THE THERAPEUTIC FACTORS OF GROUP-ANALYTICAL TREATMENT.

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Theoretical Considerations.

The term " therapeutic factor " will be used to denote any agency which is potentially capable of producing such changes in the personality of a patient that an alleviation or cure of clinical symptoms may result. Such agencies originate either in the environment of the patient or in his organism. In psychotherapy we are primarily concerned with environmental agencies, namely those which are introduced, regulated and controlled by the therapist, and which are therapeutic only if the patient responds to them in a manner that is conducive to producing the desired changes in his personality. We can therefore distinguish three elements in a therapeutic process: environmental factors, responses by the patient, and ultimate personality changes.

In individual analytical treatment the technique of the therapist establishes environmental conditions, which, if properly adjusted to the needs and the responsiveness of the patient, will elicit such reactions from him that an ultimate remedial effect is achieved. Alexander (1946), for instance, characterized the therapeutic process thus: " In all forms of aetiological psychotherapy the basic therapeutic principle is the same: to re-expose the patient, under more favourable circumstances, to emotional situations which he could not handle in the past. The patient, in order to be helped, must undergo a corrective emotional experience suitable to repair the traumatic influence of previous experiences."

In group-analytical treatment the principles are essentially the same; but the environment is more complex, its impact on the individual patient more manifold, and the therapist's control over environmental factors less complete.

If we examine the environmental factors to which group patients are exposed, we can distinguish two different social phenomena which may have a dynamic influence on group events. In the first place there are certain environmental factors which impinge collectively on all group patients. In accordance with K. Lewin's field theory (1935) these factors will be called " field forces." Secondly, there are person-to-person interactions among the patients. These phenomena will be called " interpersonal relations." They have been extensively studied by Moreno (1934) and his sociometric school. Thus, the two types of social phenomena noticeable in a group situation

correspond to two basically different forms of methodological approach to the study of group events.

The best known example of field forces in group situations is the attachment towards the same leader by which all group members are activated. Freud (1921) saw the essence of group formation in the establishment of such a relationship between a leader and his followers. A group, he said, consisted of "a number of individuals who have put one and the same individual in the place of their ego-ideal and have, through doing so, identified with each other in their ego." This conception of group formation is, however, too narrow in several respects. F. Redl (1942) has pointed out that groups can form round different types of leaders or "central persons," and that such a central person need not necessarily be the model by which the ego-ideals of group members are shaped. He may be the collective target of libidinal or aggressive drives, or a person who is capable of rendering a special service to the ego of the group members. Similarly, in the group-analytical situation, the common transference to the therapist is not merely based on the collective adoption of the therapist as an ego-ideal, but on the whole gamut of other transference feelings. Redl has also emphasized that the emotions which develop between group members are not merely those which can be characterized as "identifications in their ego." To quote Redl: "It is obvious that the group members, on the basis of that very identification, also do develop new emotions in relationship with each other."

Finally it must be stated that the common transference towards the therapist is not the only field force which is operative in a group-analytical situation. Among other field forces which have been found to be therapeutically active may be listed: the association with neurotic compeers, the size of the group, the sex of the members, the topics of group discussion, and the various group tasks.

The group tasks are of particular dynamic significance, no matter whether they are explicitly stated by the therapist or tacitly assumed by the patients. Group tasks require overt actions from each member; the responses to other field forces may remain more concealed and private.

The group tasks are essentially and fundamentally verbal in character. The patients are expected to keep the group discussion going. This may be called the general verbal task. There are, however, three specific aspects of this general task:

1. The task of candid self-revelation. Every patient is required to reveal his symptoms, problems, ideologies, and opinions to the group. Without it he does not qualify for acceptance as a group member.

2. The task of transforming personal problems into group problems. The patients want to compare and contrast their symptoms, problems and experiences. They are also eager to elicit relevant information from more reticent participants in order to ensure that problems of personal significance should acquire a collective quality.

3. The task of giving interpretations. The patients are encouraged to search for the meaning and significance of neurotic phenomena, and to try to unravel the underlying motivational tangle.

All the patients in a therapeutic group are equally exposed to the impact of the various field forces. Yet their overt reactions to them will vary from person to person. We can regard the behaviour of a person at any particular moment as the resultant of the interaction between two dynamic systems: his personality and his environment. K. Lewin (1935) expressed this interaction by a simple formula which, slightly altered, reads: $R_1 = f_1\ (P_1\ E)$. In this equation P_1 stands for the psychodynamic organization and immediate responsiveness of a particular patient, R_1 for his overt response, E for the field forces impinging equally on all persons in the group, and f_1 indicates that the interaction between P_1 and E follows along lines which are characteristic for P_1, but not for any of the other persons in the group.

This formula is, however, inadequate for two reasons. First, it only applies to the response of P_1 at any particular moment of time. If a longer period of time is considered, then one has to take into account that any momentary response R_1 is capable of secondarily modifying both P_1 and E. In other words, there exists a circular reaction, or to use the current fashionable term, a "feedback system." The modification of P_1 in its ultimate form will correspond to the therapeutic result. The modification of E will be noticeable in a structuring of the social field through the establishment of hierarchies, and in the development of group-characteristic traditions, manners, rites, mores, beliefs, etc.

The second reason for finding the formula $R_1 = f_1\ (P_1\ E)$ not entirely satisfactory concerns the fact that underneath the diversity of overt responses in a group one can discern a common matrix of actuation which is due to a common emotional resonance to field forces. In a crowd this common matrix of actuation might issue in collective overt behaviour, whereas in a therapeutic group the individuality of behaviour is maintained. An example will illustrate this point. The general verbal task activates all group members. As a result, they all experience a desire to take part in the conversation. Yet it is only on rare occasions that the tension in the group becomes so great that everybody speaks at once. Generally the conversation is conducted in an orderly manner without much overlapping or interrupting of speech. The amount of talk contributed to the discussion by the different group members will, in the long run, vary according to their personal characteristics and their ability to comply with the common desire to speak. If it is desired to amend the formula $R_1 = f_1\ (P_1\ E)$ in order to express the fact that a common matrix of actuation exists in response to any particular field force, one would have to introduce the symbol f, which would apply to all group members indiscriminately, and indicate that the interaction between P_1 and E initially produces reactions which are common to every participant. The formula would then become $R_1 = f_1\ [f(P_1\ E)]$.

The common matrix of actuation can be used as a criterion to differentiate between the responses of the various group members to a particular field force. If we would merely have regard to the form in which responses manifest themselves, we would be confronted with such a diversity in quality that we could hardly find a common denominator that would allow a quantitative comparison of responses. If we, however, accept as the common denominator

the common matrix of actuation aroused by a particular field force, we can compare the responses of patients according to the degree to which this common actuation manifests itself. For example, patients can be ranked according to the facility with which they can comply with the general verbal task.

There exists also another criterion by which the patients' responses can be quantitatively compared. The general behaviour of a patient in the group is the response to the impact of the total constellation of all the field forces in it. By virtue of the circular reaction which exists between R on the one hand and the interacting dynamic systems P and E on the other, the general response of a patient will tend to modify E in a manner characteristic for him. There are two modifications of the social group environment which can be readily observed: the effect a patient's behaviour has on the group proceedings, and the effect it has on the feelings of fellow members.

The degree to which patients influence the group proceedings will determine their dominance in the group. The degree of friendly feelings patients evoke in other members during sessions will determine their group popularity.

Group dominance and group popularity can therefore be used as criteria by which the general group behaviour of patients can be compared. It is possible to align patients both on a scale of group dominance and on a scale of group popularity.

Between these two scales a low and insignificant coefficient of correlation has been found. The mere fact that a patient has a dominant influence on group proceedings does not necessarily assure him a high degree of popularity. In fact, a patient who becomes a scapegoat target of group hostility may be a very influential "central person," but by no means a popular one.

So far we have exclusively examined the effect of field forces on the group members. We shall now have to investigate the second category of social phenomena which we mentioned before, namely the interpersonal relations.

The term interpersonal relations refers to the interaction between two people. If these two people were by themselves and not jointly subject to a particular field force, such as a common task or objective, then the relationship between them would be determined directly by their respective personalities, or at least predominantly so. This type of relationship will be termed "direct" interpersonal relation. If, on the other hand, these two persons are members of a group or are otherwise subject to particular field forces, then the relationship between them will be determined indirectly, or at least predominantly so, by their joint responses to common field influences. This type of relationship will be termed "indirect" interpersonal relation.

This differentiation between direct and indirect interpersonal relations is important and indispensable. The two types of relations have, in general, little in common with each other. It can be shown that direct relations and the feelings they engender tend to be private and concealed in a group, whereas indirect relations tend to manifest themselves openly. This difference is of general validity. Two persons may feel affectionately towards each other as individuals but, when required to perform a joint task—be it the co-operative undertaking of married life or merely a temporary partnership at a game of bridge—their mutual attachment will frequently be masked by field-determined

emotions of a different kind. The same observations can often be made with regard to direct interpersonal feelings of hostility.

The fact that direct interpersonal feelings do not readily manifest themselves in a group setting was also shown by the application of a "sociometric test" which inquired, without reference to any group activity, into feelings of liking and dislike between members. In a previous paper (1950*a*) the results of such an investigation were reported, and a method outlined by which the tangled criss-cross pattern of direct relationships could be transformed into a rank scale of direct popularity. It was found that the patients were, in general, not aware of the feelings other patients had towards them, and therefore had, in general, no knowledge of their own status on the scale of direct popularity. The rank correlation between the status of direct popularity patients expected to have and the status they actually occupied was $-\cdot 23$, which was far from being significant statistically.

There are thus two scales of popularity in a group: the scale of direct popularity which can be obtained by means of a sociometric test, and the scale of group popularity which can be readily estimated by group observation.

To assess the potential therapeutic value of the various group factors which have been outlined, an investigation on two therapeutic groups has been carried out.

The Groups Investigated.

Our data were obtained from two sexually mixed groups of 7 patients each. The male and female patients had, at first, been treated separately in one-sex groups. After 10 and 7 months of treatment respectively the groups were amalgamated. The emotional reactions evoked by this amalgamation have been described elswhere (1950*b*). The treatment of the two mixed groups continued for another 9 months. During this time no new patients were introduced, so that the group composition remained unaltered.

The patients suffered from long-standing neurotic illnesses. They were out-patients, and came for treatment twice weekly. The sessions lasted $1\frac{1}{2}$ hours. The therapeutic approach was "group-analytical" in the manner described by Foulkes (1948). Shorthand notes of the discussion and other group events were taken by the author during the sessions.

One month after the termination of treatment the members were asked to complete a questionnaire. This was couched in fairly general terms.

One series of questions referred to therapeutic results, and the manner in which different symptoms had altered during treatment. The patients were encouraged to give specific examples and to avoid general statements. They were also asked to say whether their social relations had changed, and whether people had made spontaneous remarks concerning a change in the behaviour of the patients.

Another series of questions tried to elicit the patients' opinion of group treatment. Which aspects of treatment had been most helpful or most disturbing? What criticisms and suggestions concerning treatment did they have to offer? Had treatment helped them to gain a better understanding of themselves? What was their opinion of interpretations?

Other questions dealt with their feelings and opinions concerning fellow members. Were they still in touch with any of them? Whom had they liked or disliked? Whom had they considered helpful or unhelpful? Would they have liked to exclude any members?

These questions were interspersed with requests to give specific examples and explanations.

All patients responded by sending detailed replies. These replies and the record of the group discussions form the basis of this investigation.

Therapeutic Results.

There are no valid or generally accepted criteria by which therapeutic results can be assessed. It was therefore decided to rely arbitrarily on two criteria: (*a*) subjective and objective improvements in social relationships, and (*b*) the patients' own detailed assessments of clinical improvement.

Improvement of social relationships.—The patients were asked to report whether there had been any change in their attitudes and feelings to members of their family, to friends, colleagues, casual acquaintances or strangers, and whether other people had spontaneously remarked on such a change in them.

Ten of the 14 patients reported that they had improved socially. They found it easier to talk to people, and to be friendly and companionable. Four were able to add that this improvement had been corroborated spontaneously by other people. One patient who was otherwise dissatisfied with his therapeutic result stated that it was not surprising that group treatment could produce some social improvement, as it " tends to skim away one's expressly social symptoms " through enabling one to rehearse a neurotically disturbed social role before a sympathetic audience.

Clinical improvement.—The patients were asked to describe in detail the nature and intensity of their symptoms before and after treatment. From their accounts it was evident that 8 patients were satisfied with their clinical improvement and 6 patients were not.

Scale of therapeutic results.—The two criteria of improvement are not sufficiently exact to allow a quantitative estimate of the degree of improvement shown by each patient, or to allow a detailed ranking of the individual patients according to differences of clinical improvement. But an approximate subdivision of the patients into three categories was possible (see Table I): (1)

TABLE I.

	Patients.													
	♀ A.	♀ B.	♀ C.	♀ D.	♂ E.	♂ F.	♂ G.	♀ H.	♀ I.	♂ J.	♂ K.	♀ L.	♂ M.	♂ N
Therapeutic results	++	++	++	++	++	++	++	+	+	+	+	−	−	−
Laliophobic symptoms	−	−	−	−	−	−	−	−	+	+	+	+	+	−
Positive identifications	+	+	+	+	−	+	+	+	−	−	−	+	−	−
Greatest group disturbance: Sexual discussions	+	+	+	+	+	+	−	+	+	−	−	−	−	−
Direct popularity (in rank order)	1	4	11	14	2	3	13	8	8	5	6	8	10	12
Group popularity	+	+	+	−	+	+	+	+	−	−	−	−	−	−
Dominance	−	+	+	+	+	−	+	+	−	+	−	−	−	+

" Good " results—patients who were socially improved and also satisfied with the alleviation of their neurotic symptom. (2) " Fair " results—patients who only admitted improvement on one of these scores. (3) " Poor " results—patients who were neither socially improved nor satisfied with the result of treatment.

" Good " results : There were 7 patients in this category. Patients A, B, C, and D were female, the other three male. A brief history of Mrs. A will serve as an illustration of a " good " result.

The leading symptoms of Mrs. A had been panic attacks in the street, especially in crowds, and when travelling on buses or trains. For years she had only been able to leave her home in the company of either her husband or mother. She had been irritated by housework and the care of her infant son. Sexual relations had become abhorrent to her. At the end of treatment she could " travel quite happily on buses, trams and cars." She even went on a holiday to France and enjoyed it. She no longer " bore a grudge " against her son, sex life had become " normal," and she could do housework " quite happily, though sketchily." Her " relationship with people had altered considerably for the better," and this was spontaneously remarked on by husband, mother and a female friend.

" Fair " results : There were 4 patients in this category, patients H and I being female. Patient H reported an improvement in her clinical condition, but no change socially ; the other three patients were improved socially, but dissatisfied with the treatment result. The history of Mr. K is presented as an example.

Mr. K had been unable, for 13 years, to do any work when he was, or felt, observed. His work record had deteriorated, and when treatment started he was in casual employment as an unskilled worker. Even at home he would rather go hungry than pour himself out a cup of tea or cut off a slice of bread if another person was in the same room to observe him. At the end of treatment he was in regular and skilled employment, was happily married and the proud father of a baby girl. Yet he was not satisfied with the result of group treatment as he was still left with a number of unpleasant symptoms. He said : " I do not think embarrassment whilst under observation is so acute now. I try to concentrate on what I am doing and to shut people out. But I think this old symptom has been ousted by a new one which is more troublesome." The new symptom was a fear of being considered " illiterate " by other people. He had become more sociable, but had " occasional lapses."

" Poor " results : Three patients were in this category and only patient L was female. Mr. N's history will be quoted because he seems to have had the worst therapeutic result.

Mr. N was a schizoid, gawky and emotionally inhibited person. He had left his parents as soon as he was financially independent, and had, since then, led a lonely and friendless existence. He had found some compensation in daydreams of ambition and achievement, and in occasional short-lived affairs with casual female acquaintances, which started with sexual bravado and ended in masturbation fantasies. He was engaged in industrial research

work, but was unable to complete any investigation, however simple. In the course of group treatment he lost his research job, and was then employed in routine tasks, which he could perform quite satisfactorily. He remarked: "I am not quite sure that a psychological change is responsible for this slight improvement. It could be that the job is easier than the last one." At the end of treatment his relations with people were "somewhat worse," as he had become more self-conscious, more handicapped by a slight stammer, and more aware of his shortcomings. He was, however, not discouraged by this failure, and is at present attending a therapeutic group elsewhere.

The Therapeutic Effect of Field Forces.

In trying to assess the therapeutic effects of field forces we are hampered by the limitations of our present investigation. A reliable assessment would require an experimental approach such as, for instance, the observation of two comparable groups, of which one is subject to a particular field force and the other not. It is, however, not feasible to test every type of field force, which is operative in a therapeutic group setting, in this experimental manner.

In this investigation the therapeutic potency of field forces has been judged in the following ways: In the first place, each field force was considered separately, and the varying responses of the group members compared. As has been pointed out in the theoretical introduction, each field force aroused a common matrix of actuation from which the individual diversity of manifest responses springs. The immediate effect of each field force was reflected in the group scale indicating the degree of overt expression which the common matrix of actuation caused by a field force attained. This group scale could be correlated with the scale of therapeutic results, and this correlation used as an indicator of the differential therapeutic potency of a field force.

Similar considerations were applied to the total constellation of field forces in the group setting. The scales which reflected the immediate and joint effect of all field forces were the scales of group dominance and group popularity. The correlation between these scales and the scale of therapeutic results furnished a measure of the differential therapeutic potency of the total constellation of field forces.

It must, however, be pointed out that this measurement of therapeutic results is only a differential one, which compares the different degrees of improvement attained by the various patients but does not allow a comparison of the clinical condition of the group generally before and after treatment. Thus it can only serve as a standard of comparison for those field forces which have a markedly differential effect on the patients. The assessment of the therapeutic value of those field forces which have a more uniform effect on the group has had to be based on general considerations, and on the patients' opinions that these field forces are therapeutically indispensable.

In the following paragraphs only those field forces will be considered which appeared to be therapeutic factors.

In calculating the correlations between the various scales the rank correlation coefficient τ of Kendall (1948) has been employed throughout.

The general verbal task.—This is the most constant and fundamental demand that group members have to meet. Some patients will respond to it with great eagerness and an undue amount of talk. In most patients it will appear that their desire to speak is, for the most part, regulated by the opportunities and requirements of the group situation. There will also be some patients in whom the prospect of having to speak in front of the group will arouse anxiety and apprehension.

Such patients with a neurotically anxious response to the general verbal task will, for the sake of a succinct description, be termed laliophobic patients.

There were 5 such patients in the 2 groups (see Table I). They could only contribute to the discussion by fighting against their laliophobic disturbance.

One of these laliophobic patients, Mr. M, gave the following description of his response to the general verbal task: "In the group I suffered from my usual symptom, which appears when I am in the company of more than one person and am not absolutely sure of my complete intellectual superiority and their recognition of it. Thus I was almost always unable to take part in the discussion." This description reveals some of the roots of the laliophobic symptom, namely a narcissistic over-concern with verbal productions, and an aspiration to a level of linguistic excellence and intellectual competence which would assure general acclamation.

Mr. K made these remarks concerning his laliophobia: "The few occasions when I held the floor I experienced relief afterwards, a feeling of elation. But when questions were put to me and I could not speak, I had a feeling of frustration, a feeling that I had fallen down and not done all I should have done. I think these occasions have been more harmful than helpful."

The presence of laliophobic symptoms does, however, not necessarily preclude a patient from joining effectively in the group discussion. Mr. J, for instance, gained a fairly dominant status in the group. He could speak at length, once his initial trepidation had been overcome, and particularly when he could be aggressive and derogatory.

The rank correlation between laliophobic symptoms and the scale of therapeutic results is $-\cdot65$, which is significant at the 4 per cent. level. This finding indicates that a phobic difficulty in discharging the general verbal task tends to be a prognostically unfavourable sign for group-analytical psychotherapy. It is in agreement with this finding that 4 of the 5 laliophobic patients volunteered the opinion that they should have been excluded from the group because they felt they had been unable to co-operate adequately. It was not that they had derived no benefit from the treatment, but that, whatever improvement they had achieved, had been bought at an inordinate emotional expense.

The task of candid self-revelation.—This is an obligation which does not stir the group as continuously as the general verbal task. To expose one's intimate and guilt-charged problems to the forum of the group caused anxiety and embarrassment in every patient. The laliophobic patients were not different from the other group members in this respect; one even gained the impression that they sometimes welcomed an opportunity to perform this task, which was generally recognized as difficult and anxiety-provoking.

The task of candid self-revelation was regarded by the group members as an indispensable group performance which they expected—or, if necessary, exacted—from everybody. This was strikingly illustrated by an incident that occurred when the male and female groups had been amalgamated. For about 4 weeks the members guardedly avoided frank self-revelation apart from the recital of relatively harmless symptoms. Yet there was a mounting tension and dissatisfaction in the two amalgamated groups. Eventually the patients decided that, in order to re-establish the therapeutic atmosphere to which they had become accustomed in the one-sex groups, they had to be frank about those personal data of which they felt ashamed. The author did not encourage this plan, but the patients disregarded him and carried out their decision. In turn they performed the initiation ceremony of confessing embarrassing symptoms and problems, and the result proved beneficial.

The task of candid self-revelation may therefore be regarded as having a general and fairly uniform therapeutic effect.

The task of transforming personal problems into group problems.—This task is closely associated with the preceding one, as the knowledge that the group will attempt to deal collectively with personal problems facilitated candid self-revelation. Mrs. B expressed this by saying: "There was the initial effort of making confessions of things I was ashamed of. But I knew they would be seen in their right perspective by you and treated as problems by the rest of the group—not as horrible aspects of my character."

The feelings which accompanied this task were obviously those of a positive identification with the group. These feelings and their therapeutic effect will be considered presently in connection with the field force of associating with neurotic compeers.

The giving and receiving of interpretations.—The task of giving interpretations divided the group in a similar way as the general verbal task. The laliophobic patients disliked stating their opinions of the meaning and psychogenesis of symptoms, dreams or peculiarities of behaviour. They were therefore inclined to regard the giving of interpretations as an unhelpful group task. Mr. M, for instance, felt that his views might have been considered "stupid or unimaginative," and he had therefore avoided taking part in interpretative discussions.

Some patients remarked shrewdly that giving interpretations did not only throw light on the mind of the interpreted person, but also revealed the mind of the interpreter.

With regard to the receiving of interpretations the group was almost unanimous. All the patients, with the sole exception of Mrs. I, stated that they had been helped by interpretations given to them. They had, they said, learned to understand themselves better. Several patients added that this self-knowledge had aided them in analying their own feelings, and had enabled them to cope more adequately with personal difficulties.

Yet this universal acceptance of interpretations was a limited one, and hedged in by reservations concerning their validity in their own personal case. Here are some characteristic remarks. Mr. F: "I found the interpretations given to other people easier to accept, especially in Mr. E's case. In fact,

I used to get half-annoyed with him because he could not see the point. It seemed so obvious to me that what we had worked out was correct." Mr. M: "It is quite puzzling, but it seems to me that interpretations are quite reasonable in theory, but when it comes to accepting them and to applying them to myself, then they are ridiculous."

Several patients remarked that it was not the intellectual aspect of interpretations which was of therapeutic importance, but the emotional effects produced by them. To quote Mr. F again: "Whether interpretations were true or not, they set people thinking and created emotional disturbances in the right direction." Mrs. A was even more outspoken: "These emotional upsets stamped on the mind more definitely than any amount of mere talking would have done the main causes of your symptoms." Mrs. B analysed her reactions to interpretations in a most revealing manner: "It seems to me that one raises a wall against an interpretation immediately, but it gradually comes true to one. I can remember the feeling when something became real to me, but I think it was such a gradual process that often the realization was not entirely due to the interpretation. Some of my relationships with people have clarified themselves though they had never been interpreted and without any conscious realization on my part."

From these examples one can infer that the receiving of interpretations has a fairly uniform therapeutic effect.

Transference to the therapist.—The therapeutic importance of transference reactions needs no emphasis. It must, however, be pointed out that there is a difference between the transference to the therapist in individual and in group treatment. Whereas in individual treatment all essential therapeutic processes operate within and through the emotional relation between doctor and patient, the sphere of therapeutic activity in group treatment is a wider one because the interactions among the patients absorb some of the feelings which, in individual treatment, may be entirely focused on the therapist. The transference to the group therapist is therefore not of the same exclusive therapeutic significance.

The therapist has, of course, a unique position within the group. He has not joined the group in order to be treated, and he is not subject to the group task of candid self-revelation. In fact, the patients would regard it as a disturbance were the therapist to intrude his personal problems on the group; this does not mean, however, that the patients do not welcome the therapist's occasional admission of human frailties and foibles. In general, the patients want to look up to the therapist as a person of prestige, responsibility and superior knowledge. He therefore holds potentially the most dominant status in the group, and is frequently obliged to counter the patients' attempts to see in him an oracle of wisdom, a beneficent and magical healer, and an authoritative arbiter in all disputes and controversies.

Transference feelings are composed of positive and negative elements. Positive elements will link the patient to the therapist either through a bond of affection and admiration, or through a sparring contest which allows the release and correction of aggressive feelings; negative elements will tend to sever the association with the therapist by the patient's repudiation of him and

his treatment. No therapeutic effect is likely in individual treatment when negative elements gain and maintain the upper hand. The same is, generally speaking, true of group treatment.

Yet there was one exception among the patients investigated here. In this patient negative feelings towards the therapist predominated during the later months of group treatment. He began to repudiate the therapist, but did not relinquish his attachment to the group, in spite of the fact that he was not too kindly treated by the other members. This is an observation which is obviously rare, and which does not seem to have been mentioned in the literature before.

The exception was Mr. N, whose case-history has been briefly outlined already. His predominantly negative transference feelings were revealed by disparaging remarks about the therapist which he made privately, and which had a more spiteful sting in them than similarly critical remarks made by other patients. Mr. N was very unpopular in the group, and he was frequently the butt of hostile and derogatory remarks. Yet, not only did he not leave the group, but he advocated daily group meetings, and suggested that the presence of the therapist would not be required in them. He was the only patient who approached the author, after the group had been disbanded, with a request for further group treatment.

What, then, was the particular attraction that group treatment had for him, and why did he not leave the group as most patients would have done under similar circumstances? There seem to have been two reasons. He was a lonely, friendless person to whom the group offered the unaccustomed experience of being an active participant in a sociable gathering. But he also derived a less salubrious gratification from the group. Under the guise of being helpful he frequently took the lead in eliciting embarrassing experiences from others. The pose of helpfulness hardly concealed his egocentric desire to exploit the group situation in the service of scoptophilic tendencies.

Apart from Mr. N the transference to the therapist was predominantly positive in the two groups described. This transference was the strongest group-cohesive influence among the members. When treatment ceased there were a few desultory meetings between some members, and then the social bond that had held the group together disappeared.

Negative transference feelings were, of course, not absent during treatment, but they never outweighed positive emotions towards the therapist. There had been only one occasion in the history of the two groups when the collective transference of the group members threatened to become predominantly critical and negative. This happened at the time of the amalgamation of the male and female group. Yet this transference hostility was subdued by the fear of losing the therapist's support at a time of insecurity and apprehension. It found expression, however, in an indirect manner. The most dominant member in either group was substituted for the therapist as a target for aggression. At that time there was a revolt against the influence of the leading patients, but this revolt was as short-lived as the excessive animosity against the therapist.

The questionnaire contained a request to criticize the author's handling of

the groups. There was only one major complaint which was voiced by 9 patients irrespective of their degree of therapeutic response. They complained that the author should have been more active in leading the group discussions, in giving interpretations, and in offering practical advice. They were, however, aware that this desire for dependence on the therapist ran counter to the latter's policy of encouraging self-reliance and group initiative.

The transference to the therapist influenced indirectly the interpersonal relations among the patients. The most obvious effect of this kind, apart from identifications, were feelings of jealousy and rivalry for the therapist's affection and esteem. Six patients, irrespective of their degree of therapeutic response, stated that they had at times been convinced that the therapist had deliberately favoured others, or had failed to defend them when they were attacked. They knew also that these feelings had been common to all members, as this transference effect had been a recurrent theme in group discussions. This transference-determined jealousy had been most prominent in Miss D, who frankly acknowledged, " I did not want to share you with others." Her feelings towards the therapist, which were often too conspicuous during group sessions, were one of the reasons for her unpopularity.

Another transference effect which caused unpopularity was a desire to emulate the therapist's group role. Miss C and Mr. N were most active in this respect. They were both frequently criticized for wanting to " run the group " to suit their own purposes rather than the benefit of all.

Among the many interpersonal relationships that exist in a group the transference relation to the therapist stands out as a unique influence on all and every group activity. It is also so complex and many-sided that it cannot be considered as a single therapeutic factor, but must be viewed as a concatenation of multifarious factors, some of which may have a general, others a differentiating therapeutic effect, and others may even give rise to responses which hamper therapeutic progress.

Association with neurotic compeers.—Eight of the 14 patients (see Table I) mentioned in their replies to the questionnaire that it had helped them to realize that their neurotic difficulties were shared by others, that they were not unique misfits in a society of apparently normal people. It was somewhat surprising that these feelings were not voiced by all the patients, because all of them had, in the beginning of treatment, reported a feeling of relief when other patients had admitted to have symptoms in common with them which previously had been guiltily concealed. As one patient had put it : " It was rather a relief to know that other people felt the same as you, and that it was nothing to be ashamed of."

It is obvious that the association with neurotic compeers under the conditions of group treatment favoured the emergence of feelings of identification. It was, however, evident from the observation of the groups that these feelings of identifications were ambivalent. Sometimes identifications were welcomed, at other times rejected. " I saw too much of myself in them," said one group member, " and I disliked what I saw." Thus the identifications with the group contained positive and negative elements.

We may assume that in the 8 patients who had emphasized the helpfulness

of associating with other neurotic persons, the positive elements of identification had predominated, at least temporily as long as treatment was in progress. If we correlate the scale of these positive identifications with the scale of therapeutic results we obtain a r of $+\cdot 52$, which is, however, not fully significant statistically ($P = \cdot 11$).

This low statistical significance may be mainly due to the small number of patients and the rather crude method of ranking. Theoretically, it is likely that positive identifications with the group contribute to the final therapeutic outcome, but this contribution is certainly counterbalanced by desires to be different from the other group patients, and to identify with persons who are considered normal.

Topics of group discussion.—The emotions which stir the group find expression in the topics which are discussed. At the same time these topics evoke an emotional resonance even in those patients who did not participate in the conversation. These patients respond like an audience whose emotions are excited by the impersonation of actors on a stage.

Eight members mentioned that group discussions which dealt with sexual matters had been most disturbing to them (see Table I). Half of them added that these disturbances had been ultimately helpful. Indeed, when the correlation between disturbance by sexual topics and the scale of therapeutic results was calculated a significant coefficient of $+\cdot 63$ ($P = \cdot 04$) was obtained.

During the sessions one had gained the impression that all members had been anxious and tense when delicate sexual matters had been considered. This impression is not contradicted by the above finding, if the meaning of the positive correlation is considered as indicating that those patients whose improvement was less satisfactory had been most intensely disturbed by other group events than sexual discussion.

There is some support for this interpretation of the above correlation. Laliophobic patients, according to their own evidence, were most intensely disturbed by the obligations of the general verbal task. It may therefore be a revealing fact that only one of the laliophobic patients mentioned sexual discussions as disturbing. The correlation between laliophobic symptoms and disturbance by sexual discussions was, however, only $-\cdot 56$, which was not high enough for statistical significance.

The group discussions on sex were, of course, controlled and guided by the therapist, so that the emotional tension they produced should remain within the limits of tolerance of the most sensitive group member. Regulated in this manner, the emotional resonance which accompanied sexual discussions became a "corrective emotional experience" in the sense in which this term is used by Alexander (1946). At the same time, because these emotional experiences were engendered by the spectacle of group events, one might term them "cathartic" experiences, using the term "catharsis" in its Aristotelian sense.

Topics of aggression were not listed by the group members among the most disturbing group events. Aggressive and sarcastic comments did, of course, occur and, at times, the group temper had been rather critical and hostile. Yet only Mr. N had been a consistent target for group aggression,

and he was the only one who mentioned that the criticism of the group had disturbed him. The patients never had the same difficulty in revealing aggressive symptoms, desires and fears as they had with regard to sexual phenomena. The mere discussion of aggressiveness never raised the emotional atmosphere to the same pitch as sexual topics did.

The sexual composition of the group.—Groups composed of members of one sex only activate an undercurrent of homosexual motivations, which need not, however, be too obvious under normal circumstances. In groups containing both sexes there is similarly a heterosexual stimulation. Both these facts might be inferred theoretically from our preceding findings that sexual topics of discussion have intense emotional repercussions. Whatever the content of the sexual discussions, the presence of the same or the opposite sex in the group will tend to evoke, among other emotions, homo- or hetero-sexual responses respectively. Such responses were clearly revealed at the time when the two one-sex groups were amalgamated. The author has described these responses in detail elswhere (1950*b*).

It is likely that these group-conditioned homo- and hetero-sexual responses are of potential therapeutic value, but their effect in this respect will depend on individual characteristics. One half of the patients did not express any preference for either one-sex or two-sex groups. Mr. E, F and G considered that the mixed groups had been more helpful, but Miss D, Mrs. I and Mr. J and M were of the opposite opinion. The two male patients with overt homo-sexual leanings, Mr. G and M, had responded differently to the group amalgamation. Mr. G formed easy friendships with the female patients, whereas Mr. M became distressed in the presence of women and his laliophobia increased.

Size of groups.—It is generally considered that the optimum size of groups for the purpose of group-analytical psychotherapy lies between 6 and 9 members. As this number of participants is, however, too disturbing for some laliophobic patients, it might be advisable to treat such patients, at least initially, in groups containing 2 or 3 patients only.

Popularity.

Direct popularity.—The rank scale of direct popularity (see Table I) was drawn up from the replies to the questionnaire, and after equalizing individual differences in the degree of professed friendliness. The method employed for this purpose was described elsewhere (1950*a*).

It will be seen that among the patients with " good " therapeutic results were four who occupied the first 4 ranks and three whose ranks were very low. The rank correlation between this scale of direct popularity and the scale of therapeutic results was +·26, which was not significant.

It may therefore be concluded that the degree of direct popularity has no therapeutic effect. This conclusion is in agreement with previous findings that the patients are, in general, unaware of the friendly feelings they evoke in direct interpersonal relationships irrespective of the group situation.

Group popularity.—This scale of popularity (see Table I) was derived from the manifest degree of friendly feelings a patient received during group sessions.

It was not difficult to draw up this scale from the observation of the group behaviour of patients and the record of group proceedings.

Let us, for example, consider the three patients with "good" therapeutic results but low status of direct popularity. Two of them would have been very surprised, and justifiably so, if they had been told that they were disliked by most of the other patients. Miss C could have offered plenty of evidence in favour of her popularity in the group. She had formed a fairly close friendship with two members which continued for several weeks after the termination of treatment, and two other members of her mixed group were friendly disposed towards her during the sessions. Thus she could have claimed that 4 of the 6 fellow patients in her group liked her. She would have admitted that she had often been rather critical and aggressive in the course of treatment, but it had been one of the beneficial experiences of group treatment for her that "criticism need not destroy friendship." Mr. G had also been accepted as a pleasant and well-mannered person by the 4 female members of his mixed group, and he had sometimes met them privately in between group sessions and even afterwards. It was only the third patient, Miss D, who would have acknowledged her unpopularity as deserved. She stated truthfully that she had often gone out of her way to upset and annoy others.

These examples show that direct popularity and group popularity need not go together; the correlation between them was only $+\cdot32$, and therefore too low to be significant.

The correlation between group popularity and the scale of therapeutic results was $+\cdot70$, which was significant at the 2 per cent. level. The manifest group popularity, therefore, plays an important part among the therapeutic group factors.

Dominance.

The scale of dominance (see Table I) was derived from the frequency with which members contributed to the group discussions and the extent to which they influenced the conversation. Dominance is a conspicuous group factor which can be readily discerned by any group observer, and which allowed the patients little room for self-deception concerning their own status. Patients whose desire for dominance surpassed their actual group influence were, in general, painfully aware of the discrepancy between their aspirations and their actual performance.

There was no significant correlation between dominance and either of the two scales of popularity.

The correlation between dominance and therapeutic results was equally insignificant; it was only $+\cdot30$.

Discussion.

In individual psychoanalysis three therapeutic factors may be distinguished: (1) the task of free association (the "basic rule"), (2) the emotional interplay between analyst and patient (the transference + counter-transference relationship), and (3) the intellectual relationship in which the analyst, by means of adequate and suitably timed interpretations + explanations, attempts to

guide the patient towards "psychological insight" (the psychoanalysis in a narrow sense).

In group therapy these three therapeutic factors are modified, and there are, in addition, therapeutic factors specific to the group situation.

The basic rule of free association is similar to, though not identical with, the general verbal task of group therapy. As far as the author is aware there have been no investigations in psychoanalytical literature of the effect on the therapeutic outcome which a neurotic inability to comply with the basic rule has. Some indirect light is perhaps thrown on this question by an investigation into analytical technique. This was carried out by Glover (1940), who sent a questionnaire to 29 members of the British Psychoanalytical Society and received replies from 24 of them. One of Glover's questions was, "What is your method of dealing with patients who need constant encouragement to talk?" The answers he received were "rather indefinite," but Glover remarked that "the persistent silences of some patients are a common source of trouble," and that "this type of resistance appears specially liable to rouse anxiety in the analyst." This suggests the possibility that a patient's inability to comply with the basic rule may retard or even frustrate individual analytical treatment.

In a therapeutic group the neurotic inability of some patients to comply readily with the general verbal task is a very conspicuous group feature. It is therefore surprising that group therapists have said little or nothing about this phenomenon. Foulkes (1948) and Bion (1948) have mentioned silences of the whole group, and have considered their significance and methods of dealing with them. Foulkes has also given an incidental example (supplied by de Maré) of a group patient who had not taken an active part in the discussion because he felt less educated than the other members—a reason for reticence which some of the laliophobic patients in our groups also advanced.

One explanation for the fact that such a conspicuous group feature as laliophobia has been so consistently ignored may be the dislike of group therapists to retain disturbing and troublesome patients in the group. Laliophobic patients are difficult group members because they find group treatment uncongenial and distressing. They tend to be critical, and they either leave the group prematurely or are encouraged to do so. Foulkes, for instance, who gives detailed advice about group technique, suggests that the therapist should take rather a sharp line with people who have doubts about the efficacy of treatment, as it would not be a loss to the group if some patients dropped out and were replaced by more co-operative ones.

This suggestion was not followed in the present investigation, because it was intended to keep the group membership constant in order to be able to study interpersonal relations and group hierarchies. A changing group population would have defeated this aim. Special efforts were therefore made to keep all patients in the group. Two of the laliophobic patients, for instance, were given individual treatment concurrently with group therapy to prevent them leaving the group. They were almost as reticent in individual sessions as in the group environment, but they preferred individual treatment as it caused them less anxiety.

Laliophobia is, of course, not a clinical entity. The dichotomy of the group patients into those who tended to speak freely and those who could only speak with anxiety is to some extent an artificial one. A graduated scale of speech anxiety would have been preferable if it had been possible to measure speech anxiety more adequately. The patients who have been labelled laliophobic suffered from this symptom not only in the therapeutic group, but also in most other social situations in which they were confronted by a number of comparative strangers.

Laliophobia may be regarded as a particular instance of a more general category of allied symptoms which all have their root in, what may be called, an exhibitionistic fear, i.e. a fear produced by performing certain activities before spectators. In this sense laliophobia is related to stage fright, examination fears, erythrophobia, shyness, paranoid fears, etc. Laliophobia acquires its particular importance in group therapy because the general verbal task obliges every group patient to speak in front of an audience.

Patients who suffer from exhibitionistic fears which do not, however, involve speech anxieties are not unduly disturbed by the group tasks. One patient whose exhibitionistic fear was almost exclusively concerned with the activity of writing, suffered no neurotic handicap through performing the usual group tasks, but became distressed when he was asked to fill in a questionnaire during sessions, or had to use his hands conspicuously when offering a light to anybody in the group. Another patient with severe erythrophobia attained a high status of dominance and group popularity because he was not self-conscious when he could speak and keep the group discussion going. Even patients with a slight stammer were not necessarily handicapped by laliophobia; some of them spoke a great deal and with obvious pleasure, but they generally irritated the group because they tended to be repetitive and to use circumlocutions to avoid the pronunciation of difficult words. Thus, if it were possible to change the group task into a non-verbal one, laliophobia might lose its particular significance for group treatment.

In individual treatment the transference relationship between therapist and patient is the most potent therapeutic force. Its influence transcends the treatment sessions and extends into the interpersonal experiences of the patient's life. In Alexander's (1946) opinion the analyst should take note of these secondary transference effects and guide them because "the therapeutic achievements result in part from these life experiences." In group therapy these secondary transference effects need not necessarily transcend the group situation, as the patients find an immediate outlet for them in the emotional interactions with the other patients. Some of the therapeutic achievements result therefore from transference-determined experiences with other group members. But not all interpersonal group experiences are determined, directly or indirectly, by the transference to the therapist; some of them exert their influence independent from transference effects. Transference is thus a less exclusive therapeutic force in group than in individual treatment.

The intellectual relationship between doctor and patient is sometimes credited with a greater therapeutic efficacy than it actually possesses. Interpretations as such do not produce psychological insight, nor is the acquisition

of psychological insight a purely, or even mainly, intellectual phenomenon. Alexander (1946) has emphasized that this form of therapeutically beneficial insight is the result of preceding emotional experiences rather than the effect of an intellectual communication. Mrs. B's account of her group experiences supports this view. She said: "I can remember the feeling when something became real to me, but I think it was such a gradual process that often the realization was not entirely due to the interpretation."

Interpretations given by the analyst arise out of the transference situation and have a personal significance for the patient; they therefore evoke chiefly and primarily an emotional response from the patient. It would, however, be untrue to say that interpretations have no helpful intellectual effect at all. The patients often attempt to view an interpretation in an objective manner as though it did not concern them personally. It frequently happens that a patient will accept an interpretation intellectually, but without the conviction which comes from an emotional experience.

This distinction between the intellectual and emotional aspects of interpretations is very obvious in therapeutic groups. Interpretations given to fellow members can be viewed in a detached manner and judged by their logical consistency or plausibility. From group observation one gains the impression that this intellectual exercise has some therapeutic value of its own. It has the comforting effect of providing an intellectual scheme which seems to bring order and understanding into phenomena that had appeared to the patients to be beyond the range of reason and familiarity.

The therapeutic significance of interpretations is thus very complex. Interpretations coming from the therapist have a different group influence than those which the patients themselves suggested. The former have a prestige component and are inevitably bound up with transference feelings; the latter may have a more poignant significance, however, at times, as the patient who suggests an interpretation to another member is an equal to whom the same interpretation might apply with equal force and validity. Furthermore, the giving of interpretations has to be distinguished from the consideration of interpretations given to the group. The giving of interpretations is part of the general verbal task, and was differential in its therapeutic results. The consideration of interpretations, on the other hand, appeared to be more uniform in its therapeutic effects; emotionally these effects were linked with transference and interpersonal feelings which provided an emotional support to all group members; intellectually they furnished a frame of reference which was of some general help in combating the patients' anxious speculations about the nature of the illogical and repudiated forces which assailed them.

This complex therapeutic significance is not a characteristic of interpretations only. The same is true of other therapeutic factors, such as the transference factor and the general verbal task. With regard to the general verbal task some specific elements could be singled out and examined, as far as possible, in isolation. It was found that the specific tasks of giving interpretations and of transforming personal problems into group problems put laliophobic patients under a disadvantage. These specific tasks therefore were, like the general verbal task, differential in their therapeutic effects. It was otherwise

with the specific task of candid self-revelation ; this did not handicap laliophobic patients more than other group members, and, consequently, appeared to be a more uniform therapeutic factor.

Other field forces with differential therapeutic effects were : the association with neurotic compeers, the sexual topics of group discussion, and the size of the group. These three field forces had an unfavourable influence on the therapeutic progress of laliophobic patients, who were not so much disturbed by sexual topics as by the fear of talking, who would have preferred a smaller group, and who could not form strong positive identifications with their neurotic compeers in the group.

Identifications with the group are of a complex and ambivalent character in all group patients. Positive identifications are due to the common transference towards the therapist, to the task of transforming personal problems into group problems, and to the fellow feelings engendered by the association with neurotic compeers. Negative identifications derive from a desire to be different from neurotics, to be cured so that they could join the larger community of normal people, and from a fear of being rejected. The last-mentioned cause was chiefly responsible for the attitude of laliophobic patients towards the group. They were dissatisfied with their own group performance, and imagined that others felt just as critical and would have liked to exclude them from the group. By disparaging the group members and by repudiating feelings of identification with them, they tried to alleviate the hurtful effect of the imagined rejection by the group.

If one views a therapeutic group as a miniature model of a larger community, these patients with inadequate feelings of unity with the group and its aims would correspond to a proletariat, according to Toynbee's (1946) definition that a proletariat is that social section which is ' in ' but not ' of ' any given society. The dissatisfied laliophobic proletariat in the two groups described had the effect of reducing group cohesion and of increasing the aggressive temper of the discussions because these patients were critical, suspicious and rebellious. They longed to defy irksome group conventions and to replace them by turbulent interactions. This, for instance, was the ideal of a therapeutic group for one of the laliophobic patients (Mr. J) : " A quickfire discourse is required. Tempers should be frayed, voices raised, blasphemy should be the order of the day ; above all, the therapist must forever be prompting and probing, making interpretations, however incorrect, constantly and importunately. Members must expect to be upset. Every time a patient is able to leave the group in such a state of equanimity as mildly to wonder what he would be having for supper, treatment has failed."

There are two hierarchies which establish themselves in groups as the result of the patients' responses to the total constellation of field forces operative in them : the hierarchy of dominance, and the scales of popularity.

The hierarchy of dominance was found to have had no effect on the therapeutic outcome of treatment. This finding may at first appear to be contrary to expectation. One might have supposed that a patient who was able to exert a conspicuous influence on group events would have tended to lead the group in a therapeutic direction. This was, however, not the case. First of

all, a dominant person need not necessarily be a leader. A scapegoat or a paranoid and aggressive person can acquire a dominant status but without leader qualities. Secondly, a patient may gain true leadership and yet exploit the group for personal ends. He would then be likely to guide the group along pathological pathways. Here again a group can reflect, in miniature, events which have become all too familiar on a large-scale international plane.

The lack of correlation between dominance and therapeutic results obliges the therapist to utilize his unique group position of prestige and transference popularity in order to pilot the group towards a therapeutic goal.

Laliophobic patients are not necessarily devoid of dominance. If and when they can overcome their fear of speaking they can gain an influential position by aggressive and self-assertive arguments. There was no correlation between dominance and laliophobia.

The investigation of the popularity of patients revealed that there are two independent types of popularity. One type is based on the feelings of friendliness evoked directly by the interplay of personalities. This "direct" popularity is essentially a phenomenon of private pairing without any reference to an immediate group situation. A popular person in this sense is one who is chosen as a desirable private companion by a majority of people in a community. Direct popularity can therefore be assessed with the help of Moreno's (1934) "sociometric test." It was found that in a therapeutic group direct popularity is of little account, has no influence on the therapeutic outcome, and is so inconspicuous during group sessions that members are, in general, not aware of their own status of direct popularity.

This finding seems to contradict the results of investigations of the sociometric school. But this contradiction is only an apparent one. The communities examined by sociometrists had a greater social mobility than therapeutic groups. In those communities members could associate in pairs, triangles or bigger sub-groups, based on direct friendliness and detached from the influence of the wider community. In a therapeutic group no detached pairing of members is possible without a disruption of the immediate group situation. It seems that this is the main reason why direct popularity is so little in evidence in therapeutic groups.

The second type of popularity, which has been termed group popularity, is one that arises immediately out of the group response of the patients. It is therefore not only group-determined, but also overt and noticeable in the group. It was found that this group popularity had a significant positive correlation with the differential therapeutic result of treatment.

Laliophobic patients, because of their aggressive leanings, tended to have low group popularity. The question arises here: Is the degree of group popularity a patient achieves a prognostic indicator of the benefit he can derive from treatment? Or is it merely a sign of his neurotic inability to speak freely in the group? The same question may also be asked with regard to positive identifications with the group, and the upset caused by sexual group discussions.

In the present investigation laliophobia has loomed rather large, but there are other types of patients, e.g. those with paranoid, obsessive, aggressive or

unduly intellectualizing tendencies, who are also apt to be unpopular, detached from the group and relatively undisturbed by sexual discussions. Group popularity, group identifications and an anxious response to sexual group discussions may therefore be considered to be valid + favourable prognostic criteria of the therapeutic outcome of group treatment.

SUMMARY.

The therapeutic factors in two sexually mixed groups of 7 members each have been examined.

It was found that certain field forces may have a generally beneficial effect, such as the common transference to the therapist, the group task of candid self-revelation, the emotional and intellectual responses to interpretations, and the sexual composition of the group.

Other group influences had a differential therapeutic effect. Among these the general verbal group task was of particular importance. Laliophobic patients who were unable to comply readily with this task did not respond as favourably to group treatment as other patients.

Of favourable prognosis was the ability to form positive identifications with the group, to be more disturbed by sexual topics of discussion than by other group events, and the attainment of a high degree of group popularity.

Group popularity was distinguished from direct popularity. The latter was based on the desires for private friendship which patients felt for each other. It had no reference to group performance, and had no effect on the therapeutic outcome.

The degree of dominance which patients gained in the group had no influence on their improvements.

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