Group Psychotherapy and Related Helping Groups Today: An Overview

SAUL SCHEIDLINGER, Ph.D.*

Following an historical summary of the broader group helping field, the article differentiates among clinical group psychotherapy, "therapeutic" groups, human relations and training groups, as well as mutual-help and self-help groups. Twelve major theoretical models of group interventions are delineated, followed by an account of the current status of group treatment theory, practice and research. The role of group interventions in the fields of physical, sexual and substance abuse, chronic illness, and trauma—as in the aftermath of the September 11, 2001 terrorist attacks—are highlighted. A glimpse at the future of group treatments considers the obstacles and prospects occasioned by the managed care "revolution" in mental health.

HISTORICAL BACKGROUND

The use of groups to heal human ills is as old as humankind. However, the professionally-guided helping group is an American invention. Beginning with Joseph Pratt, a Boston physician who used "classes" in 1905 to teach his tubercular patients proper home care measures, there were a few subsequent psychiatrist precursors who worked with psychiatric patient groups. Among them were Cody Marsh, Edward Lazell and Trigant Burrow in America, with Alfred Adler (Freud's erstwhile disciple) and Jacob Moreno (1), practicing in Europe. In the 1930's, the fledgling, now more sophisticated group therapy movement, advanced in the United States guided by such psychoanalytically-geared pioneers as Lewis Wender, Paul Schilder, S.R. Slavson and Alexander Wolf. The lone theoretical dissenter was Jacob Moreno, the founder of psychodrama, who had by then emigrated to America. Moreno (1950) was very critical of Freud's psychoanalysis because of its major reliance on intrapsychic processes, in contrast to his own preference for spontaneity and for overt action in human behavior.

*Professor Emeritus of Psychiatry, Albert Einstein College of Medicine; Adjunct Professor of Clinical Psychology in Psychiatry, Weill Cornell Medical College, NY. ***Mailing address:*** 715 Bleeker Avenue, Mamaroneck, NY 10543. E-mail: rossaul@AOL.com

Group therapy's major growth spurt occurred during World War II when the understaffed military hospitals in both the United States and in England, were forced to adopt group treatment measures to attend to the unexpectedly large numbers of psychiatric casualties. In 1942, during the war years, two major organizations of group therapists came into being, founded by Jacob Moreno and by S. R. Slavson, respectively. Moreno's *Society for Group Psychotherapy and Psychodrama* was designed as an interest group attracting both social scientists and clinicians as members, while the *American Group Psychotherapy Association* chose a more restrictive route, becoming a body limited only to mental health professionals. Moreno and Slavson, both intense ideological and personal rivals, maintained a profound influence on their respective organizations including their separate conferences and publications, well into the 1950's. After the deaths of these two Founding Fathers, the *American Group Psychotherapy Association* created by Slavson, survived as the largest and most respected organization of group therapists. This was made possible only by the shedding of its "partisan" psychoanalytic image and its becoming a truly pluralist entity, which attracted group therapists of varied ideological persuasions under its umbrella. 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 [Scheidlinger & Schamess, 1992 (2)].

During the 1950's all psychotherapy, including group psychotherapy, was beset by unprecedented squabbles, as claims for hegemony emerged from the many different schools of thought. Within group therapy, in addition to the early ideological conflicts among the 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. While Transactional Analysis [Berne, 1961 (3)] and Gestalt Therapy [Perls, 1969 (4)] emerged in group contexts, the other approaches soon began to extend their initial concepts of individual therapy to the group medium.

The rapid development of group practice modalities after World War II, influenced by the seminal contributions from the separate, yet related, fields of group psychotherapy and group dynamics led to an almost chaotic proliferation of theoretical orientations and to a great variety of practice methods with blurred boundaries. This situation was compounded during the youth revolts of the 1960s by the emergence of numerous nontraditional group intervention models, addressed to the general public

which operated under nonprofessional auspices. Among the best known were the controversial Encounter and Transcendental Meditation groups. Carl Rogers (5), an internationally-respected clinical psychologist referred to Encounter groups as " . . . perhaps the most significant social invention of the century" (1968, p. 16). Producing at least one motion picture, many publications and even one best-seller (Schutz, 1967) (6), the popular Encounter group movement which included some professionals, both challenged and embarrassed the group therapy establishment, partly because many emotionally vulnerable participants flocked to these commercial undertakings, and this resulted in a significant number of psychiatric breakdowns (Yalom & Lieberman, 1971) (7). A united protest by the official mental health organizations succeeded eventually in stopping at least the most serious abuses inherent in these programs.

The Group Intervention Categories

Given the above-noted confused state of affairs in the mushrooming "group helping" fields, Scheidlinger (1982) (8) proposed a classification scheme comprising four distinct, yet related categories of group interventions. I. Clinical Group Psychotherapy; II. "Therapeutic" Groups operative in mental health settings; III. Human Development and Training Groups; IV. Self-Help and Mutual-Help Groups. It is useful to think of these varied kinds of group modalities as planned efforts to effect behavioral changes in individuals. While the bulk of this paper will be devoted to the first category, clinical group psychotherapy, following is a brief digest of what each of these categories entails: Category I. *Group Psychotherapy* is a specific method of clinical practice within the broader context of the psychotherapies. It refers to a psychosocial process wherein a specially-trained mental health professional (usually psychiatrist, clinical psychologist, clinical social worker or nurse-clinician), utilizes the emotional interaction in small, carefully planned groups to effect amelioration of personality dysfunctions in individuals specifically selected for the purpose. Each group member has undergone a prior assessment of his or her personality problems and strengths and has accepted the group approach, alone, or in combination with other interventions (i.e., individual therapy, drugs) as a means to "repair" his pathological mode of functioning. Category II. *"Therapeutic" Groups* comprises all group approaches (other than group therapy) utilized by human services personnel (not necessarily trained professionals), in outpatient or inpatient psychiatric facilities. Serving usually as auxiliary or as conjoint measures, these groups are aimed at some kind of remediation or at the achievement of

optimum individual functioning. In inpatient settings, examples would be therapeutic community, occupational therapy, rehabilitation, art or dance therapy, as well as special rehabilitation groups. In the outpatient context, there can be short-term waiting list groups, as well as medication groups. Category III. *Human Development and Training Groups* belong more to the realm of affective or cognitive education than to therapeutics. This category contains, on one end of the continuum, the myriad of consciousness-raising, sensitivity and organizational development measures which usually operate under three different auspices: A) The laboratory Method with its T-Group theory and practice, initiated in the 1940's in Bethel, Maine by the followers of Kurt Lewin (Golembiewski & Blumberg, 1970) (9). B) Self-Analytic Groups employed in the human relations departments of universities, as well as experiential (T-Groups) used in the graduate training of human services professionals (Gibbard, Hartman & Mann, 1974; Horwitz, 1964) (10). Included here would also be the so-called Balint Groups originated by Michael Balint, a British psychoanalyst who pioneered small group programs aimed at sensitizing physicians to the psychological factors in medical ailments (Balint, 1957) (12). C) The A.K. Rice or Tavistock Group Relations Conferences for professionals, based largely on the group process theories of W. R. Bion (Rioch, 1970) (13). Category IV. *Self-Help and Mutual-Help Groups* which are voluntary face-to-face struetures for the aid of sufferers with common maladies and for the achievement of personal or social change. Some of the best-known examples here are Alcoholics Anonymous, founded in 1935, Gamblers Anonymous and Recovery, Inc. It is not generally recognized that these "grass roots" groupings comprise masses of people; they comprised 7½ million in 1992 alone (Lieberman & Snowden, 1993) (14). They are largely self-governing and emphasize self-reliance and indigenous leadership. Levy (1979), distinguished among four kinds of self-help groups: 1) Behavioral control or conduct reorganization groups (i.e., Alcoholics Anonymous, Gamblers Anonymous, Overeaters Anonymous). The sole purpose here is to help the members control their shared problem. 2) Stress coping and support groups (i.e., Al-Anon, Emotions Anonymous, Recovery, Inc.). With the undesirable, fixed status of the problem taken for granted, the aim is to offer support and to advise the participant on how to cope. 3) Survival-oriented groups (i.e., Gay Rights, Women's Consciousness-Raising). This mission entails the enhancement of self-esteem and to fight against societal discrimination. 4) Personal growth and self-actualization groups (i.e., Landmark Forum, Integrity Groups). Not unlike the encounter groups of the 1960s, the focus here lies on the

improvement of personal effectiveness and on the enhancement of one's quality of life. Given the fact that groups in the earlier-noted "stress coping and support" category are especially prevalent and cover a slew of diseases such as phobias, depression, psychosis, cancer, and a variety of neurological disorders, there is an implied suggestion that our existing health-care institutions are somehow amiss in the provision of adequate services.

The above delineation of the myriad of "people-helping groups" is not to suggest that they are inferior to group psychotherapy but rather that they are *different.* It is also important to note that there are different generic pieces of knowledge and skills applicable to the group treatment of various age groups ranging from children and adolescents to the elderly.

GROUP TREATMENT MODELS

Following World War II, group therapy 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 conducted their groups within the lines of their theoretical framework. The initially predominant "classical" Freudian approach and that of psychodrama were soon joined by neo-Freudian methods used by Sullivan, Horney, and Kohut. As might be expected, there were periodic changes in theoretical fads and fancies. Although different ideologies such as Gestalt [Perls, 1969 (16)] Transactional Analysis [Berne, 1961 (17)] and Group Focal Therapy [Whitaker & Lieberman, 1964 (18)] had their phases of special popularity, by the end of the decade, the following 12 distinct, major models of group psychotherapy had come to the fore: 1) Interpersonal, 2) Freudian, 3) Group Analysis, 4) Object Relations, 5) Self Psychology, 6) Social Systems (Group-as-a-Whole), 7) Systems-Centered, 8) Redecision, 9) Existential, 10) Behavioral, 11) Group Rational-Emotive, and 12) Psychodrama.

Yalom's *Interpersonal Group Therapy,* based on Sullivan's principles, has gained in popularity in recent years with four editions of his best-selling book (1995) appearing. In contrast to the Freudian's 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 also elaborated on 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* sponsored by

most of the earlier pioneers—Wender, Schilder, and Slavson—in the 1930s, continues to hold a large proportion of the older practitioners of group therapy to this day. In distinction from the interpersonalists, 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), dreams, and resistances. The main elements of the Freudian approach are fostering a therapeutic regression and reconstructing genetic connections [Rutan & Stone, 1993 (20)]. 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, to object relations theory, or to the role of the actual therapeutic relationship [Tuttman, 1991 (21)].

Group Analysis is a method of group treatment that was founded in England by S. H. Foulkes (1964) (22). Trained as a Freudian psychoanalyst, he also became intrigued by group psychology. Foulkes played a major role in the introduction of group methods at England's Northfield Military Hospital during World War II. Upon his return to civilian life, and with the assistance of a circle of colleagues, Foulkes developed his group approach, gradually evolving a comprehensive conceptual system. He founded the Group Analytic Society in England in 1952 and the journal *Group Analysis,* followed in 1971 by a training institute of group analysis. A basic Foulkes concept is that of the "group matrix," a hypothetical web of communications in which the group serves as a kind of mother vessel. Foulkes spoke of his method as analysis of the group by the group, including the conductor. Although he enunciated a group-centered focus in his writings, his followers also emphasized the importance of the therapist's work with individual group members. While very popular among British and European practitioners, group analysis has failed to gain many followers in the U.S.

On a broader plane, the recent ideological ferment within psychoanalysis depicted by Greenberg and Mitchell (1983) (23) has effected the emergence of three distinct but related theoretical camps within the field of psychodynamic group psychotherapy: (1) Object Relations [Kibel, 1991 (24)]; (2) Self Psychology [Stone, 1992 (25]; and (3) Social Systems (group-as-a-whole) [Bion, 1959 (26)]. 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.

Based on some earlier formulations of Durkin (1981) (27), Agazarian (1992) (28) introduced a *Systems-Centered Group Treatment Approach.* In her view, communication occurs in the therapy group at the boundaries of hierarchical systems: the group, the subgroup, and its members. Major emphasis is placed on the communication process across subgroups, followed by analysis of defenses that stand in the way of problem solving.

The time for a comprehensive psychodynamic group therapy theory is obviously not at hand. In the words of Klein, Bernard, and Singer (1992) (29), "Each theory speaks to an aspect of those clinical realities that are 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).

Redicision Therapy was developed by Goulding and Goulding (1979) (30) combining elements of the newer therapies that have come into being during the turbulent 1960s. Among them is *Transactional Analysis,* whose theory of ego states (child, parent, and adult), games, transactions, and scripts (Berne, 1961) (31), used together with *Gestalt Therapy's* "chair techniques" (Perls, 1969) (32), evokes emotional awareness and change. The major elements of *Redecision Therapy* include the following: group members reclaim 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; and errors in patients' thinking and behavior are confronted. Gestalt techniques are used for the expression of feelings while group maintenance rules are enforced.

Existential Group Psychotherapy contains both concepts of existential philosophy and those of therapeutics. Mullan (1992) (33) 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 that range from autism to phobias in a group context. Except for Ellis's *Group Rational-Emotive and Cognitive-Behavior Therapy* (1992) (34) (to be discussed later), there

are very few comprehensive models of such treatment. Instead, there are numerous reports in the Behavior Modification literature of using the group setting for the systematic application of explicit procedures to change an individual patient's problem behavior. The common underlying assumption shared by these diverse reports is that pathological behavior is learned behavior and thus is subject to modification of the conditions that serve to maintain it. After prolonged and stormy debates wherein psychodynamic and humanistic practitioners had accused behaviorists of a dehumanizing effort at mind-control [Rogers & Skinner, 1956 (35)], there has emerged a gratifying recent trend of trying to bring about a productive integration of these approaches (Messer, 1986 (36)]. Some of the behavior modification concepts have also become mainstreamed into various aspects of group treatment; these include "positive reinforcement" or "modeling" in outpatient group psychotherapy, as well as the "token economy" in residential treatment (Ayllon & Azrin, 1968) (37). *Group Rational-Emotive and Cognitive-Behavior Therapy* (Ellis, 1992) (34) is anchored in Ellis's 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 uses traditional behavioral techniques such as desensitization, reinforcement, skills training, and relapse prevention.

Rose (1993) (38) summarized the contemporary trends in cognitive-behavioral group psychotherapy. He regretted that the method's practitioners had failed until the 1980s 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 use of special exercises where peer reinforcement, feedback, and role-modeling were employed, he placed special emphasis on techniques that were designed to facilitate the transfer of behavioral change from the treatment situation to the patient's 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 basic tenets of Moreno's *psychodrama,* including its long-standing feud with Freudianism, have been mentioned earlier in this article.

The above-described multifarious theoretical positions—mere samples of those appearing in group psychotherapy literature—invite bewilder-

ment for anyone trying to categorize the principal dimensions of the contemporary group treatment modality. As Dies (1992) (39) noted: "There remains much controversy and uncertainty about the most fruitful ways to distinguish among prevailing models of group treatment" (p. 2). Nonetheless, this state of affairs, represents an improvement over earlier decades during which, as I noted earlier, competing authorities were involved in endless squabbles for hegemonies not excluding *ad hominem* attacks.

RESEARCH

After decades of benign neglect in some quarters and 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) (40) brought together group research articles prior to the 1970s.

In addition, some initial findings in the 1970s that the "new" group formats such as Encounter and Self-Help groups produced beneficial results (Lieberman & Borman, 1979) (41), were followed by comprehensive meta-analytic studies by Smith, Glass, and Miller (1980) (42) which concluded that group therapy was as effective as individual treatment, in the alleviation of psychological problems. To compound this, Toseland and Siporin (1988) (43) 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, Piper (1993) (44) discussed 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) (45) that group therapy researchers focus on their field's special "fringe benefit"—why and how the group process works, when compared to other modalities.

As for the rarer investigation of group treatment processes (as compared with "outcome" studies), MacKenzie and Tschuschke (1993) (46) found in one such investigation, demonstrable shifts in the objectively measured interactional climate in long-term groups. This confirmed the frequent clinical observation that a positive group therapeutic alliance can serve as a predictor of good treatment outcomes. Given the fact, that the newest health care delivery systems have begun to place major value on time-limited treatment models, MacKenzie's (1996) (47) overview of the

impressive amount of empirical support for the effectiveness of short-term group measures was especially timely. In this connection, there has also been considerable recent research pointing to positive outcomes in the group treatment of physically ill patients (Leszcz, 1998) (48). The best-known studies have been those of supportive-expressive group therapy for women with metastatic breast cancer.

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 effectiveness of their group methods.

CURRENT DEVELOPMENTS IN THEORY AND IN PRACTICE

In recent years, the earlier-described varied and often tenaciously-held theoretical orientations in psychodynamic and in other group therapy models have given way to a promising new eclecticism, pragmatism and search for commonalities among the different approaches. Hand-in-hand with this desirable emergence of an integrationist-theoretical orientation in group psychotherapy, professional organizations, among them the American Group Psychotherapy Association, relaxed their membership boundaries replacing an earlier unitheorist stance with one of openness and pluralism. They recognized that no single conceptual approach to group psychotherapy could claim superiority over any others.

A related development aimed at the integration of varied theoretical models and techniques occurred earlier, in the broader field of psychotherapy (Beitmann, Goldfried & Norcross, 1989) (49). In this connection, the following pertinent realities came to be increasingly evident: 1) Single system ideologies and techniques, i.e., "support" versus "uncovering" therapy were found to have distinct clinical limitations. 2) Research had shown that experienced clinicians from divergent theoretical camps, tended to get similar outcomes. 3) The commonalities in all forms of psychotherapy were more impressive than was generally acknowledged, and, 4) the integrationists were in good company since surveys had revealed that between one-half and one-third of American psychotherapists of varied theoretical persuasions, had come to view themselves as eclectics.

Group psychotherapy proper and its earlier-noted derivative group approaches experienced a phenomenal rise in the mental health enterprise. It is noteworthy that from 1980 to 1995 alone, over 9000 group work

articles appeared in at least 1042 journals. In addition to four major group work organizations, the International Association of Group Psychotherapy with its semi-annual conferences sponsored by 30 national organizations had begun to prosper, after years of growing pains. The mushrooming use of group methods in professional outpatient and inpatient psychiatric settings in the United States had become dwarfed by the thousands of indigenous self-help and mutual-help groups in the community. The original 12-step approach of Alcoholics Anonymous was augmented by many other 12-step programs (Freimuth, 2000) (50), as well as by an unprecedented number of support groups geared to help fellow sufferers with a myriad of human maladies, both social and physical.

During the last three decades there has emerged an increasing interest in the treatment of traumatized individuals through the use of group interventions alone, or conjoint with other therapies. Most of this work has centered on war veterans, on Holocaust survivors, on victims of physical and sexual abuse or of political persecutions. Klein and Schermer (2000) (51) offered an operational definition of trauma as " . . . a situation-specific severe, and stressful violation or disruption that has serious psychiatric consequences for the individual, either soon or long after the event itself" (pp. 5–6). They conceptualized the impact of trauma, under four headings: 1) Posttraumatic Stress Disorder clusters (American Psychiatric Association, 1994) (52). 2) Changes in the "assumptive world" and cognitive schemata of the victim. 3) Pathology of the internalized object relations and the self. 4) Clinical syndromes other than Posttraumatic Stress Disorder.

Johnson and Lubin (2000) (53) developed an empirically-validated model for treating traumatized individuals through the group medium. Termed the Interactive Psychoeducational Group Therapy Model, it comprises the following goals: a) to educate the clients about the impact of their traumatic experience on their lives, b) to provoke a reorganization of the ideas and feelings about themselves, c) to facilitate a differentiation between the traumatic schemas and unimpaired characteristics of the clients and thereby, d) to reduce the stress disorder's maladaptive behaviors.

In this connection, following the Sept. 11, 2001 attacks, most clinical reports delineated a series of steps in the group healing process: managing and reducing the posttraumatic symptomatology, expressing and re-experiencing the trauma in a supportive environment, re-establishing of trust, coupled with cognitive restructuring and reintegration of the self system (Ehrenreich, 2003) (54).

The recent advent of the managed health care "revolution" has shaken the very foundation of this prospering, institutionally as well as private practice-based group therapy movement, while probably enhancing the use of the indigenous group-helping modalities where budgetary considerations are virtually non-existent. The psychotherapy literature in general, and the group psychotherapy literature in particular, have accordingly become filled with disturbing reports about third party payers drastic interventions in therapist-patient contracts. Therapist plans based on patient needs and pertaining especially to the kind and length of treatment are not infrequently countermanded by insurance administrators bent solely on cost cutting. The related unprecedented threat to the traditional autonomy of the clinician-group therapist has led to wide concerns often bordering on demoralization.

Publicly-funded programs seem to have been hurt the most, with considerations of quality care being very often replaced by the forced use of short-term and pharmacological measures in situations where these do not represent the optimal treatment. The only relatively unaffected area appears to be that of private practice serving well-to-do patients.

As might be expected, professional organizations have responded to the new challenge in a variety of ways. In the case of group psychotherapy, the American Group Psychotherapy Association has mounted appropriate educational endeavors directed at legislators, insurers, and service consumers. The formation of the *National Registry of Certified Group Therapists,* reassessments of *Ethical Guidelines for Practitioners,* and a *Consumer's Guide to Group Psychotherapy,* are a part of this picture. New writings have sprung up aimed at providing clinicians with a business orientation so that they may learn how to deal with the insurers and how to best market their services (Spitz, 1996) (56). The field of time-limited group psychotherapy, a field understandably attractive to third party payers, has assumed an important role in recent professional education and in the literature [Budman, 1996 (57); MacKenzie, 1995] (58). One can hope that in the current ferment evoked by the managed care movement, new knowledge will emerge that will permit group therapists to practice their craft with greater flexibility in a minimally restrictive environment (Spitz, 1997) (59).

A GLIMPSE OF THE FUTURE

Notwithstanding the clouded future currently envisioned for the traditional psychotherapies, including group psychotherapy, history has

taught us that *extreme* social trends, such as beaurocratically managed health care, are usually supplanted, in time, by forces of *moderation.*

It is, accordingly, quite possible that political changes in America will effect new administrative and legislative bodies that will be friendlier to health care consumers than to third party payers. As a result, the traditional decision-making power of therapists is likely to be restored, at least in part, so that patient needs rather than costs, will again emerge as the primary criterion in all treatment choices.

Pending such a development however, within group psychotherapy, the currently most popular longer-term psychodynamic group therapy models will probably remain largely with the independent private practitioners and with the rare, advantaged free-standing institutions, all geared to serving well-to-do patients. Some clinicians will hopefully also continue to offer longer-term group treatment to a proportion of their patients for lower fees, based on income. Most other treatment groups, especially in the public sector, will very likely be time-limited in character, combining a number of interventions, i.e., psychotherapy and psychopharmacology. Some outpatient clinics may manage under more flexible state rules to receive public reimbursement for treating severely disturbed and poor patients who are systematically re-referred to newly formed, time-limited groups—not an optimum procedure, but one preferable to no treatment.

Given their proven effectiveness and manageable costs, short-term groups addressed to such homogenous populations as substance abusers (Khantzian, 2001) (60), the recently bereaved (Piper & Joyce, 1996) (61), the sexually abused [Dolan, 1991 (62); Ney & Peters, 1995] (63), medical patients (Bernard, 2004) (64), and victims of trauma are bound to prosper.

In this connection, the traditional training programs for group psychotherapists, embedded in the theory and practice models of long-term treatment, will need to be augmented by teachings about time-limited group interventions. The latter might be geared to the traditional clinical settings as well as to such newer locations as businesses, community-based multiservice health practices, or universities. In the meantime, I would hope that public or private funding could be found for clinical studies that would demonstrate the efficacy and cost containment inherent in the longer-term groups (perhaps combined with individual sessions) designed for the "hard-to-reach" severely disturbed patients such as the borderline and narcissistic personality disorders.

The following factors bode well for group psychotherapy's longer-range, future development: (1) The unique motivational elements for change and growth inherent in small planned groups; (2) The demon-

strated effectiveness of this method, especially with the above-noted four special patient populations, the bereaved, the abused, the medically-ill, and the traumatized; (3) The lower cost of group interventions when compared to dyadic sessions, and (4) The flexibility, creativity and resiliency inherent in the large cadre of group therapy's practitioners.

REFERENCES

1. Moreno, J. L. (1950). The ascendancy of group psychotherapy and the declining influence of psychoanalysis. *Journal of Sociopsychopathology and Sociatry, 3,* 121–141.
2. Scheidlinger, S., & Schamess, G. (1992). Fifty years of A.G.P.A. 1942–1992. An overview. In K. R. MacKenzie (Ed.), *Classics in Group Psychotherapy* (pp. 1–24). New York: Guilford.
3. Berne, E. (1961). *Transactional Analysis in Psychotherapy.* New York: Grove.
4. Perls, F. S. (1969). *Gestalt Therapy Verbatim.* Lafayette, CA: Real People Press.
5. Rogers, C. (1968). Interpersonal relationships. *Journal of Applied Behavioral Science, 4,* 3–19.
6. Schutz, W. V. (1967). *Joy. Expanding Human Awareness.* New York: Grove.
7. Yalom, I., & Lieberman, M. A. (1971). A study of encounter group casualties. *Archives of General Psychiatry, 25,* 16–30.
8. Scheidlinger, S. (1982). Focus on Group Psychotherapy. Clinical Essays. Madison, CT: International Universities Press.
9. Golembiesky, R. T., & Blumberg, A. (1970). *Sensitivity Training and the Laboratory Approach.* Itasca, IL: Peacock.
10. Gibbard, G. S., Hartman, J. J., & Mann, R. D. (1974) (Eds.), *Analysis of Groups.* San Francisco: Jossey-Bass.
11. Horwitz, L. (1964). Transference in training groups and therapy groups. *International Journal of Group Psychotherapy, 14,* 202–213.
12. Balint, M. (1957). The Doctor, the Patient and his Illness. New York: International Universities Press.
13. Rioch, M. (1970). Group relations conferences: Rationale and technique. *International Journal of Group Psychotherapy, 20,* 340–355.
14. Lieberman, M. A., & Snowden, L. R. (1993). Problems in assessing prevalence and membership characteristics of self-help group participants. *Journal of Applied Behavioral Science, 29,* 166–180.
15. Levy, L. H. (1979). Self-help groups: Types and psychological processes. *Journal of Applied Behavioral Science, 12,* 310–322.
16. Perls, F. S. (1969). *Gestalt Therapy Verbatim.* Lafayette, CA: Real People Press.
17. Berne, E. (1961). Transactional Analysis in Psychotherapy. New York: Grove.
18. Whitaker, D. S., & Lieberman, M. A. (1964). *Psychotherapy Through the Group Process.* New York: Atherton.
19. Yalom, I. (1995). The Theory and Practice of Group Psychotherapy (4th ed.). New York: Basic Books.
20. Rutan, J. S., & Stone, W. (1993). *Psychodynamic Group Psychotherapy.* New York: Guilford.
21. Tuttman, S. (1991). (Ed.). *Psychoanalytic Group Theory and Practice.* Madison, CT: International Universities Press.
22. Foulkes, S. H. (1964). *Therapeutic Group Analysis.* New York: International Universities Press.
23. Greenberg, J. R., & Mitchell, S. A. (1983). *Object Relations in Psychoanalytic Theory.* Cambridge, MA: Harvard University Press.
24. Kibel, H. D. (1991). The therapeutic use of splitting: The role of the "mother-group" in therapeutic differentiation and practice. In S. Tuttman (Ed.), *Psychoanalytic Group Theory and Practice* (pp. 113–132). Madison, CT: International Universities Press.
25. Stone, W. (1992). The place of self psychology in group psychotherapy. *International Journal of Group Psychotherapy, 42,* 335–350.
26. Bion, W. R. (1959). *Experiences in Groups.* New York: Basic Books.
27. Durkin, J. E. (1981). (Ed.). *Living Groups: Group Psychotherapy and General Systems Theory.* New York: Brunner-Mazel.

28. Agazarian, Y. M. (1992). Contemporary theories of group psychotherapy. A systems approach. *International Journal of Group Psychotherapy, 42,* 177–204.
29. Klein, R. H., Bernard, H. S., & Singer, D. L. (1992). (Eds.). *Handbook of Contemporary Group Psychotherapy.* Madison, CT: International Universities Press.
30. Goulding, R., & Goulding, M. (1979). *Changing Lives Through Redecision Therapy.* New York: Brunner-Mazel.
31. Berne, E. (1961). *Transactional Analysis in Psychotherapy.* New York: Grove.
32. Perls, F. S. (1969). *Gestalt Therapy Verbatim.* Lafayette, CA: Real People Press.
33. Mullan, H. (1992). Existential therapists and their practice. *International Journal of Group Psychotherapy, 42,* 453–468.
34. Ellis, A. (1992). Group rational-emotive and cognitive-behavior therapy. *International Journal of Group Psychotherapy, 42,* 63–80.
35. Rogers, C., & Skinner, B. F. (1956). Some issues concerning the control of human behavior. *Science, 30,* 1057–1066.
36. Messer, S. B. (1986). Behavioral and psychoanalytic perspectives as therapeutic choice points. *American Psychologist, 41,* 1261–1271.
37. Ayllon, T., & Azrin, N. M. (1968). *The Token Economy.* New York: Appleton, Century, Crofts.
38. Rose, S. D. (1993). Cognitive-behavior group psychotherapy. In H. I. Kaplan & B. J. Sadock (Eds.), *Comprehensive Group Psychotherapy* (pp. 205–214). Baltimore, MD: Williams & Wilkins.
39. Dies, R. R. (1992). The future of group therapy. *Psychotherapy, 29,* 58–64.
40. Roback, H., Abramowitz, S., & Strassberg, D. (1979). *Group Psychotherapy Research. Commentaries and Selected Readings.* New York: Krieger.
41. Lieberman, M. A., & Borman, L. (1979). *Self-Help Groups for Coping with Crises. Origins, Members, Processes and Impact.* San Francisco, CA: Jossey-Bass.
42. Smith, M., Glass, G., & Miller, T. (1980). *The Benefits of Psychotherapy.* Baltimore, MD: Johns Hopkins University Press.
43. Toseland, R. W., & Siporin, M. (1988). When to recommend group treatment: A review of the clinical and of the research literature. *International Journal of Group Psychotherapy, 36,* 171–201.
44. Piper, W. E. (1993). Group psychotherapy research. In H. I. Kaplan & B. J. Sadock, (Eds.), *Comprehensive Group Psychotherapy* (pp. 673–681). Baltimore, MD: Williams & Wilkins.
45. Kaul, T. J., & Bedner, R. L. (1986). Experiential group research. Results, questions, suggestions. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of Psychotherapy and Behavior Change,* (3rd ed.), pp. 671–714. New York: Wiley.
46. MacKenzie, K. R., & Tschuschke, V. (1993). Relatedness, group work and outcome in long-term inpatient psychotherapy groups. *Journal of Psychotherapy Practice and Research, 2,* 147–156.
47. MacKenzie, K. R. (1996). Time-limited group psychotherapy. Has Cinderella found her Prince? *Group, 20,* 95–111.
48. Leszcz, M. (1998). Introduction to special issue on group psychotherapy for the medically-ill. *International Journal of Group Psychotherapy, 48,* 137–142.
49. Beitmann, B. D., Goldfried, M. R., & Norcross, J. C. (1989). The movement toward integrating the psychotherapies. *American Journal of Psychiatry, 146,* 138–146.
50. Freimuth, M. (2000). Integrating group psychotherapy and the 12-step work. A collaborative approach. *International Journal of Group Psychotherapy, 50,* 297–314.
51. Klein, R. H., & Schermer, V. L. (2000). (Eds.). *Group Psychotherapy for Psychological Trauma.* New York: Guilford.
52. American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders* (14th ed.). Washington, D.C.: American Psychiatric Press.
53. Johnson, D., & Lubin, H. (2000). Group therapy for the symptoms of Posttraumatic Stress Disorder. In R. H. Klein, & V. Schermer (Eds.), *Group Psychotherapy for Psychological Trauma* (pp. 141–169). New York: Guilford Press.
54. Ehrenreich, J. H. (2003). Understanding PTSD: "Forgetting trauma." *Journal of Social Issues, 3,* 15–28.
55. Spitz, H. I. (1996). *Group Psychotherapy and Managed Health Care.* New York: Brunner-Mazel.
56. Budman, S. H. (1996). Introduction to special section on group therapy and managed care. *International Journal of Group Psychotherapy, 46,* 293–295.

57. Mackenzie, K. R. (1995). The Effective Use of Group Therapy in Managed Care. Washington, DC: American Psychiatric Press.
58. Spitz, H. I. (1997). The effect of managed health care on group psychotherapy. Treatment, training and therapist morale issues. *International Journal of Group Psychotherapy, 47,* 23–30.
59. Khantzian, E. J. (2001). Reflections on group treatments as corrective experiences for addictive vulnerability. *International Journal of Group Psychotherapy, 51,* 11–20.
60. Piper, W. E., & Joyce, A. S. (1996). A consideration of factors influencing the utilization of time-limited short-term group psychotherapy. *International Journal of Group Psychotherapy, 46,* 311–328.
61. Dolan, Y. (1991). *Resolving Sexual Abuse.* New York: Norton.
62. Ney, P. G., & Peters, A. (1995). (Eds.). Ending the Cycle of Abuse: The Stories of Women Abused as Children and the Group Therapy Techniques that Helped them Heal. New York: Brunner-Mazel.
63. Bernard, H. S. (2004). Group intervention for patients with cancer and HIV disease: An introduction. *International Journal of Group Psychotherapy, 54,* 23–28.