14

Group processes

- Man is a SOCIAL ANIMAL; people who are not members of SOCIAL NETWORKS show an increased mortality.
- ALTRUISTIC or HELPING BEHAVIOUR depends upon the ATTRIBUTIONS that are made for the person needing help; help being given if the causes are felt to be EXTERNAL rather than INTERNAL.
- The FUNDAMENTAL ERROR OF ATTRIBUTION is that individuals attribute their own behaviour to external causes whereas observers attribute it to internal causes.
- SELF-ATTRIBUTION is used to understand our own behaviour when it contradicts that of others around us, as in the ASCH EXPERIMENT.
- Groups differ in their purpose according to whether their goals are OPEN-ENDED or SPECIFIC, and INTRINSIC or EXTRINSIC, but nonetheless usually go through a similar evolutionary sequence of FORMING, STORMING, NORMING and PERFORMING.
- Groups sometimes have a single LEADER, but will often have both a TASK SPECIALIST and a SOCIO-EMOTIONAL SPECIALIST, who perform different ROLES.

Man, like most primates, is a SOCIAL ANIMAL, continually interacting with other individuals. An extensive social group provides SOCIAL SUPPORT, from a SOCIAL NETWORK. Epidemiological studies find that individuals with least social support have a higher mortality than those who are well connected within a network (Fig. 14.1), partly because social isolation is stressful, and partly because supportive, caring relationships provide informal psychotherapy for minor psychopathology and encourage healthier behaviours such as less drinking or smoking.

As groups get larger so the complexity of their interactions increases until finally they are the province not of psychology but of SOCIOLOGY. Small groups do however have particular psychological features of their own, and since they are very common in the social world, such as teams, committees, juries, hospital wards, general practices, etc. we must consider them.

Groups differ in their effects according to their size. Groups of two, or DYADS, are the smallest possible, and immediately show an important problem: should the individuals cooperate, and if so, how to decide if
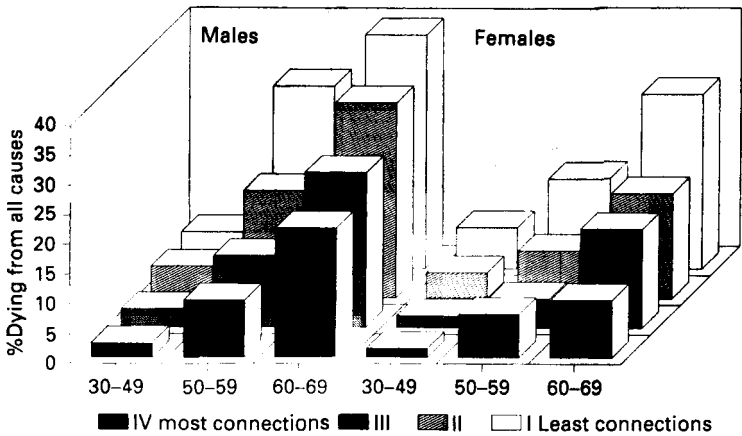
Fig. 14.1 Mortality during a nine-year period in relation to the age, sex and size of an individual's social network, those with most connections having large, complex networks, and those with least connections having few individuals within their social network. Adapted from Berkman L S and Syme S L (1979), Social networks, host resistance and mortality: a nine-year follow-up study of Alameda County residents, *Am J Epidemiol*, **109**, 186–204.

it is worthwhile? A much studied situation is the PRISONER'S DILEMMA game.

You and your accomplice in a serious crime have been arrested and are in separate cells. Each is told that if neither confesses then each will receive a three year sentence on minor charges. However, if you confess and turn Queen's evidence then you will only receive a 1 year sentence while your accomplice will get 20 years. The twist is that the same option is also given to your accomplice, and if you both confess then neither party will need to be Queen's evidence, although in mitigation for confessing you will only receive eight year sentences. What do you do, given that you cannot communicate with your accomplice? The dilemma is that your best outcome, to confess, is only best if your accomplice does *not* confess. Should your accomplice think of confessing then the *joint* best strategy is for neither to confess, when each receives a three year sentence. However, since you cannot rely on your partner cooperating (because if certain that you will *not* confess then his best strategy is to confess) then the best individual strategy overall is to confess, meaning that each receives an eight year sentence.

The game illustrates the central problem for group processes. If individuals optimize their own benefit then they might not attain the maximum benefit achievable with optimal cooperation. Many social situations are similar NON-ZERO-SUM GAMES, in which losses to one player are not gains to another; in a theatre fire, it is to each individual's benefit to run for the exit, but if everyone does so, the resultant panic

benefits no one; similarly, individual investors may decide to sell shares to avoid a Stock Market crash but *en masse* they precipitate the crash; and likewise when motorists park on yellow lines, thereby blocking the traffic system which they will later wish to use. Many social rules evolve precisely to avoid the catastrophes that result from individual maximization of benefits. In experiments, the likelihood of cooperation depends upon the individual personalities of the players (are they both trusting or suspicious?), on the previous response of the other player (one successful strategy is TIT-FOR-TAT: cooperate this time only if the other player cooperated last time), on the details of the rewards and losses and their consequences, and on the ability of players to communicate with each other.

A variant on the prisoner's dilemma concerns ALTRUISTIC or HELPING BEHAVIOUR. A person collapses in the street. You are in a hurry, and in some sense it would cost you to stop whereas you would gain by hurrying past, perhaps by reaching an appointment on time. In the future though it might be *you* who needs help, and therefore it may be to your long-term benefit to help now. Social psychologists started investigating such situations, often using stooges who would 'collapse' while hidden observers watched the behaviour of passers-by, after a notorious incident in March 1964. A New York woman, Kitty Genovese, was attacked and killed in the street, the half-hour long incident being witnessed from windows by 38 people, none of whom went to help, or even telephoned for the police. One explanation, of the DIFFUSION OF RESPONSIBILITY ('Somebody else will have phoned by now'), is rejected by experiments in which passers-by were *certain* that only they had witnessed the incident, but still did not help. A better explanation invokes a cognitive analysis of justice and fairness. All other things being equal, an unconscious person in a street is assumed to be 'responsible', or to 'deserve' being in that condition ('Just another alcoholic'), unless there is evidence otherwise, such as a white stick, or smart city clothes, when it is then felt unjust for a person to be in that condition, and help is given. Of course such an analysis does not explain the implicit moral calculus used by the passers-by. The origins of morality and conscience are complex but from empirical studies it seems that a well developed conscience develops when parents use withdrawal of attention and love rather than physical punishments, when parents reason with children about moral issues, are consistent in their attitudes and behaviour, and when there is warmth, mutual trust and esteem within the family.

Situations like the prisoner's dilemma and helping behaviour emphasize that responses in social contexts are not simple reflexes. Instead people interpret the origins of the situation and the actions of other people: they try to make CAUSAL ATTRIBUTIONS about the situation, to explain the *reasons* for the situation occurring and for the behaviour of the persons present.
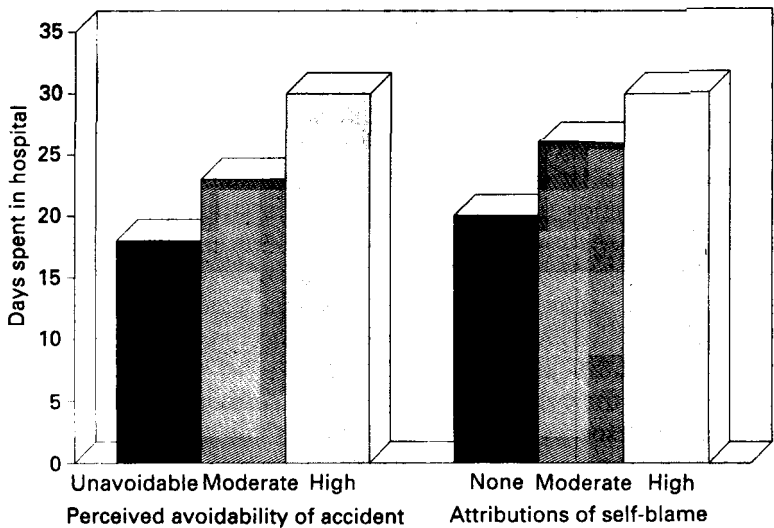
Fig. 14.2 Days in hospital recovering from an accident in relation to the patients' attributions of responsibility for the accident. All mean values are adjusted statistically to take account of differences in severity of accidents. Adapted from Frey D and Rogner O (1987), The relevance of psychological factors in the convalescence of accident patients, in Semin G R and Krahe B, Eds, *Issues in contemporary German social psychology*, London, Sage.

The nature of patients' explanations of illness or injury, of their attributions of blame and causality, can affect recovery, as is seen in a study of hospital patients recovering from accidents at work, on the road or at home. Those who felt their accidents were highly avoidable and blamed themselves took longer to recover in hospital than those who felt the accident was unavoidable or not their fault (Fig. 14.2). Individuals with less perceived control over their world (who did not avoid 'avoidable' accidents or who were to blame for accidents) also have less control over their own recovery processes, and hence recovered more slowly.

To understand attributions more clearly, consider the case of a student interrupting a lecture and asking a question. How can the situation be interpreted? Consider the information available. There are EFFECT DATA, describing the event itself. *What happened?* 'A question was asked about a topic mentioned by the lecturer.' What was the *outcome?* 'The lecturer replied and the student asked a subsidiary question'. How was it *experienced* by the questioner? 'They felt embarrassed and anxious, but angry that the lecturer hadn't answered their question properly'. There are also CAUSE DATA: What in the *environment* stimulated the behaviour? 'The lecturer was unclear and the student who had disliked the way the lecturer answered a previous question, had also misheard what was said'. What were the questioner's *intentions?* 'To show the class that the lecturer was wrong,

to clarify the situation and to display their own superior intellect'.

In attributing causes for events, different types of information are available to an ACTOR, the person carrying out the action, and to an OBSERVER, a person watching the action. *All* five types of information are available to an actor, whereas only two types of information, about the *event* and the *outcome*, are available to an observer, the other types being private to the mind of the actor.

The FUNDAMENTAL ERROR OF ATTRIBUTION results from this distinction between the knowledge available to actors and to observers: actors, being privy to all information, particularly about their own perception of the environment, make attributions that are EXTERNAL, in which they ascribe causes to the specific environment — 'I asked the question because the point was unclear and because I thought the lecturer had paused for a question'. In contrast an observer's limited information means attributions are typically INTERNAL, in which causes are ascribed to factors intrinsic to the actor involved — 'that sort of person is always asking questions, likes the sound of their own voice, and craves attention'. In other words, *I* perceive myself as carrying out an act in response to events in the world around me, but I perceive *you* as doing the same act because you are that sort of person.

Attributions (and mis-attributions) underlie many social behaviours. After failing to take their tablets a patient (the actor) will attribute failure to specific side-effects, such as nausea, whereas a doctor (the observer) will blame the personality of the patient — they don't care, lack will-power, etc. Likewise smokers (actors) attribute smoking to SITUATIONAL FACTORS such as being under stress, whereas non-smokers (the observers) attribute smoking to DISPOSITIONAL FACTORS, smokers being weak-willed, self-indulgent, inconsiderate, etc. Altruistic behaviour occurs when attributions are external rather than internal (so that help is deserved since the person is not responsible for their condition): is the person *drunk* (internal cause, the sort of person they are) or have they had a *heart attack* (external, situation-specific cause)?

The human desire to attribute causes is so strong that patients and relatives will often search for causes when no rational basis can exist for one. Parents of children with leukaemia often cannot accept medical assurances that the disease is the result of a random mutation, without real cause, and instead will blame the illness upon themselves, for not treating the child properly, or upon local factors such as a nuclear power station or a chemical plant, and will apparently gain reassurance from such attribution. Attribution is important in maintaining a sense of CONTROL, in maintaining SELF-ESTEEM, and in SELF-PRESENTATION or IMPRESSION-MANAGEMENT. As doctors we may regard such attributions as irrational or stupid; nevertheless we should follow the advice of George Bernard Shaw in *The Doctor's Dilemma*: 'When the patient has a prejudice, the doctor must either keep it in countenance

or lose his patient... If he gets ahead of the superstitions of his patient he is a ruined man'.

Attributes derive not only from observing an event, but also from observing other people's responses to that event. Since these other observers are also making attributions, we try to make our own attribution consistent with others. If everyone else ignores a person who is slumped on the ground then as a lay person we assume this is not a heart attack or *the others* would have helped, and hence their absence of involvement supports our own attribution of drunkenness. However as doctors we will feel entitled to ignore these other lay attributions as ignorant or ill-informed, and will use the ashen face, blue lips, shallow breathing and expression of pain to diagnose a myocardial infarction. Our specialist knowledge permits us to ignore the erroneous attributions of others.

Attributions are not only made about other people, but also about ourselves, by observing both our own and other people's behaviour. This process has already been seen in cognitive theories of emotion (see Chapter 9), and is also seen in laboratory studies of the ASCH EFFECT. An experimental subject in a group of 'subjects', who are actually stooges, has to make a simple perceptual discrimination, saying which of three clearly different lines is the same length as a standard. The other subjects report their decisions before the experimental subject, and unanimously report what is clearly and blatantly the wrong answer. The experimental subject will then, in about a third to half of cases, also report the wrong answer. The degree of YIELDING depends on the group size and on the extent of unanimity between the stooges, one dissenter 'immunizing' the experimental subject against yielding. Yielding occurs even in groups of two if the other person has high status or authority. In a famous variant of the experiment, Stanley Milgram asked subjects to assist a scientist in a 'learning experiment' by giving increasing electric shocks to a supposed 'learner' in another room (actually an actor simulating the effect of shocks). Most subjects complied, giving shocks far above the voltage marked 'Danger', for as long as the experimenter insisted, and despite the cries and pleas of the learner, and indeed of the protests of the subject themself.

The Asch and Milgram experiments can be understood in terms of SELF-ATTRIBUTION. In the Asch experiment the subject tries continually to account for their own behaviour, and make attributions for the continual disagreements. The subject might think all the other subjects are wrong, but in so doing they have to attribute each one's behaviour to blindness, stupidity, or malevolence, an unlikely situation in each of these apparently random chosen subjects. The only rational conclusion must be that the other subjects are right and they themself are wrong; and then appropriate self-attributions have to be made to explain the discrepancy: 'I am sitting at an awkward angle', 'Perhaps

I misunderstood the task', etc.

Self-attribution is also seen in an experiment involving placebos (see also Chapters 20 and 21). Base-line pain threshold is measured and a subject then given a placebo injection which they are told is an analgesic. When retested the pain threshold is then higher. The subject is then told that the injection was actually a placebo, and that there was no active drug to account for the higher pain threshold. Finally the subject is tested a third time, without a further injection, in a condition which should be equivalent to the base-line, but the threshold is found to stay at the raised level. From the subject's point of view the raised pain threshold after the injection cannot be attributed to a drug (an external cause), since only a placebo was given, and hence the only possible attribution is the subject's own actions which have raised the threshold (an internal cause); and if those actions could cause the threshold to rise once then they could raise it again, producing the high threshold on the third testing.

Individuals differ in the way they typically choose to explain events in the world, and this applies also to symptoms and disease states. Individuals with an INTERNAL LOCUS OF CONTROL believe they are responsible for and control their own bodies, and that diseases arise due to a failure of control, which can be reinstated as a part of therapy. In contrast, those with an EXTERNAL LOCUS OF CONTROL believe they cannot influence their own bodies, and that disease is due to events from outside that are beyond their control, seeing themselves as hopeless victims of circumstance, beset by fortune.

The prisoner's dilemma and helping behaviour are unusual in that small numbers of people are involved, who do not know each other and can only communicate little with each other. However, most groups do know each other, if only for a few hours, and can communicate to some purpose. Groups have many reasons for existing, and have different objectives. Groups differ in their SPECIFICITY (are they there to solve a specific problem or to produce an open-ended form of result?), and in their FOCUS (an extrinsic goal or the group's own interpersonal relations?). Thus a works committee to increase output is *specific* with an *extrinsic* goal; a therapy group for drug addicts is *specific*, to treat the addiction, but *intrinsic*, trying to change the members' own behaviour; a scientific committee of a professional society has an *open-ended* but *extrinsic* aim (solving a broadly-based problem with many possible answers, such as decreasing the incidence of heart disease); and an ENCOUNTER GROUP is *open-ended* and *intrinsic*, trying to increase awareness of interpersonal relations within the group perhaps in order to help the members in their normal social roles, be it as managers or therapists. In each case, the GROUP DYNAMICS, the inter-relations of individuals, will be different, reflecting different means and ends. Certain processes do seem to be common in most groups, irrespective of their *raison d'être*. Groups evolve in a fairly

standard series of stages, particularly if all members are new at the same time; FORMING, in which the members orient themselves to their task, and to each other; STORMING or REBELLION in which hostility develops between members as they resist the formation of particular structures; NORMING, where resistant disappears and members accept the norms of the group, and become a cohesive unit; and PERFORMING or COOPERATION in which interpersonal problems have been resolved, and the group can get on with its main task.

Groups carry out most activities by talking, and the structure and relations between individuals can be assessed by taking detailed measurements, preferably from video-tapes, of the amount of time that each individual spends talking, to whom they are talking, and what sort of thing they are saying, in a general sense, looking not at the specific CONTENT but rather at its FORM; the *way* things are said rather than *what* is said. A popular scheme for analysis is Bales' INTERACTION PROCESS ANALYSIS (IPA, Table 14.1), in which statements are categorized either in terms of the group's TASK AREA (producing questions or answers) or its SOCIO-EMOTIONAL AREA (is it positive, helping the group work better, or negative, attacking other members of the group?). When group members are asked who guided the discussion most, who had the best ideas and who stood out as leader, there is general agreement that the three tasks are all carried out by one individual called the TASK SPECIALIST, who makes most task area statements. Alternatively when asked which individual was liked best then the task specialist is often not liked, but a second person, the SOCIO-EMOTIONAL SPECIALIST, emerges, who makes most positive socio-emotional comments. Task specialists often produce hostility, monopolizing discussion and concentrating single-mindedly upon the task objectives, and this hostility, which might endanger the group's existence, is neutralized by the socio-emotional specialist. Not all groups develop two leaders, and one person often fills both roles, particularly in FORMAL or LEGITIMATE groups (such as a committee with an appointed chairman rather than an AD HOC group), or if there is one individual with both greater status and knowledge than the other members. Failure to achieve a socio-emotional leader, or for a formal chairman to adopt such a role, can lead to a group failing to achieve its objectives.

In any group of any size a DOMINANCE HIERARCHY tends to form, which is analogous to the PECKING ORDER that is formed in most social animals, and at the top of which there is a LEADER. There is some evidence that leaders have particular sorts of personality. Compared with other group members they tend to be more intelligent, more extraverted, more dominant, more masculine, show better personal adjustment and sensibility to the needs of other people, and to be more liberal in their outlook; although of course there are many exceptions. There are also tendencies for them to be taller, better educated, more verbal

Table 14.1

The observation categories of the Bales Category System. Reproduced with permission from Gahagan J (1975), *Interpersonal and group behaviour*, London, Methuen. 103.

Socio-emotional orientation

A. Emotionally positive responses.

a. <u>shows solidarity</u>, raises other's status, gives help rewards.
b. <u>shows tension release</u>, jokes, laughs, shows satisfaction.
c. <u>Agrees</u>, shows passive acceptance, understands, conceives, complies.

B. Emotionally negative responses.

a <u>Disagrees</u>, shows passive rejection, formality, withholds help.
b. <u>Shows tension</u>, asks for help, withdraws.
c. <u>Shows antagonism</u>, deflates other's status, defends or asserts self.

Task orientation

C. Problem-solving responses: Answers.

a. <u>Gives suggestion</u>, direction, implies autonomy for other.
b. <u>Gives opinion</u>, evaluation analysis.
c. <u>Asks for suggestion</u>, direction.

D. Problem-solving responses: Questions.

a. <u>Asks for orientation</u>, information, repetition, confirmation.
b. <u>Asks for opinion</u>, evaluation analysis.
c. <u>Asks for suggestion</u>, direction, possible ways of action.

and of higher social class. Leaders can also show different styles of leadership. In one experiment, carried out with teenage boys, a leader allocated to each group adopted one of three styles; AUTHORITARIAN, allocating specific tasks to each group member, allowing little choice, and permitting little extraneous activity, and not providing information on the purposes of the group; DEMOCRATIC, in which members chose their own project, allocated tasks amongst themselves, and were allowed to communicate freely with one another; and LAISSEZ-FAIRE in which the leader provided materials and general instructions but otherwise was passive and did not intervene. The authoritarian and democratic groups were similar in terms of actual production of

end results, and superior to the laissez-faire group. In social terms, the democratic group performed better, there being less aggression or oppression between members, and the democratic group also performed better in the temporary absence of its leader. The laissez-faire group performed poorly in every respect. The role of the leader is therefore best exercised when the abilities of the individual members are maximally utilized, rather than all control and decision-making coming from the top. Groups are also more successful when the particular styles of the individuals are consonant. In one study experimental groups of four individuals were made up either of an authoritarian or non-authoritarian leader, and three members, all of whom were authoritarian or non-authoritarian, and the groups functioned best when the leader and the group members all had the same style.

Very often the role of a group is to make a decision of some sort. Because each individual in a group will arrive at the group with their own particular opinions, it is tempting to assume that the group's overall decision will simply be the average of the individual decisions. A series of experimental studies seemed to falsify that assumption, as committees seemed to make decisions that were chancier, or less cautious, than those made by the individuals, the so-called RISKY SHIFT PHENOMENON. Thus a group would be more likely to recommend that an individual should leave a steady but boring job and take up an exciting but uncertain post in a smaller company, where failure was a real possibility. Further research showed that the risky shift only occurred if most members of the group were the sort of people who would tend to take chances anyway; if instead most group members are staid, solid, non-risktaking individuals then the group would be *less* likely to recommend taking a chance. This phenomenon, of POLARIZATION, the tendency to move to a position away from the population norm, and beyond the average position of the group members, can readily be seen at the annual meetings of political parties, where conferences vote for more extreme policies than the members present would support individually (and certainly more extreme than their voters would support).

Groups can encourage loyalty amongst their members, and this produces COHESION, and a sense of group identity. Cohesive groups tend to meet frequently, to interact a lot, to contain members of similar interests and attitudes, and to have a purpose or task that requires cooperation for its successful completion. An external threat to the existence of the group can also increase the cohesion as the members rally around one another.

Cohesive groups are regarded as in EQUILIBRIUM, able to resist external forces and changes, such as the loss and replacement of members by others who slot into the vacant place. If groups are very large, or alternatively if members have well-defined activities within groups,

as for instance do doctors, nurses, etc. in the hospital ward then individuals have ROLES to play, the allusion to acting and the theatre being intentional. If played strongly then roles can restrict the behaviour of other individuals; for instance it is difficult *not* to play the role of 'patient' if all other group members act their roles.

In a psychiatric setting one of the most important, and relatively recent, uses of groups is in GROUP PSYCHOTHERAPY, in which a number of patients, perhaps four to ten in number, often with a range of different problems, will meet regularly under a group leader or FACILITATOR, whose purpose is to maintain order, motivate members, guide discussion as appropriate, interpret when necessary, and observe. Conventional psychotherapy involves a single patient talking to a therapist about their problems. Group therapy aims not only to be more cost-effective, by treating several people at once, but also has theoretical advantages over conventional therapy, since the increased number of individuals will produce a greater flow of ideas, and of free associations, and will also allow SOCIAL SKILLS to be developed, so that a patient can observe responses of other people to their statements and actions, as well as observing the problems and needs of other people.