CHAPTER 1

Groups in Today's Society

We allow our ignorance to prevail upon us and make us think we can survive alone, alone in patches, alone in groups, alone in races, even alone in genders.

—Maya Angelou

Human beings are essentially herd animals. We begin in small groups—our families—and live, work, and play in various groups. The formation of our personalities is predicated upon our experiences with the different groups in which we interact, and the opportunities for modification and change of our personalities are very much affected by the groups in which we are involved. As Harry Stack Sullivan (1953a) maintained, it takes people to make people sick, and it takes people to make people well again.

Since the first edition of this book appeared in 1984, a striking change has occurred in the world of groups. Could anyone have even imagined at that time making a stark statement such as this?: *Personal groups are on the precipice of being replaced by virtual groups*. Scott Adams, in a Dilbert cartoon, noted, "When virtual reality gets cheaper than dating, society is doomed." Although the quest to belong is evident in the vast increase in social networks such as Facebook, LinkedIn, and Twitter, one has only to read such insightful works as those by Turkle (2011) or Carr (2011) to wonder at the profound price being paid for these changes. Slater (2013), in an in-depth exploration of the effect of technology on meeting and mating, makes the case that the technological path to dating is adversely affecting authenticity in relationships. Commenting on Slater's work, Young (2013) suggests his conclusion is that, rather than enhancing the dating experience, online dating and other technologies are actually contributing to "making people less authentic, more deceptive, less committed, quickly intimate, more paranoid, less sexually discerning, and less trusting" (p. 1). (Young

also notes that Slater's parents were among the first to have met online, and the fact that they separated when he was 3 might have influenced his judgment on the matter.)

CULTURE AND MENTAL ILLNESS

The psychopathologies confronting modern clinicians differ from those that confronted Sigmund Freud and his colleagues. Freud (1914/1958) analyzed the pathologies of the members of the society in which he lived, and through that examination made revolutionary discoveries about the formation and complexion of personality. The pathology that most fascinated Freud was hysteria; this disorder became the lens through which he focused his conceptions of individual psychodynamics.

In contemporary society, classical hysteria is not the pathology around which theory is formed. The cutting edge of modern psychodynamic thought focuses on character disorders, especially narcissistic and borderline conditions, and attachment disorders. In these and similar clinical presentations, pathology is manifest in the disturbed quality of relationships with others. We maintain that each of these specific diagnoses may be a different way of coping with difficulties in gaining and sustaining viable relationships.

These "new" pathologies have been accompanied by other post-Freudian developments in our understanding of psychopathology and in our practice of psychotherapy. Giovacchini (1979) observed that as psychoanalysis began to treat character-disordered patients, this "shifted our focus from a predominantly id-oriented psychology to an ego psychology. . . . It highlighted the importance of early development. The subtleties and vicissitudes of early object relationships have assumed paramount importance" (p. 3). Moreover, the practice of psychodynamic psychotherapy has moved toward adopting an intersubjective approach to the therapy process in which the therapist is viewed more as an active participant than simply an expert expounding interpretations.

The etiology of psychopathology is multidetermined. Elements of genetics, biology, and temperament go into the human experience, along with the intrapsychic and interpersonal forces that are the province of psychodynamic theories. Unfortunately, most theory and research focus on one side of this interactive axis rather than trying to understand how these forces interrelate. Current research demonstrates just how powerful psychodynamic treatment can be (see Shedler, 2010).

The search for a link between cultural factors and mental illness began as early as 1897, when Emile Durkheim (1897/1951) wondered about the connection between suicide and social conditions. In 1939 Faris and Dunham suggested a causal relationship between schizophrenia and the living

conditions in Chicago slums. Leighton (1959), in his well-known Stirling County (Nova Scotia) study, discovered an overall correlation between mental illness and social disarray, as well as correlations between specific sociocultural settings and particular types of psychiatric disorder. Several clinical syndromes, such as *koro, latah*, and *amok*, are clearly culture bound (Leff, 1988). *Koro*, for example, is the strange syndrome in which there is a belief that a man's penis will disappear into his body, and relatives are prepared to take action to prevent this from occurring. At times this belief has reached epidemic proportions in native populations. Dohrenwend and Dohrenwend (1974) found that although schizophrenia seems to be present in all cultures, there is considerable discrepancy in the types of schizophrenia that dominate in different cultures. Likewise, Cohen (1961) demonstrated the presence of cultural factors in the etiology of depressive reactions, and Kleinman and colleagues (Kleinman, 1980, 1988; Kleinman, Das, & Lock, 1997) highlighted the profound interpenetration of culture and psychiatric conditions.

Thus, the notion that there is a connection between cultural factors and the formation and expression of mental disorder has already been examined in some depth. For our purposes, that cultures and eras have their characteristic and dominant pathologies is of particular relevance. In the modern world, for example, there is evidence that individuals have difficulty obtaining and sustaining intimate interpersonal relationships. Ours is a culture that emphasizes individual gratification.

EARLY VICTORIAN CULTURE

The early Victorian era was both stressful and comforting to people in specific ways. Victorian society offered far fewer choices than does current Western society. Although it was vastly more open than societies that preceded it, members of Victorian culture were, nevertheless, born into roles largely determined by class, church, ethnicity, and gender. Because there was little opportunity to go beyond those roles, the individual's hopes and aspirations were often sources of frustration. On the other hand, individuals were spared the burden of ambiguity and choice. Acceptable behavior was highly codified, typically by a strong church morality, with the result that sexual and aggressive drives, in particular, were restricted. Exceptions exist, of course. For example, the presence of a vigorous body of Victorian pornographic literature suggests that sexual drives were not thwarted altogether.

In Victorian society, individuals had a definite place, though not necessarily a place they chose or relished. Concomitantly, individuals had a clear identity. Relationships were set within the framework of the nuclear family, the extended family, the neighborhood, the world of work, and the

church, all of which provided most people with natural sources of support and stability.

Individuals in Victorian times were presented with fewer choices about how to live their lives and with whom to live them. This is not to imply that there was an absence of frustration and pain. If few complained about being "bent out of shape," it was only because *being shaped* was so universal. It is reasonable to assume that the restrictiveness of that society might have led to pathologies that expressed conflict between individuals' powerful innate impulses and the introjects of a superego-ridden society.

VICTORIAN PSYCHOPATHOLOGY: HYSTERIA REVISITED

Freud's theories developed as he treated his patients, many of whom were neurotic hysterics. Students of Freud are familiar with the case of Anna O, the young woman Josef Breuer treated from December 1880 until June 1882. She suffered from classic hysteria, or "conversion reaction." While nursing her dying father, she developed paralysis of three limbs, contractures and anesthesias, a nervous cough, and other symptoms. Breuer conducted his first analysis of Anna O using hypnosis throughout the treatment. In the course of this treatment it was discovered that Anna O had two quite distinct personalities. Further, during the treatment the patient developed toward Breuer what later became known as a *transference love* (Freud, 1937/1964).

Freud and Breuer often discussed this case, and out of these discussions came many of Freud's original formulations about the existence of unconscious material and the structure of personality. Shortly after this case Freud saw Emma von N, and in this case he could observe firsthand the strange behaviors present in hysteria. Freud postulated four major premises about personality:

1. All behavior is determined, not random.
2. Behavior is purposeful and serves to protect the self (*der Ich*), with even the most bizarre symptoms serving such an adaptive/compensatory purpose.
3. There are unconscious urges, memories, wishes—a vast reservoir of information outside the individual's awareness.
4. Freud eventually suggested that there are two basic drives within the personality, the libidinal (pleasure seeking) and the aggressive; personality was presumed to be formed in the thwarting and harnessing of these two drives.

These four postulates are, of course, a most summary attempt to distill the essence of Freud's theories.

Do we psychotherapists see patients like Anna O or Emma von N in our offices today? Probably not, unless we work in highly contained ethnic communities where the role of nuclear family, extended family, neighborhood, and church still hold sway. When these patients do appear, they often come to our colleagues in neurology or internal medicine. That the types of psychopathology present in our society are different from those observed by Freud suggests a powerful correlation between society and mental illness.

Freud not only observed the patients of his day, he observed them within the framework of that society. People in the Victorian era had a conviction that "structure" could harness the very forces of nature. This belief in the ultimate dependability of matter led to unprecedented productivity, wealth, and hegemony over peoples of a more "primitive" nature around the world. It is little wonder that Freud began to hypothesize about the "parts" that make up personality—his theory fit comfortably with the science of the era.

In the intervening years, more modern psychodynamic theories began to refer not so much to faulty parts as to dysfunctional relationships and dissatisfying ways of living. Modern concepts of pathology are cast less about mismatched or improperly fitting *parts* than about disrupted developmental *processes*. However, in the current atmosphere, there is a press to return to a more Victorian approach—of understanding our patients as "broken," suffering from a specific and discrete illness for which there is, presumably, a specific and discrete treatment. (We are not referring here to the significant advances in theory brought by the internal family systems model [Schwartz, 1995], which emphasizes the struggle for hegemony of the various parts of the personality.)

Whereas current psychodynamic theorists chart the evolution of personality through social systems, Freud viewed the ego as essentially the product of intrapsychic conflict. Though individual personality was understood to be affected by interactions with significant others (especially the mother), it was nonetheless not seen as predominantly formed in those interactions. Rather, personality was understood to be the result of a thoroughly inward process. The ego was conceptualized as a rational, unemotional arbiter between the instinctual urges common to all people and the acceptable mores of the particular society in which they lived. The superego was "the alien it which tyrannizes the ego" (Binstock, 1979, p. 56).

Freud should not be criticized for this focus, given the genius required to hypothesize as much as he did about human development. Rather, we should simply understand that he did not have time or opportunity to expand all his observations to their logical conclusions, though he began this quest in *Civilization and Its Discontents* (1930/1961). The expansion of his observations was left to later authors, who elaborated on the impact of human interactions and developed theories about personality resulting

from interpersonal interactions. The apex of this trend is seen in modern theories of object relations and self psychology, where the need for human relationship is understood to be common to all people and fundamental to the forming of personality.

If personality is formed in, through, and by relationships, then a therapeutic modality that uses the interactions of networks of individuals should be capable of altering disturbed or disturbing personalities.

In modern culture, the traditional sources of identity and continuity are waning or gone. It is as if the Victorian and modern eras are opposites along many important axes. Mainstays of the community and identity, such as the extended (or even nuclear) family, the neighborhood, religious institutions, and the ethnic group are all diminishing in stability and dependability. The rate of change is now so accelerated that each generation would seem to have its own culture. For example, mass media, including the growing influence of the Internet, penetrates the nuclear family while mass transportation explodes it, and those central places that once gave individuals a sense of themselves are changing dramatically.

There was a dependability about the future in Victorian times. If a goal could not be attained in an individual's lifetime, there was always the reasonable expectation that it might be attained in the lifetime of his or her children or grandchildren. This is not so today. Changes in technology are exponential, occurring at a faster rate than at any time in history. If that were not enough, technology has contributed even more lethal weapons of mass destruction, and there is little in human history to inspire confidence that at some point this awesome capacity will not be used. The value of working for and investing in the future has been diminished, and most modern individuals "live for today." In recent years, fears about the shakiness of the historically trustworthy safety net of Medicare and Social Security may have added to this focus. If Victorian culture provided stability at the cost of choices, in modern culture individuals are confronted with a bewildering array of choices (Brown, 2002). Along with choices come ambiguity and uncertainty. If Victorian culture provided secure but restrictive relationships at the price of internal conflict, modern society underestimates the importance of maintaining and sustaining relationships.

MODERN PSYCHOPATHOLOGY

Although in the psychodynamic world there is increasing emphasis on the importance of relationships in the etiology and the healing of psychopathology, in today's world there is another school that understands mental illness in purely biological terms. Thomas Insel, MD (2011), Director of the National Institute of Mental Health, lecturing at the 164th annual meeting of the American Psychiatric Association, said:

> It's time to fundamentally rethink mental illness. . . . Psychiatric research today promises to produce a true science of the brain. . . . Mental disorders are brain disorders. . . . What is emerging today is a picture of mental illness as the result of a pathophysiological chain from genes to cells to distributive systems within the brain, based on a patient's unique genetic variation. . . . With a true science of mental illness—from genes, to cells, to brain circuits, to behavior—psychiatrists will be able to better predict who is likely to develop a mental disorder and to intervene earlier. Once that happens, we will be in a different world.

The perspective from which we write this book does not reject this idea for we, too, believe that neuroscience has a great deal to offer in understanding the substrate of psychological distress and psychiatric illness. Even if we agree, though, that the brain and the body are involved in essentially everything, we do not believe that every visit to a therapist or a group therapist is for a "mental disorder" or "mental illness," even if the "disorder" is described in some version of the DSM. Our focus on psychopathology and psychological well-being is much broader and is directed not only toward the reduction of suffering that attends a biologically based illness but also to improving the ability of individuals to engage in healthier and more gratifying interactions when they have been unable to do so.

In this context, we maintain that the ability to enter into cooperative, loving, interdependent relationships has always been a sign of psychological maturity and health. This is particularly so today. Indeed, one quick but accurate indicator of mental health is the degree to which individuals allow themselves to know how important others are to them. Conversely, feeling excluded is not only an emotionally painful experience, it can have neurobiological consequences. Ijzerman and Saddlemeyer (2012) report:

> A number of research groups, including labs in Canada, Poland and our own in the Netherlands, have reported that having the memory of being socially excluded—or just feeling "different" from others in a room—is enough to change our perception of the environment around us. Such feelings can prime individuals to sense, for example, that a room in which they're standing is significantly colder than it is. (p. 12)

Given the changes that have occurred in the world since Freud's time, it is quite understandable that the stereotypical pathologies of today involve the ability to effect, experience, and enjoy intimate and sustaining relationships. Consequently, the psychopathologies that confront modern clinicians, many of which have attachment issues at their core, are character disorders (such as borderline and narcissistic personalities) and mood disorders (such as depression and anxiety). These conditions can be understood as relational problems. The borderline patient is too aware of the importance of others, whereas the narcissistic patient appears incapable

of knowing how important others are. Depression and anxiety can both be understood as adaptive responses to the terrors of intimacy. Fairbairn (1952a) was among the first to state that it is the relationship with the object (another), not the gratification of an impulse or drive, that is the fundamental fact of human existence. It is as though modern patients do not disable physical "parts" of themselves, as did Freud's patients, so much as they disable their relationships (Kernberg, 1976) and cannot adequately relate to others (Havens, 1996; Kohut, 1971).

GROUP THERAPY

Our understanding of the structure, functioning, and objectives of therapy groups is consistent with our description of modern society and the pathologies it fosters. Freud's patients lived in a structured and mechanistic world. These characteristics both affected the ills that beset them and determined the form and focus of the cure that would work for them. The focus of the cure for hysterical patients was abreaction, catharsis, and access to repressed wishes and memories. Given the strong sense of what were acceptable thoughts and behaviors in Freud's time, the form of treatment was one to one and very private. Freud's patients did not lack social connections. If anything, the social element was all too present, and therapy offered a much-needed private place wherein one could explore the feelings, wishes, and behaviors that society prohibited.

Typically, the situation is reversed today. Individualism is so dominant that social connections are not formed or, if formed, eventually unravel. The requirements and goals of psychotherapy are different. Modern patients need authentic human relationships, the skills for building them, and the ability to make the compromises necessary to live intimately with others. They need less help with the structure of their being than with the process of relating. From this perspective, the benefits of group therapy begin to become clear. Therapy groups are supportive yet, in a way, restrictive communities. They incorporate some Victorian values of dependability, and it is expected that group members will work at their relationships with others in the group. The easy "out" of changing relationships is highly discouraged in favor of resolving conflict. As Rutan and Alonso (1979) wrote:

> Group therapy, by its very format, offers unique opportunities to experience and work on issues of intimacy, individuation, and interdependence. In such groups the community is represented in the treatment room. It is usually impossible for individuals to view themselves as existing alone and affecting no one when in a group therapy situation over any significant period. (p. 612)

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