

PSYCHOTHERAPY WITHOUT INSIGHT: GROUP THERAPY AS MILIEU THERAPY¹

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A generalization which seems to apply to all schools of psychotherapy is that successful treatment is achieved through: (a) the novel experience of the therapeutic relationship for the patient, and (b) the increased self-awareness and new insights which develop out of this relationship. The various schools do differ, of course, as to the nature of the relationship between therapist and patient and the kinds of insight which bring about the desired changes in the patient.

From the point of view of Individual Psychology, the relationship should be one of cooperation and active participation for the therapist as well as for the patient. Beyond a mere professional acceptance of the patient, the therapist brings an active and vital social interest which decreases the patient's feeling of inferiority and insignificance and encourages him to develop remnants of social feeling on his own. Within this favorable atmosphere the patient, with the aid of the therapist, gains insight into his neurotic life style and the distortions which it includes. These new insights enable the patient to discover more successful behavior patterns which lead to greater happiness and satisfaction for himself and the people around him.

INDIVIDUAL THERAPY

The two factors, therapeutic relationship and development of insight, are closely related and intertwined. We never know where one ends and the other begins. As patient and therapist communicate and interact in individual therapy, they explore together the patient's behavior, feelings and motivations. Whenever the therapist offers an interpretation or explanation, the patient feels this as an expression of some kind of judgment, involving praise or criticism, like or dislike, even though the statement may be presented in an objective manner. This happens only, of course, because the patient is involved with the therapist and it matters to him what the therapist says. If there is no such relationship, then the insights which are apparently achieved are

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merely so-called intellectual insights, lip service. They neither change the neurotic distortions, the patient's private views, nor his motivations and behavior.

Granted that insight without relationship does not produce the desired changes in the patient, we should like to ask, what about the reverse? Can therapeutic change occur through a relationship, but without insight?

To answer this question let us first state what we mean by therapeutic change and insight. We define therapeutic change as a reorganization of the patient's life style based on lessened insecurity and a strengthened social feeling, which results in a less rigid and more correct appraisal of reality along with better relationships with others and a fulfillment of one's creative potentialities.

By "insight" we mean a perceptual recognition which goes "below the surface of things." Woodworth, for example, defines insight as consisting "essentially in seeing a situation as an organized whole" (17, p. 145). In our terms this means an accurate perception of the purposes of the current life style, the "Aha!" experience of sudden, sharply defined "falling into place."

The simple, empirical fact is that there are many cases where this process or experience of insight just does not occur. Rather, a slow change of perceptual organization and concept formation takes place in the patient, but at no point does he give an indication that he comprehends the dynamics of his behavior. This kind of perceptual reorganization, which no doubt occurs through the experience of therapy, is similar to the non-insightful learning which takes place before the patient enters therapy.

A simple example would be the case of a patient who never seemed to be able to find the right mate, the right job, or even a friend, because he always felt rejected, or himself rejected the other. Through therapy he begins to feel less rejected, less insecure, and hence is more free to be spontaneous and accepting of others. During or after therapy, he finds himself in a satisfying job or with good human relations. From his point of view, these changes have occurred in his life because his luck has changed for the better. All he knows is that he feels better about himself and the world. What had previously been a hostile world becomes a more friendly one for this patient, and while he might not have been aware of why his insecurity decreased or how his self-concept of being a helpless person shifted to a positive self-image, the therapist is in a position to watch this slow process take place.

Such step-by-step modification of biased perceptions occurs without any conscious insight, in the usual definition of the term. In this

sense, then, we may give an affirmative answer to our question, whether therapeutic change can occur through a healing relationship without insight.

GROUP THERAPY

Now, if it is true that the "healing relationship" is the crucial factor in individual therapy, it is even more important in group psychotherapy where there are a number of "healing persons." Observations on several groups in the setting of a mental hygiene clinic (13) have led me to further thinking on the possibility of psychotherapeutic change without insight.

There are several reasons why these groups afforded particularly pertinent observations. The patients generally came from lower economic backgrounds, had less education, and were for the most part less verbally and intellectually inclined than most private patients. Unlike groups in private practice, these patients rarely responded to interpretations (which were hence kept to a minimum), and rarely achieved insight into their life styles and related distorted perceptions. Nevertheless, it was my impression that their life styles changed; their neurotic, self-centered goals were replaced by more social ones; and their behavior became guided by more realistic apperceptive schemas. This impression was confirmed by projective tests, given before and one year after group therapy, which indicated that therapeutic change had taken place in most of the patients. May it not be that what occurred was something more basic to therapeutic change than interpretation and insight?

Just what is this "more basic" something? In answer to this question it may be helpful to consider the therapy group as a special kind of "social stimulus situation," special in so far as its purpose is to influence individual people toward greater mental health. The use of a social stimulus situation for a therapeutic purpose is usually called milieu therapy. In other words, I would like to suggest that group therapy has many features in common with milieu therapy. Though this term is usually used for the "total push" approach in institutions, it also seems meaningful for the brief, but repetitive, milieu of the therapy group. Psychotherapists who speak of the group's "social climate" (3), of its values, and the like, come very close to the concept of the group as a "healing milieu" (4, 15). And there is much to be learned about group therapy from the literature on milieu therapy (e.g., 9, 14, 16).

THE GROUP AS THERAPEUTIC MILIEU

If we view the group as a healing milieu, we can focus on the kind of structure which would make it therapeutic and on the processes we would want to develop within this milieu in order to maintain and further our therapeutic goals.

In institutional milieu therapy, the staff members are educated to keep the therapeutic goals uppermost in their minds. Similarly, in group therapy, the group members are educated to become therapeutic to one another. In neither method does the therapist engage in individual therapy, but creates a setting in which the therapeutic potentials in each individual and the group as a whole are developed.

Social norms. What makes a group therapeutic? To begin with, it must be cohesive and yet flexible. It must have what Redl terms "resiliency" (14). And what makes a group resilient? The patients must like the group. It has been shown experimentally (2) that they will like the group the more, the more they communicate in a friendly way with each other (5).

But friendliness alone would not lead to therapeutic change. A prerequisite is that in the subculture of the therapy group certain social norms are promoted by the therapist and shared by the patients (12). Thus the group becomes therapeutic if its structure is democratic, with equal rights for all patients and with responsible leadership by the therapist. In such a setting freedom of expression and openness of communication, as well as mutual helpfulness and respect for each other are encouraged (11).

Open communication and mutual helpfulness are of crucial importance. I feel that they are underneath all interaction in the group and account more for therapeutic change than any interpretations and insight. In this sense the various relationships within the group can become "healing relationships," and the group as a whole a "healing milieu." In other words, the more the therapist is able to keep communication lines open and to encourage mutual helpfulness, the more therapeutic the group will be, whatever else may occur between patients or between therapist and patient.

Through openness of communication, which the patients rarely experience in their daily lives, the group becomes a "cognitive matrix" (6, 12), a milieu in which the patients can make a series of realistic observations on one another. These observations become a kind of spontaneous, implicit analysis which leads the members of the group

to know and understand each other in a way far surpassing anything they had hitherto encountered. This increased clarity and correctness of person-perception gives behavior toward others more purpose, and makes interpersonal relationships more gratifying. At the same time that this process is going on, a cognitive reorganization takes place in which the self-image changes, even though there may be no conscious awareness of the various shifts slowly taking place. The patients find themselves becoming more secure, and less motivated by inferiority feelings.

As they are more able to help one another their social feeling increases. One of the basic assumptions of Individual Psychology is that it is innate to find pleasure in being useful to others, but that the ability to do so has to be developed. Precisely in the setting of the group this can happen naturally, directly, and without interpretation, as the relationship between the patients improves and they come to feel more adequate.

According to Heider, "Social intercourse, talking to other people, becoming involved in their point of view, is considered of great importance for the establishment of cognitive objectivity" (6). This is another way of saying that "private logic" is replaced by rational thinking, or common sense in the Adlerian use of the term (1). The group offers opportunities to test assumptions and expectations in social interaction thus keeping person-perception under constant revision. It is therefore clear that the group itself must be based on healthy social values for which, as stated above, the therapist is primarily responsible. If it were otherwise, as in a gang or any group hostile to the society at large, social validation within the group would result in less rational and more biased thinking. In such an instance, "private logic" is replaced by "socially shared autisms" (8).

Composition of the group. Another important factor in the group structure is its composition. The criteria for selecting patients for a group are innumerable. But what matters most is not the particular diagnostic categories to which patients belong. Rather, their life styles must be sufficiently different to enable the individuals to stimulate change in one another. At the same time, of course, they must be enough alike to be able to communicate and understand each other.

Within the group each patient assumes a certain role. Which role he assumes depends, in part, on his age, sex, social status, and the other patients in the group. But the most important factor is his

current life style. To the extent to which the group differs from the patient's usual social environment, a certain modification may occur in his manner of relating to others. Each patient achieves some kind of initial compromise of his life style with the group, and a certain balance develops. If matters remain in this state, a firm and cohesive structure emerges. However, this would not provide the necessary flexibility, since in this initial compromise the neurotic life style will be perpetuated.

Therapeutic change takes place if there is a conflict between the patient's role in the group and his neurotic life style. His role in the group should force him to change his individual pattern, or the group pattern should force him to change his role. Sometimes this occurs automatically through the milieu of the group, sometimes the therapist has to take the responsibility of promoting a change in the social structure whenever an opportunity arises. As an example, consider the patient whose life style is attention getting through provocation. If he persists in this, he will soon fulfill the role of the scapegoat in the group. But as long as he satisfies his neurotic goal through this role, no change will occur. Only if the neurotic interaction between him and the group is interrupted, will the group structure shift and a change in the patient's life style take place. It is because these continuous shifts in the structure of the group are essential for therapeutic progress, that the group has to be resilient enough to remain a cohesive unit in spite of inner changes.

I have described only two ingredients, social norms and composition, which contribute toward making the small face-to-face group a therapeutic milieu. Much research is needed on this question, which could parallel the research being done with other therapeutic milieus. Redl, whose specialized experience is in institutions for disturbed children, has very well described the research needed: We should attempt to isolate milieu ingredients as they "hit" the patient, to trace the actual experience which a concrete situation produces in the patient, and to know just what the patient does with this experience (14). In other words, we must study "milieu impact" as well as how the patient copes with it.

It is today almost a truism that the individual cannot be considered apart from his social situation. Group psychotherapy as a form of milieu therapy is based on this proposition and applies it in practice (10).

Function of the therapist. In group psychotherapy as milieu therapy, the crucial functions of the therapist are: He selects the patients and thereby determines the group's composition, and he influences directly or indirectly the whole group and each patient to behave in accordance with the norms found desirable for therapeutic change.

Redl describes the "umpiring" and "traffic regulating" function of the person in charge of a children's institution (14). Similarly, the therapist regulates by his interventions the degree of anxiety, hostility, and "acting out" which may be disruptive to the group while, on the other hand, necessary as challenge for therapeutic change. The therapist's interpretations, his verbal and non-verbal activities have to be geared toward keeping individual members and the whole group not static, but moving in the direction of the therapeutic goal, that is, more honesty and openness to oneself and others, more security for each, and more mutual social feeling. During this process of growth and change, the therapist is the watchdog for the "resiliency" of persons and of the group.

THE THERAPEUTIC EFFECT ON THE PATIENTS

All patients. The cohesiveness of the group which provides a feeling of belonging and an opportunity to be mutually helpful, helps to bring about changes of the self-image in a positive direction, increases self-esteem. Open communication, which leads to increased verbal facility, finer conceptualization and greater rationality, produces a mutual understanding. All patients benefit from these ingredients.

Another such ingredient, due to the democratic set-up of the group, is the opportunity the patients have to challenge and test the authority and leadership of the therapist. This results in growing independence and autonomy of all members.

Specific diagnostic categories. The nurturing factors of the group milieu have a special therapeutic effect on those patients who, in their childhood, have had very few healthy social experiences within their families and, in adulthood, remain isolated, frightened and suspicious. The therapy group offers them a second chance to experience communal life and to understand its tasks. These patients tend to fall into the diagnostic categories of severe personality disorders, such as the emotionally unstable, the schizoid and paranoid personality, and the borderline schizophrenic.

Patients who are neurotic or have less severe character problems benefit from the group milieu in more specific, individual ways. Whereas the more disturbed patients benefit most from learning what human beings have in common, the less disturbed learn from the differences between people. As a result of the variety of personality patterns in the group, a rigidly compulsive person, for example, may become emotionally freer and more expressive. The hysterical or impulsive patient may learn to be more restrained and considerate of others. Each of these patients, then, tends to use the group in a specific way.

As the patients observe each other's behavior and the effect they have on each other, and as they identify with each other, an unadaptive style of life, with extremes of attitudes and behavior, can change to one more adaptive and less extreme. Group psychotherapy offers a healing situation with alternating security and challenge, graded anxiety, opportunities for varied interpersonal relationships, openness and freedom of communication, and a balance of self-assertive and cooperative forces. Each patient can use these opportunities according to his needs for healthy growth and change. Or, he can avoid change by misusing the available opportunities and repeat and reinforce his patterns. Such a stalemate may result if the group composition is such that the neurotic pattern is reinforced by the immovable role the patient adopts in the group.

CONCLUSION

I would like to conclude with a few remarks on the place of insight in psychotherapy. The intentions behind this paper would be misunderstood if it were thought I maintained that insight is a mere epiphenomenon and of no value in promoting therapeutic change. On the contrary, in many cases it is quite crucial. My point is that insight is of no avail where there is no healing relationship from which the insights spring, and that there are many cases where the relationship alone can engender change without the aid of insight. Unless this is understood, therapists may give up too soon on patients who, for a variety of reasons, such as socio-cultural background, education and personal inclinations, are not prone to respond to intellectual interpretations and are unable to gain insight into their neurotic behavior patterns. Nolan Lewis recently predicted that in the future "insight will not be stressed as much since its usefulness is quite limited in so many cases," and "some of the greatest triumphs may well be in

improved techniques with group therapies which are growing fast in popularity and application throughout the nation" (7). Just as patients improve in individual psychotherapy with or without insight so long as a healing relationship is operative, so, too, patients may improve even more in group therapy with or without insight through the medium of the healing milieu provided by the group structure and the regulating activities of the therapist.

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