CHAPTER NINE

group psychotherapy of the adolescent

There is something inherently seductive about the idea of treating disturbed adolescents in a group. It is a well known fact that the age group has a spontaneous interest in getting together and the conditions of current social reality require adolescents to spend most of their waking hours interacting within formal and informal peer groups. Developmental pressures cause these groups to hold great fascination and importance for the young person (Buxbaum, 1945). Theoretically, group psychotherapy should lead to effortless success.

It has been reasoned that group therapy would take full advantage of this natural grouping in the adolescent period, converting a distraction from individual therapy into a powerful therapeutic alternative. The troublesome dependency-independency-authority conflict with adults would be diluted by the presence of other young people in the treatment setting. Prompted by friendship and mutual concern, group members would recognize and confront maladaptive behavior in one another, including self-destructive pathological clashes with authority figures. These interventions would have great impact since they could not be dismissed as "uptight adult hasseling".

Sounds reasonable, doesn't it?

It is—in theory.

Unfortunately in practice group psychotherapy with adolescents often does not unfold in that way. Group members do not settle into a friendly acceptance of one another. Instead they approach each other with silence, suspicion and defensive affectations. They may not approach at all. Many groups disintegrate after a meeting or two.

If the group survives, perhaps because of external pressure to attend, the authority conflict is not diluted. In fact, instead of struggling with a single snarling youngster, the therapist is confronted with an angry and disruptive mob. Therapists have been known to disband groups out of fear for their own safety or at least their reputation in their clinic or private office building. Naturally, this extreme is unusual, but there are plenty of frightening war stories around to alarm the uninitiated.

Some therapists have succeeded in coralling their group, only to find that their reasonable, cooperative patients expect them to do all the work. The therapist is clearly accepted as a powerful leader and is beseiged with requests for advice, practical help and infantile support.

These unfortunate experiences (and others even worse) follow from a failure to consider all aspects of adolescent development, psychopathology and the dynamics of group formation during adolescence as they affect the formation and function of therapy groups.

There are many youngsters who need psychotherapy who will either fail to respond to the group approach or who may even be damaged by this technique. These youngsters may easily be screened through careful evaluation prior to group placement. If diagnostic study suggests that the presenting complaint results from ego depletion with panic and disorganization barely contained, the youngster is not a candidate for group therapy (Josselyn, 1972), at least not before a period of individual therapy. In individual work, youngsters of this kind can utilize an extremely dependent transference to gradually strengthen and widen their defensive skills and to partially resolve the primitive conflicts which are dangerously near eruption. At that point they have the potential to utilize interaction with peers constructively. Earlier they would have merely experienced a lively, challenging group as another stress to an already over burdened coping system. (Sugar (1972) has described the utilization of self-selected peer groups in cases of this kind).

A second category of youngster who cannot benefit from group therapy is fixated at a level of development which does not value the opinion or support of peers. Such adolescents often present with psychosomatic or self-destructive behavior which seems clearly motivated by a need to coerce nurture from adults. They require an infantile feeding relationship with a caring adult to maintain marginal functioning.

Ann, a thin, tense fourteen year old girl had been in psychotherapy with three different therapists since age eight when her multiple neurotic symptoms of school phobia, abdominal pains, vomiting episodes, and multiple phobias first became evident. Her mother was a narcissistic, infantile, and extremely unhappy woman who had been in psychoanalysis for eight years. She made no secret of the fact she experienced Ann as an unlovable burden. Her father was distant and rigid, confining his family interactions to occasional outbursts at his daughter when she interfered with any of his plans and criticism of his wife for not coping better with the children's management and control. Ann's problems had been variously diagnosed as an anxiety neurosis, borderline psychosis and childhood schizophrenia. Psychotic diagnoses had been considered because of Ann's general disorganization and because some of her phobic concerns were quite bizarre. For example, she feared she might wet herself at school but responded to this common worry by wearing four to six layers of undergarments. She also was periodically fearful that her hair was falling out, that she had cancer or that she had performed acts that she had only thought about. Reality testing clearly was shaky.

After a year and a half of therapy with her latest therapist she had stabilized markedly and was symptom free. She began to move toward adolescent concerns and behaviors, but complained chronically that she had no friends at school. The therapist tried to explore her role in this state of affairs with very little success. Motivated more than a little by countertransference annoyance, he pushed her to join an adolescent group where her ways of relating to agemates could be directly observed. She agreed reluctantly, insisting on continuing individual sessions concurrently (though she complained constantly that they were valueless).

In the group she was paralyzed with anxiety, developed a blind hatred for the female co-therapist, and alienated the

other group members with her childish and demanding behavior. In one active session while being confronted by another group member, her eyes rolled back in her head and her neck muscles went into spasm so that she literally could not "see what was being said". She had to leave the meeting. The support of extra individual sessions allowed her to recover quickly and, after some ambivalence, she decided to return to the group where by subduing herself, she was able to attain a degree of acceptance. However, it was the therapist's opinion that she had only survived the group experience, not that it had benefited her. She remained in individual therapy after the group was terminated, and maintained her symptomless but constricted adjustment even as the frequency of appointments was gradually reduced to one a month.

Similar failures, more dangerous to the group than to the patient, may occur with unsocialized acting-out youngsters. Of course, many adolescents who present with antisocial behavior are basically well socialized and are handling neurotic or developmental problems in an alloplastic manner. They work out quite well in group therapy. However, those youngsters who have never shown evidence of adequate object relations and the capacity for affectionate attachment will not respond to group pressure and cannot adapt to group expectations.

Fortunately, most youngsters who should not be in group have some awareness of this fact. They, like Ann, resist the plan for psychotherapy. Although some youngsters who do well in group resist the idea initially, strong reservations should lead the therapist to review his diagnostic thinking carefully before pressuring the youngster to enter group psychotherapy. As a rule, the appropriate group candidate is anxious about the prospect of group work but is also fascinated and intrigued by his fantasies of what may happen.

WHY ADOLESCENTS WANT TO BELONG

Some consideration must also be given to the nature of spontaneous adolescent groups. The developmental pressures which drive the adolescent toward his peers and the emotional needs

which he hopes to satisfy in peer groups strongly affect the readiness with which adolescents will relate to one another in a therapy setting and the style of communication which will tend to occur. These developmental factors also influence the reception the therapist can expect as the therapy group's leader.

In early adolescence the youngster turns toward peers under the pressure of his need to emancipate himself from his family. It is more of a panicked flight than a positive quest. As the parents are rejected and devalued, their utility as sources of narcissistic support is weakened or lost. The youngster does not yet have a suitable substitute internal mechanism for maintaining his sense of worth. The peer group provides a temporary emergency support system. However, this means that the adolescent's friends must be people he can view as equals or superiors and that they must offer him a primarily positive reflection of himself. Naturally, he is willing to conform slavishly to group norms in order to obtain this acceptance. The adolescent is very particular in choosing his associates. His ties are somewhat fickle, since he will drop any friend who falls from favor with the remainder of his gang. It is the rare fourteen year old who will maintain an open friendship with a youngster who "everyone else" regards as "weird" or "queer".

As the youngster grows older, the peer group increasingly becomes important as a support system in the task of modifying the superego. The group shares guilty secrets with bravado and even encourages previously unacceptable behavior, particularly actions which defy adult authority. However, group members are not merely "partners in crime", they also offer one another limits based on the human rights of other members of the group. They may also persuade individuals not to "go to far" because certain behaviors may be dangerous to the individual or may threaten the continued existence of the group. Therefore the group serves both to loosen the constraints of the latency conscience and to provide an alternative, reality based, system of controls.

As these developmental tasks are mastered, the adolescent becomes increasingly interested in his peers as real people. Relationships become less narcissistic and attachments are based on positive

attraction rather than flight from the family of origin. Bonds are still somewhat tentative and there is considerable role playing, but relationships are warm and enduring over relatively extended periods of time. Even friction and controversy are accepted as necessary and valuable aspects of a rounded experience in the group.

This progression is often interrupted or uneven in the troubled adolescent. Many patients, even in late adolescence, are still more invested in the search for "psychic bandaids" than in learning from an honest give-and-take relationship. This fact creates two kinds of problems in the early stages of adolescent group psychotherapy.

First of all, the troubled adolescent is reluctant to accept his fellow group members. It is difficult for the patient to idealize people who are gathered with him because they too "have problems". He is frightened by the prospect of losing self esteem through accepting membership in a group of "misfits". If some group members have strikingly different defenses, social styles, or socio-economic backgrounds, the patient's certainty that he is in the wrong place grows exponencially. Some patients are often lost to the group at this point. As those who remain begin to find some group members who seem acceptable as "friends", there is a strong tendency for the group to fragment and develop cliques and scapegoats. It is a trying time for the therapist whose goal is to promote total group cohesion.

A second problem is created by the narcissistic vulnerability of the adolescent. Because of the need to use peer relationships for narcissistic confirmation, the adolescent tends to hide his problems and to cooperate fully with the same strategy as it is utilized by the other group members. The patients desire to avoid criticism and are understandably reluctant to throw the first stone. Each patient pretends to offer what he hopes to receive—total acceptance and admiration. Any confrontations that occur tend to be directed toward scapegoats and are hostile and distancing. It is easy for the therapist to become the only one in the group who "hassles the kids who are okay". He must be careful also to avoid being the only one who "takes up for the dopey ones".

The adolescent's use of peers to assist in the modification of

his conscience also carries a threat to the successful formation of a therapeutic group. Most groups will test the therapist in this area. In more subdued groups, the discussions of forbidden thoughts and actions will be carried on initially before and after the therapist enters the group. Sooner or later, however, some group member will be either brave or nervous enough to broach the topics in the therapist's presence. Other groups are much more bold. In either case the group must know the therapist's stance. Will he encourage acting out or will he come across as a parental-superego figure? Will he be corruptible, seducible and manipulatable or will he be repressive and rigid? Of course, the opportunity of therapeutic exploration is lost if the therapist is drawn into an unholy alliance with either the id or the superego. This problem has been considered earlier in regard to the development of the therapeutic alliance in individual psychotherapy and the principles of management are the same in groups. However, the counter transference pressures of facing a group involved in externalizing superego issues are greater than those encountered with individual patients, particularly when the group seems in danger of transforming itself into a vicious, salacious street gang before one's eyes. Skilled group therapists have managed to navigate this risky period spontaneously, but many problems may be avoided by utilizing some of the technical structuring patterns suggested later in this chapter.

This brief discussion of developmental issues which influence the achievement of group cohesion underlines the fact that the natural tendency of adolescents is indeed to form groups, but not groups that are inclined to explore the meaning of behavior (Meeks, 1973). Of course, groups can be helpful, even therapeutic in the broad sense, without investigating the meaning of behavior. One successful strategy of group therapy with adolescents is to simply accept the basically narcissistic, supportive patterns of spontaneous groups and to harness these forces for constructive goals. This technique does not encourage introspection and will be described briefly. A second approach which utilizes structural techniques intended to encourage introspection, investigation of motives and scrutiny of the emotions which underlie interpersonal transactions

will be discussed in greater detail. Many groups actually develop some characteristics of both types of group structure.

THE OPEN-ENDED SUPPORTIVE GROUP

Therapeutic groups which focus on changing self-destructive behavior by embracing and manipulating natural patterns of adolescent behavior in groups have been rather successful in a variety of settings (Sadock and Gould, 1964; Franklin and Nottage, 1969; Kraft, 1968). These groups have certain characteristics in common although there is considerable variation in their membership, specific procedures and goals. Initial membership is often compulsary and enforced by outside agencies such as probation agencies or the officials of a residential treatment institution. The groups are open-ended, and, in fact, often define the addition and successful assimilation of new members as their primary function. Members are selected primarily on the basis of their symptom or because of their presence in a particular institution. The group, then, is rather homogeneous, either for symptom (drug usage, delinquency, etc.) or through their common experience in daily living circumstances. The work of the group is oriented toward fairly circumscribed goals, usually either altering the common symptom behavior or improving the adaptation to the common living situation.

The basic force for change in these groups is a core of committed "old members" who have been converted from a prior involvement in the symptomatic behavior to an alternative life style. They credit the group and its leader for their success in changing. They are familiar with the gratifications and temptations of the negative behavior and recognize immediately the common defensive patterns and attitudes that insulate the new group member from awareness of the destructiveness of his maladaptive symptoms. Since they have decided that the symptomatic behavior is unwise and self-destructive, they are quite willing to confront the new member. Their self-esteem now depends on maintaining the wisdom of their decision so the new member's defense of the rejected behaviors represents a personal threat and is vigorously attacked. However, since they have also "been there", the old

members tend to temper their assault with empathy, support and open confession of their own shortcomings.

The technical devices utilized by leaders in these groups are primarily inspirational, supportive and directive although group members may actively pursue hidden motivations. Exploration is primarily directed toward subtle manipulations of the group and its leader by the unrepentant new member. Interpretations and confrontations are mainly aimed at unmasking the new member, helping him to "shape up" and stop "playing games". On the other hand, extended discussion of personal genetic and dynamic material tends to be viewed with suspicion since such material may be used as a justification for the unacceptable behavior, an excuse to avoid essential change, a "cop out".

In many ways the leader of these groups serves primarily as a consultant and support to the old members who carry the main thrust of the rehabilitative work. He is there to help if the old members become discouraged or if they are manipulated into an unnecessarily punitive or overly permissive position in relation to a particularly difficult new member. The leader assists the group in maintaining focus on its tasks and values. Usually he does this without commenting on the motives or problems of the old members. The leader points out that the old members may temporarily lose sight of the purpose and correct procedures of the group because their task is difficult. He avoids criticism or discussion of the old member's psychopathology since this might weaken their loyalty to the group and lessen their influence on the new members.

The narcissistic value of being "right" and "cool" are usually sufficient reward for the old members' work in the group, especially as these values are continually reinforced by the successful conversion of new members to the group ethic. The group provides an opportunity to obtain admiration from a peer group which is acceptable (i.e., the members are street wise, tough, know the drug scene, etc.) without engaging in behaviors which are dangerous and self-destructive. The group also provides a reasonable new superego model divorced from childhood and the parents. The almost evangelical drive to help other youngsters provides an

important sense of worth and mission which can substitute for the need to prove one's self in daring and illegal actions.

Although these groups are powerful agents for change, there are many limits to their application. It may be that some environments are so brutally unfair and destructive that adolescents subjected to their viciousness are unreachable. However, skilled workers with honest committment can ameliorate some of the damage in the worst environments (Stebbins, 1972). The difficulty of finding therapists with sufficient empathy, skill, toughness and concern to activate the group and form the original pro-therapy core of "old members" is an important limitation. Many are called, but few succeed and persevere.

Some youngsters cannot respond to any form of group therapy. Those so socially immature as to be immune to group pressure and group rewards cannot respond to a therapy based on these factors. Open-ended support groups are also relatively ineffective in correcting symptomatic behavior which is grounded in severe neurotic conflict, particularly when the behavior is part of a generally masochistic pattern.

Even with an appropriate leader and members who fit, there are potential problems. Failure to influence one or more new members is demoralizing and can erode collective self-esteem. Trusted old members can relapse in response to increased stresses in their lives with an even greater disruptive impact on the group. Charismatic new members may tempt the entire group to return to old value systems. In short, the group ties are basically narcissistic and therefore somewhat unreliable when pressures mount. The group leader's own charisma, flexibility and clinical wisdom will be severely tried as he attempts to maintain a positively functioning group entity over time.

THE CLOSED, EXPLORATORY THERAPY GROUP

The developmental impediments to adolescent group work may also be circumvented by altering the structural characteristics to encourage the development of a group ethic of emotional openness and exploration. The model described here does permit the addition of occasional new patients at infrequent intervals, but is basically designed for a group with constant membership and a reasonably prolonged existence. It is basically designed for outpatients. Under these circumstances, further modifications are necessary to insure continuing parental cooperation in the group work.

The open ended group described above can afford to neglect parental involvement since the group basically substitutes for the family and discourages extensive discussion of family relationships. In contrast, the dynamically oriented group is virtually certain to consider in detail the impact of family problems on the attitudes, feelings and interpersonal quirks of its members. These discussions will tend to activate latent family conflicts and may lead the parents to sabotage treatment or even terminate the adolescent's group membership. The needs of the parents must be considered if the group structure is to be successful. This parental involvement in the group will rarely substitute for specific therapy directed toward their marital or personal problems. Although some parents benefit personally, the primary goal is to enlist their enlightened support for the work of the adolescent group.

We can now turn to a description of the model. As in the remainder of the book, the procedures will be described explicitly with the clear recognition that other therapists have utilized other techniques successfully. Models must be altered to fit treatment conditions and personal preferences.

GROUP SELECTION

Members must be chosen carefully for outpatient dynamic group psychotherapy with an eye to both the needs of the individual youngster and the overall composition of the group.

The criteria of group selection are hardly scientific, but some principals seem clinically sound. We have already mentioned some youngsters who should be excluded from groups. Additional criteria should be mentioned. It seems important for the prospective member to have parental permission and, preferably, parental encouragement to join the group. Good group work produces anxiety and resistance. If the parent is poised to support flight from the experience, it is unlikely that most adolescents will be

able to resist this invitation to escape immediate pain in the interest of long term benefits.

The youngster himself should have at least a modicum of positive motivation for the group experience, perhaps limited initially to a mixture of interest and anxiety with an agreement to try the group for a month or two. The youngster's motivation will be evaluated in more depth during the evolution of individual treatment contracts, a process which will be described later.

Some attention should be given to choosing a group population which will be socially compatible within broad limits. Early impressions of other group members are important and adolescents are often harsh in their judgement of superficial characteristics. For example, a psychotic youngster with the same style, vocabulary, dress, and social experience would probably be less threatening to an adolescent group than a healthier youngster with a disfiguring physical defect or a background and life style which seemed "weird" to the other members.

> An adolescent group jelled with surprising rapidity except for Bill, a seventeen year old who remained withdrawn and uncomfortable through the first four meetings. He requested an individual interview where he told the therapist the group wasn't helping him. The other kids seemed strange and unfriendly and he intended to quit. When pressed about his discontent his complaints were vague. The therapist commented on Bill's uncharacteristic silence in the group meetings and wondered if he could really assess the other members' friendliness without being more open. Bill responded with angry tears. "I can't".
>
> "Why not?"
>
> "You're stupid. Why did you put me in a rich kids' group?"
>
> Though the therapist hadn't realized it, every member of the group except Bill came from very affluent families. They spoke casually of their cars, going out to dinner and attending concerts. Bill's father was a university professor who couldn't afford such luxuries.
>
> In this case, Bill's educational and social background were actually quite similar to those of the other group members. They were quite prepared to accept him although he felt very "different" from them.
>
> Bill was able to resolve his discomfort and work successfully in the group. His reaction is described merely to illustrate the adolescent's exquisite sensitivity to superficial social differences.

Some attention must also be given to the "balance" of the group. Passive and silent members must be offset with some "talkers". Youngsters inclined toward "acting out" solutions to conflict should be placed in groups which include some youngsters who reflect or even ruminate on their feelings before acting. Mostly one must depend on an intuitive sense of how the group will fit together. This sense is never infallible, but the chances for success are increased by knowing the individual youngsters reasonably well. This kind of knowledge can only be obtained through fairly prolonged pre-group individual evaluation.

PRE-GROUP EVALUATION

The diagnostic advantages of pre-group evaluation have been mentioned but these sessions are central to group success in other ways as well. The early stages of group therapy are extremely anxiety producing for many adolescents so it is important for each group member to have a stable, trusting relationship with the therapist prior to the first group meeting. Many youngsters should be started in group only after a period of individual psychotherapy with the therapist. Others may be referred by therapists who do not do group work themselves but believe the patient would be helped by a group experience. If the colleague's assessment is correct, these youngsters may require only a few individual sessions to get acquainted with the therapist and learn something of the pattern of group work he follows. Of course, the group therapist also uses these meetings to assure himself that the youngster is ready to function constructively in the group. If he does not think so, the patient can be referred back to the original therapist for further individual work.

If the group will have co-therapists, they can divide the evaluative work between them. This has practical advantages since most

therapists do not have group evaluation time in their normal schedule and are somewhat overburdened by the extra work involved in preparing to begin a group. The procedure does produce some technical problems since group members may resist group involvement and cling to their individual relationship to the co-therapist who evaluated them. However, this problem is preferable to the risk of early group dissolution. In any event, this excessive attachment to the therapist quickly diminishes as the group members become acquainted and form attachments to one another.

Pre-group meetings also allow patients to elaborate their anxieties and fantasies about group therapy. The therapist can correct frightening misconceptions and explain the goals and procedures of the group. The ground rules of the group such as prohibitions against physical contact, the desirability and limitations of confidentiality, the need for regular attendance, the procedure for quitting the group, and the expectation that each group member will formulate a treatment contract for the group can be discussed fully. The youngster has the opportunity to consider his treatment goals and to solicit the therapist's help in shaping a treatment contract which he would be comfortable in sharing with the group. This is important since many youngsters wish to discuss very sensitive topics in the group, but would be understandably reluctant to disclose these fully in an initial meeting of the group. For example, the fifteen year old boy who has never had a date and is terrified of girls may need permission to limit his first treatment contract to "I would like to improve the way I get along with girls". At the other extreme from youngsters who might say too much are those who require pressure and assistance to come up with any personal treatment goals. The pre-group individual sessions provide an opportunity to explain that comments like "I'm only here because my parents sent me" or "I was just curious about what happens in groups" will not suffice.

Pre-group meetings also permit the therapist to clarify his expectations about how the group will proceed. Comments such as "when a group really gets going, you get pretty involved with the other people" both explains the importance of regular attendance and sets the expectation that group members *should* comment on

each others' absences, consistent lateness, or precipitous desire to quit the group. The therapist has defined these behaviors as evidences of concern rather than meddling in someone else's business. Similar double duty is accomplished by predicting some of the problems the youngster may expect in the course of the group experience. "If this group really works like others I've had, there will be pretty open talking about how people feel about one another. Sometimes you may not like what people say about how you're coming across". "You know, there may be things about people in the group that annoy you. Now at school you might just avoid that person, but in a group it's important to talk about how you really feel even if you're afraid the other person may get mad or have their feelings hurt. Do you think you can do that?" Of course, these comments are tailored to the dynamics and relating style of the individual youngster. The diagnostic evaluation often allows a fairly accurate prediction of the types of group interaction which a given youngster will find most uncomfortable. Naturally these structuring comments do not guarantee that the group will actually move toward confrontation, emotional openness, and exploration of interpersonal processes, but it begins that process by presenting the possibility for such interactions and implying that the therapist expects these possibilities to occur.

The therapist predicts the patient will be emotionally accepted in the group and also states a rule when he explains, "the reason we make a fuss about someone stopping is because a lot of times the group wonders why someone quits, maybe even blames themselves. If you decided to leave the group—let's say you got your problem worked out—it would be important to explain that. The rest of the members would probably hate to see you go and they might wonder if it happened because of something they said or maybe they weren't interesting or good enough. So we ask anyone who thinks about quitting to bring that up at the start of a meeting and to tell why they're thinking of leaving the group. The other good thing about this is for you, the person who's thinking of quitting, it gives you a chance to hear what the other people think about your reasons for quitting and gives you a chance to think it over. And that's good, because stopping the

group is a pretty important decision and you'd want to think about it pretty seriously".

OBJECTION! Your honor, Dr. Meeks is leading the patient.

You bet your sweet id.

And that's only the beginning.

THERAPIST ACTIVITY

The leader of an adolescent group must work actively at promoting spontaneity and intimacy (Anderson, 1972). The therapist's activities include structuring group tasks and procedures and the usual group leader's activity of conceptualizing and verbalizing the group experience (group process) as it unfolds, but these professional activities are not enough. The therapist must also be active as a person, alive and involved in the group. He needs to share his own feeling responses to the meaningful emotional interactions which develop between group members.

Obviously this activity poses potential dangers of encouraging excessive dependency in group members. The therapist may be seen as a guru, a teacher, a good parent. These developments need not be unhealthy if they are recognized and discussed openly. If the therapist is alert and free of excessive needs for power or status, there will be plenty of chances to support emerging leadership in the group. The therapist's overt and explicit interventions can often decrease as the group's momentum grows, but he must remain an actively interested and emotionally invested observer.

In the seventh session of an adolescent group the therapist confessed his discomfort.

"I don't know. It seems like I'm talking too much in here. I don't think I'm giving other people enough chance to talk and that's really bad, because I'm not even getting to know you guys well enough to know whether I'm saying the right things".

Mike, a previously silent sixteen year old, said, "You're not. I'm sorry, but we need to get the kids talking. Me too, I guess. I haven't said much myself. I think we ought to interview each other, like take turns being the patient. Everyone could ask three questions—Course if you don't think—"

"Sounds great to me, but maybe you'd better ask the other kids".

"Okay, but Mike has to go first". Everyone chimes their agreement that Mike had to be the first "patient".

Everyone has their own style of activity. The important point is that passive, detached, dispassionate scrutiny may have great value in some scientific settings. The adolescent psychotherapy group is not one of them.

THE GROUP CONTRACT

The group contract or the group rules of the group are nothing more than a set of conditions which group members agree to follow in order to achieve treatment results they desire. This quality of informed consent and mutual committment needs to be emphasized to offset any fantasy that group contracts are made in heaven or in the therapist's head. The anticipation of possible control problems in adolescent groups may lead the therapist to focus on a long list of prohibitions as the primary content of the group contract. The adolescents correctly perceive this as a frightened insistence on a superego alliance and respond according to their particular pathology. Overly inhibited youngsters slavishly obey the rules and youngsters in rebellion fight them. Neither group becomes involved in treatment.

The fundamentals of the group contract have already been discussed with each youngster during his pre-group individual sessions. Each therapist must decide for himself the basic working conditions under which he can conduct meaningful group therapy. Many would consider most of the following rules important for the reasons given.

1) No hitting in the group. The therapist explains the obvious fact that people cannot speak honestly with one another unless they are assured that the therapist and the group will neither permit them to hit or be hit. Some therapists extend this rule to "no physical contact" to rule out physical expression of positive feelings (kissing, sitting on laps, etc.) along with the expression of aggression. This may be questioned on the grounds that it introduces some confusion by including "hittin' and huggin' " in the

same category as though they were somehow interchangeable or related to the same emotional origin. Secondly, the vagueness of the general rule suggests that the therapist is reluctant to confront adolescent sexuality directly. Finally, from a practical viewpoint, some physical contact (i.e., embracing a crying fellow member) may be decidedly constructive.

2) Regular attendance is expected. If it is totally impossible to attend a session, it is the patient's responsibility to contact the therapist and explain why the absence is unavoidable. The therapist explains that the members need to get to know one another very well in order for the group to be helpful. This requires very regular attendance. In addition, the unexplained absence of a member wastes valuable group time as the present members speculate on the reasons for the absence. Some members may even inhibit their group participation out of concern that some interaction with the absent member drove him away.

3) Any member who considers leaving the group should announce his intention at the beginning of a group session and permit full discussion of the decision. The reasons for this rule have already been discussed. Some therapists require a group notification of two sessions or more. Theoretically this makes sense, however it may invite passive aggression if some group members perceive the rule as a disguised attempt to force members to remain in the group when they have definitely decided to quit.

4) Each group member will be expected to make an individual treatment contract. This expectation will be discussed further below.

5) The group is told that the group will function best if there is no discussion of the group proceedings with others. Some therapists feel that this rule is impossible to enforce and add, "If you must discuss something that occurs in here with your parents or anyone else, at least don't use names".

The therapist (or co-therapists) may also wish to explain their position regarding confidentiality, namely that they will not discuss things that occur in the group or information revealed there unless, in their judgement, a group member is in danger of harming himself or others. Some therapists also reserve the right to answer

parental questions regarding treatment progress. Most adolescents seem to accept their parent's right to know if the youngster is utilizing treatment appropriately, but some therapists feel uncomfortable with "sending home report cards".

6) The group is told that any contact between members outside the group sessions should be reported in the next group meeting. It is explained that important group issues may be missed if group members have discussions which exclude the remainder of the group.

Some therapists forbid outside contact, but there are serious difficulties in taking this position. It is a rule that cannot be enforced, seems artificial, and invites rebellion. Also, many therapists have observed that much extra-group contact is supportive, pro-therapy, and conducive to the development of group cohesion.

These conditions are not presented as a list of dogmatic regulations. They are discussed with the group as important issues which require resolution. This does not mean they are totally or even primarily negotiable. For example, few therapists would consider working with a group that could not agree to refrain from striking one another. The therapist must press for the conditions he needs, attempting to convince the group of the therapeutic necessity of each rule. There is no reason to avoid "sales talk". The resulting contract is designed to benefit everyone, especially the group members.

THE INDIVIDUAL TREATMENT CONTRACT

The practice of requiring each group member to formulate a personal treatment goal and verbalize that goal to the group has several advantages. It is not an unreasonable expectation when the adolescent receives assistance with the difficult job of thinking through his contract in the pre-group individual sessions. It is probably true that any youngster who is suitable for outpatient group work is able to make this degree of commitment. However, the therapist must be willing to permit some face-saving reservations. For example, it is probably acceptable for the adolescent to say, "Well, the *real* reason I'm coming to the group is because my father says I have to, but since I'm here, I might be interested in learning more about how boys should treat girls".

The group presentation of individual treatment contracts is taken up as soon as the group completes consideration and acceptance of the group contract, often in the first session. The therapist introduces the topic by saying, "Okay, since we've agreed on those things, let's get on to people's individual contracts. Remember we said everyone would tell the group why they're coming here and what they hope to accomplish in the group. Who wants to go first and get it over with?"

Usually someone will volunteer, but if not, the therapist can ask a member to begin. Each contract is open to discussion by the group and the therapist and may be accepted or rejected as inappropriate. Generally speaking, any serious goal which seems neither destructive or foolishly grandiose is accepted. One does not expect or need psychologically sophisticated contracts at this stage in adolescent group work.

The two primary purposes of requiring contracts in the initial sessions are to open problem areas for group discussion and to provide the therapist with legitimate, neutral instrumental authority. Since each member has asked for help with a specific problem, the "mutual protection pact" of denial which often characterizes adolescent groups during their formative period is less likely to develop. The open admission of difficulty and the request for help give both a focus and permission to the other group members as they consider commenting on a fellow-member's verbal or nonverbal behavior in the group. For example, if a youngster has stated that he is coming to the group because he wishes to learn how to make friends, the group feels more free to confront him with his silence, sarcasm or egocentricity without feeling they are intruding or merely being hostile. "Maybe the reason you have trouble making friends is that you're always cutting people down. At least you do here".

The therapist is also in a better position to avoid the unholy alliances with either id or superego. The process of making individual treatment contracts defines him as a consultant to the group; an expert given the responsibility for guiding the group toward behaviors which will permit the individual members to accomplish their chosen goals. If it becomes necessary to set limits on group

behavior the therapist does this as a leader exercising his duty to help the group accomplish its aims, not as an offended uptight parent figure. His function is executive and oriented toward promoting better ego functioning with the group.

Any contract which is sincere will accomplish these two purposes. As the group work continues, contracts may be altered and refined. The therapist may suggest changes or new definitions of the problem may be offered by the patient or other group members. For example, the therapist may comment to a patient, "I would like to suggest a change in your contract now that I know you better. I don't think you exactly have a problem in making friends. I think you should consider working on your tendency to expect too much of friends and the way that causes you to be disappointed in people and overly critical". Later yet the contract may evolve to, "Trying to stop setting people up to prove they don't like me and that I'm better than they are".

The treatment contract is only a tool so its value will depend on the skill with which it is used to further the group work. Some therapists are worried that adolescent patients will not accept this condition of group work. They might consider the possibility that a group so resistant to the treatment process is unlikely to be successful in any case. Perhaps it is better to dissolve an unworkable group early in its course so that more suitable treatment approaches can be attempted. In actual practice, most adolescent groups will accept this condition of treatment. Naturally some of the more resistant members will hold back, but as more and more group members commit themselves to a treatment contract, the pressure to "get aboard" grows. The contracted members point out that it is only fair that all members reveal their problems and aspirations to the group.

THE PARENTS

Many patterns of parental involvement have been utilized in group work with adolescents. Some therapists conduct concurrent treatment groups for the parents or arrange for such groups to be conducted by a colleague. Attendance at these groups may be required as a condition for accepting the adolescent in the group.

These groups are sometimes quite difficult and unsatisfactory because the parents are unmotivated and do not recognize a need for treatment. However, a skillful therapist can often make these groups effective by permitting the parents to focus on their youngsters initially, gradually using common themes and problems to build group cohesion and a capacity for personal therapy work.

Another successful approach involves periodic family meetings, basically an adolescent group meeting with the parents invited. The adolescents may also be seen individually with their families. These approaches are effective and are well received by the parents. The only potential disadvantage is that family work closely linked to the group may dilute the intensity of the attachments formed within the group. If the aim is to maximize group intimacy so that the group can serve as a microcosm of emotional life, this may be a disadvantage too serious to accept.

Another alternative is to approach the parents as collaborators in the group process, leaving any direct therapy they may require outside of the group involvement. A parents' meeting is called just prior to beginning the adolescent group. The therapist or co-therapists present the aims and methods of the group didactically, explaining all aspects of the group procedure in detail. The parents are told that their youngster's individual problems will be approached indirectly through the creation of a human relationships laboratory experience in the group setting. The parents are offered examples to demonstrate how this experience serves to develop the capacity for self-awareness and skill in relating to other people in a fair and honest way.

The parents are told of the problems and disadvantages of this approach. The therapist admits that this kind of work creates considerable anxiety which may cause their youngster to express desires to leave the group. They are warned that youngsters often attempt to manipulate their parents to support their flight from the group by suddenly claiming all problems have been solved, being amazingly cooperative in the home, expressing concern about the morality and mental health of other group members, or trying to imply that the therapist is hostile toward the parents. The parents are assured that they are not expected to force their

youngster to remain in group. The desire to quit may be appropriate. The therapist merely wants their support in asking the youngster to discuss his decision and the reasons for it in the group setting. The parents are asked to refer any complaints their adolescent may have about the group or the therapist to a group meeting, encouraging the open expression of negative feelings in the group setting so that the youngster's emotional experience within the group can be as complete as possible. The parents are told that if *they* have any questions about the group or the therapist's behavior, these should be discussed directly with the therapist.

The importance of confidentiality is discussed so that the parents can understand why the therapist cannot fully disclose the happenings in the group to them. The therapist also explains why he needs their permission to talk openly with their youngster about any contacts the parents and therapist may have. Parents are encouraged to call the therapist with any questions or information but to inform their youngster that they are calling. They should also tell their adolescent the general content of what they intend to say.

Group fees and policies around absences are discussed along with an explanation of the importance of regular attendance.

The parents are encouraged to ask questions and to be sure they understand and agree with the plans for the group. The therapist tries to discourage extensive discussion of individual problems except when these lend themselves to illustration of general group concerns and techniques. Some questions may be referred to the other parents and some worries, such as fears that a particular youngster may not speak in group, may be generalized. The therapist can then talk in a general way about the way the problem will be handled in the group.

Similar meetings may be held periodically during the life of the group. They are always announced in advance to the adolescents. The parents develop considerable camaraderie and an atmosphere of mutual support for the adolescents' group work as these meetings continue. Some group interaction often develops among the parents. Frequently this is of both diagnostic and therapeutic value. In all meetings the therapist maintains the confidentiality of

the group, but permits the parents to share information they may have regarding the progress and behavior of group members including their own youngster.

THE WORK OF THE GROUP

Once the tasks of developing cohesion and open communication are achieved in an adolescent group, the observed interactions are very similar to those seen in adult groups. The words and issues differ, of course, but the work of recognizing, confronting and resolving interpersonal blocks to group progress is technically similar to adult work. The therapist gradually becomes less of an active structuring agent and moves toward a more reflective, interpretive stance in the group.

There are two rather common patterns in adolescent group work which do differ somewhat from the typical adult group. The first concerns the frequency and intensity of direct competition with the therapist. Of course, similar interactions occur in adult groups, but the adult patient is usually less frightened by his effrontery than is the adolescent. Often the adolescent can express his new strength only in the context of totally discounting the therapist's importance to him. Frequently he announces his desire to leave the group. The persistence of occurrences of this kind in adolescent groups is related to the adolescent's need to utilize adults as identification figures. With the support of the group, the adolescent goes through a cycle of testing the therapist, accepting (or even idealizing) him, challenging the therapist and testing him again at a less dependent level, and then accepting a new relationship on this more equalitarian basis. No special group techniques are necessary in the management of this pattern of behavior. The cycle merely needs to be recognized as a natural growth experience which is basically constructive for the adolescent involved. If the group therapist can comfortably accept the challenge and support new strength in the member, the remainder of the group can usually remind the challenger of remaining problems and prevent his precipitous departure from the group.

The second problem results from the adolescent's relative lack of conceptual skill with which to describe the subtle and intricate

nuances of interpersonal transactions. This deficiency can usually be countered verbally if the therapist can develop the capacity to describe complex social phenomena in words and images familiar to the adolescent. This kind of translation is sometimes insufficient or unconvincing. In these situations, judicious use of psychodrama and gestalt techniques to concretize the impasse may be indicated. These experiments often permit the group to comprehend the emotional factors beneath surface behavior and to feel the power of hidden forces operating in the group.

> Pat, age 15, was silly and disruptive in a group that had decided to work seriously. He fended off efforts of group members to engage him in serious talk with clowning and flippant remarks. The group was angry and wanted Pat ejected since he was "just goofing off".
>
> Pat had made an individual treatment contract but had described considerable anxiety about joining the group during pre-group individual sessions. The therapist was sure that the clowning reflected this anxiety rather than lack of motivation, but comments to that effect did not decrease the group's anger at Pat or change his defensive style.
>
> The therapist proposed a "psychological exercise" which he said "might help the group members to understand one another better". One member (a popular boy) was blindfolded. He was asked to choose someone to lead him around the room. Without hesitation he chose one of the attractive girls in the group. After they had traversed the room without incident, they were asked to describe their feelings. The boy laughed and said it was fun—"A good excuse to hold hands with Cathy". The girl said she'd worried a little that he was walking too fast. Once or twice she thought he might bump into things and blame her.
>
> "Okay, we'll talk some more about how you reacted later. Right now let's try someone else. How about you, Pat?"
>
> "No siree, you're not gonna put that snot-rag on my face. Germs. Germs!"
>
> "Yes, come on Pat".
>
> Pat ambled up slowly, rolling his eyes in mock terror.
>
> "Stop clowning, Pat," a member said.

Pat ran his hand over his face as though to wipe off a smile and pulled a solemn expression. The handkerchief was tied in place and he was asked who he wanted to lead him. He named the female co-therapist. She declined and told him he had to ask a group member. Pat began to look tense and worried beneath the blindfold as the silence lengthened.

"Come on, Pat, who do you pick. Hurry up".

Pat abruptly tore off the blindfold and rushed to his seat, clearly troubled and upset.

"You look scared," the therapist commented.

"They'd run me over something. They hate me anyway". Pat was obviously serious.

"God, he's really scared," a member said.

"Yeah, he doesn't trust anyone but the doctor".

Pat continued to have problems in the group, but the members were more sympathetic and were able to sense and explore his very real fear of people his own age.

ADOLESCENT GROUP THERAPY IN PERSPECTIVE

It seems that therapists are increasingly eclectic in their choice of treatment techniques. This would appear to be a reasonable development in a field where no single treatment approach has been demonstrated to have clear superiority. One benefit of this eclecticism is that it permits various combinations of treatment approaches tailored to the individual needs of a specific adolescent and his family. The combination and integration of individual and group therapy with the same therapist as described by Kaplan and Sodock (1971) for adults is gaining deserved popularity among adolescent therapists. The two forms of treatment appear to catalyze movement in each.

Group work may also be combined with family therapy or utilized to assist in dealing with a specific problem in on-going therapy. For example, a group experience may provide a transition between successful but extremely dependent individual therapy relationship and termination. Placement in a group may help an adolescent who is excessively enmeshed in his family to emancipate during the course of family therapy.

In short, group psychotherapy is a technique which can be

helpful or disastrous to the troubled adolescent. Careful initial and continuing diagnostic evaluation should dictate when it is used and decide which other techniques need to be combined with it for maximum benefit.

The method of beginning and conducting group therapy described here is only a skeleton. It is useless even dangerous, without training and experience both in group therapy and work with individual adolescents. There is no substitute for supervised experience in a live encounter with real adolescents.

TERMINATION

The issues involved in termination of group psychotherapy differ from individual work because group members are at various points in their development, yet the group must stop at one moment in time. In practice, termination of group therapy can occur because of clinical progress for the individual, but entire groups are usually terminated because of external events. Many therapists designate the life of the group at its very outset. A common pattern is to start groups in September and terminate them in June since many adolescents are unavailable in the summers. Individual decisions are made at termination as to whether a youngster should return for another group in the fall, continue in individual work, or leave treatment entirely.

Regardless of how this practical issue is handled, it does seem important for the group to have a clear and definite point of cessation. If the group is permitted to merely drift apart, the therapist deprives the members of the opportunity to face and learn from their idiosyncratic responses to separation. There is also considerable value in the process of reviewing the group's progress and assessing its benefits to each member. This can be organized around the individual treatment contracts of each member. The opportunity to address both the triumphs and failures of the members and the therapist offers both a chance for consolidating gains and for identifying areas that require further attention, in or out of formal therapy.

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