BRIDGING DICHOTOMIES THROUGH GROUP PSYCHOTHERAPY

HELENE PAPANEK, M.D.
New York, N. Y.

Adler's distrust of fixed and separate categories, of artificial entities, of dichotomized thinking, is vividly illustrated by the way he characterizes mental health. This paper will limit itself to the discussion of two factors which are crucial to the definition of mental health and of great importance for the practice of group psychotherapy.

The first factor is social interest or social feeling. As a barometer of mental health, it is conceptualized by Adler as a continuum with two purely theoretical poles. The one end of the continuum, the ideally normal individual with an ideal amount of social interest, is as non-existent as the sick person without any social interest on the opposite end. Since man develops in a community and his physical and mental growth is shaped by it, he can only understand and accept himself in relation to and as part of a social group. Everybody's life goal, therefore, is influenced by some social feeling. Even an asocial or antisocial life goal, in this sense, is *for* somebody, though it is perhaps more against others. Such a life goal is based on underdeveloped, misdirected and misunderstood social feeling, but never without it.

The second factor is a certain open-mindedness and flexibility. Adler's recognition of it derived primarily from his holistic approach, and secondarily from his ideas concerning inferiority feelings and their compensation. It is a quality of cognitive processes ranging from dichotomous and inflexible modes to more realistic flexible modes. Here again it is a matter of gradation and not of exclusively one or the other cognitive mode. Adler described essentially the dichotomous, antithetical mode of the neurotically disposed. The Ansbachers (1, p. 229) used Kurt Lewin's term of "homogenization of psychological processes" (5) to describe the constructive, mentally healthy, way of thinking. Adler called it "common-sense" thinking, as opposed to the neurotic or psychotic "private world."

Adler's View of the Neurotic Antithetical Schema

Adler presented his classic description of the antithetical mode of thinking in 1912 in *The Neurotic Constitution*, of which the following is an excerpt.

> The neurotically disposed individual has a sharply schematizing, strongly abstracting mode of apperception. Thus he groups inner as well as outer events according to a strictly antithetical schema, something like the debit and credit sides in bookkeeping, and admits no degrees in between. This mistake in neurotic thinking, which is identical with exaggerated abstraction, is also caused by the neurotic safeguarding tendency. This tendency needs sharply defined guiding lines, ideals, and bogeys in which the neurotic believes, in order to choose, foresee, and take action. In this way he becomes estranged from concrete reality, where psychological elasticity is needed rather than rigidity, that is, where the use of abstraction is needed rather than its worship and deification. After all, there is no principle to live by which would be valid to the very end; even the most correct solutions of problems interfere with the course of life when they are pushed too far into the foreground, as for example, if one makes cleanliness and truth the goal of all striving.
>
> . . . Phenomena which do not belong together must, of course, be sharply separated by abstractive fiction. The urge to do this comes from the desire for orientation which, in turn, originates in the safeguarding tendency. This urge is often so considerable that it demands artificial dissection of the unity, the category, and even the self into two or several antithetical parts.
>
> The neurotic carries the feeling of insecurity constantly with him . . . He has chained himself so much to guiding lines, takes them so literally, and seeks to realize them so much, to the exclusion of any alternative, that unknowingly he has renounced the unprejudiced, open-minded approach to questions of reality (1, p. 248).

The "primitive orientation in the world" based on antithetical thinking may be appropriate in specific situations or as a simplifying working method "which measures a thing, a force, or an experience by an opposite which is fitted to it" (1, p. 229). But the neurotic's apperceptive schema lacks elasticity; one pair of opposites is "pushed into the foreground" and a variety of interpersonal situations are fitted into this antithetical schema, instead of a variety of appropriate concepts. If one had been, as a child, especially insecure or frightened whenever one committed an error, then the opposite becomes all important: one wants to be perfect. Then, the dichotomy of being at fault, wrong, or incorrect as against right and perfect becomes not only a very sharp contrast of black and white, with no grays in between, but the main axis of one's whole conceptual structure, around which attitudes, relationships, and so-called transference distortions evolve. Then, any decision looms dangerously, as it could be the "wrong" decision. When one has constantly to prove to oneself and to others that one is right, other persons who want to be right, too, become threatening.

Other examples of antithetical conceptual pairs will be described below. I hope it has become clear at this point that if one concept means the threat of destruction, the desired opposite becomes the main life goal. Striving for it means safeguarding one's survival.

RELATED CONCEPTS

The problem whether thinking and conceptualizing are or can be continuous and dimensional rather than antithetical or dichotomous is an age-old issue. The Ansbachers point out (1, p. 229) that this point raised by Adler, was worked out later by Lewin in his paper on "Aristotelian and Galileian modes of thought." According to Lewin the criterion of a good theory is that "the places of dichotomies and conceptual antitheses are taken by more and more fluid transitions, by gradations which deprive the dichotomies of their antithetical character, and represent in logical form a transition stage between the class concept and the series concept" (5, p. 10).

Erik H. Erikson, whom we may consider a neo-Freudian, takes a stand against the Freudian antithesis between the desires of the individual and the "repressive" forces of society.

> It was important to conceptualize certain intrinsic antagonisms between the individual's and society's energy households. However, the implicit conclusion that an individual ego could exist against or without a specifically human "environment," i.e. social organization, is senseless; and, far from being "biological" in its orientation, threatened to isolate psychoanalytic theory from the rich ethnological and ecological findings of modern biology (3, p. 150-151).

According to Erikson, the conflict between self-interest and the interests of others occurs as a problem in development, and the idea of mutuality becomes central to mature ethics. Logically, then he states, "Ego dominance tends to be holistic, to blend opposites without blunting them" (2, p. 216).

George A. Kelly seems, on first sight, to hold the opposite viewpoint. And yet he is close to Adler in phenomenological, teleological, and subjectivistic trends. As Sechrest points out, "It is of more than passing interest that an analysis of the interpretations made of a clinical case by a number of exponents of leading personality theories . . . revealed that Kelly's conclusions were most similar to those growing out of Adlerian, Sullivanian, and non-directive positions" (9, p. 231). Nevertheless Kelly states, "A person's construction system is composed of a finite number of dichotomous constructs" (4, p. 59).

In studying Kelly's approach further, it seems to me that it bridges the contradiction between theories which explain thinking and conceptualizing as dimensional, holistic, field-oriented, and those which explain thinking as dichotomous and classifying into contrasting categories.

Kelly's dichotomous constructs are not static. Psychological processes, to do justice to reality and to serve their function of "antici-

pating events" have to be fluid, adaptable, changeable. This is expressed by Kelly not only in his fundamental postulate, "A person's processes are psychologically channelized by the ways in which he anticipates events" (4, p. 46), but is also spelled out in much detail by his eleven corollaries and throughout his whole book. The most fascinating aspect is his ability to describe conceptualization as based on repetitive experience, subjectively consistent and organized, but also shifting according to situations, purposes, and new experiences.

Mental health and disease can be understood again as dimensions of a continuum. If constructs are less varied, less flexible, less tentative, impermeable and not fluctuating, they neither serve the purpose of anticipating events correctly, nor are they based on commonalty or consensus. Rigidity of constructs is an obstacle to "sociality," as Kelly calls the ability to understand others, to communicate with them, and to influence them. The neurotic construes his apperceptive schema more for protective, safeguarding certainty; his constricted conceptual structures are mostly rooted in the past; while the healthy person has a tendency to extend and redefine creatively his construction system to plan for his future.

PSYCHOTHERAPY

The purpose of this paper is to show that in all successful psychotherapy, the patient grows toward more social feeling and gives up some rigidly dichotomized thinking. Group psychotherapy illustrates this healthy development even more clearly than individual therapy.

Psychotherapy is possible because the emotions, thoughts, ideas, attitudes, and values of maladjusted individuals, as in the case of well-adjusted individuals, have been formed by interaction with others and are therefore capable of being further influenced by others. Of course it is necessary that the person starting therapy wants to communicate with others and is able, although perhaps only in some rudimentary and unusual way, to relate to them. Whether it be criminals who want to impress others and rebel against them; or schizophrenics who, in their confusion, try to fit into a regulated milieu which takes care of them; all these deeply isolated people have some ideas in their sick minds of the "other ones" with whom, for whom, and also, unfortunately, off whom they want to live.

Psychotherapy of any kind is based on social feeling, on man's universal need for close social contact and for mutual communication. Whatever remnants of social feeling there are at the start of therapy

have to be used by the therapist so that they become strengthened and channelled in their development in the right direction.

Behavioral scientists, including psychoanalysts, have differed in their emphases on intrapsychic versus interpsychic processes. Adler's viewpoint is expressed by the fact that he named his theory *Individual* Psychology, while stressing man's social context. He said repeatedly: "Individual Psychology regards and examines the individual as socially embedded. We refuse to recognize and examine an isolated human being "(1, p. 2). Consequently, the socialization of the individual is not achieved at the cost of repression, but is afforded through an innate human ability, which, however, needs to be developed. It is this ability which Adler called social feeling or social interest (1, p. 2).

All techniques which use groups as the basis for health-promoting interventions, such as milieu therapy, group psychotherapy, family therapy, do rely explicitly or implicity, overtly or covertly on the *inter*personal, social dimension to achieve therapeutic change. Some professionals who avoid the label of group psychotherapists, but prefer to call themselves group psychoanalysts (and who have difficulty in defining the healing effect of groups), are afraid of group-dynamic forces and, therefore, concentrate even in the therapeutic group on so-called intrapsychic phenomena, on transferences and resistances. They have great difficulty in bridging the gap between intrapsychic and societal concepts. Thus Harris Peck writes in a recent paper that he has made what he calls a "rather naive discovery," namely, that we may now *begin* to interrelate phenomena at the individual and community levels and to recognize the constant reciprocal effect between the individual person and his social environment (8, p. 272).

GROUP PSYCHOTHERAPY AND SOCIAL FEELING

We do not believe that groups have a built-in, automatic healing quality. Social scientists have known for many years that group pressures, group leadership, group cohesiveness, can have the most pernicious antisocial effects. The result of these group dynamic forces can be the formation of gangs, of chauvinistic groups, of brainwashing, and of all the horrors of misused social feelings.

The principle in these sick groups is always closeness and strengthening of the in-group against outsiders. Though the individual members have social feelings for each other, the group, as a whole, has no social feeling for people outside it.

Groups have a tremendous impact on the thinking and feeling of their members. The study of group-dynamic forces makes it possible to use the knowledge derived from it for the benefit of group members. Much could be said about the necessary and sufficient characteristics of the therapy group, its subculture, its values and norms. What are the characteristics of a group that can develop in its members the "right kind" of social feeling, that can change their life goals in a healthy direction? We consider the group an open system which is different from the sum of its units, the individual members. Any change in the group is followed by a change in its units, the individual patients, and vice versa; each member can influence and change the group. Because the therapy group has its own boundaries, cohesiveness, and equilibrium, its own structure, it is of crucial importance that this psychosocial organization should have healing characteristics to achieve its goal, the healthy change of the patients' life goals (6, 7).

The therapist starts a group by inviting six to eight patients to meet regularly. It is his job to create, out of these isolated, discouraged, frequently ineffectual people, a group situation with health-promoting norms. The therapist's personality and his behavior in the group have the strongest impact in shaping an atmosphere in which rudimentary and misdirected social feeling slowly evolves or suddenly bursts forth into attitudes of mutual helpfulness, tolerance of differences in comparing the self with others, awareness of similarities through empathy or by identification, ability for purposeful communication which leads to understanding and communality of feelings. With the non-authoritarian leadership of the therapist representing a model of an empathic, responsive, accepting and democratically guiding personality, the patients change from an attitude of dependency, demandingness, or rebellion against authority to an acceptance of equality and differentiation by testing, experiencing, and correcting prejudices and distortions taken over from childhood.

As group members learn to accept differences between themselves and are able to profit from mutual observation, understanding the needs and fears of others, cooperation and group cohesiveness develop. Then open expressions of feelings of hatred, competition, and envy alternate with positive feelings of mutual acceptance and helpfulness. The patients feel free enough to express their destructive feelings. This creates anxiety whenever the wholeness of the group seems threatened. When the level of tension and anxiety becomes too high

for individual or group tolerance, the therapist helps the members to master these fears. This gives the therapist the opportunity for interpretation.

BRIDGING THE DICHOTOMIES

The health-promoting group, then, has as its purpose not only to bridge the theoretical gap between individual and community, but also to give its members the opportunity actually to experience that life is not a dichotomous matter of "self versus others." They can experience as real possibilities what they had previously held mistakenly to be paradoxes: that one can be different from others, develop and preserve one's autonomy and still be accepted by others; that one can be oneself and at the same time be able to communicate with and understand others; that one increases one's self-esteem and sense of identity by being useful to others and seeing oneself reflected in them; that one can be honest and socially acceptable; Group members learn that subjective reality is fragmentary unless supplemented by exchange and, at least sometimes, by agreement with others, and so on. They learn to replace "private logic" by rational, common-sense thinking.

The group can become a laboratory for bridging dichotomies, if the leader is capable of gaining access and responding to the group-process phenomena at the same time that he is aware of each individual patient, sensitive to him and able to communicate with him.

Forces and properties inherent in the group situation, the norms and standards accepted and shared in the group, the conflicts occurring between patients and the collective efforts of all to understand and dissolve these conflicts, all these factors contribute to the necessary therapeutic experience, to correct distorted and rigid dichotomies and to resolve them in the community of social feeling.

Kelly agrees that group psychotherapy does

> assist the person to develop more effective channels through which he and others may anticipate events. Since such a large portion of the events to be anticipated are human events, group psychotherapy, like most psychotherapy, deals particularly with the improvement of one's anticipations of his fellow man. . . . Keeping up with the world has become a very complicated business, altogether too much for a person who relies upon antiquated ideas (4, p. 1155).

Kelly describes in detail the advantages of this method for "shaking out pre-emptive constructs. Pre-emptiveness is a particular kind of rigidity which causes therapists a lot of trouble" (4, p. 1157).

In the therapeutic group the patients are exposed and their eyes are opened to the variety and variability of human relations. This broadens their rigid cognitive field and restructures their self-images and their understanding of others, so that they become able to achieve more successful, healthier, and socially oriented life goals.

The group structure and composition, and the therapist's technique and method help this step-by-step process along. The group has to be a setting which is challenging but not overwhelmingly demanding. The patients, first under the therapist's guidance and later by helping each other, learn to see choices and alternatives to their unsatisfactory behavior, so that the incongruity between life style and social demands diminishes and finally disappears. New behavior emerges if the dangerous consequences anticipated in their faulty cognitive schemas do not occur. In the therapeutic environment of the group, social feeling surrounds the patient from the outside and, at the same time, by developing inside the patient, promotes his growth and his emotional health.

Group and personality move in an evolutionary growth process. The varied situations and interactions, accompanied by alternating feelings of anxiety or security, either in the whole group or in individual members, furnish emotional experiences which necessitate a constant testing, exploring, widening, and clarifying of thinking and feelings in oneself and others. This leads to a better understanding of others' verbal and non-verbal expressions and a more predictable, successful way to communicate with them.

TWO CASE HISTORIES

Two short examples will illustrate how insecure people, caught in their dichotomous thinking in spite of experiencing the incongruity of their life style with social demands, can become socially competent through psychotherapy.

Group psychotherapy approaches the problem of the neurotic — and the psychotic who, to a certain extent, gives up on social demands —from two sides: social demands which appeared threatening and overwhelming become manageable and understandable; and the individual patient becomes socially more competent by developing more realistic person-perceptions based on a variety of concepts open to reality testing and adaptable to the variety of human situations. Then he not only accepts demands of society, but becomes able to enjoy his contributions to the community.

Lea's story shows this development from insecurity and dichotomous thinking to cognitive objectivity and social feeling. The youngest of three, with two older brothers, she lived with her parents at the age of 32. She had been working as a bookkeeper for many years at the same firm. Petite, delicate, attractive, and well dressed, she was never able to have dates more than two or three times with the same man, because — and this symptom brought her to therapy — she threw up whenever she was invited by a man to a public eating place. She could hide this symptom — which had started at six years with the first school day — during a first date, by excusing herself and then vomiting in the ladies' room. But when it happened on the second date and her restlessness, discomfort and paleness became apparent, the man did not ask her out again.

In the group Lea was timid, subdued, insecure. Her behavior showed how she wanted protection, support, and direction from everybody. She was the helpless, compliant little girl. It soon became apparent that her "dichotomy" was: I have to be good, obedient, and helpless so that I may be taken care of by my all-powerful parents and survive. If I express myself, I will be destroyed. Therefore, I should never make a choice, never have an opinion of my own. She perceived an aggressive and controlling male co-patient in the group as a strong protector, but also as a possible destroyer. As this man was a borderline paranoid schizophrenic, the second perception was more correct than the first, even though the first was more flattering and acceptable to the male patient. Lea had dreams in which I gave her, with the best of intentions, injections which resulted in her fainting or being paralyzed. In Lea's "private world" the fear of independence as a threat to her very existence was in the foreground of all her actions. Her relationships had the purpose of finding an all-powerful and completely reliable protector. In a group of peers she soon discovered that neither her parents, nor the therapist, nor even the admired "strong man of the group" could serve this purpose. With the group's encouragement and challenge to risk expressing her ideas freely, trying out independent decisions, and experiencing her ability to help others, the concepts of her helpless self surrounded by dangerous, unmanageable, and potentially destructive people changed.

Though she remained a dependent person, she found a protective, considerate husband and could soon experience motherhood , in spite of some anxiety, with the satisfactions and pleasures that come with a mature responsibility. Her self-image and her perception of the people around her became integrated into a societal, reality-oriented whole.

Another pair of opposing constructs are represented in George who had grown up with a paranoid father who had committed suicide, and a selfish, punishing, and frequently cruel mother. He felt threatened in a close relationship, especially with a woman, if he showed the slightest sign of vulnerability; for him a cooperative attitude meant weakness, giving in, being exposed to hurts. In his view only utter aggressiveness could prevent this fate. In spite of high intelligence and strong motivation for change, in spite of being aware of the destructiveness of his flare-ups, he could not stop himself from, e.g., hitting his wife in front of their children when she dented the car fenders. If he let her do that, she would destroy him next!

In Lea's cognitive structure, only submission guaranteed survival, in George's, only aggression. In the group George experienced that cooperation does not mean weakness, that one can give in without being destroyed. He could be considerate, quiet, uncertain, make a mistake like any other person in the group and still not be overwhelmed or exploited by anybody.

I purposely selected as illsturative examples two people whose past experiences, cognitive structures and behavior based on them —in other words, whose life styles and life goals —were nearly diametrically opposed. Lea thought she could not feel safe and be loved by a man, except if she blotted herself out completely. George could not

feel safe in a close relationship to a woman if he did not frighten her into submission. Neither one could reach his or her neurotic goal, as no partner could fit their demands, based on conclusions which had been drawn from childhood experiences but were not applicable to the real and varied experiences with people in their adult world. Other patients have similar irreconcilable constructs, widespread and infiltrating and destroying all relationships.

Every human being wants to feel safe, to be loved, to be respected, to be understood. This can only be achieved through interdependence. Lea, George and other patients learn the meaning of this attitude in the therapeutic setting of the group. Their previous roles, as e.g. "the helpless child" (Lea) or the "dictator" (George) do not fit the social reality of the group.

SUMMARY

In all successful psychotherapy the patient grows toward more social feeling and gives up some rigidly dichotomized thinking. Good theories and more effective relationships to the environment call for "homogenized" concepts rather than antitheses, for seeing variations along a continuum rather than opposites. The therapist's behavior and leadership shape a group situation and atmosphere in which the patient's rudimentary social feeling evolves through opportunities for empathy, communication, and mutual helpfulness, and his falsely antithetical schema of apperception is dispelled in the variety and variability of interpersonal relationships.

REFERENCES

1. ANSBACHER, H. L., & ANSBACHER, ROWENA R. (Eds.) *The Individual Psychology of Alfred Adler*. New York: Basic Books, 1956.
2. ERIKSON, E. H. *Young man Luther*. New York: Norton, 1958.
3. ERIKSON, E. H. Identity and the life cycle. *Psychol. Issues*, 1959, 1 (1).
4. KELLY, G. A. *The psychology of personal constructs*. New York: Norton, 1955.
5. LEWIN, K. *A dynamic theory of personality*. New York: McGraw-Hill, 1935.
6. PAPANEK, HELENE. Ethical values in psychotherapy. *J. Indiv. Psychol.*, 1958, 14, 160-166.
7. PAPANEK, HELENE. Psychotherapy without insight: group therapy as milieu therapy. *J. Indiv. Psychol.*, 1961, 17, 184-192.
8. PECK, H. B. Some relationships between group process and mental health phenomena in theory and practice. *Int. J. Group Psychother.*, 1963, 13, 269-289.
9. SECHREST, L. The psychology of personal constructs: George Kelly. In J. M. Wepman & R. W. Heine (Eds.), *Concepts of personality*. Chicago, Ill.: Aldine, 1963. Pp. 206-233.