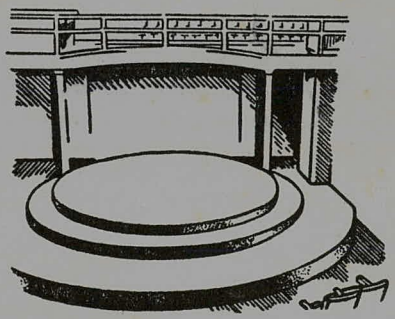
GROUP PSYCHOTHERAPY

A Quarterly



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Volume XIII September-December, 1960 Numbers 3-4

CONTENTS

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GROUP PSYCHOTHERAPY

Volume XIII September-December, 1960 Numbers 3-4

GROUP PSYCHOTHERAPY

Volume XIII September-December, 1960 Numbers 3-4

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SOCIOMETRY AND GROUP THERAPY IN THE MENTAL HOSPITAL*

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The question, what psychological conditions underlie the long term living together and group formation of the mentally ill, and the problems of a systematic group therapy in psychiatric institutions have recently begun to become the object of scientific investigation. Stimulated by a visit from Moreno, we have worked since June, 1957, along sociometric and group therapy lines in a large closed women's ward for the mentally ill. It is known that the patients in such a ward do not live beside each other without interpersonal relationships. Rather, this "forced community of sick people" (Friedemann) is full of interpersonal relationships which we attempted to make visible through sociometric methods and to employ therapeutically. Besides, we have led group discussions with patients who were both able and willing. In the field of German institutional psychiatry we owe thanks to Merguet for the impulse toward the extension of psychotherapeutic possibilities through group discussions.

Experienced physicians and attendants have long recognized and taken into consideration the fact that there are groupings, currents, interplays of sympathy and antipathy among the community of patients. Thus, patients who did not feel happy in one ward or could not adjust there were always transferred within the confines of the institution or to a larger ward. Similarly, patients who got along with each other were allowed to draw together. The treatment was substantially facilitated through these transfers for they brought about a more favorable therapeutic milieu.

Upon the base of this pre-scientific application of later sociometric experiences, that is, through numerous transfers over a period of decades, there arose—within a large ward with over 200 beds in the sections—small communities in the sense of "open groups." These groups were observed and analyzed. Half of the patients suffer from chronic schizophrenia, a fourth are feeble-minded, and the rest are divided among the following diagnoses: epilepsy, psychopathy, paralysis, senile dementia, cerebral sclerosis, and manic-depressive insanity.

We have several methods at our disposal for the analysis of inter-

* Translated from the German original.

personal relationships and group-building forces. With small children we have to confine ourselves to *bare observation* because they cannot yet explain their choice of partner in words (Moreno). As a part of our patients are intellectually at the level of the small child and others, by reason of their psychosis, are negativistic or mutistic, only the method of simple observation is applicable to all patients. This is especially true of the security room which contains high grade morons and patients with severe schizophrenia who, for the most part, establish communication with each other for only a short time. At best, we could make only *Aktograms* (Friedemann) in which the communications of the group members are registered every 5 minutes. Above all, the seating arrangement at table proved to be illuminating. As it is determined by the patients themselves, it already answers the question "Beside whom do you wish to sit?" and thereby leads over into *sociometry* (Moreno) in the closer sense. The sleeping arrangement in the dormitory is less illuminating, since the beds are assigned by the nurse and any changes have to be approved by the ward physician. A *sociogram* prepared at a particularly well set up section showed that the essential bonds and group positions had already been correctly perceived through observation and analysis of the seating arrangement. Therefore, we have dispensed with *continuous sociograms* for the moment as such questioning could spread unrest in the ward and impair the naturalness of the patients. For, it was revealed in the group conversations that the patients were very anxious not to be used as "guinea pigs." Moreno warns specifically against questioning without a reason recognizable to the questioned. We also had to restrict ourselves to the test by Teirich since some feeble-minded and demented patients are not capable of differentiating answers. It was not even easy to make clear to all patients the questions: "With whom are you *least* congenial?" Moreno designates such a test, which does not refer to a specific criterion, as "near sociometric" or "infra sociometric." This simple test, however, is completely satisfactory for the purpose of perceiving the basic structure of a group of patients.

Unfortunately the group positions do not have uniform designations. The suggestions from three important publications are brought together in Table 1. We are going to restrict ourselves to these partially synonymous designations.

A section, well-isolated with respect to space, proved an especially suitable object for research. It is occupied predominantly by epileptics with the addition of a few schizophrenics and feeble-minded patients. The patients have, in the course of many years, grown together into a close community

in which each has her fixed place. Only seldom is a change brought about through transfers or admissions.

TABLE I

DESIGNATIONS OF GROUP POSITIONS AMONG THREE AUTHORS

Schindler	Friedemann	Moreno
= dynamic center	central figure	star
= expert	one who can do	
= follower, drudge	follower, hanger on	
= scapegoat	wallflower	black sheep
= opponent	adversary	

We can already make some interpretations from the seating arrangement at table during a meal. (Figure 1.) The three table groupings exhibit a dissimilar set up. All schizophrenics, of whom two (2, 3) react autistically,

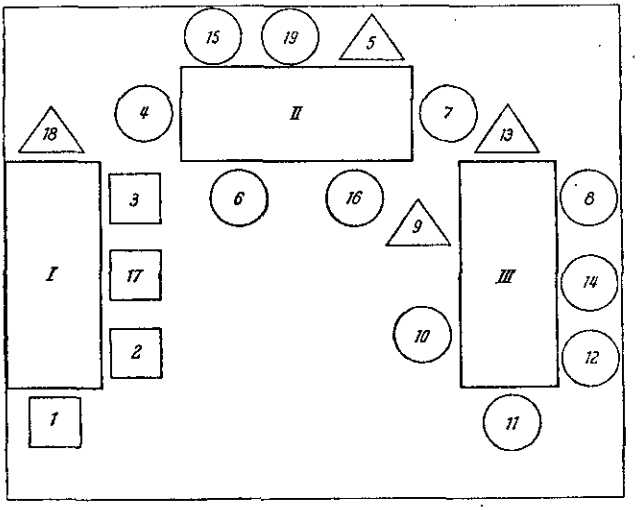

FIGURE 1

Seating arrangement during the meal. □ Schizophrenia. ○ Epilepsy. △ Feeble-minded.

sit at the first table. All patients who are mentally still so active that they can carry on a meaningful conversation sit at the middle table. The predominantly dull feeble-minded patients have gathered together at the third table. Through extended observation of the section we can perceive the striking group positions. The leading role is played by a pyknic hyperthyme

epileptic (14) who is called "Chief Mother" or "Mother" even by the physicians and nurses. She takes charge of the other patients and sees to it that they are orderly and clean. She is by no means the most intelligent but her authority is universally recognized. A constantly complaining schizophrenic (1) and a quarrelsome feeble-minded epileptic (12) are rejected by everybody. It is interesting to note in which neighborhood these two "black sheep" of the group sit. The complaining one (1) is isolated from the group by means of a completely autistic and mutistic catatonic (2) who does not react to her constant talk. The fighting urge of the other "black sheep" (12)

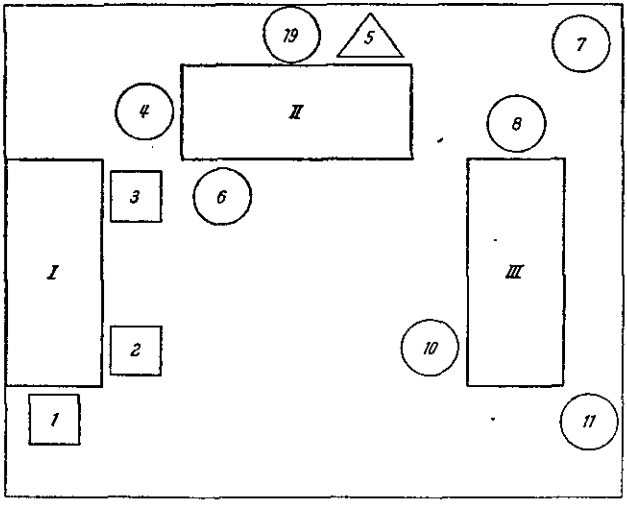

FIGURE 2
Seating arrangement outside of mealtime.

is dampened on one side by the authority of the "star" and gets no nourishment from the remaining dull and peaceful neighbors (9, 10, 11). Also, two other often disturbed patients are calmed down by suitable neighbors (13, 19). The seating arrangement is also widely observed outside of meals by the patients who remain in the day room. Some have sat for years in the same place (Figure 2.).

The *sociogram* (sociometric test according to Teirich) verifies our observations (Figure 3.). While the schizophrenics have developed no relationships with each other, the epileptics form a close-knit community with pair and triangular connections. The pairs (15 and 16, 12 and 13) spend most of the day together. They keep busy in the same way and take walks

together. They often have violent disputes which are soon followed by reconciliation. *That is why one pair (12 and 13) are not plotted on the sociogram* for they had just had a fight. This example shows that continuous observation is superior to a single *sociogram* because the latter catches only the momentary state. The triangular group (10, 11 and 14) lives likewise in a tight community. Should any of these three patients have an attack, she would be lovingly cared for by the others. The "central figure" and the "black sheep" (14, 12) appear very clearly on the plotted *sociogram*. The

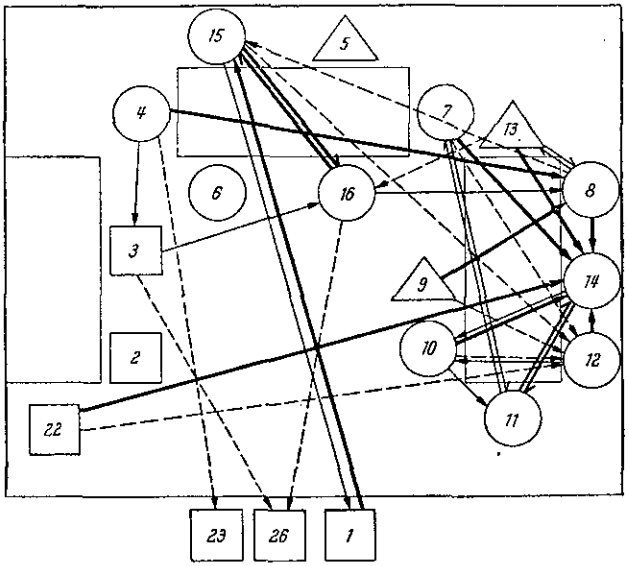

FIGURE 3

Sociogram according to the sociometric test (Teirich). ⟵ most congenial, ⟵ *also congenial*, ⟵ — — — *least congenial.*

"central figure" is chosen 7 times and the "black sheep," who, on her part, recognizes the authority of the "star" through her vote, is rejected 5 times. An old, energetic epileptic (8), who is responsible for order in the day room, is recognized as a partial authority. It is her job to see to it that the needlework is put away promptly and the table is set. Besides that she washes the dishes. Should anyone fail to follow her directions, she can become very angry. Another epileptic, with great zeal, keeps one of the dormitories clean and drives the late sleepers out of bed (16). *Thus, every member of the group has her function, and the day passes according to unwritten but stringent rules.*

Some patients have given reasons for their choice of partners. These answers show the motives that lie at the base of the results of the choice and shed light on the situation of the individual. So, the severely autistic schizophrenic (3) asserted in reply to the question, who was most congenial to her, that she could not say; "*Nobody would vote for me,* so what do I need with sympathy?" This patient was aware of her isolation from which she apparently suffers. Another patient (22) with a metencephalitic condition resembling schizophrenia explained her choice for the "star" with the following words: "She beats me with the scrubber if I spill only a little soap, *but she impresses me,* she does such a perfect cleaning job." Even though the chosen one is far inferior to her mentally, this patient acknowledges her leading role within the section.

The observation of the group revealed further how a change of milieu can alter the conduct of a patient. A newly admitted patient (18) had sat down, in an unguarded moment, at the place of a deaf feeble-minded patient. This imbecile had sat for a long time at the first table next to the autistic schizophrenic and imitated her conduct. She sat idly at her place all day long and at visiting time only extended her hand mutely. After she had eaten for a while together with the livelier patients at the second table, she became more open to contact, and since she was transferred to another section, she is daily tirelessly busy in a tea kitchen. The *pseudoautism* of this feeble-minded patient was thus set aside by a fortuitous change of surroundings. The constantly complaining schizophrenic patient (1) had, during the period of observation, herself deduced the consequences from the rejecting behavior of the group and moved to another day room during the day. Upon being questioned, she asserted that all the others were "bewitched." At her own request she was later moved to another building, whereupon her behavior took on a fundamental change. Whereas formerly she had raised complaints at each visit, now she sat happily without desires in the other ward and addressed the patients surrounding her—mostly bedridden old women—as "Ladies." The members of the old group were contemptuously referred to by her as "patients." She made only one exception (15). These two patients (1 and 15) felt drawn together by reason of their high degree of education. (Figure 3). In this case a patient could be freed from the uncomfortable position of "black sheep" through transfer, whereby life was substantially improved for her and her surroundings.

Our theory that the seating arrangement does not depend upon chance was proved by an involuntary experiment. Since a whole floor in one of the ward buildings had to be evacuated due to remodelling operations, the

section whose *sociogram* was under discussion, became a billet for those displaced. (Figure 4). Two schizophrenics (25, 27) sat at the first table, and the others scattered among the remaining two tables (28, 29, 30). A very difficult psychopath who annoyed her fellow patients with her constant sweet talk and her aggravated helplessness, tried to take over the "isolated place," because it was probably only there that she would be tolerated. (31). A mutistic foreigner with a defect-cured paralysis who was in the habit of sitting dully and without contact at her place could at first find

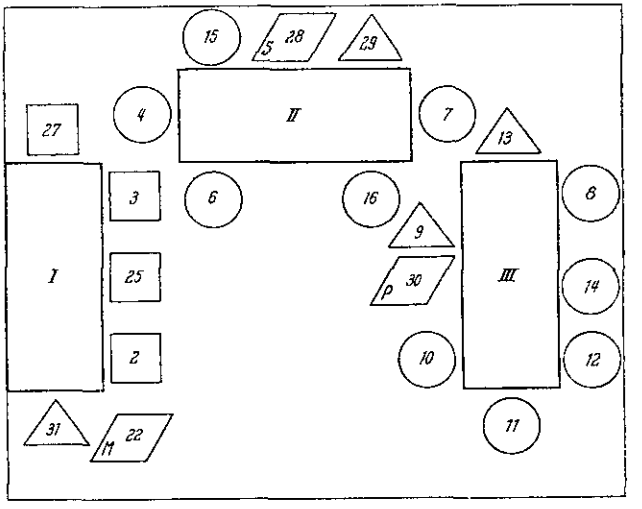

FIGURE 4

Seating arrangement after the quartering of six patients (25, 27, 28, 29, 30, and 31). organic brain diseases; *M* metencephalitis; *P* progressive paralysis; *S* senile dementia.

accommodation only at the third table, but soon changed over to the first table to surroundings more suitable to her, in order to have her peace (30).

The seating arrangements and the *observation of the patients* also presented the same picture in the other sections. The autistic patients continually seek to set themselves apart and often are found together at one table. They prefer to sit along the wall where they are least disturbed. Similarly everywhere, patients who can carry on conversations with each other or even play social games together gather at one table. Women of a strongly marked or especially difficult character distribute themselves among different tables. Patients who work outside the ward shut themselves off

against their psychologically strange surroundings. Occasionally they also form a kind of "family": an older woman takes over the role of mother for several younger feeble-minded patients, for example, sews dolls for them, keeps them orderly and clean, gives them small presents at Christmas time, etc. Friendships are rarer than enmities, which is not surprising considering the cramped conditions and the illnesses disposed to conduct of an anti-social nature. Patients from other sections are for the most part treated as strangers. Several months ago a catatonic patient who wanted to visit a fellow patient in another section, to whom she felt much attached was driven, by the hostile conduct of some patients who turned her away with harsh words and gestures, to make a serious attempt at suicide. We can gather from this how close to the heart of a mentally ill person these interpersonal relationships which she formed in the ward, can be.

The group ties between the patients in the security ward are looser. They are either high grade morons or patients engrossed in their psychosis. With few exceptions definite "condensed nuclei" are formed only for a short time at the most, that is, the attention of some of the members of the group is focused on one object—for example, a letter, a package, a fine piece of needlework or a talk with a nurse.

The question now arises: what causes the formation of groups and which part of the personality—the sick or the healthy—determines the place of the individual in the community of the institution? The formation of groups among the sick is probably brought about in the first place through the external daily routines. In a closed ward there is no question of a voluntary formation of groups but of *a community of living and suffering forced upon them from the outside.* For the patients it is simply the necessity for getting along with each other in a confined space (Simon). That is why the ties in a small clinic or private ward with small rooms are looser—if we disregard the formation of separate pairs and cliques. Within a "forced community of sick people"—we must note Friedemann's formulation—many actions and relationships are actually *voluntary*: friendships, enmities, pair and triangular attachments. When autistic and pseudo-autistic patients gather together at one table in order to have peace, the impulse to do so probably stems from the sick part of the personality, while friendships can arise from a *healthy* sympathy or need for communication. If a patient isolates herself voluntarily, during which act she seats herself in the day room, this situation can be laid to a *paranoidal* misunderstanding ("They are all bewitched"), but it can also be a conscious or unconscious reaction to the *actual* general rejection, therefore the expression of a side of the

individual which has remained healthy. Probably, in the formation of groups, as much outside compulsion as voluntary impulses play a part in the healthy and morbid spheres of personality.

> Williams and co-workers have instituted a program for the further analyzing of the behavior of patients through the questioning of members of the family, doctors, social workers, and through investigation with psychological tests. Such a diagnostic program requires a large expenditure in both time and personnel. A considerable part of our patients could not understand the test problems.

Such a group of patients, however, does not live isolated from the wider environment but is exposed to various influences from the outside. Apart from the relatives and employers (work therapy, family care) the physicians and nurses exert the greatest influence upon the group.

> Belknap points out the "hierarchy" in an institution (under North American conditions). The patients are confronted by three groups of personnel: 1. The head of the clinic, the superintendent and their staff; 2. the doctors, dentists, nurses and "social workers"; and 3. the untrained attendants. The attendants, who are with the patients 24 hours a day and in part have to perform menial tasks (cleaning up), attempt, through a system of rewards and punishments, to maintain their authority and social distance over the patients.—R. Schindler has attempted to reduce the *sociogram* of a section of patients to a basic plan (see Table 1) and to exhibit the dynamics of the connections and identifications equilaterally. The atmosphere on a ward depends decisively upon what position the members of the "upper class," the nurses and the doctors, take in a group. The nurses can, for example, remain coolly and objectively in the position of opponent. Accordingly, the atmosphere is severe and strained, and the living together is without friction but "unwilling." If the nurse is in "Alpha" position, the climate of the section is warm and personal but a personal note of likes and dislikes enters in; in "Beta" position the climate is clean and objective, without exaggerated affects, at the same time somewhat puritanical. It is bad when a new or uncertain nurse gets into "Omega" position; then nothing goes right and the patients irritate each other. The foregoing is correspondingly valid to the position of the doctor. His plans are decisive in organizing the group for therapy. The circumstances become much more complicated when two doctors wrestle for a favorable group position. The details of these very important observations are worthy of being read in the original.

We can, through longer observation of the group, as a rule classify the

patients according to one of the group positions described by Schindler. If the physician is himself clear as to which position he occupies within the section, he can regulate his conduct accordingly and influence and direct the group in a systematic fashion. The therapist must continuously check his attitude toward the group (Friedemann).

The perceptions gained hitherto already reveal *some possibilities for the application of the sociometric methods* which we have tested:

New admissions are not simply accommodated wherever there is an empty bed but, as far as it is possible, are integrated into the group so that their adjustment is facilitated. We can draw their attention to the authorities (stars) and warn them against the quarrelsome patients.

Desires for transfer are complied with as much as possible if they do not arise from merely a passing ill humor. Patients who are rejected by the whole group or who isolate themselves by sitting in another day room, are transferred inside the ward, the hospital or exchanged with other hospitals. A person can only be freed from the position of a "scapegoat" by being taken out of the group (Höhn). Therapeutically favorable friendships should be fostered through association. However, transfers for this purpose seldom take place among our patients. Simon had already made use of the transfer within the institution for the purpose of forming milieu.

Leading personalities (among the patients) who exert a favorable influence upon the group can easily be persuaded to cooperate. Often a small bit of praise or an encouraging word is sufficient to win over the "central figure" and the members of the group who identify themselves with her. It is a first step toward self-government and self-education when the patients urge each other to be orderly, clean and punctual.

If possible, every patient within the community should receive a *task* which stimulates her activity and strengthens her self-confidence. Many patients conduct themselves more responsibly if we give them responsibility, as Simon in particular has pointed out. Several times patients have resisted a transfer because they did not wish to lose their job. Two patients actually wanted to stay in the security ward. One washed the dishes there and the other helped take care of severely mentally deficient fellow patients. Transfers without cause can drive patients to suicide, so attached are they to their surroundings.

Alongside the favorable therapeutic bonds others exist that are undesirable. The formation of cliques is detrimental to the community, besides that there are also *negative groups* ("gangs") whose members instigate forbidden actions and insubordination (Friedemann). *At any rate it is*

part of the fundamental job of the physician so to place the individual in his group as to promote the good and the healthy in him.

Up to the present moment we have confined ourselves, to a great extent, to observing and investigating the groups in as inconspicuous a manner as possible, in order not to disturb the naturalness of the patients. Further experience must show if a more drastic procedure, perhaps through radical re-shuffling of the groups, can produce better results.

The practical application of sociometric observations in the treatment of patients carries over into *group therapy*. In several long standing methods of treatment in mental hospitals, developed by Simon, there was already a bit of group therapy; they were described by Moreno as "intuitive group therapy." (Merguet).

Family care, which had already been introduced in Ilten in 1880 by Ferdinand Wahrendorff and developed by him, has the task of integrating the patients into the community of the family through the cooperation of all members of the household. However, the family is, as Moreno calls it, a "natural group." In the family the unfavorable effects of the hospital milieu are sidetracked and the patient is led back into normal living conditions through example, love and various stimulations.

As Simon has already pointed out, *work therapy* can likewise promote the formation of groups. The patients in the work groups are supposed to educate themselves as well as take over a specific measure of responsibility. Thus, the conduct of a schizophrenic Russian woman, who had sat idle in the security ward for years and repeatedly refused nourishment, has basically changed since she began to work in the potato peeling group and took charge of it. She gives the impression of being contented, conducts herself circumspectly and for the first time in a long while inquired about her children. The patients in our hospital laundry, who live and work together, form an especially close living and working community.

Occupational therapy—as a treatment through the use of various art-handicrafts—also has (under the guidance of licensed therapists and practitioners) a place in groups. Williams and co-workers pointed out that this work, which in itself already creates a common bond, can be shaped still more toward fostering the group if the patients make only separate pieces which they have to coordinate and put together themselves. Conversations often get started spontaneously through outside stimulation, and likewise, community singing or reading during the hand work fosters the togetherness.

A close community—conditioned by the specialty of treatment—can be formed in an *insulin section* (Friedemann). The patients help and nurse

each other and thus remain more open to contact in spite of the acute psychosis.

Every visit can be shaped along group therapy lines (Friedemann). The physician can listen to joint wishes, settle disputes, praise good pieces of work and censure offences against the hospital rules. However, the possibilities of such "visit group therapy" are limited. Thus, the attempt to bring about a group conversation in a day-room without preparation failed repeatedly. The patients able to take part sit too widely scattered, and attention-seeking characters crowd forward and monopolize the physician.

Group conversations, which have been carried on in this ward for more than a year, constitute a thoroughly conscious effort toward group therapy. We could not draw all the patients into them. We had, rather, to make a *selection.* The circle was to be limited to those patients who were sufficiently ready for contact and intellectually capable of carrying on a sensible conversation. Likewise, continuing formal difficulties of comprehension and severe deafness exclude a number from participation. Only a *fourth* of the ward could be chosen (Table II.). Seven women came on the

TABLE II

DIVISION OF PARTICIPANTS IN GROUP CONVERSATIONS BY DIAGNOSIS

Diagnosis	Considered	Number who participated	Additions	Total participants
Schizophrenia	31	12	5	17
Psychopathy	7	7	1	8
Epilepsy	5	3	2	5
Man. depr. psy.	3	2	—	2
Others	6	2	5	7
Grand totals	52	26	13	39

first evening, and then the circle was widened, step by step. The participants were themselves allowed to suggest who else should be invited. At first the patients were personally invited, later the general announcement that there was to be a session was sufficient. In the course of time the evenings became so popular that further patients came spontaneously, most of whom could be allowed to take part. Only a few feeble-minded (imbeciles) had to be rejected, because they could not have followed the conversations (Merguet). Participation is voluntary. If a patient stays away, she is not reproached. Invitation and participation are supposed to be an honor. Through discharges, transfers and stay-aways, it becomes possible to a limited extent to

rejuvenate the circle. In time a core of sixteen women who came regularly was formed. The average number of participants varies from 15-20 people. The circle of participants is thus considerably larger than the groups used for analysis, for which 8-12 persons are considered optimal (Berry and co-workers, Guggenbühl-Craig, Langen, Maizlish, Steinig, Williams and co-workers). On the other hand, the count of 30 patients, as reported from Gütersloh (Schulte and co-workers) proved to be too high. However, that may be due to particular conditions. On the one hand, only about 25 people can sit in the room available to us, on the other, when the circle of participants is too large, the group threatens to fall apart.

Group discussion takes place regularly every Tuesday night and last an hour. In the literature, *one group conversation per week* is also preponderantly recommended (Guggenbühl-Craig, Harlfinger, Kotkov, Maizlish, Merguet, Schulte and co-workers). Other authors report two conversation a week (Berry and co-workers, Langen, Steinig). Greater frequency may be necessary if the treatment time is limited. For manifest reasons we select at first *only female patients* as participants. A choice according to social aspects is not made (Guggenbühl-Craig, Schulte and co-workers). The *external framework is, in comparison to other hospitals, very simple.* The participants sit in a small unadorned room upon chairs, arm chairs and sofas. No food or drinks are served. The attention is concentrated only upon the conversation. We can dispense with introductions of participants at the beginning of an evening as all of the women come from one ward and have known each other for years. The seats are not assigned by the physician, but soon a stable *seating arrangement* (Guggenbühl-Craig) develops. No *sociogram* was made of the group in order not to disturb their naturalness (Schulte and co-workers).

In addition to the group leader, who is at the same time the ward physician, in order that actual problems of the ward can also be discussed, after a time the occupational therapist also participates as "co-therapist." It has also proved of value in other clinics for a pair to play the role of hosts (Maizlish, Schulte and co-workers). The "hostess" will be recognized as participating authority for female interests. In addition, it is good if the group leader can later talk over the evening with a partner (Guggenbühl-Craig). In contrast to the group for analysis, only *one fixed topic,* determined by the group leader, is discussed (Schulte and co-workers). The topic is not announced beforehand, for it proved to be that the patients do not prepare themselves. The general tension of expectation is sufficient stimulation.

In the beginning we opened the discussion with a short introduction.

This procedure proved to be a failure. The physician in such a ward possesses so much authority that nobody dare to question his views. The discussion takes a much livelier turn if only one question is raised at the start. The group leader, who should remain in the background as much as possible, has, in the main, the job of seeing to it that only one person talks at a time, the shy get a hearing, and disputes are settled. The patients are much more eager if they themselves shape the evening. It is by no means easy to find the mean between leading them like a school master or giving them too much freedom. The therapist sees to it that the group stays on the topic. The discussion is very easily side-tracked and has to be led back to the topic. However, we can approve a change of subject if there are fruitful digressions over questions which are important and lie close to the hearts of all. The group leader must inform himself ahead of time about the subject of the discussion in order to provide stimulation from time to time, should the conversation lag. Painful silence is not used by us as stimulus (in opposition to Guggenbühl-Craig). According to the topic, it may be necessary to speak a few words as summary or for clarification at the end. Several evenings took on a musical atmosphere through piano playing or community singing. An introduction with music did not handicap the conversation (in opposition to Harlfinger).

Just as in Lengerich and Gütersloh, questions which concerned everybody were talked about, and all discussions of personal problems avoided unless they were of a universal meaning. Pathological trends of thought were not tolerated; they were also only expressed at the beginning. Besides the vital questions which interest all women—raising of children, equal rights for men and women, women's occupations, fashions, shopping, dowry, the building and furnishing of a house—and general problems such as how to act in traffic, science, politics, the weather, etc., concrete questions which arise out of the existence in the hospital were especially discussed. The "bastion of lack of insight into the illness" (Schulte) did not seem impenetrable to us. It is true that for the most part the schizophrenic patients consider themselves "sound," but, at least, the participants in group conversations have the ability to perceive that they have to remain in the hospital for some time and are ready to talk about the problems arising from this situation. We are surprised again and again by the degree of sense and critical judgment and what strong moral perception these patients exhibit (Guggenbühl-Craig, Harlfinger). Thus, our conversation partners approved the separation of the sexes in the hospital and recognized that some patients have to be protected from harm by means of closed

doors. They often made useful suggestions for the architectural re-modelling of the ward. As far as possible all wishes are granted and suggestions utilized so that the group realizes that we are *taking them seriously as partners* (Guggenbühl-Craig). Thus they can make suggestions for radio or television programs and for work and occupational therapy as well as express wishes concerning the planning of get-togethers. Even the mistakes in conduct of the nurses, the key-policy and the meaning of disease were discussed. For a change we planned parties or a bus trip. Such events bring the patients longlasting pleasure.

Only the healthy part of the personality should be addressed in this form of group therapy, and no analytic treatment should be undertaken. The method must be adjusted to the type of patient. *Our type of patient* is fundamentally different from that in most reports on group therapy. The patients suffer almost exclusively from *chronic* diseases. Most of the women are of middle age or older. The youngest are around 25, the oldest over 70. In part the disease is congenital so that a number of patients have been sheltered in nursing homes or institutions since childhood. Only a few have been in the hospital less than a year; a large number, however, have been in 20, 30 or more years. *The participants in our group have, on the average, been ill for 21 years and under uninterrupted hospital care for 14.* The prognosis with respect to their capability for discharge is unfavorable almost without exception. The most active participant, an old woman 74 years old, suffering from manic-depressive insanity, has been ill for 61 years and, with short intermissions, institutionalized for 53 years. Such cases do not permit optimism.

Teirich, at the session for group psychotherapy in Bad Nauheim in 1958, suggested that a difference be made between group therapy and group psychotherapy. The *analytic group psychotherapy* works consciously with the elements of psychoanalysis according to Freud: transfer, identification, opposition, aggression, catharsis, etc. According to W. Schindler, the therapist represents the father, while the whole group takes over the role of the mother and the participants feel like brothers and sisters. The object of analytic group therapy is the unconscious (Derbolowsky). This method which in necessary conjunction with individual treatment, has been employed with good results in the treatment of neuroses, has also been tried with new schizophrenics (Klapman and Meyer, Williams and co-workers). Group discussion was employed in part to supplement general somatic measures of treatment (insulin therapy, reserpin, etc. (Guggenbühl-Craig).

Our own experiences with new schizophrenics and other clinical patients are limited. The dynamics of analytic group conversations exist only in modified form when it comes to *group therapy with chronic cases;* the "acting out" does not assume importance. Still, through speaking up, the patients can often practice criticizing life within the hospital and in that way release hostile feelings (Guggenbühl-Craig). Even the non-analytic conversation group satisfies the social hunger (Bierer), stimulates spontaneity (Moreno, Ackermann quoted according to Harlfinger) and increases self-confidence (Bierer, Harlfinger, Kotkov). Most of the effects allow the *sub-conscious* to operate and remain unknown to the patients. It is a help for even the chronic patient to see that other people have similar problems. They learn to listen to each other and to adjust themselves to a voluntarily acknowledged order (Friedemann). Besides the interest in the topic of the evening, they are always united by the common fate of the (incurable) disease and the necessity for overcoming this fate. For the physician group therapy means a valuable enrichment of therapeutic possibilities. The direction of a large ward in a mental hospital is substantially facilitated and at the same time intensified. Kemper pointed out, in that respect, that a physician who is responsible for 100-150 patients must, to a large extent, limit himself to the exploration of the adjustments. It takes months to give a personal interview to over 200 patients. The group, on the contrary, allows the physician to make contact with several patients simultaneously. But group therapy has even more to offer. *Through the group the physician can gain influence over the whole ward.* Therefore, it is an advantage if the group leader is at the same time the ward physician. We can talk over the medical and nursing problems and the technical problems of administration with the patients. They pass on their perceptions voluntarily to the other patients and thus become an "extended arm" of the ward physician. The participants in the group develop a group pride (Schulte and co-workers). They try to guide themselves.

They know that the faults of the patients are openly discussed and they give the whole ward a good example. The social cleavage which results from the special position of these group participants has often educational value. But it should be avoided to give anyone in the group a "special" status.

The patients are permitted to comment and give advice as to the organization of life within the institution (Merguet). They have *the feeling of co-responsibility.* As they have to find an answer for many problems, they learn through their own experience how difficult it is to guide such a large

community in an adequate manner. Their *social adaptability* is being stimulated, as the patients learn to integrate themselves into a community and to help and educate themselves.

In addition the group discussions stimulate *intellectual activity*. This aim is not left only to radio, television and magazines. The intervention of clarifying discussions of current problems has educational and ethical value. (Schulte et al.) Finally the group discussions have also a diagnostic value because the physician can observe the patient in another environment. It is easier to estimate the social attitudes of the patients and their educational backgrounds (Guggenbühl-Craig). The basic personality becomes more clearly visible. The cleavage between physician and patient is overcome, they understand each other better, especially if the physician does not hesitate to discuss his own experiences.

SUMMARY

We have examined whether it is possible to recognize the *structure of groupings* in a large closed ward of a mental hospital. As methods we used: 1) the observation of living together in a ward; 2) the sitting order in the various situations, and 3) a *sociometric test*. The large number of catatonic and mentally deteriorated patients required more sophisticated test procedures than usual.

We come to the conclusion that in a large hospital ward several smaller units develop in the sense of "open groups" whose inner structure and dynamic meaning we described in a special case. We came also to the conclusion that the *sociometric* findings should be taken into account in the case of new patients, in the reassignment of patients from one unit to another and whenever patients become co-workers.

The patients who live at times in a very loose and poorly structured community can be placed in closely calculated *therapeutic groups*.

Group psychotherapy in the form of group discussions stimulate the social adaptability of every patient and facilitates the treatment of a larger number of patients because the participants in the discussions spread their own insights and learnings throughout the entire ward. The application of sociometric insights and the group discussions established a more favorable therapeutic milieu and develop in the psychiatric hospitals a valuable combination with the methods of Simon.

BIBLIOGRAPHY

BELKNAP, I. *Human Problems of a State Mental Hospital.* New York, 1956. Ref. Group Psychotherap. 10, 254 (1957). Berry, R.V. and Cunningham, E.L. *U.S. Armed*

Forces med. J. 9: 391 (1958). Ref. Arztl. Praxis 10, 544 (1958); Bierer: *Vortrag auf der Arbeitstagg der allgem. ärztl. Ges. für Psychotherapie,* Bad Nauheim, 1958; Bufe, E., *Die Familienpflege Kranksinniger,* Halle, 1939; Derbolowsky, U., *Vortrag auf der Arbeitstagg der allgem. ärztl. Ges. für Psychotherapie,* Bad Nauheim, 1958; Friedemann, A., *Gruppenpsychotherapie in Handbuch der Neurosenlehre und Psychotherapie,* München u. Berlin, 1958; Guggenbühl-Craig, A., *Erfahrungen mit Gruppenpsychotherapie,* Schriftenreihe: Psychologische Praxis, Basel u. New York, 1956; Harlfinger, H., *Z. Psychother. med. Psychol.* 8, 51 (1958); Höhn, E., *Soziometrie. Vortrag auf dem Kongr. der allg. ärztl. Ges. für Psychotherapie in Freudenstadt,* Stuttgart, 1956; Kemper, W., *Vortrag auf der Arbeitstagg der allgem. ärztl. Ges. für Psychotherapie,* Bad Nauheim, 1958; Klapman, J. W., and R. Meyer, *Dis. nerv. Syst.* 18, 95 (1957). Ref. Zbl. Neurol. 143, 236; Kotkov, B., *J. Nerv. Dis.* 123, 546 (1956). Ref. Zbl. ges. Neurol. Psychiatr. 143, 236; Langen, D., *Sonderheft Gruppenpsychotherapie der Z. diagn, Psychol.* 5, 219 (1957); Maizlish, I. L., *Group Psychother.* 10, 169 (1957); Merguet, H., *Veröffentlichung des Hermann-Simon-Arbeitskreises.* Gütersloh, 1954; Moreno, J. L., *Die Grundlagen der Soziometrie* Köln-Opladen, 1954; *Sonderheft Gruppenpsychotherapie der Z. diagn. Psychol.* 5, 139 (1957); Schindler, R., *Sonderheft Gruppenpsychotherapie der Z. diagn.* Psychol. 5, 227 (1957); Schindler, W., Siehe Bierer; Schulte, W., H. Harlfinger u. R. Stiawa, *Sonderheft Gruppenpsychotherapie der Z. diagn. Psychol.* 5, 205 (1957); Simon, H., *Aktivere Krankenbehandlung in der Irrenanstalt,* Berlin u. Leipzig, 1929.

SOME DIFFERENT DIMENSIONS OF GROUP AND INDIVIDUAL THERAPY

A Group Treatment Project

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We start with Dr. J. L. Moreno's observation:

> "Group psychotherapy treats not only the individual who is the focus of attention because of maladjustment, but the entire group of individuals who are interrelated with him."[1]

Next we add a surprising statement by Le Bon in which there is a suggestion concerning the broader, different dimensions of group behavior, in contrast to individual behavior:

> "The most striking peculiarity presented by a psychological group is the following. Whoever be the individuals that compose it, however like or unlike be their mode of life, their occupations, their character, or their intelligence, the fact that they have been transformed into a group puts them in possession of a sort of collective mind which makes them feel, think, and act in a manner quite different from that in which each individual of them would feel, think, and act were he in a state of isolation. There are certain ideas and feelings which do not come into being, or do not transform themselves into acts except in the case of individuals forming a group. The psychological group is a provisional being formed of heterogeneous elements, which for a moment are combined, exactly as the cells which constitute a living body form by their reunion a new being which displays characteristics very different from those possessed by each of the cells singly."[2]

For casework practitioners we can add a third ingredient. This would be a remark by an illustrious social worker, Mary Richmond (1930).

> "This brings me to the only point upon which I can attempt to dwell at all, to a tendency in modern casework which I seem to have noted and noted with great pleasure. It is one which is full of promises, I believe, for the future of social treatment. I refer to a new tendency to view our clients from the angle of what might be termed small group psychology. . . . Halfway between the minute analysis of the individual situation with which we are all familiar in casework, and the kind of sixth sense of neighborhood standards and backgrounds which is developed in a good settlement, there is a field as yet almost unexplored."[3]

By using the above three references from divergent sources as our frame of reference we wish to describe to you an experience at Berkshire Farm for Boys in working with a cottage group.

For several years, the notion of supplementing individual therapy with group therapy methods was considered in the clinical program at Berkshire Farm for Boys, a treatment center for delinquent adolescent boys, ages 12-16. This evolved primarily because of the fact that the casework supervisor was trained in psychodramatic method and other group therapy techniques in addition to the use of individual therapy. A number of the clinical personnel "tried their hands" at group therapy with small groups of four to six boys. In most cases group therapy was used in addition to individual therapy, whereas for a few, a boy was assigned to a group instead of individual sessions. Groups were formed by caseworkers largely from their own caseloads, while individual therapy continued to be the primary treatment technique being relied upon.

When the clinical program had become rather well established, the search for more effective treatment techniques was intensified, and out of this arose the present research endeavor. The project is a response, so to speak, to crucial problems that arise in an institutional setting in which various disciplines function separately from one another—e.g.—casework-homelife; administration-management. The clinician in his individual relationship with a boy, learns about life in the cottage, classrooms and other areas of the institution, primarily from the boy. Whenever an incident occurs, for example, in a cottage, it is very difficult, if not impossible to get the full explanations out in the open where everyone at the same time can hear about it, can ask questions, and can try to satisfy himself as to what happened and the motives behind it. The problem of communication, a major issue to be considered in institutional work is not effectively met when the trend is toward differentiation of function with concurrent isolation of disciplines from one another. Admittedly, attempts to cope with this by means of staff meetings, and conferences, have value, but, almost universally, the main protagonists—the patients—are excluded from this. Thus, it was felt, in setting up the project, that a real attempt at integration and establishment of a therapeutic milieu would involve meetings with boys, therapists, cottage parents, cottage supervisory personnel, and when indicated for specific problems, any other staff members or boys in the institution. Ideally, the therapy of the group would involve the total population housed in five cottages, plus all the staff members in the institution, inter-acting together. Even more ideal is Moreno's view that: "A truly therapeutic

procedure cannot have less an objective than the whole of mankind."[4] Communication networks, in working with the 5 cottages, would be too unwieldy so that unless the focus of meeting would be to deal with only very broad general problems with limited participation of the individual members, the latter project was ruled out. The effort of the project we are describing is therefore geared toward a group program in one cottage, to include boys and staff persons additional to the group leader.

The aims of the project have been characterized as follow:

1. To possibly cut down the length of stay in the institution by providing a more economical method of rehabilitating delinquent boys. In part, this is seen as a demonstration project to work out a program that state schools and other institutions, with limited resources in terms of personnel, might emulate.
2. To develop a treatment method which enables staff members to deal with their conflicts and disagreements in a constructive manner, hopefully to decrease the number of inter-staff problems and to eliminate some that often result from the lack of effective communication. The goal in this is to increase the mutual understanding of each other's role as well as to provide a common base of knowledge about the boys in the cottage group.
3. To give the boys more responsibility for dealing with and working out problems of living together by providing a setting in which they can share their ideas and attitudes with one another and with staff. Hopefully, the project would enable boys to develop an acceptance of social responsibility as well as to help them to learn how to participate in setting standards for socially acceptable behavior.
4. To develop on the part of staff greater skills in working with delinquent boys by enabling them to learn more about the cultural norms and value systems of the delinquent sub-culture. The meetings afford an opportunity for staff to become familiar with the on-going life of the boys and to learn more about the functioning of the inmate system.
5. To give staff an opportunity to influence the boys' behavior so that leaders who emerge from the group take on more positive attitudes in identifying with the values of staff. This is an attempt to effect changes in the sub-culture and inmate system through democratic discussion techniques.
6. To provide an avenue for staff to "level" with boys, that is, to tell them what is really happening so that the rumors and distortions of what goes on, especially when the institutional grapevine operates, will be minimized. An example of the application of this aim is the case of a boy in the group whom the institutional personnel recom-

mended for transfer to a mental hospital, and who, himself, had asked to be sent to a hospital. The boys in the cottage, the boy himself, and the cottage group team discussed the transfer. When the boys were able to recognize that this move was not a punitive one, were able to express their anxiety about what would happen to them, heard the boy express his own desire to be transferred because of his fears of inability to control his impulses, we had a demonstration of the therapeutic milieu operating in its truest sense.

7. To allow and to encourage criticism of boys by one another and of boys by staff and staff by boys (somewhat similar to point 3) so that change can be brought about through the influence of the adult authority persons *and* through the influence of the peer group.

As we review the aims outlined above, one can readily see the obvious differences from the aims that one would have when working with the individual patient. One can also surmize some of the problems involved in this type of expanded multi-dimensional treatment, especially in an institutional setting in which, traditionally, the various disciplines themselves *and* the clients, tend to enforce and to re-enforce distinct, exclusive roles and territorial rights, similar to state's rights as against a federal, central, unifying system.

I would like to devote the remainder of this presentation, in fact, to more specific focus on this above point. We must first make the assumption that, in terms of treatment, it is desirable to cut across territorial lines and vested interests, as for example, penetrating the delinquent inmate system, or moving into and influencing the value system of staff engaged in custodial care of the inmates. We must also accept the premise that the custodial staff are in fact treatment staff and that their inter-action with the boys and influence on them in the cottage living situation is perhaps of greater significance than that of any other agents within the institution.

An evaluation of our cottage group program to date, after ten months of operation, would indicate that some of our aims have already been achieved. For example, point 1—length of stay—we have discharged several boys from our first group in less than 10 months (the average length of stay at Berkshire Farm for Boys is 18 months). In regard to point 3—more responsibility for boys to work out their problems of living together—committees were instrumental in changing some institutional practices. Also, there was a decrease in the number of runaways as compared to the 10 month period of the previous year. As for the remaining aims, I will now refer to comments by various staff persons working in the project. The

cottage mother reported the following: The project has given the boys more initiative, good and bad; their problems aren't kept bottled up until they can get to see their caseworkers; they have more trust in staff, in being able to unburden themselves toward some staff without repercussion; they have more compassion for each other, having been given insight into other boys' problems; they enjoy the prestige of having a voice to solve another's problems, they have a better and quicker opportunity to express themselves, their problems, and to solve same; they have a better understanding of the staff and their problems. The cottage mother also thought that a future goal should be eventually to have the boys themselves say who should go home on vacation and who should be discharged.

The cottage father reported "a closer working arrangement with the clinical department with attendant advantages to boys. Cottage staff certainly has better understanding of clinicians' problems, difficulties, etc., in working with individual boys. Cottage staff undoubtedly learns more about boys in cottage, and vice versa. This can be especially helpful with new boys. Meetings seem to have lessened the amount of 'bruting' in cottage life. Boys seem to be more relaxed; however, meetings apparently have confused the 'inmate' system."

The assistant cottage supervisor reported: "The problems of the cottage group meetings are as follows:

1. Resistance and lack of cooperation from other departments and staff, to the project, its methods, and its means.
2. Maintaining supervision over boys, not present at the meetings, without making the meetings compulsory.
3. Meetings at which no topic can be found to hold the group's interest, and controlling the general confusion which frequently follows.

The accomplishments of the cottage group meetings are as follow:

1. Many boys now realize that cottage life problems, and boys' personal problems can be understood, and sometimes remedied by discussions in the project meetings.
2. Some boys have learned to understand themselves better from discussions on other boys.
3. Project has intensified and boosted the cottage group morale.
4. Many of the boys in the project have gained a better understanding of adults (their individuality, desirable and undesirable traits and characteristics, and their mood cycles) from the discussions of events, and admissions and statements of staff at the meetings. Thus, they should be better able to get along with their families,

and to cope with their elders whom they will encounter after discharge.

The goals of the cottage group meetings are as follows:

1. The complete liquidation of the boys' present social structure (anti-staff, anti-ratting, strong-arm organization) so that
   a. Honest complete discussion of problems and events can take place without any boy being in fear of reprisal from other boys.
   b. An honest evaluation of the boys' Farm life and program can be obtained, with the asset side aired in accurate proportion with the gripes."

Additional reports from the caseworker, group leader-in-training, and from the Berkshire Farm psychiatrist all reiterate that staff and boys have moved closer together, and that tremendous inroads in solving the problem of integration of institutional staff have been made.

In view of our findings thus far in the group experience cited in this paper, we are now prepared to make some observations as to the different dimensions of group in contrast to individual therapy. We accept the premise that group therapy and individual therapy are two different species, so to speak, and that it is inappropriate to *compare* the two. This premise might not be acceptable to some followers of the group therapy movement who, perhaps, are at this point contemplating the familiar assault on the "ivory towered isolation" of the individual therapist. The stalwart individual therapist, too, may be disarmed in that we are not concerned with specious arguments about the "superficial aspects" of group therapy as compared with "intensive work" with the patient. We heartily concur with Dr. Moreno's observation quoted at the beginning of our paper, in which group therapy is viewed on a basically different plane than that of individual therapy. This view, by the way, is contrary to some schools whose focus remains on treatment of the individual with limited regard for, and awareness of, the intricate relationship between the individual as a part of, and not apart from the group. We have now seen critical evidence to the effect that treatment of the group as a whole, which includes not only the client but the therapist and other staff, requires a different level of abstraction and interpretation than one applies in the more traditional individually focused work in the institution. It is not by accident that at present the cottage parents and the boys in the group often now sound like therapists for one another. It is also not accidental that the group leader himself underwent some changes in his own attitudes and behavior toward other staff and the client population.

We are now at a point, too, at which we can readily recognize some of

the resistances of anxiety which one encounters in attempting to implement a program of the nature described. For instance, one takes the chance of laying bare before his colleagues, clinicians and fellow staff members and clients, one's basic therapeutic repertoire. The great anxiety involved in this exposure can be handled by recognizing that everyone else is exposed in the situation and from this, that everyone begins to question himself, his performance and his effect on others. This is one of the pay-offs that we can settle for, in the face of our recognition, too, that we have limited awareness of the multiple variables of inter-action in the group. Then, too, we are satisfied that we have confronted one another—boys, caseworkers, cottage parents, leader and others—in a direct, on-going relationship through which our mutual problems can be enacted, and dealt with on the spot. In institutional work, and, I think increasingly on all fronts in work with patients and clients, this movement toward working with the larger group —the gang, the family, the employees, the cottage group—represents a vital forward step in bringing help to greater numbers. The very fact that these procedures arose can be seen as *a response by therapists to the necessities dictated by certain treatment situations.*

Briefly, consideration of some basic aims of our particular project can help us to abstract some group treatment dimensions.

1. On the Staff level—an attempt to develop understanding of one another's institutional role and to improve communication. A remark by Fritz Redl seems relevant at this point. His comment was that often a patient will be brought into a treatment situation for help, and he will immediately become enmeshed in the network of staff confusions and problems, the difficulties ensuing for the patient in relation to this will become defined as the patient's problem. All resources are then brought to bear on helping the patient to deal with what has been defined as "his problem" although this is really a problem that has been super-imposed on him as a result of institutionalization. He finally is helped to work through "his problem," so to speak, and when ready to leave the institution will have exactly the same *basic* problems he had when he first arrived for help.

2. On the Staff-Client level—an attempt to focus on problems of living together and to effect change through mutual sharing and example with less focus on insight in the traditional sense. Everyone in the group is affected and may expect, or be expected, to change so that staff members including the leader, are also clients in the group, to some extent.

3. On the Client level—an attempt to exploit the tremendous influence of peers on one another to effect change. Increasing attention is being paid to

this aspect of treatment in studies of institutions and patient groups.

In this context, we can perhaps make a final distinction between the individual and the group work relationships. In the individual relationship the therapist is attempting to help the patient to use the potential of the transference, and the concomitant factors involved in the one-to-one contact, while the group leader is attempting to use the potential of the group and the concomitant factors involved in a multi-personal contract.

It would seem obvious from the content of our presentation that we are suggesting, at least for work with delinquent adolescent boys, that the group treatment procedure involving the "entire group of individuals who are interrelated" with the client should be considered as the basic treatment of choice in an institutional setting.

An immeasurable contribution those of us in treatment work can make to all disciplines concerned with administering help of a psychological nature lies in our development of concepts and techniques to utilize the group approach, and to appropriately incoporate individual treatment when this is deemed to be in the best interest of effective service to the client.

BIBLIOGRAPHY

1. MORENO, J. L., "Who Shall Survive?", 1934, p. 301.
2. LE BON, "The Crowd: a Study of the Popular Mind," 1920.
3. RICHMOND, MARY, "Some Next Steps in Social Treatment," reprinted in "The Long View" (New York: Russell Sage Foundation, 1930), pp. 487-488.
4. MORENO, J. L., *ibid.*

SUPERVISION OF ANALYTIC GROUP PSYCHOTHERAPY

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PSYCHOANALYTIC SUPERVISION AS MODEL EXAMPLE

Psychoanalytic training has become the model for training in psychotherapy. Experience in analytic supervision is taken here as the point of departure for the necessary variation of such supervision in the field of group psychotherapy.

Supervision is an essential part of analytic training. It was practiced in the Berlin Institute for Psychoanalysis in 1920. One early controversy concerned the separation of training analysis from supervisory analysis. Michael Balint suggested a combination of both functions by the training analyst but the majority of analysts tend to favor delegation of two training psychoanalysis and supervisory analysis into the hands of different analysts. In 1937, Edward Bibring advocated a special form of associative reporting to the supervisor which was intended to give simultaneous insight into the patient and into the relationship between the patient and the reporting doctor. Carl Landauer joined the early authors writing about analytic supervision. The discussion was continued, recently, by Lionel Blitzstein and Joan Fleming and summarized by Martin Grotjahn in 1955. The most recent report on current views on analytic supervision was given by Paul Sloan (see bibliography).

The most important aspect of analytic supervision seems to be the same to all authors: it is the recognition of the transference-countertransference problems of patient and doctor. The supervisor should take an active part in the interpretation of the countertransference. Therefore, recent authors prefer to speak of "supervisory analysis" instead of "supervision of analysis". Only a supervisory analysis involves more than a classroom procedure in the interpretation of the patient's material. A supervisory analysis ought to be more than only the learning of technical devices for the handling of specific problems.

A psychotherapist is ready to start analytic supervision when he has learned how to activate the unconscious of his patients with due understanding of transference and resistance, without reacting with undue anxiety or unrecognized feelings of countertransference; and when he has learned how to use interpretation as the essential tool of psychoanalytic technique. The therapist should have reached that stage in his own analysis where he

willingly demonstrates his unconscious motivation in his work to the supervisor, be it his own analyst or a colleague whom he consults.

In my supervisory work, I assume that the doctor wants to start his consultation with a discussion of his entire work, not only of one selected case. I assume further that he wants to talk more about difficulties than about situations which he can handle. I am inclined to leave the choice of patients or groups for supervision to the doctor. I know that the search for a patient suitable for supervision is frequently a sign of resistance (or of the supervisor's counter-resistance). If given a free choice, the candidate finally and frequently will settle on a case which reflects, more or less, the doctor's own central conflicts.

I like to pay a visit to the student-doctor's office in order to see his field of operation. Only in special cases do I agree to a consultation with the patient, with or without the presence of the student-analyst.

For the sake of the discussion, supervision can be divided into three stages:

The first phase of supervision is a period of preparation and information until the doctor and the supervisor get acquainted with each other and with the patient as reflected in his history.

The second phase of analytic supervision is a period of growing insight into the psychodynamics of the patient's personality and his sickness. The supervisor also gains insight into the personality of the student-analyst and his way of reporting. The student now should develop a free associative way of reporting which is a sign that he loses his anxiety about showing his technique.

The third and final phase changes from a patient directed supervision to a doctor directed supervisory analysis. The aim is no longer the avoidance of beginner's mistakes but an analysis of the total situation, including and emphasizing the handling of countertransference phenomena.

During the supervisory analysis the analyst in training, so to speak, is "caught with his defenses down" or, in better terms, shows himself without resistance and without anxiety in his work. With necessary tact and timing, interpretation can be given to him which may have been given previously in his analysis but are now offered in new forms and with a new change of integration. Where there are less favorable circumstances or intensive countertransference difficulties and conflicts, the need for further or repeated analysis will become obvious.

This last stage of supervisory analysis may rightfully be called supervision of the doctor's beginning self-analysis which should last the rest of

his life. This should be true whether the therapist works in the field of psychodynamic psychiatry, psychoanalysis, psychotherapy or group psychotherapy.

If given freedom to choose problem cases or problem situations from his practice, the therapist in training may often surefootedly step into trouble. A therapist*, in the last stage of his training, described his reaction to his supervisory analysis as follows: "I had unconsciously chosen the best case to illustrate my countertransference problem that was nearest consciousness. When I began to understand that particular counter-transference problem, the next "case chosen again turned out to be the best unconscious choice to illustrate the emotional problem nearest to my consciousness; and so on for four consecutive cases.

"The theoretical hypothesis is that by your technique of allowing me to choose the patient and by an interpretation of the patient, turned the same interpretation back to me as an interpretation of myself, you have brought the technique of supervision as close to being an analysis as possible. When I chose a case to present and presented it, it was identical to the situation where a patient would choose a dream, a screen memory, an incident, or a fantasy and associate to it. The patient in the later stages of analysis always chooses a dream, a screen memory, etc., that represents the material closest to consciousness. Therefore, when the analyst interprets this material and associations he is interpreting the unconscious material closest to consciousness. Similarly, when you give an interpretation to a patient I present you are interpreting my unconscious conflict closest to consciousness. It is usually the interpretation appropriate to the stage of my self-analysis."

Supervisory analysis is geared to show and analyze countertransference difficulties—hardly anything needs to be added to this report. The art of analysis and of group work is partly based on mature identification with the teachers and the teachings of psychoanalysis. In this respect, the technique of supervision is more difficult but not different from other fields of medical education.

The Advisability of Joining the Group Session in the Supervision of Group Psychotherapy.

The special aspects of supervision in analytic group psychotherapy has great difficulties to describe group psychodynamics correctly. To overcome

* I wish to thank Dr. James Jackson for his permission to use his material here.

these difficulties the supervisor ought to join the group therapist in a session with the group for supervision.

A clinical example may illustrate such an experience:

The group therapist* consulted the supervisor to find out: (1) whether he made proper use of his psychoanalytic knowledge in group psychotherapy; (2) whether he could deepen his psychoanalytic technique in group psychotherapy; (3) whether the supervisor could recognize technical mistakes which might have remained unnoticed by the therapist.

The supervisor was well acquainted with the therapist for four years. The group was composed of 3 men and 3 women between 30 and 40 years of age. Diagnosis ranged from depressive episodic-hypochondriasis and delinquent behavior to several more or less severe character neuroses expressed in marriage difficulties and hysterical symptoms.

The first 6 supervisory hours were spent in single interviews with the therapist to get acquainted with the group members through the reports of the therapist and to renew the acquaintanceship with the therapist who was familiar with the technique of supervision. We went through the period of preparation and understanding the psychodynamics with special emphasis on describing problematic situations.

A visit to the group was then suggested and arranged. I was introduced as a friend of the therapist, as an experienced analyst and group therapist. I was accepted by the group which was previously prepared for my appearance.

After a short time of waiting, I went into action, mostly interpreting resistive behavior. I tried to activate emotions of bitterness in one patient, of impatience and hostility in another. Later, the group discussions centered on one of the young women who was going to be married soon and whom I asked whether she had some sexual experience or whether she still was a virgin.

I closed the group session (which by then I had taken over) with an explanation and an interpretation of my activity, pointing out that only a visiting therapist is allowed to be that active. My joining the group session was followed up by further supervisory hours with the therapist.

Analyzing my activity, I could say that I tried to illustrate to the therapist the kind of activity and interpretation which I considered possible and indicated. I also gave some illustrations of technique, timing and

* I wish to thank Dr. Max Sherman for his permission to use his material here.

dosage of therapeutic activity. In later hours of supervision I could demonstrate to the therapist the many different therapeutic functions which were exercised in a short interval of time.

We agreed that a correct and effective group technique probably lies somewhere between the therapist's passivity and the supervisor's activity. I felt clearly that this was a well-trained group which could take care of the analytic stimulation which I had created by freely offering interpretations. I could expose the weakness, the soft-spots, the resistance and defenses of some members with such toughness and activity if they were not willing to show their defenses. I felt that I had worked, like an analyst should, almost exclusively on the defenses and on the resistance.

The therapist (M. S.) was not defensive at all and summarized his opinion later:

"I became aware of anti-therapeutic countertransference attitudes in myself such as competitiveness, sibling rivalry, irritability, anxiety about therapeutic failure which I could then better bring into self analysis. These are not necessarily points which you actively demonstrated (but which were brought out through your activity).

"The presence of the observer who, at first, was mainly passive but obviously interested, seemed to stimulate the group and they participated more freely than usual. It seemed as if there were a temporary circumvention of transference-resistance. My fear of a possible loss of prestige, of incompetence or inadequacy, and of competitiveness was ameliorated by the acceptance of the observer by the group and the continuance of the group activity. I felt pleased, then, that you had the opportunity to observe my function in a fairly representative manner, considering that this was my first experience in this kind of supervised group work.

"Then you turned the tables, so to speak, by allowing me to observe you in the role of active therapist. Several things were soon apparent: You were much more a participant with the person in focus at the time than with the group as a whole. You described it as a greater activity which could not be advisable or even possible for the permanent group therapist yet it made me aware of barriers within myself against recognizing and accepting and dealing with patients' feelings which, to me, had seemed subtle. In effect, by practical demonstration I could see unconscious material in patients illuminated which had escaped my attention and which opened new areas. It was also an opportunity for me to separate the wheat from the chaff. For example, that your flare for showmanship is not of the essence

of therapy and that, while you may be able to use it as a vehicle to show genuine interest in a patient, it is not an essential for myself.

"A number of your interpretations and comments were valuable in reinforcing previous interpretations and stimulating the patient to work through problems with renewed impetus. The renewed interpretation by an impartial observer reinforced the reality testing of the patient but, in an instance when the observer made a completely new interpretation of comments, the patients tended to ignore it."

This example of group supervision shows two phases: supervisory analysis of the therapist and the checking of observations by joining the group and actually observing the therapeutic process in action.

It is possible that one-way screens, tape recorders and photography may open new ways for supervision. It is also possible that such technical devises are more suitable for research of the therapeutic process or seminars on technique than for the limited aims of supervision. The relationship between teaching and learning in psychotherapy is still such an intimate process and so personal that, perhaps for some time to come, the essentially unique relationship between teacher and therapist should not be mechanized but remain what it is in spite of technical insufficiency. Under the special setting of group psychotherapy teacher and therapist should join a group session in order to experience together the complicated therapeutic atmosphere of group psychotherapy.

The supervisor should not enter the group before the therapist feels confident about it. This does not imply that he should feel sure of "making a good impression" or of "recognition, praise or recommendation." He should feel free of anxiety towards the supervisor and should be glad to show his work and invite inspection. These anxiety-free transference relationships between therapist and supervisor are a sign of the therapist's maturation. He is no longer assuming the role of the son who tried to compete with his father. If he does, this must be interpreted and analyzed. If he relates himself as a younger therapist to a more experienced therapist then the time of relative maturity has arrived. Then therapist and supervisor both may feel confident that the joint meeting can take place. The suggestions of the therapist to the group that the supervisor—or consultant—will attend the meetings will then be accepted by the individual members of the group without difficulties and loss of spontaneity. The group can tolerate the presence of the supervisor without endangering the status of the therapist as the central figure and will not lose its identity as a working group, for the supervisor is merely an interested and receptive onlooker.

Direct observation enables the supervisor to survey the situation. Such observation includes the set-up of the office which give invaluable clues to the supervised work. The seating arrangements of the group members, the therapist's mannerisms and behavior may provide clues. The supervisor can validate material which he gathered from the therapist's report. In addition, he can make direct observation which may defy description or which, if described, take up more time than is available. The experienced supervisor has trained himself to observe, simultaneously, the therapist, the group and his own place in the proceedings.

The supervisor has a chance to demonstrate his criticism, corrections and suggestions through action and not through words alone. The shift of roles by the supervisor from the receptive observer to an active participant takes place during the second half of the supervisor's visit to the group. The therapist has the chance to observe the technique of the supervisor when the supervisor becomes active.

The experience of the teamwork can be used as a new stimulation and basis for further cooperation in the subsequent hours of supervision between the supervisor and the therapist. It may be possible that the contrast between the supervisor's and the therapist's behavior and the group's reaction to this behavior may activate anxiety in the therapist. This, then, will be analyzed in the follow-up sessions with the therapist. It is seldom used by the group as a form of resistance in hours to come. If this should occur, it is open for interpretation by the therapist who is aware of this possibility. Occasionally, it may happen that the group joins the supervisor and supervises the therapist, as it were, and may continue where the supervisor left off. This can be of great therapeutic effect, at first for the therapist, and, secondly, for the group. A situation may develop as in the case of growing-up children who have a chance to show their understanding of their parents —an experience which mature parents may cherish greatly. In the group, such an event can be of therapeutic efficiency.

SUMMARY

Supervision of group psychotherapy can be divided into supervisory analysis with the therapist which is conducted according to the principles of psychoanalytic supervision. Due to the specific setting of group psychotherapy, joint sessions between the therapist, the group and the consulted supervisor are necessary. The dynamics of such a technique are discussed and illustrated.

The Analysis of the Countertransference in Group Work and the Maturation of the Group Therapist

A well conducted group gives the analyzed therapist an opportunity to study the influence of countertransference on group psychotherapy. The group situation almost forces the therapist to use, to observe and to analyze his feelings of countertransference. It gives him an unusual chance to continue the process of analytic working through. The group therapist works in front of a gallery of mirrors who show his own image in different reflections.

Countertransference which corresponds to group transference has to be analyzed and resolved when it becomes a counter-resistance which corresponds to group resistance.

The result of such working through will be manifested by increased reality adaptation of group and group leader, who will be better adapted to each other towards outer and inner reality.

As the transfer of past patterns towards present reality remains, to a limited degree, a characteristic feature of our mental life, so will countertransference remain, to a limited and controlled degree, a tool of the therapist's empathy and emotional relation to the group. Without dedication to his work, without, to a certain extent, showing this dedication to his patients or making them feel it, therapy would be shallow, meaningless and ineffective.

At the end of the group therapy, transference and countertransference feelings will approximate a resolution manifested by increased spontaneity, directness and frankness of expression. By then the group members will discuss their conflicts relatively free from anxiety and defensiveness. Insofar as the group therapist is concerned, this will express itself also in anxiety free relationship between group therapist and his supervisor.

Lest we forget: the supervisor ought to know about his countertransference to the therapist; without such knowledge and insight, satisfactory analytic supervision is not feasible. There, the complicated therapeutic process finds its practical end.

BIBLIOGRAPHY

FRIESEN, A., "Training Psychiatrists for Group Therapy," Group Therapy Association of Southern California, First Annual Report, 1953-1954.

GROTJAHN, MARTIN, "The Process of Maturation in Group Psychotherapy and in the Group Therapist," *Psychiatry*, XIII: pp. 63-67, 1950.

GROTJAHN, MARTIN, "Special Aspects of Countertransference in Analytic Group Psychotherapy," *International Journal of Group Psychotherapy,* Vol. III, No. 4, October, 1953.

GROTJAHN, MARTIN, "Problems and Techniques of Supervision," *Psychiatry,* Vol. XVIII, No. 1, February 1955, pp. 9-16.

GROTJAHN, MARTIN, *Beyond Laughter,* The Blakiston Division, McGraw-Hill Book Company, Inc. (New York, Toronto, London), 1957, pp. 285.

GROTJAHN, MARTIN, "The Role of Identification in the Training of Psychiatrists," *Monthly Review of Psychiatry and Neurology,* Vol. 117, No. 4/5/6, 1949.

JACKSON, JAMES, Quoted from a written communique to Martin Grotjahn.

MORENO, J. L., "Transference, Countertransference and Tele," *Journal for Group Psychotherapy,* Vol. VII (No. 3 and 4), Pg. 309, 1954.

MASSERMAN, J. H., "Moreno's 'Transference, Countertransference and Tele,'" *Journal for Group Psychotherapy,* Vol. VII (No. 3 and 4), Pg. 309, 1954.

SEMRAD, E. V., AND ARSENIAN, J., "The Use of Group Processes in Teaching Group Dynamics," *American Journal of Psychiatry, Vol. 108, Pg. 358, 1951.*

SHERMAN, MAX, Quoted from a written communique to Martin Grotjahn.

SLOANE, PAUL, "The Technique of Supervised Analysis," Panel Report on Scientific Proceedings of the Mid-Winter Meeting, New York, December, 1956, *Journal of the American Psychoanalytic Association,* Volume V, July, 1957, Number 3, pp. 539-597.

ZIFERSTEIN, ISIDORE, AND GROTJAHN, MARTIN, "Working Through, Acting Out, and Psychodrama," GROUP PSYCHOTHERAPY, Vol. VIII, No. 3-4, December 1954, pp. 321-322.

ZIFERSTEIN, ISIDORE, AND GROTJAHN, MARTIN, "Psychoanalysis and Group Psychotherapy," published as a chapter in *Progress and Psychotherapy,* edited by Frieda Fromm-Reichmann and J. L. Moreno (Grune & Stratton, Inc., New York, 1956). Pp. 248-255.

PSYCHOTHERAPY IN THE SOVIET UNION

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The basis of the theory of Soviet psychotherapy is the philosophy of *dialectical materialism.* The psychic processes are considered by us as a "reflection" of reality by the brain. The physiologic nature of the processes of such reflection is a system of reflective acts. The formation of the personality as a whole, the development of all *psychic acts,* is determined by socio-historical conditions.

Acquaintance with the patient is the first stage of psychotherapy, in the process of which we aim in some degree to achieve not only the necessary information about the patient, not only rapprochement with him, but also certain partial psychotherapeutic effects. We place the utmost importance on the factor of discovery of the cause of the illness, as described in the monograph of E.K. Yakovleva. The physician's acquaintance with the patient is effected by the following means: (1) conversations between the doctor and patient; (2) if necessary, conversations between the doctor or his assistant and the family and close friends of the patient, with his colleagues at work, etc.; (3) clinical, pathophysiologic and pathopsychologic investigation. The program and the extent of this acquaintance usually is correlated with the concrete tasks of psychotherapy. When a limited problem confronts the physician (for example, the alleviation or the removal of pain), we frequently achieve success without a deeper acquaintance. A more complete biography of the patient, we think, should be understood as the history of the development of a personality, in the light of which should be viewed the immediate cause of the disease, the immediate psychotrauma, the situation in which the patient finds himself, and the perspectives which are before him. S.P. Botkin and G.D. Zakharin recommend that the physician utilize not only what the patient talks about, but also *how* he talks about it and what he *avoids* talking about.

Soviet psychotherapists appreciate the importance of physiologic investigation. Valued physiologic indices are "conditioned reflex" methods, electroencephalography, galvanometry, plethysmography, and examination of motor reactions, etc. K.I. Platonov especially has done much for the study of physiologic indices in the hypnotic state and under the influence of suggestion.

As to the question of the correlation of the conscious and unconscious,

I.P. Pavlov thought that the physiologic basis of consciousness is the nervous activity of a certain region of the hemisphere of the brain. This optimum *excitability* is variable. This physiologic concept negates the presence of firm boundaries between what is being experienced consciously and unconsciously.

Soviet psychologists view this in the same way. One of the most prominent of our psychologists, S. L. Rubinstein, wrote about this question: "The supple, variable dynamics of continuous transitions do not permit one to speak about impenetrable barriers of the conscious and unconscious separating one from the other."

After initial acquaintance with the patient, the psychotherapist makes the transition to a more active stage of psychotherapy. The "active" character of the psychotherapist's work in our country is a principle which is accepted not only among the physicians but also among our patients.

The therapist exerts his influence by combined explanation, persuasion, and suggestion, by organizing the patient's own "activity" and by influencing, strictly within the limits of his own professional competence, the family environment and the conditions of his work and life. We place great significance on the *training* of the nerve processes. "Training" is viewed in the unity with the reconstruction of "relations" of the personality to the functions which suffered in the disease and are now being trained again.

Soviet psychotherapists do not distinguish psychotherapy from work therapy. Given in certain doses, attractively presented, *work* acquires high therapeutic value, especially in our country where work is held in great esteem.

Soviet psychotherapists also like to apply the hypnotic method but distinctly in combination with nonhypnotic methods. Some of our psychotherapists evaluate positively the inclusion of *self-suggestion* in the psychotherapeutic methods. We think that self-suggestion should be understood as a certain form of self-regulation by the patient of his own behavior, based on the persuasion and suggestion by the physician.

We accept in psychotherapy the principle of "stages." Often in the early period, calming or "soothing" therapy is used; if necessary, in combination with drugs. Later, depending on the condition of the patient, activating and stimulating factors are gradually strengthened. It goes without saying that in the treatment of certain patients the psychotherapist begins directly with the second stage, while with other patients psychotherapy may remain basically limited to the calming technique. This might apply, for instance, to the somatic patient whose condition is considered as incurable.

Soviet investigators approach *schizophrenia* as an organic disease, one

in which psychotherapy is very useful but is not a substitute for active medical treatment.

Some successes have been noted in the application of psychotherapy in the total treatment of epilepsy, and psychotherapy plays no small role in the complex treatment of *chronic alcoholism*. Due attention is given to psychotherapy in the clinical treatment of somatic diseases, in which the central nervous system is essentially involved in the pathologic process, with participation in one way or another of personality factors. This is especially true in obstetric, gynecologic, and dermatologic clinics, as described by the writings of K.I. Platonov and his associates. Our obstetric clinics have developed psycho-prophylactic methods of "painless" delivery. In addition, obstetricians, dermatologists, internists and others have pursued psychotherapeutic work in their own fields of treatment with success. Only physicians apply psychotherapy, as with every other kind of medical treatment, but nurses and pedagogues working under physicians' supervision can aid them. We are also aware of the methods of *group* or *collective* psychotherapy, these having been written about by V. M. Bekhterev, V. A. Guilyarovsky and many others.

A GROUP THERAPEUTIC PROJECT INVOLVING A TOTAL ADMISSION WARD

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I. PRELIMINARY CONSIDERATIONS

I have been concerned over what would be the most useful employment of my abilities and time to help the mental patients in our hospital meet their problems and leave the hospital. Many responsibilities keep coming to me; some are challenges I see, others are demands placed on me. And when I walk on the wards, so many of the patients ask to talk to me privately about their problems. Thus, I have become acutely aware of the need for patients to discuss and look into their own problems with someone. Also I am acutely aware of the lack of staff to do this with them. To which of these patients can I devote my abilities and time to obtain the most useful and most immediate response?

I noticed that the admission patients were the ones that usually were in the greatest turmoil. After some observation I concluded that this was because the admission patients were, on the whole, filled with anxieties, not being as yet adjusted to the hospital, nor sufficiently adjusted to the stresses which led up to their hospitalization. The admission patients having as yet not made clarification and resolution of their inner problems, experience much turmoil, have the greatest fluidity in their mental structure, and have an acute desire to integrate their inner experience. This desire can be worked with to help them reintegrate themselves; (1) in a more healthy manner than they had before their hospitalization or, (2) in a more healthy manner than they might, if left to do it alone. It might be, I thought, that some of these might make an adjustment on their own, at least a hospital adjustment, yet, one which would not be sufficiently helpful to them to cope with the problems with their families and the society at large.

I concluded that these patients having a need for help because of their acute anxieties, would respond better than others to a limited effort from me. Furthermore, I felt some confidence in their constructive interactions for I observed these patients searching for help from each other, and some of them appeared capable of giving and receiving help if and when their constructive emotions and realistic perceptions were elicited. The following points seemed to fit these patients.

A. As I regard the individual patient on the female admission ward

1. And I look into her sources of anxiety, I note these to be outstanding.
   a. The events just prior to, and leading up to the patient's hospitalization, especially the final ones involving the relatives, police, parents, children, friends, even strangers—that is, events with people—are fraught with pain.
   b. The disruption of and separation from long range desires and goals, activities, forces; the disruption of her ties, not only to persons but to her work, her interests, her habits—these are cut off with a sense of loss.
   c. Her emerging concept of herself as "crazy" and having or feeling her symptoms, her sensing that "part of me is out of control," or that something in herself is not part of herself, the awareness of this and the reaction of others to these symptoms is frightening.
   d. Her reactions to other patients, "who are those others?" especially to see that she is classified with some others whom she can plainly see to be "crazy"; the external or superficial interests, sometimes the indifference of the staff as experienced by the new patient (for the nurses, the aides, the doctors and other hospital personnel usually appear to the new patient as being impersonal and generally insensitive and indifferent to her with her own unique personal problems), "the hospital" has an impersonal and cold feeling. All this gives her the feeling that no one could really care for her.
   e. The hospital routines impose restrictions, medications, clothing, etc. This may also have depersonalizing, constraining, and inhuman influence.
2. The admission patient, however, has reality contacts and is able to appreciate many aspects of reality. For example:
   a. She may appreciate another patient's distortions and recognize them as distortions.
   b. She may appreciate another patient's pains and fears, and perhaps the true basis of the pain and fear.
   c. She may appreciate another patient's talents, her goodness, hostility and other real motivations behind the patient's expressions.
   d. She may appreciate the limitations of the hospital due to impersonal circumstances such as lack of staff time, lack of information in a staff member who may answer a question with "I don't know," may appreciate problems around plumbing, food, linen, her physical ailments, lack of privacy, etc.

e. She may give understanding and companionship to a degree wanted by another.

f. She may correctly describe her own or another's problems, the situations on the ward or at home, and may go on to look at their own contribution to the problems.

3. The new patient asks himself "What am I"?

a. What are my problems?

b. What are my abilities, what are my strengths, what can I do?

c. Can I trust myself? When? With whom? What do I really know?

4. And when we study her:

a. We may look to observe what does she accept and what does she reject in herself. We may look to see what are her plans, her desires, her frustrations, her purposes; what is her past and her future, as she sees it and as we think it possible.

b. We may wonder and look into whether she thinks and feels of herself as an object or whether she thinks of herself as a person within herself.

c. We may wonder and look for information on whether she feels responsible for herself, for her problems, for her treatment, for her recovery, for other patients, for ward problems and for staff matters.

B. Let us also see and note a few features of the ward to which she comes.

1. There are the formal lines of authority which the patient must know, the channels through which she must go in order to get her needs attended to. What can she expect from each of the various staff people? The personal aspects of these staff people are important.

2. Then there are the lines of influence within the patient groupings; that is, which are the most respected patients, the ones that would protect you, the ones who might be able to speak for you, the ones whom you should fear, the ones to whom you could go when you have a problem on your mind, the ones whom you can trust.

3. Then there are the ward routines. The sequences of the getting up, the dressing, the breakfasting, the cleaning, the activity programs, the staffings, etc., and how does one react to these routines—obediently, passively, rebelliously, with understanding and cooperation, or in some other fashion.

4. Then there are the important ward programs, the student nurses, the activity therapies, the visits from home, the orientation group.

C. With all this, I felt that the ward milieu was too impersonal. There were not enough personal contacts built into the administration of the ward. I suspected that perhaps the staff and I were allowing the clear formalized demands on our time push us away from the unclear, the novel, the vague reachings out of the personal problems and the personal contacts with patients. I also felt that because we might be somewhat unskilled and unfamiliar with some of the problems in patients, we might find it too easy to stay away from them and become engrossed in the familiar and known duties and treatment programs. In addition, I noticed that it is easy to allow one's self to be caught up in a rush of "necessary" business and then to remain caught up in this business such that the important, personal matters were left to be done later and often not at all. *I decided to attempt to make the ward society more therapeutic.*

II. How Could I Implement This Concern and Theorizing About the Admission Ward Patients?

By getting better acquainted with the patients and the ward and build up to the establishment of "group therapy" sessions on the ward if I were asked.

A. There had to be a process in which I would choose certain patients as being of value to me and they would choose me as importance to them. I did this in the following ways:

1. I visited the ward informally, greeting the patients, chatting here and there, asking questions and listening to as much as they were willing to tell me, never staying with any one patient very long.
2. After a time, certain individuals went into their problems a little more deeply and occasionally two or three would gather around me and talk rather intimately about their problems. It seemed that at this point there was beginning a group that was spontaneously choosing to be open together. At one point, as I was talking to one woman, several others, I believe it was 5 others, gathered around. Several of these others made comments showing that they had a similar problem as the one that was opening up. After about 20 or 25 minutes of this we felt that we had achieved a feeling of mutual trust and understanding. They asked whether we could meet again. I agreed to meet with those patients and asked whether they would mind if we had a general meeting to which all the patients who were interested could come. They accepted this idea. Then I asked whether we could not meet regularly on a scheduled basis. They enthusiastically took this up.
3. When I thought about this group meeting later, alone, I decided to put up an announcement of the meeting on the ward bulletin board, inviting anyone who was interested in discussing their

problems—their feelings about the hospital, their families, and themselves—and anyone who was interested in hearing others discuss their problems, and anyone who wanted to ask questions about such a group, would all these sign their names to the paper bearing the announcement of the first meeting. At the time of the meeting, there had been fifteen signatures affixed to the announcement.

4. At this first meeting, there was a discussion of the tentative purposes, and the schedule for the meetings was made up. We were to meet twice a week for one hour each time. Then we went on to questions about personal problems and hospital procedures.

B. The first meeting was on October 24, 1958 and we have continued to the present.

1. At first there were anywhere from 15 to 20 patients in the group and very few of these took an active part. These few were usually those who were quite hostile or the few who had great anxieties and had to talk about their problems. There was not so much a careful search of how they felt but a pouring out of pent-up feelings.
2. At first the people attending this meeting were mainly the mature women, excluding for the most part, the senile patients and the teenagers. Teenagers, at first, attended irregularly, but gradually they have attended more and more frequently.
3. The attendance has increased to the point where almost everybody attends every meeting at present. Very few stay away and when they do so it is for compelling reasons, such as that they may be at a staff meeting, they may be ill, they may be off the ward for some special reason. The number of people present varies from between 30 to 50 patients, according to the ward census and the number on home vists, sick, etc.
4. Now, it seems that the total patient population is participating to a greater or lesser degree in the meetings; but not only the patients, also the nurses, aides and the student nurses attend whenever possible—so that it does seem as if the total ward is participating.

III. What Type of Interaction Occurs?

A. My original ideas have determined this, in part.

1. I had proposed to try activity to draw out the group's response to any given patient. I ask for problems similar to one stated; I ask for reactions to the stated feelings of a given patient; I ask for advice from the patients when a given patient asks for advice; when a patient seems to need sympathy and I notice some of the group responding sympathetically, I sometimes encourage such patients to express their sympathy as openly and clearly as possible. Occasionally

when one patient has broken down and cried, I have sent that patient with one or two others who were able to appreciate this one, to one side where they try to listen and comfort the crying one while I continue with the rest of the group discussing some other problems.

2. Another idea I began with, which I am carrying out, is that I direct the patients to express as much as they can in the group meeting, and if ever an additional problem comes to them which they cannot express publically then they should think as far along as they can, up to the point where they feel frightened and hurt in their thinking. I advise them not to stop there, but to continue in their thinking through the pain, and then to find some one patient or staff member to whom they feel they might be able to communicate privately some or all of this line of thought. I persist in the response that my time for individual sessions with them is very limited and though I am willing to see them, it will be infrequently. Perhaps it might be two or three weeks before a person who asked to see me privately would be able to meet with me.
3. Another idea I have is that I try to protect any one patient that is not being protected by any other and who is being singled out for hostility by some of the patients.
4. I also proposed to myself that I would not search deeply into any one patient's problem. I am willing to go only as far as the patient is willing to disclose publicly. Furthermore, I may have to relinquish working with a patient even though she wanted to go more deeply if the group is uninterested or unable to go along with this patient in her deeper search.

B. The inclusion of the ward personnel is needed to make the ward people more understanding and helpful of one another.

1. I ask the ward personnel present to make comments and answer those questions asked that were within their scope of information or personal reaction.
2. I urge the patients to go to the ward attendants and nurses with problems of a personal or ward nature. For this to occur under the best conditions I think it important that the ward personnel should attend the group meetings. I encourage them in this and they attend whenever possible.

C. There have been some progressions in the type of meetings.

1. We began with questions and answers but we are now at the point where individuals can sometimes bring up very deep problems and group members can help in the participation and discussion. Quite often the therapist remains silent while several patients carry on around a given issue.

2. Whereas the problems began pretty much on a superficial basis, we now sometimes get to the point where some proceed to bring up a great deal of anxiety. This often arouses much involvement in the other patients.
3. Whereas we began with a great deal of hostility toward the hospital, criticism of policies, personnel, routines, etc., this had dropped out completely, We have gotten to the point where there has been occasional criticisms of the therapist for his lack of time or his lack of sympathy with some of the patients who want to receive more understanding and time from him.
4. There has been an increasing willingness on the part of the patients to accept responsibility for their own symptoms and their problems and look at their contribution to their difficulties.
5. Since patients are rarely kept on this ward longer than three months, there have been many changes in the population. I have seen many improve and leave; others improve only mildly, a few do not get any better. These last two types are usually transferred to other wards. As some patients calm down and find some understanding and a better order, newer patients begin their expression of distortions and chaos. There is a continuous beginning and ending.

IV. Some of the Techniques I Have Used Have Already Been Indicated, But a Few More Can Be Noted

A. At times dreams have been brought up for group interpretation.

B. Hypnosis has been used, on one or several patients at one time. They have been hypnotised and asked to think about whatever questions they have in mind and to penetrate whatever block they have about it. Sometimes there have been stated problems which are investigated through hypnosis. Occasionally there have been questions which a person had in mind but would not state to the group. However, even these were investigated so that the person would be able to discover the answer to the questions and see through certain blocks. At various times, some of the patients so helped have stated that they have not wanted to remember what they have found out because it was too frightening. At such points, the hypnotist then suggested to them that they would forget what they had discovered.

C. Psychodramatic techniques have been used. Patients have taken various roles with respect to each other, often the roles of family members, and they have had practice in expressing their attitudes toward these. Occasionally the therapist has deliberately taken on the role of a family member with respect to a given patient and has stated the words of the family member which the patient had described, in this way seeking to get direct responses to the therapist

and to handle in a vivid, present way the relationship which is held with an absent family member.

V. What Have Been the Effects of This Project?

A. There have been some beneficial results.

1. The charge aide says that she feels definitely that the ward is much better. There seems to be more sociability, more friendliness, there are not as many complaints about food and medications as there used to be. There seems to be much more willingness to talk about their problems with each other and with the ward personnel. Aides feel more included and accepted by the patients as well as more understanding of the patients. This aide notes that previously the patients, "every single last one of them would say 'There is no reason for my being here' ". Now she overhears them saying, "I know I am sick and I am here to get help." Previously the admission ward used to be known as the "violent ward" because these acutely disturbed people would have great upheavals on the ward. "About every other day there used to be a hairpulling, wrestling fight. This has ceased completely and there has not been any fight for weeks." There are arguments, there is teasing, there is loud talking, but not the physical attacks. Instead of the fighting, there is more playing and fun, more dancing and conversations. Many of the patients now, are "as good as the ones on the open, the privileged wards."
2. The nurse in charge of the ward says that she sees more companionship. The patients stick with each other more, they are much more out-going verbally and in action. There seems to be much more communication between the patients and she feels a much greater understanding being expressed. She notices much less EST being prescribed and does not know how to account for this.
3. One ward physician said that since he only works part time and is too busy, he has not looked for any consequences and cannot report any.

   The other ward physician states that:

   a. The ward is quieter.
   b. There are more patients going home on visits and sooner than previously.
   c. The patients are better dressed.
   d. Previously when he would come on the ward he would be surrounded with patients demanding "When will I go home," "Let me go home," etc. This has ceased almost completely. He has fewer questions and problems about the hospital procedures and routines. There seems to be, he feels, more understanding, more friendliness.

4. The therapist, himself, notes the better dress of the patients. There seems to be more pride in their appearance and in their ward. Interactions developed during the group meetings apparently continue between patients after the group meetings, so that there is a greater (perhaps therapeutic) interaction in the discussion of problems, on the ward between group meetings. He also has noted a greater understanding by patients of the problems of the staff in trying to understand them and work with them in a helpful way. There is greater appreciation of our limitations of time, limitations of knowledge, limitations even of interest at times. The patients themselves have frequently stated their thanks to the therapist and some have privately approached him and expressed appreciation of comments which he makes, sometimes to them, sometimes to another person. And some have said that because of these discussions and occasional insights, as well as occasional release in expression of pent-up emotions, they "feel better."

B. The patients still have deep problems. There are still quarrels, there are still distortions, there are still anxieties, there are still criticisms, guilt and turmoil.

C. All in all I now believe that this project is worthwhile. Occasionally there have been sessions in which I have felt almost unable to respond intelligently or meaningfully to the attacks of some patients on one of the others, or to the excessive demanding of a given patient, to the paranoid expressions or attacks of another. And yet, I have the feeling that I am learning something very important when I am brought up to the edge of what I do not know and still am able to stay with the situation and respond the best I can. I personally feel a slow growth within myself in this project and I trust that this reflects a similar growth in some of the patients.

GROUP PSYCHOTHERAPY AS AN APPROACH TO A PSYCHOTHERAPEUTIC COMMUNITY

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The Psychiatric Clinic of the Cracow Academy of Medicine has now been carrying on group therapy for four years. When we began, we had not had any theoretical preparation. During our initial experiments our psychotherapeutic groups, patients from a certain ward in the Clinic, simply met once a week, usually in the evening, in the Clinic Library, as we had no other quiet place at our disposal.

The meetings were of the nature of a friendly tea-party. Ordinary conversation was freely carried on on subjects connected with the patients' life in the ward and with various everyday difficulties. The patients asked to have the effect of certain drugs explained to them or certain morbid symptoms; some of them tried to amuse their fellow-patients by telling jokes and stories; sometimes one of them spoke of his own symptoms more extensively, or presented his delusions. Most of the patients in the ward, usually about twenty in number, took part in these meetings. As a rule only a few took part in the conversation, while the others remained silent and were often bored.

These meetings could scarcely be called group-psychotherapeutic, but still they played an important part in changing the atmosphere in the Clinic. Even the fact that they were held in the Library, a place solely for the use of the Medical Staff, where professional meetings and demonstrations took place, had its effect in breaking down the barriers between the patients and the staff. Allowing the patients to enter the Library, as if to a sort of "doctors' sanctuary," was in a sense a social advancement. This happened by sheer chance, as at that time there was no other room we could use. The doctors themselves also tried to lessen the distance dividing them from the patients, by keeping up a free-and-easy atmosphere, serving tea, and so on.

Only the perspective of time can show the importance of facts, often incidental as in this case, where the meetings were by mere chance held in the Library. This was a distinct break in the previous clinical structure, which as in most hospitals—and not only in psychiatric clinics—had been divided into two separate worlds, that of the patients and that of the "Men in White."

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A gulf of this kind exists in every hospital, and perhaps to a certain degree and under certain circumstances even has a beneficial effect on the results of treatment. Mysterious apparatus, the magic of numbers in the various supplementary tests, the unknown words muttered by the doctors —all these accessories to the art of medicine make the physicians seem to the patients like beings from another world. Here of course there comes into action that tendency to magical thinking which is present in every individual and which plays no small part in every therapy, in spite of the lessening of the gap by, for instance, the popularization of medical knowledge.

We do not think, however, that this "magic corner" of the human psyche should be exploited in psychiatric treatment. In neuroses, indeed, some practitioners do so, and they often see dramatic effects from their therapy; but these are generally transient. In psychoses, on the other hand, in which the magical interpretation of the world reaches the confines of morbidity, and in which the links with the surroundings are broken, the deepening of the gulf between the practitioner and the patient is obviously harmful. We should take exactly the opposite direction, and lessen the distance between the doctor and the patient. Only in this way can the doctor lead the patient out from his closed world into the world common to us all.

After this first breaking of the barriers, the further erosion of the differences between the doctors and the patients, a psychiatrical "democratization," went on more rapidly and spontaneously. Weekly meetings between the patients and the doctors and nurses began to be organized in all the wards. The patients raised various complaints about the wards, criticized their treatment or living conditions in the clinic, asked to have their morbid symptoms or the effects of the drugs administered to them explained, and thought out plans to make life in the clinic better and more varied.

It was from these plans that the idea arose of starting a club for the patients. This differs from similar clubs because in principle it is founded on complete autonomy by the patients.

A group of doctors and patients, directed by an artist-friend, set to work themselves and turned a rather dull corridor into a pleasant, colourful corner, which the patients have named "The Cape of Good Hope." This is an "extraterritorial" place, which only the patients and the people they invite, e.g., members of their families, doctors or nurses, have the right to enter. No one from the "Men in White" is in charge of the club, and so far this, or indeed any sort of intervention, has proved unnecessary. The patients run the club themselves, do any necessary shopping, make tea or coffee, get

up evening entertainments, and organize chess competitions, bridge-drives, and ping-pong matches.

During the entertainments spontaneous representations of the patients' conflicts may sometimes be observed. A patient, acting some part may happen to introduce his own personal conflicts into a text with which they have nothing to do. In this way what Moreno enjoins in his psychodramas is achieved, that is, the spontaneous acting of their conflicts by the patients. It may also happen that a patient acts the part of the doctor giving treatment, which as a rule arouses merriment and again lessens the distance dividing the doctor from the patient. The bad side of the complete autonomy of the club is that sometimes there are stagnant periods when there is a lack of more energetic patients to undertake the organization of social life in the club. Fortunately, these periods do not last long.

Naturally we realize that neither the club nor the meetings with all the patients are even a substitute for group psychotherapy. As our theoretical knowledge of this method increased, we tried to carry on psychotherapy in a manner approximating that of the analytical schools. We established groups of eight patients, more enlightened as to the general principles of group-therapy, on a voluntary basis, and attempted to create a group-atmosphere rendering it possible to converse freely on the patients' conflicts. Unfortunately the results were very modest. The patients were not willing to talk of their conflicts, and confined themselves to complaining of various things, usually of a hypochondriacal nature, or wandered off on to other subjects, sometimes connected with methods of physical treatment.

It was particularly difficult to carry on meetings in groups in which neurotics predominated. These showed the strongest resistance to answering frankly and though it was always emphasized that professional medical secrecy is binding on everyone at the meetings, they were too embarrassed to speak of their personal affairs in the presence of their fellow-patients. In groups composed mainly of psychotics, on the contrary, the atmosphere of sincerity and mutual confidence was on the whole better. Quite often patients presented their most personal conflicts without much embarrassment, and described their difficulties in childhood and early adolescence. On the whole they took a livelier interest in the fate of their fellow-patients than the neurotics. It happened particularly often that patients with delusions explained the senselessness of these to others, while themselves remaining convinced of their truth.

The difficulties of carrying on group psychotherapy with patients under treatment in hospital come mainly from the fact that these patients are

constantly in touch with one another in the daily life of the wards and are consequently shy of discussing their own affairs for fear that these may later be spread around among their fellow-patients. Besides this, the patients' stay in hospital is usually too short (from six to eight weeks) to allow of bonds being set up within the groups, and so compels the formation of "open groups," in which the members change.

Only one of our groups has been "closed." In the beginning it was formed of in-patients, who continued to come to the meetings after their discharge from the clinic. This group has already been in existence for over a year, and strong bonds of friendship have been formed among the members. It should be pointed out on the adverse side, however, that this group has become too strongly attached to the woman doctor on whom it depends.

As we know, the character of the therapeutic meetings depends to a great extent on the personality of the doctor in charge. In our Clinic two principal methods of carrying on meetings have been developed. One leaves the initiative to the patients, allowing them to speak on optional subjects, while the doctor endeavours to direct the conversation on to more personal problems only when the discussion digresses on to subjects quite unconnected with psychotherapy. With this method of carrying on meetings there often occur long periods of silence and some sessions are distinctly unsuccessful; the discussions do not pass beyond the sphere of somatic symptoms of neurotic origin.

The second method is more active; the doctor endeavours to direct the discussion himself, usually by presenting some problem as a stimulus towards a discussion of a more general nature, when the patients in spite of themselves project their attitudes and their conflicts. The subjects suggested are quite varied, but always refer to problems of neurotic origin, such as, for instance, sexual life, difficulties in work, etc. Meetings carried on by the second method are in general more animated and have not the atmosphere of embarrassment which is felt at meetings when the discussion is not directed.

When we saw that the effects of our group psychotherapy were insignificant, we tried to break away from the standard patterns described in the literature and transfer the main emphasis on to the creation of a psychotherapeutic atmosphere among all the patients in a ward. We considered that meetings for group psychotherapy could not be separated from life in the ward, and that to concentrate solely on psychotherapeutic meetings without linking them up with life in the Clinic in general was to form an artificial group which was doomed to fail in advance, and so in our

further psychotherapeutic efforts we took group-therapy meetings to be a component part of the general life of the community in the Clinic, to which the weekly meetings and the social life developing around the club belonged.

Indeed the patients themselves treated the group psychotherapy meetings in this fashion, and often discussed everyday life in the wards or events in the club at them. At first we had a false idea that these were digressions from the subjects for debate and tried to avoid them, but then we found that we were wrong and that we were keeping to the pattern of the artificial group instead of following the trend of the communal life spontaneously developing in the ward. The patients themselves were interested in the fate of their fellow-patients and tried to help them by comforting them or holding themselves up as an example, showing how they had been in a still worse condition and yet were getting better, or encouraging new patients to take a more active part in the social life of the Clinic. In this way a psychotherapeutic atmosphere was slowly created in the wards. Patients who had been longer in the Clinic and felt better took care of those who had just been admitted. Almost all the patients as they were convalescing had, in a manner of speaking, one or more recently admitted patients under their care.

The patients themselves made up their psychotherapeutic groups, and as it turned out, their choice was on the whole better than if the doctors alone had selected the members. We let patients carry on group-psychotherapy meetings quite on their own, and it was often found that they did so in the same way as a physician would have done, and sometimes even better. What we wanted was to make a psychotherapeutist out of every patient, so to say. This cured the patients of their egocentric outlooks, since by taking care of others they thought less of themselves, and in addition a patient has more confidence in a fellow-patient in the same situation as himself than in a doctor who to him represents the world of healthy people.

A line of advance of this kind changes the social structure of a hospital; instead of a dual structure of a world of patients and a world of doctors, there arises a manifold structure in which a homogeneous group of patients breaks up into smaller groups, among which spring up frictions, rivalries and antagonisms thanks to which the former sharp division between patients and staff is effaced. At the same time an atmosphere of understanding and interest in the conflicts of others and mutual friendship is created amongst the patients.

In this way the gulf separating the doctors from the patients has been considerably lessened. Some of the doctors have attempted to take an active

part in the daily life of the patients, behaving as their equals in the club, in games, or free conversations in the wards. It should be pointed out that this "democratization" of communal hospital life requires great tact and flexibility on the part of the doctor, but in return it gives him the possibility of seeing his patients in a new light, different from that in which he sees them when speaking to them in his consulting-room.

SUMMARY

The authors have presented their own attempts to apply group psychotherapy to in-patients. Their experiences have led them to consider that group psychotherapy should not be separated from the general communal life of the ward, but on the contrary it should be linked up with this, so creating a psychotherapeutic community. The aim should be that each patient should, as it were, become a psychotherapeutist for his neighbour, having some understanding of his sufferings and trying to help him.

THE ESSENCE OF PSYCHODRAMA*

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I should like to speak of the universal applicability and the depth of psychodrama. I have known the method through the founder himself; and I have known it through many years of experience with all classes of mental patients; and perhaps most importantly, through experience with healthy, superior parents and children who have sought opportunities for resolving everyday stresses of family life. I should like to say: *Psychodrama is a way of life.* I would even go further and say that psychodrama dips down so basically into the essence of what man is that it is *without bounds* culturally. I say this not flamboyantly on a crest of enthusiasm from the remarks of previous speakers; I speak not only from use of the method with individuals from the gamut of sub-cultural groups of the United States, but also from ten years of experience in administration and research with 36 nationalities. The principles inherent in psychodrama have served equally for contacts with any of these national cultures.

Psychodrama need not be conceived as a highly specialized method used with a circular stage and an elaborate system of changing colored lights. To be sure some workers have found these materials to reinforce the power of the essential process. But from my experience I would say that they have used them successfully because they have first of all understood the basic psychodramatic processes which transcend such accessories.

If one recognizes "spontaneity" as the central principle of psychodrama, one finds external props falling into secondary importance. If the psychodramatist recognizes a common, creative power in man, a deep, primitive, elemental force, he becomes free to contact and release this energy wherever and whenever it can serve a situation.

Many daily questions can be answered rather easily on the basis of cumulative experience. Other questions are so complex and so fraught with new implications that only by sloughing off the usual ways of thinking and acting can a person or a group open up a new approach. It is in such unyielding and multidimensional situations that the availability and potency of psychodrama become especially significant.

Children's International Summer Villages, Inc. (CISV) begets complex

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types of questions, partly because its core program consists of bringing eight to twelve nationalities together, with all the uniqueness of their respective cultures, for close daily living in a single camp; and partly because its goals pertain to human relationships rather than to simpler behavioral processes such as the learning of a physical or artistic skill. An example is found in a situation met in 1951 in Cincinnati, Ohio, when 17 adults from nine countries gathered for a seminar in connection with the first camp of CISV. This corporation, conceived in 1946, was implemented in 1951: six eleven-year-old children (three boys and three girls) from each of nine nations were brought together for one month. Two adults accompanied each delegation. The purpose was to promote world peace by starting with children in their formative years, by giving them opportunity to make close friendships with people of many nationalities and to become aware of the possibilities of peaceful global living.

While the children followed a program of sports and games, swimming, arts and crafts, daily chores, rest periods, hikes, and free time, the adults met to discuss the significance of the camp in terms of its contribution to peace. Each adult, some weeks in advance of the opening of camp, had been given an opportunity to apply his creativity to the new experience he was anticipating. He had received a letter asking him how the adult discussions should be organized and what should be their content. This was part of the "warming-up," part of preparing for free discussion after arrival. To some this invitation to participate actively was a shock. "I thought you would tell us," wrote one adult from Sweden. "Now I have to think it over and tell you my own idea . . . ." For this first CISV camp two adults came from Austria, Denmark, England, France, Germany, Norway, Sweden, and the United States, and one from Mexico.

The first two adult meetings after camp opened were general discussions on what should be the purpose, content, and schedule of the Adult Institute, building on the answers each had given by mail. But by the third meeting, a question was thrown out which might open up a new depth of self: "What shall we make of these four weeks together? Shall we speak safely and politely of matters that are near the surface? Or shall we move boldly and honestly and speak from the deepest parts of ourselves? To speak deeply is painful, sometimes more for the person himself and sometimes more for those who hear. What shall we choose? How shall we from nine countries spend our time?"

Unanimously the members chose to use frank, free expression—though painful. The need for finding a new approach to peace was too great to

ignore. This group of adults who represented both the Axis and the Allies of World War II could not turn their backs on the challenge. No one knew better than each individual how difficult it would be to grow together into one group united in purpose. Several, within the first hours after arrival had confided to me his or her difficulties in relationships, for example, in accepting certain other members of the Adult Institute. One exclaimed: "*She* is the image of the matron of the concentration camp where I was held. I cannot sit near her!" And another, "You will have to excuse me that I ask questions. I am sorry but we have been taught to be suspicious." And another: "I should not have been sent. I should not have come. My husband died in prison as a conscientious objector. I still do not know how I shall be accepted by my people. I was surprised that they chose me as a delegate."

Here in the seminar were 17 adults filled with scars of World War II: England, Denmark, and France, exhausted by their sufferings and a little bewildered; Norway and Austria from concentration camps, face to face with Nazi Germany—because what school administrator in Germany survived who had not given at least lip service to the Party. The Swedes, face to face with citizens of Denmark and Norway who criticized them for their neutrality. The Germans, tight and strained and watching to learn how they would be accepted, asking shortly after the plane had landed and a friendly comedian had tossed bunches of different colored suckers into the air for the children to catch: "Did he throw us the dirty-colored ones because we are German?"—not perceiving that the dark ones were coveted chocolate. Obviously we could not proceed with an organization for world peace without unity and peace within the group. Such cohesiveness could not be achieved by ordinary means. And clearly, no circular stage or colored lights could be fetched. But the universal force by spontaneity was available. Knowing the internal conflicts of the individual members, as leader of the first sessions, I had to act on the spot in a way to cut through the barriers of resentment and hostility and doubt. I had to give opportunity for these adults to come into new relationships with one another.

Briefly, I said that we faced so important a task that we needed to find each other, what he was, beneath the scars of the war years. I pointed out that deep friendships could not flourish if we held back choked-up feelings about others in the group or about ourselves. I said that down at the core of the person was a human being so much like every other one in the room that we could work together. One way of loosening ourselves up and finding the inmost selves was, I said, to become receptive like babies, to lie on the floor and for a few minutes to "be a baby."

I knew that these adults could not bare their hurts without support: I therefore gave them the mother-figure "love" and "protection" of the "Crib Scene" exercise. This I had used successfully for years with mental patients who needed to "go back" and "start over"; and I had used it also with professors and college classes who had come to the hospital for seminar demonstrations and discussions. I had received from these college groups only favorable reactions regarding the inner peace that resulted. On this June morning, with this international group, with a Danish delegate improvising a repetitious lullabye with a three-note range on the piano as background, I gave the recitation of the "Crib Scene":

> "So the baby goes to sleep, warm and quiet. So the baby closes its eyes and goes to sleep. So the baby gets sleepy and goes to sleep. The mother comes and pats the baby, cares for it, and keeps it warm. The mother loves the baby, gives it milk, watches over it, and loves the baby . . . ."

As I spoke, I walked quietly from one to another as they lay on the rugs in the living room, dining room, hall, and music room. I touched each as I came around the close circle of rooms. Twice and three times I went through the recitation; and all the while the improvised piano lullabye was the connecting background. Relaxation progressed only gradually for one or two: how, for example, can you suddenly drop English tradition and you, the principal of an internationally known Royal Grammer School, become a baby? I gently, firmly helped him to get off his elbow and lie wholly flat on the rug. The professor from Vienna also needed help to lie flat. Several were near sleep by the end of the third recitation.

Then the waking up:

> "And now you begin to waken, you open your eyes, and sit up, you feel rested and comfortable and content. You get up. You are rested and ready to be an adult again. You are comfortable. You are wide awake and you are content. You are your adult selves again, but rested and content."

The recorder's notes state: "The entire group testified to the efficacy of the process."

The immediate result of this exercise was that during the month it was possible for every member to open up: basic interpersonal conflicts were aired—on both sides; and tears were shed—on both sides; and close friendships were formed. Looking at long-range results, one finds that most of these adults today, ten years later, are leaders in the National Associations

which they organized in their respective countries; are National Committee members or even National Presidents of their Associations; or members of the International Board of Directors. One is currently International President of CISV; and another is the International General Director. During these ten years since this first Institute, a slogan has been: "In CISV we should be able to speak just at we feel."

This is part of what I mean by, "Psychodrama is a way of life." It stipulated, by principle, that free expression should obtain in all discussions, that each person should loosen up and speak and act from his deep self and find peace with others at this depth. It further indicated, by principle, its applicability to healthy, superior adults. It pointed to role playing as a means of finding a common base where, out of reach of the distortions of war, close friendships could be started, and from which firmness of base, differences could be faced, understood, and accepted.

In this same first Village another special example of the ever-availability of psychodrama occurred in the children's camp. Although typically the children had no reservations in reaching out for friendships, it was necessary to bring three or four children with their respective deep-seated conflicts into sympathetic understanding and open the way for whole-hearted friendship *without barriers*.

A pillow fight started one night in the boys' dormitory after lights were out. An Austrian boy was especially aggressive, and what had started as a playful rough-housing progressed into some intent to attack. With the shadows of war still hanging over them, an Austrian boy and three Danes became especially antagonistic to each other. Twice the Danes drove the Austrian aggressor back to his bunk, but again he returned, more aroused than ever. One Dane, beside himself to know what to do to quell the Austrian's aggression, conceived the idea of retaliating verbally. The Dane called him the worst name he could think of. Instead of stopping the action, as calculated, it made the Austrian worse; he lost all control. An adult arrived and order was established for the night, but the Austrian fighter was poorly adjusted for two days. The staff asked the psychologist to find the cause since ordinary guidance had proved inadequate.

Again, as with the adults, I had to act immediately on the spot, within the camp setting. Arrangements were made with a young German-born psychologist of the research team, and an experienced psychodrama auxiliary, to join the three Danish boys, the Austrian aggressor, a counselor fluent in five languages, and me for a psychodramatic session. We walked down across the brook and up the woods path to a clearing on top of a small hill. Here in

quiet isolation was our "stage." I said that the pillow fight of two nights ago had become more than play, and that one, at least, had not seemed happy since, but that he could not say why, even though his good friends, the counselors, had talked with him. I explained that sometimes when we cannot talk we can act out what happened and we can understand ourselves better; that sometimes when we do not know why we are unhappy we can discover why by acting out an episode. So, I said, we could act out the pillow fight.

The translator put himself in the spirit of the act and translated sentence by sentence in a manner that made one quite unaware of translations after the first. Each boy started to take his own part, but in a moment the Austrian had run into the woods. I said *I* was Isaak, the Austrian. I removed my glasses and started action. We threw and dodged the imaginary pillows and giggled. With our laughter Isaak began to peek around one tree and then another, each one nearer than the first. As I "dropped" the "pillows" and went after the Danes with my fists (not actually hitting, but delivering blows in the air), Isaak joined the group—as if not to miss anything. And then I got more violent and rushed at the Danes. I arrested a blow in mid air, whirled toward Isaak, who now stood close to me as through he and I were one, and I cried indignantly, "And what did they do to me!" Without hesitation Isaak replied soberly: "'He's Hitler! He's Hitler!' They called me Hitler." He added, almost inaudibly as though the thought were too horrible to be heard: "Hitler killed my aunt; if *I* am Hitler, *I* killed my aunt!" We stood in a circle on the grass. The Danish-speaking counselor and the German-born psychologist translated. We discussed until the understanding of Isaak's torture had penetrated around the circle. The Dane who had used the unmentionable word (a son of a judge) explained that he had not known the meaning to Isaak, that he only had tried to think of the worst thing to call him in order to subdue him; that Isaak had become so violent the Danes were frightened; he had thought something had to be done. This now was Isaak's turn to understand. When the exchange seemed complete and tension seemed discharged, each adult male hoisted a boy onto his shoulders and galloped down through the woods. The supper bell was ringing.

In this example, action, not the quiet relaxation of the adults' "Crib Scene," had facilitated an opening up of closed conflict areas: the muscular involvement, even vicariously, of the actual "fight" had helped to dissipate internal barriers and to leave naked a common foundation for understanding and friendship. Without going into the multiple aspects of the psychodramatic

process, one can say that antagonists had opened up and shared their deep hurts; the obstacles to friendship had been removed. The psychodramatic method had again proved efficacious in releasing the spontaneous forces of the inner selves and permitting new inter-relationships.

In closing, I repeat: "Psychodrama is a way of life." It is always available to use in any situation, in any place, with any persons. It can be especially fruitful in situations made more difficult by differences of cultural values.

THE DEVELOPMENT AND PRESENT STATE OF PSYCHOTHERAPY IN CZECHOSLOVAKIA

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In the following, the designation "psychotherapy" covers an elaborate system of psychological treatment, not the mere occasional advice or incidental additions to other treatments as current in general medical practice. It is true that from this point of view psychotherapy has been used since time immemorial, throughout the ages; the conditions and development in Czechoslovakia are, thus considered, no different from those in any other country.

I am not considering psychotherapy in the strict acceptance of the term, attempts at directly influencing the diseased state as undertaken by physicians and laymen, nor as magic performances, e.g., exorcistic manipulation. The latter's scientific, psychological and medical foundations are primitive, and even though these methods continue to be applied in civilized countries, it is impossible to range them within the sphere of psychotherapy. In Czechoslovakia exorcistic manipulations are found to occur rarely, whereas magic incantations are common, for instance, in a number of Asiatic nations.

By psychotherapy I mean the psychological influencing of psychic or somatic processes on the basis of knowledge of the genesis and mechanism of the origin of such states and aimed at their remedy. No matter what the influence and effect of rational analysis (whose prototype is persuasion) or of rational instruction there is no disputing the fact that the prototype of psychotherapy is suggestion, direct or masked, strictly purposeful or accessory, simple or intensified by hypnotic intervention.

Suggestion therapy and hypnotherapy are the oldest methods of accessory and systematic psychotherapy known, and in this Czechoslovakia is no exception. It is hard to assess when hypnosis was first used with a distinct purpose and in the proper fashion, in this country. It is known that in the nineteenth and twentieth centuries cursory communications have recorded the existence of quacks whose therapy consisted primarily of the application of hypnosis.

The employment of systematic, theoretically founded and constructed psychotherapy is of a more recent date.

At the start of this century, suggestion and hypnosis were first elaborated

and practically employed by Dr. Simsa. In theory he remained an eclectic, in practice he focussed his attention largely on amorphous neurotic and the so-called hysteric states. An attempt at theoretic clarification of hypnotic phenomena was undertaken by Professor Forster, a psychologist of psychotechnical orientation; he, too, was an eclectic of the Bernheim and Forel type.

Suggestion and hypnotic therapy were first given a truly systematic and theoretic elaboration by Professor Stuchlik, the present writer. He undertook studies of a general orientation and casuistry, particularly of functional disorders (e.g., stuttering, other functional speech disorders, functional paralyses, sensorial disorders, blindness, deafness, amorphous or polymorphous general asthenic states, etc.) in keeping with Bleuler's concept to prove the justification and plausibility of the affective foundation of suggestion and hypnosis.

In spite of the fact that in recent years, hypnosis in Czechoslovakia has found its way into the university clinics of psychiatry and neurology—on the model of Russian psychiatry—it is not being dealt with systematically, nor have any works of fundamental significance been published. Although some informative synoptical publications have appeared in this field, they do not bring any new ideas, either in theory or practice.

Eclecticism in theory and practice are characteristic of the psychotherapeutic application of systematic suggestion and hypnosis. By and large they are at present merely existing. Perhaps this accounts for the fact that even Schultz's "autogenous training" which in neighboring Germany is rather widely used, has not achieved any foothold in Czechoslovakia at all and has failed to meet with even the slightest response in literature.

Besides the works on the casuistry of conversion hysteria and other functional disorders as mentioned above, I may refer to my scientific elaboration of the technique of hypnosis. I have proven the possibility of provoking deep hypnosis in a patient who spoke a language unfamiliar to me, through the mediation of an interpreter-physician, without any reduction of the therapeutic effect. Another paper dealt with the analysis of post-hypnotic states emphasizing particularly the therapeutic value of deep hypnotic states without any suggestion of "sleep," and without stressing the sensual isolation from environment.

On the basis of psychological analyses of tribal and national characteristics, I devised special techniques of hypnotic induction which accorded with the predominant "typical" properties of these groups. My latest study on this subject was presented at the International Congress of Psychotherapy

in Barcelona, 1958. (My first publication on the subject appeared in 1921 in "La Psychologie appliquee" in Paris.)

No systematic hypnotherapy is used in this country, and such schools or clinics as existed, for instance, in Paris or Nancy, have never been known here. It does not seem they will ever come into being.

Another large area of systematic psychotherapy is based upon concepts of depth psychology, primarily upon psychoanalysis and individual psychology.

Psychoanalysis was introduced into Czechoslovak medicine by myself some forty years ago. In 1917 my first publication on Freud's psychoanalysis was issued. Side by side with informative textbooks, always documented by casuistry of my own, I have published papers on the application of deep psychology of Freudian orientation to the explanation of social phenomena and during World War I, a psychoanalytically oriented study of mass vaccination.

Psychoanalysis, however, has never achieved a foothold in this country and has not become a psychotherapeutic domain as is the case, e.g., in the United States.

My students and assistants supported my work and studies and they have continued them in their own work, at the present time mostly abroad. In this connection I wish to remember Dr. Sandor Lorand, professor at the State University, Psychoanalytic Institute, New York, and his associate at the same Institute, Dr. Jan Frank, formerly of the Menninger Clinic, Topeka, Kansas. An analogous function is occupied in San Francisco by my former pupil, Dr. Emanuel Windholz. At the University of Zagreb, the late Professor Des. Julius, formerly my assistant, continued my work.

It was Dr. Boh. Dosuzkov who was active as therapist and scientist for a number of years. He edited a number of annuals of Pychoanalytic Volumes and shared in the translation of some of Freud's older books.

With a considerable tinge of ethical stamping, psychoanalysis has been promoted by a non-physician, a philosopher, Dr. Karel Haspel, author of a synoptic smaller work of this orientation. And under the denomination of "ethicotherapy" the method of superficial catharsis was applied by Dr. Ctibor Bezdek.

Adler's individual psychology failed to meet with a deeper response, despite the fact that Professor Otakar Janota and Professor Vladimir Vondracek, two clinical psychiatrists, were more inclined towards it than towards psychoanalysis.

Since the revolution in 1948, due firstly, to the negative standpoint of

the official marxist philosophy towards psychoanalysis, and secondly, to the putting across of pavlovian concepts of a massive physiological orientation, all systematic psychotherapy has been shifted into the background. Psychoanalytic works were banned from publication and their release in recent years has remained without practical effects.

The present-day development of the trends in psychiatry and general medicine allows of expressing the expectation that the near future may bring a wider and deeper application of all kinds of psychotherapeutic methods. Group therapy has come to be applied as well as hypnosis. They are, however, not of uniform theoretical foundation. They keep in line with pavlovian concepts as much as possible. Judging from the rarely published casuistries or more general communications, interviews are practically being conducted in the form of a superficial analysis with masked suggestions and persuasion.

The recent Czechoslovak Congress of Psychiatry (September 1959) opened a new area of international communication between East and West. Congress attendants from this country and abroad presented their reports related to individual and social therapy methods. Alcoholism, delinquency, the mass misuse of drugs on a smaller scale, were analysed and their therapy documented by way of casuistry. Special attention was paid to Dr. Moreno's lectures and demonstrations. They have become the starting point of the practical application of psychodrama and group therapy in the broader acceptation of the term in polyclinics and institutes throughout Czechoslovakia. Their systematic elaboration is under way, casuistry has been already published.

The combination of various forms of psychotherapy with work therapy has become the domain of institutional therapy with all forms of minor psychoses.

Fortunately, psychotherapy has become in recent years a very important component of institutional and out-patient treatment. The results of experiences hitherto have been made topics of discussions at scientific meetings and congresses and their elaboration in publications is forthcoming in the foreseeable future.

PSYCHODRAMA AND PSYCHOANALYSIS

Historical Note

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The comparison, or rather the contrast, between psychodrama and psychoanalysis under discussion in current issues of *Group Psychotherapy* brings to mind the question of their actual historical contact and the possible influence of one upon the other. Because of the extreme divergence of the two theories, it is sometimes difficult to remember that, while Moreno was born many years after Freud, they were both working on their theories contemporaneously in the same city for many years. They met on one occasion as Moreno reports.[1] We have ample evidence from Moreno's writings what place psychoanalysis had in the development of psychodramatic theory. In short, Moreno describes himself and Freud as "worlds apart." So far, however, we have had no direct evidence as to whether the founder of psychoanalysis felt as much at odds with the founder of psychodrama as was true in reverse.

Moreno recounts[2] " . . . . in the winter of 1923, when the opening of the *Stegreiftheater* produced quite a sensation in Vienna, Dr. Theodore Reik, at one time secretary of Dr. Freud, told me he would show Dr. Freud my book on this topic. I do not know whether he ever did, nor what Freud's recation was." To trace this further, the author wrote to Dr. Reik asking if he remembered the incident. His reply was that he did, in fact, show the book to Freud and that, while he no longer recalled Freud's exact reaction, he described it as probably negative.

Thus Freud evidently read enough of the book to form an opinion and, on the reliable word of Dr. Reik, reacted as we might have expected.

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1 Moreno, J. L. "Who Shall Survive—Preludes XXVII".

2 *Ibid.*

CHANGES IN ADJUSTMENT DURING A COURSE IN MENTAL HYGIENE

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It is common for students entering a college level course in Mental Hygiene to expect that attendance in the course will provide them with personal benefits in terms of their adjustment to themselves and the world around them. To the extent that this is a realistic motivation, the course in Mental Hygiene holds the promise of serving as an inexpensive "psychotherapeutic" experience.

However, unless empirical evidence can be developed which verifies this hope, prospective students for such a course should, in all honesty, be disabused of the idea.

PURPOSE, METHOD AND POPULATION

If exposure to a course in Mental Hygiene does indeed produce an improvement in the level of the student's adjustment, some evidence of the favorable change may be detectable psychometrically. Therefore, the Student Form of the Adjustment Inventory by Hugh M. Bell (1) was administered to a class of 37 students (29 females and 8 males) in Mental Hygiene at DePaul University.

The instrument was administered twice; once during the first lecture period of the quarter (pre-test), and once during the last lecture period (post-test). Students participated anonymously, each being identified on the Inventory answer sheets with a code number assigned by lot.

Between the two testing periods, in addition to hearing regularly scheduled lectures, students in the course were required to read completely the text, Mental Hygiene by D. B. Klein (3), and saw the following films:

Act Your Age—Coronet Instructional Films (W. W. Wright)
Emotional Health—McGraw-Hill
City of the Sick—Ohio Department of Public Welfare
Angry Boy—International Film Bureau: Mental Health Film Board (A. C. Rennie and E. Middlewood)
Feeling of Rejection—McGraw-Hill: National Film Board of Canada
Feeling of Hostility—McGraw-Hill: National Film Board of Canada
Feelings of Depression—McGraw-Hill: National Film Board of Canada

Psychiatry in Action—British Ministry of Information
Shades of Gray—United World Films (U.S. Army)
Unconscious Motivation—Seminar Films (L. F. Beck)

The form of the Inventory employed in the study yields four sub-scores, described in the manual as follows:

> "a. Home Adjustment. Individuals scoring high tend to be unsatisfactorily adjusted to their home surroundings. Low scores indicate satisfactory home adjustment.
>
> "b. Health Adjustment. High scores indicate unsatisfactory health adjustment; low scores, satisfactory adjustment.
>
> "c. Social Adjustment. Individuals scoring high tend to be submissive and retiring in their social contacts. Individuals with low scores are aggressive in social contacts.
>
> "d. *Emotional Adjustment.* Individuals with high scores tend to be unstable emotionally. Persons with low scores tend to be emotionally stable."

Raw scores were employed in processing the data statistically. A decrease in raw score on any of the four scales from pre-test to post-test served as operational evidence of improvement in adjustment; while an increase was interpreted as indicating a change in the direction of maladjustment.

Arithmetic mean differences between the pre-test and post-test scores on each of the four scales were tested for significance with the t-ratio as computed from the following formula (2):

$$t = \frac{M_d}{\sqrt{\frac{\text{Sum } x^2_d}{N(N-1)}}}$$

The formula takes full account of the fact that the two arithmetic means are correlated. In this case, with 36 degrees of freedom, a t-ratio of 2.72 is required for significance at the 1% level of confidence, while a t-ratio of 2.03 indicates significance at the 5% level. (2)

Results

A description of the experimental sample in terms of age, sex and Adjustment Inventory raw scores is presented as Table I. The arithmetic mean and standard deviation for each variable except sex is entered at the foot of the table.

Table II compares the arithmetic mean pre-test and post-test performance of the sample on each of the Adjustment Inventory scales, and shows

TABLE I

ADJUSTMENT INVENTORY RAW SCORES, AGE AND SEX FOR 37 STUDENTS IN MENTAL HYGIENE

			Adjustment Inventory Scores							
			Home Adjustment		Health Adjustment		Social Adjustment		Emotional Adjustment	
Case	Age	Sex	Pre	Post	Pre	Post	Pre	Post	Pre	Post
1	37	F	7	12	6	12	26	27	18	11
2	24	F	5	17	2	5	3	7	2	6
3	20	F	4	6	5	1	25	20	20	20
4	—	F	7	4	6	6	5	3	11	8
5	23	F	3	4	7	9	14	19	10	11
6	30	F	5	4	6	5	17	14	5	8
7	35	F	18	29	8	6	8	10	2	4
8	20	F	6	6	6	6	15	11	17	14
9	23	F	15	15	15	8	11	5	19	13
10	24	F	13	14	11	9	23	19	18	13
11	19	F	10	14	11	11	4	7	20	18
12	25	F	18	18	17	12	14	18	23	21
13	33	F	8	7	9	9	19	15	14	13
14	24	F	11	19	7	5	5	13	4	9
15	20	M	7	11	3	4	6	3	7	7
16	25	F	1	1	6	5	7	6	7	8
17	21	F	21	17	8	9	8	8	14	10
18	39	F	13	16	9	7	23	21	5	6
19	23	M	0	0	2	0	2	5	5	1
20	22	M	18	20	8	8	1	2	5	8
21	19	M	4	2	5	4	14	9	2	2
22	43	F	1	3	12	9	30	31	15	17
23	30	F	1	1	2	3	8	10	8	3

TABLE 1 (*Continued*)

Case	Age	Sex	Adjustment Inventory Scores: Home Adjustment Pre	Home Adjustment Post	Health Adjustment Pre	Health Adjustment Post	Social Adjustment Pre	Social Adjustment Post	Emotional Adjustment Pre	Emotional Adjustment Post
24	30	F	2	2	11	6	7	9	1	3
25	22	F	6	6	5	6	20	23	14	17
26	40	F	2	1	6	3	5	2	2	2
27	20	M	2	5	12	7	5	9	11	13
28	37	F	19	24	12	13	22	24	16	18
29	25	M	10	7	10	11	18	11	7	2
30	37	F	5	4	15	11	19	18	10	9
31	33	F	5	2	4	2	15	15	4	7
32	27	F	23	22	4	5	16	18	14	14
33	22	F	8	8	3	3	10	8	12	9
34	36	M	1	3	11	10	24	21	11	11
35	29	F	12	17	8	12	2	1	9	8
36	21	F	6	4	6	8	6	7	11	11
37	20	M	2	16	6	12	11	14	12	9
Mean	27.2*	—	8.1	9.8	7.7	7.1	12.6	12.5	10.4	9.8
S.D.	6.9*	—	6.3	7.6	3.7	3.4	7.8	7.5	5.9	5.2

* Based on 36 cases. The age for case 4 was not given.

that mean post-test score was significantly higher (more maladjusted) for the Home Adjustment scale than it was when the Inventory was administered at the start of the course. Although mean scores on the remaining three scales were lower at the conclusion of the course, none of these differences were statistically significant.

TABLE II

MEAN ADJUSTMENT INVENTORY SCORES OF 37 STUDENTS OBTAINED *BEFORE AND AFTER A COURSE IN MENTAL HYGIENE*

	Arithmetic Mean Score	t-Ratio
Pre-test Home Adjustment	8.1	2.46*
Post-test Home Adjustment	9.8	
Pre-test Health Adjustment	7.7	1.24
Post-test Health Adjustment	7.1	
Pre-test Social Adjustment	12.6	0.25
Post-test Social Adjustment	12.5	
Pre-test Emotional Adjustment	10.4	1.15
Post-test Emotional Adjustment	9.8	

* Significant at between the 5% and 1% levels of confidence.

SUMMARY AND CONCLUSIONS

No statistically significant improvement in adjustment (as indicated by scores on the Adjustment Inventory) was observed in a group of 37 students who had completed a course in Mental Hygiene.

The only significant change observed was an increment in mean raw score on the Home Adjustment scale, suggesting that this group of students became significantly more *maladjusted* in the home situation as a function of exposure to the course. The reasons for such a change are not immediately apparent; although, it may be speculated that the inept application of the superficial knowledge gained by these students acts to irritate relatives and others at home and therapy tends to exacerbate relationships.

At any rate, it would appear from these data that the outlook for immediate improvement in adjustment as the result of taking a course in Mental Hygiene is rather bleak.

REFERENCES

1. BELL, H. M. Manual for the Adjustment Inventory, Student Form. Stanford University Press, Stanford, California.
2. GUILFORD, J. P. Fundamental Statistics. New York: McGraw-Hill, 1956, 220.
3. KLEIN, D. B. Mental Hygiene. New York: Henry Holt, 1956.

A NOTE ON DANCE THERAPY*

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In the act of dancing, patients can transcend communication barriers of certain kinds. Psychotics are very unsure about their body and the identity of their body parts. Without elaborate steps, by using simple rhythms, and frequently, by beginning body dance movements as individuals, patients can begin to share rhythms with others. This helps create a context for group participation. As a result, the satisfaction becomes a shared experience, a recognition of commonality of response with another.

The use of a circle appears helpful in initiating dance therapy. Primitive man danced in circles, and the patients seem to show a tendency toward re-grouping in this simple structural form. In this circle, the therapist attempts to discover in what added forms the patients prefer to work —waiting for spontaneous rhythms and patterns, as well as introducing previously planned designs. From the experience of this therapist, the waltzes are the most productive in terms of music background.

There is a great deal of movement variation from patient to patient. Some mental patients have discarded the social mores, and are substantially uninhibited; others are very shy about dance. The schizophrenic patient frequently manifests dance movements from the wrists or ankles on out.

Dance furnishes a means of relating to the patient's illness-produced difficulty in communicating. This fact, among others, has led to the acceptance of dance therapy in the integrated rehabilitation programs of many hospitals.

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* Presented at the monthly meeting of the District of Columbia Chapter of the American Society of Group Psychotherapy and Psychodrama, February 26, 1957, Howard University School of Social Work, followed by a demonstration of techniques.

A CLERGYMAN'S FIRST PSYCHODRAMATIC EXPERIENCE

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Ministers deal in values, and the most common form of expression for these values is verbal. The congregation is exhorted to practice what is preached, and they are offered some opportunities to perform good deeds. But constant vigilance is necessary lest we slip back into being hearers of the word and not doers.

Religion should be dramatic and activistic. Theology may be thought of as a dramatization of philosophy.

With some such thinking in the background, this minister was intrigued by psychodrama. Here were people who did not talk in platitudes about loving one another, but acted out the frustrations and resentments that keep people from loving one another. Thus the way is cleared for the ideal to become real.

It was a shock, that first day. Whereas one can read case histories with interest and feel no strain, in psychodrama one is thrust into the midst of a problem, feeling strongly with the protagonist, who may bring out violent feelings which he had been repressing. Each participant in psychodrama uses up large amounts of emotional energy. A person can become accustomed to this; but on the first day, several hours of this activity can lead to exhaustion.

On this particular first day, there were two protagonists: one a patient in the sanitorium, the other a normal person highly trained in psychology. It just happened that way, and yet there is symbolized the fact that this technique has value for the treatment of mental illness and also for helping normal people to function more efficiently and happily. My early impression is that its batting average might be even better with normal people (assuming that it is normal for people to have emotional problems) than with people who are really sick.

There has been a recent tendency for theological training to include psychology and counseling skills. For a minister to use psychodrama in the church would require some additional training, of course, but it seems a logical development. While people might hesitate to work out their problems in a group that included the boss's wife and other members of one's bridge club, this may not be a real obstacle in a large church. Some psychodramatic techniques can be used without an audience. It should be possible

for a youth group or an adult study group to act out hypothetical problems that may be relevant to several persons in the group, if not all. Possibilities in the use of sociodrama are also very interesting.

One observation that cries out for expression is this—that large amounts of brotherly love and good will seem to be concomitants of psychodrama, and from a clergyman's point of view, this is very gratifying.

ACCEPTANCE OF ROLE AND RESULTANT INTERACTION IN THE GROUP PSYCHOTHERAPY OF SCHIZOPHRENIA

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In every exchange between humans, there develop dimensions to that relationship which are shaped by, and at the same time determine, the definition and function of each individual within the situation. The end result of such an exchange depends, in great part, upon how nearly there is a common assessment of the situation by all its participants and a consensus among them regarding the behavioral demands that are thereby made upon each individual. Usually such demands separate themselves so that a number of discrete behavioral patterns develop. A single such pattern indicates the demands made on one individual, or upon a sub-group of individuals who are regarded as having similar purposes within the situation. There is a complementarity between the several behavior patterns which determines the outcome of the total interaction.

The appropriate behavioral pattern of an individual is designated as his *role*.[1] His adherence to this behavioral definition and the fashion in which he meets its demands in the course of his contacts with other people within that situation determine his acceptance of that role. There is, then, a consistency between role prescription and role acceptance that must be observed by the participants in a situation in order that the declared common ends of the group can be met. This paper will undertake an evaluation of this phenomenon as it occurs within a situation whose declared end is the group psychotherapy of hospitalized schizophrenics.

Within a therapeutic situation, role differentiation is based initially upon the distinction between the treated and those treating them, i.e., between patients and staff. Within the specific situation of group psychotherapy of schizophrenics, one essential, active role may be defined as that of the leader or therapist. The other roles which are essentially active may be specified to be those occupied by the objects of therapy, the patients. If there are other treatment personnel within the situation, their roles can be designated as passive participants.

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[1] Linton, R., "Status and Role," in Stein, H.D. and Cloward, R.A. (Eds.) *Social Perspectives on Behavior,* Glencoe: The Free Press, 1958, pp. 175-176.

If a patient attempts to remain passive in a treatment situation given such definitions, this does not give him acceptance as one of the group not in need of therapy. Rather he is regarded as isolated from the meaning of the treatment situation by reason of his rejection of his appropriate role as patient. If a staff person abandons his role as passive participant, and enters actively into the deliberations of the situation, as if seeking therapeutic assistance, he is not regarded as one appropriately seeking therapy, rather he is viewed as failing to fulfill his major role as a therapeutic agent. He will be expected to make correction of his performance in the direction of a greater effectiveness, or he will be removed from the therapeutic situation. (See Chart 1)

CHART 1

DISTINCTNESS OF ROLES IN GROUP PSYCHOTHERAPY FOR PATIENT MEMBERS AND STAFF MEMBERS (OTHER THAN THERAPIST)

	Participation in Group Psychotherapy	
	Active	Passive
Patient Members	Appropriate role—leads to improved functioning	Inappropriate role — retains pathological patterns
Staff Members (other than Therapist)	Inappropriate role—obscures the total treatment situation —decreases effectiveness of staff	Appropriate role—lends support to patients in their treatment efforts

Within any group situation, there develop distinctive roles for its participants. It is by this means that a functional definition of each group member is made, so that the exchange of communication proceeds with some order. It is when the economy of such order is badly taxed by the refusal of individuals to assume or maintain a role complementary to others that disturbance can arise.[2] It is suggested that the complementarity of roles is not, in itself, sufficient to insure the healthy productivity of a group. Rather, such complementarity could serve to confirm the aberrations of a pathologically oriented group and to perpetuate them.

An example of this latter state would be a group of psychotic patients on the "back ward" of a psychiatric hospital, where they received only custodial care. Here each patient is much inclined to allow each other to indulge his own private fantasy. No opposition would be raised unless there was presented some real immediate threat, such as that of physical violence. In this fashion, the maintenance of aberration is achieved by a group con-

[2] Ruesch, Jurgen, *Disturbed Communication*, New York: Norton, 1957, p. 144.

sensus in regard to the activity of the individual. In this situation, the functions of the group are primarily those of maintaining the group in its aberrant state. The other type of major group function, that of the achievement of a group goal, is not so immediately discerned.[3] The group goal then would appear to be the concerted attempt to avoid the adopting of any goal which would require any investment of energy toward change.

Quite in contrast to such a group is the psychotherapy group. The maintenance of a stable equilibrium is not an object of such a group.[4] It is the altering of the stable change-resistant equilibrium of the individual which is the object of therapy with the psychotic individual. The efforts are attempted so that the individual will dispose his energies differently and in a fashion that will bring about some more productive results than the mere maintenance of a psychotic isolation.

To a considerable extent, the favorable response of an individual to psychotherapy manifests itself through the taking on of new interests and the making of new investments, in contrast to the concentration of effort upon maintaining the earlier isolated orientation that is defined as the illness. There is, then, an element of self commitment which distinguishes the schizophrenic individual in group therapy who is to be successful in freeing himself from the toils of his illness.

The most obvious distinction between the schizophrenic patient who "gets well" in group psychotherapy and the one who does not is that the improved patient leaves the therapy situation enabled to order his life and activities free from the demands that his illness had earlier made upon him. This individual goes from the treatment situation to one which is within the range of normal human experience, wherein he participates in the ordinary affairs of living, in contact and transaction with a variety of other people.

In contrast, the individual, who in treatment had resisted any engagement in the therapy process, struggled to maintain his own peculiar notions of the world about him, and more especially his ideas about his own omnipotence. Because of his refusal to enter into any reciprocating relationship, wherein his voice would not be the sole one, or even the major one, in defining his reality, he remained untouched, unchanged by the total therapeutic process.

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[3] Cartwright, D., and Zander, A., *Group Dynamics,* Evanston: Row, Peterson and Co., 1953, pp. 541-543.

[4] Talland, George A., "Task and Interaction Process: Some Characteristics of Therapeutic Group Discussion," in Hare, A.P., Borgatta, E.F., and Bales, R.F. (Editors) *Small Groups,* New York: A. Knopf, 1955, p. 462.

Thus, within the group psychotherapy situation, there are two contrasting attitudes that the patient can take toward the therapy endeavor. He can declare the situation as one relevant to himself and behave within the situation as a committed participant, who has a personal stake in the outcome of this cooperative venture which involves him with his therapist and his fellow patients. The individual cannot know, at the outset, the full range of what will be expected of him in the course of this therapy. He knows only that he is desirous of exchanging his current modes of behavior and affect for the means of more satisfying relationships with others. He knows that he has some confidence that these goals can be approached through his involvement in the group psychotherapy process.

The second attitude is in direct opposition to the first. This latter position is that held by the schizophrenic patient who remains unmotivated for change and is wary of those who may seem to suggest its need. Hospitalized, he finds himself surrounded by such people whose very presence argues that he is, indeed, aberrant and in need of help in order to change. Presented with such a sizeable opponent, the adamant schizophrenic redoubles his efforts to maintain his defenses. These defenses consist of his own distorted views of himself and the world. Since distortion is a major quality to these defenses, they are strengthened through an elaboration of their distortions. The reaction of the resistant schizophrenic is to move even farther from any meaningful, warm, human contact.

Setting of the Study

A study of these two distinctive responses to therapy by schizophrenic patients was made to assay the extent to which these responses could be viewed as prognostic signs. This study was conducted at an Army hospital where a milieu therapy ward had been established for the treatment of schizophrenics.[5] This therapeutic approach stressed the role as therapeutic agent of each staff member.[6] The major direction of these therapeutic endeavors was for the staff person to take a strong and unyielding stand for reality and to encourage the patient that he would be helped to make corrections of his own perceptions and behavior in the direction of this commonly defined reality.

[5] A detailed description of this setting is to be found in Artiss, K.L., (Ed.) *The Symptom as Communication in Schizophrenia,* New York: Grune and Stratton, 1959, pp. 172-228.

[6] Schwartz, M., "What is a Therapeutic Milieu?" in Greenblatt, M., Levinson, D.J., and Williams, R.H. (Eds.) *The Patient and the Mental Hospital,* Glencoe: The Free Press, 1957, pp. 130-144.

The subjects of this study had all been on active military duty at the time of their hospitalization. All were enlisted soldiers of some experience, their lengths-of-service ranged from one to eleven years. To each, the current hospitalization was the initial hospitalization for psychiatric reasons. For each, his illness had been regarded as of sufficient severity to have caused him to be evacuated to a major treatment center. In his behavior immediately prior to hospitalization, each patient demonstrated the deviation from reality-functioning typical of the schizophrenic.

> Arnold had behaved from the time he had been placed in his last duty assignment so as to accentuate his differences from the other members of his unit. The military experience of the others differed from his own in that only he had had extensive service in Korea. When others made slighting remarks about the Orient, he felt that these had a personal reference because of his wife's Korean origin. He participated decreasingly in the solidarity-maintaining activities of his work group, such as eating together, spending leisure time together. His isolation from his fellows was deepened by his growing suspicions about their poor regard for him. His hospitalization was effected after he had begun to make direct accusations of those officers and men whom he regarded as among his tormentors.

The segment of activity on the milieu therapy ward selected for study was the group psychotherapy meeting. This meeting occurred daily throughout the week. It was the group activity that was most frankly labeled therapeutic, in that therapeutic group discussion was the central activity of this meeting. All patients were also seen individually by the psychiatrist as well as becoming engaged therapeutically by other members of the treatment staff in the course of their daily activities. However, it was in the group psychotherapy meeting that the patient had most openly to indicate his personal stand in response to the therapeutic endeavor.

Present at the group psychotherapy meeting were the patients, the psychiatrist and all treatment staff on duty at that time, i.e., the nurse and the neuropsychiatric technicians.[7] The psychiatrist was in charge of these meetings and acted as leader. The other staff members, by design, were minimally

[7] The neuropsychiatric technician is the subprofessionally trained nursing assistant who, in civilian settings, is variously called aide, attendent, etc. Cf. Technical Manual 8-243, "The Neuropsychiatric Technician," Departments of the Army and Air Force, July 1955; Belknap, I., *Human Problems of a State Mental Hospital,* New York: McGraw-Hill, 1956, pp. 145-163; Stanton, A.H., and Schwartz, M.S., *The Mental Hospital,* New York: Basic Books, 1954, pp. 63, 106-107, 163-166.

active in the discussions. This situation then provided for the patient maximum opportunity for participation, and made all those present available as objects for his communications.

Procedures

Data on the group processes of psychotherapy were gathered through direct observation. This method of data gathering was selected since it was regarded as most appropriate to the situation in which there was to be a prolonged series of observations. Any more concealed method of observation would have been contrary to the general atmosphere in which other research endeavors were conducted with these subjects. In addition, it was considered that the paranoid orientation of the majority of subjects would have probably alerted them to the presence of any such concealed techniques, but their poor ability at reality testing would have prevented any adequate explanation of such activity. Selection of the method of participant observation was not made for the reason that the problem-solving processes of group psychotherapy could have required an extent of participant activity that would have impinged considerably upon the demands of the observational procedures.

Others, including Caudill and Stranton and Schwartz,[8] have noted the facilitating effect of a functional role in addition to the observational one. The observer can be tolerated, or even accepted, more fully by those in the field of observation if there is some "useful" role that he occupies. In the present experience, both observers had a previously established role by which the participants knew them. The senior observer was established as the advisor to the patient government. The junior observer[9] was the ward secretary. Both these roles were functional ones, but were extra-participant in that neither assumed a therapeutic posture toward the patients in the execution of these roles. By contrast with a therapeutic posture, wherein the aberrant behavior or mentation of the patient served as a focal point for the exchange between the staff person and the patient, with a correction toward reality as the goal, the response of the observers was a more permissive and non-committal one.

The group psychotherapy meetings were conducted on the ward. A

[8] Caudill, W., *The Psychiatric Hospital as a Small Society*, Cambridge: Harvard Press, 1957, pp. 21-25; Stanton and Schwartz, *Op. Cit.*, pp. 426-437.

[9] Mrs. Eve F. Dickman, Psychological Aide, Therapeutic Methods Analysis Section, Department of Psychiatry, Division of Neuropsychiatry, Walter Reed Army Institute of Research.

sunroom, otherwise used for pingpong and reading, was converted to a meeting room by linen laid over the table and chairs drawn around the table. Customarily, coffee was served at the beginning of the hour. The observers were located within the conference room, seated in a corner away from the main table.[10]

Methods of Data Collection

One method by which the observations of group psychotherapy were recorded was the interaction process analysis system devised by Bales.[11] By this system, all observed interaction is categorized as to its qualitative contribution to either the problem-solving or solidarity-achieving activities of a group. Interaction is also described as to its originator and objective. These three dimensions of interaction determine the data that are collected by this means.

In addition to the collection of the interaction data described above, a record was kept of the topical content of the meetings. This latter record accumulated not only an account of the subjects that were discussed, but also served as a journal of the impressions of the observers that did not totally describe themselves within the interaction process analysis system. Account was kept of certain qualitative aspects of the tenor of the meetings, for example, the non-verbal response of the group to a presentation by the therapist which might range frm apathy to one of generalized interest and concern. This sort of concerted response, or "feeling tone" cannot be adequately accounted for by interaction process analysis.

Another type of data collected was a descriptive account of the presession behavior of the subjects at each meeting. The behavior during this unstructured period was immediately discerned to be distinct from that which occurred during the more formal phase of the meeting proper. A generalized process account was kept of these data. The use of seating space within the group psychotherapy situation was recorded also. Since the choice of seating was a free one, it was regarded that the subjects might express some social choice in the manner in which they disposed themselves within these situations.

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[10] The presence and purpose of the observers were explained by the therapist at the outset of this therapeutic experience. Thereafter, little attention was given to the observers by the participants. Cf. Heyns, R.W. and Zander, A.F., "Observations of Group Behavior," in Festinger, L., and Katz, D., (Eds.) *Research Methods in the Behavioral Sciences,* New York: Dryden Press, 1953, pp. 381-417.

[11] Bales, R.F., *Interaction Process Analysis,* Cambridge: Addison-Wesley, 1950.

Findings

The group psychotherapy meetings were observed for a series of 98 meetings extending over a six month period. The time interval selected was the same as the maximum period of hospitalization allowed for the patients on this ward. It was considered that such a period would provide for the observation of the total course of hospitalization of a maximum number of patients. At the beginning of this period, there were six patients on the ward. During the period five more patients were added.

By the end of the period of observation, only one patient of the original six remained on the ward. Two had been returned to duty after successful completion of their course of therapy. One who had made a positive engagement in therapy went on Christmas leave and was influenced by his mother to go AWOL. The other two had failed to make adequate response to milieu therapy and were transferred to wards offering more traditional therapies, including the somatic and chemical therapies. Of the total eleven patients, the final disposition of them was that six of the group were returned to duty; the remaining five received continued hospital care in other military psychiatric facilities.

Within the group psychotherapy situation, there were clearly two subgroups which existed with mutual exclusiveness. One group was the staff who were the originators of therapy. Their presence was justified by their role as agents of therapy. They were distinguished also that they were not overtly seeking treatment, nor were they expected to be doing so. The other distinct group was the patient group. The primary reason for its members being present was that they were regarded by the staff and, in extension, by society, as being in need of treatment. The patients then qualified on the basis of the poor quality of their health. Should a patient object to his being categorized as a patient and in need of treatment, he could in consequence reject the role of patient as it required his active participation, and thereby foil the endeavors of the staff. He could not, however, avoid being identified as a member of the patient group. What option he did have consisted in his being able to distinguish himself as a non-engaged member of the patient group. This position was implemented through his failure to make the expected response in the treatment situation, and through his retention of the pathological modes of behavior that had described his condition of ill health.

> Dempsey disclosed very early in his experience in group psychotherapy that he "saw through" the total plan of deception that was being worked against him. He "knew" that all the other

"patients" were, in his reality, members of the staff disguised as patients. He "knew" that he was the only "real" patient on the ward. Once he had stated his position, he never deviated from it in the course of his hospitalization. He responded to the staff in a fashion that was superficially congenial, but he never yielded his orientation that all were his antagonists.

As the time of admission to the ward, none of the patients was distinguished by his response to therapy. Without exception, all patients indicated a lack of desire to associate with the therapeutic staff in the purpose of achieving some change within their personal life. Rather, the individual patients showed that they recognized that there was a kinship among their own kind, and that they felt a preference for association with and orientation to this group. Clearly, the differentiation that occurred among the patients in their attitude toward therapy was developed *after* they had had personal experience within the therapeutic situation.

Within a relatively short time, well within the first month of therapeutic experience, each patient had selected the subgroup with which he chose to be identified, either the subgroup favorably disposed toward therapeutic engagement, or the one opposed to this. Once he had thus committed himself, there was no likelihood that he would change his affiliation. Perhaps the most predictable outcome from this was the ultimate result of his experience as a psychiatric patient. Without exception, the patient who refused or failed to engage himself in the therapeutic process left this experience with much of the same pathology that he possessed when he entered. His clinical picture was changed only in its extremes. His ability to order his own life satisfactorily was no greater, often it was necessary that he go to another hospital or other arrangement wherein such matters are handled for him by others.

On the other hand, the patient who engaged himself fully in the therapeutic venture gained considerably in his ability to order his own life in a fashion that had only the limits that are those normally encompassing the lives of all people. No longer were the energies and creativity of the individual bound by the demands of his illness. He went to a life in which he *knew* himself to be a peer to others. He had come to know that there could be a satisfying return to himself from a relationship which was shaped by all its participants. This was in contrast to his earlier orientation in which the nature of every relationship had to be foreordained through his self-assumed omnipotence.

Caudill had noted in his study of staff group interaction in a psychiatric hospital that there was a distinctly different performance in staff meetings

among the several professional groups.[12] For example, while there was a wide range in the extent of verbal participation in these conferences by the physicians, even the most reticent physician spoke more extensively than did the chief nurse, who was the most active participant for her reference group. Throughout the data the discreteness of performance of the groups of physicians, nurses, and other personnel presented itself consistently. The extent to which any individual felt free to talk within this group situation was greatly determined by his professional status, even to the extent of showing his rank within the group and his acceptance of, or at least compliance with the general *modus operandi* of the overall group. Caudill found that from within the varied operations of the members who made up the group there emerged the whole of the problem solving effectiveness of the group and its administrative endeavors with which it concerned itself.

Caudill elaborated his findings from this experience through the use of Interaction Process Analysis. As a result he found that not only did the physician group participate more extensively within these meetings, but additionally, that there was a clear cut separation in participation between those physicians who were senior staff members and those who were in a training status. Even among the resident physicians, it was found that their rank as to participation within these meetings was quite consistent with the fashion in which their effectiveness within their profession was regarded by their superiors. It was noted that such ordering of behaviors within this situation occurred without an overt reference to its presence and without any deliberate endeavors to maintain or enforce this order.

Through a similar approach to the group presently under study, the schizophrenic patient group in psychotherapy, there was found to be a similar discreteness as to the performance within this situation. Through ranking of the patients from data gathered by interaction process analysis, it was found that the behavior of the patients who made a positive commitment to the psychotherapeutic endeavor was distinct from that of the patients who refused to become thus engaged.

When the participants in group psychotherapy were rated according to their productiveness in the treatment situation, i.e., by the number of "acts" originated, it was found that there were four distinct segments to the group's composition (see Table 1). At the extreme of greatest activity was the therapist. In all except the first and last months of observation, his productivity exceeded that of any other participant. In those two months,

[12] Caudill, William, *Op. Cit.*, Chapter 10, "Status and Role in Group Interaction," pp. 231-265.

the therapist's productions were exceeded by a single patient. In each instance the patient whose productions outnumbered those of the therapist was very active in overcoming his resistance to therapy and in moving toward the resolution of his difficulties. Each of these patients was a member of the second segment of participants. This segment consisted of those patients

TABLE 1
STRATIFICATION OF PARTICIPANTS IN GROUP PSYCHOTHERAPY

	ACTOR	MEAN RANK[1]
A Leader	Therapist	1.33
B Engaged Patients	A———	1.50
	B———	2.50
	C———	3.60
	D———	4.00
	E———	4.00
	F———	4.00
C Disengaged Patients	G———	4.50
	H———	6.50
	I———	6.50
	J———	7.00
	K———	9.00
Treatment Staff	Nursing Staff	8.66

[1] These figures are derived from the rank orders of actors throughout the period of observation.

who made a positive engagement in the therapeutic endeavor. They were more apt both in responding to the acts of others, and in the initiating of acts themselves. Their productions concentrated upon the solution of problems. The patients in this group were those who effected a sufficient resolution of their difficulties that they were able to return to duty.

At 0901 hours, the therapist entered. Almost immediately Holden began to speak regarding habits and how these get involved in one's difficulties. He then elaborated to the therapist a situation which had occurred that morning. Holden indicated that he felt that he had been rudely awakened by one of the technicians. He found himself regarding the technician as acting arrogantly. He indicated that rather than talking this over he had experienced anger. In further elaboration of this Holden suggested that perhaps rather than the rudeness of the other individual the more crucial aspect was his own sensitivity. The therapist responded to this to suggest to Holden that this was indeed a source of difficulty to Ireland, that Ireland was particularly sensitive whenever he met opposition.

The therapist spoke with Holden to elaborate further how Ireland is learning to control his reactions to this sensitive area. Ireland entered this conversation to elaborate further.

Ireland then switched to a concern as to why his lawyer had represented him so well in court. In attempting to elaborate this, Ireland began to guess with the therapist what could have happened. He met with disagreement from the therapist when he suggested ethics. When Ireland suggested the reason the lawyer had helped him out was because he was sick, the therapist immediately agreed with him. Ireland was able to accept that he had indeed been very sick at that time. He evoked some humor from the group by speaking of how persistently he had beaten a path to the lawyer's office.

Following this the therapist again spoke to the entire group. He said that he was a member of the group and that he planned to speak his mind clearly. One of the matters of great concern to him was the use of dishonesty by the patients in their dealings with the doctor and with the doctor's staff. Going to the blackboard, the therapist indicated that what he was talking about was dishonesty which occurred in a fashion which was clear, conscious, and deliberate. In turn he illustrated the forms that dishonesty could take: lies, evasions, trickery and deceit. He elaborated out that these were the means used by patients. He then gave a strong suggestion to the group that to deal with the doctor in such a dishonest fashion was as crazy as it is possible to get.

The first patient to respond to this was Holden, who contested what the therapist had presented with the suggestion that there were cases in which the staff itself could not deal too honestly with the patients. In response to this the therapist indicated to Holden that this may well be his last opportunity to receive psychotherapy and that he should take full advantage of it. Holden continued to elaborate regarding the technicians and the inability to get technicians to deal honestly with them.

Ireland entered this conversation to suggest that the activity of the technicians might well have been due to their not having felt well, to their having had headaches. In response the therapist agreed that the staff did have headaches. Directing his attention to Evans, the therapist indicated that the number one headache there was Evans himself. In further elaboration the therapist supported his staff totally and indicated that as a group he felt that they were unequaled for the low incidence of clear, conscious and deliberate dishonesty.

At that point, Ireland attempted to appropriate the group's attention to speak regarding the dishonesty of his former wife. He was stopped in this by the therapist, who redirected the attention of the group to the present situation. In setting the stage the

therapist indicated that it was here that there was opportunity for the group to deal with these matters.

The therapist told the group that it was through acting in the opposite of such dishonesty that they would be able to get well. In turn, the therapist evaluated the honesty of each member. First he indicated that Ireland had been able to confront himself honestly and because of this he was giving some indication of improved health. In speaking of Holden, the therapist said that Holden was so honest that he would be able to get well even in the face of efforts of others to prevent his doing so. The therapist said that from what little he had spoken with Jackson he was sufficiently convinced of Jackson's honesty to be able to predict his ultimate recovery. Turning then to Arnold the therapist indicated that he had not been honest with the group, that there were times the staff doubted that he was honest with them even as much as once a day. In response to this Arnold agreed immediately. The therapist then suggested that if it were Arnold's purpose to get rid of his wife through his hospitalization he should say so in front of the group. This met with immediate denial from Arnold. The therapist then told Krueger that he was uncertain regarding his honesty since he did not know him sufficiently well. Turning then to Evans, the therapist spoke very strongly regarding the dishonesty that Evans had undertaken. He indicated that this included his numerous attempts at suicide, his taking on of the symptomatology of other patients, his refusal to respond to treatment efforts.

The therapist then issued the ultimatum to Evans that he had made time available to him that afternoon which would be his opportunity to be completely honest with the therapist. Turning again to Arnold, the therapist spoke of Arnold's knowing what would happen to him. Immediately Arnold replied with some antagonism, "state hospital." The therapist then suggested that if Arnold were to go to a state hospital he should know that there are only two types of treatment available to him. One was electric shock treatment. The therapist suggested that Arnold could learn about this treatment from Krueger. Krueger rejected this bid from the therapist by denying any awareness of the treatment. He then inquired regarding what was planned, how long his own treatment would persist. The therapist indicated that it would only be so long as necessary. The therapist then suggested that the other treatment available to Arnold would have been drug therapy and he could learn about this from Holden. Holden made no response to this suggestion. Ireland then entered the conversation to mention that he believed that Arnold had had some effect on his wife because she no longer wore pedal pushers. This was not responded to or elaborated on by others.

The therapist then spoke of dishonesty as trickery. He equated

trickery with sickness and said it had ever been thus. Turning to Evans, the therapist asked him "do you care?" There was no response from Evans for almost a minute, at which time the therapist again repeated his question and gained no response. The therapist then turned to Arnold and asked him "do *you* care?" Arnold immediately replied "no, sir." The therapist then told Arnold "that is sickness—what the world calls insanity." This was followed by a silence which lasted for five minutes. During this time it was noted that Arnold attempted to give the appearance of total detachment from the group by leaning back in his chair looking out the window and looking around the room. It was noted that the other members appeared to be sitting in a profound silence which continued until the therapist arose and left the room.

This meeting was marked particularly by the candid nature of the therapist's approach to the members of the group. His evaluation of the individual members' attitude toward therapy was an unprecedented occurrence and drew some greater evaluation among members than had ever occurred earlier. It was regarded by the observer that in this meeting there was, as called for by the therapist, much more in the way of honesty on the part of several of those present. It was to be noted that the efforts of Holden and Ireland in this took the direction of a more positive affiliation with the treatment effort. In contrast, there was a tacit indication by Evans of a negative reaction and overt evidence of a similar reaction on the part of Arnold.

The third segment of the group, arranged by the extent of productivity within the psychotherapy situation, was composed of those patients who rejected a positive engagement in therapy. At their most active, these patients were likely to be resisting the therapeutic direction of the meeting or attempting to subvert it through the extensive production of extraneous material. Upon infrequent occasions, a member of this group might respond as if to indicate that he was moving toward a positive engagement. However, he would never carry this through to completion, but rather, would fall back into his earlier patterns of disengagement. These patients did not abandon the schizophrenic orientation with which they had come to the hospital.

The final segment of the therapy group consisted of the other staff members present, the nurse and the psychiatric technicians. These staff members, by design, did not enter actively into the discussion. Throughout most of the period of observation the contribution of this segment, which consisted of four to six persons, seldom approached in its total production the amount of activity of the least active patient member. As therapeutic

agents, the nurse and the technicians were more actively engaged with the patients at other hours of the day, both within the routinized activities and during less structured leisure periods. As participants in group therapy, albeit quite inactive ones, they shared this experience with the patients and thus could freely make references to its happenings while dealing with the patients at other times.

The two extreme segments of this therapy group consisted of staff persons. To an extent the positions of these two segments in the distribution of productivity were by design and to be expected. Further, the behavior of these two alternate segments were subject, if necessary, to an ongoing criticism and correction which would insure their being retained in the interest of the most effective use of the therapy situation.

On the other hand, the approach to the patient members of this group was calculated to be one which did not at the outset discriminate between the ultimate failure and the ultimate success in the therapeutic endeavor. A reasonable assumption would be that the expectation of the staff was that all patients within the situation would make a positive response and a subsequent positive engagement in the therapy. It is particularly to be noted that there was no area of overlap in productiveness between the segment of engaged patients and the segment of disengaged patients. As indicated earlier, there was occasional incomplete behavior on the part of some of the failures as if to indicate an approaching change in their attitude toward the therapeutic endeavor. Conceivably this sort of phenomena occurred in some part because of the repeated efforts by the therapist and by some of the engaged patients to draw the disengaged patients into a more meaningful and committed performance within the group therapy situation. This present analysis of the overall performance of the members of the therapy endeavor would seem to indicate the steadfastness with which the uncommitted members maintained their position outside the purposes of the therapeutic endeavor despite the efforts of those within to draw them in also.

> As the patients entered the room for group psychotherapy, Carter chided Dempsey for bringing a hi-fi catalog to the meeting. He described this as rude and suggested that Dempsey stop doing this. Dempsey's response was totally to ignore these remarks and to sit down and begin reading his catalog. Although the other patients entered generally into an impromptu conversation with the nurse as they waited for the meeting to begin, Dempsey occupied himself with his hi-fi catalog.
>
> At 0901 hours the therapist entered and there ensued a silence which lasted for three and one-half minutes. This was terminated

by the therapist who addressed remarks to Dempsey, commenting that earlier he had brought only a folder to read but that on this date he had brought a catalog. The therapist inquired if on the following day he might bring a newspaper. Dempsey made no verbal response and acted as if he ignored these remarks totally. After another silence of two and one-half minutes the therapist asked that the group give some consideration as to why members of the group attempted to get the therapist's goat. This suggestion was incorporated and acted upon by the members in a fashion that focused on Dempsey. Initially Arnold defended Dempsey's position, suggesting that he actually was more perceptive and more aware of what was going on among the other members than was immediately apparent. He was challenged in this regard by Carter. This was elaborated further by the therapist who asked if Arnold felt that Dempsey knew him as a person and could distinguish him. In this analysis Arnold agreed that Dempsey failed to distinguish individuals in the group. This point was agreed to also by Garland, Evans and Carter.

The therapist raised the issue that if Dempsey did not know the other members as individuals, who then were they? After some effort by Carter to elaborate the idea of Dempsey's failure to differentiate in his dealings with others, the therapist made the interpretation that "we're all Henry." He explained that Henry was Dempsey's father and that it was only after this fashion that Dempsey was able to relate to others at all. The therapist then elaborated the concept of Dempsey's confirmation to this orientation throughout his experience generally.

The therapist made the suggestion to the group that while he and they had elaborated this idea it was of value only to the extent that it would "hold water." He suggested to the group that they should check out this idea and determine whether or not it would work. In elaboration of this, the therapist said that he wanted to present certain "public facts" bearing on Dempsey and his experience. He then elaborated how it had been that Dempsey had graduated from high school almost at the very bottom of his class. He described that Dempsey's father had, in the face of this, sent Dempsey on to college and to certain failure. The therapist suggested that this sort of experience, known to have happened on at least one occasion, had probably happened repeatedly and had driven Dempsey to erect the shell of himself that he presented to those present. (Throughout all the proceeding and later parts of the meeting, even though he was the focus of attention, Dempsey feigned indifference and busied himself with his magazine. It was noted however, that as the therapist elaborated the facts regarding his school experience, he called for confirmation of these facts from Dempsey. Dempsey immediately replied in appropriate fashion in

agreement with the presentation of these facts by the therapist. He was not, however, able to enter more fully into participation within the group.)

Shortly following this the therapist commented that Evans was smiling to himself and asked that he share this with the group. Evans became increasingly tense but did not verbalize this. There then ensued some effort by the therapist and by Arnold to draw out Evans but to no avail. The therapist then verbalized the impasse to which each member of the group comes in his attempt to make contact with the rest of the world. The therapist specified this as having particular application to Evans and to Dempsey. In closing he meeting he strongly affirmed to Dempsey that reality demands that none of those present can play the role of his father.

One of the observations made during this meeting was that while almost total attention of the group members was directed toward their relationship with Dempsey and the frustrations that they experienced therein, there were almost no hostile expressions directed toward Dempsey. Rather, the affect of the group on this occasion appeared to be more nearly one of general compassion. Distinctly the observer felt that the affect was of such a positive nature, in contrast to the position of detachment from Dempsey earlier held by the other members.

Qualitative Distinctions Between Successes and Failures

The discreteness of performance between those patients who made a successful response to the treatment endeavor and those who did not was consistent as their behaviors were compared along the qualitative dimensions as well as quantitative ones. The reality of the group therapy endeavor as a part of the current experience was not to be denied by any of the patients. This activity occurred regularly and was attended by all patients. As a matter of routine, group therapy took place following ward rounds each weekday morning. There was, then, an implicit expectation that every patient would attend these meetings to participate actively in them as a part of his total treatment.

The initiating of acts of a positive social-emotional nature can be regarded as an evidence of the esteem with which an individual actor views the operations of his group.[13] An individual would be very unlikely to address the other members in a positive fashion, unless he viewed them and the current situation as having some relevancy to himself. As an example, if patient A said to patient B, "You've hit on the right idea this time; I'll back you up all the way," he has made implicit reference to all

[13] Bales, *Op. Cit.*, pp. 65-73.

that has gone before in their relationship. He indicates some ongoing interest and investment in the other. He shows that he notes change in the other, and indicates not only his approval, but also his intention that his own behavior and affections will reflect this observation, both presently and in the future. The type of interaction then that is of a positive social-emotional value comes from the individual who is in meaningful contact with others in his group. Such behavior is born of a "reaching out" by the individual toward those around him.

As soon as the therapist was seated, Arnold said that he was ready to talk with the group today and wanted to get their help. He stated that an event had occurred the previous evening which seemed to him remarkably similar to that which had occurred at the time of his becoming ill. For this reason he was concerned as to whether or not he was improving. He elaborated that in the movie on the previous evening there had been an incident in the story in which a new bride had served her husband some rather unsavory food. In response to this, from the other side of the theater, someone called out "that's like a Spec/deuce's (Specialist second class) wife." Arnold said that his immediate reaction to this was to feel that this was a personal reference to himself. He stated that he was concerned since there was no way that he could check this out. He said that he had done a great deal of thinking about it and his thoughts had caused him to be all the more convinced that not only the person who spoke, but many of the other people in the theater knew of his "case," and about the circumstances which had brought him to the hospital.

As soon as the therapist asked the group if they had any suggestions to help Arnold, Garland responded immediately to outline a similar experience he had had on the previous evening in which he had felt that there were two other soldiers who, by their laughter, were referring to him.

Carter then entered the conversation in an attempt to assist Arnold in grounding his observations more nearly in reality. Garland re-entered into this to point out that the action to be taken in this regard would have seen to seek out the people who were making these remarks. He secured agreement from Arnold in this regard who then raised the question as to whether or not one could believe what was heard in this regard.

As Arnold developed this issue further, the therapist interposed a suggestion, asking whether or not these references had seemed to do with his Oriental wife. Arnold rejected this idea totally and felt that the references were to himself personally. The therapist elaborated further for Arnold what his experience had been. He mentioned the situation in which Arnold had felt uncertain of

the sincerity of the reception given his wife on her arrival in this country by his relatives. When the therapist suggested the difficulty that one would have in being absolutely certain as to the motives and intentions of others, Arnold accepted this and elaborated it to include the impossibility of being uncertain.

In response to solicitation by the therapist, Garland entered this discussion and spoke of being able to develop a scientific approach in one's evaluation of his dealings with others. In response to this production by Garland, the therapist spoke further of the difficulty in arriving at a totally scientific and unbiased view. In elaborating this further, the therapist used the analogy with Arnold of attempting to get an accurate volt meter. The therapist pursued this thesis further, indicating for the entire group how a small error is of sufficient deflection in one's perception that, with the passage of time, the error is greately magnified.

The therapist brought this situation to bear on the position of each member. He pointed out to Holden that the two dollar bribe at age ten was not insignificant but rather increasingly significant with the passage of time. The therapist elaborated for Garland the importance of the incident which had occurred to him at age five in which his father had attempted to teach him to fire a rifle. The therapist pointed out that the feelings of peril and danger aroused at that time have influenced Garland's experience since that time. The therapist mentioned to Carter the magnification of the error made by his family by allowing him to play alone throughout his childhood. To Evans the therapist pointed out the error of his having been allowed to continue with his cowboy games well toward the time that he was grown.

Arnold was then able to verbalize how it was that he had, throughout life, felt doors slamming on him. He stated that in the present experience he thought that this was occurring and that neither the therapist nor the other members were insisting that he was wrong in his perceptions and that they had the solution to his difficulties.

Throughout much of the hour Ireland made brief interjections into the discussion. To a considerable extent, these had been overlooked or, at any rate, not incorporated by the therapist and the others. Towards the end of the hour Ireland elaborated further his acceptance of the thesis developed by the therapist of the importance of earlier deflections in accuracy. He elaborated how it had been that he had been determined to marry his German wife. "Ten thousand other soldiers could walk away and leave them, but I had to marry her." He spoke of having been "hell bent with determination." The therapist elaborated Ireland's production to indicate that, to a considerable extent, he had been motivated through having been opposed in his original purpose in marrying his wife. Ireland

accepted this interpretation and was able, in the opinion of the observer, to elaborate it in a constructive fashion to a considerable extent.

The meeting ended with the therapist reassuring Arnold that he recognized that all his difficulties had not been solved in this one meeting, but pledged the assistance of himself and all the other members in continuing to work with Arnold toward the resolution of the difficulties of which he had spoken with the group.

This meeting was marked by an extremely purposeful use of time and energy by members of the group. The immediate impression was that there was a high degree of understanding among the members with little effort expended on clarifying communications. This meeting marked the first time that Arnold had been able to ask for group help. He described to the group that this was a new experience and one toward which he had been moving for some time.

An additional observation was that in this meeting there was no reference by the therapist or anyone else to Dempsey, even during the time that the therapist was making application of his thesis to each individual member. Dempsey sat throughout this meeting and read his hi-fi catalog. It is to be emphasized that, despite occasional differences among members and between members and the therapist, the overall impression of this meeting was that it was an extremely positively oriented one which had to do not only with the resolution of Arnold's difficulties, but those of each member.

During the period of observation, the subgroup of patients who made a successful response to therapy distinguished themselves from the patients who failed to make an adequate response to therapy in the extent to which they initiated acts of a positive social-emotional nature. The discrete performance of the successful patient bears upon his acceptance of the role of patient within the treatment situation. In effect, he demonstrates a reality-based functioning that is not apparent in the behavior of the failure in treatment. The successful patient is able to assess properly the situation, and to respond within this situation in a fashion that is highly self-relevant. There was a similar discreteness in the performance of the two subgroups of patients in the problem solving activities of the group. The patients whose behavior was most relevant to the declared purpose of therapy, the resolution of conflict and reduction of poor interpersonal functioning, were those whose ultimate response to therapy caused them to be regarded as successful. This subgroup contributed to a markedly higher extent to the group's efforts to solve problems.

In those elements of behavior which most interfered with the group's

objects of solving problems and achieving a high degree of solidarity, it was not found that the patients who ultimately failed in therapy predominated. The successful patients also initiated interaction which was categorized as being non-contributory to the purposes of the group. There was, however a distinction to be made in that the negative behavior of the successful patients was more than countered by the extent of their behavior into the positive elements of interaction. In contrast, the patients who failed showed a paucity of positive behavior. The negative behavior of the successes then, could be regarded as evidence of ambivalence within the treatment situation. On the other hand, the negative behavior of the failures more nearly seemed to indicate a stance on their part from which they would fend off any bids for their positive engagement in the therapeutic process.

As noted above, the acceptance or rejection of the patient role was not marked by a total discreteness of performance between the two subgroups. The rather opposite responses to the therapeutic situation did not prevent interaction between the two subgroups. An analysis was made of the reciprocal initiation of acts of a positive social-emotional nature. It was found that within each monthly period, every patient effected such a reciprocal exchange with the therapist. When such reciprocal relationships were sought between patients, it was found that such relationships occurred only either between two patients who accepted the patient role, or between an accepting patient and one who had rejected the role. Throughout the observational period there occurred no instance of such an exchange between two patients who rejected the patient role. (See Table 2). This is suggestive

TABLE 2

INCIDENCE OF DYADIC RELATIONSHIPS BASED ON RECIPROCAL POSITIVE SOCIAL-EMOTIONAL INTERACTION

Month	Dyads Composed of:		
	Two subjects accepting role	One subject accepting; one rejecting role	Two subjects rejecting role
October	0	3	0
November	3	1	0
December	3	1	0
January	1	2	0
February	3	3	0
March	3	3	0
Totals	13	13	0

of the circumstances necessary within a relationship in order that a subject who rejects his role as patient can enter into a positive affective exchange. It would seem that he must have assurance of the nature of response of the other individual before venturing such an exchange. It is thought that he finds such assurance in the therapist that he can, consistently, maintain such a relationship. From time to time, he can discern and respond to such conditions in his relationship with those patients who have accepted the patient role. He never notes this in those who share his own evaluation of the therapeutic milieu.

These are seen also as descriptive of the greater flexibility of the patient who is accepting of his role. Just as he can give expression to his negative reactions within the treatment situation, without significantly altering his overall direction, so also he can venture into relationship with another with less prior assurance as to the response of that other to him.

SUMMARY

An analysis of the behavior of a group of schizophrenic patients within the group psychotherapy activity of a milieu therapy program has been presented. Their performance within this situation has been equated with their acceptance or rejection of the role of patient within the treatment situation. It has been noted that as the schizophrenic individual accepted this role and ordered his behavior and interactions accordingly within the treatment situation, he would benefit from the therapeutic venture. The behavior of the accepting patient more nearly approximated normal behavior as it may be exemplified by the therapist within the treatment situation. On the other hand, the behavior of those patients rejecting their role was of a nature that limited their involvement either in the problem-solving process or in affective exchanges.

GENERAL BIBLIOGRAPHY

MEAD, G.H., "Mind, Self and Society" Un. of Chicago Press, 1934.

MORENO, J.L., "Who Shall Survive?" Beacon House, 1934, 1953.

MORENO, J.L., (Ed.) "The Sociometry Reader" The Free Press, Glencoe, 1960.

DEFINITIONS OF GROUP PSYCHOTHERAPY

Definition 1: "A method which protects and stimulates the self-regulating mechanism of natural groupings. It attacks the problem through the use of one man as the therapeutic agent of the other, of one group as the therapeutic agent of the other." From *Application of the Group Method to Classification,* p. 104, 1932.

Definition 2: "The groups function for themselves and the therapeutic process streams through their mutual interrelationships." From the same publication, p. 61.

Definition 3: "Group psychotherapy is the result of well calculated, spontaneous therapy plus proper social assignment. . . . The leader is within the group, not a person outside." Same publication, p. 94.

Definition 4: "Group therapy will be advantageous for persons who do not recover by themselves or through some form of psychological analysis or medication, but only through the interaction of one or more persons who are so coordinated to the patient that the curative tendencies within are strengthened and the disparaging tendencies within checked, so that he may influence the members of his group in a similar manner." Ibid., p. 97.

Definition 5: "Spontaneous formation of social groups based on the enthusiasm of the participants or on common interests and aims achieves often miraculous results, but cannot be called grouping in our sense as most of the interrelations remain unanalyzed." Ibid., 1932, p. 72.

Definition 6: "Group psychotherapy treats not only the individual who is the focus of attention because of maladjustment, but the entire group of individuals who are interrelated with him." *Who Shall Survive?,* 1934, p. 301.

Definition 7: "A truly therapeutic procedure cannot have less an objective than the whole of mankind." Ibid., p. 3.

DEFINITIONS OF THE TRANSFERENCE-TELE RELATION

There is a tendency to ascribe many irrational factors in the behavior of therapists and patients in group situations to transference and countertransference.

I. It takes *tele* to choose the right therapist and group partner, it takes transference to misjudge the therapist and to choose group partners who produce unstable relationships in a given activity.

II. The greater the temporal distance of an individual patient is from other individuals whom he has encountered in the past and with whom he

was engaged in significant relations, direct or symbolic, the more *inaccurate* will be his perception of them and his evaluation of their relationship to him and to each other. The dynamic effect of experiences which occur earlier in the life of an individual may be greater than the more recent ones but it is the inaccuracy of perception and the excess of projected feeling which is important in transference; in other words, he will be less perceiving the effect which experiences have on him the older they are and less aware of the degree to which he is coerced to project their images upon individuals in the present.

III. The greater the social distance of an individual patient is from other individuals in their common social atom, the more inaccurate will be his evaluation of their relationship to him and to each other. He may imagine accurately how A, B, C whom he chooses feel towards him, but he may have a vague perception of how A feels about B, A feels about C, B feels about A, B feels about C, C feels about A, or C feels about B. (Analogous to transference we may call these vague, distorted sociometric perceptions—"transperceptions.") His transperceptions are bound to be still weaker or blank as to how people whom he has never met feel for E, F, or G, or for A, B, or C or for how these individuals feel about each other. The only vague line of inference he could draw is from knowing what kind of individuals A, B, and C are.

IV. The degree of instability of transference in the course of a series of therapeutic sessions can be tested through experimental manipulation of the suggestibility of subjects. If their sociometric status is low, they will be easily shaken up (sociometric shock) by a slight change, actual or imagined, in the relationships of the subjects around him. It is evident that transference has, like tele, besides psychodynamic, also sociodynamic determinants.

CONCERNING THE ORIGIN OF THE TERMS GROUP THERAPY AND GROUP PSYCHOTHERAPY*

Sir: In a review of Corsini's *Methods of Group Psychotherapy,* in the March 1959 issue of this Journal, p. 840, Mr. Illing says: "Moreno claims for himself the first coinage of the term 'group psychotherapy' (1932), without, however, substantiating his claim, although he cites many 'witnesses'

* Reprinted by permission from *The American Journal of Psychiatry,* Vol. 116, No. 2, Aug., 1959.

for his testimony, such as William Alanson White, Winfred Overholser, Pierre Renouvier, S. H. Foulkes. . . ."

Here follows the record in my *own* publications: *Application of the Group Method to Classification,* Congressional Library, No. 32-26884, Publisher: National Committee on Prisons, New York, 1931-32, a chapter "Concerning Group Therapy," pp. 60-61; "Illustration of Group Therapeutics," pp. 74-76; "Group Therapy in an Institution of the Insane," pp. 77-79; "Definition of Group Therapy," p. 103.

The *Group Method* monograph was the topic of a Round Table at the annual meeting of the APA, May 31, 1932, Moderator: William A. White. At this meeting the term "group psychotherapy" was first given currency by the author.

The term "group *psycho*therapy" is recorded in my book *Who Shall Survive?* with a Foreword by Wm. White, Nervous and Mental Disease Publishing Co., Washington, D. C., First edition, 1934, Congressional Library No. 34-18502; see p. 437, referring to chapter "Group Psychotherapy," and the definition, p. 301, "Group therapy treats not only the individual who is the focus of attention because of maladjustment, but the whole group of individuals who are interrelated."

Group psychotherapy owed its emergence to sociometry and small group dynamics which was expounded by the author between 1931 and 34; he formulated group therapy as a scientific methodology with the help of Drs. White, Whitin, Branham and Jennings. There have been forerunners of pre-scientific group methods in the U. S. A. and Europe *before* 1931. The most important influence came from Vienna since 1909. Many of these methods (psychodrama, 1911, interaction methods, 1913, psychodrama combined with group therapy, 1923) have been launched by this author and described in his German books.

It is farfetched to trace the origins of group psychotherapy to European sociologists. One could equally quote American sociologists. Every new idea has forerunners but the moment of emergence of the scientific group psychotherapy movement into scientific history, its *kairos*, was the year 1932, within the fold of the American Psychiatric Association.

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AN OBJECTIVE ANALYSIS OF THE GROUP PSYCHOTHERAPY MOVEMENT

J. L. MORENO, M.D. AND Z. T. MORENO

Moreno Institute

Group psychotherapy, in one form or another, has become the most popular form of psychotherapy of our time. The movement has taken global proportions. It is practiced in the western countries as well as in the communist countries whereas psychoanalysis is limited to the West. Because of intervening forces however, its international recognition is still unclear and its theoretical foundations are controversial. The question is: which forces have blocked its development and hindered it from attaining the universal, scientific approval and honor which it deserves.

The organized group psychotherapy movement had five starts. The first was in Philadelphia in 1932, during the meeting of the American Psychiatric Association, with William Alanson White as moderator.[1] The second was in the founding of *Sociometry, A Journal of Inter-Personal Relations* in 1937, with Gardner Murphy as editor. The third was in New York City at the Sociometric Institute with the founding of the American Society for Psychodrama and Group Psychotherapy (ASGP) in 1942, and the *Bulletin* of the Society in 1943.[2] The fourth was the publication of the first group psychotherapy journal in 1947 (*Sociatry, A Journal of Group and Intergroup Therapy* whose title was changed to *Group Psychotherapy* in 1949), and fifth, the establishment of the first International Committee on Group Psychotherapy in Paris in 1951,[3] announced in *Group Psychotherapy*, Vol. VI, 1951, p. 126 and in the *American Journal of Psychiatry*, 1951.

Up to 1953, J. L. Moreno was the prime mover. From then on the other national society in the USA (AGPS) joined forces with the Moreno movement in the planning of an International Committee consisting of W. C. Hulse, J. L. Moreno, S. R. Slavson and W. J. Warner. They activated two international congresses, the first in Toronto, 1954, the second in 1957 in Zürich, Switzerland; the third congress and a world society are still in their planning stage.

There are several blocks which have interfered with the movement's

[1] See the *American Journal of Psychiatry*, 1932.

[2] See *Bulletin of the Society for Psychodrama and Group Psychotherapy*, SOCIOMETRY, Vol. VI, 1943, pp. 349-355.

[3] U.S. Section: J. L. Moreno, Joseph I. Meiers, L. K. Supple; French Section: S. Lebovici, L. Chertok, V. Gachkel, F. Pasche; British Section: J. Bierer, S. H. Foulkes.

spontaneous development and the professional status of its practitioners. We may distinguish, among others, three types of blocks: (a) professional blocks, (b) ideological blocks, (c) economic blocks.

(a) Let us begin with the professional blocks, because they are particularly disturbing to workers in the field. The pioneers of modern group psychotherapy were doctors of medicine; but the majority of group psychotherapists today are not doctors of medicine, they are psychologists, sociologists, social workers, nurses, educators, ministers and others. In order to support this claim we are bringing here certain facts and figures from the two large and dominating societies of group psychotherapy in the USA —the ASGP and the AGPA (See Table I and II). We have also calculated approximate figures (not included) as to the number of psychologists, sociologists, social workers, nurses, etc., who are practicing group psychotherapy. Although the non-medical group psychotherapists number about 50%, the percentage is probably higher, as we know from surveys made in many state and VA hospitals, psychological clinics and therapeutic institutions. Many non-medical group psychotherapists are not members of the official societies now operating, either because of limited economic means or because of difficulties in meeting the standards set by the societies they would like to join. Considering that clinical psychologists and sociologists, social workers, educators and ministers are produced in larger number than medical psychotherapists and show an increasing attraction to group methods, the probability is that in the years to come the non-medical workers will further outnumber the medical ones.

The division of group psychotherapists into two groups, the compact group of doctors of medicine versus all other professional groups has developed meanwhile a strong tendency for a double status of group psychotherapy—medical doctors versus non-medical doctors.

The meaning of the medical vs. the non-medical trends in the countries outside the USA is difficult to assess because the conditions differ widely from those in our country. Only in a few countries outside the USA have group psychotherapy societies been formed: in Great Britain, Austria, Israel, Argentina and Cuba. In France, Germany, Denmark, Sweden, Norway, Holland, Switzerland, Turkey, Spain, Italy, Greece, as well as in the Asiatic countries, a great deal of group psychotherapy is practiced but societies in a formal sense are not structured; therapists are scattered, linked to hospitals, clinics and schools. In the USSR group psychotherapy is practiced widely but it is not distinctly separated from psychotherapy; the emphasis is on its application "in situ" as f.i., *work therapy*.

The tensions between the two groups is so great that it may come to a splitting up. These tensions are objectively reflected in both major societies in the USA (Table I and II). From the point of view of scientific exchange

COMPARISON OF CATEGORIES OF MEMBERSHIP

TABLE I

AMERICAN SOCIETY OF GROUP PSYCHOTHERAPY AND PSYCHODRAMA (ASGP)
(Based on membership lists from 1955-60)

Total Membership	Medical*	Non-Medical**
736 or 100%	345 or 47%	391 or 53%

* M.D.
** Psychologists, Sociologists, Nurses, Social Workers, etc.

TABLE II

AMERICAN GROUP PSYCHOTHERAPY ASSOCIATION (AGPA)
(Based on membership Directory for 1957)

Total Membership	Medical*	Non-Medical**
711 or 100%	376 or 53%	353 or 47%

* M.D.
** Psychologists, Sociologists, Nurses, Social Workers, etc.

a split would be an unfortunate development. The common factors are by far the larger and more decisive ones. Global movements cannot afford the splitting up of factions prematurely. Christianity, f.i., was first a single formation before it broke up into several subforms, Catholicism, Calvinism, Lutheranism, Quakerism, etc. Communism too, was a single formation before it broke up into Stalinism, Trotzkyism and Maoism, etc.

The only thing which can avert a split is the development of *professional standards* which are sufficiently broad in scope to include medical as well as non-medical subjects, anatomy, physiology and chemistry on the one hand, medical sociology, social psychology and sociometry on the other hand. The problem of *standards* is, therefore, in the foreground of consideration. The training standards of doctors of medicine differ greatly from the training standards of psychologists, sociologists, pedagogues, nurses, at least in the USA. A nucleus of common study and training should be designated.

(b) The ideological blocks are even more serious. They are due to the three theoretical roots of group psychotherapy, medicine (psychiatry), sociology and religion. A natural enfoldment of group psychotherapy should

include psychiatrists and psychologists because of the psychiatric origin of group psychotherapy, but it should invite also sociologists because of its sociological origin and finally it should invite also ministers, educators, counselors of all sort because of its religious origin. Actually, from all of these disciplines, individuals have entered the movement and have made contributions in theory and practice. But a serious ideological block has established itself deeply into the movement, deteriorating it and distorting its meaning. The factor which provoked this is psychoanalysis which as a movement preceeded group psychotherapy and which also originated in Vienna. After the formulation of group psychotherapy had been established and its organization had begun, psychoanalysts entered the movement and tried to make a contribution towards it. In itself this was, of course, and still is a laudatory effort. The psychoanalysts, in various degrees of intensity, however, tried to impose upon group psychotherapy the psychoanalytic system of theory, concepts and terms and tried to establish a sort of aristocracy, emphasizing that only such group psychotherapists who have been psychoanalyzed are clinically fit to practice group psychotherapy and that all other group psychotherapists are second class. Thus there developed two groups: the one group, regardless whether they were medical or non-medical practitioners, claimed that they have been psychoanalyzed and therefore have a special status among group psychotherapists, and then the second group, group psychotherapists who have not been psychoanalyzed but whose training and skill was attained by other methods. The Neo-Freudians are producing unaccountable confusion in the entire field engendering an ideological war which has split the group psychotherapy movement into several parts which can be traced in every clinic, hospital, community organization and in every association of group psychotherapists. This block has harmed the development of group psychotherapy more than anything else; it has hindered the integration of a common system, a common terminology and a common aim. The fact is that by far the largest number of group psychotherapists practice without the benefit of psychoanalysis. Many have been trained by psychodramatic, role playing and sociometric methods and reached through this kind of training a level of knowledge and skill which is *superior* to psychoanalysis. We have to develop a tolerant attitude towards *all* methods which produce standards of competence acceptable to unbiased, authoritative juries.

(c) The third block is *economic*. Doctors of medicine, especially psychiatrists, have larger incomes than psychologists, sociologists, social workers, nurses, etc., and are better able to meet membership fees and other expenses.

The result is that the latter are stigmatized as the underdogs of the movement.

In the last few years, however, a new factor has entered which may well become the turning point in the global movement. With the re-entrance of the communist countries, particularly the USSR into scientific exchange, their attitude towards group psychotherapy is already playing a prominent role and will do so increasingly in the future structure of the development of the group psychotherapy movement. The communistic psychiatrists, as far as they are interested in group psychotherapy, are strictly anti-Freudian and represent an increasing counterforce against psychoanalytically oriented theory and practice.

Not only the layman, also scientists and scholars began to think little of the movement which thought so little of itself that it ascribed the original inspiration to psychoanalytic theory. These professional and ideological controversies may explain why the group psychotherapy movement has not taken an undisputed first place in its course as a therapeutic "Weltanschaung." When it stepped in around 1931 to surpass the psychoanalytic movement, it had all the potentials to take over the leadership and to give the world a new therapeutic social system fitting the needs of our twentieth century. The benefits which come from the group and action methods are universal.

One must hope, however, that the group psychotherapy movement would not become the playground in which one or another doctrine will try to dominate the field through political pressure and manipulations, but that it will be open to all varieties of group psychotherapy which are practiced. In a similar spirit as the UNO, it should be a forum for all methods, however large or small their following. Its international congresses should mirror the actualities of the work done. The entire matter will boil down to the question whether we therapists and scientists can do a better job in the matter of co-existence than the politicians.

References

Moreno, J. L. *The First Book of Group Psychotherapy,* Beacon House, 1932 and 1956.

———. Psychiatric Encounter in Soviet Russia, *Progress in Psychotherapy,* Vol. V, pp. 1-25, 1960, Grune & Stratton, New York, N. Y.

BOOK REVIEWS

ALCOHOLICS ANONYMOUS, Third Ed. *Alcoholics Anonymous Publishing, Inc., New York, 1959.*

This is the new and revised edition of the Big Book, the basic text for Alcoholics Anonymous. As such it covers the philosophy of this movement from abstain to zymosis. As one reads it, one is struck once again by the "religious" nature of the movement. It has its God—"A Power Greater than Ourselves," its Bible—"The Big Book" and its converted communities—the ever increasing group of alcoholics banded together with the focused purpose of sobriety. Many other elements of the movement can be understood from the "religious" interpretation.

The Big Book is a compendium of personal stories of reformed or rather reforming alcoholics (since the process never seems to terminate), medical opinions about the effectiveness of the movement and essays which deal with the basic philosophy behind the Twelve Steps and Twelve Traditions of A.A. It describes in detail the efforts of the individual and the group in aiding the alcoholic along the tortuous road to sobriety.

This reviewer felt that the essays which amplified the philosophy of the Twelve Step approach were much more provocative than the thirty-six personal "experiences." The weighty mass of personal experience and medical opinion tended to make one feel that "over-protesting doth occur." The very real impact of A.A. of personal witness and meaningful group experiences does not come clearly through the printed word and some difficulty in appropriating personal meaning from these experiences would be anticipated.

A portion dealing with the historical emergence of A.A. would seem to be of especial interest to those actively engaged in A.A. work. For those interested in group processes, the portion dealing with the Twelve Traditions seems most appropriate. The extremely fluid structure of the groups, the efforts to preserve autonomy and the avowed singleness of purpose bring forth certain group processes and problems which would lend themselves to further exploration.

This book offers as complete an understanding of A.A. to the alcoholic as any printed material can. Its 575 pages show real pictures and sometimes only glimpses of its processes. It is recommended as helpful to those in need of this type of information.

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HYPNOSIS AND RELATED STATES—PSYCHOANALYTIC STUDIES IN REGRESSION (Austen Riggs Center Monograph No. 2) by Merton M. Gill, M.D. and Margaret Brenman, Ph.D. International Universities Press Inc., New York, 1959, $7.50. 400 pages including 231 references, and subject index.

> " . . . the abyss which used to separate the academic psychologist from the psychoanalyst is narrowing. . . . Problems of unconscious motivation in human relationships, for instance, are no longer the concern of the psychoanalyst alone; . . ."

With this observation the authors delve into a goldmine of hypnotic and psychoanalytic philosophy and practice which dips generously into the classic and current literature of both disciplines. The authors' own researches are profound and searching, sparing no one not even themselves in their critical investigation of the large body of contributions from the great pioneers in the study of human behavior.

Therapists who are unfamiliar with hypnosis need to be reminded of the fact that ". . . the person in hypnosis appeared to have significantly readier access to his own unconscious conflicts than he did in the normal state." There is also some critical analysis of the *personality of the operator* (both hypnotist and psychoanalyst): his motivation, his subjective participation in the therapeutic relationship and also his mixed reasons for pursuing or abandoning the techniques.

Even Freud is not spared in this appraisal as the authors discuss his retention of the symbolic couch. They quote Freud's own hypnotic induction verbalization, and present his justification for touching the patient with one finger (laying on of hands) for hypnotic conditioning and the release of repressed material, while allegedly minimizing his reliance on hypnotic therapeutic procedures. Clearly Freud never abandoned his hypnotherapeutic approach completely.

Chapter eleven contains an excellent review of contributions and progress in psychodynamics as well as a rich collection of brief but informative clinical applications of hypnosis in psychoanalysis from the authors' own wide experiences. While the authors are commendably objective, too many of their studies are admittedly insufficient in scope for statistical validation. Illustrative case-studies are scattered throughout the book. But these are often lost in a maze of theoretical distinctions and technical discussions of "Metapsychological viewpoints in psychoanalysis," transference and hypnosis, theoretical concepts on the stages of anxiety, regression, sub-systems of the ego, autonomy of psychic functioning and technical distinctions between fugue, somnambulism, multiple personalities, hypnosis and sleep.

On the Theory of Hypnotic Induction they have this to say, "The psychoanalytic theory of hypnosis clearly implies . . . that hypnosis is a form of regression . . . (but) our own distinction (is that) induction is the process of bringing about a regression, while the hypnotic state is the established regression." (page 105)

Some of the chapters suffer more than others from unduly long and involved sentence structures, but even at best the diction is unsuited for beginners and must be sampled sparingly, like rich dessert.

Chapter 1. "The Induction of Hypnosis" is especially good showing a comparatively readable style and clinical approach after the rather ponderous and rambling introduction. Other chapters which may be of interest to workers in group psychotherapy include: Ch. 2, Hypnotic State, Ch. 8, Traumatic Neurosis & Hypnosis, Ch. 9, Hypnosis & Brain-Washing, and Ch. 11, Explorations of the use of Hypnosis in Psychotherapy..

Chapter 10 "Trance in Bali" draws heavily on Bateson & Meade's reports of cultural teasing of Balinese children, and discusses the subsequent withdrawal into trance-like states to avoid emotional traumatic experiences and also as a defense against anxiety.

There is also an interesting foot-note on brain-washing (Ch. 9) "But it must not be forgotten that the reality power is not necessarily grossly in evidence. Compare the cogent remarks of Moloney on how psychoanalysis may be perverted into brain-washing, particularly in the training situation where the analyst has reality power over the candidate." (page 168)

The authors conclude that some form of regression (including transference) develops in all psychotherapeutic relationships; that there is no correlation between the depth of hypnosis and the therapeutic results; that the term "hypnotherapy" should be dropped from scientific nomenclature since they do not regard hypnosis as a separate kind of therapy; that if the unconscious motives for being hypnotizable in the first place are sufficiently analyzed, then the patient's hypnotizability will lessen; that the patient in hypnosis attempts to deal with the resultant anxiety by a change in the depth of hypnosis sometimes by going deeper and at other times by disrupting the hypnosis entirely.

On hypnosis and hysterical mechanism they concur with Schilder that the majority of hysterics, like the majority of psychiatric patients, cannot be classified as good hypnotic subjects; and, interestingly enough, "that a good hypnotic subject, with certain exceptions . . . will respond with this abdication of his independence to almost anyone who casts himself in the role of the hypnotist. The potential hypnotic subject responds in about the

same way to the experienced psychiatrist, the fraternity colleague, the vaudeville performer, the student in his class of abnormal psychology, or the army captain in the medical corps—regardless of the sex, age, experience, prestige, etc., of the hypnotist." (page 28)

The book suffers from inadequate editing, and would be more useful if broken up into separate volumes to include:

1. Clinical experience with hypnosis as an aid in psychotherapy.
2. Theory & Practice in Psychodynamics of Hysteria and Allied States.
3. Historical review of contributions to Psychoanalysis and to Hypnosis.

As it now stands the book is best suited as a research reference. Clinicians will need to spend a great deal of time and effort in order to obtain useful therapeutic guides.

CALVERT STEIN, M.D.

LEARNING ABOUT ROLE-PLAYING FOR CHILDREN AND TEACHERS, by Hildred Nichols and Lois Williams, Assn. for Childhood Education Int., 1960, 3615 Wisconsin Ave., N. W., Washington 16, D. C., paperbound, price $0.75.

It is always gratifying to see skill and courage combined in a human enterprise. This little booklet exemplifies these qualities in the two teachers who have shared the task of writing it. The report starts with a genuinely psychodramatic self-presentation on the part of Mrs. Nichols and a statement of her reasons for using role-playing in the role of the teacher, her own warm up. Then it goes on to record the various steps she took in warming up her pupils to the role playing process, (1) pantomime, (2) solving actual problems by role playing, beginning with familiar, home situations, later going into the children's own problems, (3) finally completing unfinished stories of typical school problems by role playing. Lois Williams served as inservice consultant and as verbatim record-keeper, analyzer and in general, enthusiastic stimulator. These verbatim records are contained in the book and each session is interspersed with comments, interpretation and a description of the learning process which grew out of the role playing series. The report ends with a description of how sociodrama was used by a group of teachers who started the session with an unfinished story about a faculty committee, extending and completing it by role playing, taking the roles of the various members of the committee (not themselves, but a commonly experienced situation).

The booklet also contains several photographs of sessions in progress, and can be heartily recommended to anyone who is in anyway interested in the integration of role playing methods into the educational system. Above all, it proves that pioneering is still part of the role of the teacher, for although clinical methods are now well established, role playing in education is still a new frontier. Nevertheless, the clinician will find confirmation of his own experiences in the monograph, when in the section entitled *The Teachers Assesses,* the authors state: "Fears and anxieties were lessened." And again, "An increased ability to identify with others brought with it more insight into the needs and feelings of others." And, "they came to understand the many ways in which there are likenesses and the ways in which there are differences." Therapy may not have been the essential focus of the process, but surely the educator and therapist meet, especially in the final statement of this section, "I, the teacher, gained valuable insight into the children in my care. . . . We teach the whole child"!

Fortunate indeed, are the children who have such teachers. We congratulate the authors on their splendid job.

ZERKA T. MORENO

AMERICAN SOCIETY OF GROUP PSYCHOTHERAPY AND PSYCHODRAMA

Preliminary Program

20th Annual Meeting

Friday, Saturday and Sunday, March 24-26, 1961
HOTEL COMMODORE
New York City

FRIDAY, MARCH 24TH

Morning Meetings:

Section I—"Training of Professional Personnel"
Section II—"Sociometry and Group Dynamics"
Section III—"Psychodrama and Religion"

Afternoon Meetings:

Section I—"The Patient and the Mental Hospital"
Section II—"The Open Community"
Section III—"Psychodrama and Group Methods with Children and Adolescents"

Evening Meeting:

PLENARY SESSION:

"Sociometry in its Relation to Sociology"
Paul F. Lazarsfeld, Pres. Elect, Am. Sociol. Assn.
"Communism, Psychoanalysis and The Group Psychotherapy Movement"
J. L. Moreno, Director, Moreno Institute

SATURDAY, MARCH 25TH

Morning Meetings:

Section I—"New Approaches to Problems in Industry"
Section II—"Treatment of Marital Partners and Families"
Section III—"Psychodrama and Group Methods in Education"

Afternoon Meetings:

Section I—"Crime and Delinquency"
Section II—"New Horizons in Psychodrama and Group Psychotherapy"
Section III—"Psychodrama, Autogenic Relaxation, Psychomusic and Psychopuppetry"

Evening Meeting:

PLENARY SESSION:

"Twenty-Fifth Anniversary of the American Theatre of Psychodrama, Highlights of the Pioneering Developments."
Review of progress. Living contemporaries will reflect upon their "kairos" in the movement.
Chairman: Zerka T. Moreno, President, F.A.S.G.P.P.

SUNDAY, MARCH 26TH, AT THE NEW BUILDING OF THE MORENO INSTITUTE
236 W. 78 STREET, NEW YORK CITY.

Morning Meetings:
PLENARY SESSION:
"Dedication of the new Theatre of Psychodrama"
Chairman: Lewis Yablonsky, F.A.S.G.P.P.

Afternoon Meetings:
PLENARY SESSION:
"The Spontaneity Clinic, Town Meeting of Group Psychotherapists"

SPEAKERS ON THE PROGRAM

CALIFORNIA

George R. Bach (Chm.)
Robert Boguslaw
Eya Branham (Chm.)
Walter Bromberg
Gertrud Rothman
John Weilgart

COLORADO

James McDaniel

DISTRICT OF COLUMBIA

James Enneis (Chm.)
Arthur Laney
Robert P. Odenwald

CONNECTICUT

Abraham Knepler (Chm.)
Nina Toll

DELAWARE

Sheldon W. Weiss

FLORIDA

Vernon J. Fox
Thomas A. Routh

ILLINOIS

Theodore W. Franks
Esther Gilliland
Adaline Starr

INDIANA

Manuel J. Vargas

IOWA

Norman Bourestom, Jr.

MARYLAND

Fernando J. Cabrera
Robert M. Carr

MASSACHUSETTS

Dale A. Anderson
John E. McManus
N. L. Peterson (Chm.)
Calvert Stein (Chm.)
Lewis Yablonsky (Chm.)

MICHIGAN

Robert S. Drews (Chm.)
Henry Feinberg
Richard B. Hicks
Clarissa Jacobson
Joseph Mann
Marguerite M. Parrish (Chm.)
Edna Rainey
Martha Steinmetz
Cecelia Wells

MISSISSIPPI

Laurie Mae Carter

MISSOURI

Herbert Cohen
Lee Fine (Chm.)
Reiko Fine (Chm.)
Rolf Krojanker
James C. Logan
Abel Ossorio (Chm.)
Allan N. Zacher

NEW JERSEY

John R. Green
Malcolm Marks

NEW JERSEY (*Cont'd*)

Jiri Nehnevajsa
Priscilla Ransohoff
Jack Ward

NEW MEXICO

Robert Fortier

NEW YORK

Max Ackerman
Sylvia Ackerman
Jacob Chwast
Eugene Eliasoph
Abel Fink
A. Friedman
Jerome Goodman
Harold Greenwald
A. Edwin Harper
Martin R. Haskell (Chm.)
Sylvia R. Heimbach
John J. Hoffman
Helen H. Jennings (Chm.)
Richard Korn
Paul F. Lazarsfeld
John H. Mann
J. L. Moreno (Chm.)
Jonathan Moreno
Zerka T. Moreno (Chm.)
John J. Pearse
Jerry M. Rosenberg
James Sacks
Jay Sanford
DeOnne Sorensen
Wellman J. Warner
Hannah B. Weiner (Chm.)
Herman R. Weiss
Joseph Wilder
Wallace Wohlking

SPEAKERS ON THE PROGRAM (*Continued*)

NORTH CAROLINA

Janet A. Haas

OHIO

Doris Twitchell Allen
Marlin Butts

PENNSYLVANIA

N. William Winkelman, Jr.
Kurt Wolff (Chm.)

TEXAS

Robert S. Blake (Chm.)
Dorothy Brin Crocker
Jane S. Mouton
Betty Murray
Neville Murray
Jim Thomas

VERMONT

Benjamin Kotkov

VIRGINIA

David J. Greer

WASHINGTON

Walter J. Garre

WISCONSIN

L. Muskatevc
Harold F. Uehling

For complete program and reservations, write:

AMERICAN SOCIETY OF GROUP PSYCHOTHERAPY
& PSYCHODRAMA
P. O. Box 311, Beacon, New York

ANNOUNCEMENTS

The Moreno Institute

The building at 236 W. 78 Street, near Broadway corner, as its permanent New York City home. A staff of psychiatrists, psychologists, sociologists and educators will be available for research, therapy and training, under the direction of Dr. J. L. Moreno.

Daily Program. Sessions *every weekday* evening at 8:30. Courses in psychodrama, role playing, group psychotherapy, group dynamics, sociometry and industrial training.

Special Psychodrama Sessions: Every *Friday* evening, 8:30-10:30. Participants may choose the topic.

Matrimonial Clinic: Every *Saturday* evening, 8:30-10:30. Marital and pre-marital problems are treated by Psychodrama and follow-up interviews. The Friday and Saturday evening programs are conducted by Dr. J. L. Moreno.

Family Therapy Clinic: By appointment only.

Small Therapy Groups: Under the direction of a psychiatrist.

Psychological Clinic: Diagnostic consultation and interviews.

Admission: $2.50. Courses to be announced.

Beginning on February 1, 1961, the Moreno Institute will offer sessions of psychodrama open to the public on every night of the week, Monday through Saturday. An educational and therapeutic program offering psychodrama, group psychotherapy and sociometry is also available. We shall be most grateful to you if you would direct the attention of your associates and students to the open part of our program, which follows:

FRIDAY, 8:30 P.M.—Directors: Dr. J. L. Moreno and Mrs. Zerka T. Moreno

The Friday night psychodrama sessions have become traditional in New York City, having been presented by the Founder of the Institute continuously since 1942.

SATURDAY, 8:30 P.M.—Directors: Dr. J. L. Moreno and Mrs. Zerka T. Moreno

Families are invited to present their problems; pre-marital and marital problems as they reflect upon mental health in the community are explored by the actual persons involved.

MONDAY, 8:30 P.M.—Director: Dr. James Sacks

Dr. Sacks is a certified psychologist in private practice, the Senior Psychologist at the Brooklyn Community Counseling Center. His work

and training in psychodrama was done at the University of Chicago and with Dr. J. L. Moreno at the Moreno Institute at Beacon, N. Y.

TUESDAY, 8:30 P.M.—Director: Dr. Martin R. Haskell

Dr. Haskell, sociologist, has been on the staff at the Moreno Institute since 1954. For three years, as Placement Director of Berkshire Farm for Boys, he actively applied role training and psychodrama to problems of families with adolescent children.

WEDNESDAY, 8:30 P.M.—Directors: Dr. Max Ackerman and Mrs. Sylvia Ackerman

The Wednesday night sessions are under the direction of Dr. Max Ackerman, psychiatrist, member of the American College of Neuropsychiatrists, and Sylvia Ackerman, M.A., psychologist, with diversified background in individual and group psychotherapy, who will demonstrate, through teamwork, psychodrama as a therapeutic tool.

THURSDAY, 8:30 P.M.—Director: Hannah B. Weiner, M.A.

Miss Weiner has been a Director of Psychodrama at the Moreno Institute since 1952, and is widely experienced in directing large groups. She is Secretary of the American Society of Group Psychotherapy and Psychodrama and a Contributing Editor to the journal, Group Psychotherapy.

ALTERNATE DIRECTORS:

Dr. Helen H. Jennings, Professor of Ed. Psych., Brooklyn College
Dr. Jack L. Ward, Psychiatrist, Belle Mead, N. J.
Dr. Lewis Yablonsky, Assoc. Professor of Sociology, Univ. of Massachusetts.
Mr. Eugene Eliasoph, M.S.W., Berkshire Farm for Boys

Admission: $2.50 per person. For further information, telephone: ENdicott 2-6165

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