may express such emotions as anger, delight, suspicion, nervousness, or superiority. Some feelings and attitudes are expressed in words; others come through in non-verbal behavior. Certain patterns may emerge in terms of who dominates, who is silent, who talks to whom, and who expresses what feelings. After about an hour of complex interaction, the therapist will signal that the time is up, and the group will disperse. It will meet a few days later for another session.

What has happened? We assume that the diversity observed during a group-therapy session is apparent rather than real and that the many different elements of the session "hang together" in relation to some underlying issue. For example, the first session of an inpatient group was marked by long tense silences, brief staccato periods in which the patients compared notes about physical ills but seemed careful to avoid references to psychological worries, and an animated period in which the patients discussed the architecture of the hospital and wondered whether it was well designed and built on solid ground. On the surface these elements are diverse and unrelated, but they gain a certain coherence if one assumes that they all refer to some shared underlying uneasiness about having been placed in a group and a shared concern about the competence and strength of the therapist. As another example, a group of patients which had been meeting for some time were told that the sessions were to be interrupted for the therapist's vacation. They warmly wished him a good time, ignored him for the rest of the session, and turned to an older member for information about college admission procedures and policies about "dumping" students after the end of the first year. Again, these elements gain coherence if one assumes that they all refer to shared underlying feelings about the impending separation from the therapist.

In this view, the observable elements of the session constitute the manifest material. These elements include not only content, but also non-verbal behaviors, mood, pace, sequence, and participation pattern. Thus, an animated period in which everyone joins the discussion is an element of the session, as is a period of desultory conversation or a period of sober but ritualistic "work" on one patient's problems. A seating pattern in which the chairs on either side of the therapist are left vacant is an element of the session, as is a seating pattern in which male and female patients take chairs on opposite sides of the room. Non-verbal behaviors—looking only at the floor when speaking, directing oneself exclusively to the therapist, or directly engaging one another—are also important elements.

We assume that a subsurface level exists in all groups, but is hardest to detect in groups in which the manifest content is itself relatively coherent and internally consistent. When a group is talking about something, one might assume that this is all that is happening. In the brief illustrations just presented, one group was talking about architecture, and the other about college policies. Yet, even when the group situation consists of a conversation which is coherent in itself, we assume that another level of meaning also exists, for, even in such a group, breaks and shifts occur in the topic under discussion. There are reversals and non-verbal accompaniments, suggesting that to assume that only a conversation is going on is to miss an important aspect of the situation. In therapy groups, covert levels are most apparent in groups of sicker patients, where there is less capacity to maintain coherence on an overt, public level. However, even in non-therapeutic groups, one can observe the same phenomenon.¹

The covert meaning of the manifest material is not likely to be within the patients' awareness. From the patients' point of view, the conversation is about architecture or college admission policies. But an observer is in a position to grasp the underlying issue. Once he "sees" the core issue, aspects of the session which might on the surface appear diverse, contradictory, or meaningless gain coherence and meaning.

This view assumes that the successive manifest elements of the session are linked associatively² and that they refer to feelings experienced in the here-and-now situation. Whatever is said in the group is seen as being elicited not only by the strictly internal concerns of the individual, but by the interpersonal situation in which he finds himself. Of all the personal issues, worries, impulses, and concerns which a patient *might* express during a group session, what he actually expresses is elicited by the character of the situation. Moreover, a comment is likely to include a number of elements and is responded to

selectively by others. An individual may make a comment which includes a half-dozen elements. As the others listen to an individual's highly personal contribution, they will respond to certain aspects and ignore others. The aspects which are picked up and built upon are in some way relevant to the other patients and gradually become an emerging shared concern. As this suggests, the group-relevant aspect of an individual's comment is defined by the manner in which the other patients react to it. To cite an example, in an inpatient group a patient told a story about a man who had been misunderstood when he used the word "intimate." It was known that this was a personal concern of this patient, who was always apologizing for his sexual thoughts. However, the comments by other patients elaborated on the "misunderstood" aspect of his comment and ignored the "intimate" aspect. We therefore assume that being misunderstood was the shared concern and that the issue of intimacy was not a common concern.

We assume that the content of the session, no matter how seemingly remote, refers to here-and-now relationships and feelings in the group. The patients who worry about the competence of the architect and the strength of the building are really worrying about the competence and strength of the therapist. The patients who complain about college administrators who "dump" their students after the first year are really expressing resentment toward the therapist. The same is true for elements of the session other than the manifest content. Non-verbal behavior, such as a seating arrangement in which male and female patients sit on opposite sides of the room, might reflect concern about heterosexual contact in the group. A participation pattern in which one patient is allowed to dominate might mean that the others are using him to protect themselves from having to participate.

Our point of view is similar to that of Henry Ezriel, who uses the term "common group tension" to refer to the covert, shared aspect of the group process:

The manifest content of discussions in groups may embrace practically any topic. They may talk about astronomy, philosophy, politics or even psychology; but it is one of the essential assumptions for psychoanalytic work with groups that, whatever the manifest content may be, there always develops rapidly an *underlying* common group problem, a *common group tension* of which the group is not aware but which determines its behaviour. . . . In the beginning of each session there is always some probing when some member of the group, who seems to feel a particular urge to speak, broaches one subject or another. Often a remark made by one member is not taken up by anybody, apparently because nobody can fit it into what is unconsciously at the back of his or her mind. If, on the other hand, it can be fitted

in . . . if it "clicks" with the unconscious phantasy of another member, and then perhaps with that of a third, then gradually the subject catches on and becomes *the* unconsciously determined topic of the group. . . .⁸

The view of the group situation developed so far is summarized in Proposition 1.

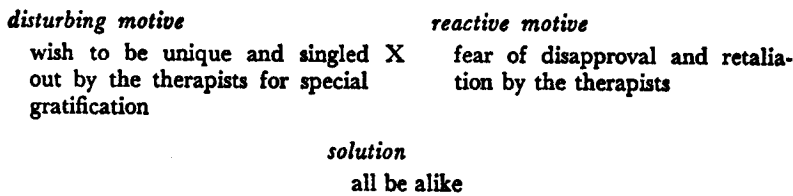
Proposition 1

Successive individual behaviors are linked associatively and refer to a common underlying concern about the here-and-now situation.

We view the covert, shared aspects of the group in terms of forces and counterforces, particularly those involving the shared impulses, wishes, hopes, and fears of the patients. For example, in a session presented in detail later in this chapter, there emerged scattered clues that many of the patients in the group wished to be unique and to have a special, close relationship with the therapists. At the same time, there was awareness that the other patients would not permit this and then, more strongly, fear that the therapists would punish them or retaliate in some way. As the session went on, the patients seemed to search for things that they had in common, finally agreeing that they were all alike in some surface traits. Such a session can be understood in light of the force of the wish to have a uniquely gratifying relationship with the therapist and the counterforce of the fear of retaliation. The wish and the fear constitute opposing forces: the fear prevents the wish from being expressed directly or perhaps even recognized. The wish cannot be pursued actively or thoroughly satisfied. At the same time, the wish cannot quite be given up and keeps the fear in the foreground. This situation creates tension in the group. The patients are beset with strong, conflicting feelings and impulses which are, at best, only dimly perceived. Strong impulses are exerting pressure, yet the patients can neither express nor recognize them. Under such circumstances, the patients attempt to find some way of dealing with their conflicting wishes and fears. In the above illustration, the search for things in common and the final agreement that everyone is alike can be seen as an attempt to allay their fears. It is as if the patients were saying, "Don't punish me; I didn't ask the therapist for anything special." Of course, such a solution cannot really be satisfying, since it involves renouncing the wish. It might temporarily reduce anxiety, however.

In attempting to describe the covert, shared aspects of the group's life, we have adopted a theoretical language which utilizes the key terms "group focal conflict," "disturbing motive," "reactive motive,"

and "solution."⁴ The events of a group-therapy session are conceptualized in terms of a slowly emerging, shared covert conflict consisting of two elements—a disturbing motive (a wish) and a reactive motive (a fear). These two elements constitute the group focal conflict. The term "group focal conflict" summarizes the key features of this view of groups, indicating that the disturbing and reactive motives conflict, pervade the group as a whole, and are core issues engaging the energies of the patients. Concomitant with the group focal conflict, one sees various attempts to find a solution. A group solution represents a compromise between the opposing forces; it is primarily directed to alleviating reactive fears but also attempts to maximize gratification of the disturbing motive. Thus the group session just described could be summarized in the following diagram. This form, which will appear throughout the book to summarize group situations in focal-conflict terms, uses the symbol "X" to indicate "opposed by" or "in conflict with."



This conceptualization of the character of the underlying shared concerns can be stated in the following two propositions.

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|---------------|--|
| Proposition 2 | <p><i>The sequence of diverse events which occur in a group can be conceptualized as a common, covert conflict (the group focal conflict) which consists of an impulse or wish (the disturbing motive) opposed by an associated fear (the reactive motive). Both aspects of the group focal conflict refer to the current setting.</i></p> |
| Proposition 3 | <p><i>When confronted with a group focal conflict, the patients direct efforts toward establishing a solution which will reduce anxiety by alleviating the reactive fears and, at the same time, satisfy to the maximum possible degree the disturbing impulse.</i></p> |

No two group sessions are exactly alike in the group focal conflict which emerges. Even when similar feelings are involved, they are expressed in unique imagery. The solution may also vary in the manner in which it copes with the patients' fears and in the extent to which it satisfies and expresses the disturbing motive. The following examples illustrate some of the variations.

In an outpatient group of schizoid young men, there were a number of symbolically expressed indications of resentment toward the therapist because of his failure to provide direction. For example, the patients shared complaints about the local library: the filing system was chaotic, nothing was labeled, and the librarians were of no help. At the same time, the patients hinted at fears of abandonment and fears of possible angry reactions from the therapist. One patient reported an early memory in which he pitted his will against that of his mother, who threatened to leave if he did not comply with her wishes.

The patients also reported that, following the previous meeting, they had discussed matters and decided to talk and talk rather than to ask the therapist questions. In this way, they expressed thinly veiled anger toward the therapist, as well as compliance with the therapist's implied demand that they, not he, provide direction. This session was summarized as follows:

<i>disturbing motive</i>		<i>reactive motive</i>
resentment toward the therapist	X	fear of abandonment and of the therapist's angry reaction
<i>solution</i>		
band together to express angry compliance		

Focal conflicts in which the disturbing motive involves covert, shared resentment toward the therapist are, of course, not uncommon. Such feelings are expressed in many ways, depending on the character and composition of the group. For example, in an inpatient group of schizophrenic patients, the following occurred:

Bill responded to Lester's account of his problem by saying, "I have a similar problem. When you have legal problems, you go to authorities, and they don't want to give you any help." He mentioned having "done wrong with" a girl, then told about a friend who had been given the electric chair for robbery. He corrected himself, "No, it must have been for something more serious than that." He again complained that whenever he went for help, "There's no satisfaction." Larry agreed: "He is right—you can't get protection."

In an outpatient neurotic group, similar feelings were expressed in different terms:

There was some agreement that the trouble with officers in the Army was that they always expected their men to do things that they were frightened to do themselves. Jerry said that the officers "learned never to turn their backs on their men," and Tom said he actually knew of a case in which an officer had been killed by one of his own men during a battle. The man was never found out or punished because it was assumed the officer had been killed by the enemy.

In another group, composed of nonpsychotic patients, the members drew on shared hospital experiences in order to express anger toward the therapist over presumed deprivation:

There were shared complaints about the patients' cafeteria, especially about having to stand in line for so long. Bert told of being too late for dessert because the cafeteria had run out, but George said, "It's not that they don't have it; they don't want to give it to you." Others said they got enough food, but it was always cold. Grover said that his "big gripe" was with the clothing room and told of an experience in which the clerk was so slow and disinterested that he had had to forego part of his week-end pass.

Sometimes a precipitating event which activates a particular focal conflict can be identified. For example, in an inpatient group of patients with psychosomatic complaints, one patient, with great difficulty and misgiving, confessed his long-time fear of being followed and attacked. Between this session and the next, one of the other patients in the group approached this patient from behind, tapped him on the shoulder, and "teased" him by saying, "Hey, somebody's following you." Clearly, this was the precipitating event for what happened in the next session. The victim of this "joke," after some false starts and prodding from the others, appealed to the therapist: "What do you think of a fellow who hurts another fellow with things that are said here? Don't you think that shouldn't be allowed?" He, as well as the others, was quite reluctant to mention names but persisted in pressuring the therapist to censure such behavior. The meeting was summarized in the following focal-conflict terms:

precipitating event

between sessions, a violation by
one patient of an implicit group
standard

<i>disturbing motive</i>		<i>reactive motive</i>
angry, destructive feelings to- ward one patient	to- X	fear of guilty feelings about tat- tling
<i>solution</i>		
get the therapist to express and implement angry feelings		

The impulses and fears involved in a group focal conflict exist outside the awareness of the patients. Although an outside observer can perceive and link the covert references to a shared concern, the individual who is in the focal conflict does not have this perspective. Under some circumstances, the patients may become aware or may be helped to become aware of these feelings. Ordinarily, however, and especially during the period in which the focal conflict is emerging, the patients are not in a position to recognize the character of the disturbing or reactive motives. A solution differs in character from either a disturbing or a reactive motive. It is usually expressed in more direct terms and is more readily observed. The patients may be aware of the content of the solution, although they are not likely to perceive its relevance to the underlying focal conflict.

A struggle about an emerging solution sometimes develops among the members. When this occurs, we refer to the group as being in a state of "solutional conflict"; one solution is acceptable to most of the patients, but one or two fight against it or offer a conflicting alternative. When such a situation develops, the group is confronted with the new task of resolving the group solutional conflict. This variation can be schematized as follows:

<i>disturbing motive</i>	X	<i>reactive motive</i>
<i>group solutional conflict</i>		
<i>group solution</i>	X	<i>alternative solution</i>
<i>modified group solution</i>		

Solutions may be successful or unsuccessful; in order to be successful, a solution must be unanimously accepted and must alleviate anxiety. Unanimity is necessary, for if one patient fails to accept such a solution as "all be alike," it cannot be effective. If one patient opposes asking

the therapist to rule against a deviant patient, he is interfering with the solution. But unanimous acceptance does not imply that everyone must indicate overt willingness to abide by the solution. Most typically, acceptance is implicit, and some patients indicate through silent acquiescence that they will not interfere. Solutions also vary in the manner in which they deal with the associated conflict. Some solutions concentrate on the reactive fears; it is as if the patients are so concerned about their fears that they adopt a solution which copes with their fears at the expense of satisfying the associated wish. For example, the solution "all be alike" was established in response to this focal conflict: "wish to be unique and singled out by the therapists for special gratification" versus "fear of retaliation." This solution dealt exclusively with the fear. It reduced the fear of retaliation by renouncing the wish for a uniquely gratifying relationship with the therapist. Other solutions alleviate reactive fears and still allow some gratification or expression of the disturbing motive. The solution in which the patients banded together to express angry compliance was of this type—it relieved fears of abandonment by making it impossible for anyone to be singled out for abandonment or rejection, and, at the same time, allowed the disguised expression of resentment toward the therapists. In this case, the solution allowed for the disguised rather than direct expression of the disturbing motive. In other instances, one sees solutions which reduce fears and simultaneously permit the direct expression of the disturbing impulse. The most critical characteristics of group solutions are summarized in the following propositions:

Proposition 4

Successful solutions have two properties. First, they are shared; the behavior of all members is consistent with or bound by the solution. Second, successful solutions reduce reactive fears; individuals experience greater anxiety prior to the establishment of a successful solution, less anxiety after the solution is established.

Proposition 5

Solutions may be restrictive or enabling in character. A restrictive solution is directed primarily to alleviating fears and does so at the expense of satisfying or expressing the disturbing motive. An enabling solution is directed toward alleviating fears and, at the same time, allows for some satisfaction or expression of the disturbing motive.

We assume that, with time, one can observe the gradual emergence of a group focal conflict, along with concomitant efforts to resolve the conflict. Often, during the period when a group is struggling to find some way of dealing with its current focal conflict, several solutions are suggested before one which is acceptable to everyone develops. Some potential solutions are ignored or rejected immediately; others find support, then are built on and modified. By this process, a generally acceptable solution eventually emerges. One does not expect this process to be completed in a single group session, for the session is a convenient but arbitrary unit. The close of a particular session often finds a group still in the grips of some focal conflict without a successful solution having been reached. A series of sessions may revolve around the same conflict. Sometimes several sessions go by in which a group "plays out" a particular solution (for example, taking turns at recounting personal problems and getting advice from the others).

The basic unit in a therapy group can be defined as follows:

Proposition 6

The group focal conflict is a unit of group life encompassing the period during which a single disturbing and reactive motive dominates the group situation. The unit is terminated by a successful solution.

No single illustration can be expected to illuminate all aspects of the propositions stated thus far. The detailed illustration to be presented now should not be regarded as typical, except insofar as it demonstrates how the manifest material of a session refers to covert concerns and how a single group session may be summarized in focal-conflict terms.

The session to be described is the first of a reorganized inpatient group which included eight male patients, three female patients, and two female therapists. Only one patient was regarded as psychotic, two were alcoholics, and the rest were suffering from acute anxiety which had reached incapacitating proportions. Five of the patients had previously been in group therapy with Dr. T. The other six, as well as the other therapist, Dr. E., were participating in the group for the first time.

Dr. T. made a general statement about the purposes of the group. She commented that the group presented an opportunity for the patients to talk about whatever was important to them—events in the

hospital, personal problems, or things that happened in the group. She introduced Dr. E. and announced the meeting schedule.

Such an opening offers little structure, yet communicates to the patients that they are expected to attend and to take responsibility for determining the content of the sessions.

Carl said that he would drop a bombshell into the group by asking Dr. E. how her hair could look like she combed it with an egg-beater and yet look so good.

When Carl uses the term "bombshell," he is calling attention to the daring and perhaps potentially dangerous quality of his comment. His comment has both an aggressive and a sexual flavor. It focuses the attention of the group immediately on the new therapist.

There was a brief silence. Tim said, "That was a left-handed compliment," and there was general laughter in the group. Carl said that his wife was too fussy about her hair, and Tim made some comment about his wife's hair. Margaret defended Carl's wife by saying that he should either compliment her or coax her into changing her hair style.

Apparently Carl was right, and his comment was really a bombshell, because the group seemed momentarily stunned into silence. Tim's comment seemed to provide tension release for the group by making explicit both the hostile and complimentary aspects of Carl's bombshell. Carl then felt impelled to take back the hostile elements of his comment by comparing Dr. E. to his wife, to Dr. E.'s benefit. With Margaret's attack on Carl, there is a suggestion of a battle drawn on sexual lines.

To this point in the session, several potential focuses have appeared, but it is difficult to see which way the group will move. There has been a direct approach to one of the therapists which seems to have both sexual and hostile elements to it, but in any case emphasizes the femaleness of the therapist. It certainly brought Carl to the forefront of the group and focused attention on him. There followed a retreat toward a discussion about outside persons and a hint of contention within the group. But so far, an underlying trend is not apparent.

Dr. T. suggested that there might be some feeling in the group because there were women patients present for the first time. The group did not respond to this comment but continued talking in a general way about hair styles.

This was a premature intervention—a guess at a focus which seems to have missed the point. Underlying this intervention was some assumption that the heterosexual problem being introduced had to do with feelings among peers. In a sense, the comment asks the patients to focus on their feelings for one another. The patients are not prepared to do this and continue their discussion of hair styles, which could be seen as a displaced and symbolic expression of sexual interests.

A trend toward focusing on sexual interests and impulses seems to be emerging, but neither the target nor the implications for the group are clear.

Melvin, who had been silent up to this time, commented that he wanted a medal for being in a therapy group for the third time. Carl said that this was the fourth time he had been in a group, and Melvin said that he would have to back down.

On the face of it, this is an abrupt shift in content and focus. Although in a different area, this comment, too, has a bombshell quality. Melvin seems to be wanting to gain some kind of recognition or attention, either from the therapists or from the other patients, by pointing out that he is special. He points out the difference between himself and all the others and perhaps, secondarily, reminds the group that there are both old and new members present. Carl immediately attacks Melvin's claim to specialness and superiority. He is competitive and effectively gains the upper hand by implying that, if anyone is special and deserving of recognition, it is he and not Melvin.

Jean commented that she was an alcoholic and therefore had different problems from all the other patients. Carl said, "We're all addicted," but Tim argued that this was not true. A discussion followed in which the patients tried to arrive at a definition of "addiction." Carl suggested that Tim might be addicted to sleep. Carl said that his wife thinks he is an alcoholic.

Jean makes her own claim to distinction. Like Melvin, she is immediately countered by Carl, who, this time, rather than suggest that he himself is superior, suggests that everyone in the group is the same and that Jean therefore has no claim to being special. It is interesting that it is always Carl who insists that everyone is alike and no one is special. Others in the group are not ready to agree with him.

At this point in the session, one might hypothesize that an issue is developing as to whether people are unique or the same. Two patients—Melvin and Jean—have made distinct bids to be singled out. Carl's first comment—the bombshell—might also be regarded in this light.

By that comment, Carl was clearly lifting himself out of the mass of patients and making himself conspicuous; in particular, he was bringing himself to the attention of one of the therapists. From a focal-conflict point of view, a disturbing motive may be emerging which involves a wish to be unique and to receive special attention. The object of the wish is not clear. For Carl, it is the therapist; for Melvin, it is probably the therapist (a medal from whom?); for Jean, it is less clear. The reactive motive—the force which keeps the wish from fruition—is not clear. All we can see is that one of the members, Carl, will not allow anyone to satisfy this wish. Whenever anyone makes a bid for uniqueness, Carl interferes. It is uncertain how the rest of the group feels about this issue. Perhaps they don't care; perhaps they care very much but are letting Carl fight their battle for them. In terms of focal-conflict theory, Carl is also suggesting a solution—"let's all be alike"; it is as if he is saying, "Let's not let anyone win this competition." But there is no evidence yet that anyone else supports this view.

Tim and Melvin (both old members) began to talk about Dr. Y. (a psychiatrist who had been permitted to sit in as an observer of several previous sessions). They referred to an argument the group had had at that time about the cost of psychiatric treatment.

If one paid attention only to the content of this portion of the meeting, it might appear that these two patients are wondering whether the feelings stirred up in the group may be too much to handle. Perhaps they are indirectly questioning whether the group sessions will be worth while. However, the interactive characteristics of this episode suggest another line of thought.

Both Tim and Melvin were old members. By discussing a topic which was meaningless to the new people in the group, they excluded the new members from the conversation and brought sharply into focus the difference between the old and the new. Entirely apart from the content of their conversation, this behavior might be regarded as an interesting variation on the theme of claiming uniqueness. Before, each member has made a personal bid for attention or uniqueness. Now, two members collaborate in their attempt to establish a special place for themselves in the group. This behavior may be seen as a solution to the developing focal conflict. One might conceptualize such a focal conflict in the following manner:

disturbing motive

wish to be unique and singled out
for special gratification from the
therapists

reactive motive

interference by other patients

The behavior of Tim and Melvin partly involves giving up the wish to be unique, but still attempts to reserve a special place in the group for themselves as old members. The reactive motive does not involve feelings of fear or guilt, or the like, but simply indicates that, thus far, any bids for uniqueness have been blocked by another patient.

Two of the new patients, Sam and Margaret, began to ask Dr. E. questions. Sam asked whether tranquilizing drugs would help him. Dr. E. asked whether they had helped him in the past. Margaret asked whether tranquilizers were sedatives. Dr. E. responded with medical information. At this point, both Tim and Melvin reacted with exaggerated pleasure. Tim said, "For the benefit of new personnel, doctors do not answer questions in this group, so this is really something."

Here, Sam and Margaret interrupted the conversation between Tim and Melvin. In effect, they did not permit reminiscences about special experiences. At the same time, they made their own bid for attention. These two new patients were seeking attention from the new therapist in the group. When it looked as if they were succeeding, Tim and Melvin interfered. Although they were ostensibly telling Sam and Margaret that they were getting something special, they were also implicitly telling both the patients and the new therapist that an old standard was being violated. Thus they are not only interfering with Sam and Margaret's bid to gain special notice from the therapist, they are also re-emphasizing the differences between the old and the new members. Here one sees a repetition of what has occurred earlier: a bid for a therapist's attention is blocked by other patients. Such repetition strengthens the hypothesis that a disturbing motive which involves a wish to receive something special from the therapists is operating. It also strengthens the assumption that the other patients will not allow anyone to be singled out in this way.

This interpretation re-emphasizes the interactive characteristics of the group. Turning to the content, one might wonder why the patients focus on tranquilizers rather than on something else. It is not clear whether this focus carries a symbolic implication, whether it expresses some wish to have things calmed down in the group, or whether it merely grows out of some private assumption that this is what doctors are for.

Melvin referred to a discussion the group had had a number of meetings previously about automobiles. He then told Carl that this meeting would be a good opportunity to sell chances (again referring to something that had happened in a previous session). There was some talk among Carl, Tim, and Melvin about the cost of the chances and

about Ford, Mercury, and Lincoln cars (all these were topics which had been discussed in previous sessions).

This conversation involves strengthening the ties among old members and excluding the new members. Earlier it was suggested that in the group a solution was developing which would reserve a special place for the old members. It is as if the old members were saying, "Perhaps we cannot be unique and receive special attention as individuals, but at least let us band together to exclude these newcomers." The car conversation suggests that this solution is gaining adherents and being put into practice.

Dr. T. suggested that the group was asking Dr. E. a lot of questions in order to find out what sort of person the new doctor was. The group responded with laughter. Dr. T. then suggested that the group was concerned about the new members versus the old members and pointed out that some of the conversation introduced by old members could not possibly be understood by new members.

The first portion of this comment appears irrelevant to the shared concerns which seem to be developing in this group. The reference to curiosity about Dr. E. does, however, touch on the wish, which several patients have revealed, to get close to Dr. E. and obtain special help from her. More clearly, however, the second portion of the therapist's comment directly confronts the old members with the alliance they are establishing and makes one aspect of the developing focal-conflict pattern—the solution—explicit.

Tim said he really wanted an answer to the question he was about to ask and asked Dr. E. about a shot he had had which produced anesthesia in his arm. Dr. E. did not answer this question directly. The group began to discuss spinal taps. They expressed considerable apprehension about this procedure and wanted to know why it was used. The gist of the conversation was that spinal taps were about the most painful and horrible treatment that one could undergo.

Again, this constitutes an abrupt shift in topic. It might seem that the patients have not heard Dr. T.'s intervention or at least are not responding to it. But interactive characteristics show the patients turning away from Dr. T. and toward Dr. E. In terms of content, the discussion about injections and spinal taps may be a symbolic expression of the patients' feeling that doctors are potentially dangerous and capable of inflicting great pain in the guise of aid. It seems reasonable to suppose, then, that the patients actually are reacting to Dr. T.'s intervention. This intervention had blocked a developing solution by

communicating disapproval. Perhaps it has elicited some covert angry reaction which the patients now express by turning to Dr. E. The content also suggests that the patients perceive Dr. T.'s intervention as a punitive one. Perhaps they are indicating indirectly and symbolically that the therapist's previous comment was as punitive as actually performing a spinal tap. Perhaps—although this is more speculative—they feel that their angry reaction deserves punishment. It is not clear which aspect of the therapist's comment they are responding to—whether it is the exposure of their solution to exclude the new members or whether it is the exposure of their curiosity about Dr. E. In any case, the reaction is a strong one, as is demonstrated by the primitive quality of the symbolism—spinal taps and anesthesia.

From a focal-conflict point of view, the therapist's intervention has led to a shift in the reactive motive. Previously the wish was held in check by an awareness that other patients would block any bid for uniqueness; now it is held in check by a fear that the therapist will punish the patients. It is as if the therapist will disapprove of not only the wish to be special, but even of the modified solution—a special place in the group for the old members.

It is interesting to note, parenthetically, that in this instance Dr. E. did not respond directly to the patients' questions. She appears to be responding to the earlier suggestion that to answer questions is to violate a custom of the group.

The group began to talk about the value of their meetings. Alan said that he might learn to get along with this group, but added, "What good will it do me with friends and relatives?" Jean said, "I am a stranger, and yet you talk to me." Carl said, "This is because we've been through the same thing." Jean talked about Alcoholics Anonymous and said that the value of the group was that "you think you are alone, but you're not." Carl said that he would feel free to talk about anything in this group.

This portion of the session displays a drop in morale and then a recovery. The first part, in which the group is devalued, may express veiled anger toward the therapist; it may also suggest the patients' sense of despair when confronted with difficult issues and feelings. Then, rather abruptly, there is a shift in mood. The patients become more friendly to one another. For the first time, they begin to break down the barriers between the old and new members. (Jean, a new member, tells Carl, an old member, "I am a stranger, and yet you talk to me," and Carl responds, "This is because we've been through the same thing.") There is a new emphasis on the value of peers and the possibility of closeness among them.

From the point of view of the group's focal conflict, this shift suggests a renunciation of the wish to be unique (the disturbing motive), as well as the adoption of a new solution. The patients' friendly overtures may indicate that they will no longer insist on being unique, nor will the old members insist on being a special subgroup. It seems reasonable to suppose that the shift in the reactive motive—from the threat of active interference by other patients to the fear of punishment by the therapist—has led to this change. With such intense, primitive fears involved in the reactive motive, it seems that the only solution is to renounce the wish.

Dr. T. responded to Carl's comment by saying that an important issue in the group would be what people felt that they could talk about and what they felt they could not talk about. Alan said that the group might be a place where he could learn to understand himself. Tim said he did not know what his problems were, but he did know his symptoms. He described them as eating, sleeping, and indefinitely postponing any attempt to do his job. Jean said she felt the same way and described a drinking pattern in which she drank alone until she was stuporous, ate nothing, and sipped straight whisky for weeks at a time. There was some conversation between Jean and Tim, identifying common problems.

The therapist's comment seems to be an attempt to slow down the headlong rush into complete trust and suggest to the group that it is appropriate to move more slowly. The interaction between Tim and Jean is a continuation of the previous friendliness but has now shifted to sharing the content of problems. In part, the patients seem to be turning to one another for support; in part, they may be mollifying the therapist by doing what they assume the therapist wants them to do. In either case, this portion of the session may be seen as a solution which focuses largely on the reactive motive. It is an attempt to deal with fears about the therapist's displeasure.

Melvin brought up the subject of hypnotism. He said that he trusted his individual therapist, Dr. J., and would let him do anything, even hypnotize him. Jean said that Dr. J. had tried to hypnotize her once and that it had not worked. Ella said the same thing. Several patients asked Melvin about hypnotism, expressing a good deal of skepticism. Sam asked whether the pills he took produced the same effect as hypnosis. Alan suggested that sleeping was really like being hypnotized. Dr. T. asked, "You mean that everyone has been hypnotized?" Alan described blackout spells he had had. Jean and William were asking him questions about his spells as the session ended.

This portion of the session begins with Melvin indicating that he can-

not accept the group solution—finding common ground and renouncing the wish to be unique. He is indicating that, if he cannot get what he wants in the group, he will turn to his individual therapist for a special relationship. He thus rejects the possibility of finding strength through relationships with peers. In effect, he says to the group, "You can trust one another if you want to; I will trust my own doctor." From a focal-conflict point of view, Melvin is disavowing the group solution. More importantly, he is also reintroducing the disturbing motive and making a bid for special attention. He is telling the others that he refuses to settle for giving up the wish as they seem willing to do. The others apparently think Melvin's comments will upset the applecart. They attack and depreciate Melvin's supposed special relationship with his therapist. Then the group copes with the anxiety which Melvin's comment has aroused by reconfirming their earlier solution: they insist that everyone is alike and no one, certainly not Melvin, has any claim to uniqueness. They claim that pills and sleep and blackout spells are all the same as being hypnotized. They end the session reaffirming the earlier solution: "We are all alike—friendly people with a great deal in common."

It is now possible to trace the detailed development of the focal-conflict pattern and to summarize the session in terms of a single focal conflict. The detailed development takes the following form:

disturbing motive

wish to be unique and singled
out by the therapists for special
gratification

angry and competitive feelings
toward newcomers on part of old
patients

reactive motive

reality factor: bids for unique-
ness are blocked by other patients

X

solution

old members band together to
exclude newcomers

(Therapist's intervention exposes the solution and the competitive feelings and indicates disapproval.)

new reactive motive

fear of punishment from ther-
apist

new solution

give up the wish entirely; turn
to one another for support and

find similarities among old and
new patients

(Melvin's comment makes a new bid for a special relationship, thus reactivating the wish and threatening the solution.)

solution

all be alike; tolerate no individuality or uniqueness

This formulation identifies some of the details of the interaction. The following summary captures the most significant elements of the session in terms of a single focal conflict:

disturbing motive

wish to have a uniquely gratifying relationship with the therapist

reactive motive

X fear of punishment from the therapist

solution

all be alike

With reference to the disturbing motive, the evidence about the nature of the wish is clearer than the evidence about the object of the wish. Yet it seems reasonable to suppose that the wish for uniqueness is associated with a wish to have a special, perhaps exclusive, relationship with the therapist. It also seems clear that the character of the reactive motive changes markedly. At first, it involved the recognition that attempts to achieve a special place in the group would be interfered with by the other patients. The level of anxiety during this period was relatively low. Later, it shifted to fear of punishment by the therapists. Here the anxiety mounted. Eventually, a solution emerged around the implicit agreement to give up the wish and insist that everyone in the group was alike.

Subsequent sessions suggested that this solution became a basic group standard and held sway for some time. However, eight or nine sessions later, the solution was altered. The patients agreed that they were basically alike but different in superficial ways. This modified solution allowed some differentiation in the group and perhaps a partial satisfaction of the disturbing motive; it was also consistent with reality, as the solution achieved at the end of the first session was not. This development is discussed in detail in Chapter 5, where we examine the culture of therapy groups and the manner in which group solutions become modified.

Methodological Considerations

The analysis of a group therapy session involves certain judg-

ments about the meaning and relative importance of events in the session. At times, the content is interpreted as having a symbolic reference to the here-and-now situation. For example, in the illustration we assumed that the discussion about spinal taps implied some fear that the therapists might harm the patients. At other times, the characteristics of the interaction carry greater weight than the specific content. At one point during the session, for example, the most significant fact seemed to be that an old and a new patient were finding things in common. Sometimes much is made of a rather minute bit of interaction; at other times, a broader sequence of interaction may be summarized and regarded as relatively less important.

These comments suggest some of the methodological difficulties inherent in making complex judgments about a multitude of overt events with reference to assumed covert issues. Questions arise as to whether standard procedures are really possible, whether the bases on which judgments are made can be explicitly defined and communicated, and whether one can expect agreement among independent analyzers. An appropriate, reproducible procedure for making a focal-conflict formulation of the group-therapy session is required. Two choices are available: the holistic approach, which we have adopted, in which a global judgment is made about the import of the material, and a molecular approach which is based on a rating procedure. A molecular approach requires that judgments be made about successive, equivalent units of the interaction, that each unit be placed in one of a limited number of categories, and that the results be summed to characterize the session as a whole. Bales' "interaction process analysis"⁵ and Leary's "interpersonal reflex"⁶ are examples of molecular procedures applied to therapy groups. A molecular approach is preferable because it lends itself to concise definition, reproducibility, and statistical treatment. Agreement between independent raters can be easily measured; the bases for the judgments are relatively clear and can be communicated. In contrast, the bases on which judgments are made in an holistic approach are harder to define and communicate. It is more difficult to guard against subjective judgments.

Despite the fact that a molecular approach has many methodological advantages, the assumptions underlying our theory make such an approach inappropriate to our task. We assume that all of the varied elements of a session—the content, sequence, rhythm, mood, context, and non-verbal behaviors—are relevant to the group focal conflict. These elements differ in kind: the content of specific comments, for example, is easily specified and occurs within a narrow time limit; in contrast, context and sequential characteristics refer to broader aspects

of the situation. Content can be summarized easily, but non-verbal behavior must be interpreted and involves more inference. Mood frequently must be grasped rather than measured. Because of these differences, the elements of a session cannot be regarded as equivalent and cannot be treated additively. Nor do we believe that the various elements are always of equal importance. Sometimes content may outweigh other aspects; at other times, context or sequence may provide the basic cue. The final decision about the character of the group focal conflict requires an integration of these non-equivalent elements. Thus the concepts of "unit," "category," and "summation" become inapplicable.

Our task, then, requires an holistic approach in which the various elements of the session are considered simultaneously and a general judgment is formed. We have tried to minimize the problems of such an approach by making the analytic procedure as explicit as possible and by relying on the combined judgments of two independent analyzers. By identifying the cues used for making judgments, by detailing specific problems, and by breaking the procedure into discrete steps, we have attempted to ensure that the judges are working on the same task in the same way. We have found that making intervening steps explicit allows independent analyzers to pinpoint disagreements and identify the source of their differences within narrow limits. Although we do not intend to provide a detailed procedural manual here,⁷ we would like to outline certain procedures which we regard as appropriate.

The first consideration is the kind of data from which to work. We have found it most useful to work from a written summary backed by a tape. The summary is made by someone who has been present at the session—the therapist or an observer—so that important non-verbal behaviors can be included. If an analyzer listens to the tape with the summary of the session before him, he can familiarize himself with such details of the interaction as pace and tone, which cannot be communicated by the printed word. This method also makes it possible for the analyzer to correct any omissions or wrong emphases in the summary.

A second consideration involves keeping certain relevant cues in mind. Most obvious is content. We assume that the manifest content of successive associations has some relevance to the here-and-now interaction of the group; so, when examining content, we attempt to be alert to symbolic or displaced references to the current group interaction. For example, a complaint about the therapist's white coat might suggest a complaint about the type of relationship the therapist is

maintaining with the group. Another important cue is the kind of interpersonal interaction going on in the group, quite apart from the content. Occasionally, a group will permit or even encourage one patient to dominate the discussion. This in itself might be of greater importance than the details of the patient's conversation. Or a therapist's intervention might be followed by a change in the topic or a shift toward more general conversation. Again, the interactive characteristic might be highly relevant. Non-verbal behavior is often very revealing. In one group session, the patients lined themselves up along one wall and jokingly referred to this as "the line-up." This was the first indication that the major preoccupation of the session involved guilt. In another session, a wish for help was expressed behaviorally—the patients consistently addressed themselves to the therapist rather than to one another. In an adolescent group, horseplay in which a boy pretended to snatch a purse from one of the girls expressed a preoccupation with sexual feelings. The context in which a session occurs is sometimes of such importance that an adequate formulation cannot be made without taking it into account. For example, a particular session might be understood only if one knew that the therapist had changed the meeting time or that this was the first session after an interruption or that the previous session had ended on a note of frustration or suppressed anger. A somewhat related aspect is the sequence of associations during the session. A comment which comes as a shift in topic might have very different implications from one which fits into the preceding train of association.

In assessing these cues and weighing their meaning, an analyzer should be alert to the distinction between idiosyncratic and group-relevant material. One of the special problems related to defining covert concerns in group therapy, as contrasted with individual therapy, is the presence of a number of patients. The question arises as to whether all comments are relevant to the group focal conflict or whether certain contributions are truly idiosyncratic—that is, the property of the individual and not the group. We feel that neither is strictly the case; any comment has both a personal meaning and an implication for the total group. The clue for the group meaning is the manner in which the other patients react to the comment. A particular aspect of a contribution may be reacted to while other aspects are ignored. When three or four patients react to a topic or a story introduced by one, it is relatively easy to see how individual comments contribute to a developing group theme. In other circumstances, the judgment is more difficult. For example, if a patient tells a long story about a personal experience and elicits no response from the others,

it is difficult to know which aspect of his story has group relevance or, indeed, whether the most relevant aspect might not be the fact that he has been permitted to talk at such length. Here one must be more cautious in making assumptions about the implications of individual comments for the group.

In summarizing a session in focal-conflict terms, we wish to avoid, on the one hand, a mere summary of overt content and, on the other, an overly speculative formulation. We attempt to formulate the group focal conflict in terms specific to the session being studied. A formulation which is too general may be relevant to the group focal conflict but has probably missed the unique quality of its expression in that particular session. Such a formulation is not wrong, but it has lost its usefulness since it is likely to be equally applicable to a number of group sessions.

In general terms, the analytic process involves building, testing, and revising hypotheses until a formulation is achieved which satisfactorily accounts for all aspects of the session. Two major steps are involved. First, two independent analyzers produce group focal-conflict formulations of a session, aided by work sheets which (1) help the analyzer to attend to all relevant material and cues, (2) require him to move through the material noting general themes and making tentative hypotheses, (3) require him to trace the detailed development in focal-conflict terms, and (4) ask him to produce a summary of the entire session. Thus, each analyzer records not only his final conclusion, but also the details of his formulation and the evidence he has utilized in making it. In a second step, the two analyzers compare their formulations, noting discrepancies and arguing out their disagreements until they have achieved a final "official" formulation which satisfies both.⁸ Although the analytic process is made as explicit as possible, some steps must remain implicit and uncommunicable. The procedure can be specified up to a point, but the crux of the matter is the final integration of the elements into a focal-conflict formulation. The achievement of such a Gestalt is essentially a creative act in which the steps and ingredients are difficult to specify.

In this analysis, the most crucial criterion of reliability is that of reproducibility by independent investigators. Ideal agreement would occur if two analyzers produced not only the same final formulation, but also agreed at every step along the way. Thus far, perfect agreement has not been achieved by any pair of independent analyzers; but, on the other hand, neither does gross disagreement occur. What is likely to happen is that the analyzers agree on the final formulation of the focal conflict but emphasize somewhat different aspects of its de-

tailed development. Or they might agree on the significant elements but build these into the focal-conflict formulation in somewhat different ways. We have found, however, that it is almost always possible for two independent analyzers to resolve such disagreements by sharing and discussing the steps they have followed in producing each formulation. Although too many clinical judgments are involved to expect perfect agreement, we believe that the procedure described permits the maximum possible specification of points of disagreement and aids their resolution into a final joint formulation.

Notes

- ¹ In any small face-to-face group, whether it be a committee meeting, a staff meeting, or a cocktail party, one can observe "illogicalities" which suggest these covert levels. However, it is not the business of such groups to attend to such aspects of the interaction (unless, perhaps, they become grossly disruptive). In fact, the members are likely, without realizing it, to fill in gaps and ignore irrelevancies that are not too intrusive.
- ² For a discussion of the associational process in groups as compared with individual therapy, see Chapter 11.
- ³ Henry Ezriel, "A Psychoanalytic Approach to the Treatment of Patients in Groups," p. 63.
- ⁴ These terms are adopted from the work of Thomas French, who developed them for application to individual psychoanalytic sessions and dreams. See Thomas French, *The Integration of Behavior*, Vols. I and II (Chicago: University of Chicago Press, 1952, 1954). We have modified and extended this approach for application to group processes. The application of these concepts to the individual is discussed in Chapter 7.
- ⁵ Robert F. Bales, *Interaction Process Analysis: A Method for the Study of Small Groups* (Cambridge, Mass.: Addison-Wesley, 1950).
- ⁶ Timothy Leary, *Interpersonal Diagnosis of Personality* (New York: The Ronald Press, 1957).
- ⁷ A full discussion appears in a previously published paper, from which some

of the material in this section is adapted. See Dorothy Stock and Morton A. Lieberman, "Methodological Issues in the Assessment of Total-Group Phenomena in Group Therapy," *International Journal of Group Psychotherapy*, 12 (1962), 312-325.

- The full procedure has not been illustrated here. To avoid repetition, we have condensed several steps in our example.