TOWARD A THEORY
OF
GROUP DEVELOPMENT
IN
GROUP PSYCHOTHERAPY

BRYAN M. GRAY F.M.S.

(Thesis requirement for Master's Degree in Psychological Counselling.)

AUSTRALIAN NATIONAL UNIVERSITY

CANBERRA 1970
May, 1971.

THESIS DECLARATION

"I hereby declare that all the sources used in the composition of this thesis have been acknowledged, and that the thesis is the work of the undersigned."

Signature: [Signature]

(Br. Bryan Michael Gray F.M.S.)
ABSTRACT

There is a paucity of theories of group development in group psychotherapy. Within the available theories, there is a variety of explanatory models. Some stress linear stages of group development, in which the units or phases of development are conceptualised in content, interactional or affective themes. Other models stress recurring phases which may also be conceptualised in content, interactional or affective themes.

The five theories discussed, varied in theoretical orientation, yet they tended to report similar trends, in that they described the therapy group developing from a loosely knit psychological group to an integrated group, through phases dealing with 'dependence' and 'interdependence'. There seems evidence to suggest that a 'critical point' in the development of the therapy group, is a transition phase, in which group members begin to adopt a new 'frame of reference' ..... that of the therapist. It is also suggested that the crucial role of the therapist is reflected in his dominant position. Some implications are drawn. The function of anxiety and emotionality are discussed.

Finally, the possibility of designing models of psychotherapy which are applicable across different social systems, is explored in a theory of group development, based on Pentony's theory of the psychotherapy 'team'. A tentative formulation of a 'teams' theory of group development in group psychotherapy is outlined, and its potential for explaining the critical features of group development, noted in the five models discussed earlier, is discussed.
# CONTENTS

<table>
<thead>
<tr>
<th>CHAPTER 1:</th>
<th>INTRODUCTION</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHAPTER 2:</th>
<th>LINEAR MODELS OF GROUP DEVELOPMENT</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bennis &amp; Shepard (1956)</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Martin &amp; Hill (1957)</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>C.R. Rogers (1967)</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>Concluding Discussion</td>
<td>51</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHAPTER 3:</th>
<th>CYCLICAL MODELS OF GROUP DEVELOPMENT</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>W. Bion (1961)</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>Whitaker &amp; Liebermann (1964)</td>
<td>68</td>
</tr>
<tr>
<td></td>
<td>Concluding Discussion</td>
<td>80</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHAPTER 4:</th>
<th>CRITICAL ISSUES IN A THEORY OF GROUP DEVELOPMENT</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>General Indicators of Group Development</td>
<td>86</td>
</tr>
<tr>
<td></td>
<td>Phases of Group Development</td>
<td>97</td>
</tr>
<tr>
<td></td>
<td>Features of Transition Phase</td>
<td>103</td>
</tr>
<tr>
<td></td>
<td>Four Critical Factors in Group Development</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Summary</td>
<td>116</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHAPTER 5:</th>
<th>THERAPY GROUPS AS 'TEAMS'</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pentony's 'Team' Model of Dyadic Therapy</td>
<td>119</td>
</tr>
<tr>
<td></td>
<td>Therapy Group Becoming a 'Therapy Team'</td>
<td>124</td>
</tr>
<tr>
<td></td>
<td>'Teams' Model of Group Development</td>
<td>147</td>
</tr>
</tbody>
</table>

| BIBLIOGRAPHY | | Page |
|--------------||------|
|              | | 151  |
CHAPTER 1
INTRODUCTION

The concept of 'development' in individual psychology has been used to explain growth and predictable change in emotional (Freud, 1923; Erikson, 1950), cognitive (Piaget, 1950), and behavioural (Havighurst, 1953) aspects of the individual.

Some authors (Freud, 1940; Bennis & Shepard, 1956; and Schutz, 1958) suggest that a group has a life cycle and developmental history which parallels that of the individual. Others see the therapy group as developing through a series of phases which were peculiarly its own (Rogers, 1967; Martin & Hill, 1957). Others describe the development of the therapy group as similar to the development of the dyadic therapy relationship (E.J. Anthony, 1967).

Regardless of which orientation one takes, the promise of a theory of group development which would deepen our understanding and predictive ability about group life, (as theories of individual development increase our understanding of individual behaviour), is worthy of deeper theoretical analysis and speculation. Especially promising are theories which could apply across social systems, i.e. a theory of, the development of a social system, which would apply to a social system of one, two (e.g. dyadic therapy), three or more (e.g. group therapy). One such theory, will be tentatively formulated in the final chapters of this paper.
There has been a paucity of theoretical models of group development in group psychotherapy. (Martin & Hill, 1957). Those attempts which have been made or can be inferred (Corsini, 1957), reflect diversity. Some are couched in terms which may be more representative of the group therapist's clinical orientation than a group therapy orientation. (Scheidlinger, 1960). The following summary of some of the theories or models of group development in group psychotherapy, may illustrate the point.

Psychoanalytically oriented group therapists often describe phases of group development in terms which are 'borrowed' from individual-centred analysis. (Anthony, 1968).

(a) Wender (1936), describes a four-phase model:
   (i) intellectualisation, (ii) patient to patient transference, (iii) catharsis, and (iv) group interest.

(b) Stout (1950), discusses three phases:
   (i) resistance, (ii) gradual discussion of deep problems, and (iii) friendliness and freedom.

(c) Taylor (1950), states three phases:
   (i) candid self revelation, (ii) transforming personal problems into group problems, and (iii) group interpretation.

(d) Abrahams (1950), offers a four-phase model of group development:
   (i) relationships in terms of the past, (ii) interaction, (iii) lessening of resistance, and (iv) development of a therapeutic attitude of mutuality.
(e) Thorpe & Smith (1953) found a three-phase development in the group treatment of drug addicts:
(i) testing the therapist, (ii) group centred operations, (iii) group acceptant behaviour.

(f) Bach (1954), presents one of the most extensive theories of group development. He suggests a seven phase model of group development:
(i) initial situation testing, (ii) leader dependence, (iii) familial regression, (iv) associative compaering, (v) fantasy and play, (vi) in-group consciousness, and (vii) the work group phase.

(g) Kaplan & Roman (1963), base their model on Bennis & Shepard (1956), and propose three phases of group development:
(i) a loosely organised psychological group based on the medical model, (ii) coalescence of the psychological group, with dependency power and intimacy themes based on interaction models, and (iii) the partial dissolution of the psychological group.

(h) Anthony (1967), suggests two main phases centred around two focal conflicts:
(i) dependency – independency, and (ii) recognition of interpersonal differences.

A more interactional - dynamic model has been suggested by Cholden (1953), who describes three phases of group development:
(i) self conscious searching to understand limits, (ii) attention
to events in the group which provide anger, worry and fear, and
(iii) discussion of the origins and causes of emotions and their
effects.

Dreikurs (1951), suggested a more cognitively oriented
theory. This can be seen in his four-phase model: (i) establishment
of relationships, (ii) interpretation of dynamics, (iii) group
members increase their self understanding, and (iv) reorientation.

Corsini (1957) gives a brief eclectic statement,
suggesting a three phase model: (i) hesitant participation,
(ii) discussion of sensitive matters, and (iii) solutions.

No attempt has been made to summarise the theories of
group development which have resulted from training and sensitivity
groups. (Bradford, Gibb & Benne, 1964; Schein & Bennis, 1965;
Schutz, 1957; Mann, 1967; Mills, 1964; Slater, 1966; Dunphy, 1964;
and Tuckman, 1965).

The variations reflected in the summaries presented above,
illustrate the range of therapeutic orientations of the authors,
the influence of concepts 'borrowed' from dyadic therapy, the
patient populations these therapists worked with and the differing
amounts of theory on which these models were built. Also, all these
models are based on a 'linear' theory of group development .......
i.e. one assumes the group passing through phases, in a logical,
predictable order. There are of course 'cyclical' models of group
development (e.g. Ezriel, 1950.a; 1950.b) which describes the group
in terms of recurring phases or themes.
With such potential variability at hand, and with the limitations imposed by the length of this paper, five models of group development in group psychotherapy have been selected for discussion, in an effort to search out some of the critical issues which a theory of group development should be able to describe and account for. The five models which were selected, satisfy the following criteria:

(a) Representativeness: The models range from depth-oriented and psychoanalytic type theories, to interactional and group oriented theories, to experiential-existential descriptions of group therapy.

(b) Variation: Two types of 'movement' models were chosen:
(i) 'linear' phase models, which describe group development in terms of steps, phases or units. These phases follow a logical, predictable order. Movement, is usually in one direction ..... i.e. to the next phase,
(ii) 'cyclical-equilibrium' models which conceptualise the group in terms of 'forces' within the group, that continually interact to produce both change and stability (or equilibrium). These forces are usually considered as affective in character, and their 'themes' keep recurring. However, the word 'cyclical' may be misleading, as the recurrence of the phases or themes doesn't happen in a predictable fashion (as seasonal cycles do), but are the result of the forces operative in the group at the time. (cf. Lewin, 1951).
(c) Depth of Theory: The models chosen appear explicitly in the literature as, 'theories of group development', or are easily discernable in a theory of group psychotherapy (e.g. Bion, 1961). Several current theories of group psychotherapy suggested themselves (Gazda, 1968.a; 1968.b), as they inferred theories of group development. However, such inferences were too tentative to warrant selection for discussion. Where models were similar (e.g. Bennis et. al. 1956, and Kaplan & Roman, 1963), selection was made on the depth and extent of their theoretical formulations.

(d) Group Therapy Model: Due to the current confusion in the literature between training-sensitivity, type groups and therapy groups (Peck, 1970), only theories based on therapy groups or theories which had been successfully applied to therapy groups (e.g. Bennis et. al. 1956; Rogers, 1967), were chosen for discussion. Further, the critical field of group dynamics related to group therapy (Parloff, 1963; Hare, 1963; Durkin, 1954; 1964; Hoffman & Arsenian, J., 1966; Zinberg & Friedman, L.J., 1967) is not developed due to limitations imposed by the length of this presentation. Its crucial role in group development would merit separate treatment (e.g. Lakin & Carson, 1966).
The five models chosen to fulfil these criteria were:

(a) Bennis & Shepard (1956; Martin & Hill (1957); and Rogers (1967) ...... linear models, and

(b) Bion (1961); and Whitaker & Liebermann (1964) ...... cyclical-equilibrium models.

On the assumptions that; the group is a valid concept (Lewin, 1947; Durkin, 1964), and that the psychotherapy group progresses and changes during its history, these five models are reviewed and discussed in the hope that some of the critical issues in a theory of group development will become apparent.

The usefulness of these theories will be evaluated by the following criteria, which a valid theory of group development should clarify:

(a) Does the theory order the complex behavioural data of the group, into some comprehensive and manageable form by the use of some classificatory system? Does this system, allow statements to be made about the group in terms of its level of development?

(b) Does the theory increase the therapist's understanding of the group therapy processes so that he can;

   (i) assess the growth and maturity level of the group,

   (ii) predict the direction of the group, and (iii) make more appropriate therapeutic interventions, which would facilitate conditions for group development and individual change?
(c) Does the theory enable researchers to identify different factors at different levels of the group's development?
(d) Does the theory clarify the relationship between group development and individual development and change, in group therapy?

After the five theories are reviewed and discussed, with these questions in mind, some of the critical issues will become the focus of attention. It is hoped that chapter 4 will clarify some of current issues in group therapy such as;

(a) The relationship between interaction and insight in group development. (Sager, 1964; Azima, 1969);
(b) The function of group atmosphere in the progress of the group. (Scheidlinger, 1966; Papanek, 1969; Truax, 1961);
(c) The changing patterns of communication and interaction, as the group develops. (Talland, 1955; Hill, 1965);
(d) The major areas of conflict which patients learn to resolve or adapt to. (Bennis et. al. 1956; Kaplan et. al. 1963; Pentony, 1970.c);
(e) The function of the 'central persons' (Redl, 1942), in the development of the group. It seems possible that the 'central persons' may not be the therapist. The therapist's knowledge of these people's role makes it possible for the therapist to use the 'central persons' for the growth of the group and the progress of individual patients;
(f) The emphasis in group therapy. Some suggest it should be on the individual in the group (Wolf & Schwartz, 1962; Slavson, 1964; Locke, 1961). Other theorists claim that the emphasis should be on the group, as an entity in itself. (Whitaker et. al. 1964; Stock & Liebermann, 1960; Bion, 1961). The need to clarify whether group development is to emphasise, the 'group' developing or individuals developing in the group has been noted by E.J. Anthony (1968);

(g) The role of the therapist in the progress of the group. Some authors suggest that the therapist 'controls' the development of the therapy group. (Haley 1963; Anthony, 1967). His role as leader, influencer and specialist, need close scrutiny, if group therapists are to understand and accept the ethical issues and moral responsibilities that are part of their role;

(h) The possibility that group therapy can be seen in terms of a 'conversion' experience or in 'brainwashing' terms. (James, 1929; Schein, Schneier & Barker, 1961);

(i) The role which stress, anxiety and tension plays in group development. It may be, that group therapy builds up anxiety, so that progress comes as a result of some 'emotional experience'. (Frank & Ascher, 1951; Glatzer, 1969);

(j) The choice of 'units' of group development. Some suggest 'themes' which have a 'content' base (e.g. Powder-
maker & Frank, 1953; Winder & Hersko, 1958). Other authors have units based on 'affective characteristics'. (Bion, 1961; Ezriel, 1950). The criteria for choosing the 'unit' of group development, will determine the type of measurement to be used in its research. (Psathas, 1960; Stock & Liebermann, 1962);

(k) The notion that as a group develops, individuals gain an understanding of their own and the group's behaviour is a common one in group psychotherapy (Slavson, 1969). It may be that this insight is gained by using the therapist's 'frame of reference' or cognitive structure (Kelly, 1955). It seems possible, then, that the patient's frame of reference changes during group therapy.

(l) And whether a group develops in any ways which are similar to individual development. Suggestions, that 'independence-interdependence' is the key learning in group therapy, will be discussed.

Once these and other critical issues have been discussed, some attempt will be made to formulate some phase-model of group development, which encompasses these key issues. Another way of conceptualising these phases of group development will be formulated in the final chapter, which will attempt to open up the area mentioned previously. i.e. the possibility of a theory of group development which can be applied regardless of the size of the social system being studied. The promise, that sociologists, group
psychotherapists could all benefit from a 'systems' approach to group therapy may be implied in Anthony (1967), and in this presentation of the development of a psychotherapy group in terms of the therapy group becoming a 'therapy team'. That 'teams' could offer a way of conceptualising group development, regardless of the therapeutic orientation of the group therapist, may enhance its further exploration and conceptualisation, as a theory which is applicable across social systems.
CHAPTER 2
THE LINEAR MODELS OF GROUP DEVELOPMENT

A. BENNIS & SHEPARD (1956)

Although Bennis & Shepard's theory of group development was based mainly on training group data, their theory has been chosen for discussion because of the depth of its theoretical treatment in integrating group dynamic and interpersonal theories (H.S. Sullivan, 1945, 1955; W. Schutz, 1957), as well as Bionic and Freudian group psychology. Further the theory has been adapted and used successfully in therapy groups (Kaplan & Roman, 1965). They, themselves, claim that their theory is basic to an understanding of group therapy. "This suggests that group therapy ... begins at the least enabling time. It is possible that before group members are able to help each other the barriers to communication must be partially understood." (Bennis & Shepard, 1956. P. 436). For these reasons their theory of group development was chosen for discussion.

They conceive of the group as having a particular task or problem (be it training-educational or therapy oriented), and the development of the group may be gauged by the extent to which basic anxieties which interfere with such a task are overcome. Two major areas of anxiety which interfere with the valid communication necessary for the group to perform its task, are:

(i) relations with authority (the dependence-independence conflict), and

(ii) interpersonal relationships pertaining to emotional
closeness or intimacy.

These are the "two major areas of internal uncertainty" (Ibid. P. 416). They claim that the group, as a whole, moves regularly from preoccupation with authority relations to preoccupation with interpersonal relations. A more detailed description of their phases of group development is presented.

(a) Phase I: Dependence

(i) Subphase 1: Dependence - Flight

The structureless nature of the early sessions, the search for a common goal, the unexpected behaviour of the therapist as well as his apparently irrelevant interpretations, the ambiguous nature of the interpersonal situations, are all stimuli which trigger off anxiety and operationalise the first major area of internal uncertainty, viz., 'relations with authority'.

The authors, however, claim that the source of the anxiety is not the lack of group structure, but the 'dependence' on the therapist, which is common to all the group members. Thus, the behaviour typical of this phase is similar to behaviour which has gained approval from authorities in the past. For some it is 'dependence', for others it is 'flight'. The dependent group members are the more vocal and this phase terminates when their 'repertoire of behaviours', which is based on the therapist's potential power for good and evil, comes to an end. They become increasingly frustrated.
(ii) Subphase 2: Counterdependence - Flight

Since the therapist fails to satisfy the needs of the group, it begins to split into two sub-groups:

(a) Counterdependents, who vocally and openly ridicule the power and ability of the therapist, and

(b) Dependents, who cling to the omnipotent power of the therapist.

This division leads to increased anxiety, tension, expressions of hostility and disenchantment. The therapist's interpretations are misrepresented by both groups, thus increasing the tension and anxiety. Group fragmentation appears and "brings the group to the brink of catastrophe". (Ibid. P.422).

(iii) Subphase 3: Resolution - Catharsis

This is the most crucial stage in the group's life up to this point, because if the group is to survive, it must shift from;

(a) polarisation of two competing sub-groups, (with a third sub-group which to date has been powerless and a therapist whose interventions have only served to further fragment the group), to

(b) a group which has resolved the conflict and can proceed as a unit to the task of therapy.

Bennis and Shepard say that this resolution occurs at the "moments of stress and catharsis, when emotions are labile and intense". They see these as "the times in the group life when there is readiness for change. (Ibid. P. 425)."
Three factors operate at this emotional period to bring about a change in the group.

(a) The growth of mutual support among group members has quietly increased as people have felt less isolated and helpless.

(b) The therapist role, previously seen negatively, can be interpreted as permissive and understanding.

(c) The presence of 'non-conflicted', independent members who up until this period have not been needed by the rest of the group. They see the permissive role of the therapist and either suggest resolution or precipitate 'barometric events' which are accepted by the group as a means of reducing the heightened anxiety in a meaningful way.

This phase terminates "with the acceptance of mutual responsibility for the fate of the group and a sense of solidarity .....". (Ibid. P. 427).

(b) Phase II: Interdependence

Having adequately resolved the problem of the distribution of power in phase I, the group unity and solidarity brings up the second major area of internal uncertainty, viz., interpersonal concerns such as intimacy and identification.

(iv) Subphase 4: Enchantment - Flight

The unity and cohesion which follow the barometric event is short lived. Individuals begin to perceive that the group
demands conformity at the expense of denying reality and interpersonal friction. Sub-groups develop as a result of the anxieties aroused out of the deep involvement which characterised the first part of this sub-phase.

(v) Subphase 5: Disenchantment - Flight

The two main sub-groups which characterise this sub-phase represent the extreme attitudes toward the degree of intimacy desired in interpersonal relations.

(a) One group responds to this anxiety by avoiding any real commitment to others as the only means of maintaining self-esteem.

(b) The other group maintains self esteem by obtaining "a commitment from others to forgive everything".

(Ibid. P. 431.)

Bennis and Shepard refer to these as the 'counterpersonals' and the 'overpersonals'. Both sub-group reactions serve as "a generalised denial of the group and its meaning for individuals" (Ibid. P. 431), for both sub-groups are "created almost entirely on fantastic expectations about the consequences of group involvement" (Ibid. P. 432).

As in subphase 2, the group life is characterised by increased conflict, tension and anxiety, which builds up to a point where its resolution is essential if the group is to remain operative.

(vi) Subphase 6: Consensual Validation

Fear of rejection and the need to validate their self
concepts characterise both the 'counterpersonals' and the 'overpersonals'. Once again it is the sub-group, who are 'unconflicted' on this issue, who help resolve the conflict. By asking for some type of feedback and evaluation and by responding positively to such assessment, the 'unconflicted' or 'independent' person shows that he wasn't rejected, nor was his self concept disturbed (on the contrary, it was enhanced). This encourages the 'counterpersonals' and 'overpersonals' to exchange personal communications, receive feedback and test this realistically. The authors also suggest that a growing trust in the therapist and the approaching termination of therapy aid in the resolution of the interdependency problem.

Bennis and Shepard suggest that some of the values that appear to underlie the group's work during subphase 6, are:

(a) "Members are aware of their own differences without associating 'good' and 'bad' with the differences.

(b) Conflict exists but it is over substantive issues rather than emotional issues.

(c) Consensus is reached as a result of rational discussion rather than through a compulsive attempt to unanimity.

(d) Members are aware of their own involvement and of other aspects of group process, without being overwhelmed or alarmed.

(e) Through the evaluation process, members take on greater personal meaning to each other" (Ibid. P. 433).
It seems that in the resolution of the 'interdependency' conflict, members' personalities play the crucial role. In this way the resolution touches all group members in a healing fashion, as well as allowing each member the opportunity of helping others, a function which enhances their own self concepts.

An issue in any discussion of the Bennis and Shepard model of group development is the grounds on which 'dependence' and 'interdependence' were chosen as units of group development. The authors claim that these are the two "obstacles to valid communication" and support their claim by saying that these were "identified by induction from common experience" (Ibid. P. 416), and supported by the theoretical writings of Freud (1922), Schutz's FIRO theory (1958) and Bion's group dynamic theory (1948-1951). Since these theories have already been criticised on logical and empirical grounds (Bach, 1962; Sherwood, 1964; Durkin, 1964.), it is not surprising that Bennis and Shepard's theory may be challenged on similar grounds.

For example, they argue, "In the development, the group moves from preoccupation with authority relations to preoccupation with personal relations. (Ibid. P. 417). This observation is based on Freud's observations and this assumption that groups are similar to individuals in that individuals develop from dependence conflicts to interpersonal conflicts. Bennis et. al., use this assumption to explain how group members develop or change in group therapy as the group develops and changes. This epigenetic parallel has been criticised by Durkin (1964) and contrasts to
those theorists who see these and other basic themes recurring during the life of the group. (Bion, 1961; Coffey, 1962).

However, to the extent that the group and its members may share common areas of conflict, this theory does offer an explanation as to why the therapist can respond to 'the group' yet fulfill his role as helping individuals to adjust. To the extent that the group conflict is solved, the individual members of the group learn to adjust to the same conflict in themselves.

It is also debatable whether all intra-group conflict can be explained in terms of just two major conflicts. For example, Bennis et. al., say that the group anxiety in subphase 1 ('dependence - flight'), "can be best understood as a dependence plea. The trainer (therapist), not the lack of a goal, is the cause of insecurity", and that "this phase is characterised by behaviour that has gained approval from authorities in the past" (Ibid. P. 42D). However, it seems logical that people respond initially to unstructured situations by having recourse to past learnings and accepted forms of behaviour such as asking a 'specialist' for modes of coping or adapting. This is usually seen as 'reality oriented' behaviour. It would not constitute dependence. Bennis et. al., don't seem to allow for this period in group development.

The fact that his interpretations are "vigorously contested by the group" may be explainable in cognitive dissonance terms (Festinger, 1957), since the therapist's 'depth' orientation would be quite different to that of the group members. However, to the
extent that correct interpretation was made about 'pre-conscious' and conscious material, and couched in simple language, one could expect the group members to accept the therapist's interventions. As the members reject reliable information and respond emotionally and inappropriately, then the concept of 'dependence' may be a useful explanatory concept. Bennis et. al. don't concede this distinction.

For this model of group development to be functional, the assumption is made that a group possesses a 'central person or persons' (c.f. Redl. 1942). The authors say that these 'unconflicted persons' are necessary for the group to cope with the 'dependency' and 'interpersonal' conflicts in the group. They are the key people or 'catalysts' who offer satisfying alternatives or precipitate 'barometric events' to alleviate group anxiety when it reaches 'disaster' point. They also offer a more acceptable 'frame of reference', (which ironically is akin to the therapists!).

Their function is explainable not only in terms of the present theory, but also in terms of the 'cognitive dissonance' theory (Festinger, 1957). Their role seems logical and functional. (Redl, 1942). However, the assumption that all therapy groups are heterogeneous enough to contain one or more who are 'unconflicted' members is debatable. Bennis et. al., recognise this point: "Occasionally, there may be no strong independents capable of bringing about the barometric events that precipitate movement". (Bennis et. al. P. 427). They say that the absence of such 'central persons' causes the group to 'fixate' at that point and "founder
permanently". The assumption of the 'central person' may be reasonable for 'T' groups but would be far less predictable for therapy groups.

Nor does this theory allow the therapist to take the role of the 'unconflicted person', because he is the source of the conflict in phase 1 and presumably is involved in the conflict in phase 2. It would appear then that the use of Redl's concept poses a problem in that the development of the group depends on the presence of people who may not always be present.

What role does the therapist play in the development of the group? Bennis et. al. do acknowledge his function in this regard. They describe him as being the transference object in subphase 1, where he is seen as the "cause of insecurity". Later on, he is perceived as 'permissive' and finally just another one of the group! This of course is mainly the group's perception of him. In fact, his key position as therapist and specialist can be seen in his influence throughout the life of the group. It is the therapist who offers interpretation and expertise. He is the major focus of attention in the critical early stages of the group's life. He is the one who decides whether a topic or "source of communication distortion is to be highlighted and made the subject of special experiential and conceptual consideration". (Ibid. P. 427). His 'personality' and 'philosophy' determine his interest and response to explicit considerations of dependency and interdependency. It is his therapeutic 'frame of reference' which the group members are to adopt by using the interpretations he makes, about
the areas, he decides, are relevant.

In fact the authors acknowledge the therapist's influential position when they consider the role of the 'barometric events' in the development of the group. This, together with the linear phases and the function of the unconflicted members, could place the therapist in such a strong position that their picture of group development enables him to operate on the 'self fulfilling prophecy' - i.e. since the group has predetermined phases of development, the therapist's interventions are selected to fulfill the theory. Bennis et. al., acknowledge this possibility and conclude that the problems arising out of a 'self fulfilling prophecy' "can only be solved on the basis of more and more varied experience". (Ibid. P. 436).

Another feature of this model of group development is the gradual increase in rational and reality oriented behaviour. From the early phases, in which regression, debilitative anxiety and fantasy predominate, the group develops to a maturity in the phase 'consensual validation', in which self acceptance, rational discussion, consensus, self and group awareness, and self evaluation, predominate. However there doesn't appear to be a strictly linear development in this regard, but two cyclical phases which could be summarised as follows:

(a) Phase I - Dependence: The movement would be from regressive, dependent behaviour to progressive, interdependent behaviour.

(b) Phase II - Interdependence: The cycle would repeat itself,
viz., regressive, emotional interdependent behaviour to progressive rational interdependent behaviour.

The cyclical nature of the model can also be seen from the ebb and flow of anxiety, which reaches crescendos prior to each conflict resolution.

However, underlying these cyclical features, is the general notion that as the group develops there is an increase in rational communication channels. A therapy group that has developed to that stage can "resolve its internal conflicts, mobilise its resources and take intelligent action ...." (Ibid. P. 415). This is only a general indicator of group development, but it is one which can be easily operationalised for research (e.g. Psathas, 1960).

Bennis and Shepard give a central place in their theory of group development to the concept of anxiety, which they see as preventing "the person's internal communication system from functioning appropriately and improvements in his ability to profit from experience hinge upon overcoming anxiety as a source of distortion" (Ibid. P. 415). This being the case one may expect to see a gradual decrease in anxiety as the group develops. This is not so. At the beginning of subphases 3 and 6 the group anxiety brings the group to the "brink of catastrophe". As mentioned earlier, anxiety is a recurring and cyclical factor in the group life. However, as the group progresses, people learn to understand and adjust to anxiety in more realistic and appropriate ways.
There can be little doubt that Bennis et. al., place great stress on the function of anxiety in the progression of the group. Both, group and individual, change and development seem to rest on the level of tension and anxiety which can be generated. "For it can be argued that the moments of stress and catharsis when emotions are labile and intense, are times in the group life when there is readiness for change" (Ibid. P. 425).

Their theory of 'conflicting sub-groups' explains how this anxiety is generated. It also acknowledges the fact that both the therapist and the 'unconflicted persons' can determine the level to which the anxiety can be tolerated. The therapist can generate anxiety by his interpretations, silences etc. The theory could be used to hypothesise that the 'unconflicted' people are least able to cope with anxiety. Thus their role of alleviating anxiety. This possibility will be taken up later.

Another feature of the Bennis and Shepard model is their effort to integrate cognitive aspects (interpretation, understanding and insight) with affective aspects (dependency, intimacy and anxiety). The success of this integration may reflect the progress of the group.

Recent use of short term and marathon therapy (Gazda, 1968a; 1968b) has brought attention to the possibility that 'time' plays a role in the development of the group. Bennis et. al., claim that groups often work through a conflict because they know the group is about to terminate. The use of 'time' as a contributing factor in 'consensual validation' is a feature of this theory.
In brief then, Bennis and Shepard argue that group life causes anxiety over two basic issues; dependency and interpersonal relationships. A group's development can be gauged by the extent that the anxiety arising from these conflicts has been resolved. They propose a six subphase model to explain this group development, placing emphasis on the role of 'central persons', the therapist and cathartic experiences.

B. MARTIN & HILL (1957)

Whilst the Bennis and Shepard model of group development relied heavily on inferences (re dependency and intimacy), the Elmore Martin and William F. Hill model remains closer to the behavioural data and in so doing relies more on interactional dynamics. Even so, the influence of Bionic thought (through contact with H. Thelen and W. Dickerman) and psychoanalytic theory is noticeable, though not acknowledged in their theory.

These authors make the assumption, based on "empirical observation and theoretical conjecture", that therapy groups "have distinct and common growth patterns which are describable, observable and predictable" (Martin & Hill, 1957. P. 20). They describe these phases in terms of the key therapeutic problems the group faces and the behavioural data characteristic of each 'phase-problem'. They present, "A Scale of Group Development" (Ibid. P. 21), containing the six phases and their transitional periods. The model can be summarised as follows.
(a) Phase I - Individual Unshared Behaviour in an Imposed Structure

In this phase there is no interpersonal, group-relevant structure and this can be seen from the social isolation of the group members together with some minimal awareness of the therapist as leader or specialist. Individual idiosyncratic behaviour is stimulated by past experience, but the level of regressive behaviour depends on the nature of the members' pathology. Martin et al., suggest that dependency, cathartic experiences and transference responses are minimal.

(b) Transition from Phase I to Phase II

In this transition period members begin to acknowledge the leadership role of the therapist. Also there is an increase in 'asynthetic' behaviour (i.e. "some element in the statement of one member serves as a cue or trigger for statements made by the next speaker" - Ibid. P. 22). This asynthetic behaviour begins to establish 'oblique social contacts'. The therapist's mode of response is not asynthetic but reality oriented and 'person' centred.

(c) Phase II - Reactivation of Fixated Interpersonal Stereotypes

In this phase, the authors suggest that the 'transference' mode of response becomes clear. Members respond to each other in terms of previously learned stereotypes. 'Projection' is a common phenomena. Much of this behaviour is the previously learned maladaptive behaviour, which in the group, is again to prove an inadequate mode of responding. The authors suggest that 'dependency' on the leader is most apparent during this phase, as the inter-
personal anxiety begins to increase. Despite this anxiety, the 'social exchanges' which go on do have a therapeutically 'socialising' value.

(d) Transition from Phase II to Phase III

The dissatisfaction and inappropriateness of 'stereotype' responses leads the group to a position of inability to develop new patterns of behaviour. Resentment and tension are pointed out by the therapist, whose role is solidified by a "group consensus", rather than weakened by the fragmented 'idiosyncratic perceptions' of the members. The leader's role in helping to clarify the present stereotyping of members (especially of himself) leads members to a gradual appreciation of individual differences.

(e) Phase III - Exploration of Interpersonal Potential Within the Group

This leads the group to a more 'here and now', open interpersonal exchange. The group values individual differences. 'Problem-centred' exchanges appear calmer, whilst if the group participates in 'affect-laden' exchanges, then they are rapid and shifting. "In both cases the group task is to differentiate group members and give them recognition as individuals" (Ibid. P. 25). The therapist's skill and central position allow him to articulate individual motivations and perceptions, as well as providing a language and frame of reference for members to understand their behaviour.
Martin and Hill claim that many theorists would see, the 'we' feeling and group cohesiveness which facilitate the 'emotional feedback' and the increasing awareness of interdependence, that members develop during this phase, as the goal of therapy. They see the earlier 'abreaction' and 'socialising' phases as necessary preliminaries for this phase, in which individual change occurs.

(f) Transition from Phase III to Phase IV

The group closeness begins to wane and boredom with the exploration of interpersonal differences grows to a point where, once again, a transition is necessary. It is the therapist whom the authors see, as helping the group to change from the 'unilateral' to an 'inter-relationship' orientation.

(g) Phase IV - Awareness of Interrelationships, Subgrouping and Power Structures

In the give and take of interpersonal interactions, certain relationships have developed. The authors refer to pairing, symbiotic, hierarchial and complimentary relationships, which have developed, and which now become the "warp and woof" of the group. Problems related to leadership, the satisfaction of emotional gratifications in sub-groups and the polarisations and sub-group rivalries, become crucial issues which have to be resolved and understood if the group as an entity is to be maintained "to provide for their emotional gratifications" (Ibid. P. 27).

The authors claim that new learning and therapy occur to the extent that members can perceive the effects, "that their
emotional need-meeting have on their behaviour". (Ibid.) Again, Martin et. al., point to the central role of the therapist in identifying and clarifying these group phenomena.

(h) Transition from Phase IV to Phase V

The conflicting needs as represented by the subgroups leads to increased tension which the therapist can use to shift the group into phase V, provided he can "provide the group with some models and concepts for getting at group level abstractions" (Ibid. P. 28).

(i) Phase V - Responsiveness to Group Dynamic and Group Process Problems

If the therapist can intervene by providing concepts, then the members become aware that the group is an 'entity' or 'organism'. The authors see phase V as a growing understanding of and use of group dynamic concepts as a frame of reference for understanding individual problems and response patterns. Martin et. al., see this phase as similar to 'T' group and educationally oriented group dynamic therapy (cf. Durkin, 1964).

(j) Transition from Phase V to Phase VI

As the group comes to see that some of its 'intra' processes are dysfunctional, it endeavours to change some of these processes. Because the group members aren't proficient at this adaptive behaviour, the therapist again becomes the key to the transition. He explains, teaches and suggests techniques for
utilising group data in a 'problem-solving' manner.

(k) Phase VI - The Group as an Integrative-Creative Social Instrument

Realistic 'here and now' interactions which allow for individual differences and shared leadership are typical of this 'healthy' phase. The acceptance of roles by members reflects their increased self acceptance. The therapist is seen by the group, not so much as a leader, but as a 'resource person'. The authors summarise the groups functioning at this phase, as being capable of "co-operative problem solving diagnose its own process problems and develop techniques to handle them" (Ibid. P. 30).

Martin and Hill point out that although this model describes the development of the group, regression to early phases can occur, but as the group progresses to the later phases, such regressions are less harmful and disruptive, and can be easily handled by the group.

The first major issue to be discussed is the units or themes on which Martin et. al., propose their phase theory. These units are "described in terms of the major therapeutic problem confronting the group" and recognised by the characteristic behaviours which accompany, and presumably point to, these problems. These appear to be centred around; lack of structure, the rigidity of dysfunctional interpersonal behaviour, including relations with the leader, intolerance of individual differences, conflict between sub-groups over intimacy and power, and a lack of knowledge of group dynamics.
It can be seen that the familiar dependence - interdependence problems are central to their theory, as it was to Bennis and Shepard. However this theory does differentiate between the types of behaviour resulting from lack of structure, stereotyped and learnt behaviour, ideosyncratic behaviour and 'dependent' behaviour. The regressive nature of 'dependent' behaviour is contrasted with 'normal social exchange', which "should not be considered as necessarily pathological" (Ibid. p. 24). In brief, then, this model adds phases which makes it easier for the therapist to order the date of group development.

However, this theory has such an educational ring about it, that one gains the impression it was built on 'empirical observations' and theory from the training laboratory groups. This becomes particularly evident in phases 4, 5 and 6 where it is difficult to imagine one is reading a model of therapy group development. Still, it is interesting to speculate whether therapy groups develop to phases 5 and 6. The authors acknowledge this (P. 27), but postulate that if phases 5 and 6 were stated as the goal of therapy, and the therapist was capable of working professionally at that level, perhaps therapy groups could develop to these final two phases (Ibid. P. 28).

To concede this point would be to acknowledge the whole emphasise of this theory - i.e. that once conflicts and tensions are understood, they cease to be a source of deep concern. Like the Bennis et. al., model, this model sees the units or phases of development in terms of problems which gives rise to anxiety.
Whether this is a tension due to fixated behaviour, dependency, intimacy or power, Martin and Hill's theory sees the explanatory and teaching power of the therapist as resolving the issue and allowing the group to proceed to the next phase.

This of course may be possible, but some word of explanation seems necessary to understand how an issue which is a problem at one phase is no longer a cause of anxiety at the next phase. Perhaps the constant explanations gradually decrease the anxiety associated with the problem. Their theory may be interpreted that way. For example in relation to the resolution of the tension due to 'dependence' and 'stereotyping' the authors state: "The leader can aid and abet in this period by making the members more aware of discrepancies in this stereotyping of the leader" (Ibid. P. 24). However one interprets this, it seems that these authors don't see cathartic experiences as being central to group development and therapeutic progress.

The fact that Martin and Hill's theory of therapy groups stays close to observable behaviour may be one reason for the central role of insight and understanding. Also, if the therapist's interventions are communicated in language which is in the 'here and now', then one may expect this type of teaching intervention may be helpful. However, one is left with the question as to whether this type of intervention is enough to break the rigidity of neurotics and psychotics who attend therapy groups. The present writer doubts it.
The simplicity of this model allows one to make statements about the levels of group development. The 'phase-transition-phase' style of the theory, together with the stress on the role of the therapist in causing transitions makes it possible for a therapist to use this theory so that he may know "where the group is now and in what direction it might move and what within the group are the potentials to which he might attend to maximise development". (Ibid. P. 21). The problem of this theory being built on 'self fulfilling prophecies' must be recognised when using it. This is particularly the case, since the therapist is the crucial link between phases, in that his interventions move the group to a predetermined phase.

Another feature of this model of group development is that it seems to trace the growth of the group - i.e. the authors commence by describing the individuals in the group (phases 1, 2 and 3), but in the later phases they are referring more to the group as an entity in itself. This raises the issue; when is a group, a group? The authors point out that in phase V, "there is an awareness by the members of the group that the group is, in a sense, an organism" (Ibid. P. 28). This gives us a clue as to how they describe the development of the group, viz., the group develops from 'minimal groupness', characterised by unshared behaviour, asyndetic communication and idiosyncratic responses, to the group as an entity characterised by unity and optimal functioning.

The point being made is that the group develops to a point where the members recognise that it is an entity in itself.
They then seek to maintain this entity as if it were an extension of themselves. "Once the group has developed the ability to describe its own process and has found this desirable, there will naturally follow attempts to diagnose and remedy undesirable features that have been uncovered" (Ibid. P. 29). This point will be returned to in chapter five.

So group development in this model is seen as a progressive integration to a point where the "individual problems are reinterpreted as group problems" (Ibid. P. 29). The therapist responds to the group as an entity when the patients come to see the group as an entity. The phases of development outline a predictable way by which this point is reached.

The phases do not have a time sequence, simply an order sequence. Certain types of therapy groups may spend considerable time in phase II, where fixated interpersonal styles may well become the major task of therapy. As mentioned earlier, it is doubtful if some of the transition stages would happen as easily as described by Martin and Hill. Perhaps two factors which would effect the time sequence would be, the level of tension about a given problem and the regressive nature of members' dysfunctional behaviours in coping with the problem or conflict. These two factors would also affect the timing and effectiveness of the therapist's 'explanatory type' interventions.

One advantage with this model is, that its stress on the 'here-and-now', of interpersonal styles and group dynamics, makes the phases easy to recognise. In the first place the members have
the advantage of empirical feedback - i.e. feedback about their present and observable interactions. This may make learning easier. The therapist's interventions are such that they lead to the exploration of other 'here-and-now' situations and experiences as the group moves to the next phase. The lack of a set of symbols or terminology, that imputes causes to past events or unconscious motives, makes the learning of a new frame of reference easier.

This style of therapy may help the predictability of this model of group development.

In brief, Martin and Hill's theory of group development which is based primarily on interactional and group dynamic principles, propose that the group develops through six phases. The direction of the development is towards increased groupness. To accomplish this the group has to adjust to conflicts re rigidity and stereotyped interpersonal behaviour, dependence, individual difference, intimacy, power structures and sub-groups with vested emotional interests. This theory stresses the cognitive aspects of interaction. The central role of the leader and the 'educative' type interventions support this approach.

C. C.R. ROGERS (1967)

Just as the previous models were based on various theoretical orientations or school of thought (i.e. psychoanalytic-group dynamic, Bennis and Shepard; interactional-group dynamic, Martin and Hill), so our third model of group development is based on the assumptions of the 'client-centred' school of thought. These assumptions can best be summed up in Carl Rogers, "Necessary
& Sufficient Conditions:

"I have said that constructive personality change comes about only when the client perceives and experiences a certain psychological climate in the relationship. The elements of this climate ..... are feelings or attitudes which must be experienced by the therapist and perceived by the client if they are to be effective. The three I have singled out as being essential are: the realness, genuineness or congruence of the therapist; a warm accepting prizing of the client an unconditional positive regard; and a sensitive, empathic understanding of the client's feelings which is communicated to the client." (Rogers, 1965. P. 95-108).

Rogers most recent model of group development and group processes is presented in Bugental's, "Challenges of Humanistic Psychology" under the title: "The Process of the Basic Encounter Group" (1967). Though referring particularly to 'encounter groups', Rogers points out that this model satisfies a variety of groups from sensitivity to therapy groups (Rogers, 1967. P. 261). Because of this, as well as its contrasting orientation when compared with the previous models, it was chosen for discussion.

Below is a brief summary of the developmental group processes as postulated by Rogers (1967):

1. Milling Around: He describes the group as being confused, unstructured and frustrated. Interpersonal interactions and responses lack continuity. Early issues revolve around leadership, responsibility and group goals.
2. Resistance to Personal Expression and Exploration: Group members seem to reveal their 'public' selves, and any attempt to be too personal is met by ambivalent responses. This ambivalence cause group tension and distrust.

3. Expression of Negative Feelings: Usually some of the first open expression of feelings are negative ones, and are aimed at the therapist or sometimes at other group members. These negative feelings often reflect feelings of insecurity and dependence on the therapist. Rogers' example of a group of delinquents shouting for help (Ibid. P. 265) is aptly chosen to epitomise this phase of the group development.

4. Expression and Exploration of Personally Meaningful Behaviour: Rogers says that the group often swings from the expression of negative material to the expression of personally meaningful material. This later is expressed by one or two people. It would seem that this is a significant event in the group's life. Rogers claims: "The reason for this no doubt is that the individual member has come to realise that this is in part his group" (Ibid. P. 265). His expression of personal material reflects his desire to accept responsibility, says Rogers.
5. The Development of a Healing Capacity in the Group:
At this point it becomes obvious that there are some members of the group who show "a natural and spontaneous capacity for dealing in a helpful, facilitative and therapeutic fashion with the pain and suffering of others" (Ibid. P. 266). Rogers claims that this healing capacity .... "needs only the permission granted by a free flowing group experience to become evident" (Ibid. P. 266).

6. Self Acceptance and the Beginning of Change:
Those group members who had experienced the healing capacity of the group, learn to accept themselves as the group accepted them. Realness and authenticity begin to be noticed in the group. Rogers sees the individuals who have begun to accept themselves and be themselves, as "laying the foundation for change" (Ibid. P. 268).

7. The Cracking of Facades:
Rogers now sees a phase when the group begins to put pressure on group members who "live behind a mask and a facade". He claims that the group strives consciously toward deeper and more basic self expression. This appears to be a crucial stage in the development of the group, as it can be ruthless and violent, as well as, 'sensitive and gentle' in its quest for openness and genuiness.
8. The Individual Receives Feedback:
   In the group interactions which are now operative, much personal information and data becomes available to people. To the extent that this information is fed back into an accepting, caring, group context, Rogers claims, that it becomes highly constructive.

9. Confrontation:
   Rogers says that feedback is sometimes given in a confronting manner, when members 'level' with someone. Such confrontations are often negative and harsh.

10. The Helping Relationship Outside the Group Sessions:
    Rogers draws attention to the relationships which exist outside the group sessions. These relationships may be with group members or other significant people. He notes their help in generalising and stabilising the group learning.

11. The Basic Encounter:
    One of the most intense and change promoting contacts in group therapy is seen to be the 'basic encounter' ...... the 'I-thou' relationship. Rogers sees such intimate encounters as typical of the group at this stage of development.

12. The Expression of Positive Feelings and Closeness:
    As the group members express feelings, and to the extent that these feelings are accepted, a "great deal of positive
closeness and positive feeling results" (Ibid. P. 271).

Rogers says, that at this stage of the group's life, the group members accept both positive and negative feelings without suffering a diminution of self regard or self acceptance. Warmth and good spirit pervade the group.

Rogers claims that behaviour changes in the group have been occurring throughout the life of the group but more especially in more recent phases. Spontaneity and freedom contrast to the earlier phases where rigidity and tension pervaded the group. In these last phases Rogers says, that there has been an increase in openness, honesty, spontaneity, ownership of self, confidence, expression, and an ability to listen. (Ibid. P. 271-272).

The first thing to note in discussing Rogers' theory of group development, is his premise that the group has within itself the potential to actualise and grow, a premise which stems from his theory re individual therapy. This can be seen from the stress he places on the innate "healing capacity of the group", the presence of key people in phase 4, and the continual emphasis he places on the group members moving the group along by their various responses and developing attitudes of acceptance and openness. One may wonder why a therapist's presence is required at all!

If, for example, the group has an 'innate healing capacity', why doesn't it function from phase I? Why wasn't it functioning in the various groups these people live in, outside therapy? Rogers would see the answer to these issues in the fact that until minimal conditions of acceptance, regard and empathy
are present, such a 'healing capacity' doesn't function. Yet at the period in the group's development that the group's 'healing capacity' is operational, there has been little or no sign of these prerequisite conditions.

The writer tends to agree with the possibility of phases 1 to 5 as they are described in behavioural terms (i.e. what interactions and responses are happening in the group), but the explanation of these phases in terms of certain people taking responsible action while the group's 'healing capacity' supports this, seems logically unsound.

If it was argued that the therapist has been communicating the 'necessary and sufficient' conditions, then the data could be explained in terms the therapist's effect on one or two people. This of course would then see the interventions for change as coming from the therapist and not the group. In a sense this argument would tend to weaken the assumption of the 'healing capacity' of the group. Rogers would find unacceptable the charge that, the therapist controls the progress of the group. It seems that the supportive role of the group is obviously present, but to see group development in terms of group support may be a necessary but not sufficient condition.

The point being made is that where Rogers' model of group development, sees the progress of the group solely in terms of the capacity of the group and leaves out or underplays the crucial role of the therapist, then the model doesn't adequately explain the data of the therapeutic group.
The stress placed on the role of key members in phase 4, rests on the assumption that therapy groups are heterogeneous enough to possess such people. One has only to refer to study by Rogers and associates: "The Therapeutic Relationship With Schizophrenics" (1967), to note that therapy groups may not have any members who can take responsible action or respond to the group: "As to the therapy group, for a number of the patients who were particularly resistant to any helping relationship, the question might be raised whether they were actually in therapy at all". (Rogers, Gendlin, Kiesler & Truax, 1967. P. 82).

This of course throws the focus of attention on the role of the therapist in Rogers' model. Rogers would prefer to think of the theory as 'group centred', and this is a reasonable emphasis, provided it can be seen that the therapist gives the lead and effects the progress of a 'group centred on itself. His ability to do this is reflected in certain ways:

(i) He defines what therapy is, and sets up the criteria for group development. This can be seen by the fact that Rogers describes his first three stages of group development in terms of a 'lack' of openness, genuine expression and personal exploration. If, he were to point this out to the group or more probably, subtly communicate an emphasis by the nature of his responses (e.g. "You feel ......" or "You seem to be saying ......" or "Do I hear the group saying ......"), then the developmental phases of the group are being 'shaped' by these 'non-directive'
therapist to direct a relationship has been adequately demonstrated. (Truax, 1966).

(ii) He is the therapist, a role which is perceived by patients as that of a specialist. A denial of influence does not necessarily mean a lack of influence.

(iii) If the therapy group is to become a therapeutic system he must contribute in some way. To deny this would be to deny the need for the psychotherapists.

(iv) As pointed out earlier, Rogers' own theory of group development is logically unsound unless one has recourse to the role of the therapist.

Another assumption on which the phases of development rests, lies in Rogers' notion that when the group members begin to perceive the healing capacity of the group, and begin to accept themselves, they can then begin to change. Presumably 'change' here is defined in terms of changes in attitudes as well as behaviour. This being the case, then it may be said that even perceiving the healing capacity of the group or accepting oneself, is a change. As Gendlin points out: "In many cases, the client can perceive positive therapist (and group) attitudes only after the concrete personality change process has already occurred." (Gendlin, 1964. P. 136).

If this be so, then this model of group development is not so much a model of a group developing to the 'basic encounter' phase, where change occurs, but crucial and essential change is happening in the earlier phases, especially phases 4, 5 and 6.
It could be said that there are changes at two levels or about two key themes. In phases 4, 5 and 6 the group phases are characteristically centred on self acceptance and self exploration. In phases 7 to 11 the stress seems to shift to acceptance of others, interpersonal experiences and intimacy. Perhaps these are the two key areas which Rogers' model points to.

These points, and the preceding discussion on some of Rogers' assumptions, leads to a consideration of the actual phases or units of group development. The model is a loosely knit one as Rogers himself points out: "Some of these trends or tendencies are likely to appear early and some later in the group sessions, but there is no clear-cut sequence in which one ends and another begins" (Rogers, P. 263). So this model has a trend or direction about it, but it is so loosely arranged as to be both advantageous and disadvantageous to the therapist. The advantages seem to be in its adaptable style, the large number (12) of phases it spells out, and their easy recognition from the observable data. The disadvantage is that it underestimates the role of the therapist, it loses predictive power in phase movement and it doesn't account for all the observable data.

It should also be noted (as commented on earlier), that the criteria for the phases of development, is based on Rogers' assumption that a mature group is one that develops to 'basic encounters' and 'the expression of positive feeling and closeness', which he sees both as values in living and goals of therapy.
This of course means that the therapist using this model will only use interventions designed to meet these ends. 'Depth' interpretations, information gathering, diagnosing etc., will not be used. Once again the possibility that this theory, like the previous ones, is based on a 'self fulfilling prophecy' must be acknowledged.

One way of 'tightening up' Rogers' model without losing its distinctive characteristics, is to regroup his steps into phases. Such a possible arrangement could be as follows:

**TABLE 1:** Alternate Scheme of Group Development for Rogers' Model

<table>
<thead>
<tr>
<th>Suggested Phases</th>
<th>Phases in Rogerian Model</th>
<th>Description of Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I</strong></td>
<td>1 - 3</td>
<td>Unstructured, negative behaviour</td>
</tr>
<tr>
<td>Transition</td>
<td>4 - 5</td>
<td>'Key' people open up and the group supports them</td>
</tr>
<tr>
<td><strong>II</strong></td>
<td>6</td>
<td>Self acceptance &amp; Personal Exploration</td>
</tr>
<tr>
<td>Transition</td>
<td>7</td>
<td>Cracking Personal Facades</td>
</tr>
<tr>
<td><strong>III</strong></td>
<td>8 - 12</td>
<td>Interpersonal &amp; Basic Encounters</td>
</tr>
</tbody>
</table>

This rearrangement would retain the experiential aspects of the Rogerian model with its stress on the 'here and now'
behavioural data. At the same time it allows a reinterpretation of the group's development, which lends itself to more logical explanation.

For example, it is now possible to postulate that the 'key' members in the transition period opened up because they couldn't tolerate the tension resulting from the lack of structure. Their movement toward 'openness' could be shaped and reinforced by the therapist (c.f. Truax, 1966). The group support or 'healing capacity' could be seen as an expression of relief that someone had become the focus of attention, thus relieving their own anxiety.

The same process of tension building up could describe the 'Cracking of Personal Facades' phase again with the alleviation of anxiety leading to the 'basic encounter'.

It is interesting to speculate whether Rogers may have added another phase or set of phases, to handle the possibility of individual differences. It seems that this model develops to a point of 'groupishness' and 'closeness', but doesn't adequately explain how a person can relate intimately (as in the basic encounter) yet retain his separateness or individuality. The need for group therapy to develop this paradox has been noted by the existentialists. (e.g. Laing 1965, 1967). The claim that this occurs in phases 4 and 5 cannot be true, since phase 6 sets out to tear down people's fronts or facades.

Rogers doesn't see the group as an entity in itself. His theory appears to be a model of how people develop in the group,
rather than a model of group development. This has its advantages. Since this theory stays close to the experiential, conscious data of people's behaviour it is difficult to see the earlier idiosyncratic behaviour and the acceptance of personal explorations, as 'group' phenomena, unless some level of inference was used. It would seem that Rogers hasn't a theory on the group, but his use of the group and its development is more akin to those theorists who see the individual as the focus of attention in group therapy. (e.g. Slavson, 1960; Wolf & Schwartz, 1962).

Another feature of this theory of group development is the critical role played by the atmosphere, culture and relationship qualities which characterise the group as it progresses. There seems to be a gradual increase in the perception and expression of trust, understanding, acceptance, regard and genuineness, as the group develops. Whether these are causes of the group developing or results of previous development is debatable. One thing seems apparent, that is, these qualities are present in increasing strength and their presence is related to the growth of the group. The presence of such qualities has become a premise of a variety of therapeutic orientations (Munroe, 1955; Wolpe & Lazarus, 1966). The use of a scale to measure these qualities (Rogers et al, 1967) makes it possible to test this assumption. The stress on these qualities as being related to the development of the group seems to be a positive contribution of this theory. Its importance will be returned to in later chapters.
In brief then, the Rogerian model is more a theory of individual development in the group. The loosely knit phases keep close to the behavioural data, although some of the explanations for such phases seems to be logically inconsistent. The role of therapist, though important, is underplayed by Rogers who tends to see the development of the group as more of an actualising of the potential of the group itself. Though this also is an inconsistent argument in parts, it does emphasise the critical role of the group atmosphere and culture in aiding both individual and group progress.

D. CONCLUDING DISCUSSION

As Chapter 4 will be devoted to 'the critical issues in group development', this discussion will be brief. Therefore, some issues which will be given passing mention will be treated in depth in chapter 4.

Despite the fact that the units of group development were based on different criteria, viz.;

(i) covert affective characteristics (in the Bennis and Shepard model),

(ii) interactional characteristics (in the Martin and Hill model), and

(iii) 'here and now' experiential data (in the Rogerian model), it is possible to see some similarity and areas of agreement between the three.

It does seem that in the development of a group, three areas become centres of concern or tension. These three units
could be tentatively formulated as follows:

(i) Dependence; which is reflected in the way members come to terms with the role of the therapist and his mode of leadership.

(ii) Interdependence - Power; which can be noted by the way people learn to adjust to different group members and sub-group alignments.

(iii) Interdependence - Intimacy; which is reflected in the concepts and behaviours, 'pairing' and 'basic encounters'.

By ordering the three models, it is possible to see a model which would encompass the three theories previously considered.

**TABLE 2: Scheme of Group Development for Three Linear Models**

<table>
<thead>
<tr>
<th></th>
<th>Bennis &amp; Shepard</th>
<th>Martin &amp; Hill</th>
<th>Rogers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unstructured Phase</td>
<td></td>
<td></td>
<td>Milling Around</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependence Phase</td>
<td>Dependence v</td>
<td>Reactivation of Fixated Interpersonal Attitudes</td>
<td>Resistance to personal exploration: Expression of Negative Feelings</td>
</tr>
<tr>
<td></td>
<td>Counterdepend-</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ence.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phase</td>
<td>Bennis &amp; Shepard</td>
<td>Martin &amp; Hill</td>
<td>Rogers</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>Transition Phase</td>
<td>Resolution of Dependency</td>
<td>Leader points out discrepancies in stereotyped behaviour.</td>
<td>Personal Exploration by 'Key' people: The 'healing capacity' of the group. Self acceptance.</td>
</tr>
<tr>
<td>Interdependence - Intimacy Phase</td>
<td>Consensual Validation: Pairing &amp; Understanding</td>
<td>Consciousness of Subgroups &amp; Group Processes</td>
<td>The Basic Encounter: Expression of Positive feelings &amp; Closeness.</td>
</tr>
</tbody>
</table>

The interesting feature about this paradigm is that
Despite a difference in orientation and assumptions about therapy, pathology and group life, these three authors seem to be saying much the same thing about the units or phases of group development. That the sequence is dependence - power - intimacy is noted. A more recent model, that of Kaplan and Roman (1963), suggests a similar order. The parallel to Freudian 'epigenetic' group psychology, may support the notion that groups develop somewhat akin to the way individuals develop.

If the idea, that individual and social systems (groups) develop through similar conflicts or issues, be plausible, then it is possible to see why Bennis and Shepard can treat 'the group' in therapy. As the group learns to adjust to these three conflicts, the individuals in the group are resolving their personal conflicts in the same areas. This would support the argument that treating the group was helping the individual. It would also be the basis on which one could understand that as the group developed, the individuals in the group developed.

It does not seem so surprising then, that while Bennis et. al., can see the group as an 'entity' developing through certain phases, Martin et. al and Rogers can conceptualise the same data, in terms of, individuals in the group developing through certain phases. The fact that their perspectives of the same phenomena is different, doesn't make any of their theories, more or less plausible. The argument; 'the group' versus 'the individual in the group' in group therapy is not new (Scheidlinger, 1960; 1967: Slavson, 1960: Arsenian and Semrad, 1967). This discussion
concludes that either perspective can explain the observable data.

Another question arising from a consideration of linear models is, "At what particular phase of development does individual change occur?" As mentioned earlier, Rogers sees 'self acceptance' as a requisite step prior to change. It was argued, however, that for a person to come to accept himself, some change must have already taken place (presuming he entered the group as a 'non-accepting' person). Therefore, it seems that change is a gradual process. As the group changes the person changes. Another way of conceptualising individual change in the group stems from the discussion above, i.e. perhaps there are areas or sources of conflict which the individual learns to adapt to. In this way 'change' could be regarded as a series of 'changes' in critical areas of human functioning, viz., dependence and interdependence.

The linear models of development which have been discussed, do allow the therapist to predict what interventions will help group progression, what individuals in the group may facilitate group progress and what phase of development the group will move to. However the reliability of such predictions is tempered by the fact that these phases are not always clear cut. This seems particularly the case with the Rogerian model where interventions which prompt group movement are claimed to come from group members. In this model and to a lesser degree in the Bennis and Shepard model, the predictability of timing in phase progression is lessened. In fact, as noted earlier, the absence of 'central persons' in the latter model may cause the group progress to
'founder'. Prediction seems more accurate in the Martin and Hill model where the responsibility of group phase transitions is mainly in the hands of the therapist.

Another factor lessening predictability is the 'regressions' which occur from time to time. All three sets of authors note that the group may 'slip back' at times into previous modes of responses and interaction, but this possibility decreases as the group progresses. Where it does occur in later sessions, the group seems more capable of adjusting. So, although statements being made about particular modes of behaviour usually indicates the level of development of the group, this may not always be valid, due to periodic regressive swings. A good example of this can be seen in Bennis and Shepard. They report about late subphase 4 behaviour: "There is a certain uneasiness about the group; there is a feeling that 'we should work together but we cannot'. There may be a tendency to regress to the orientation of subphase 1: group members would like the trainer (therapist) to take over." (Bennis et. al. P. 430).

Perhaps these tendencies and regressions, together with the fluctuating role of anxiety and tension may be reasons why some authors see group progress not in terms of linear development, but in terms of cyclical and recurring themes. It is to these types of models that we now turn.
CHAPTER 3

CYCLICAL THEORIES OF GROUP DEVELOPMENT

Where the linear models describe the life of the group in terms of particular content or affective themes, conflicts, patterns of interaction or sets of experiences, which typify the group at various stages of its history, by contrast, the cyclical models tend to describe the life of the group in terms of regular and repetitive cyclical themes, interactions and/or experiences. For example, where some of the linear theorists see 'dependency' as a theme which must be handled and resolved early in the group's life, the cyclical theorists may postulate that such a theme comes to the fore from time to time throughout the group's life. This and other examples will be dealt with in detail in chapter 4.

Two well known cyclical models, that of Wilfred Bion (1961) and Whitaker and Liebermann (1964), will be presented in this chapter. Both theories endeavour to order the apparent variety of behavioural data, which the history of a group offers, by showing both the repetitive, cyclical characteristics as well as the underlying progressive shifts the group makes. Both theories will be summarised and discussed, and the chapter will conclude with a discussion of some central issues raised by both these models.

A. BION'S MODEL

Wilfred Bion (1961) does not set out a formal theory of group development for psychotherapy groups, but an 'equilibrium-cyclical' model of group development seems implicit in his collected
papers, "Experiences in Groups" (1961), where he describes the group as being in a constant state of change, shifting from one 'basic assumption culture' to another. (Thelen, 1954; Whitaker and Liebermann, 1964). The summary which follows is the writer's impression of Bion's theory of group development, which seems implicit in his writings.

Bion's theory indicates that the life of a group at any given moment can be described in terms of:

(a) the basic assumption group ('ba'), and
(b) the work group ('W').

(a) The Basic Assumption Group ('ba')

In studying and observing 'group culture', Bion found that in many situations the entire group seemed to be permeated by fairly clearly defined emotional states. The group structure, attitudes toward other group members and the ways of coping with group problems, seemed to reflect a basic belief (seldom conscious) held by the group members and from which modes of action derived. This was the basis for suggesting three 'basic assumption groups', each of which giving a peculiar character to the group social structure, group methods of functioning and the emotional complexion of the group. (Sherwood, 1964).

So, Bion says that the group can act "as if";

(i) it has met for the specific purpose of attaining security through and have its members protected by one individual. It implies the presence of a leader who is
omnipotent and omniscient, and members who are inadequate and immature. This is the basic assumption group of 'dependency'. ('ba D'),

or

(ii) it has met for the specific purpose of preserving itself and it can do so by fighting or running away from someone or something. Action is essential. It implies the presence of a leader who can mobilise the group for attack or lead it in flight. This is the basic assumption group of 'fight-flight', (ba F),

or

(iii) it has met for the purposes of reproduction, to bring forth the Messiah. This is performed by two people getting together on behalf of the group to carry out the task of pairing and creation. It is characterised by hopeful expectation. This is the basic assumption group of 'pairing' ('ba P'). (Rioch, 1970).

According to Bion's theory, the life of the group at any particular time is characterised by the presence of one of these basic assumptions, while the other two are latent during that period. Though differing in structure, methods of functioning and emotional complexion, these three 'ba' groups have certain common structural and functional features. They can all be said to be; non-rational, spontaneous, involuntary, represented symbolically, indissoluble, timeless, unorganised, regressive, unconscious, unreal, affect-laden and having a shared source of direction or leader.
(b) The Work Group (W)

The life or development of the therapy group can be characterised by the role of the Work Group (W), which is that aspect of the group functioning related to the formal task of the group, i.e. therapy. It is aware of its purpose and can define its task. The structure of the group is functional for the task. Its characteristic features contrast to the 'ba' group, in that it is voluntary, co-operative, planned, rational, scientific, reality oriented, cognitive, responsive to experience, capable of conceptualising and formulating experiences as well as taking appropriate action, and may or may not require a leader. (Sherwood, 1964).

From this it can be seen that Bion's theory of group development implies both a cyclical and a linear model of group development. Following Whitaker et. al's., suggestion (1964), we shall be treating Bion's model as a 'cyclical-equilibrium' model. However, a comment about its inherent linear properties seems appropriate here. These propositions will be dealt with in more detail in chapter 4.

According to Bionic notions, a therapy group develops toward a better integration between the 'ba' group culture and the 'W' group culture. As the group develops, the following trends may be noticeable:

(i) The group becomes more aware of and expresses a conscious recognition of the 'ba' culture on which it is operating.
(ii) The group uses this 'ba' culture in the service of the 'W' group.

(iii) The group recognises the task of the 'W' group.

(iv) There is a better integration between the 'ba' and 'W' groups.

(v) Periods of regression would occur, but the 'ba' group becomes more amenable to recognition, understanding and integration by the 'W' group.

These features contrast with the earlier life of the group which would have been characterised by the predominance of the irrational 'ba' groups with their structural and emotional features mentioned earlier. In the early life of the therapy group no integration with the 'W' group would have been apparent. Bion points out that the extent of the regressive emotionality of the 'ba' group may go beyond the 'neurotic' group culture typical of 'ba' groups, to a 'sick, psychotic' group culture governed by 'primitive fears' (P. 164-165).

The progressive features of the group, as described by Bion, is also obvious in cyclical nature of his theory of group development. Bion assumes that the history of the group "can be understood as the emergence, development and subsidence of successive basic assumption cultures" (Whitaker et. al. 1964. P. 247). The 'ba' groups recur and repeat themselves. At any moment there is a balance or 'equilibrium' which can be disturbed and changed at either of two levels:
(i) 'ba' Group level: Each basic assumption culture involves certain inherent emotional satisfactions and threats. They exist in shifting balance. Whilst one 'ba' is functioning, the other two exist in a latent state. However, to the extent that the current or focal 'ba' culture begins to be consciously expressed, interpreted or responded to provokingly, it builds up tension and anxiety. To avoid the extreme state of a 'sick psychotic' group reaction, the group shifts to behaviour and emotionality, characteristic of one of the other 'ba' cultures. Thus the process; equilibrium - shift - equilibrium. Therefore, to the extent that the 'ba' group is confronted with any anxieties inherent in that 'ba' culture (e.g. guilt, fear of leader, etc.), the heightened tension eventually causes the group to shift to another 'ba' culture.

(ii) 'ba-W' Combination: The shifts from one 'ba' culture to another is related to the 'ba-W' relationship. Regardless of what 'ba' culture is operative at the time, it is related in some way, either in a facilitatory or debilitatory fashion, to the 'W' group or culture. Thus a therapy group may momentarily find a 'balance' between the 'ba' and 'W' groups, but shifts from one 'ba' to another occur, when the relationship between; the developmental features of the 'W' group (e.g. interpretation, insight, conscious recognition of a 'ba'), and, the
regressive features of the 'ba' group, produce intolerable anxiety.

In brief, then, Bion does seem to see the life of the group developing progressively from a group in which the 'ba' cultures predominate and fluctuate rapidly, to a gradually maturing stage when the group is characterised by 'ba' cultures which are recognised, in the service of and integrated with the 'W' group, whose task is the therapeutic orientation and progress of the group. Bion sees this progression and development, not in phase units, but in terms of successive and recurring 'ba' culture units, each of which gives way to the other in repetitive fashion, and according to the regressive nature of the current 'ba' conflict or focus of anxiety.

In discussing Bion's theory, it will be necessary to critically examine his units of group progress - viz., the 'ba' cultures, since the classifications he uses to order the behavioural data of the group are primarily the three 'ba' cultures. In the development of the therapy group, these 'ba' cultures do not occur in any order or combination. Bion suggests that their lawfulness is in terms of their recurring nature. However, this does not allow the therapist to predict which 'ba' culture will operate next, nor, which type of therapeutic intervention except 'interpretation', will help the group to resolve the current 'ba' tension.

However, an even more basic issue needs consideration. The very validity of the construct, 'ba' culture, has been
questioned. Bion claims that the 'basic assumption' follows from the emotional states of the group and not vice versa: "I consider the emotional state to be in existence and the basic assumption to be deducible from it." (Bion, 1961, P. 94). Yet, he also claims that the emotions or feelings are bound in "indissoluble combination" which seems to indicate that the basic assumptions are more primary than the emotions, since they order the feelings into 'indissoluble combination. Further, if this were not so, many possible combinations of emotions may permeate the group at various times.

Bion, himself, appears unable to escape this dilemma, for in discussing 'pairing' he contradicts his position: "..... and the emotions derived from the basic assumption that two people can be met together for only one purpose .....". (Ibid., P. 62).

This theoretical contradiction poses a problem for the person endeavouring to use Bion's system in attempting to understand the development of the therapy group, viz., 'if the group therapist the basic assumption groups by the 'indissoable combination' of the emotions, then do the three basic assumptions account for all the behavioural data of the group life?' Bion's evidence for choosing three basic assumptions is unconvincing (Bach, 1962), although, admittedly, Bion only 'adumbrated' three categories.

Sherwood (1964) critically examines these issues and sums up: "The theory seems to have explanatory power only if these basic assumptions are taken to be the fundamental and determining
factors; yet there is no convincing evidence that they are in fact observed phenomena. If however, they are a priori premises or even simply descriptive labels, instead of empirical propositions, then they appear rather arbitrary and lose their explanatory power". (Sherwood, 1964, P. 120).

Another issue arising out of Bion's 'ba' cultures, is their recognition by the therapist. As mentioned earlier, each 'ba' group acts 'as if' it requires a certain type of leader (omnipotent, unbeatable, uncatchable or marvellous). However, when interpreting the 'as if' qualities, Bion suggests that the therapist base his therapeutic interpretations of the operative 'ba', on his own subjective reactions. "..... in group treatment many interpretations, and amongst them the most important, have to be made on the strength of the analyst's own emotional reactions. It is my belief that these reactions are dependent on the fact that the analyst in the group is on the receiving end of what Melanie Klein (1946) has called projective identification and that this mechanism plays a very important role in groups" (Bion, 1961. P. 149). The difficulty of using a therapeutic model based on the therapist's subjective experiences and his perceptions of his own and other behaviour and experiences, has long been a difficult area in group therapy. (Glatzer, 1966; Mullan, 1955; Slavson, 1954; Loeser and Bry, 1953).

So it can be seen that four issues confront a therapist endeavouring to use the 'ba' concepts of Bion's model of group development. The therapist is not sure;
(i) whether the three basic assumption cultures adequately explain the complex emotional data of the group,

(ii) whether the emotions or the 'ba' cultures are theoretically more primary.

(iii) whether he, as the 'object' of the 'ba', is capable of handling the countertransference involved in interpreting the 'ba' cultures on the basis of his own emotional reactions, and

(iv) which 'ba' can be predicted to follow the present one, or which intervention can successfully resolve the present 'ba' tension.

It does seem from these issues that a consideration of the 'ba' cultures by themselves is of limited use in understanding the development of the group. However, Bion's theory of group development does have value when the relationship between the 'ba' groups and the 'W' group is considered.

As mentioned earlier, the early sessions of a group's life are characterised by a predominance of the 'ba' culture at the expense of the 'W' group. As a result of;

(i) the increasing tension and anxiety leading to the shifts in the 'ba' cultures and the subsequent decrease in anxiety, as well as,

(ii) the continual interpretative interventions by the therapist,

the therapy group gradually begins to integrate the 'ba' and 'W' groups, so that eventually the 'ba' group is at the service of the
'W' group. Rioch (1970) comments on this developmental aspect of the group life as seen by Bion: "He (Bion) thinks that in groups met to study their own behaviour, consistent interpretation of the basic assumption tendencies will gradually bring them into consciousness and cause them to lose their threatening quality. The parallel here to the psychoanalysis of unconscious impulses is clear. Presumably, the more the 'ba' life of the group becomes conscious, the more the work task can emerge into effective functioning" (Rioch, 1970. P. 64-65).

Bion, gives the impression that provided the therapist's interpretation of the 'ba' group is cognitively correct, and is consistently pursued, then the 'ba' and 'W' groups will gradually integrate. His theory doesn't explain;

(i) the role (if any) of the therapeutic culture, atmosphere or relationship, or
(ii) the way in which anxiety is handled progressively, except by movement from one 'ba' group to another.

These two points seem important, because as the three 'ba' are unchangeable, then their resolution by conscious insight into their functioning, can only come about to the extent, that the anxiety aroused by them, is constructively handled. According to the Bionic theory, the anxiety is handled by a shift to another 'ba' culture. No explanation is given as to whether the anxiety itself changes, so according to the model the shifts could go on 'ad infinitum', with no insight or change in the level of 'ba'-'W' integration. As to whether the anxiety is related to the group
'atmosphere' is given scant attention. Presumably, interpretation and cognitive insight increase as the group develops. How this happens is not satisfactorily explained.

B. WHITAKER & LIEBERMANN: The Focal Conflict Model

In a series of articles (1958, 1960, 1962) culminating in their work, "Psychotherapy Through the Group Processes" (1964), these authors have built a theory of group psychotherapy based on the concept of the 'group' as an entity in itself. To meet group therapeutic requirements they utilised French's psychoanalytic 'focal conflict' theory. (French 1952, 1954).

A very brief summary of some key concepts is presented. They theorise that a group can be described at any given moment in its life by a description of its four covert, shared elements, viz.,

(a) The Group Focal Conflict: "..... is a unit of the group life encompassing the period during which a single disturbing and reactive motive dominates the group situation. The unit is terminated by a successful solution". (Whitaker et. al. 1964. P. 24).

(b) The 'disturbing motive'.

(c) The 'reactive motive'.

(d) The group 'solution'.

The nature and character of these covert factors and shared concerns may be appreciated from the following propositions.
"The sequence of diverse events which occur in a group can be conceptualised as a common, covert conflict (the group focal conflict), which consists of an impulse or wish (the disturbing motive) opposed by an associated fear (the reactive motive). Both aspects of the group focal conflict refer to the current setting."

"When confronted with a group focal conflict, the patients direct efforts toward establishing a solution which will reduce anxiety by alleviating the reactive fears and, at the same time, satisfy to the maximum possible degree the disturbing impulse" (Ibid. P. 19).

The group solutions are shared and reduce reactive anxieties. They may be;

(i) restrictive; i.e. alleviate fears but only at the expense of not satisfying the disturbing motive, and

(ii) enabling; i.e. alleviate fears and at the same time as satisfying the disturbing motive.

The 'Focal Conflict' model of group development is built on these concepts and is characterised by two features:

(i) "Certain basic issues recur during the life of the group" (Ibid, P. 116), and find their symbolic expression in the 'here and now' material of the group.

(ii) "The culture of the group changes during its life." (Ibid, P. 116). The 'culture' of the group refers to the appropriate behaviours, ways of thinking and respond-
ing which lead to successful solutions to the group focal conflicts taken collectively. It is similar to group norms, standards and expectations related to the therapeutic process.

Whitaker et al., summarise their theory of group development as follows: "The development of a therapy group from its inception to its termination is characterised by the recurrence of basic themes under progressively expanding cultural conditions" (Ibid, P. 117).

Though these authors stress that their theory of group development is an 'equilibrium' model, comparable to Lewin's quasi-stationary, equilibrium model, and Bales' action-reaction equilibrium model, they still describe a two phase linear theory of group development. They see this as of secondary importance to their main progressive cyclical theory of group development. However, a summary of their 'two-phase' theory is presented.

The two phases of group development are;

(i) the formative phase, in which a variety of themes emerge and are seen for the first time. A group culture is rapidly established and is characterised by the dominance of restrictive solutions. The initial focal conflicts and their solutions are seen as central to the establishment of the group culture, since they offer ways of handling patients' anxieties about expectations concerning groups and group therapy, the composition and structure of the group, as well as early solutions them-
selves which become a source of anxiety.

(ii) the established phase, in which old themes recur, basic wishes and fears remain essentially the same and are dealt with repeatedly. This phase is characterised by continual shifts and adaptations of the group culture, which includes both restrictive and enabling solutions. However, as the group life continues to develop, enabling solutions begin to predominate. Whitaker et. al., see confidence and trust in the therapist, and the implicit assumption of 'basic likeness', as the two key enabling solutions, which can be helpful in solving a wide variety of focal conflicts. Restrictive solutions, such as projection, intellectualisation and flight still operate as 'safety valves' when anxiety about focal conflicts becomes intolerable.

However, Whitaker et. al., stress that their theory of group development is quite different to the linear phase development models in that their central concept is the 'group focal conflict' which they see as explaining both the stability ('equilibrium') and the change ('progression') components of group development. Using the four key concepts reviewed earlier, they argue that a change in one part of their three factor system (disturbing and reactive motives, and the group solution), leads to a change in the whole system (i.e. the therapy group). Since the group can be conceptualised at any moment in terms of a 'disturbing motive', a 'reactive motive' and the current 'group solution', any intensif-
ication of the disturbing motive, or a decrease in the anxiety associated with the reactive motive, or a new group solution, will affect the group as a system.

In this way, they use their 'equilibrium' model to explain group progression. "We use an equilibrium model to account for the manner in which the group moves toward and away from pre-occupation with a single theme and shifts from one theme to another" (Ibid. P. 245).

A feature of this group model, is that the group solution is not the 'passive product of opposing forces' (c.f. Lewin), but is a dynamic functional component of the system, exerting a force of its own. It is a coping device and is thus functional for the group. Also the group solution is not a purely defensive device, but in view of its dynamic role in the system, it has a "defensive-enabling function" (Ibid. P. 248).

Since the 'unit' of group development is not seen in terms of linear phase movements, but in terms of recurring 'group focal conflicts' and their 'successful solutions', it can be seen that a group may encounter innumerable such recurrent units in its development. Whitaker et. al., realise this, and they endeavour to add to the lawfulness of their classificatory system by ordering 'related group focal conflicts' under the concept of the 'group theme', which they define as, "a sequence of related focal conflicts linked by the same or closely related disturbing motives" (Ibid, P. 248).
They give as an example of a 'group theme' in an adolescent group, "Sexual Feelings about the Therapist" (Ibid. pp. 75-93), and conclude, "Within a single theme, movement occurs toward and then away from direct expression of the disturbing and reactive motives. Such movement is determined by the character of the successful solutions." (Ibid. P. 89).

The authors make it quite clear that their 'group theme' is not based on content or topics, but on "the affective characteristics of the group" (Ibid. P. 248), i.e. the covert emotional dimensions of the group. The 'group theme', like the smaller unit of group development or progression, viz., the group focal conflict, is cyclical and recurring over time. They offer no suggestion that specific 'group themes' characterise early, middle or late sessions in the life of a therapy group.

The development which does occur is toward a more direct exploration of the 'group theme'. Using the terms of the 'focal conflict' model, one could say, that as enabling solutions are established, more direct expression of the disturbing motive occurs until anxiety interferes with the process. Then the group attempts more adequate solutions, sometimes involving restrictive ones. Movement away from exploration then occurs. One essential feature of this model, then, is that the progressive development of the group is related to the recurring themes, and the changing and expanding group culture.

Whitaker et. al., don't envisage a group reaching a stage of maturity. Perhaps to do so would contradict the central
importance they place on 'equilibrium' and the character of their therapy groups, which they see as always dealing with recurring focal conflicts and group themes in a gradually expanding group culture. Progression (enabling solutions) and regression (restrictive solutions) typify all sessions, although the regressive type solutions seem more representative of earlier sessions, whilst progressive type solutions become more characteristic of later sessions.

In discussing this theory it must be noted that Whitaker et. al., assume that, just as an individual's current behaviour can be understood in terms of his solutions to his focal conflicts, so a group's behaviour can be understood in similar terms - viz., its tensions, focal conflicts and solutions. This assumption was based on French's work (1952). Further, the assumption that a group as an entity in itself triggers off certain focal conflicts in members, may have resulted from Bion's work, since Thelen whom Whitaker worked with in the 1950's, "was the first to put Bion's group psychoanalytic concepts to experimental test" (Durkin, 1964, P. 37). This background gives the Whitaker and Liebermann model a set of psychoanalytic assumptions re the nature of focal conflicts and their etiology.

This can be seen from statements such as, that they "assume that a subsurface level exists in all groups" and, "that the successive manifest elements of the session are linked associatively and that they refer to feelings experienced in the here-and-now situation". (Whitaker, et. al., P. 16).
As mentioned earlier, it is around these shared unconscious aspects of the group process that these authors build their theory of group development. However, as there are innumerable possible focal conflicts (e.g. Ibid. PP. 14-38; 120-126), the model loses much of its power. The fact that the authors noted this and strengthened their theory by using the 'group theme' has been noted. However, the distinction between these concepts (i.e. focal conflict and group theme) becomes blurred by such statements as, "No matter how long the group goes on, the patients are recurrently confronted with such basic issues as how to manage anger constructively, how to be aware of emotions without being overwhelmed by them, how to maintain integrity of self yet enrich life through interdependence with others, or how to manage close personal relationships" (Ibid. P. 116). Presumably these are some key 'group themes', yet how one orders the 'focal conflicts' into these themes is left unstated.

It appears also, that neither the 'focal conflict' nor the 'group theme' are of much use at the predictive level - i.e. they don't function in any particular order, or combination, either in the 'formative phase' or in the 'established phase'. Any theme or conflict can become an issue at any time and may recur in unpredictable fashion. As such, this classificatory system would be unable to explain the development of the group in any sequential order, since a knowledge (or rather inference) about the particular group focal conflict or group theme, which was operative at the time of inquiry, would say little about the development of the group.
Their theory however, does partially counteract this deficiency by use of another concept; 'group culture'. "...... the culture of the group changes during its life; the standards which govern possible content and permissible feelings are continually evolving. On the whole, these progressive shifts in group culture tend to broaden the group's boundaries. As the group goes on, solutions are likely to allow the patients to talk more directly about a broader range of topics and to express more frankly, feelings about one another and the therapist". (Ibid. P.116).

So the notion of 'progressively expanding cultural conditions' seems to indicate that the group's level of awareness and expression of focal conflicts and group themes could be a measure of the development of the therapy group. This would combine the recurring-cyclical feature of this model with a linear progression dimension.

However, one is still left with the issue that results from the psychoanalytic assumptions of this model - i.e. the units of group development (focal conflict, group themes and expanding culture) are "units based on the affective characteristics of the group" (Ibid. P. 248). Consequently, in using such concepts to gauge the development of the group, one is engaged in locating emotional signs of the disturbing and reactive motives as well as the affective signs of the group culture, which are reflected in the manner in which these motives are expressed.

Unfortunately, the authors give no particular theoretical or methodological criteria for locating such emotional character-
istics stating, "..... because of his special training (presumably in psychoanalytic type therapy), experience and perspective in the group, the therapist is in a position to see aspects of the group that the group cannot see". (Ibid, P. 195). Presumably, the crucial 'aspects' are the focal conflicts: "..... the therapist's unique perspective makes him the only person who can intervene from a position outside the group focal conflict". (Ibid. P. 195).

'Group culture' seems to hold a central place in the understanding of the nature of group development, according to the Whitaker and Liebermann model. A feature of the group culture is the nature of the successful solutions. As mentioned earlier, a solution, whether it be restrictive or enabling, is successful if it is shared by the group and reduces anxiety. So, to the extent that 'enabling solutions' predominate the group culture, then according to the 'focal conflict' theory, the group has developed well into the "established phase".

In contrast to the affective units of group development which were discussed above, Whitaker et. al., do give two criteria for the recognition of a group culture predominated by enabling solutions:

(i) The extent to which the therapist is trusted and relied on to maintain a therapeutic atmosphere.

(ii) The extent to which people are prepared to see themselves in relation to the current focal conflict.

In this way the 'focal conflict' theory does allow one
to gauge the development of the group by the extent to which members; have become aware of focal conflicts, can handle covert motives realistically, and trust the therapist.

From this it can be seen that these authors see the role of the therapist as closely related to the development of the group. From the discussion so far, it can be seen that the theory offers no specific phase movements (save two general ones) which could help the therapist. Specific statements about group movements seem too difficult to make. An example may help. Suppose the manifest behavioural data led the therapist to infer that the operative group focal conflict was centred around;

(i) the disturbing motive of a wish to be close to the therapist (involving a mixed sexual-dependent relationship), and,

(ii) the reactive motive of fear of the therapist being punitive or showing favouritism.

Any of the various interventions suggested throughout their book, may be used by the therapist to help the group resolve this group focal conflict. (See Chapter 9: 'Strategy, Position & Power'). However, in terms of their theory of group development, the therapist couldn't predict from his own, or members'; interventions;

(i) whether an enabling or restrictive solution would result,

(ii) whether the group solution will be a successful one,
(iii) what focal conflict will next arise,
(iv) whether the next focal conflict will be part of the present 'group theme', or
(v) whether the intervention will commence a new 'group theme', and if so,
(vi) what that group theme would be, and,
(vii) whether the group culture would be more 'enabling' or 'restrictive'.

Experience may well help the therapist to predict such outcomes, but Whitaker and Liebermann's theory doesn't.

Two possible comments could be made re this issue:

(i) Though the therapist may appear to be at a disadvantage, the theory doesn't allow the therapist to employ a 'self fulfilling prophecy' - i.e. it doesn't allow the therapist to know which phase, focal conflict or group theme comes next, and on the basis of this knowledge, select an intervention to reach this predetermined phase, focal conflict or theme. The theory allows the group to develop its own themes, based on its own particular needs and motives, and not on a pattern of needs which a set theory of group development may tend to predetermine.

(ii) Some type of 'self fulfilling prophecy' may be inevitable, since the central position of the therapist, as outlined by the authors in Chapter 9: 'Strategy, Position & Power', indicates that whatever intervention the therapist
performs will effect group functioning in such areas as, anxiety level, content, focus on himself or a particular group member etc. This is somewhat different to point (i), in that his role demands intervention if he is to help the group and its members.

To the extent that his interventions are promoting enabling solutions to group focal conflicts, the therapist may be more certain that the group culture is expanding and that these interventions are facilitating the positive change and development of the group and its members.

C. CONCLUDING DISCUSSION

It is not surprising that these two models of group development have some similarities, since, as has been pointed out (P. 58), they are related historically through the work of Herbert Thelen.

Firstly, they conceptualised their 'units' of group development or progression in terms of the emotional - affective characteristics of the group's life. As such, both Bion's 'basic assumption' culture and Whitaker et. al's., 'group focal conflict' were inferences about covert affective factors, which were drawn from the varied content and interactions of the group members. In a sense, both theories postulated that the group acted at an 'as if' level, and that the 'here and now' behavioural data could be meaningfully classified and understood in terms of these 'as if' concepts or inferences. As with all inferential, psychoanalytic-type categories, the greater the inferential level the more
validity can be questioned. (Levy, 1963).

Beside the issue as to the validity of such interpretative units of group development, a related issue is the recognition of such affective dimensions of the group's life if appropriate therapeutic intervention can proceed. Bion, suggests that the 'basic assumption group' can be recognised by a subjective method (i.e. the therapist recognising and responding to his own emotional reactions which the group triggered off). This has an advantage, in that it may account for the ways by which a group manipulates a therapist, but it presumes that the therapist is a valid and reliable measure of such a covert group need.

Whitaker et. al., realise this 'counter-transference' problem of having a therapist involved as part of the group or system yet able to act objectively. They endeavour to position the therapist as part of the therapeutic system at one level (affective level), yet having another, more objective, perspective of the group at the cognitive level: "The therapist views the group from a unique position. Though not usually participating in the generation or expression of the focal conflict, he experiences the affect involved in it. Thus, he is in emotional touch yet stands outside the conflict and can observe its character and course". (Whitaker et. al. P. 194).

How the therapist can be 'involved' yet 'stand outside' is a key issue, in the area of recognition of affect. Bion sees the therapist's subjective involvement as a criteria for the recognition of a basic assumption culture. Whitaker et. al.,
endeavours to position the therapist in some type of 'co-existence'. The critical issue of the therapist's role in the development of the group will be taken up again in later chapters.

Some authors (Durkin, 1964), have seen the affective units characteristic of group life (viz. focal conflict and basic assumption groups) as similar. Though the present writer recognises their non-rational, affective similarities, it does seem that there is a closer parallel between Whitaker et. al.'s. 'group theme' ("a series of focal conflicts linked by similar disturbing motives" P. 64), and Bion's 'basic assumption' cultures, than between focal conflicts and 'ba' cultures. The 'ba' culture or group is a more inclusive concept than the group focal conflict, in that it extends over longer periods of time and includes a variety of emotional elements.

The similarity between the 'group theme' and the 'basic assumption' culture, is seen in the way the group moves or changes from one unit to the next. "Within a single theme, movement occurs toward and then away from direct expression of the disturbing and reactive motives. Such movement is determined by the character of the successive solutions" (Ibid. P. 89). The same authors, writing of Bion's 'ba' culture say: "As the group persists in operating on a particular basic assumption, anxieties inherent in the culture become intensified and eventually force a shift into one of the other basic assumption cultures" (Ibid. P. 249).
Both these models of group development stress the role of anxiety or tension. In both models it appears that anxiety fluctuates, but when it reaches intolerable levels, the group shifts or progresses. The anxiety can result from unconscious covert motives or fears, the expression of covert motives, or by therapeutic interventions ranging from interpretation to 'silence'. Both authors indicate that the anxiety is alleviated by shifts to another focal conflict or 'ba' culture. However, this explanation is inadequate in view of the role insight plays in group development. It seems that as the group progresses, the anxiety levels may continue to reach intolerable levels, but it is accompanied by more understanding. Neither theory adequately explains how this comes about, although Whitaker et. al's. 'expanding culture' endeavours to explain the phenomenon. The main point to note here is the importance given to anxiety or tension in the development of the group.

Closely associated with this is the idea which both these theories share, that as the group develops there is

(i) a more conscious recognition of the underlying motives and 'basic assumptions', and

(ii) more insight into their functioning.

Bion explains this in terms of 'consistent interpretation by the therapist. This of course doesn't allow for the debilitating effect of anxiety on insight. Whitaker et. al. explains this in terms of both interpretation and emotional support from the group culture as expressed in "the character of the therapeutic
enterprise the relationships among patients, and between patients and therapists, the boundaries on the expression of affect, acceptable content and acceptable modes of interaction". (Ibid. PP. 97-98).

The recognition and integration of both the cognitive and affective components in the development of the group is one of the features of the 'focal-conflict' model. This is very useful because it indicates the type of therapeutic conditions which are needed to develop an atmosphere of trust, acceptance and respect. It may also point to other 'relationship' factors which will help to; alleviate anxiety, appropriately time interpretation and develop acceptable modes of interaction.

The point being made is that Bion, whilst acknowledging the affective ('ba') - cognitive ('W') aspects of groups doesn't spell out their changing relationship in the process of group development. As mentioned earlier, as the group develops, the 'ba - W' relationship changes, with the 'W' group benefiting from the recognition and expression of the 'ba' cultures, but this is not adequately explained.

The notion that as the group develops a particular theme (be it an affective or content theme) becomes more gradually explored and expressed has been noted by Powdermaker and Frank (1953). The gradual decrease in the anxiety associated with the expression of such themes appears somewhat akin to the behaviour group therapy, where particular themes are "systematically desensitised". (Shannon and Paul, 1966: Gazda, 1968.b.)
Thus it seems that there are some grounds for the general principle that both Bion's and Whitaker et al's, models propose, viz., that as groups develop, the affective components cause less debilitative anxiety, whilst there is an increase in the rational and cognitive functioning of the group.

It is in this regard that both these models can be viewed as linear. As mentioned earlier, both these theorists see the work of therapy in terms of 'emotional insight and reorganisation'. (Patterson, 1969). This reflects their psychoanalytic background. So to the extent that successful and enabling group solutions predominate or the 'W' group is integrated with the 'ba' groups, the therapy group may be regarded as reaching a level of 'maturity'. Of course by the time this stage has been reached, a great deal of therapeutic change would have taken place.
CHAPTER 4
CRITICAL ISSUES IN A THEORY OF GROUP DEVELOPMENT

It now seems possible to draw together some of the common dimensions and key issues which these five theories have raised. The following discussion will centre around these issues and will endeavour to offer tentative suggestions as to what are the critical issues which any theory of group development would have to explain.

There seems to be reasonable support for the assumption that groups develop in some progressive way. The development of the group was noted in all the theories. This development can be seen in a variety of factors.

Firstly, there is an increase in the task or work of therapy, i.e. the cognitive aspects of therapy come to function more effectively. For example, there is a greater appreciation between the members, of feedback and information which becomes a source of rational help. Whitaker et. al., note that information becomes "available to the patient through

(i) being exposed to information which is not directed to him but which is relevant to the group focal conflict in which he shares,

(ii) being the target of interpretations and feedback by other group members of the group

(iii) examining his own position in regard to the current group focal conflict, and
(iv) observing the positions which others take with regard to the group focal conflict and the consequences of these positions" (Whitaker et. al. P. 175).

Bennis and Shepard note the same type of development in the group's "movement toward maturity", (Bennis et. al. P. 415), noting that consensual validation" is reached as a result of rational discussion rather than through a compulsive attempt at unanimity" (Ibid. P. 433).

This increase in the rationality of the group is central to Martin and Hill's theory. They actually refer to it as the 'warp and woof of the group' (Martin et. al. P. 26) and gauge its progress from the group's ability to understand interactional patterns, interrelationships, power structures and group process.

Bion actually refers to a 'work group' and identifies its function by the improvement in the therapy groups ability to be rational, reality oriented co-operative and scientific. These are all qualities which presumes the group is progressing.

Though Rogers doesn't conceptualise group development in cognitive terms, he does note that before a group matures, its members must be capable of 'receiving feedback' and using this information. He goes so far as to see some 'leveling' feedback as a 'confrontation' which implies the group's ability, in its latter stages, to handle rational material in a heightened emotional context.

Secondly, is the increasing ability of the group to understand the therapeutic process. This 'insight', which has been
variously defined, (Symposium on Insight & Interaction in Combined Therapy, 1964), is regarded by some authors as the key to therapeutic progress (Ezriel, 1950). The stress Whitaker et. al., Bion and Bennis and Shepard, place on interpretation, reflect the importance of increased insight. Although Rogers isn't regarded as being concerned with 'insight' (Whitaker et. al., 1964), it is noted that the increased 'self awareness', openness and congruence, which results from group progress, have been noted as criteria of insight (Azima, 1969).

Thirdly, and closely related to the first two points, there is an increase in interaction levels. This is related to insight, because, as some authors note, (Menninger, 1964; Slavson, 1955) it is the 'working through' which interaction provides, as being crucial to the acquisition of insight. Sager, in the 1964 Symposium, noted the need for interaction as well as insight, to explain behaviour change in combined therapy. Some authors link three factors, viz., interaction leading to deep emotional (cathartic) experience, which leads to insight. (Slavson, 1969). The point being made is that as the group develops, interaction must increase and change. Few of the models discussed in chapters 2 and 3, spell this out, but it seems implicit in their writings.

For example, Bennis and Shepard see the group's progress in terms of a movement toward adjustment in 'interpersonal' areas and this they see reflected in the way "this facilitates communication and creates a deeper understanding of how the other person thinks, feels, behaves; ....." (Bennis et. al. P. 433).
This increase and change in interaction patterns is quite explicit in Whitaker et al's theory. "As the group goes on, solutions are likely to allow the patients to talk more directly about a broader range of topics and to express more frankly feelings about one another and the therapist". (Whitaker et al. P. 116).

This development in expression communication and interaction is noted by Rogers, who judges group development on increased interaction which is reflected in more feedback and "expressions of positive feedback and closeness". (Rogers, P. 271). Bion doesn't speak in interactional terms, but again this seems implicit in his theory, where he claims that the individual must co-operate if he is to achieve his potential. "..... his ability to co-operate is dependent on a kind of give and take that is achieved with great difficulty ....." (Bion, P. 90).

Perhaps the best explanation of the changes in interaction patterns being used as a criteria for group development, was outlined by Martin and Hill. From a loose knit collection of individuals, they see the group developing distinctive patterns of interactions, including stereotyped dysfunctional patterns, to interpersonal relationships, to sub-groupings and power structures. The fact that the other authors, though writing from a different frame of reference also acknowledge a changing pattern of interaction, gives Martin and Hill's approach greater validity. The fact that this criteria is researchable in terms of Bales' "Interaction Process Analysis" (1950), and Hill's Interaction Matrix (1965), as well as Moreno's sociometric testing programme
(1960), makes this aspect of group development more acceptable.

Subsumed under interaction as discussed here is 'communication'. It is obvious that the two are so closely related that what was said above applies equally to communication. In fact, it could be said that communication is the major form of interaction. The fact that communication patterns change during group therapy has been implied. It is researchable (e.g. by HIM and the Bales method of analysis).

Another issue, the fourth in this discussion, stems from an analysis of communication patterns in therapy groups. Although none of the theories mention it, it would seem logical that a group's development may be gauged by the extent to which group members use the frame of reference of the particular therapist. This would be reflected in the terminology used. It is a common experience to note that 'analysands' talk in psychoanalytic terms of their behaviour, while some clients may talk in terms of awareness, experiences, listening, openness, etc., or perhaps of communications, double binds etc. The point is that, as a group develops, it would seem reasonable to assume that group members would be using a different terminology from earlier phases of group development. This seems a reasonable assumption not only because it is based on observation, but also because one can also assume that the frame of reference which the group members brought with them into the group, was dysfunctional, i.e. they were unable to understand or change their behaviour by use of it. Presumably, group therapy changes their behaviour and gives them a new frame
of reference by which to understand past, present and future behaviour. This would be necessary for the transfer of newly acquired learning.

That this new 'frame of reference' would reflect the therapist's orientation, seems to the present writer, to be a key issue in group therapy. This will be taken up in more detail later.

The suggestion is that a 'content analysis' of the verbal communications of the group would tend to show a progression toward the use of a terminology and frame of reference which characterises a particular therapeutic orientation. Another hypothesis, which will be discussed later, is that this progression may not be linear, but may in fact be characterised by a marked change during the first half of the group's life.

The fifth major area which can be used as a gauge of the progress of the group, is what might be called the group atmosphere or culture. Most of the theorists discussed acknowledged this in one form or another, and to greater or lesser degree. As noted earlier (P. 83), the absence of this variable in Bion's model weakened its appeal. Whitaker strengthened this position by noting the role of the expanding group culture. "....... the culture of the group changes during its life; the standards which govern possible content and permissable feelings are continually evolving. On the whole, these progressive shifts in group culture tend to broaden the group's boundaries" (Whitaker et. al. P. 116). Their criteria for the measurement of the group culture would be in terms of
content discussed, permissable emotions (e.g. intimacy), 'enabling solutions' and relationship with the therapist (i.e. confidence and trust) (Ibid. P. 132-133).

The absence of this variable from Bennis et. al's theory might be explainable in terms of the trend to greater intimacy (phase II) implying the development of 'relationship' qualities. Martin and Hill note the increase in the 'atmosphere' of the group. "Also some ego strengthening should take place where feelings of belongingness provide an antidote for anomie, and feelings of self-worth are engendered through the group's concern for the individual". (Martin et. al. P. 25). They contrast this with the early group atmosphere characterised by isolation, 'asyndetic communication' and "no identification with the group" (Ibid. P. 21).

It appears that on this issue Rogers' theory offers ideas and promise of measurement. He bases the development of the group on 'relationship' qualities, such acceptance, empathy, congruence, regard, etc. His 'if-then' model (see P. 39), postulates that 'if' these qualities permeate the group atmosphere or relationship, 'then' progress is being made. Thus he says that as the 'healing capacity' in the group and the 'acceptance' become operative, there is "the beginning of change" (Rogers, P. 267). As mentioned earlier (P. 43), his use of this theory is logically inconsistent. This does not mean that it cannot be applied in a more consistent manner. Efforts to this end were stated (PP. 44-47).

The formulation of 'process scales' (Rogers, 1959 and 1967), and earlier attempts at measurement by Barrett Lennard (1962) make
it possible to gain a measure of the development of the group with the use of these scales. Such an attempt has been made (Gray, 1969), but the author concluded that until such 'Relationship-Inventory' scales (which are based on dyadic therapy) were adopted to the group situation, they were "inappropriate for use in group counselling" (Gray, 1969, P. 103).

Although it is suggested that there are deepening relationship qualities and an expanding group atmosphere, as the group develops, it must also be noted that this atmosphere includes negative as well as positive features, i.e. 'confrontations' (Rogers), 'corrective emotional experiences' (Whitaker et. al.), and 'anxiety' (Bennis et. al) are part of this expanding culture. Regression is not uncommon. Whitaker et. al., offer a way of integrating these anxieties into a model of the developing group. "In the context of a progressively broadening group culture, themes are dealt with on a level, which would not have been possible during the formative period. The new levels of explorations elicit reactive fears which are subjectively just as intense as those which were experienced earlier". (Whitaker et. al. P. 128). They explain how the group handles this, in terms of the group culture.

These brief points indicate, that although group atmosphere and culture develop as the group develops, one would need a clear understanding of the variables involved, the possible regressions which occur and the limitations of present measurements of this factor, before research on 'group culture' would be possible. Add to this such factors as cohesion (Frank, 1957),
social pressure (Asch, 1955), influence (Scheidlinger, 1963),
conformity (Mann, 1962), group dynamic factors (Kelman, 1963),
persuasibility (Hovland and Janis, 1959), affiliation needs
(Zimbardo, 1960), and other factors affecting group standards,
atmosphere and culture (see Lakin and Carson, 1966), and the
picture takes on some of the real complexity which typifies group
therapy dynamics.

Perhaps the sixth way a group's development can be noted
is by its identification with outside events, i.e. the early
sessions of the group may contain many references to behaviour and
people outside the group. This seems implicit in all the theories
under concepts of 'stereotyped behaviour', 'facades', 'dependency'
etc. As the group develops its own life and culture, the members
seem to identify more with the group, the here-and-now relations,
and some say they 'live for the group sessions'. As the group
comes closer to termination, once again there appears to be more
references to outside events and other significant people. Most
groups seem to endeavour to handle this 're-entry' problem, be it
from hospital (in-patient), out-patient therapy, or weekly group
therapy. As Whitaker et. al., say, "The imminent close of the
group is a precipitating event which is likely to call forth
focal conflicts involving separation, abandonment anxieties and
feelings around accomplishment and achievement" (Whitaker et. al.
P. 132).

The notion is that group development may be gauged in
parabola fashion; with the weakening of affectional and relationship
ties to outside events and people; being followed by a new centre of identification, emotional satisfaction and relationships, viz., the group; and finally a concluding phase which centred around terminal problems and 're-entry' ties to other people. The latter phase seems related to the transfer of learning. The only theory which has considered such a possible theory of group development, was based on 'Semrad groups', and as yet hasn't been applied to group therapy. (Schutz, 1958). His notion of a group developing to;

(i) 'integration' by the three phases of inclusion, control and affection, and to

(ii) 'resolution' by the reverse procedure viz., affection, control and inclusion,

seem to offer a possible avenue for exploration toward a theory of group development.

A seventh way of gauging group development which suggested itself to the writer, resulted from Corsini and Rosenberg's theory (1955) of the therapeutic mechanism which functions in group therapy. They list 166 such mechanisms. They postulate that all therapy process can be understood in terms of the mechanisms related to 'emotional, cognitive and actional' components of group therapy. Following Ellis (1968), who sees these three dimensions as "interacting elements" (Ellis, 1968, P. 93), it could be said that at any given time in group therapy there is a particular integration of the three factors with one, or a combination of two, predominating. For example, following Corsini et. al., it would seem that of the
nine major factor loadings, transference ventilation, universalisation and spectator therapy would usually precede acceptance, altruism, reality testing and intellectualisation (as defined by the authors). It could be hypothesised that if the therapeutic mechanism could be adequately defined (a problem with the Corsini et al. research), it may be possible to see which mechanisms predominate during certain periods in the group's development. The writer speculates that one possible order may be:

Phase I : emotional-actional mechanism predominate with the cognitive mechanisms being impaired.

Phase II : emotional-cognitive mechanism predominate with the actional being secondary.

Phase III : actional-cognitive mechanisms predominate with the emotional being secondary.

This is a very tentative suggestion which explores an area of group development left untouched by present theories of group development. It has arisen out of the writer's present interest in this three dimensional model. (Gray, 1970).

In brief then, eight areas in which group development and progression can be gauged have been outlined. Some such as; the progression toward reality testing, feedback, understanding, insight; an expanding atmosphere and group culture; a changing pattern of interaction and patterns of communication, seemed to suggest themselves from all or most of the five models previously discussed. Other areas such as; the increasing use of the
therapist's frame of reference, the changing focus of the group members' identifications and use of the actional - cognitive - emotional paradigm (ACE), suggested themselves as possible areas which the five previous theories had neglected. That these eight areas can be used as indicators or trends in group development, leads us to a consideration of another key issue, that of specific phases or units of group development.

One of the conclusions in chapter 2; 'The Linear Models of Group Development', (P. 52) was that it was possible to offer some recognisable phases of group development. Regardless of the orientation of the model (be it based on affective characteristics such as Bennis et. al., experiential characteristics such as Rogers, or interactional characteristics such as Martin and Hill), it was possible to formulate progressions or phases of development in a therapy group. These could be summarised as follows:

TABLE 3: Phases of Group Development

<table>
<thead>
<tr>
<th>Phase</th>
<th>General Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I : Unstructured</td>
<td>'Milling around' .... 'unstructured' .... 'Individual unshared behaviour'.</td>
</tr>
<tr>
<td>II : Dependence</td>
<td>'Stereotyped behaviour' .... dependence on therapist leadership .... group efforts to adapt to the therapist's expectations.</td>
</tr>
<tr>
<td>Phase</td>
<td>General Description</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>III: Transition</td>
<td>'Resolution of dependency' .... by therapist or 'central persons' inter­ventions.</td>
</tr>
<tr>
<td>IV: Interdependence</td>
<td>'Exploration of interpersonal potential and sub-groupings .... 'Cracking Facades'</td>
</tr>
<tr>
<td>A. Power &amp; Ind. Differences</td>
<td></td>
</tr>
<tr>
<td>V: Interdependence</td>
<td>'Pairing' .... 'basic encounters' .... expressions of positive feelings and closeness' .... consensual validation.</td>
</tr>
<tr>
<td>B. Intimacy &amp; Encounters</td>
<td></td>
</tr>
</tbody>
</table>

Phases IV and V are recognised as the 'work' (c.f. Bion's 'W') of the group. The distinction between these phases is less clear.

It is recognised that this tentative formulation of group development is similar to other authors. Bach (1954), notes the group progression from initial situation testing and leader dependence through to 'in group consciousness' and 'the work group' (Bach, 1954. PP. 268-293). Kaplan and Roman (1963), describe group development from a 'loosely organised psychological group', through dependence phase to power and intimacy phases. More recently, E.J. Anthony (1967) in a comparison with dyadic therapy, notes that therapy groups develop from a phase of 'familiarisation with the environment and therapy' through two focal conflict phases,
that of dependency - independency and the recognition of interpersonal differences, to a final phase of "personal encounters". (Anthony, 1967. PP. 59-65).

Support for this formulation can also be seen in Schutz's 'Postulate of Group Development', which proposes that the 'integration' and development of the group progresses through three phases; (i) inclusion, (ii) control and, (iii) affection. Their description of the group learning gradually to handle 'interpersonal' control and affection supports our formulation (Schutz, 1958, PP. 165-174). Another theory of group development, which supports the model being presented, is that of Mann (1967) who proposes that the phases of group development are;

(i) initial complaining,
(ii) premature enactment,
(iii) confrontation,
(iv) internalisation,
(v) separation,
(vi) terminal review.

The critical role of 'confrontation' being a pre-requisite phase for the lengthy 'internalisation' phase is noted at this point as an important point in the progress of the group. Though these last two models are not strictly the result of research on therapy groups, the fact that their phase development approximates those of the proposed model, compliment the evidence from Bach, Kaplan and Roman, and Anthony.
It would also be possible to note a similar progression in the cyclical models of Whitaker et. al., and Bion. Though Whitaker et. al. do state two phases of group development, viz., the formative phase and the established phase, a close reading of their articles and book, enables one to gather data from these sources which fits the model suggested above.

For example, these authors acknowledge an unstructured period in the early part of the group's life: "When the group begins, it is unformed. The therapist has offered minimal structuring ....... Thus the patients are provided with no official guide-lines and no signposts to tell them what to talk about or how to proceed". They go on to note that in these very early unstructured sessions, group members' behaviour is governed by the "prior expectations of the patients, the nature of the group situation, and the composition of the group" (Whitaker et. al. P. 117). The features of the group endeavouring to adjust to the therapist's non-structuring behaviour, is reflected in group members' "attempts to institute relevant habitual personal solutions" (Ibid. P. 149). Both these trends are described by these authors as characteristic of the 'formative phase'.

The transition stage which the writer sees as the next phase, is the period when an 'acceptable solution' to the conflicts which have arisen. It is suggested that these conflicts are related to an acceptance of the leader, his role and frame of reference. Whitaker et. al., also see a transition period which has these features: "The close of the formative phase is character-
ised by a shared sense of commitment to the group and a subjective feeling of relief associated with the achievement of successful solutions to the initial focal conflicts" (Ibid. P. 127). They note that these initial focal conflicts often centre around the therapist's role and function. "During these early sessions, patients often attempt to handle a stressful situation by trying to get the therapist to provide the solution" (Ibid. P. 124). As mentioned earlier (p. 91) this transition phase is regarded as one of the critical developmental points in the group's history. Its role and importance will be further examined in chapter 5.

Whitaker et. al's, description of the 'established phase', which they describe in terms of recurring themes, issues and conflicts, centres around such themes as "how to manage anger constructively, how to be aware of emotions without being overwhelmed by them, how to maintain integrity of self yet enrich life through interdependence with others, or how to manage close personal relationships" (Ibid. P. 116). It is obvious that these authors are describing the same issues as those postulated in the 'interdependence' phases of our model.

In general then, it could be said that even Whitaker and Liebermann's 'cyclical' model of group development supports the phases suggested in chapter 2. Their own notion of recurring themes seems to be more applicable to the 'interdependence' phases, which are more difficult to separate.

Because Bion's theory of group development was 'implicitly' stated by that author, it is more difficult to relate
his theory (as described in chapter 3), to the present tentative formulation. However, two features which were commented on were:

(i) the group's need to accept the therapist's interpretations (i.e. his frame of reference), and,
(ii) the increasing ability of the group to integrate the 'basic assumptions' relating to the leader (dependency and fight-flight) and to interpersonal behaviour (fight-flight and pairing), with the work (W) of group therapy.

It seems logical that until they had adjusted to the leader-dependence issue, they would be less able to cope with interpersonal issues, since the theory is based on the assumption that the group members learn to solve both issues by the use of the therapist's interpretations and frame of reference. It appears a contradiction that they were capable of rational use of the therapist's help unless they had previously resolved (to some extent) their conflicts with him.

If this be so, then theoretically Bion's idea of group development approximates the model formulated above. The extent of its 'goodness of fit' can be gauged from a further discussion in chapter 5.

The discussion so far has been directed at outlining evidence which supports the proposed model of group development. The fact that stress is given to the central conflicts of in-dependence and interdependence' has its parallel in the existential writings of Laing, who refers to these two conflicts as posing the paradox of living. "Here we have the paradox, the potentially
tragic paradox, that our relatedness to others is an essential aspect of our being, as is our separateness ...." (Laing, 1965. P. 26).

There have been some brief remarks made that the critical point in the progress of the group is the 'transition' phase. (See PP. 44, 91). The important of this phase can be established by reference to several aspects of group life.

(i) Most of the theories discussed see 'anxiety' or 'tension' as central to group movement. The 'transition' period; which Bennis et. al., regard as the resolution of the dependence-counterdependence tension; which Rogers sees as the first signs of the 'healing capacity' in the group thus allowing expression and acceptance; which Whitaker et. al. refer to as "a subjective feeling of relief associated with the achievement of successful solutions to the initial group focal conflicts" (Whitaker et. al. P. 127); and which Martin and Hill see as the point where group members learn that stereotyping the leader is dysfunctional; can be regarded as the first occasion when serious group conflict has been handled successfully.

These theorists acknowledge the role of tension and anxiety which is the product of this conflict. The transition period (as defined) seems to be the 'model' on which future conflicts and anxieties can be handled. If one assumes that conflict is an interpersonal process
that patients find difficult to adjust to (Pentony, 1970 C), then a successful solution to the early group conflicts about the role of the leader becomes an important adjustment and learning, which facilitates future resolutions of anxiety.

(ii) This transfer of learning to the resolution of interpersonal conflicts is aided by the fact that the transition period brings with it a 'subjective feeling of relief', 'mutual acceptance' and 'a sense of solidarity', i.e. This transition has an impact on the group atmosphere, culture and relationship qualities. This enables trust, safety and support to be the result of expressions of anxiety and tension. In simple learning terms, these "positive reinforcements" indicate (consciously or unconsciously), that recognising and expressing sources of conflict or tension, is a 'safe' experience. This norm or standard becomes part of the expanding culture of the group. Future learning and therapy may depend on the presence of such a culture (e.g. Rogers, Whitaker et. al.).

(iii) The third important point about this transition is that it sets 'models' before group members. (Bandura and Walters, 1963). The presence of such 'central persons' has been acknowledged. (Redl, 1942; Bennis et. al., 1957). The presence of such models gives rise to a therapeutic mechanism which Corsini (1957) calls 'spectator therapy'
"watching the example of others and listening to the testimony of others ..... learning, vicariously, from the experiences of others". (Corsini, 1957, P. 41).

This 'spectator therapy' seems extremely crucial during the transition phase because of the emotionality involved.

The fact that 'unconflicted people' or the therapist (says Martin and Hill; and Bion) behave or respond in a manner which alleviates anxiety, increases the probability that that behaviour will become a mode of coping with anxiety in future. Bennis and Shepard, and Martin and Hill's model both exemplify this principle. In the former theory, 'central persons' become the models which group members use for their personal learnings. In the latter theory, the therapist fulfills these functions.

A question which arises out of such an explanation is, 'why is it that the central persons always model behaviour which is acceptable both to the group members and the therapist?' Whitaker et. al., would claim that they don't, but as shall be shown in a moment, it seems that the 'model' given is the model which both the therapist and the group members accept. This issue will be discussed again in this and the next chapter.

(iv) The fourth point, and one overlooked by previous theories, is that in the 'transition' phase, the group begins to undergo a change in perceptual or cognitive style (Kelly,
As mentioned earlier, it is at this point that group members begin to look at behaviour and interactions from the therapist's point of view. His cognitive structure or frame of reference will be peculiar to his therapeutic orientation. Regardless of the style, it seems that the group members must use the therapist's frame of reference if they are going to find a new way of understanding their behaviour.

Up to the transition period, the group members could be considered to be responding from their own dysfunctional frame of reference. Reference to 'dependence', 'stereotyped behaviour' and 'fixated interpersonal attitudes' adequately support this assumption. (See Bennis and Shepard; PP. 421-423; Martin and Hill, PP. 23-24). However after the transition phase group members give the impression of looking at the group's and their own behaviour from a different point of view - viz., the therapist's.

This seems a reasonable switch as their previous frame of reference was maladaptive and dysfunctional. Also if one agrees with some current psychotherapists (e.g. Haley, 1963; Pentony, 1967), that 'control' by the therapist is necessary for therapy to take place, then the group's change in members' perception to the therapist's frame of reference, indicates progress in the therapy group. The parallel to the Haley theory, is more obvious
when one acknowledges that this 'control' was gained during a transitional period which has the hallmarks of what Haley calls the "benevolent ordeal". (Haley, 1963, P. 187).

This change in cognitive style may come about in one of two ways. It seems possible that a major event, or 'barometric event' as Bennis and Shepard call it, can occur in the form of a sudden or catastrophic event. Frank's (1951) "corrective emotional experience" typifies this. This short lived and 'catalytic' event is noted in Rogers' key person or persons who suddenly 'open up', in Bennis and Shepard's 'barometric event', and possibly in Bion's shifts from one 'basic assumption' to another.

Another way this change in styles can come about is more akin to what behaviourist's propose in 'systematic desensitization' (Wolpe and Lazarus, 1966), i.e. there is a gradual decrease in anxiety due to a 'graded' approach to the anxiety producing stimuli. Thus the 'recurring themes' of Whitaker et. al. could also explain how the group could gradually come to successfully resolve 'initial group focal conflicts'. They recognise that the transition is slow (8-12 sessions), although they claim its termination may be 'clear or vague'. (Whitaker et. al. P. 127).

The fact that the transition can be explained in terms of a 'corrective emotional experience' or a gradual
manner has its parallel in current dyadic psychotherapy.

To return to the main point, viz., that this transition period, regardless of its sudden or gradual onset, marks a change in the cognitive or perceptual styles of the group members. Note that this change in perspective is complete. The point being made is that there is a change or switch in styles. This can be quite a researchable aspect of group development. As mentioned earlier (P. 91), some form of content analysis of the terminology used in the group, would presumably reflect a period when the group began to use words, phrases and expressions which would indicate a change from earlier emphases. The writer's own experiences in groups have found this to be observable and measurable.

This aspect of the importance of group members changing their frame of reference will be treated in more detail in chapter 5. Suffice it to say that without this change in 'perceptual stance' no personal change can occur and the future development of the group depends on this 'transition'.

(v) A fifth important aspect of this 'transition', and one which most of the theories discussed earlier overlooked, is that this 'transition' period shows a marked change in the communication and interaction patterns of the group. Martin and Hill did note the change from stereotype behaviour between members and to the therapist, to
interactions based on more 'interpersonal exploration'. If the fourth point mentioned above has any validity, it seems that an exploration of changes in interaction patterns during the transition phase, could provide it.

Following Martin and Hill, who note that phase II is characterised by 'asyndetic' communication and "fixated interpersonal perceptions", (Martin et. al. PP. 22-24), it could be hypothesised that most of the communication is directed 'obliquely' or manifestly at the therapist. There seems support for this in Bennis et. al., who see this phase as dealing exclusively with "preoccupation with authority relations" (Bennis et. al., P. 417) and note that both manifest and latent communication centre on the therapist. (Ibid. PP. 419-427).

This emphasis on interaction and communication with the therapist seems obvious in Whitaker et. al's, statement that "during these early sessions, patients often attempt to handle a stressful situation by trying to get the therapist to provide the solution" (Whitaker et. al. P. 124).

Phase III sees the interactions and communication patterns far less 'therapist centred' and more 'member centred'. As mentioned earlier, most of the theories comment on this change in interaction to 'interpersonal' issues. This is quite a different interactional pattern to phase II.
The validity of this 'transition' or change in interaction patterns seems possible to check by use of the Hill Interaction Matrix (Hill, 1965), which has as one of its basic premises, that the 'patient-therapist' interaction is one of the 'most significant' aspects of group psychotherapy. (Hill, 1965. P. 15). As mentioned earlier, Psathas (1960), has already successfully used a Bales 'interaction process analysis scale' with group therapy. It can be seen, therefore, that the hypothesis; that the transition phase is reflected in a change of leader centred interaction and communication by group members, to inter-member and interpersonal interaction and communication, can be empirically tested.

It is interesting, that points (iv) and (v) are somewhat related. It is postulated that phase II is characterised by, group member operating and functioning from their own dysfunctional interpersonal perceptions, looking at, responding to and interacting with the therapist. By contrast, phase IV, is characterised by group members operating more from the therapist's frame of reference, looking at, responding to and interacting with each other. This contrast, highlights the importance of the 'transition phase' which brings this about.

In brief then, the transition phase is seen as critical to group development as it; provides a 'modus operandi' for handling future group conflicts and tensions; provides a 'central person' who becomes a 'model' for acceptable and adaptable behaviour;
demonstrates the safe, trusting and accepting atmosphere and culture of the group; offers an alternate 'frame of reference' or 'cognitive style' from which to view interpersonal behaviour; changes the interaction patterns from therapist centred to member centred interactions.

Whether one looks at the general trends of group development (PP. 86-97) or the specific phases of group development (PP. 97-103), there are four factors which significantly affect the progress of the group. The five models discussed in the earlier chapters all acknowledged the function of these four factors in the growth of the group. They have already been discussed in various ways during this paper, but their role in group development will be briefly reviewed.

(i) The Group Therapist: Patients enter therapy with therapist-expectations. All the theories discussed note this. These expectations are based on the assumption that the patients need the therapist if they are to learn to function more adequately. Though some group therapists endeavour to indicate that they play a minor role (e.g. Rogers hardly touches on the role of the therapist; and Bennis et. al. mention his role but intermittently), a closer look at all the group models discussed, shows that the group therapist is the 'controller' of the group's development.

It is obvious from Whitaker et. al's power to direct the group to new perspectives and modes of responding may
be the result of 'timing' his interventions to moments of heightened anxiety which can be relieved by following his cues. One suspects that his ability as a 'model' is often underplayed. His position increases his influence as a model. Whitaker et. al. refer to his "influence through participation" (Whitaker et. al. PP. 216-225). Martin and Hill speak of the therapist exhibiting skills which are obvious to the members (Martin and Hill P. 25). It seems quite plausible to perceive the accepting-understanding-respecting, non-directive group therapist as possessing powerful 'modelling' qualities. (Bandura, 1965).

As there have only recently been attempts to describe group processes in 'behaviouristic' terms (Liebermann, 1970), the discussion above may seem foreign to group therapy. However, it does strengthen the proposition that the group therapist play the crucial role in group development.

Therapists can also generate anxiety by the nature of their interventions. Bion notes this, and it seems implicit in Bennis et. al., and Whitaker et. al. If the therapist operates on the assumption that the group development depends on learning to handle anxiety and conflict, it seems possible that they appreciate his prime importance when they discuss his contribution in terms of 'strategy, position and power' as well as his 'influence through participation'.
(Whitaker et. al. PP. 187-238). His role in the psychoanalytic type theories (Whitaker et. al., Bennis et. al. and Bion) of 'interpreting' immediately places him in the role of a specialist, since presumably the patients aren't familiar with this 'depth', frame of reference. In Martin and Hill's theory, the group would not progress only for the 'teaching' function they ascribe to the therapist's role. The fact that Rogers seems to see the therapist in a very secondary role, is misleading because patients leave 'group centred therapy' using Rogerian phrases, terminology and frame of reference (e.g. See Rogers, P. 272).

If one wasn't too sure as to the central importance of the therapist, the fact that patients learn to adopt the therapist's frame of reference, would further stress this person's powerful position and permeating influence. This seems to happen regardless of the therapist's theoretical orientation. Whether he subtly 'shapes' behaviour (as one suspects happens in Rogers groups, c.f. Truax, 1966), or whether direct interventions are used (as in Bion, Martin and Hill, and Whitaker et. al.), the therapists can set about increasing the anxiety by a variety of means. e.g. silences, interpretations, focusing on an anxiety producing topic such as his leadership or their lack of honesty with each other. 'Confrontation' is a common intervention to heighten
anxiety. These examples illustrate the powerful position the therapist is in. The use of this position affects the progress of the group.

(ii) The 'Central Person': Another person effecting the development of the group, is the 'central person'. Bennis et. al. developed this Redl notion (1942), noting the presence in groups of 'unconflicted persons. He refers to the "infectiousness of the unconflicted on the conflicted personality constellation" (Bennis et. al. P. 418). The presence of such persons seems implicit in Rogers.

It seems that these 'central persons' share some of the leadership functions with the therapist. Following Bandura et. al. (1963), it can be seen, they possess positive 'modelling' features and their ability to provide 'successful solutions' which alleviate group anxiety adds to their influence. However, they are secondary to the therapist in the part they play in effecting the development of the group.

(iii) Anxiety: Every group model discussed acknowledged that group development depended on tension and anxiety. Perhaps the best summary of the critical role of tension and anxiety is given by Bennis et. al.: "For it can be argued that the moments of stress and catharsis, when emotions are labile and intense, are the times in the group life when there is readiness for change".
The cyclical models described new themes, focal conflicts and basic assumptions arising from periods of anxiety which were reacted to by group movement. The linear models (See chapter 2), all noted that transition from one phase to another came during moments of 'heightened anxiety', the 'expression of negative feeling' or 'open resentment'. As mentioned earlier (P. 103) the group's growing ability to handle conflict and anxiety is one of the important learnings in group therapy. It is a key factor in our group development model. Without it group progress founders. Its role in the 'transition' phase aptly supports such a proposition. Whether it is handled by a sudden 'barometric event' (e.g. Bennis and Shepard) or by a gradual resolution (Whitaker et. al.) depends on the therapeutic orientation of the model.

(iv) Group Atmosphere: It is postulated that the growth of the group also depends on the expanding group culture. This is developed from; the qualities of the therapist and the unconflicted persons; the satisfactory resolution of early anxieties, particularly the important 'transition' phase; the group standards and dynamics (c.f. Bach, 1955, PP. 344-361; Lakin and Carson, 1966, PP. 27-40; Durkin, 1964, PP. 36-92); and the development of the group toward more interpersonal concerns.
Its importance in the development of the group makes it a 'necessary but not sufficient' condition for group progress.

In brief, this chapter has endeavoured to bring together the critical issues in a theory of group development. To begin with, it was postulated that the development of a group could be gauged by:

(i) the increase in the task or work ($\omega$) of the therapy group,
(ii) the increase in 'insight',
(iii) the change in interaction and communication patterns,
(iv) the increase in the use of the therapist's 'frame of reference',
(v) the expansion in the group atmosphere and culture,
(vi) the change in 'identification' patterns, and
(vii) the changing therapeutic mechanisms.

The tentative formulation of a phase theory of group development, which suggested itself in chapter 2, was then taken up and discussed. One of the phases, the 'transition' phase, was developed in detail and its importance noted by its relation to:

(i) the group's ability to learn to adjust to tension and conflict,
(ii) the group atmosphere and culture,
(iii) 'models' for future learning,
(iv) the group's gradual change to the therapist's frame of reference, and
Finally this chapter reviewed four factors which significantly affect the progress of the group, viz., the group therapist's role, the 'central person's' role, anxiety, and the group atmosphere.

It now remains to be seen whether a theory of group development which accounts for these issues can be formulated. It may be possible to conceptualise these issues in such a way as to develop a theory which could be used by group therapists regardless of their therapeutic orientation. Such will be the aims of the next and final chapter.
CHAPTER 5

THERAPY GROUPS AS 'TEAMS'

The proposition, that a social system of two or more (the group), may develop through a series of phases similar in nature to those experienced by a developing individual system, has already been mentioned. (See P. 4). E.J. Anthony (1967), found that designing a 'treatment model for individual and group situations', was a rewarding exercise. The possibility that social systems, be they composed of two, three, ten or more sub-systems, have certain common principles of functioning, has become a premise in Sociology. (Buckley, 1967; Von Bertalanffy, 1966).

This principle can also be seen in the field of psychotherapy where 'communications theory' has been applied to dyadic, group and family therapy. (Haley, 1963; Watzlawick, Beavin and Jackson, 1967; Satir, 1964).

These various approaches by relating different social systems through common theories, suggests the validity of designing models of psychotherapy which are applicable across social systems. One such model has been suggested by Pentony in his speculative paper: "Persons as Teams: An Analogy" (1970a). This model tentatively outlined a way of conceptualising individual change in psychotherapy. Its propositions re the development of the dyadic therapeutic relationship will be reviewed, and then these propositions will be used to conceptualise a theory of group development which will account for the issues raised at the termination of the previous chapter (PP. 116-117).
Pentony (1970a, 1970b) suggests that a concept which can apply to any social entity from the individual, the group, the organisation to the institution, is Goffman's term, 'Team', which that author defines as "a set of individuals whose intimate co-operation is required if a given projected definition of the situation is to be maintained". (Goffman, 1959, P. 104). Pentony endeavours to develop this concept of 'team' by using Polanyi's 'tacit knowing' (Polanyi, 1967, P. 6), to explain how teams have; an inward view of themselves which is the frame of reference, they attend from" (Ibid. P. 16); and an audience view which is the external stimulus the team 'attends to' (Ibid.). This aspect of Pentony's theory can be summarised as follows:

"His (Polanyi's) message, it seems to us, is that when some element or procedure is incorporated into the team so that it comes to play a part in the team's performance, it is perceived very differently from when it is looked at as something alien to the team: The inner perspective differs from that of the audience" (Pentony, 1970a, P. 232).

Take the individual as a 'team'. It becomes important for the individual team, "to maintain its identity by putting on performances that are consistent with it" (Pentony, 1970b, P. 14). Presumably, patients who come to therapy do so because of the tension, malfunctioning and inconvenience caused by the difficulties of maintaining a particular self definition. "We would say that the problem for such patients is that the definition of self which they are trying to maintain has ceased to be a viable one" (Pentony,
The goal of dyadic therapy becomes one of re-establishing the individual team's sense of identity .... 'a definition of the situation which can be maintained'.

Pentony suggests that this goal can only be achieved by establishing the 'dyadic relationship' as a team. This 'two-man team' has a different 'performer' or inward view, which it can 'attend from', than the previous dysfunctional view which characterised the patient as a team. It is in this sense that Pentony says, "We have argued that the whole determines the parts, and that teams - whether individuals or larger systems - undergo change when they become integrated into larger units" (Pentony, P. 256). He acknowledges man's ability to withstand coercion or be treated as a 'puppet', and proposes that external pressure must be accompanied by recognition and acceptance. To do this the predominant team must "provide it with a situation in which it has a sense of exercising self determination and a prospect of regaining self respect" (Ibid. P. 257), i.e. the predominant party may hold another party in subjection, but if it would win another to its point of view and enlist its active participation, it must provide it with a situation in which it has a sense of exercising self determination and a prospect of regaining self respect.

Goffman notes this and describes this feature of the team. He says the team is 'a stance taking entity', and rephrases by saying that "it is against something that the self can emerge" (Ibid.).
So the patient in dyadic therapy becomes integrated into a larger system and adopts its frame of reference, while retaining its selfhood, self determination and respect. A culture of recognition, acceptance and safety guarantee such self respect. Finally, it is within this therapy team that the new self can emerge, since the acceptance of its separateness allows it to continue to function as a stance taking entity, while adapting its outlook to that of the therapy team. In this way, we have an explanation of Laing's paradox; belongingness versus separatedness, or identification versus individuality (Laing, 1965).

So far the description of the therapeutic relationship has explained;

(i) the individual entering therapy with a dysfunctional self definition, and
(ii) the individual team becoming incorporated in the therapy 'team', accepting its 'self definition' without losing its own 'selfhood'.

Pentony describes the process which explains this 'transition' as follows. The therapist's first task is "to bring about a situation in which the patient will acknowledge the futility of his current mode of living. The effect of this is to reduce the patient to despair" (Pentony, 1970a. P. 243). The notion that personality change often occurs 'from a period of turmoil, catharsis or despair' is a common one in psychotherapy. (Munroe, 1955; Angyal, 1965; Schein and Bennis, 1965). Since the patient doesn't want to 'really' change, he more often expects
change from outside himself, from other people or other contexts. (Angyal, 1965. P. 223). To the extent that the range between the individual's actual performance and his idealised performance go beyond tolerance level, the self definition is disrupted and must be abandoned. A new definition must then be acquired. As mentioned earlier, "the nature of that new definition will depend upon the opportunities provided by the context of social forces in which it is born and to which it is attuned" (Ibid. P. 245).

Both Pentony and Angyal note that the degree of change may vary greatly. Both the anxiety associated with the disruption of the dysfunctional self-definition and the acquisition of a new self-definition may be rapid or may occur "in relatively small doses paced out over time" (Ibid. P. 245).

It now seems possible to formulate some phases in Pentony's model of the development of the therapy dyad.

**TABLE 4: Phases in the Development of the Therapy Team**

(Pentony, 1970a)

<table>
<thead>
<tr>
<th>Phase I: Dysfunctional Self Definition</th>
<th>Description of Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient exhibits a definition of self which he is unable to maintain as a viable one.</td>
<td></td>
</tr>
</tbody>
</table>

| Phase II: 'Futile' Self Definition | The therapist provides a situation in which the futility of such a self definition becomes manifest. |
### Description of Phase

| Phase III: Transition | Disruption of the self definition.  
"Persuasive emotional experience"  
|-----------------------|---------------------------------------------------------------|
| Phase IV: The Therapy Team | The acquisition of a new self definition,  
aligned with, yet separate from, the therapy team. |

Pentony acknowledges the 'conversion' theme (W. James, 1929) and the 'brainwashing' overtones which such a model presents (Schein, Schneier and Barker, 1961). The emphasis on the 'control' of the therapeutic relationship by the therapist is also acknowledged. (Haley, 1963).

It is now possible to list the critical features of the 'Teams' theory, as applied to the development of the dyadic therapy team. The critical features are as follows:

1. The role tension and anxiety has in establishing the futility of the dysfunctional self definition.
2. There is a 'transition phase', involving a corrective or persuasive, emotional experience.
3. This can be a sudden or gradual experience.
4. The therapist controls the relationship.
(v) The patient begins therapy 'attending from' a dysfunc-

(ivalional 'frame of reference'.

(vi) The therapist's 'frame of reference' becomes the team's 'frame of reference'.

(vii) The patient adopts the team's 'frame of reference' ... i.e. he 'attends from' a new frame of reference.

(viii) There is a change in 'stance taking'. The patient initially 'attends to' the therapist. He eventually 'attends from' the therapist's frame of reference.

(ix) The group atmosphere is a critical factor in the transition phase and in phase IV.

The close resemblance of these factors to the 'critical issues in a theory of group development' (which were summarised at the end of chapter 4), makes it feasible for the extension of the 'teams' theory to explain the development of the therapy group.

In chapter 4, Table 3, presents a model of, 'Phases of Group Development'. This model, it was suggested, was general enough to describe most of the theories described in chapters 2 and 3. The question of, whether a 'teams' model can be formulated which can describe the phenomena of group development will now be considered.

(a) Phase I : Unstructured Phase : (See P. 97)

This phase is characterised by 'milling around' (Rogers), fragmented communication, 'unshared behaviour' (Martin et. al.),
heightened anxiety (Bion; Whitman, 1961; Stock and Thelen, 1958), and a desire to test the limits of the new situation (Tuckman, 1965). The communication patterns reflect interactions which are mainly centred on the therapist, with minimal contact between group members.

So fragmented are the group members communications, that the term 'collection' (Pentony, 1970.b.) seems more appropriate than 'group'. Pentony describes a 'collection as "an arena of interacting teams" (Pentony, 1970.b. P. 5). The chief characteristic of the arena is that the different individual teams (group members), are primarily presenting definitions of themselves ..... definitions which they bring with them into the group. One can presume, because of the malfunctioning behaviour of these patients, that these definitions have been found to be dysfunctional. In other words, each patient or group member presents a definition of self which he is unable to maintain for any length of time as a 'viable one'.

The behavioural data, which is readily observable, indicates that the therapy situation, be it structureless or directive, is characterised by individual teams 'attending from' dysfunctional frames of reference or cognitive styles. They, individually, 'attend to' the group therapist. Communication between 'teams' is fragmented. Individual teams try to project 'idealised' self definitions, but their 'actual performances' are incongruent with such 'idealised self definitions'. The possibility that this describes the observable behaviour of this first phase of
group life can be seen in the following brief quotes:

(i) Rogers (1967): "Particularly striking to the observer is the lack of continuity between personal expressions ..... Person A will present some problem or concern on proposal, clearly looking for a response from the group. Individual B has obviously been waiting for his turn and starts off on some completely different tangent as though he had never heard A." (Rogers, 1967, P. 264). This illustrates the fragmented interaction and possibly indicates individual teams being primarily concerned with establishing a self definition in this new environment. However, the difference between 'the performance' and the dysfunctional self definition is demonstrated in this report from a group member: "There is a self which I present to the world and another one which I know more intimately. ..... To substantiate this image I will act in a way which at the time or later seem false or artificial or not 'the real me'" (Ibid. P. 264). This incongruity between the 'performance' and the self definition, illustrates the dysfunctional nature of the 'real me' or 'self definition'.

(ii) Martin and Hill (1958): The idea that this first phase of 'the arena' in which individual teams enter therapy and initially endeavour to establish their individuality by way of 'maintaining self definitions', can be seen in the following quote from phase I of the Martin and Hill
model of group development. "The characteristic most evident is the social isolation of the members ..... In groups of neurotic or less regressed patients there are mutually compatible productions, but as yet they are individualistic and egocentric, and clearly not group relevant" (Martin and Hill, P. 22).

The group as described above, is clearly not 'a team'. It is proposed (See P. 149), that until the therapy group becomes 'a team' individual change cannot take place.

(iii) Since most of the clinical data and empirical material is reported by Whitaker et. al., and Bion, in 'interpretative' form, it is difficult to apply the 'teams' theory to their writings. However, it does seem that in the early phase of group life, individuals are concerned about their self definition. It's possible to make that inference from the following quotes: "For example, a patient may fear that others will ridicule her when they find out how silly her problems are", and again, "a patient may protest that others will not be experienced enough to help him". (Whitaker et. al. P. 117).

The fragmented communication characteristic of this phase is noted by Bion: "After a while desultory conversation breaks out again, and then another silence falls". (Bion, P. 30). His interpretation that this represents 'dependence' has already been criticised. The
'teams' theory agrees that the therapist is the centre of the communications, i.e. the individual teams are 'attending from' themselves, and 'attending to' him, in the hope that he will respond in a way which will make their self definition more 'viable'.

(iv) Bennis and Shepard (1956) support this when they note, "During this phase the contributions made by members are designed to gain approval from the therapist, whose reaction to each comment is surreptitiously watched" (Bennis et. al., P. 420).

There seems to be sufficient reported observable data to justify the conceptualisation of the very early life of the group, as an 'arena', in which the group members (teams) interact in a fragmented way. The anxiety produced by the situational factors (such as lack of structure, silences or interpretations, etc.), causes the individual teams to endeavour to maintain their dysfunctional self definitions. The therapist becomes the focus of this process.

So the 'arena' phase can be described as a collection of individuals each 'attending from' dysfunctional self definitions, and 'attending to' the group therapist, whom they hope will respond in a manner which will serve to maintain this inadequate definition. The function of the therapist is to fail to 'confirm' their 'stance'. There is a minimum of 'attending to' other members.
This phase can be represented in the following diagram:

DIAGRAM I : The Arena

While both the 'arena' and the therapist attend to each other, the therapy group cannot develop and individual change isn't possible.

(b) Phase II : Dependence Phase : (See P. 97)

In the earlier descriptions of this phase, the chief features were considered to be; the growing dissatisfaction of group members with 'stereotyped behaviour', dependence on the therapist for acceptable direction, increasing asynthetic communication, more interaction between group members and a mounting anxiety arising out of the group's dissatisfaction with their inability to adapt to or cope with the group therapist. It's possible to describe this phase by the 'teams' theory.
Following phase I, as the group therapist continues to disconfirm each individual team's self definition, the group members find that they may be able to maintain their self definition by interacting more with one another. The alternate way of gaining confirmation of self definition becomes an attempt, by the group, to establish a 'definition of the situation', which would be in keeping with their self definitions. Some of the authors discussed earlier suggest ways this shift to a more group centred approach could come about.

Bion says that some group members assume the dependent-leader role. "When the leader of such a group fails to meet expectations, as he is bound to do, the group searches for alternate leaders. .... This is a temptation which the group offers to its more ambitious leaders." (Rioch, 1970, P. 59). Whitaker et. al., suggest that patients express certain wishes or fears. Some of these "touch the others" and "will be elaborated by various comments". (Whitaker et. al., P. 119). This change from social isolation to some degree of interaction may be explainable in terms of mechanisms which Corsini et. al. (1957), describe as 'spectator therapy' and 'universalisation' (Ibid. PP. 41-43). These processes are well summed up by Schilder (1940): "In a group the patients realise with astonishment that the thoughts that have seemed to isolate them are common to all of them." (Ibid. P. 42).

The function of this shift to more communication (though still usually asyndetic in nature) is an effort by the group members to;
(i) establish a definition of the situation, and

(ii) force the therapist to confirm their present self definitions.

Either way, the focus of the therapy group remains on the therapist, and it is at this phase that 'dependency' can be considered a valid concept. (See P. 52).

The group members become more present to each other. This may be observed and checked in the change in communication patterns. However, what happens is interpersonal behaviour which is severely limited because of the 'reactivation of fixated interpersonal perceptions' (Martin and Hill, P. 24) i.e. Though the individual teams endeavour to combine to establish a definition of the situation and to maintain their self definitions, the dysfunctional nature of their self definitions makes interpersonal exchanges stereotyped and unrewarding.

These features of phase II can be documented from the authors discussed earlier.

(i) Rogers notes that group members begin to interact more. "In spite of ambivalence about the trustworthiness of the group and the risk of exposing oneself, expression of feelings begin to assume a larger proportion of the discussion." (Rogers, P. 264). He acknowledges the members' inadequacy to adjust to each other and the therapist. Their anxiety and tension shows itself. "The first expression of genuinely significant 'here and
now' feeling is apt to come out in negative attitudes toward the group leader." (Ibid. P. 264). That the therapist is still the person being 'attended to', yet that he is still not responding in an acceptable way, is noted by Rogers who adds, "..... frequently the leader is attacked for his failure to give proper guidance to the group" (Ibid).

The extracts indicate that although inter-team communication increases, it is unsuccessful in establishing a definition of the situation. This is because, as noted on page 121, the therapist's major role in this phase is to gradually "bring about a situation in which the patient(s) will acknowledge the futility of his (their) current mode of living" (Pentony, 1970.a. P. 243). Though interpreted differently, the other authors note this change in interaction patterns and the process of 'attending to' the therapist.

(ii) Bennis and Shepard, for example, note the increasing tension and futility resulting from this preoccupation with the leader. "Now expressions of hostility are more frequent ..... leadership may again be discussed ..... fragmentation is expressed ..... two opposed sub-groups emerge ....." (Bennis et. al. PP. 421-422).

(iii) Whitaker and Liebermann seem to indicate that the group members efforts are aimed at forcing the therapist to establish a definition of the situation which complements
their own dysfunctional self definition. The relationship between a viable group and a viable self definition can be seen in their comment, "..... each patient's behaviour can be understood as being motivated by a wish to establish what would be a viable group for him" (Whitaker et. al. P. 149). They note that this isn't a conscious process (Ibid. P. 149). One would think that they are really concerned about structure and direction. They are, but only as a means of maintaining a dysfunctional self definition. ..... This can be seen in the phrase "..... a viable group for him". (Ibid.)

(iv) Bion also notes the increased interaction among group members in this phase. Some, he says, endeavour to lead (example of Mr. X, P. 32, Bion), others "give some details of their background" (Ibid). He also notes that this phase is primarily concerned about therapist 'control', (c.f. Haley, 1963) and the pressure the group puts on the therapist to conform to their expectations (which are keeping with their self definitions). This issue of 'control' is noted in the following passage. "The account given above (PP. 29-40) showed a group bewildered by the difference between what they expected of me and what they really found. There was anxiety that the group should proceed along well established lines, e.g. those of a seminar or lecture. Although it was understood by each individual that they were met together to study groups
and their tensions, in the group itself such an activity on my part did not appear to be comprehensible". (Ibid, P. 66).

Following Bion's passage, it could be said, that a seminar group wouldn't challenge their self definitions. Bion says it another way when he develops the theme that groups have a "hatred of learning by experience" (Ibid P. 86). The therapeutic experience being developed in this model, is that experience, which results from a group which comes to acknowledge its current mode of interacting.

(v) Martin and Hill note the increased inter-team interaction, but adds, "From an observer's point of view the flavour of the interaction will be that of disregard for the needs and the individuality of the members, ....." (Martin and Hill, P. 23). They also note that the function of this increased interaction, is to establish a definition of the situation which will be 'legitimised' by the group. "..... attributing to each other projected attitudes for which there is no consensual validation" (Ibid, P. 23). If this be so, then stereotyping of the leader and of the group members, reflects their own dysfunctional 'frames of reference' and self definitions.

In brief then, phase II is characterised by group members who continue in their endeavours to maintain dysfunctional self definitions. Increased interaction for the purpose of structuring
a viable group, fails. The group members can be conceptualised as 'attending from' malfunctioning frames of reference. While they continue to 'attend to' the therapist, change isn't possible. During this phase the therapist refuses to 'legitimise' the dysfunctional self definitions, by taking 'direct' control etc. Instead he allows the anxiety to mount in order to establish the inappropriateness of the 'stances' being taken. Pentony concludes; "..... the tenability of the definition becomes increasingly precarious until the point is reached where it must be abandoned." (Pentony, 1970a. P. 245). As mentioned earlier, this abandonment may be regarded as a sudden or a gradual process.

This phase can be represented by the following diagram:

**DIAGRAM II** : Dependent Group
For the therapy group to develop to a 'therapy team', the group must

(i) establish a definition of the situation, and
(ii) maintain this definition.

The therapy group can only establish itself as a 'team' when it changes from 'attending to' the therapist, to, 'attending from' the therapist's frame of reference. This can only come about as the result of the group experiencing the futility of their present 'frames of reference' or 'stances'. This is the function of phase II. When the 'point of abandonment' arrives the 'transition' phase is operative.

(c) Phase II : Transition

The prerequisites for the transition or "unfreezing" phase (c.f. Schein and Bennis, 1961) seem to be;

(i) Some degree of 'insight' or understanding, by the individual group members, about the futility of their present 'self definitions'. They would need not only to recognise this but also be prepared to change. How they can recognise and accept their inadequacies and endeavour to change, will be discussed in a moment, and

(ii) A heightened anxiety and tension, which accompanies the recognition that they cannot adequately cope with the present interpersonal situation. This reaches a point of frustration where members begin to change or leave the group.
All the theorists discussed earlier noted that heightened anxiety in the form of tension and emotional lability is always present in transition periods: "For it can be argued that the moments of stress and catharsis, when emotions are labile and intense, are the times in the group life when there is a readiness for change" (Bennis et. al. P. 425).

It could be said that this tension is the spark which generates the chain of events (the transition phase) leading to the group becoming a 'team'. ..... i.e. "a set of individuals whose intimate co-operation is required if a given projected definition of the situation is to be maintained" (Goffman, 1959, P. 104). The establishment of the definition occurs during the transition phase. The definition of the therapeutic situation, it is postulated, is that the group members change their 'stance' ..... i.e. they begin to 'attend from' the therapist's frame of reference or mode of performing. This becomes one of the 'paradoxes' (Haley, 1963) viz., the group members give up their 'dependency' on the therapist by 'attending to' themselves and the group. To do this they must adopt a new perspective or stance ..... i.e. they 'attend from' the therapist's position. They must not 'depend on', but 'attend from' the therapist. This novel way of conceptualising the change that takes place during the transition phase will be discussed later. The particular concern at present is how this 'switch' in perspective comes about.

The previous discussions on the five theories of group development have suggested several ways or 'Pathways' (c.f. Lett
and Woodward, 1970) this transition can take, in order that the 'group therapy team' be established. These 'pathways' will be briefly reviewed:

(i) The therapist explains what is happening in interactional terms. This explanation gives the group members "terminology and frames of reference for classifying individual behaviours" (Martin et. al. P. 25). This is a typical 'pathway' for group dynamic therapy and clearly demonstrates the proposition that group members change 'stances' and 'attend to' their own behaviour from the therapist's frame of reference. As mentioned earlier however, this doesn't explain how anxiety provoked 'defense mechanisms' are handled except by a rational, cognitive explanation. This could be called the 'teaching pathway'.

(ii) Similar in its cognitive aspects, but different in emotional dimensions, is that 'pathway' suggested by Bion, and Whitaker et. al., viz., the therapist's consistent and appropriate 'depth' interpretations. These interpretations are accepted more slowly (probably because of their 'cognitive dissonance' aspects) and in themselves often generate more anxiety. Bion doesn't describe how his interpretations come to be accepted. Whitaker et. al. suggest that the success of this 'pathway' depends on the consistency of the interpretations and the support of the expanding group culture or
atmosphere. (Whitaker et. al. PP. 220-221).

(iii) A third pathway arises from Redl's (1942) 'central persons' theory. Bennis and Shepard (1956) and Rogers (1967) both seem to see the transition occurring because certain 'unconflicted' or 'responsible' people perceive the therapist as 'permissive', or accept his 'interpretations' and explanations as valid, or take responsibility for a mode of action that is acceptable both to the group members and the therapist. This last possibility is clearly demonstrated by Bennis and Shepard, who describe the unconflicted person as perceiving the therapist as 'permissive', attending to his interpretations and being capable of precipitating the 'barometric event'. (Bennis and Shepard, PP. 422-427). The reason for the group accepting the pathway suggested by the unconflicted person, is postulated as the "infectiousness of the unconflicted on the conflicted personality constellation" (Bennis et. al., P. 418).

Rogers (1967) seems to suggest that key people in the group begin openly exploring their feelings and responses (a 'performance' Rogers regards as a sign of progress), and the group's healing power supports them during and after this ordeal. The therapist and the rest of the group acknowledge this behaviour to define the therapy situation and the acceptance, and alleviation of anxiety which follows, establishes the therapy 'team'. As mentioned earlier (P. 114) the role of the therapist or the central
person, can be explained in terms of reinforcement (behaviour) theory, or relationship theory, or 'modelling' theory.

Where the transition is slow, as some authors suggest may happen, (e.g. Bennis et. al. P. 423; Whitaker et. al. P. 127), the transition could be explainable in 'gradual self acceptance terms' (Rogers, P. 267) or in 'systematic desensitization' terms (Paul and Shannon, 1966).

Regardless of the 'pathway' taken, the end product is the same, the birth of the therapy team. Whichever pathway is taken, it leads to both, the group members and the therapist, accepting the pathway as providing a definition of the situation which all agree to. The pathway taken causes the group members to gain another perspective of the group situation. "What occurs is a sudden shift in the whole basis of group action. It is truly a bridging phase" (Bennis et. al. P. 423). As mentioned earlier, the proposition that the group now begins to 'attend from' the therapist's frame of reference, can be seen from the increasing use of the therapist's terminology and cognitive structure. All authors (except Bion), note the group's 'subjective feeling of relief', its 'happy, cohesive, relaxed' atmosphere, its 'increased interpersonal exchanges', and its 'acceptance'. The group has developed to the phase of being a 'therapy team'.

The transition phase can be represented by the following diagram:
Having established a definition of the situation, the team must maintain it. To do this the group members must come to grips with interpersonal issues. This is implied in the definition of a 'team' ..... "a set of individuals whose intimate co-operation is required if a given projected definition of the situation is to be maintained" (Goffman, P. 104). It could be said that the first major issue of independency-dependency was resolved with the birth of the team. For this to occur, personal change in most group members was required. Now if 'intimate co-operation' is to be the norm for the maintenance of the definition, then interpersonal conflicts, such as 'intimacy', 'interdependence', 'openness', 'power', 'pairing', etc., will have to be handled. These were all the issues raised in chapter 4, as being characteristic conflicts arising in phase IV.
That these interpersonal issues are paramount can be seen from the interaction and communication patterns of this phase. As mentioned earlier, these can be observed and measured (HiM, 1965; Psathas used the Bales Analysis, 1960; Query, 1964; Munzer and Greenwald 1957; and Murcock et. al., 1969).

This preoccupation with interpersonal issues is noticeable in the five theories reviewed earlier. Brief examples are given.

(i) Rogers: "The expression of self by some members of the group has made it very clear that a deeper and more basic encounter is possible and the group appears to strive intuitively and unconsciously, toward this goal." (Rogers P. 268). He develops the inter-personal issues of 'feedback', 'confrontation', and the intimate 'basic encounter', all in the safe atmosphere of an accepting group culture. (Ibid. PP. 268-272).

It seems clear that the definition of the situation is Rogers' criteria for group therapy - viz., openness, congruence, understanding and acceptance and the expression of feeling. As the team works to maintain this definition of the situation in their interpersonal relations, personal changes continue to take place.

(ii) Martin and Hill: They also note the stress on inter-personal issues. "..... the group can now, for the first time, deal with the 'here and now' of group life and the perceptions of each other's personalities and behaviours" ..... "the therapeutic value of this phase
lies in the ability of the members to perceive the
effects that their emotional need-meeting have on their
behaviour" (Martin et. al. P. 24-27).

(iii) Bennis and Shepard: These authors note that the therapy
group (team) at this phase can exert pressure on members.
They see this as the problem-area for group members who
desire an 'overpersonal' group. The 'counterpersonals'
in the group, on the other hand, fear 'intimacy and
involvement'. They note that during this phase, group
members learn not to fear 'loss of self esteem' from
other members. They conclude, "the fear and rejection
fades when tested against reality". (Bennis et. al. P. 433).

(iv) Whitaker and Liebermann: These authors note that inter­
personal issues 'recur' during this 'established' phase.
"No matter how long the group goes on, the patients are
recurrently confronted with such basic issues as ......
how to be aware of emotions without being overwhelmed by
them, how to maintain integrity of self yet enrich life
through interdependence with others, or how to manage
close personal relationships" (Whitaker et. al. P. 116).
These authors seem aware that maintaining the therapy
team requires the individual members to learn to relate
together. It is this 'intimate co-operation' character­
istic of 'teams' which is the central learnings for
group members during this phase of group therapy.
(v) Bion: notes that one of the major areas of personal conflict is in the area of intimacy. This is the basis for his basic assumption of pairing. He notes individual progress is dependent upon interpersonal success.

"..... his ability to co-operate is dependent on a kind of give and take that is achieved with great difficulty ....." (Bion, P. 90).

The point being made is that the emphasis on interpersonal issues which characterises this phase can be explained in terms conceptualisation as the intimate co-operation that is required 'to maintain the definition of the situation' (Pentony, 1970a, P. 214).

As mentioned earlier, following the abandonment of their former 'stances' during the 'transition' phase, a new self definition was required. Pentony (1970a) notes: "The nature of that new definition will depend upon the opportunities provided by the context of social forces in which it is born and to which it is attuned" (Ibid. P. 245). So the new self definition will arise out of the 'social context', part of which is that the team observe its own behaviour and that of its members from the therapist's frame of reference. All the group models considered in this paper failed to develop this feature of phase IV.

The process whereby a new self definition is gradually acquired by each group member during this phase has been given various interpretations. Rogers sees it developing as a result of the relationship qualities of the group. Whitaker et. al., describe the process in terms of the individual focal conflicts being
resolved as the group's focal conflicts are resolved. (Whitaker et. al. PP. 161-185). Bion has a similar explanation, as does Bennis and Shepard who also see the group and the individual having similar areas of conflict in their development. Martin and Hill offer no plausible explanation.

It is not the purpose of this paper to explain the process of the acquisition of new self definitions in group psychotherapy, as the purpose of the paper is the examination of the development of a therapy group. However, it does seem that the property of the individual team 'to take a stance' and its ability to 'attend to' itself, comes very close to Gendlin's theory of 'Focusing', which is a process explaining personal change or referent movement (Gendlin, 1964).

As mentioned earlier, one of the properties of a 'team', is that it is 'a stance taking entity', or as Goffman notes, "it is against something that the self can emerge". (in Pentony; 1970b. P. 17). In this sense as different group members become the focus of attention during the 'team' phase, this could be considered as evidence that 'the whole is not determining the part', but that each individual team is not losing its identity in the therapy team. It is precisely because individual teams are part of the larger system (therapy team) that they have something against which the 'self' can emerge. The safety and acceptance which characterises the team culture help to make this possible.

In brief then, phase IV deals with the group members gradually learning to cope with conflicts and tensions surrounding
interdependence issues of individual differences and intimacy. It can be conceptualised as the phase when the therapy group has become a therapy team, the essential feature of which is the 'intimate co-operation it requires of its members to maintain a definition of the situation'. Because of this requirement, interpersonal issues become the core characteristic identifying this phase. Another feature is that the team members are 'attending from' the therapist's 'frame of reference', a position which gives them a new cognitive structure whereby to understand their own and the team's behaviour, when they 'attend to' these behaviours. Individual teams don't lose their identity as the 'safe' atmosphere allows attention to individuals. In this sense the therapy team becomes the object against which the new individual 'self definitions' begin to emerge.

This phase can be represented by the following diagram:

![Diagram IV: The Therapy Team](image)
It seems then, that conceptualising group development in 'teams' theory does make initial attempts to account for the significant factors in group development. The following significant factors (see pp. 116-117), were tentatively explained in 'teams' terms:

(i) The development of the group from: initial individual behaviours, to issues concerning dependence on the therapist, to a transition phase which led the group to a consideration of interpersonal issues.

(ii) As the therapy group develops, there is a gradual increase in: insight and understanding, communication and interaction patterns, the use of the therapist's terminology and 'frame of reference', and the group atmosphere of safety and accepted standards.

(iii) The transition phase (often understressed in previous theories) is related to key therapeutic factors such as the group's ability to adjust to conflict and tension, the developing group atmosphere, the switch to using the therapist's frame of reference, the role of anxiety and emotions, the change in the interaction patterns in the group and the role of 'central persons' as catalysts and models.

These factors were seen to be stated explicitly or implicitly in the models of group development considered in chapters 2 and 3. It would appear that a 'teams' theory of group development which has been tentatively formulated in the previous
pages, is an initial attempt to describe the development of a therapy group, regardless of the theoretical therapeutic orientation the group therapist uses. The validity of this claim can be checked as one reads the following summary of "A 'Teams' Theory of Group Development".

TABLE 5: A 'Teams' Phase - Theory of Group Development

<table>
<thead>
<tr>
<th>Phase</th>
<th>General 'Teams' Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1</td>
<td>Individual teams interacting, so as to present 'dysfunctional self definitions' which each attempts to maintain. This causes initial anxiety. Each 'team', 'attends from' this dysfunctional self definition and 'attends to' the therapist, hoping he will define a therapy situation which will compliment their self definitions.</td>
</tr>
<tr>
<td>The Arena</td>
<td></td>
</tr>
<tr>
<td>Phase 11</td>
<td>Each individual team now sets out to get other team members to define a situation which will compliment their dysfunctional self definitions. This can't be done because of the dysfunctional nature of each member's self definition, rigidity and lack of adaptability. Interaction and anxiety begin to increase as neither the therapist nor the ind. teams establish a definition of the situation and since ind. teams' ways of 'attending from' and 'attending to' are inappropriate.</td>
</tr>
<tr>
<td>Phase</td>
<td>General 'Teams' Description</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Phase III</td>
<td>The anxiety is alleviated in such a way as to switch the group members from, 'attending from' dysfunctional 'frames of reference' to 'attending from' the therapist's frame of reference. A number of 'pathways' involving 'central persons' can be taken. The therapist remains in 'control', since whichever pathway is taken must lead to the alleviation of anxiety, a safe 'group' atmosphere, and a new 'frame of reference' for the group.</td>
</tr>
<tr>
<td>Phase IV</td>
<td>Since the therapist's definition of the situation has now been established in such a way that group members' 'intimate co-operation' is necessary to maintain it, the therapy group has become a 'team'. Since co-operation is necessary, interpersonal issues such as individual differences, sub-groups and intimacy become the central issues. The therapy team provides the context, for individual teams to take a stance against, thus preserving their identity in their quest for new self definitions. This helps resolve the 'identification-separateness' paradox. In this phase individual teams</td>
</tr>
<tr>
<td>Phase</td>
<td>General 'Teams' Description</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td></td>
<td>can 'attend from' the therapy team (a new frame of reference), to 'attend to' themselves and other group members.</td>
</tr>
</tbody>
</table>

The term 'dysfunctional' has been used in terms of the social environment, i.e. patients lack the type of conformity which social groups demand of people if they are to function in it. This is a different perspective to the medical model. If one accepts this view, together with the crucial role of therapist, which has been outlined previously, then it will be clear that group therapists assume a responsibility and they should be aware of this. (Lakin and Carson, 1966).
BIBLIOGRAPHY
Abrahams, A.  
Group psychotherapy: Implications for direction and supervision of mentally ill patients. In Theresa Muller, Mental Health in Nursing, Washington, D.C. 1950, PP. 77-83.

Abroms, G.M.  
Persuasion in psychotherapy.  
*Amer. J. Orthopsychiat.,* 1968, 124 (9); 1212-1219.

Angyal, A.  

Anthony, E.J.  
The generic elements in dyadic and in group psychotherapy. *Int. J. Group Psychother.,* 1967, 17, 57-70.

Anthony, E.J.  
Reflections of twenty five years of group psychotherapy. *Int. J. Group Psychother.* 1968, 18, 277-301.

Arsenian, J. & Semrad, E.V.  
Individual and group manifestations.  
*Int. J. Group Psychother.* , 1967, 17, 82-98.

Asch, S.E.  
Opinions and social pressure.  
*Scientific American,* 1955, 193 (5); 31-35.

Azima, F.J.  

Bach, G.R.  
Bach, G.R. Specific group cultures as release mechanisms for individual behaviour patterns. Group Psychother., 1954, 10, 277-286.

Bach, G.R. A review of Bion's, 'Experiences in Group's' Int. J. Group Psychother., 1962, 12, 523-525.


Bennis, W.G.  A critique of group therapy research.  
Int. J. Group Psychother., 1960, 10, 63-77.

Bennis, W.G.  A case study in research formulation.  


Bion W.R.  Experiences in groups and other papers.  

Bion, W.R.  Learning from experience.  London.  
Heinemann. 1962.

Bion, W.R.  Elements of psychoanalysis.  London.  
Heinemann Medical Books. 1963.


Cartwright, D. & Group dynamics and the individual. Lippitt, R. Int. J. Group Psychother., 1957, 7; 86-102.


Cholden, L. Group therapy with the blind. Group Psychother., 1953, 6, 21-29.


Corsini, R.J. & Rosenberg, B.

Corsini, R.J.
Methods of group psychotherapy.

Dreikurs, R.

Dreikurs, R.
Group psychotherapy from the point of view of Adlerian psychology. *Int. J. Group Psychother.*., 1957, *7*, 363-375.

Dunphy, D.C.

Durkin, H.E.
Group dynamics and group psychotherapy. *Int. J. Group Psychother.*., 1954, *4*, 56-64.

Durkin, H.E.
Toward a common basis for group dynamics: Group and therapeutic processes in group psychotherapy. *Int. J. Group Psychother.*., 1957, *7*, 115-130.

Durkin, H.E.

Ellis, A.
Erikson, E.H.  

Erikson, E.H.  

Ezriel, H.  

Ezriel, H.  

Festinger, L.  

Flavell, J.H.  

Frank, J.D.  

Frank, G.H.  

Frank J.D.  
Some values of conflict in therapeutic groups. *Group Psychother.*, 1955, 8, 142-151.
Frank, J.D. Some determinants, manifestations and effects of cohesiveness in therapy groups. *Int. J. Group Psychother.*, 1957, 7, 53-63.


Gazda, G.M. (Ed.)

Innovations to Group Psychotherapy.

Geller, J.J.

Parataxic distortions in the initial stages of group relationships. Int. J. Group Psychother., 1962, 12, 27-34.

Gendlin, E.T.


Glatzer, H.T.


Glatzer, H.T.


Goffman, E.

The Presentation of Self in Everyday Life.

Goffman, E.


Gray, B.M.

Gray, B.M.  
ACE: A three dimensional model of individual and group psychotherapy.  

Gundlach, R.H.  

Hadden, S.B.  

Haley, J.  

Haley, J.  

Hare, A.P.,  
*Borgatta, E.F.*,  
*Bales, R.F.*  

Hare, A.P.  
A review of small-group research for group therapists.  *Int. J. Group Psychother.*, 1963, 13, 476-484.

Hartley, E. & Rosenbaum, M.  
Criteria used by group psychotherapists for judging improvement in patients.  *Int. J. Group Psychother.*, 1963, 13, 80-83.
Hartmann, H.  
Ego Psychology and the Problem of Adaptation.  

Harvey, O.J. & Consalvi, C.  
Status and conformity to pressures in informal groups.  J. Abnorm. Soc. Psych., 1960, 60 (2); 182-187.

Havighurst, R.J.  

Heath, E.S. & Bacal, H.A.  

Hill, W.F. (Ed.)  
Collected Papers on Group Psychotherapy.  

Hill, W.F.  

Hoch, E.L. & Kaufer, G.  

Hoffman, J.M. & Arsenian, J.  

Hora, T.  

Hovland, E.I. & Janis, I.L. (Eds.)  
Hunt, J. McV.  Concerning the impact of group psycho-
therapy in psychology. *Int. J. Group
Psychother.* 1964, 14, 3-31.

James, W.  The Varieties of Religious Experience: A
Library. 1929.

Johnson, J.A.  *Group Therapy: A Practical Approach.* New

Kadis, A.L.  *A practicum of group psychotherapy.* New

Kaplan, S.R. & Roman, M.  Characteristic responses of adult therapy
groups to the introduction of new members:
A reflection on group process. *Int. J.
Group Psychother.* 1961, 11, 373-381.

Kaplan, S.R. & Roman, M.  Phases of development in an adult therapy
group. *Int. J. Group Psychother.* 1963,
13, 10-26.

1955.

Kelman, H.C. & Parloff, M.B.  Interrelations among three criteria of
improvement in group therapy: Comfort,

Kubie, L.S. Some theoretical concepts underlying the relationship between individual and group psychotherapies. *Int. J. Group Psychother.* 1958, 8, 3-19.


Lewin, K. \begin{itemize}
\item Frontiers in group dynamics: Concept, method and reality in social science: Social equilibria and social change. \textit{Human Relations}, 1947, 1, 5-41.
\end{itemize}

Lewin, K. \begin{itemize}
\end{itemize}

Libermann, R. \begin{itemize}
\item Behavioural approaches to family and couple therapy. \textit{Amer. J. Orthopsychiat.}, 1970, 40, 106-118.
\end{itemize}

Libermann, M.A. \begin{itemize}
\item The implications of total group phenomena analysis for patients and therapists. \textit{Int. J. Group Psychother.}, 1967, 17, 71-81.
\end{itemize}

Libermann, M.A. & Stock, D. \begin{itemize}
\item The relations between individual and group conflict in psychotherapy. \textit{Int. J. Group Psychother.}, 1960, 10, 259-286.
\end{itemize}

Libermann, M. \begin{itemize}
\item Problems and potential of psychoanalytic and group dynamic theories for group psychotherapy. \textit{Int. J. Group Psychother.}, 1969, 19, 131-141.
\end{itemize}

Locke, N. \begin{itemize}
\end{itemize}

Loeser, L.H. & Bry, T. \begin{itemize}
\item The position of the group therapist in transference and countertransference: an experimental study. \textit{Int. J. Group Psychother.} 1953, 3, 389-406.
\end{itemize}
<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Title and Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mann, J.</td>
<td>Psychoanalytic observations regarding conformity in groups. <em>Int. J. Group Psychother.</em>, 1962, 12, 3-13.</td>
</tr>
</tbody>
</table>
Mordock, J.B., Ellis, M.H. & Greenstone, J.L. Mullan, H.


O'Hearne, J.J. & Glad, D.D.

Interaction and insight in group psychotherapy: The case for interaction.

*Int. J. Group Psychother.*, 1969, 19, 268-278.

Osberg, J.W. & Berliner, A.K.

The developmental stages in group psychotherapy with hospitalised narcotic addicts.

*Int. J. Group Psychother.*, 1956, 6, 436-446.

Ottaway, A.K.


Papenck, H.

Change in ethical values in group psychotherapy. *Int. J. Group Psychother.*, 1958, 8, 435-444.

Papenck, H.


Parloff, M.B.


Parloff, M.B.


Pattison, E.M.

Evaluation studies of group psychotherapy.

*Int. J. Group Psychother.*, 1965, 15, 382-397.


Pentony, P. Some thoughts on working with groups. Paper Presented to the Sydney Catholic Counselling Institute, May, 1970c.

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Title</th>
<th>Publication Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claster, D.S.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frank, J.D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Redl, F.</td>
<td>Group emotions and leadership.</td>
<td>Psychiatry, 1942, 5, 573.</td>
</tr>
</tbody>
</table>


Scheidlinger, S.  Identification, the sense of belonging and of identity in small groups.  *Int. J. Group Psychother.*, 1964, 14, 291-306.

Scheidlinger, S.  The concept of empathy in group psychotherapy.  *Int. J. Group Psychother.*, 1966, 16, 413-424.


Scheidlinger, S.  The concept of regression in group psychotherapy.  *Int. J. Group Psychother.*, 1968, 18, 3-20.
Schein, E.H.  Coercive Persuasion: A Socio-psychological
Schneier, I. & Analysis of the Brainwashing of American
Schein, E.H. & Personal and Organisational Change Through
Bennis, W.G. Group Methods: The Laboratory Approach. New
Schilder, P. Introductory remarks on groups. J. Soc.
Psychol., 1940, 12, 83-100.
Schutz, W.C. FIRO: A three-dimensional theory of inter-
personal behaviour. New York. Rhinehart
& Co. 1958.
Semrad, E. & The use of group process group dynamics.
Semrad, E.V., The field of group psychotherapy. Int. J.
Shapiro, D. & Shapiro, D. & Group therapy in experimental perspective.
Shea, J.E. Some theoretical concepts underlying the
relationship between individual and group
psychotherapies. Int. J. Group Psychother.,
1958, 8, 3-19
Human Relations, 1956, 9, 403-414.


Sherwood, M.  Bion's 'Experiences in Groups': A critical evaluation.  Human Relations.  1964, 17, 113-130

Silver, A.W.  Interrelating group dynamic, therapeutic and psychodynamic concepts.  Int. J. Group Psychother., 1967, 17, 139-150.


Slavson, R.S.  Current trends in group psychotherapy.  
Inter. J. Group Psychother., 1951, 1, 7-15.

Slavson, S.R.  The dynamics of analytic group psychotherapy.  
Int. J. Group Psychother., 1951, 1, 208-217.

Slavson, R.S.  Common sources of error and confusion in group psychotherapy.  Inter. J. Group Psychother. 1953, 3, 3-28.


Slavson, S.R. Freud's contribution to group psychotherapy. *Int. J. Group Psychother.*, 1956, 6, 349-357.

Slavson, S.R. When is a 'therapy group' not a therapy group. *Int. J. Group Psychother.*, 1960, 10, 3-21.


Stock, D. Interpersonal concerns during the early sessions in therapy groups. *Int. J. Group Psychother.* 1962, 12, 14-26.


Stock, D. & Liebermann, M. Methodological issues in the assessment of total group phenomena in group therapy. *Int. J. Group Psychother.*, 1962, 12, 312-325.


<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Title/Description</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thelen, H.</td>
<td><em>Dynamics of Group at Work.</em> Chicago.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>University of Chicago Press. 1954.</td>
<td></td>
</tr>
<tr>
<td>Smith, B.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Varon, E. Transition into the therapeutic phase of group therapy. *Int. J. Group Psychother.*, 1960, 10, 321-332.


Wolf, A. & Schwartz, E.K.  
Psychoanalysis in Groups. Grune & Stratton.

Wolpe, J. & 

Lazarus, A.A. 

Zimbardo, P.G. 
Involvement and communication discrepancy as determinants of opinion conformity.

Zimberg, N.E. & Friedman, L.J. 
Problems in working with dynamic groups.