

INFLUENCES AFFECTING THERAPIST ATTITUDES AND APPROACHES
TO MANAGING CONFLICT IN PSYCHOTHERAPY GROUPS

by

ROBERT ALLAN UNGER

B.S., University of California at Berkeley, 1967

M.S.W., Hunter College, 1976

A thesis submitted to the
Faculty of the Graduate School of the
University of Colorado in partial fulfillment
of the requirements for the degree of

Doctor of Philosophy

School of Education

1993

This thesis for the Doctor of Philosophy degree by
Robert Allan Unger
has been approved for the
school of
education
by

Albert Roark

Donald Weatherley

Leonard Baca

Robert Linn

Vernon Keenan

Date_____

Unger, Robert Allan (Ph.D., Education)

Influences Affecting Therapist Attitudes and Approaches
to Managing Conflict in Psychotherapy Groups

Thesis directed by Professor Albert E. Roark

This study explores therapists' attitudes and approaches to managing conflict in psychotherapy groups. The study was motivated by the fact that despite the importance of effective management of group conflict, relatively little research has been done in this area. The literature review discusses the importance of conflict to the growth and development of psychotherapy groups, some of its sources, its relationship to group cohesion, structure, and development, and the importance of group leadership in its management.

To assess therapists' approaches to managing group conflict, a two-part instrument was developed. Part I gathered demographic data such as education, theoretical approach, length of time in practice, theoretical orientation, specific training in group therapy, type of group preference, and experience in personal psychotherapy. Part II, the *Conflict Management Scale*, (CMS) consists of a Likert scale of

25 theoretical and practical questions assessing therapists attitudes and approaches to group conflict management. Each question is keyed to material on that topic outlined in the literature review.

The questionnaire was sent to 800 group therapists chosen randomly from the membership lists of the American Group Psychotherapy Association and the Association for Specialists in Group Work. Of these, 307 usable responses were received. The null hypotheses tested were that there is no significant statistical relationship between "attitudes toward conflict management" as measured by the CMS and 1) educational preparation, 2) theoretical orientation, 3) experience in practice, 4) experience in personal therapy, and 5) type of group preference.

Sixteen independent variables taken from the demographic data of Part I of the instrument were categorized into one of the five major categories outlined in the null hypothesis. A oneway analysis of variance was used to test their relationship to the score on the CMS. A secondary analysis was then performed to examine the pattern of relationships between the independent variables.

Analysis found that of the 16 categories tested, 12 were significant to the .01 level and 2 were significant to the .05 level. All of the 5 categories tested in the null hypothesis were significant in determining the results on the CMS. The secondary analysis showed the strongest relationship exists between amount of personal psychotherapy and higher outcome on the CMS. A strong relationship between group preference and outcome on the CMS also exists, with those preferring to conduct heterogeneous groups scoring higher than those preferring homogeneous groups.

DEDICATION

This dissertation is dedicated to my wife Helena, and my sons, Dylan and Julian. Their love, patience, and support enabled me to complete this project. They are the inspiration for every step forward I take.

ACKNOWLEDGEMENTS

First and foremost, I would like to acknowledge the tremendous guidance and support of my advisor, Dr. Albert Roark. From the time I entered the program, Dr. Roark gave me the feeling that I could succeed in it, and most important, that he would be there to guide me to the next step. Dr. Roark's combination of dedication, softness, and consistency always made me feel that my work was worthwhile.

I would like to acknowledge the encouragement of my teachers and analysts who inspired my involvement with psychotherapy in general and group psychotherapy in particular. I first discovered the power and potential of group therapy with Dr. Louis Ormont. His energy, presence, and particularly his ability and willingness to deal with conflict and aggression (particularly my own) in the group setting enabled my self-esteem to flourish, and inspired my interest in this field. Dr. Hyman Spotnitz, genius and teacher to so many, has inspired me to continually try to find the right combination of creativity, compassion, humility,

and outrageousness to make this work exciting and interesting to me, and helpful to my patients. Dr. Phyllis Meadow pushed me forward whenever it was most needed, and taught me the importance of dedication and fearlessness. Dr. Stanley Hayden continually teaches me grace and generosity in working with myself and my patients. And Dr. Leslie Rosenthal constantly demonstrates the importance of craftsmanship and integrity in being an effective psychotherapist.

I would also like to acknowledge the importance of friends and colleagues. Miriam Bloom's generosity and support was instrumental in enabling me to begin my practice in Boulder. My good friend, Dr. Mark Singer, offered continuous support and encouragement during my seven years in this program. And my dear colleagues, Valerie Frankfeldt and Paul Geltner have helped me become secure in the feeling that I have something to offer as a psychotherapist and teacher.

Finally, I would like to thank my editorial and statistical consultants, Michelle Asakawa and Dr. Al Nelson. Their ability to make words and numbers sing and dance has been invaluable.

TABLE OF CONTENTS

DEDICATION.....	6
ACKNOWLEDGEMENTS.....	7
LIST OF TABLES.....	11
CHAPTER I.....	13
Introduction.....	13
Statement of the Problem.....	16
Purpose of the Study.....	17
Limitations of the Study.....	18
Definition of Terms.....	19
CHAPTER II.....	20
The Need to Consider Conflict.....	21
Sources and Determinants of Group Conflict, Aggression, and Hostility.....	23
Relationship of Conflict and Aggression to Group Structure and Development	26
Transference and Conflict.....	29
Group Conflict and Leadership.....	31
Group Cohesion, Composition, and Conflict. .	38
CHAPTER III.....	41
Instrument Development.....	41
Hypothesis.....	60
Dependent Variable.....	61
Independent Variables.....	62
Statistical Analysis.....	66
CHAPTER IV	69
Sample.....	69
Description of Respondents.....	69
Number of Cases and Means.....	80
Results of Primary Analysis.....	80

Results of Secondary Analysis.....	86
Interpretation of Statistical Analysis.....	88
Summary of Statistical Analysis.....	90
CHAPTER V.....	93
Review of the Study.....	93
Discussion of the Findings.....	95
Discussion of Analysis.....	96
Conclusion.....	103
REFERENCES.....	105
APPENDIX.....	109
Cover Letter	109
Conflict Management Scale--Part I.....	110
Conflict Management Scale--Part II.....	112
Conflict Management Scale--Scoring Key....	115

LIST OF TABLES

DEDICATION.....	6
ACKNOWLEDGEMENTS.....	7
LIST OF TABLES.....	11
CHAPTER I.....	13
Introduction.....	13
Statement of the Problem.....	16
Purpose of the Study.....	17
Limitations of the Study.....	18
Definition of Terms.....	19
CHAPTER II.....	20
The Need to Consider Conflict.....	21
Sources and Determinants of Group Conflict, Aggression, and Hostility.....	23
Relationship of Conflict and Aggression to Group Structure and Development	26
Transference and Conflict.....	29
Group Conflict and Leadership.....	31
Group Cohesion, Composition, and Conflict. .	38
CHAPTER III.....	41
Instrument Development.....	41
Hypothesis.....	60
Dependent Variable.....	61
Independent Variables.....	62
Statistical Analysis.....	66
CHAPTER IV	69
Sample.....	69
Description of Respondents.....	69
Number of Cases and Means.....	80
Results of Primary Analysis.....	80
Results of Secondary Analysis.....	86
Interpretation of Statistical Analysis.....	88

Summary of Statistical Analysis.....90

CHAPTER V.....93

 Review of the Study.....93

 Discussion of the Findings.....95

 Discussion of Analysis.....96

 Conclusion.....103

REFERENCES.....105

APPENDIX.....109

 Cover Letter109

 Conflict Management Scale--Part I.....110

 Conflict Management Scale--Part II.....112

 Conflict Management Scale--Scoring Key...115

CHAPTER I

INTRODUCTION TO THE STUDY

Introduction

Over the past 50 years group therapy has become an increasingly popular form of psychotherapeutic intervention. Although some people consider group therapy to be a secondary or adjunctive form of treatment, the economics of group therapy combined with the influential t-group and 12 step movements have greatly spurred its acceptance as a primary form of treatment. Group therapy has become the treatment of choice, and sometimes the only treatment available in many settings.

Practicing psychotherapists have completed a moderate amount of formal training, usually at the masters level in psychology, counseling, or social work. This training typically includes some understanding of the dynamics of the individual and instruction in psychotherapeutic technique; ideally it is buttressed by a clinical internship. The emphasis generally is on individual treatment, although a course or two in group therapy is sometimes offered. As is

increasingly noted in the psychotherapeutic literature, group therapy demands diagnostic indications, skills, and approaches quite unlike those in individual treatment (Unger, 1989). Relatively few group therapy training programs are available, and they tend to be free-standing, post-degree programs. Thus, although the use of group therapy is increasing, particularly in treatment of addictions and impulsive behaviors, many practitioners have scant training in the specific skills required to be a competent group therapist (Battegay, 1983).

An important dynamic frequently arising in therapy groups is conflict between group members or between members and the therapist. Many authors, including Mitchell and Mitchell (1984) and Yalom (1985), note that conflict in groups is inevitable. Other authors stress the importance of dealing effectively with conflict in groups. Because of the powerful forces present in group situations, especially when emotional resonance occurs between members, conflict and aggression can be most difficult for the therapist to manage effectively. Even so, most authors agree that the successful handling of conflict is integral to the growth of a group (see, e.g. Frank, 1955).

Difficulties can arise when conflict or aggression in a group is not managed effectively. Because members will quickly intuit the lack of safety in verbalizing their conflicts toward each other, personal growth may be stifled. The level of intimacy also can be affected, since resolution of conflict usually leads to greater experience and expression of intimacy by group members. If the members feel that the leader cannot tolerate or manage conflict, they may unconsciously protect the leader at the expense of their own free expression (Slavson, 1979; Mitchell & Mitchell, 1984).

Perhaps the most serious consequence of poor conflict management is when the leader allows fear of conflict or unresolved personal conflicts to surface while working with the group. This can take the form of attacking or criticizing group members, unconsciously enabling and encouraging group members to attack one another, or inducing feelings of inadequacy and blame in the group. The author has heard many reports of people who have had strong negative experiences with aggression in therapy groups and consequently refuse to continue to participate in them. The adverse forces in groups are potentially so powerful that people can sustain psychological damage from these experiences

(Hayden, 1983).

Surprisingly, as vital as conflict management is to effective group leadership, the author has found little research that specifically defines the therapeutic skills most needed to manage conflict and aggression and the elements of training that help develop these skills. It is important to know more about how to train therapists to effectively deal with conflict and aggression in group therapy.

Statement of the Problem

Although it is well recognized that conflict management is a crucial element of effective group leadership, little has been done to define the specific elements, actions, and influences of conflict management in group therapy. It is important to know more specifically how to assess therapists' skills in working with conflict and aggression in groups and how these skills are influenced by training, experience, and other factors. This information can then be incorporated into group therapy training programs resulting in better-trained group therapists, particularly in the area of conflict management.

Purpose of the Study

The purpose of this study is to a) assess group leaders' skills in and approaches to managing conflict in groups, and to b) see how these skills and approaches correlate with factors such as amount and kind of training, experience, and theoretical orientation. An instrument was developed to assess these skills and approaches and to gather information on training, experience, theoretical orientation, and demographic factors. The instrument was administered to a selection of group therapists; the results were then analyzed to evaluate the likelihood that management of conflict and aggression in groups is influenced by some of the factors mentioned above.

Limitations of the Study

The primary limitation of this study concerns the notion of effective or skillful conflict management. There are many theoretical and practical approaches to group psychotherapy and many defined or implied approaches to conflict management. In this study it would be impractical if not impossible to arrive at an all-encompassing definition of effective conflict management in groups and to evaluate therapists on the basis of this decision. The instrument developed for this study functions as a first step toward definition, bringing together some of the more popular notions of conflict management found in the group therapy literature and investigating how group therapists define themselves relative to these ideas. As research continues in this area, more specific, universally acceptable ideas regarding effective conflict management in groups should emerge.

Definition of Terms

Conflict has been defined in a variety of ways in the literature, and for the purposes of this study will be considered an aggregate of the following definitions: Cima (1985) defined conflict as, "those times when one party complains about the behavior of another, and more precisely, when a line of communication is challenged" (p. 4). Thomas (1976) noted that conflict begins on a perceptual basis when one "party perceives that the other has frustrated, or is about to frustrate, some concern of his" (p. 891). Deutch (1973) stated that we have conflict whenever "incompatible activities occur" (p. 7). Watkins (1974) and Kiesler (1978), focused on the incompatibility of goals. Some argue that a situation is conflictual whenever an impasse has been reached (Shatlin, 1981), or when there is a genuine difference among the parties involved (Lippitt, 1982). Aggression can be defined as hostility, in itself anger directed at another person (Gans, 1989, p.1).

CHAPTER II

SURVEY OF THE LITERATURE

The Need to Consider Conflict and Aggression in Groups

Many writers agree on the importance of the role of conflict and aggression in groups. Mitchell and Mitchell (1984) stated that "Conflict is inevitable in groups, and its management (and mismanagement) has strong effects on group dynamics" (p. 137). Wilson and Ryland (1949) observed that "Conflicts are everyday occurrences in every group. They are essential to the group's existence and their solution is just as essential to its survival" (p. 55). Frank (1955) noted that although therapists often tend to accentuate positive emotions such as warmth and caring, the negative ones, such as antagonism and conflict, can be an important stimulation to personality growth. Wall and Nolan (1987) saw conflict as, "an inevitable part of human existence...and probably not inherently good or bad" (pp. 189-190). This was echoed by Bonner (1959) who said that "Competition and conflict are not always negative or destructive; they can also be stimulating and constructive" (p. 87). Kormanski (1982) stated that conflict and leadership are inseparable.

Yalom (1985), perhaps the most frequently quoted writer in group therapy literature, suggested that the

absence of conflict in a group indicates impairment of the developmental sequence. Slavson (1957), considered by many to be the father of modern group psychotherapy in America, stated that, "instead of coherence, essential to socioeducational groups, therapeutic groups feed upon interpersonal conflict and overt expression of hostility among the members" (p. 134). He also noted (1979) that biologically, members of a group are a threat to one another, and while groups protect against danger and favor survival, they are sources of considerable tension for their members. Roether and Peters (1972) noted that "Group psychotherapy provides a setting in which patients who eventually become successful will improve their management of hostility" (p. 1015). Ormont (1984) wrote that therapists are beginning to see aggression as "an indispensable source of energy, often as crude energy itself" (p. 553).

Sources and Determinants of Group Conflict, Aggression, and Hostility

The literature presents a variety of ideas concerning the roots of conflict in group therapy. Yalom (1985) noted that conflict is inevitable in groups. Foulkes and Anthony (1957) stated that "The living portrait of the group is most uniformly painted in terms of conflict, which is evident in manifest or latent forms in every group situation..." (p. 118). Northen (1969) wrote that "The recognition of the differences among (group members) creates conflict, the resolution of which provides stimulation toward new and modified common perception" (p. 47). Mitchell and Mitchell (1984) and Ormont (1984) noted that members share limited time, space, and attention. Spontnitz (1968) concurred and added:

People have to share time and attention and divulge the intimate details of their lives to strangers. Patients crave attention, appreciation, admiration, and affection. They get reduced direction and lack of direction on how to proceed. Neglect provokes anger and despair...(p. 152)

The sources of conflict in a group can be many. Yalom (1985) and Frank (1955) noted that conflict often arises out of contempt of others, which is usually a projection of the patient's self-contempt. Yalom also

listed transferences, mirror reactions, rivalry, differences in outlook based on differing life experiences, anger at members who have not accepted the group's norms, and disappointment with the therapist as additional sources of conflict. Foulkes and Anthony (1957) pointed out that inner pressures drive a member toward individuality while at the same time they must behave according to the norms of the group; this they noted creates a situation of conflict.

Several writers highlighted the interpersonal environment in the group as a natural source of conflict. Bar-Levav (1977) saw competition as a major issue, with patients in a group having to compete for the "good mother" who is embodied by the therapist. This is also noted by Ali (1957), who emphasized the inevitability of situations of jealousy, social competition, rejection, vindication, and guilt arising in the group situation. Mullan (1953) felt that an advantage of group psychotherapy over individual psychotherapy is the greater amount of environmental conflict, which therapists can use to bring out issues of individual inner conflict.

Related to conflict is the issue of tension, which

was discussed in a 1977 article by Kellerman and Plutchik. They noted that tension is important to any therapeutic endeavor and that it can create behaviors such as anger. They felt that group tension helps generate greater interest in the group process and contributes to a more compelling environment for each group member, despite some overall discomfort. Tension in the group represents the ongoing struggle between defenses, which are on the side of forgetting one's history, and relinquishment of those defenses, which is on the side of remembering one's history. Because of the ambivalence surrounding this issue, the simple act of entering a therapy group can give rise to tension.

**Relationship of Conflict and Aggression to Group
Structure and Development**

Many theories of group development have been proposed, and most of them identify a stage in the group when conflict is most likely to occur. Dugo and Beck (1984) stated that the basic rules of group structure and development are the source of intimacy and hostility issues. Kormanski (1982) suggested that an initial stage of orientation and dependency is followed by a second stage of resistance and conflict, which in turn is followed by a stage of cohesion and cooperation. Tuckman (1965), in a review of the literature on group development, noted that many theorists see an initial stage of testing and dependence followed by a stage of intergroup conflict; he proposed an idea seconded by Saravey (1978): that group development parallels infant development and is analogous to the oral, genital, and phallic stages of individual growth--this being a phenomenon of all groups regardless of their size or purpose. In Tuckman's scheme, the first two stages of the group are: 1) the oral dependent phase, characterized by a passive dependent attitude toward the leader, who is represented as the mother during the first half-year of life, and 2) the oral aggressive phase, in which the

leader is the hated frustrating mother. This combination of dependence on, and frustration by, the therapist creates a situation that is ripe for therapist-member conflict.

Gans (1989) identified three phases of group development and the primary sources of hostility likely to occur in each. In the *Early Phase* hostility is brought about by overwhelming anxiety, vulnerability to attack, prejudice and fear of exclusion, and loss of control. Hostility in the *Reactive Phase* is brought on by power needs, self-confrontation through another, sibling rivalry, transference, and premature termination. In the *Mature Phase* hostility generally diminishes but can occur with awareness of limitation of the process as the member prepares to leave as a result of finding more satisfaction from everyday relationships.

Transference and Conflict

Because much of the literature in group psychotherapy is written from a psychodynamic perspective, it is often helpful to view conflict and aggression in groups in terms of transference phenomena; that is, the dynamics from early life experiences that are played out in the group process. The group may be seen as a recapitulation of the family situation, where a parental or authority figure (the therapist) is managing an interpersonal situation for subordinate peers (the group members). This symbolically recreates the parent-child family structure. In the words of Slavson (1979), "Every group, particularly small groups, represents in the unconscious of the individual his family, and he inevitably acts out his relationships to them" (p. 355).

The notion of transference phenomena suggests that group members' early conflicts will be played out in the ongoing group dynamic. This underscores the importance of working with the here-and-now situation in the group as the primary means to uncover and resolve individual conflicts. Spotnitz (1976) noted, "Creation and maintenance of a transference climate is necessary

to activate problems (conflicts) with sufficient intensity to resolve them in the group situation" (p.83). Other writers such as Yalom (1985), Slavson (1979), and Foulkes and Anthony (1957) emphasized the importance of working with the here-and-now situation in group therapy. In his discussion of the importance of working directly with anger in groups, Danesh (1977) noted that people are generally not encouraged to show anger and that something beyond insight into the causes and dynamics of anger is needed.

Group Conflict and Leadership

Many writers have commented on the difficult task of managing conflict and aggression in groups. Ormont (1984) noted that there is a strong urge to evade the anger of the group members because "there is an urge to keep the members liking us" (p. 555). He felt that unseasoned group leaders, in particular, may fear that their patients will leave if the leaders show anger. Slavson (1979) observed that a requirement of good therapists is that they make it possible for patients to express hostility towards them. Spotnitz (1976) described the tendency of therapists to use the group as a stage to conduct individual therapy rather than to explore group phenomena and relationships. He stated that "to study how the group patients band together to unseat the unhelpful therapist is a threatening experience. Individual feedback is easier to tolerate than group feedback." (p. 90). Ali (1957) observed that group members have a tendency to attempt to transform group analysis to individual analysis, recreating or establishing the one-on-one situation. If the therapist interprets individual behavior in classical psychoanalytic schemes rather than in terms of group phenomena, an authoritative climate crystallizes in the

group, hindering the analysis of underlying aggressiveness. Mullan (1953) noted that therapies where techniques such as reasoning, education, suggestion, inspiration, guidance, correction, and advice are used share one important characteristic: The therapists make their preferences known and thereby *direct* rather than *conduct* the group. The result can be that the group is unwittingly allowed to avoid conflict. Slavson (1979) saw the value of the clients resonating together in a negative transference toward the therapist. He noted:

It is in the negative phases of the transference that the members give each other the greatest support. As is well known, the common agent of hostility is the greatest unifying agent among people in the ordinary community. It is so also in treatment groups. (p. 372)

Many notions of what constitutes effective group leadership in group conflict situations have been proposed. Mitchell and Mitchell (1984) emphasized that conflict with the group leader is important and influential for developing the future course of the group. They stress the importance of the leader demonstrating interest in receiving negative feedback and being willing to learn from it. They also present several recommendations for facilitators, including 1) helping

the group to develop norms for dealing with conflict, 2) helping members understand each other's communications, 3) encouraging direct rather than indirect communication, 4) helping members to deal with different conceptualizations of a conflict situation, and 5) helping members synchronize their efforts toward conflict resolution.

Gans (1989) emphasized that the leader must appreciate the positive as well as the negative value of hostility. He stated that therapeutic handling of conflict depends on one's familiarity with how various theoretical models have interpreted hostility and on how well the therapist understands its defensive and communicative functions. The important components of the leader's reaction to hostility are, according to Gans, to 1) determine if the hostility is a resistance to group work or part of it, 2) protect the object of attack by drawing hostility to the self when indicated, and 3) shift the onus of responsibility for hostility to the group. Ali (1957) also emphasized the importance of the therapist's tolerance of aggressive feelings within the group. He noted that by adopting a laissez-faire attitude in the group, the therapist

frustrates the patients' needs for dependence and gives vent to their aggressiveness towards the analyst.

The mediating role of the group leader in relationship to conflict has been similarly addressed. Kellerman and Plutchik (1977) saw the therapist as the "reality-tension tester" and observed that group tension is affected by many of the therapist's behaviors. Group leaders can stabilize behavior and lessen tension through unambiguous and consistent leadership, clear rules of group functioning, maximum use of communication channels, a mediation system in the event of unresolvable conflicts, and good reality testing. Kellerman and Plutchik emphasized that the role of the therapist is to lead; if he or she is unclear about the leadership function, a confusion in overall group process will result, and the group tension level will be inadequately managed. This topic was also addressed by Mullan (1953), who noted that group members are usually more concerned with avoiding conflict than their therapists are. The therapist, Mullan noted, must counter the group's avoidance and maintain a proper degree of emotional imbalance in the group to enable conflicts to arise.

The casualties or injuries that result from group conflict were addressed by Kaplan et al. (1980). They recommended ways to minimize the chances of casualties, including 1) screening and training group leaders to ensure competence and to protect against abuse of peers, 2) excluding from group participation those patients particularly susceptible to injury, 3) ensuring that patients participate only after informed choice, that is, having gained a reasonable understanding of the procedures and occurrences of the group, and 4) making sure that group relationships are sufficiently developed before potent criticisms are given.

Many clients enter group therapy believing they will be free to behave and express themselves exactly as they wish. They are then quite disappointed when presented with rules of conduct for the group. Ormont (1968) discussed this phenomenon in an article on the group contract and suggests some possible elements of a group contract. Members should:

- 1) Tell the story of their lives where pertinent.
- 2) Understand others and communicate it.
- 3) Make no critical life decisions

without discussion in the group.

- 4) Take a proportional part of the talking time.
- 5) Refrain from acting out - i.e., smoking, drinking, incurring debts, socializing outside of group, physical activity in the group. (p. 148).

Ormont went on to note that deviations from the contract are expected; in fact, the ways in which members deviate from or resist the contract often tell a great deal about how they deal with conflict in everyday life. Members usually resent these limitations placed on their behavior but, particularly in the initial phases of the group, are unwilling to confront the therapist directly with their resentment. Instead, they tend to either bicker with each other or band together (usually unconsciously) to be uncooperative. Ormont termed the manner in which group members act collectively to ignore the contract or indirectly express anger toward the therapist a *group resistance* (p. 149). These include incidents in which members are late, miss sessions, or act out in other ways without being confronted by fellow group members.

Group Cohesion, Composition, and Conflict

Several writers believe that cohesiveness plays an important role in understanding conflict in group psychotherapy. In an experiment conducted with school children, Pepitone and Reichling (1955) determined that aggression and hostility were more likely to be expressed in groups that were more - not less - cohesive. Budge (1981) noted that groups become cohesive when members find that they have common problems, but that as members differentiate over time, conflicts emerge. Once these conflicts are resolved, common perceptions are restored and cohesiveness increases.

The literature suggests that a relationship exists between group composition, cohesion, and the emergence of conflict. Rosenthal (1985) found that conflict is more likely to emerge in heterogeneous groups than in homogeneous groups although heterogeneous groups take longer to obtain cohesiveness. Frank (1957) noted that members of a cohesive group tolerate conflicts by putting pressure on one another to keep communicating, but that cohesiveness might also guard against the expression of disruptive feelings. This was echoed by Groatjahn (1981), who felt that too much cohesion -

where the members are primarily interested in the feelings of security that result from the sense of belonging to a group - can be indicative of a group resistance to the process of growth. In such a case, individuals might have difficulty expressing their own individuation. Evans and Jarvis (1980) similarly stated that high attraction to the group may lead to difficulty with the negative aspects of the group experience, causing members to be overly vulnerable to the influence of the group.

In writing about group therapy with Vietnam veterans, Parson (1985) presented an example of the difficulties inherent with very high group cohesion. In these groups, cohesion was usually high so as to protect the group's narcissistically vulnerable patients. This level of cohesion keeps interpersonal conflicts in the group to a minimum. Parson observed that conflict in the group was reminiscent of conflict in Vietnam; members had a need to avoid reexperiencing these events at all costs. At risk was the destruction of the group.

In general, the relationship between cohesiveness and conflict must be continually monitored, for as

Yalom (1985) noted, the intensity of conflict should not exceed the member's tolerance for it. In this vein, the therapist must be cognizant of the nature of the cohesive forces at play in the group at the moment, so that expression of conflict will not cause members to leave or sustain narcissistic injury.

CHAPTER III

METHODOLOGY

Instrument Development

A two-part instrument was developed to assess therapists' attitudes and approaches toward conflict in group therapy. Part I gathers demographic information from the respondent and includes items such as age, sex, experience, training, and theoretical orientation. Part II (the *Conflict Management Scale*) consists of a Likert scale of 25 questions assessing the respondent's attitudes and approaches toward conflict management in therapy groups.

Because there are many possible approaches to working with conflict in groups, it would be difficult to design a survey incorporating a single unified scale of assessment. The questions I constructed for this survey thus are limited in scope, reflecting some of the prevailing theories about group conflict that appear in the literature review. A detailed description of the theoretical background of each question is presented, and the questions are keyed to the section

of the literature review where the ideas are presented. The questions can be graded right or wrong with respect to these ideas.

A pilot study for the survey instrument was administered to 20 group therapists. Demographic questions were asked in open-ended fashion to facilitate proper construction of the categories in the final version of Part II. A reliability estimate was performed on Part II to test for internal consistency of the instrument, and questions were revised or eliminated as necessary.

Following is a listing of the questions from Part II of the *Conflict Management Scale* along with a description of their theoretical bases as described in the literature review. The final version of the instrument as mailed can be found in Appendix A. The survey is structured as a Likert scale. Respondents were asked to answer on a 1 to 5 scale as follows:

1. Strongly disagree
2. Moderately disagree
3. Neutral
4. Moderately agree
5. Strongly agree

1. Conflict is a necessary and integral part of group development.

This is a premise shared by many writers, clinicians, and theoreticians in group therapy. Refer to page 21 in the literature review.

2. It is inevitable that members of a therapy group have angry feelings towards one another.

This notion is also expressed by many writers and theoreticians. Reasons include projections, rivalry, the need to share time and space, and disappointment with the group leader. Refer to page 23 in the literature review.

3. During the first two sessions of a beginning therapy group, conflict broke out between several members. The therapist should try to direct most or all of this conflict towards him/her self.

As noted in the literature (p. 23), group therapy can be a frustrating experience, and it is the therapist who put the members in this situation. Initially, the therapist should take responsibility for anger and conflict in the group; once a sufficient level of cohesion has developed, the group can sustain conflicting relationships (see discussion of cohesion, p. 38).

Slavson (p. 32) notes that a requirement of good therapists is that they make it possible for the patients to express hostility toward them.

4. *When group members get angry at the therapist, the therapist should de-emphasize engagement with her/him and deflect the anger back to the group.*

This is usually *not* preferable, particularly in a beginning group. Just as the parent serves as the child's role model, the therapist should serve as the group's role model in dealing with anger and conflict. Most group members are not comfortable with expression of conflict and anger, so the group leader should serve as an example. Therapists should generally accept anger directed toward them even if they feel that it is misdirected. When the members feel that the leader can tolerate anger and aggression and work effectively with it, they will become freer with its expression in the ongoing group process. See the section on group conflict and leadership on page 31 of the literature review.

5. *Ultimately, the therapist is primarily responsible for the anger and conflict which arises in a therapy group.*

This is essentially true. As has been noted by many writers, group therapy is usually a frustrating experience, where immediate gratification is limited and members have to share time and attention with other members. It is the therapist who placed the person in the group and maintains this situation. From a transference point of view, the therapist usually represents either or both parents, or some other authority figure, who is consciously or unconsciously perceived as the source of the client's problems. See the discussion of transference and conflict on page 29 of the literature review.

6. *Too much unresolved conflict in a group impedes its progress.*

The key word here is *unresolved*. As it is inevitable that conflict will arise in an ongoing group, it must be continually resolved if the group is to progress. If the members do not have the feeling that conflict within the group can be safely resolved, it will not surface, but will remain underground and be acted out in an indirect manner. Refer to the discussion of group conflict and leadership on page 31 in the literature review. The therapist should take responsibility for unresolved conflict in the group.

- 7. *Some conflict between group members is necessary in order to develop in-depth working cohesion in a therapy group.***

Conflict between group members is thought to actually encourage the formation of good working cohesion in a group. Although cohesion is necessary for a group to stay together and function, the literature recognizes that cohesion can also become a resistance to the accomplishment of group objectives. This is particularly true with many homogeneous groups, where members get together because of a common problem such as drug and alcohol dependencies or eating disorders. Although such similarities may at first encourage progress within the group, the need to identify with others and the corresponding fear of differentiating and individuating tends to stymie the group's effectiveness. When cohesion is flexible enough to ebb and flow with the emergence of interpersonal conflict in the group, progress usually results. Refer to page 38 in the literature review.

- 8. *Joe, who is usually silent in the group, suddenly explodes at Bill and starts calling him names. The therapist knows that Joe has trouble express-***

ing himself in the group. The therapist also feels a great deal of fear as Joe is lashing out at Bill. The best approach for the therapist to take in this situation is to interpret Joe's behavior in terms of his repressive past.

This vignette expresses the choice of dealing with conflict as an individual or group phenomenon. The therapist is, in essence, doing individual treatment in the group setting by interpreting Joe's behavior in terms of his past. Furthermore, by providing an interpretation, he/she is most likely removing the group member from the here-and-now situation of the group. Most group theorists underscore the unique value of group therapy in dealing with interpersonal situations *as they arise* rather than in context of the past (see Yalom, Slavson, and Foulkes & Anthony on p. 30 of the literature review). Also, one can derive from the discussion of sources and determinants of group conflict (p. 23 of the literature review) that any conflict between members of a group can usually be related to the overall dynamics taking place in the group at that moment and should be dealt with as such.

9. Sarah continually comes late to the group. Week

after week, the group gets angry and scapegoats her for this. A good approach for the therapist to take is to reframe Sarah's behavior as understandable in this inhospitable group.

This vignette highlights two principles in group theory; scapegoating and group resistance in the context of the group contract. In the discussion of contract and group resistance in the literature review (p. 36), it is noted that one member's deviation from the contract can usually be seen as a *group resistance*, in that the members unconsciously elect a member to break the contract and then silently support the acting-out behavior. Often, this person is scapegoated. The above vignette demonstrates one way in which the therapist reframes a scapegoating situation into a behavior in which the whole group is responsible.

10. In a court-ordered group at an alcohol treatment center chaos and denial are the norm. No one wants to be there, and members feel cheated for having to come to the sessions. The therapist feels impotent and frustrated. The therapist's best approach is to convince the members that it is their group and that they need to start taking

responsibility for it.

In this situation, the chaos and denial might be seen as an acting-out of conflict and aggression toward the therapist. Transferentially, in court-ordered groups the therapist usually represents the court and social system against which the clients maintain considerable rage. The clients cannot take responsibility for the group until the rage is focused. It has been noted in the literature that the initial point of cohesion for a group often is rage directed at the therapist (see p. 38 of the literature review). Thus, if the therapist is willing to take on the rage of the clients directly and demonstrates that he/she is not afraid of this, the group can move toward a more constructive phase.

11. Members of a group are angry at a new member, accusing him/her of denial, avoidance, and generally not fitting into the group. The best approach for the therapist is to emphasize that she/he is the real culprit for placing the new member in the group.

Although the content of the members' expressions may be accurate, this is a situation in which a member

is being scapegoated. In these cases it is most important for therapists to protect the scapegoated member by deflecting the anger to themselves. If members are allowed to be scapegoated, they get the impression that the group is not a safe place and will most likely reveal little of themselves as time goes on. Since the therapist did, in fact, place the new member in the group, it is appropriate that the therapist take responsibility for other members' anger. This is similar to a family situation where an older sibling will torment a younger sibling as an indirect expression of rage toward the parents for bringing the new sibling into the family.

12. Group therapy should work toward meeting people's needs and should not, by nature, be a particularly frustrating experience.

This question highlights the inevitability of frustration in the group experience. Due to the group's basic structure, the therapist is unable to meet all of the members' needs and to avoid frustration at any given time. See page 23 of the literature review, particularly Spotnitz.

13. In a relatively new, highly resistant group, the

members should be given responsibility for the group's stuckness so that they can learn to move it forward.

In a relatively new group, responsibility for the group's functioning belongs to the therapist rather than the members. This is in keeping with many theories of group development that liken the development of a group to that of an individual. With a young child, the initial responsibility for growth rests with the parent; it is later, as the child develops under the guidance and examples set by the parents, that the child takes more responsibility for his/her growth. See the section on group development on page 26 of the literature review.

14. The therapist should take responsibility for unresolved conflict in the group.

This is similar to the family developmental model, where parents are responsible for proper functioning of the family. Group members learn to take responsibility by modeling their behavior after the therapist's; as is true in family situations, the transfer of responsibility from therapist to clients is gradual. A common error made in group therapy, particularly in the early

phases, is when the therapist tells the group that conflict resolution is the members' responsibility. Most people wind up in groups because they have not learned to take responsibility, and need to be taught how to do this by the therapist.

15. In an ongoing group, Fred gets furious at the therapist for something he/she says, and three other members immediately interpret Fred's fury as a transference reaction. The therapist's best approach is to explore these transference interpretations to see if they are accurate.

Even if the transference interpretations are accurate, the group members' explanation can be seen as a move to protect the therapist from Fred's rage. This situation presents an opportunity for the therapist to demonstrate to the group that he/she can tolerate a member's anger. To this end, the therapist should engage with Fred around his rage directly rather than focus on its transference aspects. See page 53 of the literature review on group conflict and leadership, particularly the discussion of Gans' work.

16. Irma gets so angry at Joan that she says she would like to get up and punch her. The

therapist should gently explain that physical violence never solves anything.

Here is an example of the therapist acting in a manner that is more likely to suppress conflict than explore and resolve it. Irma says that she would *like* to get up and punch Joan. Since she is not actually threatening to do it, this impulse can be explored in the group context. The therapist's reaction would quite likely be perceived as a superego attack and result in Irma going underground with her feelings. Refer to the discussion of group conflict and leadership in the literature review, particularly Mitchell and Mitchell and Gans on page 34.

17. A group therapist decides that it is time to raise his fees. This gives rise to great anger and resentment in the group. The therapist should apologize for the fee raise, clarifying his/her life circumstances which necessitate it.

When the therapist apologizes or brings personal circumstances into the group to explain or justify group behavior there is the danger that he/she will short-circuit the clients' anger. In effect, the therapist is saying, "Take care of me." When the

therapists give the message that they can take care of themselves and fully take responsibility for their own actions, the clients are freer to experience and express their feelings. Many clients describe experiences in therapy where they were given the direct or subtle message that they had to take care of the therapist's emotions at the expense of their own. This would place the client in a role similar to the "parental child" that is sometimes seen in early family experience.

18. *It is natural and expected for a therapist to be afraid of anger in the group.*

Fear of anger within the group is a natural apprehension of most therapists. More important is how the therapist acts on this fear. Does he/she treat the group so that it will suppress its anger or act it out inappropriately? Or does the therapist serve as a model for tolerating uncomfortable or frightening feelings so that the group members can learn to do the same? Spohnitz (page 32 in the literature review) and others emphasize the power of anger in groups.

19. *An advantage to homogeneous groups is that they tend to engender less conflict than heterogeneous*

groups.

The key word here is *advantage*. The notion that less conflict within a group is an advantage is, as stated by many writers cited in the literature review (pp. 21 and 27), false. Conflict is a necessary and integral part of group development.

20. *Jeff is continually scapegoated for his monopolizing behavior in the group. The therapist should explore with Jeff how he manages to get himself in this position time after time.*

Here, the therapist is in essence furthering the scapegoating process by focusing on Jeff. As outlined in the literature review section on the contract (p. 36), Jeff's behavior should be more properly explored as a *group resistance* (Why do other members let him monopolize?) and an indirect expression of conflict within the group or with the therapist.

21. *If a group is truly cohesive, conflict will be minimal and most relationships will carry a positive valence.*

The notion here is that if a group is truly cohesive it will be flexible enough to be able to tolerate and resolve conflict. Conflict will not necessarily be

minimal. The relationships will have changing valences as subgroups change and members form positive and negative feelings toward one another. See the literature review on cohesion, page 38.

22. *In a task-oriented group, the therapist notes tension rising because of covert conflicts between several group members. Because this is a task-oriented group, the therapist should ignore or sidestep the conflicts and remain focused on the task.*

The guideline commonly expressed in the literature is that a task-oriented group should remain focused on the task unless interpersonal conflict inhibits working on the task. If this happens, the interpersonal conflicts must be resolved so that work on the task can continue.

23. *If the leader feels particularly conflicted toward a member or potential member, the person should not be in the group.*

This statement considers that conflicts arise between therapists and group members as well as between and among members. The conflicting feelings a therapist feels toward a member might be largely induced by

that member and might represent the characterological difficulty that brought the person to the group. Most important is the therapist's ability not to *act out* on these feelings. The group process is often an excellent way for therapists to monitor and control their feelings or behavior toward a member. However if therapists, are not aware of the significance of their feelings, they can unconsciously get the group to act out the feelings for them and scapegoat the member. Ormont, Mitchell and Mitchell, and Gans discuss aspects of this situation on page 31 of the literature review.

24. *It is appropriate for a therapist to feel anger at group members.*

Therapists must have access to *all* feelings to successfully work with the emotional ebb and flow of the group. This certainly includes anger. How therapists use their feelings of anger to understand the emotional current of the group and to make appropriate interventions is more at issue. See the discussion on group conflict and leadership on page 31 and the discussion of transference on page 29 in the literature review.

25. *A therapist leading a well-functioning group at a*

mental health center gets a new job. He thus has to notify the group that he will be leaving. The best way to do this is to express his sorrow at having to leave the agency and his confidence that the group will handle the transition to the new therapist successfully.

This is not the best approach in that it does not address the fact that the members are being abandoned by the therapist. Most clients have abandonment issues that get sparked by a therapist leaving, and a major difficulty is in helping them express their anger about it. When the therapist expresses sorrow or apology about leaving there can be a subtle communication to the clients to protect him/her by taking care of these sorrowful feelings. This short-circuits the clients' anger about being left. It is generally preferable for the therapist to admit that the clients are, in fact, being abandoned by the therapist and to demonstrate that he/she can tolerate the feelings of rage that may ensue. This necessitates awareness of the transference situation as described on page 13 of the literature review.

Sample

To obtain the sample for this study, questionnaires (see Appendix A) were mailed to 800 group therapists. The sample was chosen from the two national professional organizations for group therapists: the American Group Psychotherapy Association (AGPA) and the Association for Specialists in Group Work (ASGW), which is a division of the American Counseling Association (formerly the American Association for Counseling and Development). These organizations do not represent all the group therapists in the United States, but as the two main professional organizations in the field, they represent clinicians who maintain the professional identity of "group therapist."

A random sample of 800 therapists was selected from the current membership lists of the two organizations. The 800 names were divided proportionally according to the relative sizes of the two organizations. Thus 304 names were taken from the AGPA list of 3,477 members and 496 names were taken from the ASGW list of 5,673 members. This represented a split of 38% and 62% between the organizations and accounted for a sample size of 8.7% of the whole population.

A correlational analysis was performed to deter-

mine the interrelationship between independent variables. The frequency distribution for each variable was analyzed and reported.

An analysis of variance (ANOVA) was performed on each independent variable in order to analyze mean differences among the levels. Post-hoc comparisons were made where appropriate.

Because other factors such as the therapist's personal style and the dynamics of a particular group--important components of therapist effectiveness in dealing with group conflict--are difficult to measure, this study is limited to the descriptive measures described above.

Hypothesis

The hypotheses for this study, stated in null form, are that there is no significant statistical relationship between "attitudes and approaches toward conflict management" as measured by the *Conflict Management Scale*, and the following independent variables:

- 1) Educational preparation
- 2) Theoretical orientation
- 3) Experience in practice
- 4) Experience in personal therapy

5) Type of group preference.

Dependent Variable

Definition

The dependent variable in this study is labeled "approaches to conflict management." This variable is operationally defined and measured by a total score obtained on a 25 item questionnaire (the *Conflict Management Scale*) designed to measure knowledge and understanding of appropriate methods used in different group therapy situations. Each of the 25 items is scored on a 5-point scale; the higher scores indicate greater agreement with the item. Definition of "correct response" for each item is based on the available literature and is explained on an item-by-item basis earlier in this chapter. To avoid response-set bias, some items were included with their scoring direction reversed. These items were recoded appropriately during the data analysis.

Reliability and Internal Consistency of the Instrument

Item-total correlations were used to examine the internal consistency characteristics of the instrument and the relationship between each item and the total score. This method was also used to ensure correct directionality of each item relative to the total score.

Total scale reliability was determined using Cronbach's Alpha. The value for Alpha was .63.

A preliminary and exploratory principal component factor analysis was run to see whether the scale was best represented by subscales. Examination of this exploratory analysis revealed a significant overlap of factor loadings. There was little evidence to support the use of subscales.

Independent Variables

The independent variables selected for this study were designed to measure the five categories of 1) educational preparation, 2) theoretical orientation, 3) experience in practice, 4) personal therapy experience, and 5) type of group preference. The independent variables used to represent these categories are listed below along with their operational definitions:

1. Educational Preparation

Highest Psychotherapy Degree (NEWDEG)

Measured as level of degree selected from one of six reported categories (our analysis categories are combined into three categories).

Class Semesters of Training (CLASTRAN)

Measured as the number of class semesters reported into one of three ordered categories.

Clinical Internship Hours (INTERN)

Measured as the number of internship hours reported into one of three ordered categories.

Class Semesters of Group Training (GRPCLAS)

Measured as the number of class semesters of group training reported into one of three order categories.

Hours of Group Internship (GRPINT)

Measured as the number of hours of group internship as reported into one of three ordered categories.

Workshops in Group Therapy (WORKSHOP)

Measured as the number of group workshops in group therapy as reported into one of three ordered categories.

2. Orientation

Type of Group Psychotherapy Training (GRPTRAN)

Measured as the type of group therapy training as reported into one of nine non ordered categories.

Theoretical School of Practice (THEORY)

Measured as the theoretical orientation that the respondent reports to practice in as indicated by one of nine non ordered categories.

Additional Psychotherapy Training (PSYCTRAN)

Measured as the theoretical orientation of additional training as indicated by one of nine non ordered categories.

3. Practice Experience

Years Practicing Psychotherapy (YRPR)

Measured as the number of years in practicing psychotherapy as reported into one of three ordered categories.

Years In Group Therapy Practice (YRPRGRP)

Measured as the number of years practicing group therapy as reported into one of three ordered categories.

Group Sessions Conducted (GRPSES)

Measured as the number of group sessions conducted as reported into one of four ordered categories.

Group Therapy Supervision Hours (SUPERVIS)

Measured as the number of group therapy supervision hours as reported into one of three ordered categories.

4. Experience in Personal Therapy

Personal Individual Sessions (PERSIND)

Measured as the number of individual therapy sessions as reported into one of three ordered categories.

Personal Group Sessions (PERSGRP)

Measured as the number of individual therapy sessions as reported into one of three ordered categories.

5. Group Preference

Homogeneous vs. Heterogenous Preference (HOMO)

Measured as the selection of either a homogenous or heterogenous preference category.

Statistical Analysis

Primary Analysis

The study hypotheses were tested for each of the independent variables by the use of a One-way Analysis of Variance. Analysis was run using SPSS. Results statistically significant below the .01 probability level were considered significant for the purpose of rejecting the null hypothesis. Statistically significant results at less than the .05 probability level but greater than the .01 level were considered significant but viewed with caution as to the rejection of the null hypothesis.

Secondary Analysis

Following examination of the findings of the Oneway ANOVA, a secondary exploratory analysis was conducted to examine the pattern of relationships between the independent variables and dependent variable, as well as the relationship between the independent variables themselves. The purpose of this secondary analysis was to determine the degree to which independent variables were interrelated. The statistical methods for this analysis involved the use of several different measures of association including the Pearson Correlation Coefficient for relationships between ordered data, the contingency coefficient for relationships between strictly categorical data, the Eta coefficient to measure relationships between categorical and ordered data, and the use of multiple regression for ordered data.

All of the independent variables used in this study are by design categorical, although all but the three variables measuring theoretical orientation, type of training, and additional psychotherapy training derive from an ordinal scale. The indicators of the concept of theoretical orientation, for instance, are truly categorical in that the response categories to

these items have no meaningful numerical ordering. Relationships between these types of variables are appropriately measured using a statistic such as the contingency coefficient, which is derived from a contingency table analysis and is not dependent on the numerical ordering of the categories. By contrast, variables such as those measuring Years in Practice have categories representing a well-defined numerical ordering of responses (e.g., 1-5, 5-10, 11 and over). In this case, where the categorical variable might be considered to fit an ordinal scale, it may be possible and appropriate to utilize statistics such as the Pearson Correlation Coefficient. The majority of independent variables in this study fit this later definition.

CHAPTER IV

RESULTS

Sample

The responses to the survey were received as follows:

- 15 Returned by post office, address unknown.
- 38 Returned not completed. In almost all cases reason given by the respondent for not completing the questionnaire was that they were no longer practicing group therapy.
- 307 Returned completed, usable responses (38.3% of sample).

Description of Respondents

Table 1 summarizes the responses of the 307 usable surveys. In addition to the overall or total response to the survey, the summary is further broken down by two main variables, organization (AGPA or ASGW) and sex. Looking first at organization, 121 (39.4%) of the respondents were from the AGPA membership list and 186 (60.6%) from the ASGW list. This response rate was quite close to the survey rate from each organization

of 38% and 62% described in Chapter III.

Table 1**Response Summary--Total, by Organization, by Sex**

CATEGORY	TOTAL	ORGANIZATION		SEX	
		AGPA	ASGW	MALE	FEM.
Organization					
AGPA	39.4%			48.3%	51.7%
ASGW	60.6%			38.6%	61.4%
Sex					
Male	42.4%	48.3%	38.6%		
Female	57.6%	51.7%	61.4%		
Average age					
Male	49.6	54.5	45.7		
Female	45.8	49.7	43.6		
Total	47.4	52.0	44.4	49.6	45.8
Experience					
11 or more years of practice	54.5%	85.7%	34.2%	68.2%	43.8%
11 or more years of group practice	49.0%	79.1%	29.1%	62.7%	38.7%
Over 500 group sessions conducted	52.8%	85.8%	31.3%	58.9%	48.5%
Education and training					
Post-Masters degree	34.4%	56.4%	20.0%	54.4%	19.5%
M.D. degree	7.1%	17.9%	0.0%	13.6%	2.4%
Additional training beyond degree	67.1%	82.6%	56.9%	68.9%	65.2%
Specific training in group therapy	83.7%	90.0%	79.5%	86.0%	82.9%
Over 10 workshops in group therapy	38.0%	64.7%	19.8%	40.9%	35.2%
Over 50 hrs. group internship	52.9%	63.2%	46.0%	60.5%	46.1%
Over 50 hrs. group supervision	39.9%	55.0%	29.5%	46.8%	34.1%
Personal therapy					
Over 50 sessions of individual therapy	57.6%	80.0%	42.9%	56.9%	57.8%
Over 200 sessions of individual therapy	33.6%	60.0%	16.4%	35.8%	32.5%
Over 50 sessions of group therapy	42.3%	53.1%	34.6%	41.7%	42.9%
Over 200 sessions of group therapy	15.1%	23.9%	8.8%	17.4%	13.6%

continued on next page

Table 1 (cont'd)

CATEGORY	TOTAL	ORGANIZATION		SEX	
		AGPA	ASGW	MALE	FEM.
Type of group prefer to conduct					
Homogeneous groups	41.5%	19.1%	56.4%	35.4%	45.6%
Heterogeneous groups	38.5%	58.3%	25.1%	44.9%	33.7%
No preference	20.1%	22.6%	18.5%	19.7%	20.7%
Theoretical school of practice					
Eclectic	45.0%	34.7%	51.6%	39.5%	49.1%
Psychodynamic	10.7%	25.6%	1.0%	10.9%	10.9%
Family, Systems	8.1%	6.7%	9.1%	8.5%	7.4%
Psychoanalysis	7.5%	16.5%	1.6%	8.5%	6.9%
Gestalt	5.5%	4.0%	6.4%	7.0%	4.6%

As regards the sex of the respondents, 42.4% of the respondents were male, and 57.6% were female. This ratio varied, however, between the two organizations. In the AGPA the male-female ratio was almost even (48.3% - 51.7%), while in the ASGW females were more dominant (38.6% - 61.4%).

Six other categorical breakdowns were considered and are presented in Table 1. They are also briefly discussed here:

Age

The average age of all respondents in the study was 47.4 years. Males were older than females, 49.6 years to 45.8 years. AGPA members were substantially older than ASGW members, 52.0 years to 44.4 years. Within the organizations, AGPA males were 4.8 years older than their female counterparts (54.5 - 49.7), while ASGW males were 2.1 years older than ASGW females (45.7 - 43.6).

Experience

For the total sample, 54.5% of the respondents have been practicing psychotherapy for 11 or more years, and 49% have been practicing *group* psychotherapy for 11 or more years. 52.8% have conducted over 500 groups. Experience varies widely, however, between the two groups. In the AGPA, 85.7% list over 10 years of practice, compared to only 34.2% for the ASGW. Similarly, for the categories of 10 or more years of group practice and over 500 group sessions conducted, the AGPA members are substantially more experienced.

Males report greater experience than females in the above areas. 68.2% of the males list 11 or more years experience and 62.7% list 11 or more years group experience, compared to 43.8% and 38.7% for females.

The percentages for over 500 group sessions are somewhat closer, with 58.9% males and 48.5% females reporting in this category.

Education

Ninety-seven percent of the respondents had at least a masters degree, and 34.4% had gone beyond this level. Of these, 7.1% were M.D.s. Over Sixty-seven percent had psychotherapy training in addition to their academic degree, 83.7% had some training specific to group therapy, and 38% had completed over 10 workshops in group therapy. In addition, 52.9% had over 50 hours of group internship and 39.9% had over 50 hours of group therapy supervision.

Again, there was a substantial difference in education and training between AGPA and ASGW respondents: 56.4% of AGPA members held a post-masters degree compared to only 20.0% of the ASGW members. All 21 M.D.'s belonged to the AGPA. A substantial number of AGPA members (82.6%) had training beyond their masters degree, compared to slightly more than half (56.9%) of the ASGW members. Likewise, 64.7% of AGPA members completed over 10 group-therapy workshops, compared to 19.8% of ASGW members. Similar differences were reported on hours of group internship and group

supervision completed (see Table 1).

The differences between males and females in education and training were fairly large in some areas and less pronounced in others. About one-half of the males held a post-masters degree compared to one-fifth of the females. Seventeen of the 21 M.D.s were males.

Personal Therapy

Slightly more than half of the respondents have completed over 50 individual psychotherapy sessions; 42.3% have completed more than 50 group sessions. AGPA members again reported much more experience in personal therapy than did ASGW members. An even 60% AGPA members report over 200 sessions of individual therapy. The percentage was far less--16.4%--for ASGW members, Whereas 23.9% of AGPA members reported over 200 group sessions, only 8.8% of ASGW members had this amount of group experience.

In this area, males and females reported quite similarly. As shown in the table, the differences in amount of personal therapy between males and females in all categories are negligible.

Group Preference

A slight majority of the respondents (41.5%) preferred to lead homogeneous groups (groups oriented around a common theme, problem, or population), whereas 38.5% preferred heterogeneous groups (consisting of members with a variety of diagnoses or client types). The remaining respondents expressed no preference. Preference toward type of group differed markedly between the two organizations, however. AGPA members preferred heterogeneous groups over homogeneous groups 58.3% to 19.1% nearly three to one. Twice as many ASGW members, in contrast, preferred homogeneous groups over heterogeneous groups. The split was less pronounced between males and females. Males preferred heterogeneous groups (44.9% to 35.4%) whereas females preferred homogeneous groups (45.6% to 33.7%).

Theoretical School of Practice

Table 1 indicates respondent's assessment of themselves with regard to the five most frequently reported theoretical schools of practice. Although the numbers in most of the categories were too small to draw any decisive conclusions, some trends can be noted. By far, the largest reported category reported was *eclectic*, generally used to mean the use of a variety of modern up-to-date methods. *Eclectic* can also be thought to represent an unwillingness to define oneself in any specific theoretical approach. In the study, ASGW members and females were somewhat more prone to define themselves as eclectic than were AGPA members and males. AGPA members were, however, much more likely to subscribe to the *psychodynamic* and *psychoanalytic* schools of practice than were members of ASGW.

Summary

When broken down by organization membership and sex, the sample of respondents shows some interesting differences. AGPA members are more often male and are older with more education and training, experience, and personal psychotherapy than ASGW members. Members of the two organizations also differ significantly in the type of groups they prefer to conduct. Differences also exist between male and female respondents, but the differences are less pronounced. Although males tend to be older than females, and have more experience and education and training than females, they have essentially no more experience in their amount of personal therapy. This suggests that for a given age, level of experience, or amount of education and training, females are likely to have somewhat more experience in personal therapy.

Although the responses concerning theoretical school of practice are too spread out to draw any substantial conclusions, it appears that AGPA members are more likely to define themselves as working in a specific theoretical approach, particularly in the more

traditional psychodynamic and psychoanalytic schools.

Number of Cases and Means

All respondents were scored on the 25-item *Conflict Management Scale*. Because each response had a scoring range from 1 to 5, the maximum obtainable score was 125. Table 2 lists the statistics for scoring of the total sample.

Table 2

Overall Sample Statistics on the CMS

Mean	80.305	Median	80.000	Mode	80.000
Std dev	9.362	Minimum	54.000	Maximum	115.000
Valid cases	275	Missing cases	32		

Table 3 lists the number of respondents, means, and standard deviations for each response category.

Results of Primary Analysis

The results of the primary analysis are shown in Table 4. The table reports all findings that had significance levels at less than .05 probability. In all but three cases, the independent variables listed in the table also fell below the .01 probability level

Table 3

N's, Means, and Standard Deviations by Response

Category on the CMS

<u>VARIABLE</u>	<u>N</u>	<u>MEAN</u>	<u>SD</u>	<u>VARIABLE</u>	<u>N</u>	<u>MEAN</u>	<u>SD</u>
-----------------	----------	-------------	-----------	-----------------	----------	-------------	-----------

HIGHEST PSYCHOTHERAPY-RELATED DEGREE

NONE	2	78.00	5.65
BACHELO	4	77.75	8.38
MASTERS	141	77.41	8.27
M.S.W.	33	81.60	9.25
DOCTORAT	66	84.65	10.28
M.D.	19	84.36	8.49
Total	265	80.23	9.45

CLASS-SEMESTERS OF TRAINING

0-10	78	78.75	8.32
11-30	68	80.57	9.88
31-OVER	63	82.77	9.36
Total	209	80.58	9.27

CLINICAL INTERNSHIP HOURS COMPLETED

0-100	52	78.21	8.47
101-500	64	79.39	7.75
501-OVER	70	83.57	10.28
Total	186	80.64	9.22

CLASS-SEMESTERS OF GROUP TRAINING

0-5	101	79.37	9.06
6-10	71	81.15	9.27
11-OVER	62	82.32	10.25
Total	234	80.66	9.50

HOURS OF GROUP INTERNSHIP

0-50	114	79.20	8.38
51-200	81	81.65	9.92
201-OVER	45	81.62	10.85
Total	240	80.43	9.45

WORKSHOPS IN GROUP THERAPY

0-5	88	79.94	9.51
6-10	81	78.13	7.73
11-OVER	95	83.17	9.86
Total	264	80.50	9.34

YEARS PRACTICING PSYCHOTHERAPY

0-4	63	77.46	7.13
5-10	67	78.89	8.73
11-OVER	141	82.22	10.13
Total	271	80.22	9.37

YEARS PRACTICING GROUP THERAPY

0-4	69	77.94	7.89
5-10	76	79.63	9.41
11-OVER	125	82.00	9.84
Total	270	80.23	9.39

GROUP THERAPY SESSIONS CONDUCTED

0-100	60	75.90	7.75
101-500	75	79.14	7.97
501-2000	86	82.32	9.40
2001-OVE	52	83.25	10.73
Total	273	80.21	9.34

GROUP THERAPY SUPERVISION HOURS

0-10	65	78.04	8.41
11-50	97	79.41	8.84
51-OVER	104	82.76	9.98
Total	266	80.39	9.38

GROUP PSYCHOTHERAPY TRAINING

UNIVERSI	105	79.01	8.72
GESTALT	13	80.15	9.21
PSYCHOAN	14	92.78	11.23
PSYCHIAT	11	84.27	8.90
PSYCHODY	11	86.45	7.67
TRAINING	13	83.15	11.59
SEMINARS	23	81.86	9.39
ECLECTIC	8	77.12	6.03
OTHER	34	79.52	6.79
Total	232	81.03	9.39

THEORETICAL SCHOOL OF PRACTICE

ECLECTIC	126	78.62	8.97
PSYCHOAN	19	83.21	9.61
PSYCHODY	30	89.13	9.10
GESTALT	15	80.26	8.58
FAMILY,	23	79.17	7.15
COGNITIV	9	80.22	9.33
ADLARIAN	8	82.00	11.46
INTERPER	2	79.00	9.90
OTHER	27	79.88	7.99
Total	259	80.68	9.34

ADDITIONAL PSYCHOTHERAPY TRAINING

GESTALT	24	79.95	11.11
PSYCHOAN	35	84.65	10.28
FAMILY,	11	80.90	8.08
HYPNOSIS	6	76.33	6.89
PSYCHODY	11	87.00	10.84
TRANSACT	7	81.14	10.87
ADDICTIO	6	74.50	6.35
PSYCHODR	9	83.44	6.52
OTHER	71	79.94	8.42
Total	180	81.22	9.49

PERSONAL INDIVIDUAL THERAPY SESSIONS

0-50 SES	117	77.48	8.19
51-200 S	65	80.13	8.51
OVER 201	82	84.98	9.85
Total	264	80.46	9.35

PERSONAL GROUP THERAPY SESSIONS

0-50 SES	143	79.65	8.99
51-200 S	68	80.00	8.78
OVER 201	35	86.60	10.49
Total	246	80.78	9.43

PREF FOR HOMOGEN OR HETEROGEN GROUPS

HOMOGENE	117	76.93	8.22
HETEROGE	99	84.09	9.67
NO PREFE	55	80.47	8.61
Total	271	80.27	9.38

Table 4**Summary of Relationship of Independent Variables with
Total Score on the CMS**

INDEPENDENT VARIABLE	F RATIO	SIG OF F	NUMBER
Education			
NEWDEG	7.08	.0000	265
INTERN	6.26	.0023	186
CLASTRAN	3.36	.0368	209
WORKSHOP	6.95	.0011	264
Experience			
YRPR	6.91	.0012	271
YRPRGRP	4.54	.0115	270
GRPSES	8.56	.0000	273
SUPERVIS	6.12	.0025	266
Orientation			
GRPTRAN	5.67	.0000	232
THEORY	4.73	.0000	259
PSYCTRAN	2.03	.0461	180
Personal Therapy			
PERSIND	17.51	.0000	264
PERSGRP	8.39	.0003	246
Group Preference			
HOMO	34.58	.0000	271

of significance.

Table 4 summarizes the significant findings of the analysis. All independent variables tested were significant at least at or below the .05 probability level with the exception of GRPCLAS and GRPINT, which are not shown in the table. Of the indicators listed in the table, 11 out of 14 items were statistically signifi-

cant at below the .01 level. These indicators represented each of the five categories of independent variables being tested, indicating that a strong statistical relationship exists between all of the independent variable categories and the dependent variable, lending support for rejecting the null hypothesis of no relationship. With the null hypothesis rejected, it can be said that there is a significant statistical relationship between "attitudes toward conflict management," as measured by the *Conflict Management Scale* (CMS), and the following independent variables (refer to Table 3):

1) Educational preparation

a) People who have earned a higher-level degree score higher on the CMS.

b) People who have completed more internship hours score higher on the CMS.

c) People who have completed more class-semester of training score higher on the CMS.

d) People who have completed more workshops in group therapy score higher on the CMS.

- 2) Experience in practice
 - a) People who have been practicing psychotherapy longer score higher on the CMS.
 - b) People who have been practicing group therapy longer score higher on the CMS.
 - c) People who have conducted more group sessions score higher on the CMS.
 - d) People who have had more group therapy supervision sessions score higher on the CMS.
- 3) Orientation
 - a) People who have had certain types of group training will score higher on the CMS.
 - b) People who report subscribing to certain theoretical orientations will score higher on the CMS.
 - c) People who report certain types of post-degree group therapy training will score higher on the CMS.
- 4) Experience in personal therapy
 - a) People who have more personal individual psychotherapy will score higher on the CMS.
 - b) People who have more personal group psychotherapy will score higher on the CMS.
- 5) Type of group preference
 - a) People who prefer heterogeneous over homoge-

neous groups will score higher on the CMS.

Results of Secondary Analysis

The independent variables that were found to be significantly related to the dependent variable were included in an analysis to test their relationship to each other. First these variables were treated only as categorical variables and contingency coefficients were computed between each of the 14 variables. The contingency coefficients were computed by generating a cross-tabulation for each pairing of variables followed by a Chi Square analysis. The results are summarized in Table 5.

Pearson correlation coefficients also were computed for those independent variables that could be assumed to fit an ordinal scale. The correlation coefficients were compared with the contingency coefficients as a check on their validity and found to be similar in magnitude. Based on an assumption that selected independent variables could be treated as ordinal data, an exploratory stepwise multiple regression analysis was performed in order to identify the shared variance (predictability) of the independent variables on the dependent variable. The validity of treating selected independent variables as ordinal was also demonstrated

by the calculation of the Eta coefficient between each of the independent variables and the dependent variable. Eta measures the relationship between a categorical variable and an ordinal (continuous) variable and is an appropriate statistic to use for describing the relationship between any of the independent variables and the dependent variable. The values of Eta are

Table 5

Contingency Coefficients Between Independent Variables

Refer to page 63 for definitions of independent variables)

YRPR	.76	.60	.43	.18	.52	.28	.41	.31	.26
YRPRGRP		.63	.42	.19	.53	.31	.22	.29	.27
GRPSES			.34	.25	.53	.34	.42	.38	.37
NEWDEG				.35	.22	.25	.34	.31	.25
INTERN					.11	.31	.23	.21	.26
WORKSHOP						.35	.29	.33	.31
SUPERVIS							.21	.24	.25
HOMO								.33	.32
PERSIND									.46
PERSGRP									
	Y	G	N	I	W	S	H	P	P
	R	R	E	N	O	U	O	E	E
	P	P	W	T	R	P	M	R	R
	R	S	D	E	K	E	O	S	S
	G	E	E	R	S	R			G

PSYCTRAN									
GRPTRAN	.67								
THEORY	.61		.58						
	PSYCTRAN	GRPTRAN	THEORY						

THEORY	.36		.32	.38	.38				
	GRSES	INTERN	HOMO	PERSIND					

therefore meaningful for any of the independent-to-dependent variable combinations. Conversely, the Pearson correlation coefficient is only meaningful if the categories of the independent variable represent an ordinal scale. When the correlation coefficient approximates Eta, we may assume that the categories are ordinal, the relationship is approximately linear, and the correlation coefficient may be properly used with that variable. A comparison of Eta and the correlation coefficient is given in Table 6.

Interpretation of Statistical Analysis

Examination of the analysis by contingency coefficients, Eta coefficients, correlation coefficients, and multiple regression revealed the following findings

An exploratory regression analysis and examination of partial correlations showed the combination of variables PERSIND, HOMO, and INTERN to account for the majority of variance in predicting the dependent variable. Each of these items represents a different category of the independent variable groupings. PERSIND by itself accounts for the greatest predictability.

Closer inspection of the results indicates that

once PERSIND is used in the regression equation, the predictability of PERSGRP drops down near zero due to the fact that these variables share a strong relationship. This finding suggests that both of these items represent their mutual category and that either could be used as a predictor.

The variable HOMO, also a strong outcome predictor, has a moderately strong relationship with several variables outside its own category and appears to be

Table 6

Comparison of Eta and Correlation Coefficient for Selected Independent Variables and Dependent Variable

INDEPENDENT VARIABLE	PEARSON CORR	ETA
YRPR	.2004	.22
YRPRGRP	.1747	.18
GRPSES	.3277**	.29
NEWDEG	.2491*	.32
INTERN	.2371*	.25
WORKSHOP	.0751	.22
SUPERVIS	.2896**	.21
HOMO	.3708**	.37
PERSIND	.3951**	.34
PERSGRP	.2210*	.25

PSYCTRAN	NA	.28
GRPTRAN	NA	.40
THEORY	NA	.37

* < .01 probability level
 ** << .001 probability level

related to the experience variables. In other words, HOMO in itself is not a measure of experience but may well be the result of experience.

The experience variables YRPR and YRPRGRP are strongly interrelated, and either one could proxy for the other. GRPSES is strongly related to the experience cluster, however, SUPERVIS has only a modest relationship and seems to be similarly related to variables outside of the experience cluster.

The variable INTERN seems to pick up the shared variance for the education grouping. It also has a moderately strong relationship to NEWDEG, and also to the variable SUPERVIS from the experience cluster.

The distinction between the education and the experience categories is fuzzy, as there is considerable overlap between the items involved. One could make a case that to a large extent, education and experience are strongly related and are measuring one characteristic.

The theoretical orientation variables are highly interrelated and probably define their category well.

Summary of Statistical Analysis

A series of One-way Analysis of Variance runs were conducted to test the relationships between five cate-

gories of independent variables (predictors) and the dependent variable. Findings indicate a strong relationship for indicators within each category of Independent Variable. These can be summarized as follows.

There is a statistically significant relationship between the amount of Educational Training--as measured by Highest Psychotherapy Degree, Clinical Internship Hours, Class Semesters of Training, and Group Therapy Workshops attended--and the dependent variable of Conflict Management. Of these measures, Highest Psychotherapy Degree has the strongest relationship and could serve as a single predictor.

There is a statistically significant relationship between the amount of Experience in Practice--as measured by Years in Psychotherapy Practice, Years in Group Practice, Group Sessions Conducted, and Hours of Supervision--and the dependent variable of Conflict Management. Of these items, Group Sessions Conducted has the strongest relationship and could serve as the best predictor.

There is a strong relationship between Group Sessions Conducted and the independent variable Type of Group Preference indicating that the more experience one has the more the tendency to prefer heterogenous

groups (based on contingency table analysis).

There is a moderate overlap between the group of items representing Educational Experience and those representing Practice Experience. This overlap is in part related to the finding that Number of Workshops (WORKSHOP), which is grouped under the Educational Experience category, is strongly related to several of the items in the Practice Experience category (YRPR, YRPRGRP, GRPSES).

There is a strong relationship between Theoretical Orientation indicators and the dependent variable, with Psychoanalytic and Psychodynamic orientations producing higher scores on the outcome.

A strong relation between Personal Therapy, attended both as a group and individual, and the dependent variable. The independent variable of PERSIND has one of the strongest relationships with the outcome.

Last, there is a strong relationship between Group Preference and the outcome, with those preferring heterogenous groups scoring higher on the outcome.

CHAPTER V

DISCUSSION AND SUMMARY

Review of the Study

Restatement of the Problem

This study was designed to see how therapists' attitudes and approaches to managing conflict in group therapy vary by factors such as education, experience, theoretical orientation, experience with personal therapy, and preference for type of group conducted.

Restatement of the Hypotheses

The hypothesis for this study, stated in null form, were:

There is no significant statistical relationship between attitudes toward conflict management, as measured by the *Conflict Management Scale* (CMS), and the following independent variables:

- 1) Educational preparation
- 2) Theoretical orientation
- 3) Experience in practice
- 4) Experience in personal therapy

5) Type of group preference

Design of the Study

A two-part instrument was developed and sent randomly to 800 group therapists taken from the membership lists of the American Group Psychotherapy Association and the Association for Specialists in Group Work. Part I of the instrument gathered demographic data including training, experience, and orientation. Part II consisted of 25 questions designed to assess therapists' attitudes and approaches to conflict management as reflected in the group-therapy literature. The CMS score was computed as the sum of the responses for part II. The CMS score was broken down by the responses to each of the variables in Part I through the use of a one-way analysis of variance. Following the analysis of variance, a secondary exploratory analysis was conducted to examine the pattern of relationships between the independent variables and dependent variable, as well as the relationship between the independent variables themselves.

Discussion of the Findings

Significant differences in CMS scores were found related to the categories of independent variables specified under each of the aforementioned categories. All of the null hypotheses were thereby rejected. Most results were significant at the .01 level. The results, as expressed by the 12 areas of significant correlations between demographic factors and results on the scale, indicate that the CMS is a reasonable measure of respondents' knowledge and skill in working with conflict in groups. The results also indicate which demographic factors might identify clinicians skilled in group conflict management.

In reviewing the questions in the CMS and its related material in the literature, the following themes stand out:

- 1: Conflict is necessary and inevitable in group therapy.
- 2: Working skillfully with conflict is necessary for the growth of a therapy group.
- 3: Therapists must demonstrate to groups that they can skillfully manage conflict in the group and take responsibility for it.
- 4: The leader should frame conflict in terms of the

group dynamic rather than allowing scapegoating of individual members.

Most of the questions in the scale reflect variations of these primary themes. It can thus be said that the CMS measures respondents' agreement with these themes as fundamental skills and approaches to group conflict management.

Discussion of Analysis

Five categories of independent variables--education, experience, orientation, personal therapy, and group preference--were selected to test the relationship to outcome on the conflict management scale. A description of outcome on each follows:

Education

Education included 1) highest psychotherapy-related degree earned, 2) semesters of training in group therapy, 3) clinical internship hours, and 4) number of workshops in group therapy. With the exception of class semesters of training, all in this category proved significant considerably greater than the .01 level.

These results indicate that formal training in-

creases one's skills in conflict management in groups by the standards of the Conflict Management Scale. In this author's experience, current formal training in group psychotherapy does not pay a great deal of direct attention to the issue of conflict management in groups. These results might thus indicate that the experience and general confidence gained from formal training increases one's skills in group conflict management. The strongest indicator in this group was the highest psychotherapy-related degree.

Experience

The experience category included 1) years practicing therapy, 2) years practicing group therapy, 3) number of group sessions conducted, and 4) number of hours of group supervision. As in the education category, three of these four were significant at the .01 level. Number of group sessions conducted was significant below the .001 level, indicating that direct experience in conducting groups is a very strong indicator of skills in group conflict management as measured by the conflict management scale. It is defensible to say that the experience and education categories measured by the CMS tend to overlap. In the field of psychotherapy it is common for practicing therapists to continue getting training throughout their careers; thus education and experience would go hand in hand. This pattern was demonstrated in the secondary analysis.

An outgrowth of therapists' experience that was not directly measured should be mentioned here. Successfully managing difficult conflictual situations in group therapy requires a great deal of confidence and security on the therapist's part. Other factors being equal, training and experience contribute strongly to

one's confidence as a group leader and would thus indicate the potential for successful conflict management.

Orientation

This category included type of group training, theoretical orientation, and type of post-degree training. The first two categories were significant below the .001 level, whereas the latter was less indicative, at just below the .05 level.

The group training and theoretical training categories were quite similar in outcome; that is, people tended to identify themselves by the type of training they had. There were, however, many exceptions to this. Nevertheless, the outcomes for these two categories were quite similar. In each, those identifying their training and orientation as "psychoanalytic" or "psychodynamic" scored highest on the CMS, and those identifying themselves as "eclectic" scored lowest. Because psychoanalytic and psychodynamic training tend to emphasize the interpersonal aspects and dynamic forces in group therapy, clinicians with these orientations may have a greater understanding of the dynamics of conflict in groups. An eclectic orientation indi-

cates a more general approach or combination of approaches to conducting groups. Therapists who labeled themselves eclectic scored lowest on the CMS, giving rise to the likelihood that there is some relationship between unwillingness or inability to identify oneself theoretically and knowledge of conflict management.

The significance of the category "type of post-degree training" was less conclusive, although the psychoanalytic and psychodynamic categories again scored highest. It can be speculated that the kinds of training possibilities beyond formal academic training vary so widely that this category contained less accuracy than the others. It is of some note that the overall mean on the CMS for this category was above the mean for all respondents, indicating that additional training in general would increase one's understanding of group conflict management.

Personal Therapy

This category included amount of personal individual and group therapy completed by the respondents. Both variables produced very significant results, with the personal individual therapy variable producing an F-ratio that was twice that of the other variables thus far described.

An often-heard discussion in the psychotherapy field is the importance of personal therapy to the development of one's skills as a psychotherapist. Although usually not the case in formal academic programs, most post-academic or institute training programs have some requirement of personal psychotherapy as part of the training program. The results here indicate that amount of personal therapy is a strong indicator of knowledge of conflict management skills as measured by the CMS. It is interesting that the significance of individual therapy is much greater than that for group therapy in this study. However, the means in each category indicate that this significance is the result of distribution of scores between the subcategories; the highest mean scores belonged to respondents in the most-experienced subcategory for personal group therapy. In the secondary analysis,

amount of therapy also proved to have the strongest relationship with the outcome.

Group Preference

As discussed in the literature review, many writers feel that heterogeneous groups tend to have greater levels of conflict than homogeneous or theme-oriented groups. The purpose of asking this question was to see if, in fact, there was a relationship between group preference and score on the CMS. The results, with an F-ratio of 34.58 and significance well below .001, highlight the strength of this relationship. With means of 84.0 and 76.9 respectively, therapists preferring heterogeneous groups scored much higher on the CMS than did those preferring homogeneous groups. There appears to be an intelligent self-selection process in operation here: Therapists who are less knowledgeable, confident, or interested in issues of conflict in groups tend to favor conducting groups where less conflict is likely to arise. The secondary analysis also showed a strong relationship between group preference and the number of group sessions conducted, underscoring the notion that more experience leads to more confidence in handling conflict situations in groups.

Conclusion

This study is a beginning attempt to measure therapists' attitudes and approaches to conflict management in therapy groups. The goals of the study were to emphasize the importance of conflict management in groups and to describe some of the dynamics of group conflict in terms of the variety of forces present in therapy groups. The study also attempted to actually measure therapists' approaches to conflict management in groups through use of a testing instrument and to determine some of the demographic factors which might influence therapists skills in this area.

One important limitation of this study concerns an understanding of just what is measured by the conflict management scale. It is not clear to what degree the scale is measuring academic knowledge and to what degree it is measuring actual skills in group-conflict management. It is likely that some combination of both is being measured. Other more intangible factors such as attitudes and therapeutic style were beyond the scope of this instrument.

The many significant results and their interrelationships suggest that the conflict management scale

does describe knowledge and skills in group conflict-management with some accuracy and that the independent variables described in the study all contribute to the development of knowledge and skills in managing conflict in groups. Further work, however, can be done in all of these areas with a hope of gaining a greater understanding of the skills needed for conflict management. This itself is challenging; although many ideas can be culled from the literature, there is no consensus on what truly constitutes skillful conflict management in groups. More difficult to measure is the effect of the therapist's style on conflict management.

It would also be useful to study more specifically the contribution of the independent variables in this study to the development of conflict-management skills. What kind of training and experience best prepare a clinician to effectively manage conflict in groups? Intriguing, too, is the factor of personal therapy. The specific contribution of personal therapy to the development of group-conflict management skills would be a useful study.

REFERENCES

- Ali, S. (1957). A note on social climates in group psychoanalysis. *International Journal of Group Psychotherapy*, 7, 261-263.
- Bar-Levav, R. (1977). The treatment of preverbal hunger and rage in a group. *International Journal of Group Psychotherapy*, 27, 457-469.
- Battegay, R. (1983). The value of analytic self-experience groups in the training of psychotherapists. *International Journal of Group Psychotherapy*, 33(2), 199-213.
- Bonner, H. (1959). *Group dynamics: principles and applications*. New York: Ronald Press.
- Budge, S. (1981). Group cohesiveness reexamined. *Group*, 5, 10-18.
- Cima, R. (1985). An overview of confrontive counseling. *Journal of Child Care*, 2(3), 1-15.
- Danesh, H. (1977). The angry group. *International Journal of Group Psychotherapy*, 27, 59-66.
- Deutch, M. (1973). Conflicts: Productive and destructive. *Journal of Social Issues*, 25, 7-41.
- Dugo, J., & Beck, A. (1984). A therapists' guide to issues of intimacy and hostility viewed as group level phenomena. *International Journal of Group Psychotherapy*, 34, 25-45.
- Evans, N., & Jarvis, P. (1980). Group cohesion: A review and reevaluation. *Small Group Behavior*, 11(4), 359-370.
- Foulkes, S. H., & Anthony, E. J. (1957). *Group psychotherapy*. London: Penguin.
- Frank, J. D. (1955). Some values of conflict in thera-

- peutic groups. *Group Psychotherapy*, 8, 142-151.
- Frank, J. D. (1957). Some determinants, manifestations, and effects of cohesiveness in therapy groups. *International Journal of Group Psychotherapy*, 7, 53-62.
- Gans, J. (1989). Hostility in group psychotherapy. *International Journal of Group Psychotherapy*, 39(4), 499-516.
- Groatjahn, M. (1981). Group cohesion as a factor in the therapeutic process. In H. Kellerman (Ed.), *Group Cohesion - Theoretical and Clinical Perspectives*. (pp. 255-267). New York: Grune and Stratton.
- Hayden, S. (1983). The toxic response in modern psychoanalysis. *Modern Psychoanalysis*, 8(1), 3-16.
- Kahn, S. (1980). The Dynamics of scapegoating: The expulsion of evil. *Psychotherapy: Theory, Research, and Practice*, 17(1), 79-84.
- Kaplan, R. E., Obert, S. L., & Van Buskirk, W. R. (1980). The etiology of encounter group casualties: "Second facts." *Human Relations*, 33, 131-148.
- Kellerman, H., & Plutchik, R. (1977). The meaning of tension in group therapy. In L. R. Wolberg (Ed.), *Group Therapy 1977: An Overview* (pp. 82-93). New York: Stratton Intercontinental Medical Books.
- Kiesler, S. (1978). *Interpersonal processes in groups and organizations*. Arlington Heights, Illinois: AHM Publishing.
- Kormanski, C. (1982). Leadership strategies for managing conflict. *Journal for Specialists in Group Work*, 7, 112-118.
- Lippit, G. L. (1982). Managing conflict in today's organization. *Training and Development Journal*, 36, 67-75.

- Mitchell, R. C., and Mitchell, R. R. (1984). Constructive management of conflict in groups. *Journal for Specialists in Group Work, 9*, 137-144.
- Mullan, H. (1953). Conflict avoidance in group psychotherapy. *International Journal of Group Psychotherapy, 3*, 243-253.
- Northen, H. (1969). *Social work with groups*. New York: Columbia University Press.
- Ormont, L. R. (1984). The leader's role in dealing with aggression in groups. *International Journal of Group Psychotherapy, 34*, 553-572.
- Ormont, L. R. (1968). Group resistance and the therapeutic contract. *International Journal of Group Psychotherapy, 18*, 147-154.
- Parson, E. (1985). Post-traumatic accelerated cohesion: Its recognition and management in group treatment of Vietnam Veterans. *Group, 9*(4), 11-23.
- Pepitone, A., & Reichling, G. (1955). Group cohesiveness and the expression of hostility. *Human Relations, 8*, 327-337.
- Roether, H., & Peters, J. (1972). Cohesiveness and hostility in group psychotherapy. *American Journal of Psychiatry, 128*(8), 1014-1017.
- Rosenthal, L. (1985). A modern analytic approach to group resistance. *Modern Psychoanalysis, 10*, 165-182.
- Saravey, S. M. (1978). A psychoanalytic theory of group development. *International Journal of Group Psychotherapy, 28*, 481-507.
- Shatlin, M. R. (1981). Formalizing Conflict resolution in policy making. *International Journal of General Systems, 7*, 207-215.
- Slavson, S. R. (1957). Are there "group dynamics" in therapy groups? *International Journal of Group Psychotherapy, 7*, 131-154.

- Slavson, S. R. (1979). *Dynamics of group psychotherapy*. New York: Jason Aronson.
- Spotnitz, H. (1968). The psychoanalytic therapy of aggression in groups. In J. Masserman (Ed.), *Current Psychiatric Therapies. Vol. 8*, (pp. 149-155). New York: Grune and Stratton.
- Spotnitz, H. (1976). *Psychotherapy of preoedipal conditions*. New York: Jason Aronson.
- Thomas, K. (1976). Conflict and conflict management. In M. Dunnette (ed.), *Handbook of Industrial and Organizational Psychology*. Chicago: Rand McNally.
- Tuckman, B. W. (1965). Developmental sequence of small groups. *Psychological Bulletin*, 63, 384-399.
- Unger, R. (1989). Cohesion in psychotherapy groups. *Unpublished manuscript*.
- Wall, V., & Nolan, L. (1987). Small group conflict - a look at equity, satisfaction, and styles of conflict management. *Small Group Behavior*, 18(2), 188-211.
- Watkins, C. (1974). An analytic model of conflict. *Speech Monographs*, 41, 1-5.
- Wilson, G., & Ryland, G. (1949). *Social group work practice*. Boston: Houghton-Mifflin.
- Yalom, I. D. (1985). *The theory and practice of group psychotherapy*. New York: Basic Books.

APPENDIX

Cover Letter

Conflict Management Scale--Part I

Conflict Management Scale--Part II

Conflict Management Scale--Scoring Key

Refer to page 42 for the theoretical basis of questions and responses.

- | | |
|-----------|-----------|
| 1. True | 14. True |
| 2. True | 15. False |
| 3. True | 16. False |
| 4. False | 17. False |
| 5. True | 18. True |
| 6. True | 19. False |
| 7. True | 20. False |
| 8. False | 21. False |
| 9. True | 22. False |
| 10. false | 23. False |
| 11. True | 24. True |
| 12. False | 25. False |
| 13. False | |