GROUP PSYCHOTHERAPY

Journal of Sociopsychopathology and Sociatry

PSYCHODRAMA

SOCIOMETRIC METHODS
ACTION METHODS
THERAPEUTIC FILMS

RE-GROUPING
RE-TRAINING
SOCIAL CATHARSIS

SOCIODRAMA

Volume III AUGUST-DECEMBER Numbers 2 & 3

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In the photograph Dr. Moreno is addressing a group in the initial phase of a session.

"One man as a therapeutic agent of the other,
one group as a therapeutic agent of the other."

(Quotation from *Application of the Group Method to Classification*, 1931-32)

J. L. Moreno, M.D.

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This issue is dedicated to the twentieth anniversary of group psychotherapy.

We are greatly indebted to the *American Journal of Psychiatry* for releasing to Beacon House the papers presented or prepared for the Round Table Conference on Group Psychotherapy at the meeting of the American Psychiatric Association, Detroit, May, 1950

To the American Association on Mental Deficiency our thanks for allowing the republication of Dr. William Alanson White's "Comments on J. L. Moreno's Psychological Organization of Groups in the Community" and Moreno's reply, read during the joint meeting of the American Psychiatric Association and the American Association on Mental Deficiency, at Boston, May 31, 1933, and published in the *Proceedings of the American Association on Mental Deficiency* that same year.

EDITORIAL FOREWORD

1. WHAT IS GROUP PSYCHOTHERAPY? The terms group therapy or group psychotherapy are frequently used interchangeably to mean the same thing. One reads of "group therapy" societies, projects, and seminars in popular as well as scientific periodicals to the utter confusion of all communication among research workers in this field.

We could gain some clarity if the term group therapy is used to designate the therapy which takes place as a by-product resulting from other more primary activities without the specific intention of the participants and without a scientific plan; in this sense group therapy may take place, among others, in groups of theatre-goers, on the baseball field, or in automobile workshops; furthermore, if a single individual is treated in a group setting, therapy of the group may result as a by-product but it is not the primary aim. Similarly, it would be desirable for the term *group psychotherapy* to be used exclusively whenever the process is a medicine for the group treated, when the therapeutic welfare of the group is the immediate and sole objective, and when these ends are attained by scientific means, including analysis, diagnosis, prognosis, and prediction.

2. GROUP PSYCHOTHERAPY AND GROUP PSYCHOANALYSIS. It is about thirty years since group psychotherapy had its first tangible manifestations. Until 1937 the productivity in this field was limited to a few workers. Since 1942 it rapidly began to flourish and it has developed many varieties. However, one can differentiate among the scientific group psychotherapies two powerful currents: (a) *the sociometrically oriented group psychotherapies,* with their emphases upon spontaneity, experimental method, sociodynamics, and measurement before and after, and (b) *the psychoanalytically oriented group psychotherapies,* with their emphases upon clinical observation, psychodynamics and the psychoanalytic forms of interpretation. "The psychodynamics which dominate the individual psyche and the sociodynamics which determine group structure are one and the same process," says the psychoanalyst. "No," says the sociometrically oriented group psychotherapist, "there are fundamental differences in concept, structure, instruments to be used and therapeutic effects." They do not represent exclusively two extreme positions; there are many steps in between. It may be advisable, therefore, because of their different historical origins, to use the term group psychotherapy only for the sociometric and sociodynamic forms, and to use for the psychoanalytic forms the term "group psychoanalysis."

3. It is the objective of the journal *Group Psychotherapy* to become a clearing house for all opinions, pro and con, in the firm conviction that at least an approximation of consensus can be attained by means of open discussion. It is also our conviction that without a scientifically grounded theory shared by the majority of workers no sound and scientific practice can be attained. It may be found that many misunderstandings are purely semantic. Once we have described in simple terms *the operations* which are used and separate them from the verbal descriptions, concepts and interpretations accompanying them, a common core may be rapidly approached.

4. WHAT IS PSYCHODRAMA? Psychodrama is "action psychopathology," "action psychotherapy" and "action research" pertaining thereto, including role playing, situation playing and sociodrama as branch forms. It can be used in the treatment of an individual alone, without a group, as an improvement upon psychoanalysis, or it can be used *within* a group setting, or combined *with* a group. Psychodrama is *not* a form of group psychotherapy just as group psychotherapy is *not* a form of psychodrama.

5. GROUP PSYCHOTHERAPY AND PSYCHODRAMA. Psychodrama employed in the treatment of all group members, that is, as group psychotherapy, is then a synthesis of action and group methods; *group psychotherapy plus psychodrama becomes mass psychiatry.* The action problems emerge from the group and provide it with a focus surpassing every other medium in intensity of participation and potential social catharsis.

6. It would be unfair to pretend that we are so pure that we are unbiased; we are in favor of *the hypothesis of spontaneity* which we hold to be the most important discovery of modern psychiatry and the key reality behind all mental therapies, individual or group.

"Spontaneity operates in the present, now and here; it propels the individual towards an adequate response to a new situation or a new response to an old situation. It is strategically linked in two opposite directions, to automatism and reflexivity, as well as to productivity and creativity. It is, in its evolution, older than libido, memory or intelligence. Although the most universal and evolutionarily the oldest, it is the least developed among the factors operating in Man's world; it is most frequently discouraged and restrained by cultural devices. A great deal of Man's psycho- and socio-pathology can be ascribed to the insufficient development of spontaneity. Spontaneity "training" is therefore the most auspicious skill to be taught to therapists in all our institutions of learning and it is his task to teach his clients how to be more spontaneous without becoming excessive. There is ample evidence that the spontaneity of the infant has "something to do" with his arrival in this world. During pregnancy he warms up to the act of birth. The length of gestation is largely determined by the genotype of the foetus and not by the dam of the carrying individual. The infant wants to be born. Birth is a primary and creative process. It is positive before it is negative, it is healthy before it is pathological, it is a victory before it is a trauma." (From "J. L. Moreno, The Sociometric Approach to Social Case Work," *Sociometry*, Vol. XIII, 1950).

Important statements of this position are: Charles Saunders Pierce, collected papers, Vol. I, Harvard University Press (p.58-72) (c.1897); J. L. Moreno Das Steigreiftheater, 1923 tr., The Theatre of Spontaneity, 1947; Adolf Meyer, Spontaneity, 1923, 1941, *Sociometry*, Vol. IV, 1941.

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THE ASCENDANCE OF GROUP PSYCHOTHERAPY AND THE DECLINING INFLUENCE OF PSYCHOANALYSIS

J. L. MORENO
Sociometric Institute

Psychoanalysis has ceased to be the final word in everything psychological and social-psychiatric. What happened? The evolution of science has gradually caught up with it.

There is no denying that psychoanalytic theory, as in other fields of psychiatry, is exercising some influence also upon group psychotherapy. This is largely due to the political fact that an increasing number of professional psychoanalysts are entering the group and action field, bringing along the conceptual framework to which they are accustomed and applying it, often uncritically, to the new therapeutic situation—the group and the act. But as they begin to practice in these areas the momentum of clinical experience will gradually force the new generation of psychoanalysts first to modify and then to substitute their old by the new concepts which the pioneers of group psychotherapy have formulated almost a generation ago. A careful analysis of all the significant versions of group psychotherapy shows that the differences between them are only quantitative, that they do not differ in their operations as much as in the explanations given to the group dynamics involved and in the terminology used. Many of these operations are still unconscious to the group psychotherapists themselves. Making the dynamics of these operations clear to every group practitioner is of the greatest importance for establishing a generally accepted scientific platform. Many are using different terms for the same operation. Their emotional involvement in the terminology of the school of thought from which they come is difficult to erase. It is, however, not impossible. We mean it in all earnestness when we suggest that group psychotherapists should have group psychotherapy sessions in which they are the subjects themselves, instead of presenting their papers side by side when they meet at scientific meetings.

Group and action methods, especially group psychotherapy and psychodrama did not emerge in a vacuum, they grew out of a double tradition, crystalized by psychobiology and psychoanalysis on one hand, sociology and social

psychology on the other. The life line of the new era is marked by the combination of three developments: the diagnostic (sociometry), the actional (psychodrama) and the therapeutic (group psychotherapy). In the last twenty years they have led the way *beyond* psychoanalysis and the brilliant but speculative group psychologies of LeBon, McDougall and Freud. We have introduced new vehicles and new operations. Perhaps the most important change is the change of vehicle, the replacement of the psychoanalytic couch by *open social space;* an illustration is the multi-dimensional stage in the round for action and production and the free flexible auditorium for the group. The conceptual framework which was logical for the couch situation, libido, transference, resistance, abreaction, free association and so forth, had to undergo profound changes. Freud's proclamation that transference and resistance are the cornerstones of psychoanalysis loses its original vigor when applied to the group and action process.

What happens to inter-personal relations in the group? Inter-personal relations in the couch situation is a misnomer because of the one-sidedness of the therapeutic focus. Only the patient is on the couch; the doctor is not. It was within group psychotherapy and psychodrama that the genuine meaning of inter-personal relations became realized, one therapeutic agent facing the other on equal terms and with an equal opportunity for communication.

What becomes of abreaction in the group? Abreaction is of animal origin and because of man's animal substructure it persists in him and merges into "inter-action" which is characteristically human. As soon as autistic abreactions take place, to and fro, between several people, they turn into "inter-abreactions," interactions, however poorly structured.

What happens to free association in the group? Free association in the loneliness of the couch is a meaningful production of the single individual. But when in the group, two, three, or four begin to "free associate," not each by himself and for himself, but with one another, then they talk with each other, or, at least, *at* each other. The autistic free association becomes a phase well known and frequently described *within every psychodramatic process* of group treatment, particularly characteristic in soliloquy, double and mirror procedures. The free association of words as produced by the single individual is further extended in the group psychodrama by the free association of "acts." This is an illustration as to how the term "free association" can be stretched to mean more than an individual technique. Free association has been peculiarly

linked with one individual saying whatever is on his mind. But when two or more individuals are encouraged to let go with everything which is on their minds, in regard to each other, words *and* acts, it has become customary to call this "psychodramatic technique" (or interaction technique). When several individuals throw their free associations at each other, the product is a new configuration, quite different from the production of each individual. This is already true when the communications are only verbal but when they are actional, silent, interactional and coactional, the stubborn use of psychoanalytic terms sounds like a magic ritual. If we proceed further this way, we will end up by having free association between every two lampposts.

What happens to transference in a group? It is derivitative of a more elementary and genetically older relationship already operating on the subhuman level of the group before transference can emerge—"*tele;*" it is the factor which makes groups cohesive. The group cannot live from transference alone. Groups must already exist as an elementary structure before transference can effect dissociations within them. It is again as with free association; using the term vaguely, implying that every relationship, normal and pathological which exists between individuals is some sort of transference, destroys even the traditional meaning of this concept; it does not aid scientific progress. I formulated the frame of reference for *all* forms of social cohesion as follows: "The deviation of the actual groups from chance groups (and the changes from poorly structured to highly structured groups) must be ascribed to a specific factor: tele. The cohesion (c) of a group is therefore a function (f) of tele (t) C=ft." (J. L. Moreno's discussion of cohesion in Paul H. Hoch's *Failures in Psychiatric Treatment,* p. 130, Grune & Stratton, 1948). The measurement of changes in group structure and cohesion in longitudinal series is necessary in order to put the therapy of groups on a rational basis. By comparative studies of groups at different points in time we may learn of the degree of cohesion related to the greatest therapeutic benefits for them, i.e., their *optimum* cohesion.

What happens to libido and identification in the group? The group as a social configuration has no sexual organs. Freud's suggestion that "the essence of the group lies in the libidinal ties existing in it"[1] is as a dictum unproductive for group research. It would have been a hopeless proposition to expect from the divinations of psychodynamics an explanation of what the facts of group dynamics really are. The next logical step and the way out of this dilemma was sociometry which has carried out in the last twenty-seven years an enormous amount of research into the realities of sociodynamics. For Freud the mech-

anisms for libidinal cathexis in the group are the "identifications." "Identification is the earliest and original form of emotional tie."[2] But identification, in order to come into being presupposes the existence of several selves and a minimal elementary structure between them; therefore, it can hardly be conceived as the "earliest and original form" of emotional tie.[3] We have no basis for assuming that chicks, hens and other sub-humans are able to make identifications. They appear to produce social relationships among themselves preceding the emergence of sexual activities. Again, as with the libido hypothesis above, some merits of the identification hypothesis cannot be denied, but it is unproductive in situations which are "pre"libidinal. The way out was *direct* experimentation with simple groups.

All group psychotherapists have certain basic conditions in common; a) they meet with groups already formed or to be formed, on the reality level or in the clinic; b) after individual evaluations have been made, as Intelligence Tests, interviews, Rorschach tests, short psychoanalysis, and so forth, the stage is set for facing the group itself; c) the working through the group, through the individual participant (including the therapist), their relationships and the group as a whole is necessary to the process; d) lecturing, interviewing, discussing, commenting and explaining are extremely facilitated and intensified if a sociometric technique is applied to begin with. An illustration of an appropriate technique for group sessions is to ask whom among the members of the group present they would like or dislike to consult in a matter vital to them. The relationships thus expressed are plotted in a sociogram; e) the sociogram is the simplest guide in working through the group; it is a helpful enter-in wedge. It gives an immediate picture of the group as a whole and cuts short the procedure, avoiding many wasteful sidetracks. It is a "social compass," guiding the therapist through the intricate maze of the group structure. Phenomena threatening the cohesion of the group can be rapidly discovered; emotional contagion and the direction it takes can be diagnosed and its further development prevented. The therapist may try his luck without a sociogram, he may move into the group, start with himself as a focus or a particular individual. He may move from one individual to another but without guides like the sociogram or psychodrama the conduct of a session easily goes out of hand and may become diffused.

1) Sigmund Freud: "Group Psychology and the Analysis of the Ego," The Hogarth Press, London, 1948, p. 45.
2) Ibid, p. 64.
3) J. L. Moreno: "Two Sociometries, Human and Subhuman," **Sociometry**, Vol. VIII, 1945, p. 75; see also: David M. Levy, "The Strange Hen," Amer. Journal of Orthpsychiatry, 1950.

TABLE OF CORRESPONDENCES AND CONTRASTS BETWEEN INDIVIDUAL PSYCHOTHERAPY, PSYCHODRAMA, AND GROUP PSYCHOTHERAPY

(Compare with my table of Basic Categories of Group Psychotherapy, Sociometry, Vol. VIII, 1945, p. 318.

INDIVIDUAL PSYCHOTHERAPY (esp. Freud's Psychoanalysis and Adler's ego psychology)	PSYCHODRAMA (Action Psychotherapy)	GROUP PSYCHOTHERAPY
Vehicle:	Vehicle:	Vehicle:
1. Psychoanalytic couch, "therapeutic" chair in interview counseling.	1. Multi-dimensional, flexible stage in the round	1. Open social space in situ: any locus where people live (reality setting) an auditorium f.i., of a therapeutic theater, sitting "in the round" of a conference table
2. "Quasi" interpersonal situation (one person vs. a therapist)	2. Interpersonal therapy as real husband vs. real wife or real husband vs. "therapeutic (auxiliary ego) wife"	2. Genuine interpersonal situation, one therapeutic agent vs. other therapeutic agents
3. Psychodynamics	3. Action dynamics	3. Socio (or group) dynamics
4. Free Association technique	4. Psychodramatic production technique (soliloquy, mirror, double, reversal, role playing, role practise)	4. Group techniques (interactional, interview & sociometric)
5. Transference situation a "quasi" interpersonal relation.	5. Spontaneity, warming up to action	5. Tele situation interpersonal relations within groups
6. Abreaction	6. Acting and living out, dialogue, interaction, pause, climax	6. Inter-abreaction, interaction, co-action, cooperation
7. Catharsis of abreaction	7. Action catharsis, catharsis of integration (includes catharsis of abreaction and group catharsis)	7. Group catharsis
8. Unconscious	8. Action matrix	8. Sociometric matrix (if one does not take the word "unconscious" in a magic way, one could say that sociometry unearths by means of experiments and measurements the social unconscious, but it is not necessarily an unconscious "repressed," individual or collective, but the actual, continuously changing dynamic substructure of human society)
9. Libido (Freud) Inferiority of organs (Adler)	9. Spontaneity, productivity, creativity	9. Spontaneity and tele. They are more elementary than libido — in "pre" libidinal situations
10. Dream analysis re: Psychodrama of Dreams, see J. L. Moreno "Interpersonal Therapy and the Psychopathology of Interpersonal Relations," Sociometry, Vol. I, 1937, p. 40-42.	10. Dream "in action," psychodramatic dream production (shortcut of psychodrama, wedge into the deeper layers of action personality)	10. Sociogram of a group, shortcut, wedge into deeper layers of groups

CRADLE OF GROUP PSYCHOTHERAPY

Its Twentieth Anniversary Within the American Psychiatric Association

J. L. MORENO
Beacon Hill Sanitarium, Beacon, N.Y.

An autobiographic account seems to me indispensable and the shortest route in order to make clear to everyone the immediate factors which precipitated the first birth cries of what we call today "Group Psychotherapy." Without this personal account—a sort of psychodrama on the reality level—much of the dynamic participation of the reader of 1950 would be well nigh impossible. I hope that I was able to use myself as a screen through which the long-range historical factors could arouse and penetrate the reader's attention.

On June 6, 1931, anyone living in New York*, Washington*, Chicago*, Los Angeles*, Toronto*, Montreal*, London*, or Paris*, reading his morning newspaper was probably startled by headlines referring to Abraham Lincoln as a schizoid-manic personality, as psychoanalyzed by Dr. A. Brill and further by the following item:

> "An American by Adoption Rose to the Defense of a Dead President of the United States at Today's Session of the American Psychiatric Association's Convention in the Royal York. Dr. Brill's critic was Dr. J. L. Moreno, New York Psychiatrist, Formerly of Vienna."

It was at the Toronto meeting of the American Psychiatric Association that I came to the rescue of the memorable late President of the United States and this, as we shall see, precipitated the beginnings of the official birth of group psychotherapy within the framework of our leading psychiatric society. Its entrance into the world, therefore, had something of the dramatic.

I had just been elected a member of the American Psychiatric Association

*See New York Times, Washington Post, Chicago Daily Tribune, Los Angeles Times, Toronto Evening Telegram, Canadian Star, London Times, LeMatin of that date.

and walked proudly through the aisles of the beautiful Royal York Hotel when the late Dr. Walter M. English, then President of the Association approached me and said something like this: "Dr. Moreno, you may have heard that Dr. Brill is reading a paper on "Abraham Lincoln as a Humorist"; he asked me to invite you to be its discussant." I was taken aback and muttered, "I feel greatly honored to be asked by Dr. Brill but I never had the pleasure of meeting him and besides, I wonder whether I could meet his expectations. Furthermore, I am not a psychoanalyst (pause)—and I don't know anything to speak of about Lincoln." Dr. English nodded assurance and I walked on, my chest swelling with a narcissistic glow. I was but a few steps away when another distinguished Fellow of the Association interceded. I thought: "What's going on here? Is Brill short of a discussant? Will I get into trouble? Why pick on me? I see so many distinguished psychoanalysts here." Just then Brill walked by and this is how he and I became acquainted. Brill handed me a copy of his manuscript and said: "I have heard fine things about your work. I am glad that you are willing to discuss my paper." Shortly afterwards Dr. English opened the meeting and the auditorium was packed to its farthest corners when Brill began to read. As soon as he and Dr. English ended I stepped upon the platform and said:

"Mr. President, Ladies and Gentlemen: I have listened carefully but I am not sure now whether Dr. Brill's paper was a paper on Lincoln or on psychoanalysis. The title of his paper is 'Abraham Lincoln as a Humorist.' It might just as well have been called 'Dr. Brill as a Humorist.' It is not fair to psychoanalyze the personality of a man now dead as you have to do it without his consent. One must have therefore a special reason. Dr. Brill's conclusions are based on the statement of friends and contemporaries who may have had all kinds of motives to relate all kinds of stories about Lincoln. Had a contemporary psychiatrist made a study of Lincoln, Dr. Brill would have been justified to some extent in accepting the findings. But as no scientific study of the great American emancipator has been made during his lifetime there was no justification for any attempt to analyze his personality from what is related about him by laymen.

"It is difficult to understand how the dead Lincoln could have made a transference to the living Brill. It is obvious, however, that Brill has developed an extraordinary transference to Lincoln. The unconscious psychodynamics which become "available in the course of analysis" are those of Brill, only *they* are "now and here."

"Brill has attempted to prove that Lincoln's coarse and vulgar humor was unconsciously determined. My opinions have developed by means of a different method—the psychodrama. They are based on the study of persons placed in improvised situations. Those persons respond spontaneously to the occasion, much as an actor or actress on the stage of life, and cultivate a personality such as is deemed by them to be most suitable for the circumstances and which best will meet the purpose they are endeavoring to serve. In a man of Lincoln's genius an enormous amount of creativity must have gone into the reorganization of the psychic material emerging from his private person. The more unusual the character and the circumstances, the more dangerous it is to apply an "accepted formula."

"The psychoanalytic method has not developed sufficiently to the point where it could attempt an analysis of Lincoln. Not only had no expert in psychiatry first hand knowledge of Lincoln when he was alive but a genius of his type was capable of *playing roles* and saying many things which could be explained in a multitude of ways*."

"Brill was apparently nonplussed, taken by surprise and replied to my criticism: "In a histrionic manner Dr. Moreno tries to show that we don't know anything about anybody who is dead. We know a lot about Lincoln. If his friends and contemporaries tell us about him we have a right to accept what they say as facts**."

Biographic evaluation of historic personalities, is of course, not new; it is as old as the writing of history. But psychoanalysis claims that it has added the novel element of being able to penetrate the intimate dynamics of a dead hero by using the phenomena of his recorded life as clues. It is obvious that even in a strictly psychoanalytic sense the analysis of a dead person is symbolic rather than actual. According to psychoanalytic tenets an actual analysis is not possible without display of "transference" and "resistance" of the subject. Neither transference nor resistance can be expected from a dead person. A superficial student and particularly a layman may easily be carried away by suggestive writings and might take a symbolic analysis for an actual one. Brill, in his analysis of Lincoln, followed in the footsteps of his master, Freud, who tried something similar with DaVinci and Moses. I believe that in most cases of this type it would be more interesting and more resourceful to analyze the analyst instead of the dead analysand and this is what I am doing here with

*The newspaper accounts of the Lincoln incident were of an unusual accuracy. I found most of my speech quoted almost verbatim when comparing them with my notes.

**Quoted verbatim from the Toronto Evening Star, June 5, 1931.

Brill. Similarly, it would have been more interesting to find out why Freud picked on Moses and to analyze Freud as to his own involvements in Moses rather than to follow Freud in his analysis of Moses. It is from the analysis of the psychoanalyst *in situ*, when he is involved in the process of analyzing someone else who is dead that one of the most important contributions of *psychodramatic* theory developed—the subjectification of the apparently objective investigator. It stands to reason that if Brill, instead of keeping himself, his own private dynamics out of his analysis of Lincoln, would have included himself into it a scientific paper might have evolved which could have been a true milestone in the development of psychoanalysis. But he excluded himself from Lincoln just as Freud excluded himself from Moses. Thus it became my job to return Lincoln into Brill and metaphorically speaking, Moses into Freud. This is what I mean by the basic limitation of Freud's psychoanalytic theory in dealing with personality problems of this type.

After the formal meeting was over I found myself surrounded by a number of members who bombarded me with questions. They thought my discussion was incomplete and urged me to continue. What did I mean, for instance, by the statement that Brill had developed an "extraordinary transference" to Lincoln?

"Yes," I admitted, "there are four puzzling questions. First why did he pick on a dead person instead of on a living one? Second, why did he pick on an illustrious, outstanding character and particularly why on an American? Third, why did he pick on Abraham Lincoln? Fourth, why did he choose *me* to discuss his hypothesis?

"The first question is comparatively easy to answer. It is easier to analyze a dead man, that is, easier for the analyst. He is not exposed to any "counter spontaneity." And besides, he might never have had a chance to analyze Lincoln would he be alive. But there is another angle. There are millions of people who are dead. If he would have picked on an anonymous, entirely forgotten man offering a similar syndrome, the analytic results might have been equally significant. This brings us to the answer of the second question. It *had* to be an illustrious, outstanding character, because the paper was apparently intended to give psychoanalysis great publicity, to document before the world that psychoanalysis has the intellectual power of coping with the most outstanding individuals of history and put them in their proper places. But why did it have to be an American? There were many other outstanding men in recent history who should have been good schizomanic material, Nikolai

Lenin, Emperor Franz Joseph, King Edward V.. Obviously Brill picked on an American because he was personally involved with the American people. America was the country he had set out to conquer for psychoanalysis and for himself; he may have wanted to shake them out of the dream of being the greatest nation in the world and their leaders as the best. But why did he not pick on some of the other great Americans: George Washington, Benjamin Franklin, Thomas Jefferson, Theodore Roosevelt? Why exactly did he pick on Lincoln? This brings us to the fourth question. It is more difficult to answer. I may be able to, if you will permit me to psychoanalyze Dr. Brill himself. I am in a better position towards Brill than he was towards Lincoln. Brill is still living. Like towards Lincoln, he must have had an enormous transference towards me otherwise he would not have chosen me, a total stranger, to discuss his paper. Moreover, I saw him in action (he never saw Lincoln). Particularly significant was the situation in which I placed him after my comments. He was taken by surprise and so he was like a subject in a psychodramatic test. He had to counter spontaneously, he had to improvise his comments without preparation. The first remark he made was about my "histrionic" manner. This is interesting; he had been accused of being histrionic himself because of the publicity which he had given to the paper about Lincoln many months in advance. He was building himself up to appear before the world, the American public, in a great role, the role of the psychoanalytic emancipator and liberator. Seeing him in action, I could not help comparing him with Lincoln, the object of his analysis. He was little more than five feet tall. Lincoln was a giant, way above six feet. Both have a beard and both have the first name, Abe. I imagine that when Brill came to this country as a little boy he soon heard about his namesake, the great American emancipator and he felt very warm towards him. He became his idol. He thought that maybe some day he would be like Lincoln and President of the United States. But sometime after he must have been disillusioned when he heard that this honor is not available to a foreign-born. The seed for a conflict with Lincoln was beginning to take root but it remained dormant. Either he had to accept that there was a greater Abe than himself or he had to find some counter measure to overcome his own weakness. Many years later, when he became a student of medicine a solution offered itself. He came to Vienna, met Freud and became acquainted with psychoanalysis. Now he had found a weapon by means of which he could fight all the prophets and geniuses, all the superior people of history, especially a particular one. He returned to this country, rapidly rose to influence and became the outstanding exponent of psychoanalysis, the Freud of America.

Brill had waited patiently for a chance to measure up to that other Abe and today, in this hall, before all of us, he had this opportunity—The President of the American Psychoanalytic Society versus the President of the United States. Of course, I am giving you this analysis in a preliminary form and with all humility that it may require further investigation and extension.

Last but not least, the question must be answered: Why did he choose me to discuss his paper? It was, to say the least, an irrational choice.* Why did he choose as a discussant one of the opponents of psychoanalysis? Why did he choose an immigrant, like himself? Why did he not choose a native American? Why didn't he choose an ignoramus who would make a good figure in the newspapers? Why did he choose me who knows psychoanalytic tactics inside out? For Brill the reading of this paper was a climax of his career. Why did he make a slip at such a critical moment? What are the jokes and tales of Lincoln compared with this joker? I do not recall any such slip which Lincoln made in critical situations of his own, manifesting so little insight as Brill manifested today. I was already in Vienna a blunt critic of psychoanalyis.** Brill must have known of my radical theories about the group and the therapeutic theatre. Indeed, I was, long before my arrival in New York harbor one of the most outspoken opponents of psychoanalysis. I was dangerous, not as much because I knew its limitations but particularly because I had developed methods which the future will, as I claimed, prove to be superior. My answer as to why Brill slipped is: he was not quite sure that psychoanalysis is able to analyze geniuses of the calibre of Abraham Lincoln; he was not quite

*Irrational it was, in a psychoanalytic, but not in a sociometric sense. Brill and I were, as we sociometrists call it, in the "networks," although strangers closely related. We had many emotional acquaintances in common, psychoanalysts, psychiatrists and others, with numerous links between them. These links are channels of influence and communication preparing the individual target for important decisions. These "tele" factors work on an individual although he is hardly conscious of the complex network which it forms around him. Apparently at the time of the meeting, on the morning of June 5, 1931, I conveyed the perception of a pretty safe figure to the mind of Dr. Brill. This perception was probably shared and underlined by one or two people who happened to be good friends of Brill and myself.

**"Es war die Psychoanalyse, welche mit dem Kampf aus dem Hinterhalt gegen das Genie begonnen hat, um ihm seine Komplexe vorzuhalten. Sie ist die Rache des Normalkopfes: nach der Entgoetterung der Natur und der Gesellschaft. Die Entgoetterung des Geistes. Da jedermann Komplexe hat und das Schaffen aus Komplexe besteht, ist jeder ein Mann. Es gibt nur Genies. Der eine gibt sich Muhe es zu sein, der andere nicht. Nun fallen die Philister offen uber Simson her: es ist nur der Komplex, die langen Haare. Jeder kann sich Haare wachsen lassen." Translated into English: "It was the influence of psychoanalysis which waged a war from the rear against all genius in order to reproach him with his complexes. Psychoanalysis—if one looks at it from a high historical plane (which does not minimize its great contributions) is the vengeance of mediocrity: after the devaluation of nature and the devaluation of society, the devaluation of spirit. As everyone has complexes and as creativity consists of complexes every man is a genius. There are only geniuses. One tries to be one, the other doesn't. Now the Philistines dare attack Samson openly: (as there are no heroes he is not a hero) what holds him up and what makes him strong is only the complex, the long hair. Everyone can let his hair grow long." See "Rede vor dem Richter," Gustav Kiepenheuer Verlag, Berlin, 1925, p. 21, now available at Beacon House, New York.

sure that he, as an individual—an immigrant—was the one to deliver the blow to American autism and he was also not quite sure that the American people will accept him, Abraham Brill, the deliverer, as an idol instead of Lincoln. He feared that he was playing a losing game. He felt guilty and Freud was not around to help him and in a masochistic mood, with a brazen gesture he called upon the very man whose ways of production and presentation should have been as mysterious to him as those of Abraham Lincoln. He called upon myself. Like the dying Hamlet he called Fortinbras to take over.

It would be only fair for me to tell you also why I accepted Brill's invitation. I had two reasons. The one was that Brill represented psychoanalysis which I esteemed highly but considered as my natural opponent. *It is the method which I believe my methods have surpassed.* The second reason was my profound sympathy for Abraham Lincoln. I felt as if I took his place, like a double in a psychodramatic session. As I spoke, I felt as though, in a way, Lincoln spoke through me. He, the defenseless dead, defended himself. He appealed to me as a psychodramatic character in real life, a producer of ideas and actions. The psychodrama of his own life and the sociodrama of the American continent were merging on that morning of June 5th, at the Hotel Royal York, into one great, indissoluble event. The history of the last twenty years has made the Brill-Lincoln incident symbolic. Psychoanalysis has "conquered" the world, at least the western world. But, wherever psychoanalysis goes, group psychotherapy and psychodrama are coming and taking its place.

I had hardly returned to New York when I got a telephone call; it was from the president of the Pathe News. "I have read what you said about Abraham Lincoln, in the "New York Times" and other newspapers. Your statements have aroused great public interest and I would appreciate if you would permit Pathe News to interview you for its forthcoming newsreel." I answered, "I'm sorry, but my comments were given at a medical meeting. I have nothing further to say." "Well," said the spokesman for Pathe News, "that's too bad, because it was not only a scientific paper. The honor of a great American figure, which you defended so eloquently, was at stake. Besides," he added, "Dr. Brill has accepted to make a newsreel for us." "Well," I said rapidly, "that changes the situation. Whatever Brill does against Lincoln, I will do for him." And so as many people may remember, in the course of the summer of 1931 moving picture audiences could see and hear Brill getting up and trying to prove that Abraham Lincoln was a schizoid-manic personality and I standing up after him and disproving it.

The reader may reproach me for not publishing an account of the Lincoln incident immediately or soon after it occurred, instead of waiting until now, almost twenty years later. The question is appropriate. But Brill himself hesitated. What is still more surprising—as far as my knowledge goes—his paper did not appear, either in a psychiatric or in a psychoanalytic journal. It has remained unpublished*. He was obviously very much displeased. Apparently he was not only displeased with me but also with his paper and with himself. He wanted to bury the incident and my discussion with it. I did not give a public account of my own reaction because I did not want to hurt Brill and make him feel that this was a personal matter with me. I did not deal with Brill. I dealt with psychoanalysis and Abraham Lincoln.

But Brill was a great fighter and endowed with a keen sense of humor and so, as years went by, the incident would have been forgotten, were it not for the fateful relation of this incident to the beginnings of group psychotherapy. As we shall see, we group psychotherapists owe to Brill an immortal debt and this is the chief reason why the Lincoln incident is here recorded. Had I not been invited by Brill to discuss his paper the first official entrance of group psychotherapy into psychiatry may not have taken place, at least, not at the strategic moment and the dissemination of the idea might have been delayed or side tracked for many years.

First Chain Reaction

A number of circumstances made the incident the opening gun, the cradle of group psychotherapy within the American Psychiatric Association and thus for the United States. The first "chain reaction" occurred soon after the meeting. While I was surrounded by newspapermen who bombarded me with questions as to when I came to this country, what I think of psychoanalysis and whether I have a cure for schizophrenia, a man approached me and introduced himself as Dr. E. Stagg Whitin, Chairman of the Executive Council of the National Committee on Prisons; he invited me to attend a luncheon conference on prison problems and prison industries. At the end of the conference, members of the Committee asked me whether I have any suggestions to make as to how to treat mass problems, criminal populations, especially prisoners and mental patients. I recommended the use of group psychotherapy in prisons, reformatories and mental hospitals. "The classification of people as parts of a

*It appears doubtful that Dr. Brill published his Toronto address in any generally accessible publication; at least such publication is not recorded in Dr. Philip Lehrman's Bio-Bibliography (181 items) in his paper "A. A. Brill in American Psychiatry," **Psychoanalytic Quarterly**, Vol 17, 1948.

social organization assigns them neither by individual diagnosis nor by nature's suggestion in placing the homogeneous and the heterogeneous uncritically together. It should attack the problem not from the outer structure of the group but from its inner structure—The inner structures of the group have to be continuously studied as they indicate the actual, dynamic relations existing in them—The more hostile to cooperation a patient is the more important is the *finding* of persons towards whom he reacts favorably. The spontaneous choice factor is to be considered first and is to be disregarded only if all other factors and symptoms indicate that the choice is disadvantageous for either one or both persons—It is only through the interaction of one or more persons who are coordinated to the patient that the curative tendencies within are strengthened and the disparaging tendencies within checked that in turn he may be able to influence the partners of his group in a similar manner. To make this method useful for a mental hospital we proceed in relating to every patient the nearest and closest persons, the other patients and the personnel." To sum it up, "*group psychotherapy is a method which protects and stimulates the self-regulating mechanisms of natural groupings . . . through the use of one man as a therapeutic agent of the other, of one group as a therapeutic agent of the other**."

Second Chain Reaction

I had hardly left the Crime conference when I met Dr. William A. White in the lobby. He invited me to attend a conference on psychiatric education. There were many in the audience of this conference who had witnessed the Lincoln incident. Dr. White gave me an opportunity to speak; I introduced an idea new to them: the use of psychodrama and role playing in medical education. "The doctor of the future," I said, "will come to the classroom, but not only to hear lectures about medical science but to practice before the group of other students how to take the role of the doctor in various situations, to learn the bedside manner and how to gain the patient's confidence, how to take the role of patients in various situations and how to deal with other significant problem situations encountered in medical practice, members of the patient's family, nurses, consultants, colleagues, and situations of birth and death. *The analysis of psychotherapists on the couch is unrealistic* to say the least and the training by means of motion pictures, although useful, is entirely passive. No medical students, particularly no specialist in psychiatry should be graduated as doctors of medicine unless he has received adequate *action training* and passed the psychodramatic tests. It should consist of thorough

*Quotations from "Application of the Group Method to Classification," pp. 90, 96, 97, 104.

orientation and training of the future doctor in all crucial professional and personal situations." These ideas may have seemed fantastic to some of the colleagues and "unsound" but they apparently made an impression upon Dr. White. Just as in the case of group psychotherapy he became a warm supporter of psychodrama and one of its most effective sponsors. It is to this little incident that one of the historical monuments to the idea, the Theatre of Psychodrama at Saint Elizabeths Hospital* can be traced. After having done much for sociodynamically oriented group psychotherapy and sociometry* at Saint Elizabeths Hospital, the idea of giving psychodrama a niche in the capital was foremost in his mind. When stricken with a grave illness in 1937, Dr. White spoke with Margaret Hagan, then Director of Red Cross, about the future development of Saint Elizabeths Hospital She gave him the assurance that she would bend all her energies and see to it that a Theatre of Psychodrama be built there. Three years after his death it became a reality, thanks to the efforts of Margaret Hagan and Dr. Winfred Overholser, Dr. White's successor.

Third Chain Reaction

Upon my return to New York, the National Committee on Prisons began to put all its contacts into operation, in order to mobilize interest in group psychotherapy throughout the nation, in numerous departments of correction, social welfare and education. I visited prisons, reformatories, schools, where group psychotherapy could be applied, and began to experiment first in Public School 181 in Brooklyn, then in Sing Sing Prison and prepared, on the basis of old notes the monograph titled "Application of the Group Method to Classification," later renamed "Group Method and Group Psychotherapy." Through the aid of the Department of Social Welfare of the State of New York, I began my eight years' study at the Training School for Girls at Hudson, New York. I started an educational project at the Riverdale Country School. All these studies amassed significant material of great public interest. Therefore, through the aid of Dr. Vernon C. Branham, then Deputy Commissioner of Correction for New York State, the services of Dr. William A. White were harnassed as moderator of a Round Table Conference on the "Application of Group Method to Classification" at the Philadelphia meeting of the American Psychiatric Association on May 5th, 1932. My monograph on *group method* was published by the National Committee on Prisons and two thousand copies were distributed throughout the country; this book was made the core around which the Philadelphia Round Table conference was arranged. It was at-

*See Official Records and Notes.

tended by nearly one hundred psychiatrists and made the idea of Group Psychotherapy widely known. All this happened in a few months of feverish action and it all came—in a way—from that "histrionic" moment, the irrational choice of the psychoanalyst Dr. Brill of myself as a discussant of his paper on Lincoln.

Climaxing this development in which at times I was more led than the leader, the Medical Society of the State of New York presented at its meeting in New York, March 1933, more than one hundred and twenty-five sociometric charts which laid bare dynamics of group structure, making large numbers of medical and lay persons realize for the first time that the therapy of groups can be practiced on an exact basis. Immediately following I presented at a joint session of the American Psychiatric Association with the American Association for Mental Deficiency a paper entitled "Psychological Organization of Groups in the Community" in Boston, May, 1933, discussed by Dr. White, published in the *Yearbook on Mental Deficiency* in 1933. Finally, upon the invitation of Dr. William A. White and Dr. Smith Ely Jelliffe, managing editor of the Nervous and Mental Disease Publishing Company, Washington, D.C., I prepared "*Who Shall Survive?*" *A New Approach to the Problem of Human Interrelations,* which appeared in March, 1934, with a foreword by Dr. White. This book became the "piece de resistance" for the group psychotherapies of all varieties, although at the time of its publication this was recognized by only a few. For many who were satisfied with psychoanalytical explanations of group formation or with influencing the group from the outside, for instance, by means of lectures or motion pictures, my approaches appeared then as startling. But in order to study and change the group from within, I had to develop an exact science of the group, sociometry. I did not develop sociometry for its own sake but to give group psychotherapy a tangible anchorage. Without its study of socio-and-action dynamics the modern advances of group psychotherapy would hardly be what they are.

It appears from the record that three factors have been chiefly responsible for laying the ground for the experimental foundations of group psychotherapy and bringing to an end the brilliant but indirect and metapsychological speculations of men like LeBon and Freud: 1) The readiness of the soil in the United States of America for group psychotherapy fermented by the powerful philosophies of pragmatism and of progressive education embodied in such great figures as Charles Saunders Peirce, William James and John Dewey; 2) The trend towards group methods operated in many minds, each with a cradle of his own, in Europe and the United States; 3) the energy and luck of my lead-

ership; as if in a fever all the rivulets flowed into the chain of events which found their historical expression within the American Psychiatric Association. Since the psychiatric meetings in Toronto (1931), Philadelphia (1932), Boston (1933), New York (1934) and Washington (1935), during which years sociometry gave to group psychotherapy its first approximation of diagnostic foundations, group and action methods began to spread with such rapidity, emerging in so many diverse minds and places that individual contributions were washed away, the anonymity of the movement becoming one of the greatest spurs to its rapid dissemination and acceptance. World War II made "group psychotherapy" and "psychodrama" phrases used in daily coinage everywhere and in the last years since the war's end, the number of workers in these areas have gone into many thousands here as well as in Europe.

The world-wide unrest, the flaring up of social revolutions and local wars place a responsibility upon psychiatry and psychiatrically oriented workers for which there does not seem to be but one answer: the *development of methods of mental therapy* which can be applied to *large masses* of people and their development in such a way that they secure beneficial results which are lasting, measurable as well as repeatable by other workers.

OFFICIAL RECORDS AND NOTES

The Toronto Meeting of the American Psychiatric Association

(June 2-5, 1931)

a) The Brill-Lincoln Incident.

This meeting is recorded in the *American Journal of Psychiatry,* official organ of the American Psychiatric Association, Volume XI (old series: 88), p. 362, July 1931, as follows: Friday Morning Session, June 5, 1931—The joint session with the American Psychoanalytic Association convened at nine-thirty o'clock, President English presiding. President English: I have great pleasure in calling for the paper on "Abraham Lincoln as A Humorist" by A. A. Brill, of New York. Dr. Brill read his paper. President English: Ladies and gentlemen, this was such an interesting paper that I was loathe to ask Dr. Brill to stop. It is now before you for discussion. From its presentation I see nothing of which we can complain. Dr. Brill's paper was discussed by Dr. Jacob L. Moreno, and by Dr. Brill in closing.

b) Luncheon Conference, National Committee on Prisons and Prison Labor.

This meeting is recorded in the *American Journal of Psychiatry,* Volume

XI (old series: 88), p. 822-833, January, 1932: Psychiatry and Prison Problems—A luncheon conference called by the National Committee on Prisons and Prison Labor to discuss the relationship of psychiatry to the problem of the adult prisoner was held in Toronto, Canada, on June 5, 1931, during the sessions of the American Psychiatric Association. The National Committee on Prisons and Prison Labor was presented by Dr. E. Stagg Whitin, Chairman of the Executive Council. The guests included officials of federal and state penal institutions, Departments of Correction, Public Welfare Commissions, Mental hospitals and clinics, criminologists and members of the American Psychiatric Association. Dr. Vernon C. Branham, Deputy Commissioner of Correction of the State of New York, presided at the Conference and opened the discussion by emphasizing the need of further extension of psychiatric teaching and practice in the correctional field . . . . Following a general discussion the Conference adopted a resolution that a Committee on Cooperation, with Dr. Whitin as Chairman, be appointed with the advice of Dr. Russell, the incoming President of the American Psychiatric Association.

Referring to the above luncheon conference, George Gordon Battle, President of the Committee on Prisons and Prison Labor reports in the Introduction of "Application of the Group Method to Classification," March 1932, p. 3; "The National Committee in Prisons and Prison Labor, upon invitation of the officials of the American Psychiatric Association, held a round table conference at the time of the Annual Convention of the Association in Toronto in June, 1931. At this conference Dr. Moreno made some suggestions which appeared of such live interest that the Committee requested him to study types of prison discipline which would have bearing upon his proposals and to develop a concrete plan for the socialization of correctional institutions. The following formula is provisional as it is based on an investigation which is still in process. It is presented as a basis for general discussion and further research by Dr. Moreno and others."

c) Round Table Conference on Psychiatric Education, Moderator Dr. William A. White, June 5, 1931.

THE PHILADELPHIA MEETING

(May 30 - June 3, 1932)

a) Publication by the National Committee in Prisons and Prison Labor of the Monograph "Application of the Group Method to Classification" by Dr. J. L. Moreno in collaboration with Dr. E. Stagg Whitin, August, 1931, March and May, 1932.

Two thousand copies were distributed by the National Committee among psychiatrists, psychologists, sociologists, criminologists, educators and so forth, preparatory to the projected meeting in Philadelphia. The second edition of the monograph contained comments as to the value of group psychotherapy from mental hospital, prison and school authorities.

b) Announcement of the Round Table Conference.

The "Application of the Group Method to Classification," Moderator Dr. William A. White, to take place in Philadelphia on May 31. See *American Journal of Psychiatry,* Proceedings of the eighty-eighth annual meeting, Vol. XII, page 572 (-73). Chief speaker was J. L. Moreno, the originator of the group plan.

c) The Conference took place at the Bellevue Stratford Hotel, May 31 and was attended by more than ninety representatives of mental hospitals, prisons, reformatories, training schools and so forth.

The proposal of Moreno's Plan of Group Psychotherapy was read by Dr. William A. White. "The proposal for the Application of the Group Method to Classification of Prisoners has grown out of a luncheon conference arranged by the National Committee on Prisons and Prison Labor through the courtesy of the American Psychiatric Association at our meeting in Toronto last year, 1931, at which many of you were present. Dr. J. L. Moreno suggested "group psychotherapy" of prisoners and as a result the authorities of the New York State Department of Correction permitted Dr. Moreno in collaboration with Dr. E. Stagg Whitin, Chairman of the Executive Council of the National Committee on Prisons and Prison Labor, to carry on research at Sing Sing Prison. Through their efforts, the plan has developed which is the topic of our round table discussion."

Release to the Press: Prisons Plan Formation of Social Groups. New York, See *Journal American,* April 12, 1932.

d) A report of the proceedings of the Conference on Group Methods was released and widely distributed by the National Committee on Prisons and Prison Labor in 1932 and reprinted in Group Psychotherapy (Ed. J. L. Moreno), by Beacon House, 1945, p. 15-39.

Moreno's Plan was Based Upon Experiments in Group Psychotherapy Carried Out at the Following Institutions

a) Plymouth Institute, Brooklyn, 1928 (Beatrice B. Beecher); b) Grosvenor Neighborhood House, New York, 1929 (Myrtle P. Bridge); Nursery

Schools of "The School of Individual Development," Bronx, Manhattan, Brooklyn and Kew Gardens, William H. Bridge and Elsa Maller. Impromptu Theatre, Carnegie Hall, 1929-1930 (J. L. Moreno); Hunter College (Department of Speech) 1929-1930. P. S. 181, Brooklyn, New York (Nathan Peiser) 1931. Application to a Mental Hospital situation, Long Island, N.Y. (psychotic patients), 1930. Sing Sing Prison, 1931. New York State Training School for Girls, 1931-1938. Riverdale Country School, New York, 1932.

Sponsorship of Group Psychotherapy Research by Dr. William A. White, 1929-1937

Moreno's first meeting with White, 1929, interest in interpersonal therapy began. Second meeting, 1931, APA, White invites Moreno to discuss psychodramatic training at the Round Table Conference on Medical Education. 1932, Meeting in Philadelphia, Moderator of the Conference. Frequent meetings between White and Moreno in the course of 1932-1933. 1933, Joint Section, American Psychiatric Association and American Association on Mental Deficiency. White discusses Moreno's paper *"Psychological Organization of Groups in the Community,"* Summer, 1933, White writes the preface to *"Who Shall Survive?"* New York, 1934, Moreno's book *"Who Shall Survive?"* published by the Nervous and Mental Disease Company as Monograph No. 58, edited by White and Jelliffe. 1935, Moreno presents at the American Psychiatric Association meeting, Washington, D. C., a paper, *Spontaneity Training, An Approach to Personality* Development, accompanied by a therapeutic motion picture, discussed by White. White urges Winifred Richmond to undertake a sociometrically oriented group study of the nursing staff at Saint Elizabeths Hospital between 1935 and 1936, published in the Sociometric Review. 1937, Dr. White joins editorial staff of *Sociometry, Journal of Interpersonal Relations.* (See *Sociometry,* Vol. I, 1937, p. 258.)

After Dr. White's death Dr. Winfred Overholser, new superintendent of Saint Elizabeths Hospital with the assistance of Margaret Hagan of the American Red Cross, continued his efforts which brought about the establishment of the first theatre of psychodrama in a large mental hospital, 1940.

Biographic Notes

Dr. William A. White, Superintendent of Saint Elizabeths Hospital, Washington, D. C.; President of the American Psychiatric Association, 1924-1925; President of the First International Congress of Mental Hygiene, 1929; Contributing Editor of *Sociometry,* A Journal of Inter-personal Relations, 1937.

Dr. E. Stagg Whitin, Ph.D. Columbia University; Chairman, Executive Council of the National Committee on Prisons and Prison Labor; published "Penal Servitude."

GROUP PSYCHOTHERAPY, THEORY AND PRACTICE

RECOMMENDATIONS PRESENTED AT THE A.P.A. PHILADELPHIA CONFERENCE ON GROUP METHOD (JUNE, 1932)*

J. L. MORENO, M.D.

INTRODUCTION

This article is taken from an abbreviated and revised edition of the *Application of the Group Method to Classification* (released in three steps, August, 1931, March and May 1932, by the National Committee on Prisons and Prison Labor N.Y.). The monograph consisted of an original unit and numerous addenda; this revision has merged the three aspects—Plan, Diagnosis, Therapy—into an integrated whole. Except for a few explanatory paragraphs here and there the original text has remained unchanged. Two short chapters have been added, "Sexual Group Psychotherapy" and "Behavior and Action Models of Therapeutic Groups." (The complete book *Group Psychotherapy, its Origins and Foundations*, published by Beacon House, N.Y. is now in press.) The reason for presenting here large parts of a monograph which is nearly a generation old is threefold: 1) the catalyzing force it happened to have had in the development of group psychotherapy in the United States; 2) the objectives and problems which have been formulated are as vital now as they were twenty years ago; 3) it presents in an embryonic stage the experimental and analytical approach to group psychotherapy by its combination with diagnostic and action methods. The *Group Method* monograph stands among my publications midway between the *Theatre of Spontaneity* (1923) and *Who Shall Survive?* (1934). The course which group-and action research-and therapy are increasingly taking is along lines which I have initiated. This does not reduce the merits of the work of such pioneers as Joseph Pratt and Trigant Burrow. These are some of the terms and phrases which my monograph brought into currency for the first time in American literature: "group therapy," "the inner and outer dynamic structure of groups," "spontaneous group therapy," "*warming up* to a situation," "situation test," "spontaneity test," "sub species momenti," "locus nascendi," "therapeutic society," "social quotient," "interrelation diagnosis and therapy," "one man a therapeutic agent of the other." It contained the earliest sociograms and the first American publication of action diagrams (from my Stegreiftheater book) which have pioneered the analysis of interaction processes and a measuring rod to group psychotherapy.

I THE GROUP PLAN

Objective

The objective is to transform a poorly formed system of human relations into a socialized community through a method of assignment of individuals to social groups; to move towards a "therapeutic society" which can gradually take the place of the politico-economic societies of our time without sacrificing any of the positive values their ideologies have developed; to build a community which gives its citizens three things, the freedom which comes from spontaneity, the justice which comes from fair play, and the therapeutic balance which comes from linking man's world to the life and future of the universe—a free, a fair and a therapeutic society. The bourgeois and proletarian revolutions are superceded here by a therapeutic revolution: after the "contract social" the "contract therapeutique."

The plan can be applied to any human settlement, to open as well as to closed communities, cities, villages, prisons, schools, hospitals or whatever.

I The Closed Community

Distribution

The question has been raised as to whether the prison community can be "sociometrized" thereby continuing within the prison walls the process of social organization which from the earliest beginnings of primitive society, even though in varied forms, has done more to keep men from harming their fellowmen than all penal laws, punishments and charity combined.

The classification of prisoners today considers only the individual prisoner as such. *The inter-relationship of one individual to another* is not reflected in the present theory and practice of classification. The latter, however, is the crucial point in any attempt to create a balanced community.

The first step* is the breaking up of the population into social units. Every unit should consist of a limited number of persons and groups should be organized by combining a limited number of units which are fitted for association with one another. This distribution cannot be left to accident, circumstance, or superficial decision. It must be the result of a complex social and psychological analysis.

*In prisons this has to be preceded by the elimination of the sick, the crippled, the venereally infected and the psychotic, through their placement in appropriate institutions; the remaining individuals form the large mass of the community.

The terms "unit" and "group" are often used to connote a mechanical aggregation of individuals without any indication of their social interrelation. They are called a group in the open community because they belong to this settlement, this neighborhood, this church, school or political organization, in closed communities because they belong to this dormitory, to that cottage, or to one labor shop, or because they are suffering from the same malady or deficiency. But "unit" *in this plan* means that a social pattern is followed and that *the individuals in a unit are chosen, "typed" for it, through a social analysis.*

Organization

Each unit should be distinguished as a distinct functioning entity. The life of a unit should be so regulated that the major domestic, labor and social activities of all members of the unit are common to all and so balanced up, one with the other, that a therapeutic cohesion and equilibrium is reached and maintained.**

Units

Each unit should have one specially selected leader. The simplest technique in *splitting up the mass of individuals into units will be in the beginning* to pick the men best fitted for one another, then the leaders best fitted to the men of each unit and finally to each leader the men best fitted to him. Factors considered in the assignment of individuals to units are: spontaneous choice of associates, mental type, sexual characteristics, social kinship, racial traits, former performances, delinquency record, actual observations of behavior where they live and work.

In addition to the individual factors, the factors which develop through the *interrelations* of the individuals within the group are significant. They are influenced by three relations:

1. That of the individuals attracted to each other and sympathizing with the leader.
2. That of the individuals opposed to each other and opposing the leader.
3. That of the neutrals.

**When the therapeutic group plan was published sociometry was in its early stages of development. Then it seemed to be a desideratum to reduce the number of units of which a society consists to as few as possible. I had in mind the early primitive family associations which included all activities, domestic, labor and social in the same unit. It seemed plausible therefore, to recommend such a monistic form of organization to communities like prisons which needed to be governed by a minimum of staff. Since then, however, the knowledge of sociometry has grown and it is clear today that a highly diversified, flexible, pluralistic society could be maintained with a large number of units as long as the sociometric matrix is continously traced and charted and brought to the awareness of the participants.

No unit should consist of more antagonistic elements than the leader can handle.

Factors considered in the selection of leaders for units include: key position in the sociogram at the time of group formation; father qualities; greater maturity in intelligence, experience and character development than the men of his unit; similarity of social kinship with the majority of his associates; successful performance in the past in managing a legitimate business or in building a family; the socially minded are preferable to the solitaire type, the solitaire to the rebellious and so forth.

The placing of similar *and* contrasting types into the same unit prevents the formation of destructive gangs and at the same time gives impetus to socialization of interests.

Individual, Social and Work Analyses

A social and work analysis of every member of the group should be added to the case record. The individual case analysis may have given information in regard to heredity or acquired traits and so forth. The social analysis may show whether the association with certain other persons will contribute to the integration or disintegration of character, and may indicate further how a person will function in a unit with suitable co-workers. The work analysis shows special aptitudes and skills.

With this information secured, the distribution plan can be continuously balanced in the following manner: at first, the units in the work shop are identical with the social units. But if the foreman or the individual desires a therapeutic change from the work point of view, the individual can be transferred from the first unit U.1 to another, as more than one unit has been tested for him and the rate of their desirability determined. Thus he might be transferred from U.1 to U.5 or U.9 which still belong to the units desirable for him. In this manner, *within the group plan, the social requirements of the members of the group can be harmonized with an apprenticeship system in industries.*

Experimentation will make clear to which phases of the industrial process this plans is or is not applicable. Preferably it should be tried out with maintenance workers who are housed together because of special administrative needs. *This system of social organization will prove a stimulus to efficiency in labor. It will increase production.*

The Advantages of the Group Method

The inhabitants of a prison, hospital or school community are, with few exceptions, not permanently assigned to it; they come and go according to the requirements of the individuals. Consequently, the units of which the community is composed, according to the schedule above, are never final, but in continual flux. They are altered by the number and type of inhabitants who enter, are transferred, or released; in other words, the units do not have a permanent membership. The classification staff should therefore be in intimate touch with all the actual conditions of the whole community and reflect in their analysis the changing situations within every unit caused by the incoming and outgoing of members. Only by considering all the concrete facts of the life of the community will they be able to maintain a balance of forces in the units which they select.

Economic Factor

The process of grouping and co-ordination is simplified to a degree that it can be carried out under direction of a psychiatrist assisted by a socially trained staff at a *minimum* expense. Such groupings will tend to eliminate many of the disciplinary and administrative duties now entailed upon the overburdened staffs of officers, it will facilitate and strengthen the government of the institution.

II The Open Community

The group plan can be applied to every phase of the open community. It requires, of course, many extensions and modifications and more than anything else concrete experimentation in many places all over the globe in order to deal effectively with situations of great complexity, the sexual and family systems, the religious and political systems, the educational and industrial systems, the systems of legal representation and of government. In a prison, for instance, the sexual situation is by decree reduced to a homosexual system, the economic and industrial situation to a paternalistic system. The prison society is neither free nor complete; however much sociometric processes might be combined with practices of self government of prisoners it can at best be considered as an experimental laboratory in behalf of a long-range aim, to transform the open community into a therapeutic society which will have as one of the ultimate consequences the abolishment of prisons. Although the group plan should be tried in closed communities and small settlements as subsistence homesteads and cooperatives its true objective is the society at large.

The point of view which inspired me before launching the plan of a therapeutic model of humanity was that if by the miracle of a benevolent God or by decree of a total revolution human society will be atomized and freed from all its cancerous and tantalizing social disorders, from all its unfit groupings and configurations, its family-political and cultural systems, "de"structured down to its fully disconnected two billion individuals—then we could start from scratch and build a society of a therapeutic order.

Historical Aspect

There are beginnings of this plan in the history of therapeutic endeavor. We found an approach to it in a general way in the monastic system, especially in the Rule of Saint Benedict. He asked of the abbot, the governor of the monastery, that he know every monk intimately and, if the population were too large, that he subdivide it into small groups and appoint deans to head them.*

The modern problem is to bring our efforts to a conscious formulation and to introduce into all social institutions a scientific technique of group classification and assignment according to the interrelation fitness of their members. The primary question is their fitness or non-fitness for a group.

II GROUP DIAGNOSTIC TESTS

Spontaneity Test

The intelligence tests have been made after the model of formal interview. But to answer set questions and to meet reality are two different things. We need in addition to what we have a method of testing which is patterned after a life situation. This is what the "Spontaneity Test" attempts.

While a mental test such as the Binet is a standardized interview and gives specific tasks directly to be done by the subject, the Spontaneity Test gives the situation in which the subject, alone or with other subjects, is to embody functions and during this functioning, products like the tasks which are expected emerge.

The deficiencies in our methods of intelligence testing have been frequently observed and considered as problematic by numerous investigators. Also, we may add, when entire race groups (Negro, Mongolian, etc.) and entire nationality groups (Italian, Russian, Polish, etc.) are judged by some investigators on

*Among the pioneers in penology, Col. Montesinos, B. Obermayer and Sir Walter Crofton have worked in a similar direction. Montesinos, as governor of the prison at Valencia in 1835 divided the population which numbered from one thousand to fifteen hundred men into small companies and appointed prisoners to be inferior officers.

the basis of the mental tests such as the Binet to be appreciably lower in intelligence than some nationality groups of northern Europe and the United States we have good reason to suspect that the measuring instrument itself is inaccurate or incomplete.

Individual classification based on available mental tests does not suggest to the student that totality and unity of the individual which is transferred to the observer through immediate contact. Yet it is evident to all who have had occasion to meet the offender in court or in prison that there are moments, spontaneous outbursts in his behavior, which infinitely more reveal his relation to the crime committed, his character and educability, than do all tests combined, now on record. In fact, every tester is more impressed by this irrational factor than may be admitted. But as it is a true "impromptu" element, it cannot be released at will, it is not as any other mental performance, so to speak, at the command of the psychologist. So it escapes record. With it, the possibility is lost for these intangibles to figure in rational classification.

The Spontaneity Test method offers a means to improve and to make more precise and adequate our ratings in classifications. Already during the course of mental testing itself, the spontaneous element has to be evaluated. The element of "warming-up" to a state has in different persons a different influence upon the result. The personality of the tester is an additional factor. The subject and the tester may not come "en rapport" if the personal and social contrast between them is too wide. Classification as it is carried out in prisons at present may further gain in accuracy and completeness if the spontaneous behavior of the man during his interviews with the various members of a classification board is rated by each of them and considered in the estimation of his intelligence together with the results of the mental tests given him. Further, the Spontaneity Test itself, the placing of the subject into situations in which he has to produce various states of behavior, gives us an estimate of the personality as a whole. The uneducated individual who rises to greater efficiency in situational crises often leaves far behind the classification made of him in the cold, abstract classroom. There is a considerable intelligence which grows through immediate, spontaneous experience. The racketeer or gangster, for instance, who is classified as feeble-minded because only the mental tests of the present laboratory are considered, may amaze the tester with his unusually high efficiency in crucial life situations.

Situation Test

Spontaneity Test and the Situation Test are closely related. The first emphasizes and measures the spontaneity of the individual *in* a situation, the other studies and measures the situation itself as a whole and the interactions between the individual participants. Both are "action tests." Freud and Jung have studied man as a *historical* development; the one from the biological, the other from the cultural aspect. In contrast my approach has been that of direct experiment: man in action, man thrown into action, the moment not part of history but history part of the moment—sub species momenti.

If we examine the files of our correctional institutions we discover a great deal of social data but a lack of distinct social classification. In recent years laudable work in individual classification has been initiated and carried out in some of our leading correctional institutions because the idea has matured that individual treatment is possible and necessary. We find the mental condition of the prisoner expressed in individual terms: feeble-minded, borderline, psychopath, psychotic, etc., but we do not find him expresed in social terms, although social classification and group treatment of prisoners are equally fundamental.

In the course of gathering and evaluating the importance of social data for the classification of a man, we arrived at the conclusion that the individual classification, feeble-minded, psychopath, etc., should be subjected to certain modifications. The factor of the *local group* has to be considered. An individual who is rated "feeble-minded" may, in the group in which he lives, be of average mentality or even slightly above the average. The testing of mental age judged on the basis of a nation-wide standard is abstract and unrealistic. It is not beyond practicability to find a measure to estimate the local factor. An illiterate Italian who has lived in Sicily until he reached sixteen and the next three years in an Italian section of New York, until his offense, may suggest during the mental testing a certain mental age. But how can we study in a case of this kind the local group factor if this is in some distant foreign city or an undefinable locality in greater New York? It can be done right within the the prison community, that is in those prisons in which the inmates enjoy a certain amount of freedom. There they have occasion to meet regularly in the prison yard. It can be observed there that he will gravitate towards a group of men of his nationality, or to a group which is similar to the one in which he has lived outside. Within this local-group inside the prison walls, if the testing could be done by a man well acquainted with the former, the result of testing might widely diverge from the laboratory one. The contact with these natural

groups within the prison community is a source of intimate information about the man which, if it should reach the classification room, would lead to modification of judgments. But this difficulty can be offset through *situation tests; several persons of the group with whom the subject who is to be tested prefers to mix are placed with him into a number of swiftly alternating situations or states;* his behavior and performance within this group might give the psychologist closer clues not only to his actual intelligence in the national scale, but also to his intelligence within the average range of his local-group. These instances are true also of one of the same social and racial kinship when he migrates from an agricultural to an industrial environment, from a primitive to a more civilized level of living. Thus, if the relative rank of intelligence of a man is compared to that of other men of his prison, it has little significance as long as the latter is so formalized and unorganized as today. Instead of comparing his grade of intelligence with a hundred individuals unrelated to him it would be of advantage to compare his intelligence with such inmates as mix in similar local-groups and have a similar local-group history and to rate it accordingly. It is obvious that the factors which rule the relations of individuals to groups and of groups to groups are the more important the more heterogeneous a society is, especially the more heterogenous its groups are, racially and socially, as in the United States.

Psychorecording

Reactions witnessed by the psychologist and revelations given by any individual during a course of interviews, spontaneity and situation tests, casual or planned, are, at least from the point of view of cooperative, controllable research, of little value since they are after the event merely memory impressions of the observer. The multiform interpretations offered by the subjectivists in psychology are without proper demonstration and reconsideration as long as they do not conserve the moment. I suggested therefore that "a talking machine should photograph the process*" and that we should make systematic use of this machinery of personality recording.

Occasions to study the use of electrical recording* have led the writer and his collaborators to lay emphasis upon the recording of spontaneous behavior especially of situations which are unprepared and unexpected by the person to be tested. A different value for psychological analysis has to be attached to material resulting from each of the following:

*Impromptu Journal, January 1931, p. 26, earliest suggestion of psycho recordings and playback for counseling interview.

*See The New York Times, February 2nd, 1925. (Steelwire and steeldisk).

a) Prepared reactions—behavior in situations which are known in advance and for which a response is prepared.

b) Spontaneous reactions—behavior in casual situations, undetermined either by the subject or by any other person.

c) Reactions in impromptu situations—behavior in situations assigned to the person to be tested. Each situation is an unexpected, "impromptu" situation. A situation may be, for instance, *a man returning home after a long absence.* The value of Spontaneity and Situation Test, can be considerably enhanced in accuracy and completeness if the classification departments of our institutions are supplied with machinery of personality recording. Conserves of the test can be *repeated* and not only are certain striking symptoms stored for duplication at will but also the otherwise unrecordable scale of mimic expressions. Reactions which may have been undervalued in the haste of presentation are available for study. Signs which are preferred by the psychologist and consequently stressed by him are present together with signs which he may have overlooked. A level of "intelligence" which is indicated in a rich aptitude for mimic expression may be observed simultaneously with a comparatively poor aptitude for verbal expression, or vice versa, and properly considered in the rating. These inconsistencies of verbal expressions with other expressions of the subject imply that free-word-association by itself is frequently a deceptive basis of study. Many gestures and movements, unintentional or intentional, pass unobserved by the testers during the test due to the fact that their attention is absorbed by the process. These actions often have a definite bearing on the subject's behavior. During the review of the record or film later, any subtle deviations in behavior may become prominent along with clues to conflicting tendencies within the acting persons.

Summing up, it may be said that the various mental tests, as the Binet, the Otis, the Porteus Maze and so forth, are of restricted value in classification. They do not make it possible to evaluate the individual as a unit and *as a being in action.* But action is just the factor which is of outstanding importance in the understanding of men who became so demonstrative and destructively active that they developed into offenders against the law. Activistic methods of psychological testing, the Spontaneity and the Situation Tests, combined with procedures of personality recording, as the psychorecorder and sound film will make the classification both more adequate and more realistic to the individual tested.

Individual classification alone is insufficient. Man lives within groups and is in his actions to a great extent regulated by them. The criminal, moreover, takes part often in the most rebellious and unusual types of groups. Social classification and charting of inmates in correctional institutions is therefore indispensable.

Spontaneity and Situation Tests are frequently *combined* in practice, the spontaneity of the individual and his situational acumen being examined in one test. They have the following features in common:

1) They are *action tests;* the subject is seen in an action of his own; not only as in an interview answering questions or talking about himself vis a vis an interviewer—but working out situations with actual partners as he lives them in life itself.

2) They are *Reality Tests;* the situations which he works out are not only his own situations but many of them he shares with other people; they are situations which he has encountered in the past, which he is facing now or which he is expecting to meet in the near future; if the situations appear unreal and fantastic it is because of the unreal, projective and delusionary character of his perceptions. The reality to be tested, for the wife of the subject, his inferior, his enemy or a hallucinated event—is not *outside* of the test and treatment situation, it is *inside* the test, otherwise the phrase "Reality" Test would be meaningless.

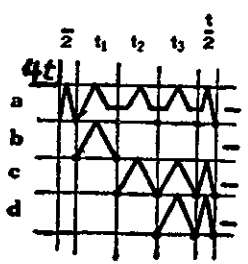
3) They are *Group Tests.* A person stepping into action and involved in a real problem cannot operate in isolation, he moves into interpersonal and group relations, and the whole immediate group of individuals interacting with him expose itself to test.

Interaction Test and Action Diagrams

Spontaneity and Situation Tests examine the individual in a group setting, the person *in situ.* The emphasis is still on the individual. But in order to treat a group as a total configuration we need tests which are able to examine groups as *wholes;* to accomplish this end interaction tests and sociometric tests have been constructed as illustrated by the following experiments. Let us describe the Interaction Test first. It grew out of a special phase of spontaneity research. As a director I wanted to give my actors at least a rough picture of the *total production* in advance, a sort of a future projection of it which might be to them and to myself a "compass" on a difficult mental voyage bound to be full

of surprising turns. I tried to visualize a string of scenes, the interactions within every scene, each possible interaction with its motive and its participant actors, the possible duration of each interaction, the number of actions and the number of pauses between them, the total duration, the positions and the movements of actors in space and last but not least some of the alternative versions the course of production might take. Once the production was on the way I realized the importance of making careful records of it, in order to compare the actual behavior of the actors *during* production with the course which I had anticipated. Two or three observers began to make records of the dialogues, movements and actions. In order to present the data in an effective manner I invented an action diagram; it portrays interpersonal communications already actualized or in the process of making. The following diagrams are records of interactions noted by observers. They must concur upon the locus of an action, its duration, the locii of each other individual participating in the situation. The following symbols are used to designate situation sequences. The sign for *a person in situ* is Λ The point of coordination or of timing between two individuals is . The sign for a pause is — The sign for time is t. p is person and s is state.

INTERACTION DIAGRAM



a (husband), b (wife), c (son), and d (daughter) are the roles taken by four individuals. The total diagram represents a process of interaction between these four. The plot consists of five situations, three of equal duration (t1, t2 and t3), two have half the duration of a time unit. Duration of plot: P-4t, t-5 minutes, p is four times five which equals 20 minutes.

a has the lead in the first situation, b takes the lead over in the second and c has the lead in the end situation.

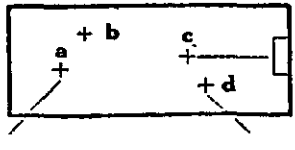
The diagram above is my earliest attempt to present the relations of a number of persons during a course of inter-action. The time relations are indicated by the abscissa. The affects projected simultaneously by each member of the group are indicated on the ordinate. Thus the diagram presents, on the one hand, a series of several individual pictures permitting a survey of the various states following in sequence; and on the other hand, the individual pictures as placed one above the other make it possible to distinguish what state of one person runs parallel with a state of another person, that is what are the points of coordination within the group.

The sign for a state preceding participation in the group process is 0. The sign for expressing a state, as fear, anger, joy or otherwise, is an ascending line (rising state) and a descending line (declining state) . Their meeting point represents the duration of each state. This sign can be modified so that fundamental states are distinctly designated.

These signs can be used to indicate the course of group action or for analysis. If, for instance, applied to the group therapeutic illustration on page 184, the corresponding states of Child I and Child II would be carefully charted so as to indicate wether the depression and embarrassment of Child I were on the increase or decrease. They would then suggest when strategic interference might be applied at the psychological moment. In our second illustration, page 186, a chart from the first phase would be able to indicate the persistence in Mrs. S. of a state of anxiety for days, so marked that no effort of cooperation from Mrs. M. could approach her, and that during the same period, Mrs. R. reacted towards both with manic excitement.

POSITION DIAGRAM

(Positions in social space)
Simplest form



Each cross indicates the position taken in the situation by the four individuals, a, b, c, and d at the beginning of interaction. The interaction and position diagram, both are taken from "Das Stegreiftheater" p. 88, published Potsdam, 1923.

The Sociometric Technique and Diagnosis of Group Structure

Another method which examines the structure of groups as wholes is the Sociometric Technique.

In classes with an average of twenty-five to thirty-five pupils, the children were instructed to chose spontaneously those pupils they would prefer to be associated with in their classrooms.

The self-assigning revealed that if the children had organized themselves of their own accord they would have chosen neighbors in their classrooms different from the ones they have now and would have developed definite groups with leaders and followers, drawing numerous outsiders from other classes into their midst and cutting off numbers of their classmates as undesired.

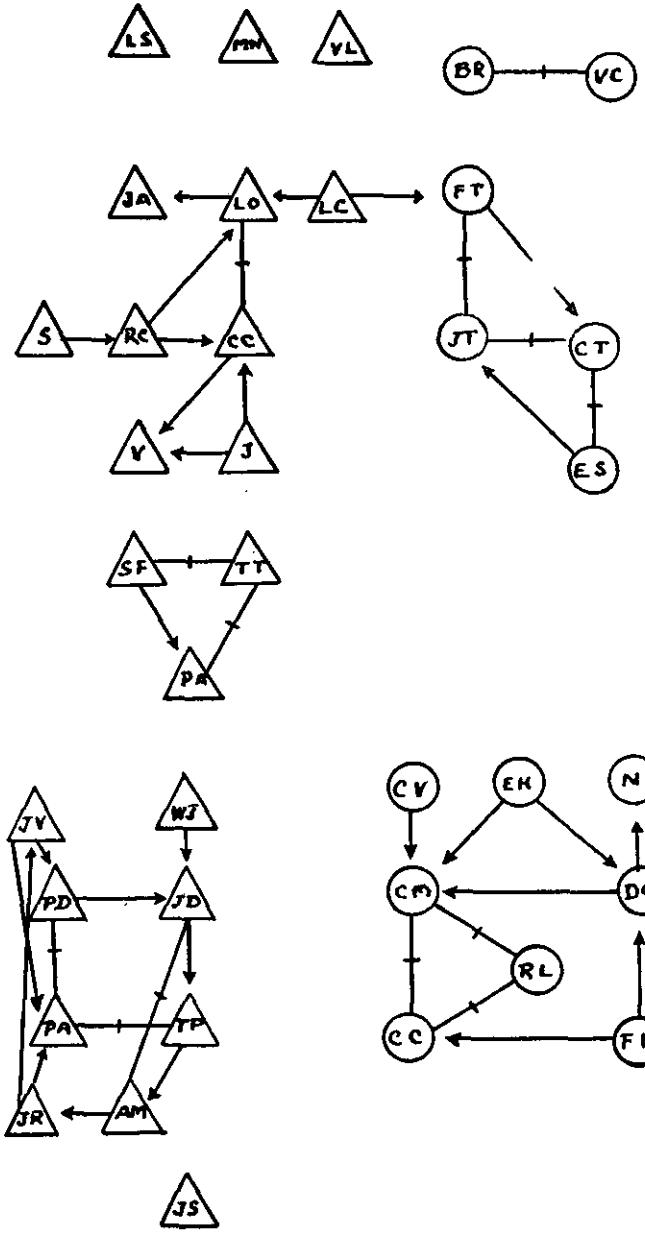
The following data are preliminary findings relating to four classes of the fifth grade of that school, Public School 181, Brooklyn, New York.

1. Approximately 10% chose one of their present neighbors.
2. Approximately 30% of the pupils were undesired by their own classmates.
3. The number of undesired pupils was considerably reduced if they could be chosen by pupils in other classrooms of the same grade.
4. Approximately 30% of the pupils in the classes here considered chose pupils of other classes, but of the same grade.
5. Over 50% of the pupils within the grade were chosen *mutually* within their own classroom.
6. There was one triple-mutual choice made by three boys and another made by three girls, cutting themselves off from the rest of the class.
7. Approximately 5% of the choices made were for the opposite sex.
8. Approximately 10% of the pupils were over-desired.
9. The estimates of the teachers as to who were their most desired and least desired pupils from the viewpoint of the children were surprisingly inaccurate (approximately 40% correct).

The objectives of sociometric experiments are to add to the knowledge of group structure. They corroborate the importance of the spontaneous choice factor in any system of classification which leads to group assignment.

The choices made by pupils for each other, in this case in reference to the criterion with whom they prefer to be associated in a particular classroom, is

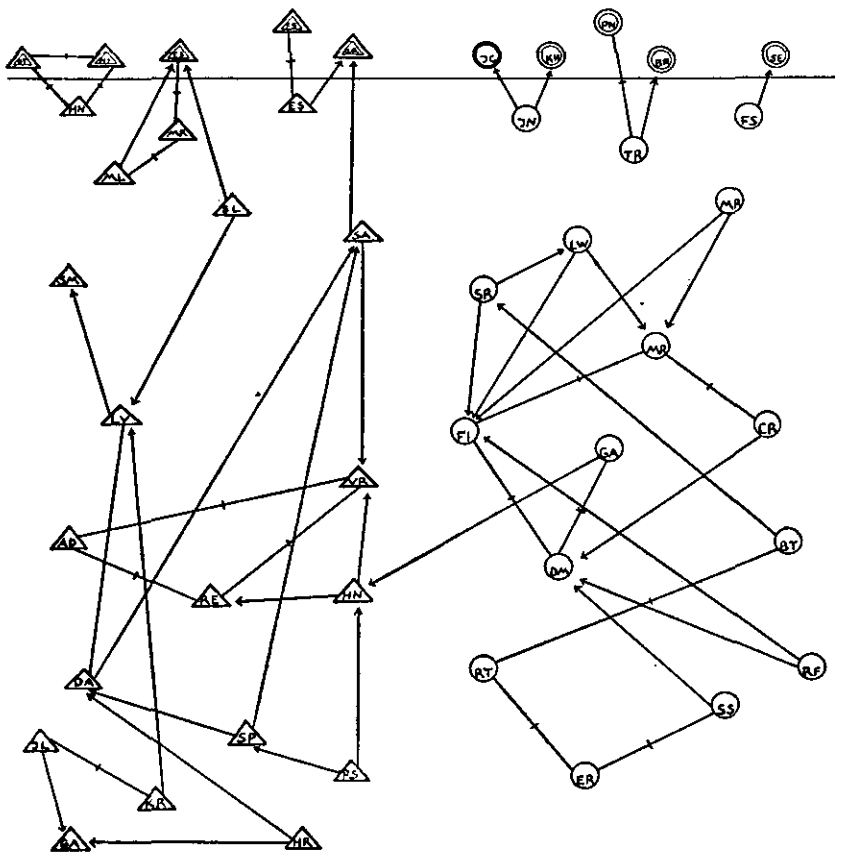
SOCIOGRAM I Some Typical Structures Within Groups



4 Isolates LS, MN, VL, TS. 4 unchosen WJ, CV, EH, FL—12 pairs BR-VC, PA-TT, LO-CC TT-SF, CT-ES, FT-JT, JT-CT, PD-PA, PA-TP, CM-CC, CC-RL, CM-RL—1 star CM (chosen by 5 individuals)—1 Triangle RL-CC-CM—1 intersexual attraction LC-FT—2 Sub groups (right and left on bottom of Sociogram), each consists of eight individuals.

SOCIOGRAM II*

Actual Structure of a Group Studied



The boys in this class are represented by triangles and the girls by circles. In sixteen cases mutual or reciprocal attractions are indicated by crossed lines. An isolated individual, TR, attracts an outside individual. Another isolate, HN, forms two pairs with two outside individuals. Another isolate, FS, attracts no one, either from inside or from outside. Only one girl in the class chooses a boy, a choice which remains unreciprocated. Thirteen choices are made to outside individuals and five come in from outside the class. There are two triangles, two girl stars FI and DM, and one boy star, YR. There are three chain structures, two subgroups, (4 boys) and (4 girls).

*The cut of the original 5th class sociogram is here replaced by one from "Who Shall Survive" (page 39).

portrayed by means of a so-called "sociogram." These choices are not to be mere fancies but reality-bearing decisions and to be carried out as far as it benefits each individual and the group as a whole. Besides these *attractions* also the *rejections* of one pupil towards another and their *neutral* relations are determined. These patterns of social feeling which individuals direct towards one another now and here in the various groupings which they are forming are of the utmost importance for the study of group structure because of the immediate and the ultimate character which they have reached, whether the causality of these choices and rejections are realistic or delusionary or even entirely hallucinatory. Their make up does not change the coercive and dynamically pressing character they manifest in the moment of living and at the moment of the test. They have, therefore to be reckoned with in every type of grouping designed for therapy, even if the therapeutic aim might be to change these attractions and repulsions, obliterate them or try to attain for their group as a whole a different configuration. The complicating forms resulting from attractions and repulsions between the different persons of a specific group are a study of the inner structures of groups and can be compared with studies concerning the nuclear nature of the atom or the physiological nature of the cell.

The structures on p. 156-57 are typical and frequently found within sociograms: boys are represented by triangles, girls by circles, boys and girls in different groups by double triangles and double circles; an arrowed line represents a one-sided attraction, a crossed line a mutual attraction.

III FORMING OF GROUPS

After the development of group diagnostic procedures the next step is the formation of therapeutic groups. A procedure is here offered for coordinating persons to other persons for the purpose of their living together with the highest possible degree of fulfillment for each of them. Procedures are known how to assign men to machines and machines to men but the more fundamental theme, the matching of individual with individual to share common goals in groups is still an untouched field for the pioneer.

For several years I have been engaged in an experiment which consists of the assignment of one person to others and of all the persons to a common objective. The objective is their attempt to cooperate in a given situation and to produce a balanced group expression. The individual psychology of each of the persons to be selected was studied in advance ranging from an analysis of his mental and artistic to his social, cultural and racial characteristics. The next

factor considered was the situation in which each of the persons had a definite function. Through an analysis of the situation it was determined who among the persons will be best able to make an effective adjustment to it. A Chinese village represents a different social situation than a village in New England. When a Chinaman took part in the experiment it was obviously difficult for him to adjust himself to a New England atmosphere. There are situations which release in given persons certain moods and actions more readily than in others. But one of the most important factors discovered was the conflicting tendencies resulting from the wish of the various persons to drive the situation into the direction each prefers. The task is not egocentric but "ambicentric." A person may be driven to initiate this or that situation or response but may have to correct his intended expression continuously before it is consummated as other persons within the group drive him into a direction different from the one which he wants. Each of the persons contributes something to make the situations surprising and unexpected for all the others. It is a gamble, a competition of different individuals which results in the production shaped by all but by no one person singly; perhaps by a scientific miracle it could be turned into a therapeutic mechanism for each individual within it and for the group as a whole.

It was observed how poorly men are able to adjust themselves to unexpected situations. Since an analysis of each of the persons as such did not evolve the desired effect, a psychology of coordination of persons with persons was considered. In search of techniques of coordination it was found that two very well organized individuals can be a very unhappy team. Two erratic individuals matched with a steady third can be stabilized and may make a very auspicious triangle. The knowledge of individual psychological states and their mechanisms did not seem sufficient to produce coordination. The problem was not what kind of reactions they have personally or socially, but what conditions enable them to *fit* together with other persons in a course of action. This task seems incapable of a solution. In the course of living one situation follows another incessantly and however thoroughly a situation had been once analyzed and put under control a new situation runs up and has to be met anew, the old arrangements changed or thrown overboard. It is already a superman's task, it may be argued, for a single individual to give full rein to all his inner strivings and still to present them in a manner as if he were always rapidly mastering the forthcoming stream of activities. But how much more difficult would it be to guide the destiny of groups and communities or that of the whole of human

society itself? The making of societies, the controlling of relations between persons and persons, seemed to surpass our intelligence.

This is the problem which challenged me when I first attempted in Vienna to put it on an experimental basis. I reduced the task then to its simplest form; *a number of persons were placed opposite one another in a situation whose pattern was unknown to them before the moment of start and in roles and states which were equally unknown to them.* My instruction to them during the initial phase of experimentation was to let loose unconcerned about involuntary gestures, actions and repartees, faithfully relying upon their spontaneous talents to act and react on the spur of the moment and trusting that a significant and fairly organized product will come forth. However, the objective was then not the guidance of a community but simply to produce together in the course of improvised action patterns of a society in miniature. After a few experiments I recognized that spontaneity in groups, however beautiful and disarming it looked from the point of view of the persons engaged in the acting, led in most of the cases to *gravest deficiencies of cooperation.* I saw disclosed then in the plainest form the workings of our society, each individual following his longings, willing the best, but the whole thing altogether going wrong. And when I found that most excellent single players acted *together* like a bedlam I thought to myself, if every person in our society should reach the perfection of a saint, the saints would play very poorly together because it takes something else beyond individual perfection to make two saints or a group of saints compatible and productive. Here lay the problem of a "therapeutic society."

I have made attempts to form homogeneous groups on the basis of individual diagnosis in the belief that they would be easier to manage and that it might also be better for the participants themselves. Similar types were placed together, the feeble-minded with feeble-minded, the social deficient with the socially deficient, the aggressive with the aggressive. This was a step forward when compared to the previous hit or miss grouping which was done without any form of analytic attack. A parallel of classification according to homogeneity is found in some of our progressive schools where the assignment of children to classes is made chiefly according to their scholastic achievement, I.Q., etc., but not according to their interrelation diagnosis and interrelation fitness. A major effort at reform was Osborne's self-government of prisoners. It emphasized the basic importance of the prisoner himself, that the prison should be more than a place of detention and deterioration. It would seem that

if he failed, the failure was due to *the lack of a group analytical basis in his experiment.*

Spontaneous formation of social groups based on the enthusiasm of the participants or on common interests and aims achieves often miraculous results. But it cannot be called grouping in our sense as most of the interrelations remain unanalyzed and nobody knows when the wonderful performance may come to a breakdown and how to prevent the latter.

The classification of people as parts of a social organization goes one step further and assigns them neither by individual diagnosis, etc., nor by nature's suggestion in placing the homogeneous and the heterogeneous uncritically together. *It attacks the problem not from the outer structure of the group, the group end, but from its inner structure,* the assignment end. This is the path on which progress will be made, the assignment of one person to other persons and their relation to a common social and cultural life. The strategy of fitting each group to all other groups in a community will be the next problem of importance. The leaders of each group have to be so adjusted in relation to one another as though they would form a group among themselves. The inner (sociometric and action dynamic) structures of the groups have to be continually studied as they indicate the actual dynamic relations existing in them. (See Action Diagrams and Sociograms, p. 153-54, 156-57).

Conditions which make attributes unfavorable or favorable to "cohesive interaction" became, therefore, the center of our investigation. Group formation is to be on the basis of the interrelationship attributes of men. At first it may seem that all characteristics of an individual will emerge from him under all circumstances under the pressure of his drives. But when we observe that the same individual is intolerant and destructive in one group, tolerant and stable in another group, that the same individual takes the attitude of a solitaire in one group but is cooperative and suggestible in another group, we begin to suspect that a great number of these traits are falsely labelled "individual" and are truly interrelationship products. While each of the group may contribute some factor which leads to the formation of interrelationship products, such factor itself may become so modified that it is unrecognizable or even reversed in the end product. For instance, a girl who has been rebellious and destructive in her family group may become docile and tractable in her school group or within the family of her own making. When different and contrasting traits are manifested in different groups, the following rules, at least for practical reasons, become the working hypotheses:

(1) Those attributes which accompany an individual into every group and which may be chiefly determined by the individual as such—only such attributes should be called individual.

(2) Attributes should be called interrelationship or group attributes if it can be demonstrated through experiment that such attributes appear only when the person is in relation to certain other persons or is a participant in a certain group or groups and that these attributes disappear when the person is in relation to other individuals and other groups. Such an attribute is a *product*, "it relates to two or more persons," it calls for contributing factors from two persons or whatever the number of persons in the group, it calls for a special group configuration "it is ambi-centric, symmetric in structure." That means that such an attribute is not the projection of one person but that the two or more interrelated persons contribute something to a synthesis which may appear subjectively as an individual attribute of each. For instance, A, when challenged by a certain man C, does not retreat, but reacts with jokes and arguments. B, when challenged by the same man C, reacts by running away. But the clever A and the cowardly B appearing on the scene together, when challenged by C to a fight, produce a kind of behavior which contradicts that which each of them singly had shown. The presence of A and the confidence he arouses in B influences B *not* to run away, the confidence which B has in A encourages A to *challenge* C in return. B joins A and both move towards C, ready to fight, if necessary. C is taken by surprise; when he attacked them, one by one, separately, he always got the same reaction. He sees himself now at a possible disadvantage, he *modifies* his challenge to fight, he cracks a joke. They all laugh and walk off together. The group attributes, *courage* and *getting along* which were produced, is thus seen to be a three-sided process, each man having contributed thereto.

Theoretical Models of Therapeutic Groups

It is possible, at least in principle, to construct artificial, a priori models of potential therapeutic groups. By therapeutic groups we mean here that the individuals are so well matched that they can help each other and the group as a whole towards a fair degree of productivity and equilibrium. The problem was to match one individual to another or one group to another without the individual partners meeting with one another, *not* to reconstruct groups "ex post facto" but "in prospect," and again, not to predict group formations in general but those which will prove to be therapeutically fruitful for its members. It was presupposed that sufficient and significant individual and

social facts had been collected about each individual, especially as they are related to his behavior in groups, without the matchmaker and constructor knowing the intermediaries who have collected the data. He would be like a chessmaster who plays a fictitious game with unknown partners, playing both sides, making his own moves as well as those of the others; he would be moving individuals like figures on a chessboard. It is obvious that only a *group reality test* can prove whether his matchings are even distantly useful. The value of such theoretical constructions is dubious but it may gain as our experiences with concrete group formations will expand and as we arrive at certain *common and constant* features, which may be indispensable to all therapeutic groups. From a practical point of view such an assumption is yet far fetched and everyone should be warned not to fall into the temptation to group people without evaluating them face to face, without their knowing each other and without taking into account their spontaneous feelings.

Following this precept I studied in Sing Sing prison the case histories of forty-seven men unknown to me personally and on the basis of the data about them I divided them up into six groups of seven and one group of five. Group I (M1-M7), Group II, etc. These a priori constructions of groups did not guarantee that the matchings would prove to be therapeutically good or that the individuals would group themselves similarly if they would be given an opportunity, but it was a starting point; I could compare them later with the behavior and action models gained from direct experience with the forty-seven men. But however great their predictive value may become in the course of time I cannot imagine how a priori models can be applied to the practice of therapeutic group formation without supplementing them in each case with the concrete, spontaneous choices and decisions of the people involved. The arguments against a priori group formation are most serious. Even if it would become some day one hundred percent accurate human beings may always resent their applications to their lives without the decisions being allowed to emerge spontaneously from their own psyche; one may call this the *ethical argument against a priori groupings. The technique of a priori groupings may* lead to the most ruthless autocracy the world has ever witnessed. The people being manipulated into groups according to the scheme of a scientific autocrat; this may be called the *political* argument against a priori groupings.

In the construction of a theoretical group-therapeutic model my first step was to distinguish between individual or autocentric attributes and ambicentric attributes. Illustrations of autocentric attributes are: all members of

the group are men, or all are women, or all are alcoholics, all are pregnant women, all are mothers with one child, all are social workers, all are physicians, all are schizophrenics. It was obvious that autocentric attributes will tend to produce homogeneous groupings, homogeneous however, only in respect to that *one* criterion, but they may be heterogeneous in respect to numerous other criteria; for instance, the group in which all members are alcoholics is homogeneous only in respect to their common alcoholic condition. They may not be homogeneous as far as sex, nationality, economic status and hundreds of other factors are concerned. It would be necessary to develop lists of all significant homogeneous factors operating in groups. A group will be the more homogeneous the larger the number of identical factors which its members have in common. But it should be clear that a highly homogeneous group is not necessarily a therapeutic one. Similarly there are many forms of ambicentric relations; f.i. *complementary* forms: three men versus three women, three alcoholics versus three former but cured alcoholics, three psychiatrists versus three mental patients, three saints versus three sinners, but the formation "three men versus three women" is complementary only in reference to this interrelationship; in order for a relation to be truly complementary other symmetries may have to operate. It would be an interesting task to define all complementary relations in groups. Then a person whose individual analysis shows him in poor equilibrium may be able to contribute a complex which in correlation with complexes of other members of the group brings the latter into balance. On the other hand, a person who is as such very sane, may send components out which in correlation with components of other members of the group throws the latter out of balance.

A group attribute with the "symmetric" structure formulated above can be described in several relations. We differentiate eight types of interrelations as follows:

TABLE I

Forms of Inter-Relationship

Full	Partial
Complementary	Discordant
Similar	Contrasting
Active	Indifferent

TABLE II

Illustrations of Eight Forms of Inter-Relationship

Full

Father	Children
Foreman	Apprentices

Partial

A group attribute indicates a partial relationship if it concerns only a part of the group membership. For instance, if in a group of seven four are male and three are female, the attributes, male and female are partial.

Complementary

Spontaneous, active attachment of one person to a complex of interests.	Passive, critical attachment of another to the same complex of interests.

Discordant

If two members of the same group have the desire to dominate the same field of endeavor, this attribute is discordant—unless they have complementary attributes which can be useful to their co-ordination or unless they have with other members of the group sufficient complementary and similar attributes to rescue the equilibrium.

Similar

Sons of immigrants (Italian) Orphaned by father	Sons of immigrants (Irish) Orphaned by mother

Contrasting

Japanese Training of a Mechanic as a Worker	Jewish Training of a Salesman

Active

A group attribute as soon as it causes differences (affinities or conflicts) is active. If, for instance, in a group of ten, seven are white and three are colored, this belonging to the white or to the colored race becomes a conflicting, active attribute. But if this differentiation is limited to a very few of the men compared to the number in the group, for instance if there is but one colored man in a group of ten men, the attribute of being colored may become one of affinity. (Resentment may be transformed into sympathy.)

Indifferent

An indifferent group attribute is one which all the members of a group possess and hence which has no active value. All the members may be white.

Besides this aspect of an attribute which describes eight types of formal interrelations, we have to consider the content of the attribute. Continuous experience in assignment has suggested to us a working hypothesis the division of all factors into four complexes: the Nationality and Social Complex (NS), the Educational and Vocational Complex (EV), the Intelligence and Personality Complex (IP), the Delinquency and Criminal Complex (DC). The material arranged in Complex NS reflects all influences which are "given" to an individual (structure of his family and of his immediate environment, nationality, race, etc.); in Complex EV all influences are reflected which, at least apparently, are not "given" but acquired, which direct and train towards an individual goal; in Complex IP are reflected the

types of reaction of an individual to the complexes above mentioned; and in Complex DC are reflected all performances which are condemned by society.

TABLE III

Factors considered under four divisions for Group Attributes:

Nationality and Social Complex (N.S.)

Age; sex; racial kinship; nationality and social kinship; immigration; structure of family; neighborhood.

Educational and Vocational Complex (E.V.)

Language; religion; education; vocation; occupation; behavior in work; home; associates.

Intelligence and Personality Complex (I.P.)

Mental age; reaction type; social habits.

Delinquency and Criminal Complex (D.C.)

Delinquency record up to offense; type of offense; sentence; behavior in prison.

This distribution of facts is preliminary to the mapping out of all attributes according to content. This study will embrace the numerous factors which come into actual group display and evaluate them according to rank, frequency and duration.

For the objective of the present investigation, the complexes of data about each individual are checked, according to their type of interrelationship (full, partial, complementary, discordant, similar, contrasting, etc.), through an analysis of each factor for coordinative ends. It evaluates the whole mass of factors, it eliminates that portion which is indifferent and it determines those useful for making reciprocal contacts among the men within the group.

From among the inmates of Sing Sing Prison forty-seven prisoners have been selected, charted and broken up into several units. Seven men have been assigned to a projected unit, Group I. There were analytic reasons which caused me to eliminate the remaining forty from Group I but to assign them to other groups to be formed. The reasons why just these seven men were assigned to Group I are given in the following tables. They present the cases of M1, M2, M3, M4, M5, M6 and M7. 21 tables would be required to present all interrelations between every man and every other man of Group I. Here only those between M1-M2, M1-M3, M1-M4, M1-M-5, M1-M6 and M1-M7 are given. A double analysis is that of two analyzed together; a triple analysis that of three persons analyzed together; and a group analysis is that of more than three analyzed together but of no more than such number of persons as can know one another intimately. "Rebellious," "sympathetic," "imitative," and "solitaire" are only for convenience so charted that they figure as individual attributes of the men. They are according to group analysis *inter-relationship ef-*

TABLE XI

SYMMETRIC RELATIONS BETWEEN M.1 and M.2

MAN 1.	MAN 2.
Data NS	Data NS
Age, 35	Age, 25
Male heterosexual	Male heterosexual
White	White
Hebrew	Irish-Scotch
American born	American born
Son of Rus. immigrants	Son of Irish-Scotch immigrants
Oldest son of seven children	One of six children; at five,
Lived with parents up to	Father died; at ten got a step-
offense, supports them	father.
	See juvenile data in DC Complex
Neighborhood, Jewish	Syracuse, N.Y.; Brooklyn,
Yorkville and Harlem,	Irish neighborhood.
New York City.	NS—Contrasting
Data EV	Data EV
Language, English	Language, English
Religion, Jewish	Religion, Catholic
Education, grad. 8th Gr.	Junior High School, 1 year
Vocation, mechanic, machines	Baker
Occupation, U. S. Army	
and Marine Service	U.S. Army
Manager, cashier, poolroom	Animal trainer
In Service, 9 yrs., hon. disc.	In Service one and half yrs.
In first position 4 years	In one position 4 years
Home—single, with parents	Single, quarrels with stepfather
Associates, gamblers, marines	Show people
	EV—Similar
Data IP	Data IP
Mental Age, fourteen and half	Mental Age, fourteen and half
Cooperative, responsive	Quiet, shy
Good mixer, energetic	Poor mixer
Sympathetic	Solitaire
Spontaneous reaction type	Conserving reaction type
Social habits, moderate	
alcoholic, gambler	Gambling on horse races
	IP—Complementary
Data DC	Data DC
	At 11, Industrial School;
Delinquency record up to	At 15, House of Refuge
offense, clear	2 yrs.)
First offender	First offender
Offense, forgery	Burglary, 3rd degree
Sentence, two and half to five yrs	Sentence, 5-10 years
Parole case	Parole case
Behavior in prison, no	Behavior in prison, no com-
complaints recorded	plaint recorded
	DC—Contrasting
Data Diagnostic Tests	
Sociometric, M2, first choice of M1	Sociometric, M1, first choice of M2
Situation, Positive	Situation, positive
Spontaneity, adequate	Spontaneity, adequate

facts which have been manifest in their past performance within various groups but which may not occur in others or fully disappear in the group to which he is assigned.

ANALYSIS OF M.1 AND M.2

Nationality and Social Complex

Age

A—Contrasting

The ten years difference between the two men, one of twenty-five and the other of thirty-five, contrasts them from each other. It indicates a different range of accumulated experience if such factors as intelligence, education and occupation are equal or similar.

It is obvious that these ten years may cease to constitute a contrasting relation between two men if the other circumstances differ widely. For instance, if the older man were of a mental age of twelve, without school training, and had immigrated to this country recently. Factors of this kind are capable of offsetting age differences and even of reversing them.

B—Complementary

As other attributes in the relationship of the two men are complementary for instance their reaction types, difference in age will contribute to drive the younger man in this case to lean towards the older one and to follow him. This holds only if discordant relations between two persons are not marked.

It is obvious that before an inter-relationship (age, education, etc.) between two men is classified all other known factors of their structure have to be considered.

Sex

A—Indifferent

Both are heterosexual males. As they share this trait with all other members of the group, it is an indifferent factor.

This considers only their manifest behavior, but as the latent potentialities may differ, the sexual "indifference" towards each other is relative. This is especially the case in institutions with a single sexed population, as in prisons.

The homosexual factor has to be considered in this case. Both are unmarried, but the state of singleness has in the two men different motivations. M.1

is emotional but too promiscuous for marital attachment. His "home" and companions are still his aged immigrant parents who need his protection and support. M.2. has the sexual attitude of the solitaire.

B—Full

As not only they, but every member of the group is heterosexual their relationship in this respect is full.

It is not a one-sided, full relationship, as between father and children, but from both sides full.

Race

A—Indifferent

The race trait is indifferent as both men are white. However, as they have in the group one colored member, superiority feelings of being white may awaken slightly either strivings to protect him or active resentment against him.

B—Full

The racial relationship between M.1. and M.2. appears at first glance full, but if all the men are considered it has to be classified partial because one of them belongs to the colored race. The feelings mentioned, if they awaken, will be balanced by other factors in the group. The harmony of all white members is not complete as they consist of three Anglo-Saxons, two Jews, and one Sicilian, which arouses their eventual superiority feelings for the colored man against one another.

Nationality

A—Contrasting

In the case of M.1. and M.2., the contrasting nationality should be rather advantageous to their relationship than disparaging.

Contrast of nationality, if it is sufficiently wide (as between Irish and Jews or between Irish and Italians, but not too wide as between Italian and Japanese or too narrow as between English and Irish) stimulates curiosity and reciprocal enrichment if a sufficient number of other factors are similar or complementary. A racial and nationality analysis has to consider the concrete factors which divide Irish, Jewish, Italian nationalities, etc., into hostile groups within themselves.

Immigration

A—Contrasting

M.1. is a son of Russian immigrants and was raised between two contrasting social patterns: on the one side, the structure of a Russian-Jewish family situation—large family, Jewish and Russian languages prevalent at home, leanings of the sentiments of the parents towards the country in which they have been brought up, poor aptitude for assimilation to the American pattern of living and with it poor English, tight sticking to a Jewish neighborhood in the Bronx and economic failure; on the other side the American customs and standards affecting him in school, movie, newspaper, and on street-corner. It is a "split society" which surrounded him, a fertile soil for the eventual division within him. This describes another kind of symmetric relationship, not between two persons, but between two diverse social organizations, each forming a side of a relationship focussed on the individual M.1.

M.2. is the son of Scotch-Irish immigrants who found the new environment not dissimilar to their former. This homogeneity prevents the development of the split society situation as it occurred for M.1. It provides protection. But this factor can become a disadvantage. Measures of overprotection are able to weaken the sense of pioneering which is stimulated in the man who grows up between two contrasting societies.

Family

Contrasting

The family structure is in the case of M.1. so developed that it survives even the natural sense and cruder goal of a family, to rear the offspring and to allow their leaving it when mature. M.1. has one sister and two brothers unmarried who live with the parents. It still continues to control M.1. who, after his army experiment of separation returns to live with his parents, also. M.1. has a very affectionate relation to all members of his family. He kept it secret from them that he was in Sing Sing in order not to hurt them. His strong family hold* may have contributed to the fact that he didn't commit any offense until the age of 35. Also, the character of his offense, an invisible, single-handed form of robbery such as it is, reveals the man who wants to win through tricks.

M.2.'s family situation broke up when he was five as his father died. He is

*The army can be well compared with the parental home. The "son" and the "soldier" have no manifest sexual role within their respective institutions.

the oldest son, five years older than his younger brother. His mother, a nurse, remarried an Irishman when he was 10 and he took it upon himself to defend her when his stepfather was rough in his treatment of her. At 17 he ran away from home on account of these quarrels. He was always attached to his mother, to whom he sent money as often as possible. He is single, although his younger siblings are married. Just as his family situation was "delinquent" he was delinquent as a child. He stole occasionally, and spent years in institutions.

Neighborhood

Contrasting

M.1. grew up in a neighborhood chiefly Jewish. Born in Philadelphia at seven he moved to Yorkville, N.Y. (German and Jewish), at eight to Harlem (section Jewish and colored) and at fifteen until nineteen he lived in the East Bronx (German and Jewish). His associates were chiefly Jews until he joined the army, where he mixed with many types. As he was well assimilated to the family, and an honorable member of it, he likewise assimilated himself well to the army, and was honorably discharged nine years later. He has adjusted himself comparatively well to prison life and has a good record.

M.2. was brought up in Syracuse and had little occasion to mix with people. At eighteen he moved to an Irish district in Brooklyn.

EDUCATIONAL AND VOCATIONAL COMPLEX (EV)

Language

Similar

In the corresponding fields of their latent and manifest forms of language, the portion which is similar is greater than the one which is contrasting. M.1. and M.2. talk a slightly different slang. M.1.'s English is permeated with slang from Jewish neighborhoods in the Bronx. M.2.'s, with the slang of a small-town in up-state New York.

A distinction between standard language and slangs in respect to social values has to be made. The standard language of a man bears out the type and rank of his educational training but the slang he uses, especially the one he has assimilated in his adolescence, is the one which counts more in emergency situations. A man may have a high degree of spontaneity and rich vocabulary in his hidden language, the slang he commands, which is less manifest or even

reversed from that in his standard language. The relation of latent manners of speech to Spontaneous Testing is evident.

Religion

Contrasting

M.1. has passed through an average amount of Jewish religious training until he was about fourteen. Later he became indifferent towards it. The continued affection for his parents indicates that the Jewish faith element persists in a form of social expression.

M.2. has had during his institutional phase Catholic instruction and attention. He is still devoted to his faith.

Education

Similar

Both received public school training.

Vocation

Similar

M.1. learned mechanics in a machine shop of an umbrella factory. M.2. learned to be a baker. Both types of work are manual.

Occupation and Behavior in Work.

Similar

M.1. held a position as a mechanic for four years. When the war broke out he joined the army and later the marines, and was for nine years in the Service. For a long period he instructed cadets in the management of horses. On the other hand, M.2. worked as a baker for some time but one day joined a circus and became for many seasons a lion-tamer. Both show at about the same age a breaking away from the occupations they have learned to occupations which were venturesome, even hazardous, and which satisfied their fancy—soldier and lion-tamer. When M.1. left the army, he didn't return to mechanics but preferred work in a poolroom. Both have done a lot of travelling and both have handled animals.

Home

Contrasting

The singleness of M.1. and M.2. are of a different kind. M.1. had a home although he was not married. M.2. had no home.

Associates

Similar

M.1. claims to have only one friend and to have loved only once. M.2. insists he has no friends. In the first stage of their careers both M.1. and M.2. mixed with workers. In the succeeding phase, with soldiers and show people respectively. In the last phase, M.1. is mixing with gamblers and racketeers, M.2. with lower grade show people.

INTELLIGENCE AND PERSONALITY COMPLEX (IP)

Mental Age

Similar

M.1. and M.2. have the intelligence of the average adult according to the mental tests.

Reaction Type

Complementary

M.1. was found to be of the spontaneous reaction type in the Spontaneity Test; M.2. was found to be of the conserving reaction type.

Social Habits

Similar

Cards, dice, horses, drinking.

DELINQUENCY AND CRIMINAL COMPLEX (DC)

Delinquency Record up to Offense

Contrasting

M.1. has never been delinquent before although one year previous to the present offense he was accused of a similar act. M.2. has been a delinquent child, stole, and ran away from home. Before 17, he had been twelve years in institutions.

Type of Offense

Contrasting

M.1. claims to be innocent. M.2. admits he is guilty. The forgery of M.1. is the act of a solitaire. It is comparatively an intelligent form of delinquency

and a delinquency without accomplices. It shows also that while he was active he was not aggressive. M.2. committed a less intelligent type of offense, also more aggressive. He attempted burglary unarmed and alone. He had been unemployed previously for months.

Sentence

Similar

Behavior in Prison

Similar

No complaints are recorded about either M.1. or M.2. M.1. works as a tailor in the prison and wants to go back to the army. M.2. wants to go back to his animals.

DIAGNOSTIC TESTS (DT)

Sociometric	M2 is first choice of M1	M1 is first choice of M2
Situation	Positive	Positive
Spontaneity	Adequate	Adequate

General Comments

In the course of such investigation, the task of finding the average score between any two inmates, their *social quotient* (S.Q.) would become an intricate mathematical problem.

Our assignment considers persons who never have been in contact before. The time element in the making of the group relations has to be taken into account. Conflicting tendencies will clash earlier the poorer the assignment is. If circumstances hold two ill-fitted persons together for a longer period than their natural affinity would suggest, complementary group attributes which were in the beginning insignificant tend to develop.

Once the assignment is made, most of the problems will be checked and regulated by the group itself. The members of the group submit themselves spontaneously to the one who is to lead. The first test of our assignment is if the men follow the one whom we have foreseen would be the leader in the analysis. Leadership is not indispensable. We have observed *groups without a leader* especially where all the members were of a similarly constructed type.

In addition to the factors which lead to the assignment of men to Group I as described,* techniques have been found to organize and guide a group:

*Six tables which appeared in the original publication of this material are here omitted.

1. The leader must have at least one attribute, similar or complementary, which joins him with each member of his group. It has been observed that otherwise mutual attachment does not take place, and consequently the leader has no point of attack to socialize every one of his men to a minimum degree.

2. A man should not have more than two attributes in common with more than one man of his group, excepting the leader, if he does not share the same attributes also with other men of the group.

3. A man may have two different attributes in common with any two other men of the group.

4. In a group of seven there should be no more than two men who have *no* attributes in common.

5. Only two men may have with two other men two sets of attributes in common.

The relationships here presented can be applied to larger memberships than groups of seven, while their proportions will vary in accordance with the size of the group. *Groups should be so constructed in size and type that every member is able to know every other member intimately.* If the size of a group develops beyond this limit, it becomes a "mass" wherein relations of a kind spring up which cannot be controlled by man's ingenuity alone. Mass development is a factor opposed to scientific community organization. A group plan, if applied to a prison or to any phase of our society, has to use as its basic foundation *the small controllable groups* which are constructed on principles as described here.

After the population is divided into many groups a number of men may remain who do not fit together into one unit. What is to be done about them? The simplest solution would be their transference to another institution. But as a community should attempt to solve the problems as they develop within itself and should not take refuge in a mechanical segregation of undesirables, another solution is here suggested as already indicated on page 145. The relations of groups to groups have to be as well balanced and corrected as the relations of persons to persons. Assignment of a man to a certain group is not absolute and final. The analysis of a man is always so carried out that other units besides the one to which he is actually assigned may still be desirable for him. On this basis some men can be shifted from their unit to a second choice and thus a possibility of adjustment of remaining members and the possibility of placing them within the existing units is open.

The objective of assignment is to mix men of similar and contrasting interrelations so that the equilibrium of the group is maintained. If all the men of a group are of a similarly constructed type, the group develops to such a conformity of behavior that it acts as an individual. This is illustrated in the behavior of nations which consist of one national type, such as France, Germany and Italy, and is perhaps the cause of their extreme nationalism. On the other hand, if the group is composed of too contrastingly constructed types, they may become discordant, as in India. But a number of contrasting types, while not too widely contrasting, may keep the group in balance, as in peaceful Switzerland, which consists of a mixed French, German and Italian population.

After the analysis was completed I became acquainted with the forty-seven prisoners but concentrated on the seven whom I had planned to put together in Group I. I interviewed each of them, introduced them to each other and had then also the opportunity to see them in spontaneous interaction. M.1. and M.2. showed a preference for each other as I had calculated on paper. But in the course of these encounters I decided to begin the next experiment in social planning with the behavior and action model the men *wished* to form, instead of with categories.*

Behavior and Action Models of Therapeutic Groups

The opposite method is to begin with and enter the actual situation. This does not eliminate the theoretical model approach and can be easily combined with it; the psychological strategy, however, is entirely different. I recall a mental hospital where the introduction of a group psychotherapy program was planned and the problem was how to start the ball rolling. We tried several procedures, for instance a) putting the patients together hit or miss, letting nature take its course, so to speak, and eliminating undesirable elements if the actual therapeutic situation required it; b) putting the patients together on the basis of their mental syndromes and various individual tests, as Intelligence, Rorschach, Aptitude, etc.; c) putting the patients together on the basis of ratings given by therapists and observers connected with the ward; d) putting together those patients who had received individual therapy by the same therapists or a team of therapists and were considered eligible for group treatment. These various approaches were climaxed by the following procedure which does not exclude any of those just enumerated: Ward A from which the pilot ther-

*It was a few months later that I experimented with such an opposite scheme in the New York State Training School for Girls at Hudson, New York. See my "Psychological Organization of Groups in the Community" 1933 and "Who Shall Survive" 1934.

apy group was to be drawn, had forty patients. At a conference attended by the ward psychiatrist, resident, nurses, attendants and myself, it was decided to start with a group of ten without giving, however, the number a mythological or scientific meaning. We planned to run ninety minute sessions twice a week for a period of twelve weeks. It was also decided to ask the patients of the ward to volunteer for this therapeutic seminar, explaining to them that the progress during this period will determine their fitness to return to the community. The next day the whole ward was assembled, staff and patients, the explanations were given by the psychiatrist in charge, a warm and likable man. The patients asked a number of questions which already turned the meeting into a near therapeutic session. After a half an hour of discussion twenty patients volunteered. As the number of possible admissions were only ten the technique of letting patients volunteer was discarded for the time being, since this was not a proper basis for selecting the number needed. The doctor now took the stand that a "sociometric" step was necessary: "I have no basis for judging whom among the twenty-seven to pick for this group. The best thing would be if *every one* on this ward will choose whom he wants most of all to have as a partner in the group to be formed." Each was then given a paper and pencil and asked to write down their choice (or was assisted by a staff member to point out or tell him the person wanted), and the reasons for this choice. Each was also given one choice for a staff member. After the choices were made they proceeded to indicate which patient and staff member they would prefer *not* to have in their group. The patients were assured of two things, first that the decisions made by them will be carefully analyzed and the group formed as much as possible in accord with their wishes; second, other groups will be formed later so that every patient of the ward will have an opportunity to participate in such a project. Finally, every staff member (seven) was asked to choose the patient and a staff member with whom they would particularly like to work. All choices and rejections were then collected, a total of one hundred and eight, which were to be charted in a "master sociogram" of the ward. I proceeded with a supplementary step and approached the ward psychiatrist, then the resident, then the nurse and two of the attendants to give us, each independently their sociometric ratings of any ten patients of the ward, as to their feelings for each other and their tendencies to help each other. We received from each of them an "observer sociogram" which reflected their opinion on the most cohesive group of ten patients from the ward. These observer sociograms were rough sociograms, results of the imagination and empathy of the participant therapist-observers. As I looked at the master sociogram now

completed I saw two or three possible units of ten, plus one or two of the staff which would make for a cohesive therapeutic group. It showed the typical structures found in sociograms, unchosen ones, pairs, triangles, quadrangles, chains, overchosen ones, rejected ones, etc. My hypothesis was that a sociometric procedure like this would enable us to select from the master sociogram a therapy group of "high" cohesion, taking advantage of an "experiment of nature" as the members of this ward have lived together for a considerable time and must have developed sensitive and sensible interactions. We then compared the master sociogram with the observer sociograms, weighing back and forth advantages and disadvantages, the reasons given as well as the social data of their case histories and determined to start with *a group of ten selected from all the sociograms combined;* thus the sociogram of this pilot group was plotted.

The advantages of the sociometric procedure is that it combines therapeutic self government, by mobilizing the total therapeutic tele operating within the group, with analytic and measurable classifications. Parallel with the master sociogram we drew a diagram of the positions each of the patients had in the ward, that is, the position of their beds, and could consider the relationship which spacial proximity had to sociometric nearness.

The next day the pilot therapy group had its first meeting. With the sociogram of this group on hand the two observers studied the interactions taking place between the participants from session to session. After eight sessions, at the end of the first four weeks, the psychiatrist assembled the ward again and addressed them about as follows: "Since you formed the first therapy group in this ward a number of changes have taken place; first, the therapy group can be increased to fifteen; second, some of the members of the therapy group may like or be ready to change to a different one; third, some of you who have not yet joined may like to belong to the first group. For all these reasons it would be desirable that you choose and reject again, that we all *repeat the test* along the same lines as the first time four weeks ago."

The second master sociogram was then drawn, in addition to the observer sociograms which were also repeated. A comparison of the first master sociogram with the second master sociogram within a four weeks' interval disclosed a number of significant developments. We could see from them a further increase in cohesion among the original ten chosen. Second, from the number of choices received from all the patients of the entire ward we saw that the influence of the pilot group upon them had greatly increased. It suggested to us the measure of

beneficial influence which the pilot group was able to exercise upon the rest of the ward, although the latter did not have the benefit of direct treatment. Third, which seems to us by far the most important finding, the new master sociogram of the ward showed a degree of cohesion which was superior to the one of four weeks earlier. The number of isolates and sub-groups was reduced, a larger number of the patients were drawn into emotional communications.

If a mental hospital is to become—what it should be—a therapeutic society, each formation of therapeutic groups should be drawn organically, not at random, from the entire hospital (this is what sociometric procedures are promising to do), and their direct and indirect effects—upon the total situation as the therapy proceeds should be traced systematically by means of over-all sociograms.

THERAPY OF GROUPS

Concerning Group Therapy in Prisons

What therapeutic value has the matching of the seven men to one another? M. 1 has a favorable prognosis but this would be the case for him under any correctional system. For the other men of his group the prognosis seems less favorable. They may profit, therefore, from their attachment to a more dependable person as is M.1. It can be expected that M.2 and M.3 if their relationships are directed as in this plan, will overcome the dangers which lurk for them in the present prison system. In this system their relationships are largely left to chance and they may preserve, if not increase, their solitaire attitude and, in addition, they may make their imprisonment, post festum, an excuse for their destructive tendencies. M.1's mature and fatherly attitude and behavior will earn prestige for him. In like manner, different other advantages accrue for each of the men, as is apparent from the reading of their tables. There are in every prison a considerable number of inmates like M.1 who can be transformed into *active therapeutic agents,* forces which are otherwise not made useful. And every man of the prison population, due to the selective relationships to other men, may add whatever he can to the correctional total. The task of controlling and improving the behavior of the prisoners, which at present overburdens the warden and his officers will be thus reduced to a minimum.

This method of assignment will gain in precision after actual observation of the group's behavior during a certain period is made. Knowledge will be gathered and changes will be carried out. But it will be found that social group-

ings of this kind, even if unprecise, are still better than none at all and a fruitful path for progess.

It offers a method of group psychotherapy of prisoners. At present, aside from the labor factor, educational and recreational facilities, treatment, if any, consists of the psychological approach of the individual prisoner. But individual treatment, even if effective, is an impossible task in practice as the number of inmates who need some form of corrective comprise the majority of the prison population. Then, too, it may be questioned if it is the most valuable method to use in prison in dealing with men who have become suspicious and rebellious. Psychological treatment copies the relation of physician and patient. One is superior, the other inferior, in this relation. These roles are fixed and the situation is *asymmetric*. In the group situation, once the assignment is accomplished, the groups function for themselves and the therapeutic process streams through their mutual inter-relationships. Every man has an equal rank. The roles are plastic and the situation is *symmetric*. The psychiatrist has his strategic position not inside but outside the group. He watches the developments closely. If group difficulties arise, it is his task to determine the causes and to restore the balance through the replacement of discordant members. Individual treatment will be limited to cases which stubbornly resist group psychotherapy or who need to be prepared for it.

Concerning Sexual Group Psychotherapy

On the Reality Level

During 1913-14 I became engaged in a group problem: The prostitutes of Vienna. They were segregated in sexual ghettos, red light districts; "Am Spittelberg" was its most famous section, near the center of the city. Here was a class of people, the "fourth" class which had been left out of the social revolutionary program of Marxism as if they were not worthy of taking part in the revolution of the proletariat. The reasoning was that prostitution had an economic causality and it would vanish in a communist society. But the reasoning was only partly true, as is the case with many Marxistic theses. I countered with the assumption that prostitution would *not* vanish and that "it needed a revolution of its own." Therefore, if the bourgeoisie, the middle class had overthrown feudalism by means of the French Revolution, and the third class, the proletariat was trying to overthrow the capitalist bourgeoisie, here was a

*We were a party of three, Carl Colbert, a newspaperman and publisher of **Der Abend**, a physician, Dr. Grun and myself.

fourth class, big and powerful, perhaps older than the State itself but found unworthy of sitting together around the same table and fighting side by side with the working class for *their* rights. I became the spokesman of these women who had no status and no party to which they belonged. The position which I took towards the girls, was the point of view they had of themselves, so far as they dared to experience it consciously, the point of view of their own world. No effort was made to change them, to psychoanalyze them, to preach to them, to baptize them, but to let them be what they are, to let them become what they wanted to become. The bourgeois forms of psychoanalysis were not able to meet with their needs. In the first place, this was not an individual problem, it was a group problem. Whatever problem the prostitute had as an individual, their collective situation was the truly burning one. In the second place their need was not adjustment to a social code which really meant group suicide ("sociocide") but open acceptance of their maladjustment.

The experiment began simply by meeting with the girls in small groups of from eight to ten usually in the apartment of an older girl, in the beginning once a week and then more frequently, as the situation required. It was a coffee party, coffee and cakes were served, and then a discussion began of what could be done to improve their lot. As we tried to give them status, to establish minimum wages, medical and hospital insurance, legal protection against vindictive and abusive clients, and protection against abuses from policemen and courts, one might say that we planted the seed for a "sexual labor union," a "union for prostitutes." Although these were our immediate goals what we actually attained was something deeper, a warm, human atmosphere of friendship and comradeship among the girls themselves, as they began to tell each other their plights as comrades in a desperate struggle for existence and held together by the same invisible law of being rejected as outcasts. They began to pay weekly dues to maintain their organization's expenses and although it was only a few cents they were the symbol of a new emancipation. One became the therapeutic agent of the other, coming to each other's rescue. It was then when the concept of a therapeutic revolution began to rise in my mind as superior to the bourgeois and proletarian revolutions of the past, a therapeutic revolution which should include all their merits but which would take care of all classes of people which had been left out of the envisioned society of the future, the prostitutes, the tramps, and above all, the enormous numbers of the emotional dispossessed who, because of not constituting a visible macrosociological "class" have no handle to attain political power or representation and to fight for their rights. The therapeutic value of the meetings became evident in the

greater spontaneity of their communications, bragging about their successes with men, the jealousies and rivalries among themselves and charting their intricate socio-sexual networks. It was group psychotherapy *in situ*, that is, within their own milieu, where they live and work, not outside of it, in an artificial setting of a clinic, where they would be individually stigmatized as patients and their group as a maladjusted and inferior minority. In our society prostitution has lost the original involvement with religious and esthetic culture and so sex, barred from them, has become a merchandise. Instead of blaming our economic and cultural order we are blaming the mold which it has created: prostitution. The objective of the prostitution movement in Vienna was not to change the prostitute against her will, however well meaning our objectives might be, but to encourage her to maintain herself, to elevate her status, positively and freely, extending the dictum of Marx that by making the proletariat conscious and proud of its status it will emancipate the proletariat. Applying this to prostitution, it meant that by making prostitution conscious of its significance we might start the beginning of its emancipation. Emancipation of prostitution has to be started by the prostitutes themselves and not by the Red Cross workers, Christian workers, social workers, government agencies or political organizations of any sort. My thesis was therefore that they should start their own socio-therapeutic organizations, that they are the only ones who might bring them salvation, that they are the only ones who eventually might elevate the function of love and even of public love to a higher meaningfulness, for the ones who give sex as well as for the ones who receive it. I had back of my mind the paradoxic concept that a social revolution of Eros has to start from the lower depths and that perhaps from the love-practice of the pariahs of our culture a new renaissance of love and sex might come.

Group Psychotherapy Applied to Problems of Children

I recall the case of a ten year old girl who was sent to us because she used to bite her nails ruthlessly. In the first phase we shifted her from one group of playmates to others, having in mind to acquaint her with a wide range of children. Then we let her choose any playmates she liked, as we do not interfere if the patient can shape a remedial situation for himself. When the proper assignment is discovered, either through the spontaneous choice of the patient or by ourselves, the therapeutic situation is also found and thus the first phase comes to a conclusion.

We had numerous reasons to regard the pupil whom Mary (Child I) chose as a useful assignment for her. She was Mary's free choice; the second child, Jane, was spontaneous and excitable like the first, but far superior in intelligence. Both were interested in their nails. Jane had them beautifully manicured and displayed them. Mary bit them off viciously and tended to hide them. We watched their interrelation, alert to note the effects produced and ready to leave the children alone or assign a third or fourth child to them if this would contribute towards strengthening the therapeutic effect. The first product of their interrelation was that the younger child started to comb her hair and to walk in the proud manner of the older one. Next, the younger child was more anxious than before to hide her hands in her pockets. One day she came with gloves on and didn't want to remove them although it was a warm day.

We purposely directed the attention of the reader here upon one behavior symptom only, the biting of nails, to simplify our presentation. But actually we had to take into consideration numerous other symptoms as well. What added to the newness of the therapeutic situation was the underlying, social pattern upon which the procedure was built. This pattern itself consisted of many factors. The place where the children met was a park in the midst of Vienna, a densely populated metropolis. Mary was the daughter of a laborer, Jane of a wealthy merchant. Both were of the same faith but of different nationalities. All such factors of the underlying, social pattern have a bearing on the procedure and the procedure must be formed accordingly.

This account does not mean to imply that the procedure in this case is the only one possible in the treatment of nailbiting. The strategy of treatment may have to change according to circumstance. But the mere understanding of the child's past, while it may make the psychiatrist wiser, adds little to the child's benefit as long as the actual constellations are not attacked in the *direction* of their development and unless active spontaneous methods are maintained at the proper place and at the proper time. This, we believe, is equally true of the great majority of patients, whether children or adults.

We laid our emphasis upon the *present tense* because we realized that the products of their interrelations were *new* constellations resulting from the clash of their individual mechanisms, interrelation effects, as for instance, the motherly attitude of Jane when Mary followed her everywhere and imitated her continually. These products which arose from the arranged, therapeutic situation became the stimuli of other products, such as Mary's wearing gloves and

Jane's increased pride in the beauty of her nails. These experiments did not take place in artificial set-ups like that of a physician-patient situation, but instead where the trouble had rooted itself, in the realm of immediate, social actuality. We used then a method of recording parallel processes of persons and the sequence of spontaneous situations which are useful for quick survey if many cases are handled at once, as in the correctional institution or the mental hospital, to determine the points of coordination and where and when strategic interference is needed. (See Interaction Diagram p. 153).

To return to our two girls, the accumulation of interrelationship effects continued until a saturation point was reached. Until that point no direct reference was made to the child by us concerning her bad habit. But at a time when the girl was warmed up to a strong desire to find solution to her problem, bred from fear, ambition, pride, etc., we unexpectedly confronted her with the question, "Do you want your nails manicured?" She nodded timidly. From then on a second phase of treatment, the phase of actual constructive guidance began..

A third person, the manicurist, entered the situation and tactfully didn't observe the horrid condition of the nails but attempted to care for them immediately after Jane's (Child II). Although Mary (Child I) continued to bite her nails between one manicuring and the next, it was obvious that she was struggling between the compulsion and the desire to show off her hands like her friend. We behaved as if we observed nothing unusual. We simply left her with the same playmate and continued to manicure her nails. Gradually she bit her nails less and less and after about three months gave it up entirely. The hands became more and more a part of her social make-up to her, like her hat and dress.

This treatment is an illustration of what can be called *Interpersonal* or *Group Therapy*. Every situation into which the child was placed was well-defined and well-prepared, but for the child each was an Impromptu situation. The behavior during each situation was analyzed afterwards. We tried to keep analysis and the therapeutic process apart. The Technique of Social Assignment was put to effect. The treatment would not have been possible without the second child, the manicurist and the interrelations between the three.

Here is a new version of group psychotherapy, a well calculated spontaneous interpersonal therapy plus proper social assignment, the matching of one individual with another and all individuals to the group as a whole. Group treatment

is projected away from the clinic into real life situations and techniques for a proper procedure to be used on the spot developed. The therapist is *within* the group, not a person outside. The therapeutic agent for the unmanageable child Mary, were not a psychiatrist or educator outside the group, but another child within the group and the manicurist.

Application of Group Psychotherapy to Mental Hospitals

In a private mental home an experiment was made with group psychotherapy in the treatment of psychoses.

From a group of ten women patients three were matched to form a therapeutic group. Each was afflicted with a different mental disorder; Sylvia was suffering from a severe form of involutional melancholia; Rose was pre-senile, complicated by a schizo-manic syndrome; Marie was a manic-depressive in a manic phase. The matching was not made and ought not to have been made on the basis of individual diagnosis, their assumed reaction types or other generalizations, but *on the basis of the sum of all symptoms and all the anamnestic facts known about each and the weighting every factor and symptom against every factor and symptom of the other two persons.*

Social History

MARIE	ROSE	SYLVIA
Age: 45	Age: 62	Age: 52
Irish Immigrant	Jewish Immigrant	Jewish Immigrant
Widow (two husbands, both Italians, second husband just died).	Widow (lost husband when 40)	Widow (lost husband when thirty)
Speaks English fluently.	Reads and writes English.	Speaks English poorly.
Opera singer, neglects her daughter. Enthusiastic and cooperative; uncritical in judgment of people. Impractical in handling own situations. Dysfunction of the thyroid gland.	Housewife. Spoiled by her two sons. They took care of her but she dominated them. Verbose, highly sociable and looking for amusement, spontaneous, sympathetic. Antagonistic towards her daughters-in-law who in turn claimed that she is unbearable, always wanting service from them and to be catered to, and to be the center of attention. Gradual onset.	Housewife. Never became interested in learning to read or write. Worked to support her 4 small children. Always reticent, obedient servant of her children. Deep attachment to son-in-law and daugh-in-law. Worried before onset of sickness because there were no grandchildren. Unhappy because two younger daughters were unmarried. Womb operation during menopause. Insidious onset of present disorder.

SYMPTOMS

MARIE	ROSE	SYLVIA
Threatened to commit suicide, that is why she was placed in a mental home. Periodic moods of joy and depression. Fond of her daughter whom she treats like an adult, like her own sister.	Constantly complains that nobody loves her. Blames her daughters-in-law for her sickness. She talks incessantly, makes off-color jokes. Feeble memory for recent events, repetitious, suffers from insomnia.	Incessantly proclaims that somebody wants to kill her and her children. Her children-in-law are the cause of all trouble. They should be punished and killed, to save her and her children from further persecution. Solitaire, hostile, suspicious, never talks to anyone. Refuses food and drink. Seldom answers a question, stuperous, hears voices, persistently non-cooperative, reiterates conconstantly: "I did not do anything to anybody; I and my children will be killed."

Spontaneous Interactions at First Meetings

Before the matching was considered the three patients were brought together, face to face in order to observe the spontaneous reactions to each other. Before any assignment is done the spontaneous choice factor is the most important clue for the "assignment therapist." It indicates the potential development of advantageous relationships. It stands to reason that the more hostile to cooperation a patient is the more important is the finding of persons towards whom he reacts favorably. These persons may not be psychiatrists, therapists or nurses, they may be *other patients.* The choice factor may be disregarded only if all other factors and symptoms indicate that the choice is irrational and disadvantageous for either one or both patients or if the cases are so grave that the assignment has to be done by the attending psychiatrist. But there is good reason here for warning against assuming therapeutic authority without the fullest respect for the patient's own affinities. The slightest sign of spontaneous desire for other persons should receive attention.

In the case of this triangle two observers were present during the meetings. They made careful notes which they compared after the session. Sylvia smiled at Rose as she was greeted by her in a Jewish-American slang. Her English was poor but she was familiar with the slang. In turn, Rose was very pleased with Sylvia and enjoyed her company. She found in her someone who

listened patiently to her incessant talking, without stopping her. For more than ten minutes Sylvia and Rose sat at a table drinking coffee and Sylvia, stimulated by Rose drank a cup of coffee which she had not done for many days. Marie entered the room later and joined the pair. Sylvia became more tense and ignored Marie who broke out in cheerful laughter. Sylvia burst suddenly into tears but Marie changed her mood, showed pity for Sylvia and began at once to mother her. Rose walked into the next room, Marie joined her there. Rose appeared refined and clever to Marie while Rose was obviously satisfied. She had found a second one towards whom she could feel superior.

As their interactions during the first meeting was satisfactory a second and a third meeting was arranged. The total evaluation suggested that their living in proximity would be of therapeutic value. Their situation tests were positive, they had many things in common, so we placed them in the same cottage.

Similar attributes: All three were widows. All were mothers of adult children. All feared men and liked the mental home because there were no men in it.

Contrasting attributes: Sylvia and Rose preferred to use Jewish-German slang; Marie talked only English. Sylvia and Rose expected to be served by Marie but Marie was willing to serve only Sylvia and not Rose. Rose had dominated her children, Sylvia had been dominated by them and Marie and her daughter had been like sisters to each other.

Complementary attributes: Rose wanted a companion to whom she could talk, etc., and Sylvia had always felt it her part to comply and listen to others. Rose wanted badly to have a partner on her walks and from the first day she began to nag Sylvia to accompany her. Sylvia had always been unsociable and occupied only with household interests and the serving of others. Marie was an indefatigable worker in the house so an additional constructive point of coordination was present between Marie and Sylvia.

Herewith some of the factors which suggested the assignment of Sylvia, Rose and Marie to one group have been described. It is apparently the first time in literature that such an analytically prepared experiment is reported, therefore the reader may overlook the incompleteness of the report. I believe, however, that the principles of the procedure are made clear. The complicated therapeutic development of the group has been carefully recorded and will be presented at a later occasion. It may be significant that Sylvia, Rose and Marie,

as long as they were treated apart, individually, with considerable monetary sacrifice on the part of the family, failed to improve appreciably. The group psychotherapy program was introduced eighteen months ago and Sylvia is now on the way to full recovery, Marie and Rose have much improved.

The same method of group therapeutic formations which we have described for prisons consisted in relating to every prisoner the nearest and closest persons, the other prisoners. Similarly, it consists for the patients in a mental hospital in relating to him the nearest and closest persons, the other patients and the attendants. Group assignment and group psychotherapy *in situ* will be advantageous for persons who do not recover by themselves or through some form of individual 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 are checked. In return, he may influence the members of his group in a similar manner.

To make this method useful for a large mental hospital the rating of the pre-psychotic factors, the complex of their symptoms and the connections between them have to be done systematically, as a preparatory step. They have to be followed up by concrete procedures, situation, spontaneity, sociometric and interaction tests which will provide us with reliable behavior ratings of the patients. Trial groups may lead to various practical rules as to how the treatment can be applied to the entire population of a mental hospital.

Entrance and exit tests are essential to therapeutic group formation in mental hospitals. Besides entrance and exit sociograms interviews which take a psychodramatic form are particularly instructive. Approximately the same amount of time is allotted to each patient. The patient is placed in standard situations, for instance, home, work and community, in which he acts out his *own* home, work and community problem. When the time of discharge comes he is put through a similar series of situations. A jury of therapists and patients evaluates his condition when he enters and leaves the hospital. They may disclose—or he may discover for himself—that he is or is not ready to go home. The exit performance can be used as a control of the entrance performance.*

*See "A Sociodramatic Audience Test" by Zerka Toeman, **Sociometry**, Vol. 8, 1945, p. 161; "Situation Test" by J. L. Moreno, **Sociometry**, Vol. 9, 1946, p. 166, and **Sociometry**, Vol. 3, 1940, p. 317-37.

COMMENTS ON MORENO'S "PSYCHOLOGICAL ORGANIZATION OF GROUPS IN THE COMMUNITY" (1933)*

by

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I know perhaps a little more about Dr. Moreno's paper than he had an opportunity to present because he has taken occasion to acquaint me with what he is doing, and I am glad to discuss it briefly.

There are some fundamental attitudes that one assumes towards problems of this sort, to begin with. In the first place, if perhaps I have any characteristic in the exercise of my curiosity, it is that I like to see two things developed: First, the historical background that has led to certain experimental study such as this and secondly, the confirmation, if there is confirmation, not only within the horizon of study but from other disciplines.

Everybody knows that we have been classifying people one way and another for I don't know how long, perhaps from the beginning of time. Naturally in our institutions, as they grow up, we do classify people, usually on a very crude basis, without any very definite underlying goal except a purely practical one.

On the basis of such classifications, however, we know already that certain patients in our institutions—and I am thinking now of hospitals for the mentally ill more particularly because I am more familiar with them—get along better with certain other patients; that there are antagonisms that grow up just as Dr. Moreno has complained and not infrequently in a purely practical way we find it necessary to separate patients that don't get along. So we very crudely are doing the things which he has described.

On the other hand, we haven't perhaps consciously known for so very long that the character of the relation between the nurse and the patient is one of significance and of very great importance for the welfare of the patient. Dr.

*From the "Proceedings of the American Association on Mental Deficiency, 57th Annual Meeting," Boston, 1933, read at the joint meeting of the American Psychiatric Association and the American Association on Mental Deficiency, May 29th, June 3rd, 1933.

Sullivan, for instance, has entered into that situation in this society, I am sure, and called attention to it. Very recently, for example, I have had occasion in a number of instances to have employees referred to me for disciplinary purposes who had done something or other that was contrary to the rules and regulations of the hospital, and in going into the whole matter I have sometimes found that these employees were not very intelligent people, that they had been guilty of doing things that they shouldn't have done but sometimes when we examined into their relations with the patients, we found those relations most beneficent. So we immediately get the suggestion that the relationship sometimes of beneficence or the opposite as between patient and employee is not necessarily a matter of I.Q. for example.

Dr. Moreno has instituted a much more carefully worked out, systematized plan of investigation of the relations between these occupants of an institution to one another and to those other individuals, the house mothers, who control for the time being the destinies of these people, and who act as surrogate parents. I can see that is a most important investigation to have pursued, and I am wondering as I heard him tell some of his results how far they can be corroborated by other disciplines.

In the first instance, he shows a choice as between the sexes occurring among very young children. Then there is a considerable period up to the eighth grade during which that choice between the sexes is eliminated almost entirely and the choice is a homosexual choice. Then about the eighth grade we again get a large number of inter-sexual choices.

Perhaps it isn't fair to ask Dr. Moreno a lot of questions which perhaps he can't answer because after all this is in a preliminary, investigative stage, but I would like to know and I can't help but wonder for it seems to me that these results correspond to the psychoanalytic concepts: First, the pre-genital period of development, then a period of latency, and later on the recurrence of this heterosexual attitude of these youngsters.

It seems to me we get a suggestion that these two lines of research are producing similar if not more or less identical results.

I should like to ask Dr. Moreno whether he can tell us anything about these isolated personalities that he mentioned, that have no choices addressed to them from any source. I think we know that the individual in society who has no affection directed towards him from any source is a most unfortunate individual. Most assuredly he is an unfortunate individual if he is a child. A

child who has no love expressed for him in his environment I should say is in a pretty good way of developing some pretty serious symptomatology in later life, and I am wondering what the future history is of that child. Perhaps the doctor hasn't been at this long enough to tell about these isolated characters. I should suspect their history would be much more malignant than that of the others.

There is one other thing I should like to call attention to. In his summary he made a point of the analogy between this growth of group distinctions the analogy of this growth to a biological growth and to a social growth. I can't avoid the opportunity of calling attention to a further analogy and that is that we used to think and still think very largely that the growth from the simpler stages to the more complex ones has been an additive growth. The old idea of the nervous system was that it was a combination of units and that these units were reflexes and somehow or other you added reflex to reflex and you got a nervous system. In the same way on the psychological side, the unit at one time was supposed to be a sensation. You added sensation to sensation and somehow you got this infinitely complicated psyche that we talk about in this organization.

This whole business has been reversed. People are thinking in exactly opposite terms now. If you heard the paper contributed the other day by Miss Lauretta Bender on "Gestalt Function in Mental Defect," on gestalt concepts as they affect our field, you would have gotten the idea there which I think is also the same idea that some of our biologists are getting, that we start off with a more or less undifferentiated—I sometimes call it protoplasmic—background, and that what happens is that background is constantly differentiated, the complexity occurs by a process of differentiation, that when the child sees an apple, it doesn't have a sensation of roundness and a sensation of hardness and a sensation of taste and a sensation of smell which it adds together and then makes an apple out of it but it sees the whole apple, only it sees it in a very much simpler way as the drawing which the contributor presented demonstrated: and as the child gets older and as that child learns more and more about the apple and then draws that apple more and more, you see these differentiations expressed in the drawing. So in these social groups, introduced by Moreno, you see a constant tendency to differentiation and the resulting complexity is the result of that differentiation. That is exactly what is happening in society.

If we are going to do the best thing we can for our various types of abnormal growths, we must realize that we have got to act in accordance with the laws which govern social groups under any circumstances, and one of these

laws is the law which is expressed by this function of differentiation. Here we have a suggestion about the organization of a certain type of institution based upon what I call the emotional cross currents in that institution as between individuals. We are so convinced of that, for example, that when we take in nowadays at St. Elizabeths a registered nurse who has had all of her preparation of three years of technical training in a general hospital for somatic diseases, and try to assimilate her to our population and try to make her useful to us, we don't assume she knows anything about our work at all. So far as we are concerned, her three years of training doesn't mean anything to begin with. And who do we put that nurse under for training? Not somebody who has passed an academic examination, not somebody who can do integral calculus or something of that sort, but someone who has been with us for years and who has demonstrated those character qualities which are intangible and indefinable and which are expressed by such words as "intuition" but whom we know by experience knows how to handle patients, how to acquire their affection and their cooperation.

We take this trained person, put her under the care and direction of this person who very frequently is not trained in the ordinary intellectual sense, and we are beginning to get results which combine, don't you see, all the possibilities of intellectual training with such possibilities as this person may have inherently and which can be brought out by this other type of individual.

I have said enough. I don't want to talk as long as the giver of the paper talked but I just want to call your attention to what I conceive to be an exceedingly fruitful and profitable objective and worthwhile attitude to take toward these problems, and why I believe that attitude is worth while and what its possibilities may easily be.

Dr. Moreno's Reply

I am very grateful for Dr. White's words.

Dr. White discussed the reason for this study—that was the question he raised. I want to inform you that the motive for this study was a *therapeutic* motive.

When I was invited by Mrs. Fannie French Morse, the chief exponent in the treatment of the under-privileged child, and superintendent of the New York State Training School for Girls, at Hudson, we were interested if it was possible to develop a technique of assignment of individuals to other individuals or to groups on a more accurate basis that it is being done at present, trying to

develop a scientific form of assignment. We were faced with the problem of studying the Hudson community before we could assign and treat it, we had to consider all the emotional currents within Hudson. That is how this study developed. It was a therapeutic motive which led me to the analysis.

The second question Dr. White asked was if there was any relation between psychoanalysis, Gestalt theory, and that which we have presented here. Psychoanalysis and Gestalt doctrine naturally coincide in sociometry because it is a synthesis of the two. The study of the characteristic patterns of group organization and of community organization and their relation to evolutionary (temporal) and geographical (spacial) aspects may appeal to the Gestalt student as corresponding to his studies in the sensory fields. On the other hand, we study individuals just when they enter *spontaneously* into interrelationships which lead to the forming of groups, "sub species momenti." And as we study these spontaneous reactions in the initial stage of group formation and the organized attitudes developed in the course of such organization, we may coincide with the psychoanalyst. We are "present" during the "trauma" of birth and attempt to foretell the future: the psychoanalyst faces the ashes, the derivatives. It is as if psychoanalysis is reversed. Our procedure is *psychocreative.* We begin with the *act,* the initial attitude one person shows for the other, and follow up to what fate these interrelations lead, what kind of organization they develop. The psychoanalyst approaches a late developed stage and runs back the historical line to reconstruct the "trauma." It should be expected, therefore, that sociometric findings may corroborate many psychoanalytic concepts. However, sociometry, due to its methodology, promises two things which psychoanalysis could never accomplish: (a) a more precise presentation of the facts, as our procedure moves from the act to the symbol instead of from the symbol to the act; and (b) an analysis of the actual organization of groups and masses. For instance, the psychoanalytic concept that a pregenital period of development is followed by a period of latency and the recurrence of a heterosexual attitude, etc., appears to correspond to our findings. But the psychoanalyst covers only the attitude of the individual. Yet it is the effect these attitudes have upon group organization in different age levels and the counter-effect group organization has upon these attitudes which can be disclosed through sociometric approach only. And this seems to be the salient point. We never consider Gestalt separated from the creative act.

It is through such study of groups, from simpler to higher forms of differentiation that we have been able to follow the destiny of an isolated individual and the effect this position has upon his conduct. We have found, first, that

there are many structures of isolation: the simply isolated child so to speak, the forgotten child; the isolated and rejected child; the isolated child who rejects the group; the isolated child who wants to "belong" to the group but is not wanted; etc. The effect that such a position has upon the conduct of an individual is very unfortunate, especially in the formative age as Dr. White said. Something has to be done about it as these individuals are so frequently incapable of spontaneous adjustment.

Through techniques of assignment we take an isolated individual from the group in which it has such a position to another group to which he is better fitted. A new soil with attractions and contrasts better suited to him is developed and with it the prospect of a change of his position and of his conduct. This group better fitted for him is uncovered through the sociometric test. We observe then how the same attitudes receive different responses from the members of the two different groups. What was evaluated as boldness and impudence in the first group can be so affected by the different psychological currents in the second group that a relief from the former stresses and tensions takes place; the actual emotional constellation behind the boldness and impudence may change slightly but this minimal change often suffices to precipitate in some members of the new group expectations in his favor; from these attentions and expectations, new emotional currents flow back to him which gradually turn boldness into the direction of leadership and fearlessness into the direction of courage. It is a circular process consisting of attitudes from the new member and counter attitudes from the new group which combine to produce a better *psychological* setting and a different end-effect for the subject.

To return to another question which has been raised, I remember, for instance, a Jewish girl in Hudson who is repulsed and rejected by about eighteen girls in this community and three of these girls don't know her at all. They reject her only as a symbol and the other fifteen know her through all kinds of interrelations they have developed in school or in the workrooms. She is a special form of an isolated and rejected individual. I feel that the social worker, our public schools, and our special education classes can profit from studies of this kind which can be done very rapidly and simply. They are not very elaborate, but they do give very quick information and, of course, the student has an opportunity to work the details out.

Finally, I should like to say a word about the sociometric analysis of family patterns. I have examined family group organization but not from the point of view of the psychoanalyst who studies it from the standpoint of the in-

dividual, his relationship to the father, to the mother, etc., as these are reflected within the individual. I have studied the interrelations from the standpoint of each member of the family, from all the standpoints. The psychoanalytical approach of the Oedipus drama is correct as long as it considers the Oedipus complex as an individual reaction of Oedipus mirroring all other persons around him. But to represent the real, whole Oedipus drama, an "interrelation analysis" is necessary. An individual analysis of each of the three persons, and then towards each other, Oedipus, his father Laius and his mother Jocaste, has to be made. We will find, then, just as Oedipus may have in his complex hate towards his father and love towards his mother, that his father has towards him and Jocaste a complex which we may call briefly "Laius" complex and that his mother Jocaste has toward him and towards Laius a complex which we may call "Jocaste" complex. Then you will find complexes which Laius has in relation to Jocaste and Jocaste has in relation to Laius. The interlocking of these three persons, the complexes and frictions between them, the clashes between their complexes will produce the actual psycho-social process of their interrelations which is different from the manner in which the dramatic process reflects in Oedipus alone, or how it is reflected within his father or mother singly, each apart from the other. In other words we get a multiplicity of interrelationships which are, so to speak, "*ambicentric*" i.e. centered in two or more individuals, and through this kind of study we get an insight from within as to how the family group is organized.

COMMENT ON RELATION OF SOCIAL PSYCHIATRY TO GROUP PSYCHOTHERAPY

By

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Perhaps the greatest contribution the present era has made to the welfare of Mankind is Global Thinking—The individual no longer finds himself to be a man apart. His interests are indissolubly linked with those of his neighbor.

If these assertions are true, an estimate of his personality (and the treatment of the disorders thereof) must likewise be subject to revision. Hitherto, Psychiatry as a medical entity has concerned itself exclusively with a thorough study of the individual. The milieu in which the patient lived and worked was of little moment. Such a position is no longer tenable. The advent of Group Psychotherapy and its attendant success as a therapeutic force is proof positive.

Social Psychiatry, which is the application of psychiatric principles to the individual in his relation to the Social Structure (particularly the family unit), should extend its influence into the field of Anthropology. The cultural pattern is a factor of primary importance in the evaluation of the individual. Only by means of such an estimation can the impact of racial and community ties be understood.

The techniques of Group Psychotherapy are closely related to Sociology and Anthropology. The careful screening of patients for Group Psychotherapy is a clear indication of this linkage. The employment of a small group which restricts the family situation in a benign setting provides the sociological aspects of this type of therapy. Whereas cultural standards necessarily evaluated in screening must include racial traits, socio-economic strata, and mores related to the general cultural pattern from which the patients are drawn.

GROUP PSYCHOTHERAPY IN RELATION TO RESEARCH*

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Despite the wealth of clinical experience in psychotherapy there is still no universally accepted body of knowledge as to the nature of its active principles or the relative merits of different approaches. This unhappy state of affairs seems largely due to the great difficulties of research with respect to both the therapeutic process and evaluation of patients' improvement. Our attempts to do research on analytically oriented group psychotherapy during the past three years have made us acutely aware of these problems but also of certain advantages of group as compared to individual psychotherapy for research into the therapeutic process.[1]

Psychotherapy is in essence the modification of the attitudes of the patient through interaction with the therapist. Group psychotherapy also introduces the effects of interaction with other patients, but this does not change the basic problem which is how to study a process while one is trying to modify it and in which one is oneself involved. To be a good therapist the doctor must have an emotional interest in helping the patient and must be more concerned with doing therapy than observing it. Thus his reports are subject to two sources of error—divided attention and the distorting effects of emotions on observation and memory. Psychotherapists report their cases without raising the question as to how correct their observation of what went on in psychotherapeutic interviews really is. Actually comparison of retrospective reports of interviews with recordings of them shows that even the most unbiased and objective psychiatrists make significant errors of omission and distortion. The psychiatrist may fail to observe important events or observe them inaccurately. He may forget or incorrectly remember what he observed. Such errors might be expected to be greatest at those points in the interview most important for the study of psychotherapy, where the therapist's own emotion partici-

*From the Group Psychotherapy Research Project of the U.S. Veterans Administration, Johns Hopkins Hospital, Baltimore, Maryland. (Published with the approval of the Chief Medical Director.) The statements and conclusions published by the author are the result of his own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

1 For fuller consideration of problems of research in Psychotherapy see Brenman, Margaret, et al, "Research in Psychotherapy. Round Table, 1947." **American Journal of Orthopsychiatry, XVIII: 92-118,** January, 1948. Bronner, Augusta F., **et. al;** "The Objective Evaluation of Psychotherapy. Round Table, 1948." **American Journal of Orthopsychiatry,** XIX: 463-491, July, 1949.

pation was greatest. Almost all descriptions of psychotherapy, moreover, are presented to illustrate the writer's particular method and to demonstrate its effectiveness. This leads to a selective bias which may result in further distortion.

Just as a therapist cannot produce a full and undistorted report of what goes on in the therapeutic interview, so he cannot form a completely unbiased judgment of the effects of therapy. As the one who knows the patient's problems most intimately, his evaluation of the patient's progress is indispensable, but having a personal stake in the outcome he cannot be regarded as strictly impartial.

For these reasons research in psychotherapy requires the use of observers trained in observing therapeutic sessions and in methods of evaluating patients and the effects of therapy on them. Since the observer is not himself involved in the events being observed and can devote his full attention to recording them, he can produce a much more complete and accurate record than the doctor. The use of an observer may actually improve the doctor's therapy, not only by permitting him to devote his undivided attention to treatment, but also by supplying him with a relatively full record of what went on, including his gestures, tones of voice and other clues he gives the patients of which he is often unaware.

The use of observers, however, leaves unanswered the important questions of what to observe and how to analyze the observational data. Psychotherapy proceeds by meanings rather than overt activities. The feeling the patient or doctor conveys may be more significant for therapy than what he says, and what is not said may carry more weight than what is spoken. The same act may have different meanings at different times, or apparently dissimilar behavior may carry the same meaning. Meanings cannot be directly observed, but can only be inferred from the total context of the situation in which the behavior carrying the meaning occurs. This increases the chances of error in reporting what occurred and also means that a gestalt approach is necessary with all the methodological problems it involves. In this connection it may well be that the effect of as yet undefined aspects of the doctor's personality may be more important than the technique he says he uses[2]. Experience with group psychotherapy shows that different doctors may elicit startingly different reactions from the same group of patients.

2 Alexander, Leo. "General Principles of Psychotherapy." **American Journal of Psychiatry.** 106: 721-731, No. 10, April, 1950.

A further difficulty is posed by the impossibility of making experiments or repeated observations of the same phenomena. Obviously, no two people are alike so that one cannot repeat the same observation on different people. The same observation, moreover, cannot, strictly speaking, be repeated on the same person, because the situation has inevitably been modified by the preceding one. Also the fact that one is working with human beings makes it impossible to maintain a rigid experimental design. One seldom can wait for just the patients needed to fill out a pre-conceived plan. Patients' desires and activities are not at the disposal of the experimentor. Unpredictable and uncontrollable circumstances can be counted on to interfere with any experimental design that involves a considerable period of time, as all research on psychotherapy must.

The obvious recourse when strict experimentation is not possible is to resort to statistical methods to isolate significant relationships. These methods have serious limitations when applied to psychotherapy because they cannot take into account the gestalt nature of the process. Analyzing a therapeutic situation into a series of variables abstracted from the total situation and considered without reference to it destroys its meaning, in which we believe its therapeutic relevance resides. In order to set up statistical controls, furthermore, one must use either some principle of random selection (every other patient, for example) or matching. The first is not feasible in most situations involving psychotherapy because the sample is not large enough. Matching presupposes that we know what are the important attributes to match, which we do not. Attempts to match patients in terms of diagnostic categories, for example, run into two methodological difficulties. Agreement between trained clinicians as to which category a given patient belongs in is very low because almost all patients have features of several diagnostic categories[3]. Furthermore, diagnostic categories often seem to bear little relation to behavior under therapy. Group psychotherapists almost all agree that it is frequently impossible to pick a patient's clinical label on the basis of his behavior in the group. Matching with respect to those aspects of people which are relevant to psychotherapy is not yet possible. A similar lack of satisfactory criteria exists with respect to the evaluation of patients' improvement. Although progress is being made in developing objective methods of measuring this through the use of special interviews and tests only the most optimistic would consider the problem adequately met at present.

The complexity of research in psychotherapy may be indicated by consid-

3 Ash, Philip. "The Reliability of Psychiatric Diagnoses." **Journal of Abnormal and Social Psychology,** 44: 272-276, 1949.

ering what is involved in evaluating the relative merits of various methods, as well as their indications and contraindications. What is the relative effectiveness of psychoanalysis, group psychotherapy, psychodrama, hypnotherapy, intensive psychotherapy, brief psychotherapy, for different patients? To compare therapies, we would have to know how to determine what are the essentials of the therapeutic process in each, the same therapist would have to use and be equally at home in them, and satisfactory criteria for matching patients and evaluating their improvement would need to be devised.

While these problems make experimental or statistical studies of psychotherapy very difficult, they do not, of course, mean that scientific study of this field is impossible. As Cohen and Nagel[4] have pointed out "scientific method is simply the way in which we test impressions, opinions or surmises by examining the best available evidence for and against them." Experimental and statistical methods do not create insights, they merely verify them. In the field of psychotherapy it may be that too much energy is being expended on trying to devise adequate controls rather than on accumulation of observations, because of the misapprehension that the former in themselves lead to the discovery of significant relationships.

In our present state of ignorance, research in psychotherapy must be largely exploratory and is inevitably expensive and time consuming. Therapy is a slow process. The psychotherapist is forced to strike a balance between the number of patients he treats, the frequency of his contacts with them, and the duration of treatment. The more frequently he sees each patient and the longer he treats him, the fewer the number of patients he can study in a given span of time. As making and studying research records takes at least as long as treating patients, a research therapist working 40 hours a week cannot devote more than 20 hours a week to therapy. This would enable him in six months to treat individually 20 patients on a once-a-week basis, or 7 on a three-times-a-week basis. Thus, accumulation of adequately treated patients is slow.

From the standpoint of the observer, no adequate substitute for the fullest possible narrative account of the therapeutic session has been found. Attempts at selective recording, condensation, or other short cuts incur too great a risk of omitting potentially important material.[5] This means that records are necessarily voluminous, an average record of an hour-and-a-half group session for

4 Cohen, Morris R. and Nagel, Ernest. **An Introduction to Logic and Scientific Method,** New York, Harcourt Brace & Co. 1934, p. 192.

5 Though some investigators use special categorizing schemes, these do not replace the narrative accounts but are used in addition to them. Bales, Robert F. **Interaction Process Analysis.** Addison-Wesley Press, Cambridge 1950.

example containing ten to twenty single-spaced typewritten pages. Our observers could not handle more than two groups (or about 20 patients) apiece including keeping records of meetings and evaluating progress of their members.

Thus, research in psychotherapy, though it requires little equipment other than recording instruments and writing materials, needs a relatively large number of highly trained personnel in relation to the number of patients treated. Initial costs are low, but continuing expenses in the form of salaries of therapists and investigators are high.

Certain of the difficulties of research in psychotherapy are diminished, though not overcome, by group as compared with individual therapy. It greatly increases the rapidity with which data can be accumulated. A therapist can treat and study 4 to 10 times as many patients (depending on the size of his groups) during the same period of time as he can individually. It facilitates the use of trained observers. An observer in a private interview might be expected to change the situation significantly—"Two is company, three's a crowd." An observer added to a group seems to change the situation practically not at all. After a few meetings he is literally not noticed unless the doctor seems aware of him (which makes it impossible for the patients to forget him) or something in the immediate situation causes a patient or patients to turn to him. This itself then becomes something potentially significant to study.

In the individual interview the doctor elicits some of the patient's important attitudes by his personality and techniques. These he can directly observe, but since he is always involved in them the accuracy of his observations may be impaired. The rest of the patient's reactions, those elicited only by persons outside the interview, he knows only from the patient's report which may be distorted by his relationship with the doctor in addition to other emotional influences. The doctor is either directly involved in what he is trying to study, or he must rely on hearsay. The group situation offers an improvement over this in two ways. A much wider range of the patient's responses are stimulated and so become available to direct observation, and in many of them the doctor is more or less a bystander and so can observe more accurately than if he were directly involved.

In particular, the group elicits not only neurotic but healthy attitudes which are at least as important for therapy and which it is so easy to slight in individual treatment. The private psychiatric interview is far removed from anything in daily life and tends to bring out primarily those aspects of the

patient's functioning which cause him trouble, since he seeks treatment for these. The group situation also elicits an abundance of pathological reactions, in fact more readily than the individual one. The number of transference reactions the doctor can easily stimulate is limited by his personality and technique. The group is more apt to contain persons who resemble in some way significant persons in the patient's life and so touch off transference and other distorted responses, partly because more people are present, and partly because each is revealing himself more freely than the doctor who usually tries to remain as bland and neutral as possible. In addition, however, the group confronts the patient with social realities—persons of the same and opposite sex, his elders and juniors, his social, educational, or economic inferiors and superiors, those who attack, protect, compete with or try to manipulate him, and so on. Thus it reveals more of how he functions in daily living, including his capacities for handling interpersonal problems successfully.

The group also tends to bring out reaction patterns more clearly than the private session. One reason for this is that patients serve as distorting mirrors for each other as it were, accentuating certain aspects of the others' personalities. It is frequently easier for a patient and others to see something in himself after he has seen it in someone else. Sometimes the intensification of reaction seems to be merely a matter of numbers. A poor therapeutic maneuver in an individual session blocks only one patient. In a group it may block ten simultaneously which makes it much harder to overlook. Among other factors making for the intensification of reactions in the group are the greater degree of social reality and the tendency for emotions in a group to be contagious.

The extent to which the findings of group psychotherapy are applicable to individual therapy remains to be determined. Our impression is that the similarities are marked. Certainly both have similar goals and proceed by the interplay of personalities, and most phenomena which have been described in individual therapy have been noted in groups. In both, similar types of neurotic defenses, resistances, distortions, transference reactions and other interpersonal phenomena relevant to therapy are richly displayed. Insofar as group and individual therapy differ, this should in time help to isolate which aspects of the two approaches are really efficacious and which irrelevant to the therapeutic goal.

To sum up, the therapy group has several advantages over individual therapy for research. It allows a more rapid accumulation of patients, it can be readily observed without appreciably influencing what goes on, it multiplies op-

portunities for the occurrence of therapeutically relevant interactions, both sick and healthy, and tends to make them more obvious. It thus offers hope of gradually resolving some of the formidable difficulties involved in research in psychotherapy.

PSYCHOANALYSIS AND GROUP PSYCHOTHERAPY*

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At the present time, the effort to shed light on the dynamics of group psychotherapy, through the application of psychoanalytic concepts, is fraught with complications. It is a task indispensable to progress, nevertheless, and in the end promises a substantial reward. The serious interest of psychoanalysts in group psychotherapy is distinctly on the increase. A number of them, myself included, have been groping toward a better understanding of the relevance of psychoanalytic principles for the dynamics of group treatment.

With the wide gaps of knowledge which prevail in this field, there is great room for prejudice in the approach of individual analysts to the issues of group therapy. My present views, highly tentative as they are, may reflect some amount of personal prejudice. For this reason, it may be useful to offer the background on which I have developed these views:

1. A primary orientation as a psychoanalytically-trained psychiatrist.
2. Experience in the application of group psychotherapy to school-age children, adolescents and adults.
3. Acquaintance with the literature on group psychotherapy.
4. A personal incentive towards the study of processes of social interaction, expressed in membership in two committees: The Committee on Social Issues of the American Psychoanalytic Association and the GAP Committee on Social Issues.

One episode out of the past will illustrate the particular slant with which I approached the problem of group psychotherapy. At a luncheon meeting of the American Orthopsychiatric Association, at which the plan for the American Group Therapy Association was launched, I timidly suggested that a study

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of the processes of Group Therapy might provide a natural setting for the acquisition of sorely needed knowledge in a new science, social psychopathology. My remark was not then received with favor, but I still cling to that same prejudice. I believe careful study of the processes of group psychotherapy may yet give real substance to the now-emerging science of social psychopathology.

I should like, first, to point concretely to some of the difficulties involved in applying psychoanalytic thinking to the problems of group treatment. Immediately, three types of phenomena and three kinds of knowledge are involved:

1. The psychodynamics of group behavior, including both the processes of group formation and the processes of group change.
2. The dynamic processes of emotional integration of an individual into a group.
3. The internal organization of individual personality.

In all three areas, we are handicapped by an insufficiency of knowledge, but the lack of knowledge is conspicuously great in categories 1 and 2; i.e., in the processes of integration of an individual into a group, and in the dynamics of group formation and group change. In addition, there is the difficulty of correlating the intra-psychic functions of personality with those adaptive operations of personality which are involved in the integration of an individual into a group. Partly because of these handicaps, we are not yet able to set up an adequate conceptual frame for applying psychoanalytic principles to the processes of group treatment.

At the very outset, we are confronted by a thorny semantic problem. Conventional psychoanalytic terms and definitions have not yet achieved a satisfactory level of scientific clarity and precision. The term "psychoanalysis" itself has come to mean many different things. The more important usages of this term offer at least four distinct meanings:

1. A theory of personality.
2. A therapeutic technique.
3. A method of investigating the unconscious life of man.
4. A special point of view toward human nature and toward the problems of living.

In addition, each of these connotations of psychoanalysis has been continuously changing through a process of evolution, especially the psychoanalytic

theory of personality, and the psychoanalytic concepts of therapy.

It is now almost axiomatic that psychoanalysis, as a device for systematic exploration of unconscious mental life, does not by itself guarantee therapeutic change. In exceptional circumstances, it may even constitute a crucial danger to the therapeutic objective. Mental health is not achieved in a simple way: it is not achieved merely by increased awareness or release of unconscious urges. It means not only the elimination of specific disabilities of personality, but also the positive fulfillment of the potentialities of the individual in the context of prevailing patterns of social relations. It is reached through the establishment of an optimal balance between the individual's orientation to his deeper strivings and his orientation to the real requirements of his relations to other persons and to the group as a whole.

This immediately sets up a distinction between psychoanalysis as a means of study of the unconscious and as a therapy. This consideration has direct relevance for both the goals and processes of group psychotherapy.

Psychoanalysis, as a theory of personality, has added a wealth of insight into the nature of man's inner conflicts, but has not yet reached the status of a scientifically unified theory. As a biological psychology, psychoanalysis has done much to correct the deficiencies of the older academic theories of personality. Yet, this very advantage has introduced certain complications. Psychoanalysis stresses the individual's deeper relationship to himself and those operations of personality which are oriented to the task of gratifying basic biological needs. It emphasizes unconscious motivation, the individuality and the egocentricity of man, and the primary importance of the individual's relation to body function. It gives rise, however, to a definite complication; namely, the difficulty of integrating the concept of man as an individual and man as a social being.

From the first, Freud admitted the importance of the social determinants of behavior, with special reference to the conditioning influences of family life, but a measure of ambiguity has always characterized Freud's formulations of the interrelationship of the biological and social determinants of behavior. This is rather clearly reflected in Freud's own statement concerning individual and social psychology:

> "A contrast between individual psychology and social or group psychology, which at first glance might seem to be full of significance, loses a great deal of its sharpness when it is examined more closely. It is true that individual psychology is concerned

> with the individual man, and explores the paths by which he seeks to find satisfaction for his instincts, but only rarely and under exceptional circumstances is individual psychology in a position to disregard the relations of this individual to others. In the individual mental life, someone else is invariably involved, as a model, as an object, as an opponent, and so from the very first, individual psychology is at the same time social psychology as well[1]."

Here we have an illustration of Freud's brilliantly penetrating wisdom, and yet, at the same time, a fair sample of his tendency to somewhat beg the question as regards the precise relationship between the biological and the social determinants of behavior. While making his bow to the "social man," he tends to show a preferential interest in the "individual man." He sought to explain the social role of man and woman in terms of biologically-determined instincts and the related unconscious drives; the social function of man was represented as a projection onto the social scene of his unconscious strivings and fantasies. The broader patterns of culture were similarly interpreted.

While sharply illuminating the role of family life in shaping the child's personality, he tended, nevertheless, to stereotype the roles of mother and father, failed adequately to take into account the cultural patterning of these roles, isolated the dynamics of family life from surrounding social institutions and subordinated the feminine half of humanity. He failed to see the way in which child-rearing concepts were influenced by cultural as well as the developmental factors of neurosis.

But what has all this to do with group psychotherapy? Mainly this: in order to illuminate effectively the dynamics of group therapy, the conceptual frame for a theory of personality must be expanded in a way that satisfies two necessary conditions:

1. The operations of personality must be conceived in terms of a bio-social unit. The biological and social determinants of behavior cannot be dissociated. Out of the interaction between the organism and environment, a new unit of behavior emerges which is bio-social. The adaptive functions of personality must be so viewed as to take into account the continuous interplay between those processes that reflect the individual's relation to his inner (biological) being, and those which reflect his orientation to social participation. It is necessary, furthermore, to find criteria for the dynamic

1. Sigmund Freud's "Group Psychology and the Analysis of the Ego."

relations between the adaptive expressions of personality in group action and the relatively more fixed internal structure of personality, as conditioned by developmental influences. In other words, man has an identity that is, at once, both individual and social.

2. The functions of personality must be defined within the context of a broader theory of social organization and social relations. The adaptive behavior of the individual must be viewed in relation to the characteristics of the group to which he belongs. Differences between individual and group behavior must be understood. The behavior of a group has certain unique characteristics of its own, and the adaptive processes of personality, both normal and pathological, need to be viewed within this wider frame.

Until we satisfy these requirements in the basic concepts of personality structure and function, it will be difficult to usefully transpose psychoanalytic principles to a group treatment setting.

In a group setting, the therapist cannot directly observe, nor does he have access to, the total potentialities of individual personality; instead, the therapist establishes emotional contact with the shifting adaptive phases of the personality in action, which are expressed through the role of the person in that social situation. The role of the individual in the group represents a particular form of integration of his emotional tendencies in a specific situation. The adaptive expressions of the person are limited and shaped in two ways: by the relatively fixed organization of the individual personality, and by the requirements of a given situation, as this individual interprets them.

It must be emphasized, therefore, that the immediate therapeutic influence in a group is exercised not through what is called "total personality," but rather through those particular forms of emotional expression, through which the patient displays his personality in the group—namely, through his role in the group. The continuity of group therapeutic experience is such, however, as to induce in the person a series of changes in adaptive role and, through these changes, the therapist may gradually achieve access to a variety of layers of the personality.

Thus, social interaction can be understood only if we broaden our conception of personality so as to consider the continuous interplay between the individual's relation to his biological make-up and the individual's orientation to social participation. Each individual has layers of emotional reactivity which

are relatively fixed, and others which are more pliable. Each individual is capable, within the limits set by his fixed intra-psychic structure, of modifying his adaptive form in diverse social situations; he can change his "social role." The identity of each individual holds both individual and social components. In a shift from one social situation to another, the dynamic equilibrium between the individual and social components of personal identity undergoes change.

In a recent paper, "SOCIAL ROLE AND TOTAL PERSONALITY[2]," I endeavored to illuminate the relationship between the social functions of personality and individual personality. I suggested that the adaptive forms or roles of personality in different groups might be appraised by the application of the following criteria: the group-conditioned aim of the individual, his quality of apperception of surrounding inter-personal realities, the concept of self projected into the role (including personal values, ideals, standards, etc.), his techniques for control of the group environment, his pattern of conflict, the quality of anxiety engendered by this role, and the defenses mobilized against it.

It seems to me that some attempt to define the adaptive functions of the personality can be made in these terms, and this adaptive role can then be correlated with our knowledge of the fixed intra-psychic structure of this individual. In order to establish such correlation, more exact knowledge of Ego functions is needed.

When we turn to a consideration of the relation of psychoanalytic therapeutic technique to the techniques of group treatment, it becomes imperative to contrast the different psycho-social potentialities of the two therapeutic situations. The two-person psychoanalytic relationship provides a unique experience in which the earlier patterns of child-parent relations are relived and their destructive elements removed. Group Psychotherapy, involving three or more persons, however, has its dynamic base in the fact that the child's character is influenced not only by the mother, but all the interacting relationships within the family group, especially the relationship between the parents. These multiple interpersonal patterns, each affecting the other, also contribute to the distortion of personality.

The psychoanalytic method applies to a pair of persons, but the techniques are pointed almost exclusively to the experience of only one of these persons—the patient. In considerable part, the analytic relationship does not constitute

2. To be published in the American Journal of Orthopsychiatry.

a true social experience; it provides no model for society. It is a process of working-through of the patient's internal conflict with self, with the analyst acting as catalyzer of this process. External conflict with the analyst becomes translated back into terms of the patient's internal conflict with self. A further aspect of analytic therapy involves a degree of temporary shedding of the patient's inhibiting ego, of his rational control, a denuding of the social layers of the patient's identity, so as to accentuate the patient's awareness of inner conflicted emotion and biologically-conditioned urges. Thus, the importance of outer reality, and reality as personified by the analyst, is temporarily diminished. Such an experience heightens the patient's deeper communication with his private self and his unconscious, but at some cost in terms of temporary subordination of social communication. As access to the deeper self is achieved, the reality elements of the patient's ego, and the reality of the analyst are reasserted, and play their part in re-integration of the patient's emotional life. In this sense, analysis is predominantly a therapy which moves from "inside outward."

The group situation is different. Interpersonal processes emerge in a group which either are not present in a two-person relationship, or at least not in an identical form. Contact between two persons provides the potentiality for a social relationship, but does not provide the foundations of a society. Only a group of 3 or more persons makes possible an organized social unit, with a set of dominant aims, ideas, emotions, values and patterns of social relations. Here we have multiple interpersonal patterns, interacting continuously with each other. Some of these relationship patterns may be in harmony; others in conflict. They vie with each other for a position of dominant influence. The way in which the group forms, integrates, changes and is affected by leadership, determines the channels along which emotion is released or restrained. Thus, in a group, a tangible social reality is always present. The patient's contact with this reality is immediate and inescapable. The therapeutic process moves back and forth between this social reality and the patient's inner emotional life. Here we have a basis for continuous impact between the patient's image of interpersonal relations and their actual nature, as perceived and interpreted in the group interaction.

In order to try to see the extent to which therapeutic mechanisms operate similarly or differently in the group and individual settings, it is useful to outline the partial processes of psychotherapy, in general:

1. The development of an emotional relationship with a dynamic "give and take" between patient and therapist.
2. Through this relationship, provision of emotional support for the patient.
3. Reality testing; modification of concept of self, and patterns of relation to others in the direction of more realistic perception.
4. Release of pent-up emotion.
5. Expression of conflict, both conscious and unconscious.
6. Change in patterns of resistance and defense against anxiety.
7. Diminution of guilt and anxiety.
8. Growth of new insight, and emergence of new and healthier patterns of adaptation.

All of these processes overlap, influence each other, and together they provide the dynamic basis for therapeutic change. A number of questions arise.

Is therapeutic change in the group and individual settings dependent on the same or a different set of processes? Are there some processes which are specific and unique for one or the other form of psychotherapy? Do some particular processes play a more important role in one form of treatment than in the other? Or, if the basic processes are in essence similar, are the separate elements of therapy integrated and balanced differently in the two situations? On these questions, I offer my present views humbly, tentatively, with keen awareness of the handicap of limited knowledge.

First, I would tend to doubt that the group therapy situation involves any unique processes. I do believe, however, that the different psycho-social potentialities of the group necessarily modify the pattern of the balance between the partial processes of therapy, intensifying some, lessening or inhibiting others. The therapeutic processes in a group tend to operate on an interpersonal level, rather different from that which prevails in psychoanalysis. The nature of group experience is such as seems to place a first emphasis on conflict with the environment, rather than with the self. In the group, conflict tends to be externalized, projected into the social scene. Through such projections are reflected the patterns of inner conflict with self. Externalization of conflict encourages some measure of "acting out" in the group relations. Expression of feeling in a group, therefore, is more than verbal, it extends to the sphere of social action, and fosters a higher degree of motor discharge of tension. In

individual psychoanalysis, the primary emphasis is in the opposite direction; namely, on conflict with self, and, in harmony with this, the tendency to "act out" is discouraged. Through the conflict with self, one gets, in turn, the mirror reflections of conflict with the environment.

But there are other differences as well. The pattern of intensive exclusive dependence on one person is not so readily possible in a group as in psychoanalysis. Relationships in a group tend to be more influenced by reality. The irrationalities of transference are held in check. The multiple interpersonal relationships provide opportunity for displacement, division and dilution of transference emotion. Magic expectations, and omnipotence strivings are restricted.

In the group, the function of providing emotional support for the patient is divided. The therapist is not the sole source of security and gratification of emotional needs. The group, as a whole, shares this responsibility.

In the group, discharge of pent-up emotion takes place on a selective basis. Emotion which can be experienced in common with others is reinforced. Other types of emotion may be inhibited.

Free association, in the analytic sense, occurs on a more limited scale, if at all. In its stead, we have the spontaneous emotional interactions between members and with the therapist.

In the interaction between the person and the group environment, there is a two-way selective process. The individual takes out of the group what he needs. The group takes from each individual what its processes require. The individual combines his force with those tendencies in the group which will strengthen the effectiveness of his chosen role. Also, he may submit to being used by other in the interest of their self-assertion. This two-way selective process plays a part in the assertion of certain types of control, in releasing basic drives, and in dealing with conflict, guilt, and anxiety.

In the group setting, the therapist does not have immediate or direct access to the unconscious of the patient. In this respect, the analytic situation enjoys greater favor; here the access to unconscious conflict is more direct, and more systematic. In the group, conscious conflict is the first to appear. The working-through of such conflict and its reduction to concrete terms will often bring to light significant clues as to the nature of deeper conflict. Frequently, the manner in which conflict is externalized and "acted out" in group interaction, offers hints as to the content of unconscious conflict.

Some further comment may be in order here in relation to the therapeutic connotations of a patient's tendency to "act out" his impulses. In the analytic situation, "acting out" is conceived as harmful, and is systematically discouraged. In a group setting, the urge to express conflict through "acting out" is, to some degree, natural. Group psychotherapy is intrinsically an "acting out," rather than a thinking out," type of experience. Here, a patient deals with conflict by projecting it into a relationship; he lives it out with the other person. In this manner, inner conflict is translated into outer conflict with another person. It is this "acting out" in relationships which enhances the motor discharge of emotional tension. In this setting, the therapist can work with the irrational elements of conflict not in the form of fantasy but rather in those forms which are projected onto the social scene. The group therapist may then translate this back into the context of the patient's inner conflicts. Because of the selective nature of the group process, however, some kinds of unconscious conflict may remain totally inaccessible.

Patterns of resistance and defense against anxiety are dramatically transparent in the proceedings of a group. Resistance should not be regarded as pathological behavior; it can be defined as the natural mechanism of self-protection when a patient fears harm through exposure of himself in a close relationship. Anxiety, the defenses against anxiety, and patterns of resistance are a functional unit. By tracing out the resistance paths, and the types of defenses employed, one sees the way in which a patient attempts to escape his anxiety and conflict. By pursuing closely these paths of escape, one is led, step by step, to the actual content of the conflict.

Individual patterns of guilt can be modified to a variable extent by group treatment . . . some forms temporarily, others more permanently. The more superficial types of guilt are easily reached and relieved, especially if they represent a shared form of guilt. The technique of universalization is a device for mitigation of guilt through reassurance, but may not alleviate it at its source. A lasting relief of guilt in the more rigid, automatized types of reaction is more difficult in a group. In general, however, the impact between the impulse tendencies of the individual and the fluid standards and moral reactions of the group, does offer a substantial basis for diminishing guilt feeling. Here, the standards of individual conscience, immature and inappropriate as they often are, are checked against the more balanced and realistic standards of the group.

The group situation provides a wide range of possibilities for the testing of reality. In this setting, social reality is not a fixed entity. Each member of the group, and each pattern of relationship, personifies a given form of interpretation of social reality. In this sense, social reality is fluid, relative, and is represented by multiple interacting concepts, rather than by a single fixed interpretation. As the group evolves, however, there is increasing unity and stability in these interpretations of reality. On this background, the patient tests out his fear of dangers from the real world, and his fear of his own impulses. In this setting, the clash between his impulses and the standards of this fluid form of social reality offers a chance to expand his emotional orientation to his own nature and the nature of society. Such increased understanding may develop with or without therapeutic interpretation. Patients often spontaneously offer their own interpretations. Sometimes these are uncanny in their accuracy, sometimes utterly inappropriate because of the patient's egocentricity and projections. It is the therapist's task to guide these emotional cross currents toward correct understanding. He may use the technique of interpretation sparingly, and only when the emotional trends have become sufficienty ripened. Here we have a broad opportunity for growth of insight, modification of social standards, and values and the development of healthier patterns of social adaptation. Of particular importance in a group is a growth of confidence in dealing with people, and a basic increase in self-esteem.

SOME DIFFERENCES BETWWEN THE PSYCHOANALYTIC TWO-PERSON SITUATION AND THE GROUP THERAPEUTIC SITUATION

Psychoanalysis	Group Therapy
1. Two persons.	Three or more persons.
2. Couch technique.	Face-to-face contact.
3. Temporary subordination of reality.	Reality continuously asserted by group through reality takes fluid form.
Analyst reasserts reality according to patient's need.	Patient's impact with reality is immediate.
Analyst is observer; suppresses his own personality.	Group therapist is more real person, participant as well as observer.
Relationship is not social, except in later stages.	Group provides genuine social experience.
Social standards not imposed.	Group standards emerge, but remain flexible.
4. Exclusive dependence on therapist. Emergence of irrational attitudes	Dependent need is divided, not exclusively pointed to therapist.

PSYCHOANALYSIS	GROUP THERAPY
and expectations.	Irrational attitudes and expectations appear, but checked by group pressures.
Magic omnipotent fantasy prominent. Irrational motivation may rise to dominant position.	Magic omnipotent fantasy is controlled.
	Irrational motivation not permitted dominant position.
5. Direct gratification of emotional need not given.	Group offers some direct gratification of emotional need.
6. Communication largely verbal; Communication less real.	Communication less verbal;
Patient communicates deeply with self; also with therapist.	Greater expression in social action and reaction.
	Higher degree of social communication.
Patient feels alone.	Patient belongs to group, shares emotional experience, feels less alone.
7. "Acting out" suppressed; little motor discharge of tension.	Higher degree of "acting out," and motor discharge of tension.
8. Access to unconscious conflict more systematic; greater continuity in "working through."	Access to unconscious conflict less systematic; lesser degree of continuity in "working through."
Emphasis on inner conflict with self; conflict with self mirrors conflict with environment.	Conflict is projected, externalized.
	Conflict with environment mirrors inner conflict.
Modification of specific internal disorders of personality more effective.	Modification of specific internal disorder of personality less effective.
9. Patterns of resistance and defense more uniform and specific.	Patterns of resistance and defense more variable.
10. Relief of guilt and anxiety more specific.	Relief of guilt and anxiety less specific.
11. Dynamic movement to large extent from "inside outwards."	Dynamic movement to large extent from "outside inwards."
12. Emotional change and insight more immediately related to intra-psychic conflict.	Emotional change and insight more immediately related to extra-psychic conflict.
Method more suitable for specific psychiatric symptoms; predominantly a therapy for disturbance in basic drives.	Method more suitable for change in character traits; predominantly an ego therapy.

GROUP STRUCTURE AND GROUP PSYCHOTHERAPY

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The subject of group structure in group psychotherapy is a very large one. The nature of the physical organization itself involves many questions of selection, size of group, attitude of therapist, etc., which are completely related to the specific situations in which group therapy may be useful.

The psychological or emotional organization of the participating members within this physical framework is even more complex. The nature of this personal interrelationship is a direct expression of the type of group therapy attempted and usually of its effectiveness. It is obviously impossible for me even to *outline* fully the problem of group structure in either of these fields in the time available.

Therefore I would like to limit my discussion to the specific question of the way in which hostility is handled successfully in group psychotherapy. Almost every worker in the field has found that a properly organized and structured group can handle violent hostile outbursts of one of its members with astonishing ease; without danger to the group organization and with a naive directness that is frequently effective in helping the patient with poor controls to develop a much more adequate and successful mode of adaptation. The ability of the group to handle these direct assaults upon itself or one of its members is a direct expression of the nature of the emotional structure that has been established in the group.

I think most of us who have worked in the field for any length of time know of equally dramatic but destructive incidents that have developed when such outbursts of hostility were allowed to occur before a definite integration or group feeling has developed.

In our culture, there seems to be a universal dread of "aloneness" that is especially apparent in the neurotic. This fear of aloneness is probably the basis upon which group integration can be built. A group structure formal enough to give security yet flexible enough to understand and condone individual differences will gather strength quickly to control any forms of hostility and this same strength can be used as a potent therapeutic force, (derived entirely from the group), for the manipulation and alteration of other types of maladaptive behavior.

Therefore, I wish to present the idea that all questions as to the specific physical or emotional organization of the group must be subordinate to the central controlling question:—"Will this method of group organization or this type of group structure planned, be such as to develop and reinforce this group integration or subjective "togetherness"—If so, I believe it is possible to do group psychotherapy in a wide variety of situations; if not, regardless of what therapy may be given, with or without success, it is not Group Psychotherapy.

PREDICTION OF BEHAVIOR IN GROUP PSYCHOTHERAPY* FROM RORSCHACH PROTOCOLS

(Preliminary Report)

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It is of considerable importance to be able to evaluate how a person will behave in a specific group situation. In view of the usual time requirement of effective psychotherapy, the number of clinic patients who remain in treatment is staggeringly small. Utilization of group psychotherapy has been an integral feature of the development of the San Francisco Mental Hygiene Clinic. At any given time 50% of all the patients are in group psychotherapy and it constitutes 25% of our total therapy. Aid in selecting patients for group psychotherapy will, because of the important position that this method occupies, increase frequency and utilization of our services by facilitating the assignment of the proper patient to the proper group.

To illustrate the problem, let us follow for a year the 51 veterans (all males) who were seen at intake in January of 1948. Thirty-four were assigned to group psychotherapy (see Table I) and all of the 51 were assigned to individual therapy in addition (see Table II). Note that approximately 10% of these patients remained in group and in individual treatment for 25 or more visits. For comparison see the analysis by the New York City Committee on Mental Hygiene which states that of all patients seen at intake, only 4% returned to the clinics for more than 25 visits (see Table III).

At the present time there are eleven therapy groups in the San Francisco Regional Office Mental Hygiene Clinic. The first of these was started in February, 1947. Although one group uses psychodrama,** the ten others use only

*Reviewed in the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the authors are the result of their own studies and do not necessarily reflect the opinion or policy of the Veterans Administration.

**EDITORIAL NOTE: Group psychotherapy can be combined with psychodrama (action psychotherapy). Lecture, interview and analysis are natural phases within a psychodramatic session.

interview. The two most recent groups are composed of epileptics and alcoholics, respectively. Otherwise the groups treat most of our admissions, which consist of neurotic, psychosomatic, mild psychotic service-connected veterans, and there is a sprinkling of patients whose difficulties are classified as character disorders. Assignment to individual therapy is dictated usually by the number of therapists available. The patients are almost always offered group psychotherapy on intake—if an individual therapist is available, this is offered in addition. In this sense our clinic has never had a waiting list. New groups are formed when possibility of overcrowding occurs. Psychiatrists, Psychologists and Social Workers participate as staff members in the group (see Table IV).

Prior to actual observation in the group itself, our means of assignment have been based on the clinical judgment of an intake team. They are aided to some extent by the Group leaders. Although in many cases this type of prediction has been of a surprisingly high order of accuracy, we are interested in developing diagnostic techniques** which will give us more reliable estimates, even though we do not expect the tests by themselves to shoulder the entire burden of a decision in what is really a clinical situation.

Our contemplated study is a test of the hypotheses that Rorschach data and a knowledge of Rorschach scoring and interpretation may be of aid in predicting behavior in group psychotherapy. We will study the ability of population samples who have had different amounts of experience with the Rorschach to match blindly a patient's Rorschach results with transcribed interviews of his behavior in the therapy group. The interview data was obtained independently from the group leader and the attending social service worker (auxiliary group leader).

The data concerns the behavior of four members of one therapeutic group which have been meeting for over a year and half and had over one hundred hours of group psychotherapy together. It covers descriptive areas similar to those used in Rorschach interpretations. These transcribed interviews are to be matched with complete Rorschach protocols. Every matcher will be presented with four sets of interview data and four Rorschach protocols. In evaluation of this, perfect score would be the successful matching of each set of interview data with its appropriate Rorschach material. Three different population samples will be compared; the first will consist of twenty clinicians

**Editorial Note: Readers interested in group diagnostic Techniques, see Dr. J. L. Moreno's Group Method and Group Psychotherapy, Beacon House, 1932 (in abbreviated form p. 142-88 of this issue)—Also, Dr. W. A. White: Comments on "Psychological Organization of Groups in the Community," p. 189-95 of this issue.

with a minimum of three years Rorschach experience. The second will consist of twenty clinicians with a comparable experience but no knowledge of Rorschach scoring and interpretation. The third population sample which will be called "naive," will consist of twenty college students taking their first course in psychology.

From this study we hope to show that the Rorschach tests are of value in making initial group constellations. Probably, if positive findings result, they will be used in addition to other judgment factors, such as a careful intake history and as much social service data as we ordinarily use. The possibility of such a study being of use for further analysis of predictive cues in the Rorschach is implicit and it may also be of some value in throwing light on the factors which make a group.

Table V shows the results using the "1st" population sample (20 clinicians with a minimum of three years Rorschach experience). The most striking feature is the almost complete agreement in the case of White (18 out of 20 cases). This indicates high enough correlation to rule out chance. Eight experts correctly matched two cases and seven correctly matched all four. Increase in the number of experts used or possibly an increase in the group members tested are ways of increasing the reliability of our findings. We have a strong evidence, however, that in certain cases prediction of behavior in group psychotherapy is a real possibility.

CASE ILLUSTRATION: SERGEANT WHITE

a) Diagnostic Evaluation.

This is a 28 year old ex-army sergeant of average intelligence with a 10% disability for hernia. On December 20, 1946 he was accepted for treatment at the San Francisco Mental Hygiene Clinic on prima facie evidence. He showed considerable reluctance in establishing a claim and finally stated that he preferred not to submit his application and the accompanying evidence of his disability.

He was referred to us by his Vocational Rehabilitation Officer and at that time felt that he "needed to straighten himself out if he were to proceed with his schooling and later occupation."

His main complaints were lack of self-confidence, moodiness, irritability and bouts of depression while drinking. He was seen for 101 Individual Ther-

apeutic Interviews and 164 Group Psychotherapy Interviews; 35 of these were in one group and the rest in a more analytic group. He attended both group and individual therapy regularly, but his case was closed because he failed to clarify eligibility status.

At the close of therapy, patient states that he had reached a place where he could work things out for himself. He had been promoted to a responsible job which necessitated directing the work of others. He felt that the "give and take" relationship with his boss had done him a lot of good.

DIAGNOSTIC EVALUATION:

1. Obsessive, compulsive reaction, manifested by compulsiveness and rigidity.
2. *External Precipitating Stress*: Moderate—Legal separation from wife and child.
3. *Predisposition*: Moderate—Early emotional deprivation. Mother died when patient was two years old. Then grandmother died and patient was placed in an orphanage.
4. *Incapacity*: Moderate.

The development of group psychotherapy has been closely associated with attempts at evaluation. Many studies have been reported in which, although psychological tests were not used, the outcome was measured in terms of patient and physician estimates. Klopfer published his works in 1945 on the use of the Rorschach before and after group psychotherapy with soldiers and Rashkis and Shaskan in 1946 published their studies on the effects of group psychotherapy on the Personality Inventory Scores of psychiatric battle casualties.

The National Research Council has a group psychotherapy project. They are attempting, through the use of projective techniques, besides other studies, to learn more about the composition of groups. They stress the importance of increasing our knowledge of how the patient perceives others, and how the patient wishes to be perceived by others and how he thinks he actually is perceived by them.

We have not touched on, although we are aware of, the importance of relating our study to the basic features of personality theory, to the theory of group formation and interaction. Neither have we touched on the importance of methodology in group psychotherapy. We have said little about the group in which these patients were treated. These aspects will have to be considered in further studies.

We want to emphasize and develop thinking about questions or prediction. Like all clinics we seek methods which will enable us to predict patient-group-therapist reactions.

What we need is a knowledge of what patterns of impulse control are helpful and what patterns are a hindrance in the field of group psychotherapy. Our preliminary studies give promise of some prediction in certain cases. It is our hope that with the increase of actual experience of interpreters in the field of group psychotherapy, coupled with the development of projective techniques, that skill and clinical insight will progress enough to take an active position in the planning of Group Psychotherapy Constellations.

b) RESEARCH INTERVIEW

Mr. Grant: Now, if you would just talk right along and say what comes to your mind about White, how he acts in the group.

Dr. Shaskan: His behavior in the group has been consistently withdrawn. He's been saying that he likes it the most when the group doesn't talk. He uses that as a method of expressing hostility, not talking. A few weeks ago, after over a year and a half of group and individual psychotherapy, he brought up a dream of picking up money out of the asphalt, which was the key expression to the understanding of the group of that session and probably has a lot to do with his own problems. He is a very compulsive person with a great deal of hostility. He's divorced and still fighting with his wife who hasn't remarried. He visits his wife and child on a compulsive basis every two weeks, although he seems to be genuinely fond of the child, a daughter. He was brought up in an orphanage. He brings up very little relationship of historical material, which the group expresses, to his own past history.

Mr. Grant: About how much time would you say he takes up in the group?

Dr. Shaskan: I'd say he takes up very little except when he has something in particular to talk about, his dreams, or difficulties with his wife—Or when he talks about the girl who works in his place of business.

Mr. Grant: Out of all who come rather consistently to the group, would you say he talks about the least?

Dr. Shaskan: I think he talks almost the least of anybody in the group; although he is one of the most constant in attendance. The group meets twice a week and he is almost always there.

Mr. Grant: What would you say about how at ease he is in the group?

Dr. Shaskan: I would say he is probably more at ease in the group than he is in almost any situation, but he's still a very tense person. He dresses meticulously and holds himself in almost a military manner.

Mr. Grant: Then he does make contributions—he talks some about his feelings and personal life. Would you say in general those things were constructive or destructive?

Dr. Shaskan: I'd say that when he talks it's usually on a very constructive basis. You can see that he's trying. But when he's silent, I'm almost sure he is expressing destructive feelings.

Mr. Grant: How would you say he was accepted in the group?

Dr. Shaskan: He is accepted completely as a group member. He is part of the situation almost like a chair would be. He doesn't threaten anybody's position, nor does he seem to be too brilliant in the group, but

he is just an integral part of the group. As a matter of fact, he didn't start with this Group II. He originally started with Group IV. He does much better in this well-integrated group.

Mr. Grant: What about his emotional control? You mentioned this compulsive stuff, could you say anything more?

Dr. Shaskan: Yes, I'm very much aware of his terrific emotional control.

Mr. Grant: Then it's a struggle for him to keep it?

Dr. Shaskan: A struggle? Oh, I don't know, it's such a fixed pattern it would be difficult for him to give it up.

Mr. Grant: You'd be very surprised if he exploded, is that right—a flare of anger or something?

Dr. Shaskan: Well, I wouldn't know, I wouldn't be surprised if he exploded, I think he almost does explode at times, but I'd be surprised if he walked out.

Mr. Grant: Would you call him one of those with the most emotional control?

Dr. Shaskan: I'd say he is the most rigid person in the group.

Mr. Grant: You say that his aggression came out in terms of his smile and kind of enjoying the silences. Any other signs of aggression?

Dr. Shaskan: Not at all, except that you know that behind his tenseness must be a lot of aggression. He will also criticize the staff at times, but what he says seems to almost be a statement without the feeling that goes with it.

Mr. Grant: How would you characterize his relation to you as the group leader?

Dr. Shaskan: I'd say he has a negative transferance.

Mr. Grant: With this guarded aggression, though? It's negative, aggressive but he keeps it under cover, is that it?

Dr. Shaskan: It's awfully hard to say. His coming to the group gives us an indication of a very dependent relationship, which he works out in a very compulsive manner by coming regularly. He does stay away, though, occasionally.

Mr. Grant: In terms of some kind of an egocentric versus outward type of orientation, perceptions or something like that, would you say it's mostly self-oriented, or object-oriented, or towards people?

Dr. Shaskan: It's awfully hard to answer that question, because he doesn't give you too much of an idea. He has a lot of anal symptoms too, by the way—scratching his anus—almost anal masturbation.

Mr. Grant: He talks in these terms in the group?

Dr. Shaskan: He doesn't hesitate to describe his itching anus.

Mr. Grant: Is this with any degree of insight—do you think—at all?

Dr. Shaskan: No. He almost seems to be able to isolate any of his discussions from the rest of his personality.

Mr. Grant: Can you think of anything else? This covers some of the things I wanted to get at. Can you think of anything that just came to mind while we were talking?

Dr. Shaskan: I don't think so. I think this anal material—I would say he was almost an anal character and from that point of view it is hard to describe where his cathexis is—I don't know.

Mr. Grant: As you say his behavior in the group seems to follow this anal characterization.

Dr. Shaskan: I'd say his prognosis was for a long term treatment, but he does seem to be getting something out of it.

* * *

Mr. Grant: Now shall we take White?

Miss Blum: Yes. I don't think I have so much to say about White as I have about Green because I know Green better, but during the first part of the group sessions, White would be very quiet and he would rarely talk. He would sit there in an object, submissive manner like a little boy. Sometimes he would throw in a word or two, but would mostly pick up what another member of the

group would say rather than bring up something about himself. The other member might talk about his father and he would maybe be able to say something about it. He would attend very regularly and apparently get something out of it, but he wouldn't contribute very much. You got a feeling of some stubborn resistance.

Mr. Grant: Oh, then it's more than *just passive—his not talking* has some meaning.

Miss Blum: Usually when I have the group he talks more. He is apparently afraid of Dr. Shaskan. Lately he has been able to bring out more problems of his own but it is very limited. There are often hours in which he doesn't talk more than once.

Mr. Grant: In relation to the rest of the group how much time would you say he takes up with his talking?

Miss Blum: Least of any.

Mr. Grant: How at ease would you say he is with the group?

Miss Blum: I think he's at ease.

Mr. Grant: You think so, in spite of the small amount of talking?

Miss Blum: It's hard to say. I think he kind of listens. You don't see any emotional upset. It's under control.

Mr. Grant: When he does speak, would you say his contributions tend to be constructive, destructive or neither?

Miss Blum: Neither. Kind of bland or something of his own life, but I don't think he ever brought up something very stimulating or something that did bring up a great deal of group discussion or strong rebellion. But he is accepted and I think the group tried to help him. Even Mr. Green has a friendly feeling towards him. They sit and wait, then say: "Well, why don't you say something?"

Mr. Grant: You speak of his not talking seeming to have some meaning, yet you talk about the group liking him, etc. Do you think he's trying to react against the group?

Miss Blum: No, I don't think he's reacting against the group. I think he always participated in the after-group coffee sessions.

Mr. Grant: Maybe there's something about the formality of the thing?

Miss Blum: Perhaps it indicates that he does get something out of group or participates silently. Afterwards he is apparently able to discuss with the others some of the problems.

Mr. Grant: So you're saying that generally he's accepted. You spoke of some of the feelings between a couple of people. Is there anyone there who has aggressive feelings towards him?

Miss Blum: I don't think so. So far I have only noticed protective ones.

Mr. Grant: Then we can say that his control, his silent emotional control is quite good. Is there anything more to say about that, do you think?

Miss Blum: I haven't noticed anything.

Mr. Grant: Then his main control seems to be verbal withdrawal. They don't get the feeling that he is holding out on them or something? They don't sense any hostility?

Miss Blum: Not that they have brought out. I think the hostility is not directed towards the group, but is towards himself. I don't think this is just his behavior for the group sessions; I think that it is his behavior generally. Among men he probably feels kind of inferior.

Mr. Grant: *You say he talks more* when you're the leader. Does this kind of fit in there?

Miss Blum: I think it might.

Mr. Grant: Has he expressed any aggression?

Miss Blum: No, except towards his ex-wife, how uncomfortable he felt when he visited the child and found his wife with her new boy friend. Apparently she is getting married again. He talks less about it now; apparently he has a girl friend. Before that he didn't. So, apparently his life is somewhat richer.

Mr. Grant: When he does express

his aggression towards his ex-wife, it is rather controlled—he doesn't break out with feelings about it?

Miss Blum: No, I don't think so. I should say that I have the very peculiar experience with him that each time I lead the group I forget his name.

Mr. Grant: Could you say anything about his relation to the group leader?

Miss Blum: I think it's one of submissiveness, considerable submissiveness.

Mr. Grant: And he doesn't seem to have, as far as we know, any hostility running along with this submissiveness.

Miss Blum: Very possible, but he can't verbalize it towards the leader. When the group condemned Dr. Shaskan's suit, they all had something to say, but he was unable to say anything.

Mr. Grant: It not only doesn't show up in verbalizations but it doesn't show up in his attitude?

Miss Blum: No.

Mr. Grant: How about his reaction to you?

Miss Blum: He talks more. Each time I have the group alone he participates more. Maybe he is more at ease.

Mr. Grant: He doesn't seem particularly dependent on you, does he? When he talks he doesn't turn to you for the answers?

Miss Blum: I don't think so, but I think he would allow himself more dependency on a woman that on a man. I don't know whether this is really in line with his family situation.

Mr. Grant: How would you characterize him concerning this egocentric, object-centered concept?

Miss Blum: His questions and answers are pretty much more concerned with what the group says.

Mr. Grant: He has more of a tendency than Green to relate?

Miss Blum: Yes, I would say so, despite the different picture.

Mr. Grant: Would you say he tends to relate more to objects or more to people?

Miss Blum: You mean the things he talks about? More to people: his child, his wife, his boss.

Mr. Grant: And in the group, you would say he is reaching for the people there?

Miss Blum: He is reaching, I would say so. I would say he's more aware of the group than Green.

Mr. Grant: Is there anything else we could bring out?

Miss Blum: I don't think I have anything to add in regard to White.

Mr. Grant: He sits rather calmly?

Miss Blum: Rather calmly, I'd say. Another thing is that he moves around a lot.

Mr. Grant: Shows up on time?

Miss Blum: Shows up on time.

Mr. Grant: He dresses neatly?

Miss Blum: Dresses precisely.

Mr. Grant: As opposed to Green?

Miss Blum: Yes.

Mr. Grant: Does Green dress rather sloppily, unneatly, or what?

Miss Blum: Sloppily. Sometimes his jacket and trousers do not match. I think White has improved. He was not as decently dressed as he is now, and his hair is cut more often.

C) RORSCHACH GIVEN 4/2/47 BY T. LEARY

PERFORMANCE PROPER

1. 18" I'd say the face of two dogs.
2. 24" Two bears.
   26"
3. 15" Looks like two men beating on a drum.
   27"
4. 12" Looks more like a bat I'd say.
   30"
5. 10" Looks like a moth.
   19"
6. 25" Looks like skin of an

animal.
40"
7. 55" I can't think of a thing.
8. 23" These look like two animals on the side.
And a crown in the middle.
9. Looks like a blast or something; the smoke and fire.
35"
10. 23" Reminds me of a group of animals; these are crabs, yellow are canaries.

INQUIRY

Ears, nose, looks like a collie.
Just the heads; noses sticking together; (?) shape of nose and ears here . . thick neck.
The face and funny eyes, and sort of wings on side.
(?) no.
Just sitting there; (?) no.
(?) Just reminds me of a skin; tacked on wall; here are legs; head cut off; (?) fur side; looks like fur . . .
the dark and light.
This doesn't suggest anything.
2 spots remind me of an animal; (alive?) I'd say so; creeping.
Just the shape of it.
All of it; (smoke and fire?)
Red then goes into smoke and flame at top; (smoke?)
Color and formation of it; (flame?) shape of it and color: (?) both color and shape.
4 yellow are canaries; color and formation; (?) If black I'd
crabs; just from the shape of them.

D F Ad
D F A P
W M H P
Dr F A
W F A P
W Fc AOBJ P
D FM A P
D F Emb.
W CF Cm Explos
D FC- A
D F A P

LIMITS:

M, like III? VII suggests something human in a way; like two women facing each other, but . . .

(Color, like X?) Trouble is I've made up my mind what I've seen and can't change; III might be a necktie.

Smoke? When I first looked at VII it reminded me of clouds, but two of them together throws it off.

Parts of body? No, none suggest parts of body.

Blood? II. Notice first time? Yes, I did.

Sex organs? Yes, VI. I saw it the first time, but didn't say it.

D) PSYCHOLOGICAL REPORT

December 31, 1946

Wechsler-Bellevue Verbal I.Q. 110; Performance I.Q. 96; Full Scale I.Q. 102.

Minnesota Multiphasic Personality Inventory: January 7, 1947.

Scale	?	L	F	Hs	D	Hy	Pd	MF	PA	PT	Sc	MA
T Scale	66	50	62	80	82	65	75	57	56	78	74	54

Hostile feelings toward authority (Pd).

Compulsive behavior (PT).

Appearance of being rigid. Afraid to express himself.

Hildreth Attitude Feeling Scale.

Scale	F	F2	E	O	W	M	P	P2	
Score	5.3	5.1	4.4	5.3	8.1	3.3	2.8	4.1	

TABLE I

Group Sessions Attended	Number of Patients	% of Patients
0	7	21
1	9	26
2	3	9
3	3	9
4	5	14
5	1	3
6	2	6
15	1	3
25	1	3
34	1	3
37	1	3

Table I: Number of Group Sessions Attended by each of the 34 patients.

TABLE II

Number of Individual Interviews	Number of Patients	% of Patients
0	8	16
1	6	12
2	6	12
3	2	4
4	2	4
6	2	4

7	4	7
8	3	5
10	1	2
12	2	4
14	1	2
15	1	2
16	3	5
17	2	4
19	1	2
22	2	4
29	1	2
37	1	2
38	1	2
40	1	2
52	1	2

Table II: Number of Individual Interviews for Each of 51 Patients.

No. of Treatments	*San Francisco* % *Individual*	*San Francisco* % *Group*	*New York* % *(App.)*	*Individ.*
0-1	28	47	37	
0-3	43	65	67	
0-6	51	88	80	
25+	10	9	4	

Table III. Percentage of patients attending treatment a specified number of times in San Francisco and in New York.

TABLE IV

SAN FRANCISCO REGIONAL OFFICE, MENTAL HYGIENE CLINIC

Monthly Report *March,* 1949

New Cases	43
Reopened	9
Closed	34
Therapeutic interview by Neuropsychiatrists	404
Therapeutic interview by Psychiatric Social Workers	292
Group Psychotherapy Interviews	263

TABLE V

RESULTS TO DATE OF RORSCHACH AND GROUP PSYCHOTHERAPY BEHAVIOR MATCHING

	Brown	*Green*	*Grey*	*White*	*Correct Matchings of Experts*
Expert #1	ok	ok	ok	ok	4
" #2	Green	Brown	ok	ok	2
" #3	ok	ok	ok	ok	4
" #4	Green	Brown	ok	ok	2
" #5	ok	ok	ok	ok	4
" #6	Green	Brown	ok	ok	2
" #7	White	ok	ok	Brown	2
" #8	Green	Grey	Brown	ok	1
" #9	ok	ok	ok	ok	4
" #10	ok	ok	ok	ok	4
" #11	Grey	ok	Brown	ok	2
" #12	ok	ok	ok	ok	4
" #13	Green	Grey	Brown	ok	1
" #14	Grey	ok	Brown	ok	2
" #15	Grey	ok	White	Brown	1
" #16	Green	Grey	Brown	ok	1
" #17	ok	ok	ok	ok	4
" #18	Green	Grey	Brown	ok	1
" #19	Green	Brown	ok	ok	2
" #20	Green	Brown	ok	ok	2
Number Correct Matchings made on Individual Patients:	7	11	13	18	

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CURRENT STATUS OF GROUP PSYCHOTHERAPY PRACTICES IN THE STATE HOSPITALS FOR MENTAL DISEASE*

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I Introduction

Much of the work in the development of group psychotherapy has been done in hospitals for mental disease, of which group the State Hospitals handle the great bulk of the patient population. In addition, the State Hospitals, with their fairly chronic conditions of being overcrowded and understaffed, have the impetus of dire necessity present to spur them on to the development and refinement of all possible psychotherapeutic techniques adaptable to their needs. On the basis of the important part group psychotherapy might thus be expected to play in the therapeutic armamentarium of the State Hospitals, it was felt that a survey of the current status of group psychotherapy practices in this group of hospitals would be valuable.

Accordingly, during March and April, 1950, a questionnaire-survey of the 200 state hospitals for mental disease (from the official 1949 U.S. Public Health Service list) was made. The questionnaire used was kept as brief as possible to insure a maximum number of replies (see Appendix A for exact questionnaire). The essential features which the questionnaire was designed to cover were the following ones: It was to be determined, first of all, whether or not group psychotherapy was in use in the particular hospital, with all following questions being referable only to those hospitals actually employing the method. The length of time that group psychotherapy had been in use; the extent of the program; the nature of the group psychotherapy used in terms of professional direction, depth, and type; the therapeutic effects of group psychotherapy in the various psychiatric illnesses; and criticisms and comments about group psychotherapy were the other categories in which information was to be obtained.

The data which follows is based on replies received from 185 hospitals (92.5% of the country's state mental hospitals).

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*Presented at 1950 Annual Meeting of American Psychiatric Association, Detroit, Michigan.

II *Use of Group Psychotherapy*

Of these 185 hospitals which replied to the questionnaire, 94 use group psychotherapy and 91 do not. Thus, slightly over half of the country's state mental hospitals are now using this treatment method. Of the 91 hospitals not now using it, 11 have used it in the past but are not currently using it, none of them having dropped it because of discouragement over its usefulness. 7 of these 11 indicated that they plan to resume its use again as soon as possible. 13 other hospitals that have never used group psychotherapy, of the 91 not presently using it, indicated plans for beginning in the near future.

III *Length of Time in Use*

The figures in this and the following sections refer, of course, to the hospitals using group psychotherapy, without further regard to those hospitals not using it.

The breakdown for time in use shows 7.9% of the hospitals using it for over 5 years, 22.3% for from 2 to 5 years, 25.0% for from 1 to 2 years, 21.1% for from ½ to 1 year, and 23.7% for under 6 months. 92.1% of the hospitals started their group psychotherapy programs within the last 5 years, and about 70% have started within the past 2 years, making this a relatively recent addition to the treatment programs.

IV *Nature of Group Psychotherapy Used*

It is important to evaluate as effectively as possible, the nature of the group psychotherapeutic processes used. The definition of what constitutes group psychotherapy is as yet unsettled, and often, varying opinions are based on various concepts of the definition of therapy itself. Hence the definition of group psychotherapy may vary from a broad, inclusive idea that it is anything which, administered in groups, helps the psychiatric patient; to a most specific definition considering it only that in which definitive, psychiatrically handled, dynamic psychotherapeutic efforts are made. To establish a definition of group psychotherapy is beyond the scope of this paper so that information was obtained from the hospitals by way of actual operations of their programs, rather than presenting them with various definitions into which they would have to fit. This information will be evaluated in terms of the professional direction of the program, the place of the group psychotherapy in the overall program of the hospital, and the depth of therapy achieved.

The matter of which professional group handles the therapy is important in determining the status of the group psychotherapy in a given hospital. Psy-

chiatrists alone handled the therapy in 35.5% of the hospitals; psychiatrists and psychologists together in 21.1%; psychiatrists and psychiatric social workers in 10.6% and all 3 professional groups together in 7.8%. This makes a total of 75.0% of the hospitals which have the group psychotherapy handled by or in conjunction with their psychiatric staffs. In the remaining 25% of the hospitals, responsibility for the program was taken as follows: in 15.6% it was handled by the psychologists alone; in 3.9% by psychiatric social workers alone; and in 1.3% by psychologists and social workers. There remains a small miscellaneous group of therapists consisting of nurses, clergymen, attendants and occupational, recreational and music therapists. From this data, it may be concluded that the professional emphasis in the large majority of the hospitals is at the psychiatric level.

In evaluating the place of group psychotherapy in the general treatment program, 68.4% of the hospitals consider it exclusively a part of the psychotherapeutic program. 13.1% think of it in terms of its being included in their psychotherapeutic and activity and occupational therapy programs; 5.3% think of it as part of their psychotherapeutic, activity and occupational therapy, and orientation programs; and 2.6% as part of psychotherapeutic and orientation programs. From this data it may be concluded that the hospitals consider group psychotherapy in their psychotherapy programs, and almost 70% consider it exclusively a part of the psychotherapy program. The remaining 10% of hospitals apparently do not consider their programs to be formal psychotherapy, placing it in the occupational therapy and activity, and orientation programs. Thus, a total of 89.4% or approximately 90% of the hospitals place group psychotherapy a definite psychotherapeutic procedure for the most part.

The type of group psychotherapy used was based on the Division of lecture-discussion methods, repressive-inspirational techniques and the use of psychodynamic ideas. 52.6% of the hospitals use lecture-discussion methods alone; 13.1% use lecture-discussion and repressive-inspirational methods combined; 6.6% use lecture-discussion and psychodynamic techniques combined; 6.6% use psychodynamic techniques alone; and 3.9% use all three methods combined. There remains 17.1% of hospitals using none of these methods. Three of the hospitals in this last group mentioned use Psychodrama; the others not mentioning what specifically was used. Thus, it may be seen that the lecture-discussion methods are the ones predominantly in use, indicating the attainment of only superficial levels of therapy.

V *Magnitude of Group Psychotherapy Programs*

The magnitude of the programs in the various hospitals will be evaluated in terms of the number of therapy sessions, the number of patients in treatment and the trend of modifications of the programs after their initial inception.

The number of therapy sessions varied from 6 to 369 per month. 14.4% of the hospitals held less than 6 sessions per month; 34.6% from 6 to 12 sessions per month; 17.4% from 13 to 24 per month; another 17.4% from 25 to 49 per month; 10.2% from 50 to 99; 1.4% from 100 to 199, and 4.4% from 200 to 400 sessions per month. It may be seen that 69.4% of the hospitals held between 6 and 50 psychotherapy sessions monthly.

The number of patients treated varied from 6 to 700 people per month. 14.2% of hospitals helped 6 to 12 patients per month; 18.4% from 13 to 24 patients per month; 25.5% from 25 to 49 patients; 12.8% from 50 to 99 patients; 12.8% from 100 to 199 patients; 15.6% from 200 to 500 patients; and 1.4% over 500 patients per month treated with group psychotherapy. The category with the greatest number was 25 to 49 patients per month, but all of the categories except the last (over 500) were fairly evenly represented.

An indication of the modifications of the group psychotherapy programs after their original inception was sought. It was felt this would be of help in determining the practical findings which arose as a result of the actual experiences of the various therapists. 80.0% of the hospitals expanded their programs, 10.5% decreased their programs, and 9.5% indicated no charge. With those who increased the scope of their group psychotherapy program, the increases were generally by the addition of more therapy groups. The number of sessions held and the amount of diagnostic categories treated were increased in a few instances. Where there were decreases in the program, these were on the basis of limitation of the type of patient treated in 3 cases, and on the basis of time and personnel shortages forcing program curtailment in all the others. It is apparent then, that the trend whenever possible, was to increase the extent of group psychotherapy programs as experience with their uses was acquired.

Changes in content after initial inception of group psychotherapy programs were essentially by way of increasing the amount of patient discussion. There was some increase in the amount of stimulating material presented and a little in the amount of lecture material presented. Other things added by an

occasional hospital were more emphasis on patient direction of the group and encouragement of spontaneous presentation by the patients of original ideas. The chief factor increased then, on the basis of experience with groups, was the amount of patient participation.

VI *Therapeutic Response to Group Psychotherapy*

No specific criteria of response were suggested to the hospitals, and a great variety of criteria was used in the replies. They fall into essentially two groups; response related to diagnostic category, and response in terms of pre-treatment degree of illness. Each hospital reported both those patients for whom this therapy was most effective and those for whom it was least effective.

For those patients responding most successfully to the treatment, the diagnostic categories, in order of frequency reported, were mainly neurotics (52.9%) and alcoholics (27.4%). Also mentioned were schizophrenics (especially catatonics), and affective disorders. The pre-treatment degrees of illness which responded well were in recent illnesses, mild patients, acute psychotics, post-shock patients, those in good contact, and also young patients.

With those patients for whom group psychotherapy was least effective, the diagnostic categories in order of frequency reported were schizophrenics (especially paranoid patients) (41.3%) and psychopaths (19.5%). Also mentioned were organic, senile and arteriosclerotic psychoses. In terms of illness, poor response to group psychotherapy was found in withdrawn, repressed, out-of-contact and repressed patients, and those in severe stages of illness.

VII *Comments on Group Psychotherapy*

Many of the questionnaires included comments about group psychotherapy. These comments were almost universally favorable and some were enthusiastic.

Some of the unqualifiedly favorable comments were:

> "Some schizophrenics and other psychotics can be reached by group psychotherapy who cannot be reached individually. Group psychotherapy is the best means of psychotherapy in the State Hospital."
>
> "It affords excellent opportunities to eradicate patients fears concerning the illness, to eliminate superstition and misconceptions, to ventilate freely fears and anxieties, to discuss availability of vocational and avocational rehabilita-

"As we have been pleased with our results from group therapy so far and as it has proved successful in the past, we undoubtedly will expand this activity in both size and scope in the future."

"Of great value depending on the skill and enthusiasm of the therapist."

"In the short time we have used it in our treatment program, we have been favorably impressed and consider it of great value in hastening improvement and recovery, with earlier release from hospital and in maintaining and improving mental stability after release."

"The one thing that we have learned (in using group psychotherapy) has been that many patients do improve and actually make a comeback to apparent normalcy, even after long periods of psychotic reaction."

"Families sold on it, good teaching medium, patients enjoy it, good for nursing personnel morale to have "Treatment" on even chronic wards."

"It is both analysis and synthesis; it serves both insight and adjustment of needs and abilities to each other; it permits empathy and socialization. It is better than individual therapy, not a substitute at all."

"A necessary part of a psychotherapeutic program since it helps individuals to learn and to relearn ways of adjusting to their own difficulties and to possible life situations in the framework of a group which reflects attitudes and opinions similar to an actual life situation."

Other comments, while generally favorable, were more moderate in attitude as illustrated by the following:

"It (group psychotherapy) is on the threshold of becoming the most useful tool in intervention in the hospital situation. It deserves top priority in research programs. It is no panacea however and requires arduous and devoted study by all members of the hospitals' staffs and special training for ancillary personnel."

"It is helpful to the patient in gaining insight and understanding and hastens and strengthens rapport. I doubt that it is alone curative."

"It has a definite place in State Hospital psychiatry as an adjunct to other forms of therapy."

"Its importance seems to lie more in developing interpersonal relationships rather than any deep insights."

"In my experience, psychotic patients respond much more poorly to (group psychotherapy) than they do to individual therapy. However, after they have shown sufficient improvement on individual therapy, they often receive considerable benefit from group therapy."

"For many patients it is more stimulating than individual psychotherapy, for other patients individual psychotherapy must be used in addition, for a third category, individual therapy seems best."

"Good, but inferior to individual psychotherapy in most instances."

In addition, it may be seen that the usefulness of group psychotherapy in developing patient-societal relationships is recognized, the use of group psychotherapy in conjunction with other treatment techniques is recommended, and the need for careful training in its techniques is suggested.

VIII *Summary and Conclusions*

A survey of the status of group psychotherapy in the state mental hospitals has been made, based on replies from 92.5% of these hospitals.

1. It was found that slightly over 50% of the hospitals are now using group psychotherapy and another 11.7% are planning on instituting it soon. This is actually rather low for there is no good reason why all of the institutions could not undertake group psychotherapy programs. The predominant reason for not having active group psychotherapy programs is personnel shortages. This does not seem entirely valid since adaptation of duties of current staffs could permit at least beginnings of such therapy.

2. Group psychotherapy is a relatively recent addition to the general treatment program, with 92.1% of the hospitals having started group psychotherapy programs only within the past 5 years, and 70% within the past 2

years. This is fairly hopeful in terms of trends for the future. In showing a recent turn towards development of group psychotherapy in the institutions, the likelihood of the desired more widespread use of group psychotherapy in the next few years seems real.

3. The group psychotherapy used, although largely under professional psychiatric management, is not as wholly given by psychiatrists as one might wish. There is a real need, too, for definite establishment of standards of group psychotherapy, as seen in the very divergent practices considered to be group psychotherapy. It is a real disservice to the concept of a useful system of dynamic group psychotherapy to include under the term, any processes at all which better the patient. The specific psychiatric techniques and concepts of modern individual psychotherapy plus those developed during group psychotherapy should be a necessary part of a real group psychotherapy program. On this basis, of course, the number of institutions giving group psychotherapy would be even lower than previously reported.

It is hopeful that the thinking of the institutions is in terms of this as a psychotherapeutic procedure. It is to be hoped though, that more advantage will be taken of the peculiarly psychiatric tools available.

The level of therapy is essentially a superficial one, being mainly based on lecture-discussion methods. This would be corrected by the use of a more dynamic approach.

4. Between 6 and 50 therapy sessions are generally held monthly in the majority of institutions and from 25 to 49 patients, on the average, are treated per month; although some institutions treat from 200 to 500 patients per month. After the initial beginnings of the group psychotherapy programs, changes were mainly in the direction of increasing their scope. Those few institutions in which the programs were curtailed did so mainly because of staff shortages. The main change in content of sessions was an increase in the amount of patient discussion. These findings indicate a pitiably small proportion of the hospital populations being treated. It is known, of course, that intensive dynamic group psychotherapy would not be too useful for many of the long term chronic patients. It is likely though, that more patients are available for intensive therapy than are now being treated, and that many of the chronic patients could benefit from the lecture-discussion approach who may not even be reached when the criteria for intensive individual therapy are used in selecting patients.

5. Therapeutic response to the group psychotherapy sessions was most satisfactory with the milder psychiatric conditions, and in the better patients. Least satisfactory response was with the more severe psychiatric conditions and the poorer patients. The general findings here are the theoretically-to-be-expected ones, on the basis of experience with individual therapy. They suggest that not enough efforts are being made to use group psychotherapy on patients presumably unsuitable on the basis of criteria for *individual therapy.* It has been the experience of the author, as well as of one or two of those who responded to this questionnaire, that group psychotherapy reaches apparently inaccesible patients, and there has been little indication that the institutions are attempting to tap such possibilities.

6. Comments about the group psychotherapy programs were fairly universally good ones.

We see then, that group psychotherapy is gradually being undertaken by our state mental hospitals but that considerable further work is indicated in all aspects of the group psychotherapy programs.

Appendix A

The questionnaire which was sent to the various hospitals follows:

MENTAL HEALTH CENTER

City Hall Annex, Paterson 1, N.J.

1. Are you using group psychotherapy in your institution at the present time?
   Yes_____ Have used, but have dropped_____
   No_____ Not using, but planning to start_____

2. (If yes to 1.)
   How long has group psychotherapy been in use?
   Under 6 mo._____ 7 mo. to 1 year_____ 13 mo. to 2 yrs._____
   25 mo. to 5 yrs._____ over 5 yrs._____

3. What is the place of group psychotherapy in your total program?

   1. Part of occupational therapy and activity program. ( )
   2. Part of general psychotherapy program. ( )
   3. Part of orientation program. ( ) (new admission, parolees, etc.)
   4. Other

4. What kind of changes have there been in your group psychotherapy program since its inception?
   1. Expanded program.
      a. In number of groups. ( )
      b. Under range of patients treated. ( )
      c. Number of sessions for each group increased. ( )
      d. Other expansions.
   2. Curtailed program (Types of curtailment)
      a.
      b.
      c.
   3. Changed content of sessions.
      a. More discussion. ( )
      b. More lecture-material. ( )
      c. More "stimulating activities (music, movies, etc.) ( )
   4. Other changes.

5. Who conducts the group psychotherapy sessions? (Check more than one if necessary and indicate how many of each.)
   a. Psychiatrists ( )
   b. Psychologists ( )
   c. Psychiatric Social Workers ( )
   d. Others (please specify)

6. Indicate how many group sessions take place each month.
   No. of patients ( ) Approximately.
   No. of sessions ( ) Approximately.

7. For what groups of patients have you found group psychotherapy most successful?

8. For what groups of patients have you found it to have limited or little value?

9. What is your impression of group psychotherapy as a therapeutic procedure?

10. What type of group psychotherapy do you use?
    a. Lecture-discussion ( ) c. Psychodynamic ( )
    b. Repressive-inspirational ( ) d. Other ( )

11. Other comments:

THOUGHTS ON RECENT ADVANCES IN GROUP PSYCHOTHERAPY

(1945-50)

by JOSEPH MEIERS, M.D.
New York, N.Y.

It is contended that:

1. Group Psychotherapy[1], both in the wider and in the strictest sense, has continued, in the past five years, its accelerated *expansion,* in terms of places where applied, of numbers of persons treated and of group therapists, and also—partly—in the development of its theory or, rather, theories, in the increase and diversification of its techniques; and that as well in the U.S.A. as—to a somewhat minor extent—in Europe and South America.

2. This almost stormy increase should be explained *only partly* by the increased demand that has developed for "Psychotherapy" in general (meaning, mainly, "individual" therapy), a *demand* which the "manpower" of psychotherapists fails to fill by far. This demand seems to be still expanding, mainly due to three causes:

(a) aftermath of war, with its sequelae of real and apparently war-caused neuroses, etc., and the interest created with physicians (psychiatrists and others) and with the population in general through their war-time experiences with psychotherapy and group psychotherapy.

(b) as a reaction to rash and creeping cultural-social *changes* (in habits; beliefs; feelings—e.g. of rising economic or even "life" insecurity) occurring in millions of people—in varying degrees in various regions. A special demand for Group Psychotherapy may be due, too, to the novelty of this method, causing not only caution but also curiosity and hope among professionals as well as in the "therapy-hungry" lay masses. The obvious or apparent lesser costs and the—relatively—greater accessibility of this new-

1. Meiers, Joseph: Origins and Development of Group Psychotherapy A Historical Survey (1930-1945).—With Foreword by J. L. Moreno. 1946, Beacon House, Inc., Beacon and New York, N.Y. (Psychodrama Monograph, No. 17) 44 pp., 3 illustrations: Bibligraphy pp. 24-44.

er remedy (as compared with individual Psychotherapy) might play some part in the increase of demand.

3. It is, however, not only these more "external" causes (economic, etc.)—as they may be called—which have made for swift and increasing expansion of Group Psychotherapy. There is an *intrinsic* cause (which has not become so apparent to some observers)—namely the very qualities inherent in the Group Concept, or Principle, as such, qualities which make Group Psychotherapy superior, in *some* respects, to the mere "1 + 1" (psychotherapist, plus patient) situation; thus accounting for the increase of the application of Group Psychotherapy. The magnitude of *this* factor as contributing to the increase is, of course, not easy to evaluate.

4. Finally, together with the encouraging expansion in size, etc., there have increased—as was expected and mentioned, by this writer in his "Origins and Development of Group Psychotherapy," 1945/46, also some difficulties, "ailments of growth" within Group Psychotherapy[1]. These, however, *could* be overcome through a concerted effort of the leading group psychotherapists and their co-workers, nationally and, then, internationally, by: clarification in concepts (and terminology); by planned exchanges of experience; by team research; by the formation of *broader* discussion and demonstration meetings and societies, permitting more, and more careful, checking of therapeutic results, etc. All of this would be necessary to enhance the good scientific "standing" of the—still—very young method of Group Psychotherapy; thus bolstering its *much needed* usefulness for the *masses* of individual sufferers; for well-planned prophylaxis of emergencies (panics), and—beyond these, relatively smaller sectors of populations—as contribution of Group Psychotherapy to "sanity" and improvement of *societal life* (elimination of group hatreds, fears, etc.) *everywhere.*

Now, as to the four above named contentions:

Ad 1. It seems to this writer, on the basis of the published materials available to him on the number of places (institutions, clinics) where Group Psychotherapy is regularly done—and even more so as to the number of patients

and therapists involved, a statistical *estimate*[2] (namely a "large minority" approaching the half of larger institutions) may be *attempted.* This would constitute, indeed, still a stupendous step forward as compared to the end of the War ('45). When Melvin Thorner in his "*Psychiatry in General Practice*" (1948) states: " . . . it (Group Psychotherapy) is *generally* used in institutions such as civilian and military mental hospitals and in clinics," one may deem that a rather "optimistic," i.e. oversized appraisal of the situation—even merely numerically—at that time.

However, in *addition* to the mentioned psychiatric institutions and clinics (where Group Psychotherapy is practiced in the *stricter* sense of therapeutic or prophylactic action aimed at individual-and-group catharsis) we find it now also in a larger number of educational institutions (sociometric grouping in schools; role playing and psychodrama) at the elementary, secondary and college level.

Another characteristic is the spread of Group Psychotherapy into application in various other groups *in situ,* as e.g. in pastoral group therapy, in industrial relations, etc., thus beyond "selected" (or controlled) groups put together ad hoc.

A further, more geographical trait is its spread—also in various, partly in mere budding, forms—through many more countries *outside* the U.S.A. While *Great Britain* had its early group psychotherapy beginnings already in the later years of World War II, it is, then, *France* (from about 1947 on) and *Switzerland* whence we hear about the start of various forms of Group Psychotherapy; apparently, with emphasis on children and younger people. *Brazil* signals beginnings of Sociodrama and Group Psychotherapy in clinical setting.

Ad 2. One of the most often heard "motivations" (or casual explanations) for the origin and the growth of Group Psychotherapy is—still—the response to "economic necessity" (i.e. the failure in some degree of Psychotherapy of individual patients to cope with the needs). This explanation—as though Group Psychotherapy is more economic, or "cheaper"—has met with dissent and dissatisfaction on the part of many practictioners.

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2. See, Geller, Joseph I. in this issue of Group Psychotherapy, Vol. III, No. 2, p. 231-41. 1. The foundation of "Group Psychotherapy" as official organ for all versions of Group Psychothrapy under the leadership of J. L. Moreno and the forthcoming section of Group Psychotherapy within the American Psychiatric Association will be doubtless a great step forward to improve the situation.

The Power of the Group Principle[3]

Ad 3. The just described evaluation of the successes of Group Psychotherapy—as being, well nigh, a mere multiple substitute or adjunct of individual Psychotherapy—seems more frequent among those group psychotherapists who have come to group work from individual Psychotherapy (and/or continue the latter, often as their main line) . . .

There can be little quarrel with the definition, as such, of the U.S. War Department's (Med). Tech. Bulletin (TB. Med. 103) of 1944 that Group Psychotherapy *is* "any procedure which tends to improve the mental health of *more than one* individual" (simultaneously). However, this is a mere numerical approach; a "linear" description—in one dimension, so to speak. But how about the group considered as a three-dimensional "body," as it were? Not to neglect the fourth dimension—time.

It is the fact that, properly looked at, the world of "mankind" in which all of us—well or sick—live *is* a group-*structured* world which accounts, to a high degree, for the *effect* of Group Psychotherapy. ("The" world as a whole, thus becomes: the "Greatest Group"; integration "goal" of part-groups; symbol of "re-socialization" for the out-grouped individual or minority; etc.)

Group Psychotherapy—No Mere "New Technique"

Thus correctly viewed, Group Psychotherapy is far from being a mere additional "technique," or fancy as which it is still viewed by some; nor is it anything like a minor "adjunct"—to be applied or to be left out—to individual Psychotherapy. It has become, and must become even more, a *legitimate* method in its own right, deeply embedded on its foundation: a world structured-in-groups. Thus, in restoring individuals (or smaller "diseased" groups, too) to the wholesomeness of the Group, we perform a much-needed service both to the small unit (individual; micro-group) and to the larger one. Hence, it will become increasingly clear that in order to do so, Group Psychotherapists will need more (and will need to know more, not less!) than our "older brothers," the individual therapists. For beyond the techniques of working on the individual (needed by the group therapist, too), the latter would want to know the *laws* of integration, e.g., from the "lower" up to the higher groups. For not individuals only become psychologically afflicted but also groups, in various ways, degrees and inter-relations. That is why *the accomplished group psychotherapist will acquaint himself with sociometric microsociologic* methods and results as well as with the knowledge of some other useful fields

3. A more elaborate developmnt of the "GROUP" Concept (or Principle) in relation to the rationale of Group Psychotherapy" will appear in a forthcoming issue of this Journal.

as cultural anthropology, and with the science and art of sparking the patients *spontaneity, as by psychodrama.*

No time for this ivory-tower studies only . . . While they try to get their patients "out of their shells," i.e. back to *their* self-chosen group (a new or an old one—*not* one that the therapist would "prescribe") the therapists might do well to try to work for themselves in a similar direction: integration from "below" up toward the greatest attainable group. The last few years have shown significant moves towards this: establishment of the World Health Organization (WHO) and Mental Health Organization, as auxiliary organs of the U.N.; then, less than 2 years ago (1948) the founding of the World Federation for Ment. Health. Tender buds as these still may be, ought to be considered as far from insignificant in the present tense and heated state of our World . . . No lesser task arises in preparing to build up, e.g., the section of Group Psychotherapy in the American Psychiatric Association. Then, too, we may have to guard for the impact of events that might bring increased suffering, individual and groupal, to our fellow-citizens, their children and ourselves.

Thus, we turn our gaze from looking back on a decisive five-year period of the History of Group Psychotherapy, to looking forward and working forward, toward even greater perspectives.

ROUND TABLE ON PSYCHODRAMA
of the
AMERICAN PSYCHOLOGICAL ASSOCIATION MEETING
State College, Pennsylvania

DORIS TWITCHELL-ALLEN, PH.D.
Longview Hospital and *University of Cincinnati*

Psychodrama made its first official appearance on the program of the American Psychological Association at the annual meetings at Pennsylvania State College in September, 1950. This introduction occurred because of the conviction of new workers in the field that psychodrama is pregnant with potentialities which cannot be so easily realized through any other technique. At the same time it was with considerable hesitation that these same workers suggested an open meeting. A symposium at this stage of application of psychodrama seemed inappropriate. No one presumed to be the authority expected of participants in a symposium. Equally certain, however, were these workers that the time had come to exchange experiences with psychodrama and to subject its current uses to a healthy tempering by critical review.

It was decided to organize an informal Round Table and present for discussion the work in progress at Michigan University, Western Reserve, and St. Elizabeths Hospital, Washington, D.C. to let the work at Longview Hospital, Cincinnati, be the basis for a theoretical setting by the Chairman and to invite the founder of psychodrama to be present for special comments. Unfortunately, Dwight Miles of Western Reserve had to send his regrets of absence. The content was reduced therefore to a report by Rosemary Lippitt of Ann Arbor and James Enneis of Washington, D.C., with kernal comments by the father of psychodrama, J. L. Moreno, and introductory and interpretive comments by Doris Twitchell-Allen, as chairman.

The work at the Neuropsychiatric Ward for Children at the University Hospital, Ann Arbor was presented by Doctor Rosemary Lippitt. By the use of Sociodrama, she portrayed diagnostic and therapeutic uses of psychodrama with mentally sick children, 6 to 13 years of age. Here through the spontaneity of drama, children reveal sources of disturbance not uncovered by the usual interview. Here through actions on a stage, children relax tensions of hostility;

enemies can be "shot down" by gesture. Here, also, children distraught with apprehension for the future meet the new situations on the stage before they must meet them in harsh reality. Retraining forms an important function of psychodrama with children who are facing the return to society. Here Doctor Lippitt has achieved an integration of this special therapy with the individual work of psychiatrists, and the educational and activity program of the Ward.

The report by Mr. Enneis regarding the work at St. Elizabeths showed the adaptation of psychodrama for restoring psychotic adults to mental health. The forces of hypnosis, combined with acting out of traumatic memories give the therapist a power source which can be used to bring the patient back to reality.

In hypnodrama, Mr. Enneis can give patients the opportunity to recapture traumatic experiences and work these through to a variety of conclusions, both the dreaded and the desired. After locating a vital tension system, an attempt is made to have the patient set up on the stage a succession of situations that will discharge that system. The process of closure appears to be central in therapy at this level.

With a large portion of the effective self blocked off by hypnosis, Mr. Enneis finds the patient's response characterized by a larger proportion of nonverbal behavior, action heavily charged with emotion, and a flow of organic concomitants of emotion. The primitiveness and intensity of experiences in hypnodrama appear to explain in part the effectiveness of this technique.

Dr. Moreno, as founder, related these current adaptations of psychodrama to the origins of this technique. Back in 1911 he observed the multi-dimensions of the behavior of men, women, and children in the gardens of Vienna, and conceived that the therapeutic counterpart to life struggles should be sought not in the confines of a couch, an interview chair, not even in the constriction of the four walls of an office. He saw the importance of providing an opportunity for individuals to try out the manipulation of life situations. He conceived the stage, whether outside in the gardens or inside in the theatre, a locus for needed emotional experiences and practice in social interaction, divorced from the irrevocable consequences of reality.

The logic of Dr. Moreno's approach, and the effectiveness of its clinical uses as reported by Dr. Lippitt and Mr. Enneis are convincing. Why should psychodrama be successful? The Chairman raised this question and suggested

a direction of thought for finding an answer, namely, that we go back 500 million years to the beginnings of man and think of the way protoplasm has come forward. In this line of development, why should we focus attention on one of the most recent acquisitions, language, and try to contact all that a person is through this one channel? The essence of man is much more than what is expressed in words. We turn to psychodrama as a means of contacting ancient man. We cannot deal with the biological substrata merely by talking about them. We must give the person opportunity to deal with his problems in situations that involve the very roots of his being*. We have the person act in total situations under the pressure of complex social forces. We use primitive situations and intense stimuli to contact the depth of a person. As quickly as possible we bring the person into action, because action of the whole person involves more basic forces of the self.

The above summary of content of the Round Table is not an adequate report of what happened. If the session vividly portrayed the nature and uses of psychodrama—and comments by the audience indicated that it did—it was due largely to the manner of organizing the whole session. The participants spent considerable time planning in advance how the different aspects of the presentation could be presented and coordinated. They agreed on certain principles:

1. That the session should be informal and flexible, with the different participants functioning whenever the Chairman judged the situation called for it;

2. That the presentation should be through drama** wherever possible, in accordance with the conviction that, for the audience as well as the actors, drama is more potent than mere verbalization;

3. That the boundary between audience and announced participants should be fluid, with the audience stating their ideas of the session and desires for it, and actually coming forward to speak and act at scattered times throughout the session.

The Chairman has taken the liberty of thus evaluating this Round Table with an audience of about 275 individuals. Perhaps some other factors were

*Editors Note: The reader's attention is directed to "Sociometry of Sub-human Groups," Sociometry, Vol. VIII, No. 1, 1945.

**Auxiliary parts played by Zerka Toeman Moreno, Psychodramatic Institute, New York, and Beatrice Barrett, Kenneth Baldridge, and Otto Ehrenberg, Longview Hospital, Cincinnati, made this action possible.

more significant in the results of the session than those listed. The important point is that we still know too little about programming large meetings such as those of the American Psychological Association. It seems wise to give our attention to the form of a meeting as related to results in order to raise the value of presentations as viewed by the audience.

GROUP PSYCHOTHERAPY AND THE FIRST INTERNATIONAL CONGRESS OF PSYCHIATRY

Paris, September, 1950

WILFRED C. HULSE, M.D.
New York

The American visitor at the first international congress of psychiatry was impressed by the immense interest in group psychotherapy displayed in most European nations. American literature on the subject is scarce but whatever is available to the European psychotherapist has greatly stimulated their original thinking and experimentation.

While only one session of the congress was officially devoted to group psychotherapy, interesting discussions about varied methods developed at a number of meetings in the sections on psychotherapy and child psychiatry.

A colloquy on "Psychotherapie de Groupe" was held on September 22 in the beautiful surroundings of the Cite Universitaire. Carefully prepared by the efficient and charming section-secretary, Mlle Juliette Boutonier, Professor of Psychology at the University of Strasbourg, and chaired by the Director of the World Federation for Mental Health, Dr. J. R. Rees, this meeting presented a wealth of study and experience in our field. The papers of two American authors gave the central theme of the colloquy: "Group Psychotherapy" by Rudolf Dreikurs of Chicago and "Sociodynamic Foundations of Group Psychotherapy" by J. L. Moreno, (in the absence of the author excellently presented by his disciple Mrs. Liesl Ostrander).

Dr. Dreikurs spoke about the various forms and methods by which group psychotherapy is able to exert curative influences on emotionally disturbed patients. His dynamic interpretations, based on the Alderian concept of psychopathology, gave interesting aspects of the socio-psychological interrelations of patients and therapists. Dr. J. L. Moreno's sociometric approach to group psychotherapy illustrated by charts and sociograms, gave new and fascinating insights into the structure of the group and the sociodynamic changes that the group and its members undergo during scientifically introduced and measured group manipulation. This was further illustrated by Zerka T. Moreno's comments about new experiments and tests on the subject of group cohesion.

Psychoanalytic group psychotherapy, directed toward the teatment of the patient in a group rather than the treatment of the group, was represented by Dr. Henry Ezriel of the London Tavistock Clinic who demonstrated interesting phases in the therapeutic development of a small psychoanalytically treated group. Dr. Ezriel tries to limit interpretations in the group to conflict manifestations that appear as common rather than as individual problems of the group members.

Discussants from Canada, Spain, France, Holland and Central Europe covered a large variety of experiences. Especially in Central Europe group work with mental patients seems to be popular and is widely practiced. However, its two representatives (Pakesch from Vienna and Merguet from West Germany) demonstrated experimentations with insufficiently selected and poorly structured groups who seemed to be used for diagnostic purposes and for occupational therapy rather than for psychotherapy on deeper levels. Dr. J. Bierer from the London Institute of Social Psychiatry made a valid contribution to the task of managing large groups using his vast experiences with social therapeutic clubs. Dr. Torre (Paris-New York) raised the question of educating group psychotherapists and emphasized the importance of psychoanalytic training.

This interesting and varied array of scheduled discussants took up all of the morning hours and more, so that no time was left for a free discussion. This was regrettable inasmuch as the participation of prominent psychiatrists like Franz Alexander and Winfred Overholser who attended the meeting had promised to bring new stimulation and deeper criticism.

As was to be expected, the topic of group psychotherapy was resumed two days later at the same place in a symposium on "The Possibilities of Psychotherapy and Psychoanalysis in Hospital Settings." French group psychotherapy, introduced at the opening session by the imaginative and critical Parisian child psychoanalyst S. Lebovici, was prominently represented in the second meeting by two papers, parts of which were published in the daily Congress Journal. Dr. S. Shentoub (Paris) and his collaborators presented a report on an intensive six months study of group psychotherapy with four adolescent girls in a closed hospital ward. They reported encouraging results on their patients and the reactions of institutional educators, physicians, and nurses to the new and revolutionary approach. Dr. F. Tosquelles of the psychiatric hospital at St. Alban practices psychodrama with schizophrenic patients and reported on interesting results. A combination of psychodramatic and psychoanalytic methods

in the development of group psychotherapy seems to be the specific French contribution to progress in group psychotherapy.

As a representative of group psychotherapy in America this writer tried to fortify old relations and to establish new ones between the European and American workers in our field. A great deal remains to be done to attain a better understanding, a better exchange of ideas and literature and international standardization of nomenclature and methods. The growing awareness of the actual and potential contributions of group psychotherapy to the various fields of psychiatry increases our feelings of responsibility and stimulates those who are interested not only in pragmatic success but in intensified research. We are still in a period in which the theoretical foundations of group psychotherapy need strengthening and the aims and goals of the individual group psychotherapist need clearer formulation and demarcations. This goal would be well served by a survey of international scope on the dynamics, methods and goals of present day group psychotherapy.

A NOTE ON THE ORGANIZATION OF THE ST. ELIZABETHS HOSPITAL PSYCHODRAMA PROGRAM

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Because of the large number of inquiries received concerning the nature of the Psychodrama Program at St. Elizabeths Hospital, the following description of this program is submitted.

The Psychodrama Program here functions under the general supervision of the Chief of the Psychotherapy Branch. All patients are medically referred. The initial selection of patients took place on a *sociometric* basis. However, the structure of each group is subject to the approval of the Clinical Director. As vacancies occur, within the groups, they are filled by selection based on sociometry, and on individual assignment from the psychiatric staff. In general, patients who have been assigned outside of sociometric procedures, have been able to fit themselves into the group structure. Exceptions to this idea have been excluded by the group through processes which usually result in the patient deciding he does not like psychodrama. When the group's rejection of a patient cannot be sufficiently modified to allow him to function on a productive level, attempts are made to find a group in which he is more accepted, and thus can become more productive.

The Patient Program divides itself into four major sections.

(1) THE ACUTE GROUPS: Two groups are made up of patients from the receiving services.

(2) CONTINUED THERAPY GROUP: This group consists of patients who have been sick for periods of five to thirty-five years.

(3) MILLER ACT GROUPS: These consist of patients committed to the hospital under the District of Columbia's Sex Psychopath law, and are the only groups consisting of men only.

(4) THE REHABILITATION GROUP: These Patients are about ready to leave the hospital and return to the community. The sessions are designed to give a rehearsal for going out (psychodramatic Exit Test). These meetings are

held in conjunction with the Social Service Department and represent a group approach to social case work.

Special emphasis is placed on attitudes to be met in the family, job, social, and community settings. Role practice and training are used as indicated by the group, and the individual patient's needs. When practical, guests from Vocational Guidance and Personel Units, are brought in to aid in giving clear perceptions of problems in obtaining employment, and methods of handling these problems.

In all groups, other than Rehabilitation, sessions are conducted on the level of therapy indicated by the group. Parents are welcomed to sessions, and some attend. This gives an opportunity to deal with many problems of interpersonal relationships using the actual people involved. In groups where the parents do not attend, auxiliary egos from the patient group are used.

There is a total of six groups. The average number of patients per group is *twenty,* except in the continued therapy group which consists of *thirty-five.* The patient load of the psychodrama program averages about *one hundred and twenty* patients. *Eleven* sessions are given per week.

In addition to the Patient Program, the Psychodrama Section presents a training program for the hospital staff. This program includes sessions and seminars for Psychiatric Residents, Psychological Reidents, and Internes, Social Workers, Student Nurses, and Student Chaplains in Clinical Training. The members of the training group, who show sufficient interest, attend regular patient sessions and are given opportunities to apply the techniques and theories of psychodrama under the critical supervision of the psychodramatist.

The Psychodrama Section's staff consists of the director of psychodrama and one paid assistant psychodramatist. Patient assistants are used whenever available to help with clerical and auxiliary ego work.

Psychodrama is used here primarily as a group approach. However, some individual sessions are held when it seems to be in the best interest of the patent. At times these individual sessions are aimed at clarifying the nature of the tele and tranference relationship between an individual therapist and his patient, or, are held because the patient wishes to work on relationships which his relationship to the group will not allow him to disclose before them.

While psychodrama touches a comparatively small number of St. Elizabeths seven thousand-plus population, we feel that it is a technique which lends itself readily to group and mass therapy approaches. It is rather encouraging that with so small a staff of Professional Personnel, so many patients can be reached.*

*FOOTNOTE: For a description of the physical facilities of the Psychodrama Section at St. Elizabeths see "The Theatre for Psychodrama at St. Elizabeths Hospital:" Frances Herriott, and Margaret Hagan, Sociometry, vol. IV, No. 2, May, 1941, or J.L. Moreno, Psychodrama, Vol. I, Pages 264-266, Beacon House, Beacon, New York.

NOTE AS TO THE POSSIBLE MEANING OF GROUP PSYCHOTHERAPY FOR THE PEOPLE OF THE UNITED STATES

J. L. Moreno

It is quite a challenge to the sociometrist and sociatrist to let his scientific caution fall by the wayside and speculate as to how the findings in small groups can be applied to large human societies. I have called group psychotherapy "an American idea born in Vienna," but why did it develop in the United States, failing to take root in Western Europe or Soviet Russia? It may be that the American nation suffers as a group from a sociatric sickness which I have called "low cohesion!" If we could chart the nation's sociogram we would probably see millions of small groups, each gravitating around its own center, the connections between them being in a majority of cases, missing, weak, or distorted. It would suggest the conclusion that a binder is needed to tie the parts together. This is what group psychotherapy in the broadest sense of the word promises to do. It tries to transform areas of low cohesion into areas of high cohesion without sacrificing however the spontaneity and the freedom of the small groups. Cohesion of the group is measured by the degree of cooperative and collaborative interaction forthcoming from as many members as possible in behalf of the purpose for which the group is formed.

It seems that the cohesion of a group declines in proportion to the number of small independent groups within it, and with the number of independent goals (criteria) around which they revolve. A free, democratic society is more inclined to permit the production of a large number of independent small groups, with a large number of different and independent goals. In contrast with this, the more authoritarian and unfree a society is the less inclined it is to permit the production of a large number of independent little groups. The problem is therefore how to combine a society of high freedom with a society of high cohesion. History has proven repeatedly that it is easy to produce a society of low freedom, a society of restraint which then goes hand in hand with a society of high cohesion. Everyone for whom a society of high freedom is axiomatic should realize what sacrifice and risk it entails. A society of freedom needs group psychotherapy and mass psychiatry. Societies of restraint and dictatorship whether it is political, like Soviet Russia or Spiritual like the Catholic church, do not need them. In fact they do not allow them to grow. They have a substitute in their totalitarian ideology by means of which they establish a high cohesion "on the surface" of their societal organizations.

The Republic of the United States of America is a novel experiment in societal development, about 150 years old. It is the youngest among the large nations, all others come from a long tradition of legal, social and political structure some of which have been slowing down, blocking social progress. One can take the position that the British Commonwealth and the French Republic have already had their "future." As a nation and culture America has hardly started. Now what is America's future? What kind of human society are we developing here? It is not built upon a single political ideology like the Soviet Republics, or a single religion like Italy or Spain, it is characterized more by what it is *not* than by what it is. The negative position has powerful, dynamic involvements of an offensive character.

In a positive sense it means that it is fighting against the rule of any particular ideology exclusively any particular religion, nation, or race, and political system exclusively and that it protects its citizens by law and force against being ruled by them. The negative turns into positive because it implies an implicit faith in the dynamic structure of society to take care of its needs spontaneously, so to speak. Its spontaneous drive towards an optimal level of its natural cohesion is not without the profound anxiety of possible failure. This anxiety may explain the importance of *science* as an ally in the fight for freedom and its gigantic almost pathological development here that is without parallel in the development of other countries.

Biographic Notes of Authors and New Contributing Editors of *Group Psychotherapy*

Nathan W. Ackerman, M.D.

Director, Council Child Dev. Center; associate in Psychiatry, Columbia University; author, "Group Therapy from the Viewpoint of a Psychiatrist," Am. Jnl. of Orthopsychiatry, Vol. XIII, No. 4, October, 1943, 13:678-687.

Joshua Bierer, M.D.

Medical Director, Institute of Social Psychiatry, England; started Therapeutic Social Clubs; published with collaborators the handbook "Therapeutic Social Clubs," 1948.

Vernon C. Branham, M.D.

Chief, Outpatient Section, Psychiatry and Neurology Division, Veterans Administration, Washington, D.C.; author of "The Classification and Treatment of the Defective Delinquent," Jnl. of Criminal Law and Criminology, Vol 17; editor (with S. Kutash) of "Encyclopedia of Criminology," Philosophical Libr., 1948; assisted in the organization of the pioneer conferences on group method within the American Psychiatric Association, especially at Philadelphia, 1932.

E.A.D.E. Carp, M.D.

Professor of Psychiatry, University of Leiden, Netherlands; author of "Psychodrama" (Dramatising as Form of Psychotherapy), Scheltema & Holkema, Amsterdam, 1949; employs psychodramatic methods in the treatment of mental patients at the University Clinic.

John M. Cotton, M.D.

Tulane University, M.D. 1932; author of "Group Psychotherapy, An Appraisal," in *Failures in Psychiatric Treatment,* edited by Paul H. Hoch, M.D., Grue & Stratton, 1948.

Rudolf Dreikurs, M.D.

Professor of Psychiatry, Chicago Med. School; author of "The Challenge of Parenthood," 1949; using group psychotherapy in clinical work.

S. H. Foulkes, M.D.

Institute of Psycho-analysis, London, England; consultant to the Maudsley Hospital, London; author of, among numerous publications on group psychotherapy, "Introduction to Group Analytic Psychotherapy," William Heinemann Medical Books, August, 1948.

Joseph J. Geller, M.D.

Diplomate in Psychiatry; director, Mental Health Center, Patterson, New Jersey; author of papers on group psychotherapy in *The Psychiatric Quarterly* and *Group Psychotherapy.*

Martin Grotjahn, M.D.

Institute for Psychoanalysis, Berlin, 1930-1936. Chairman, educational committee, Institute for Psychoanalytic Medicine of Southern California; author, "Experience with Group Psychotherapy as a Method of Treatment for Veterans," Am. Jnl. of Psych. Vol. 103, No. 5, March, 1947, pp. 637-643.

Wilfred C. Hulse, M.D.

Adj. Psychiat., Long Island College of Medicine; author of "The Social Meaning of Current Methods in Group Psychotherapy," *Group Psychotherapy,* Vol. 3, No. 1, 1950.

J. W. Klapman, M.D.

Diplomate of psychiatry; author of "Group Psychotherapy, Theory and Practice," Heinemann Medical Publications, 1946.

Rudolf Lassner, Ph.D.

Graduated from University of Vienna, 1936; chief psychologist, Child Study Institute, Toledo, Ohio; experimented with psychodrama and other group procedures, see "Psychodrama in Prison," *Group Psychotherapy,* Volume III, No. 1, April, 1950.

Joseph I. Meiers, M.D.

Graduated from Medical Faculty, University of Berlin, 1925; author, "Origins and Development of Group Psychotherapy; a Historical Survey (1930-1945)," Psychodrama Monograph No. 17, 1946; instructor on group psychotherapy at Sociometric Institute, New York, 1950-1951.

Delbert C. Miller, Ph.D.

Associate Professor of Sociology, University of Washington, Seattle; using sociodrama in industry and in the classroom; author of a paper on sociodrama to be published in a forthcoming issue of this journal.

Guerreiro Ramos, Ph.D.

Director of Teatro Experimental do Negro, Rio de Janeiro, Brazil; experimenting with psychodrama, group psychotherapy and sociodrama in problems of race relations.

Donald A. Shaskan, M.D.

Diplomate of Psychiatry and Neurology; Chief, Mental Hygiene Clinic, San Francisco Regional Office, Veterans Administration; author of "Development of Group Psychotherapy in a Military Setting," Res. Pub. Assoc. Nerv. Men. Dis., Vol. XZXV, Chapter XXX, p. 311, 1946.

H. R. Teirich, M.D.

Assistant, Psychiatric Clinic, University of Graz, Australia, using group psychotherapy and psychodrama at the clinic.

Leopold von Wiese, Ph.D.

Professor of Sociology, University of Cologne, Germany; sponsors the use of sociodramatic techniques by students for the clarification of social conflicts; author of "Sociometry," *Sociometry,* Vol. 12, No. 1-3, 1949.

Alexander Wolf, M.D.

Cornell University, M.D. 1932; author of "The Psychoanalysis of Groups," Am. Journal of Psychotherapy, Vol. III, No. 4, October 1949, and Vol. X, No. 1, January 1950.

IN MEMORIAM

ADOLF MEYER, M. D.

(1866-1950)

We remember with gratitude the warm support which Dr. Meyer gave to group and action methods on several occasions, long before the sponsorship of group psychotherapy, psychodrama and sociometry became fashionable. He served as Chairman of the Conference on Marriage Problems at the Annual Meeting of the American Sociological Society in Chicago, December 27, 1940, which dealt primarily with the psychodramatic and sociometric approach to marriage problems. He joined the Editorial Board of *Sociometry* in 1941 and contributed the same year a paper on "Spontaneity" to that journal, Volume 4, Number 2, 1941. He attended the first National Conference on Sociometry and Its Relation to Sociology and Group Psychotherapy on June 28, 1941, at the Psychodramatic Institute, Beacon, New York, and took part in the discussion following a demonstration of the psychodramatic treatment of psychoses in the Therapeutic Theate. He warmly sponsored the idea of forming a Society of Group Psychotherapy and Psychodrama which was then in the making. Dr. Meyer attended the official dedication of the Sociometric Institute, September 6 and 7, 1942, and greeted its advent with the following letter to the Chairman*

Dear Dr. Moreno,

My congratulations on this announcement of a most important progress in sociometry. It is remarkable and very important that such an organization should be in operation. I certainly appreciate your invitation to become a member of the Advisory Board. The mere prospect of perhaps an occasional getting together with so many of the similarly-minded collaborators is enough of a gratification to justify serious appreciation of belonging to this group. It offers, I feel, an endorsement of many of the lines of serious preoccupation with the science of man.

If I should have to express myself on what I consider our common ground, this is what I congratulate you on:

Psychology, and the science of man in its broad significance, has long been sabotaged by the unwillingness of Science to rise to the nature and range of what it has to *meet*, instead of forcing the facts of the special topic into a sys-

*See Sociometry, Volume V, Number 2, May, 1942, p. XII.

tem devised largely for physics and chemistry. This is partly responsible for the fact that social functioning has often failed to get its fundamentally important share of consideration. To have it in the form of experimental work, incidentally with development of methods of measurement, is a decided progress not only of good intention but of determined concrete work. Performance under the principle of operational specification may at last remove old habits of exclusiveness and frustration. We do not expect to begin with perfection but trust that scientific method will free us from unnecessary dogma without having to become iconoclasts.

Nature shapes her methods and goals according to her means. Can we and do we share and attain nature's way of balance also in our intentional work and formulated experience?

Most sincerely yours,

April 9, 1942 ADOLF MEYER

IN MEMORIAM

TRIGANT BURROW, M.D.

(1876-1950)

Dr. Burrow organized the Lifwynn Foundation in 1927 and there evolved a method of group analysis to which he gave the name *phyloanalysis*. He did not consider his work as a form of group psychotherapy but he has exercised a stimulating influence upon the early development of its theory. We salute him here as one of its genuine pioneers.

IN MEMORIAM

L. CODY MARSH

(1883-1949)

L. Cody Marsh will be remembered by those who knew him in his young manhood and in his prime as a charming and stimulating companion, a man teeming with ideas, whose chief delight it was to provoke those around him to think along constructive and progressive lines.

Born in Cleveland, Ohio, on September 30, 1883, Dr. Marsh came of Kentucky planters on his father's side and of a Cleveland family—the Cody's—on his mother's. The colorful Col. William F. Cody—"Buffalo Bill"—too well known to need any introduction, was his cousin. But it was not only in Colon-

el Cody that lived the spirit of adventure and the urge to depart from the usual, safe pattern of life. The Cody family seemed never content with things as they were, but must ever try to leave things better than they found them. And so they built churches and became interested in causes, and in an age when the "emancipation of women" was undreamed of, the Cody women were going to college, sailing away to far countries as missionaries, and even making public speeches on the evils of alcohol. Small wonder that Cody Marsh grew up casting an inquiring eye on existing institutions.

After graduating from a Cleveland high school, Dr. Marsh entered Kenyon College at Gambier, Ohio. He had not distinguished himself scholastically at school, as he had refused, as he later humorously remarked, to "let his studies interfere with his education," and had been too much absorbed in extra-curricular activities to pay due attention to his Latin and Greek. Much more interesting to him was his work in the dramatics club and the various music clubs. An accomplished pianist and organist, he was also possessed of an unusually pleasing baritone voice, and his musical gifts coupled with his marked dramatic ability stood him in good stead all his life.

As early as during his high school days Dr. Marsh was drawn by the plights of the mentally ill, and as a youth of 17 or 18 secured permission to visit the Cleveland State Hospital—then the Cleveland Insane Asylum—and entertain the patients with his piano playing and singing. His sympathies were always with the oppressed and unfortunate and his life was built around an unquenchable drive to better their lot.

although Dr. Marsh had from early boyhood planned to enter the field of medicine, he became interested while at Kenyon in entering the Episcopal ministry and graduated from Bexley Theological Seminary in 1907. He was, in many ways, a "natural" for this field as in it he found scope for his musical and dramatic talents, his need to serve, and the beauty of the Episcopal service satisfied a yearning in him that would otherwise have been denied.

After fourteen years as an Episcopal minister, twelve of which were spent in historic Queen Anne's Parish in southern Maryland, Dr. Marsh went to Siberia with the A.E.F. as Assistant Director in charge of Red Cross work among allied troops and Teutonic prisoners-of-war. Of this expedition, which set forth in October 1918 and left Siberia on April 1, 1920, little is generally known. An article in the December 1920 issue of the National Geographic Magazine written by Dr. Marsh gives some of the highlights of his year and a half in Siberia.

When he returned to the United States, the country was in the throes of the disillusionment that follows war. He himself was disappointed and discouraged with the role that organized religion had played, feeling it had through stubborn adherence to old ideologies failed to meet the challenge of a world at war. And so, no longer a young man, he determined to leave the ministry and enter the field of medicine. Despite the admonitions of almost everyone that only a young man could master the tremendous body of facts required of a medical student, he nevertheless went ahead, graduating in 1928 at the age of 45 from Albany Medical College, Union University. Incidentally he won honors in his National Boards, upsetting a good many theories.

The next two years were spent at Kings Park State Hospital, Long Island, and it was there that Dr. Marsh began his work in group therapy. This was done with no help and little tolerance from the rest of the staff, most of whom considered him more or less psychotic himself to want to do anything over and above the daily stint. But to him the phenomenon of mental disease was an exciting challenge and one he felt driven to do something about. He had in his ministerial work seen the tremendous force exerted by the group, and it seemed natural and logical to assume that even among psychotic patients that force would also apply. It did work: the patients enjoyed the group meetings in which they were gently encouraged to take part, and staff and attendants alike had to admit that the effect on the patients were remarkable, those who were withdrawn being stimulated to venture a little into the world of reality and those who were hyperactive becoming calmer. Nurses noted that a definite decrease in sedatives administered at night was possible.

Impressed by Dr. Marsh's work at King's Park, Dr. William Bryan, superintendent of Worcester State Hospital, Worcester, Massachusetts, a really progressive state hospital superintendent, asked him to come to Worcester for a year with carte blanche to develop his ideas on group therapy. This was an unusual opportunity and it was a year packed full of accomplishment. All the services of the hospital were drawn into the plan to make it a dynamic, living place for the rehabilitation of its patients—occupational therapy, social service, the group of theological students who spent a season there becoming acquainted with types of illness they would later encounter in their parishes, etc. Lectures were given to relatives of patients, to all the different groups working in the hospital, and an enormous amount of work was done in the community through lectures in an effort to remove the stigma from the diagnosis of mental disease. Group meetings for patients were enlarged and elaborated with gratifying results. A great deal was done through the medium of music.

After leaving Worcester State Hospital Dr. Marsh came to Arizona and was thereafter in private practice. He continued his crusade to improve conditions for the mentally ill, particularly in connection with the state hospital. In Tucson, where psychotic patients were, like common felons, placed in the county jail pending court action and removal to the state hospital, he waged a vigorous campaign against the county supervisors until they capitulated and built a ward at the county hospital equipped to handle such patients. He was a fighter who would not acknowledge defeat when he knew he was right and a formidable opponent, but more of his success was due to his extraordinary personal magnetism, his articulateness, and his expertness in handling people. His genuine love of people gave him a warmth that should be, it would seem, the first qualification of any psychiatrist.

Dr. Marsh died at his home in Tucson, November 4, 1949.

MRS. L. CODY MARSH

OPEN FORUM

1. C. Clark (Cincinnati): **"When, where and who introduced the term and concept of 'interpersonal relations' ?"**

The decisive push came from religious and axiological sources which turned secular between 1914-1924 (See in G. Gurevitch, **Sociometry in France and the United States,** J. L. Moreno's article on p. 235-254, Beacon House, 1950). The English phrase "interpersonal relations" was put into currency by W. C. Perry in **Theory of Values,** Chicago, 1927. The synonymous phrase "zwischenmenschliche Beziehungen" was described in relation to therapy by Moreno, 1918. The phrase was popularized by **Sociometry, Journal of Interpersonal Relations** since 1937, and, starting one year later, by **Psychiatry.**

2. S. Noble (Chicago): **"What function has the participant-observer in therapeutic situation?"**

(The term "participant observer" was put into currency in 1925 by Eduard C. Lindeman, New York School of Social Work.) This problem is treated by J. L. Moreno in **Who Shall Survive?,** p. 12-12, also in Sociometry, Vol. I, 1937, p.209-211, and again in Vol. III, 1940, "The participant observer, in the course of his exploration, enters into contact with various individuals and situations but he himself—with his biases and prejudices, his personality equation and his own position in the group remains unexamined and therefore, himself, an unmeasured quantity. The displacement in the situation to be investigated which is partly produced by his own social pattern does not appear as an integral part of the findings. Indeed, we have to take the inviolability of his own judgments and opinions for granted and the 'uninvestigated investigator' constitutes, so to speak, an everpresent error. The psychoanalytic investigator is also an unknown quantity in the situation in which he operates as an analyst. Any educational psychoanalysis which he may have undergone at an earlier date does not alter the fact that he is not measured during the process of interviewing and analyzing any individual. Indeed, **in order to accomplish the evaluation of both analyst and patient, a third person—a super-analyst—who is in equal relationship to both, would have to be present during the treatment-situation—and yet aloof from it."**

3. F. LaPierre (Paris): **"I understand that psychodrama is an expression therapy. How can it be of help to mentally excited patients?"**

Psychodrama can be used as an "expression" as well as a "restraint" therapy. The patients are placed in roles and situations which require submission and subordination. Spontaneous acceptance of restraining roles is systematic practice in self-discipline.

4. W. Harrison (London): **"What does 'Stegreif' mean?"**

There is no word for "Stegreif" in English which carries the same meaning. "Spontaneity" and "impromptu" are limited substitutes. Phrases like "creating in the now and here," or "creating in the present" are better. Why not call "Stegreif" Stegreif.

5. E. Reiner (New York): **"What is 'Basic Language'?"**

Basic language is a spontaneous creation of words. It is void of "significant" symbols; it is subjective and private. It sounds like nonsense to an outsider who is not involved. The words are free combinations of vowels and consonants. It is an "unlearned language" and differs from the learnable languages like English, Chinese, Esperanto, etc. It is helpful to give stutterers, aphasics, certain deteriorated schizophrenics and senile patients the experience of verbal communication. See Moreno, "Interpersonal Therapy and the Psychopathology of Interpersonal Relations," chapter **Free Association of Consonants and Vowels,** p. 52-54, **Sociometry,** Vol. I, 1937.

RECOMMENDED LIST OF SCIENTIFIC PAPERS AND BOOKS ON GROUP PSYCHOTHERAPY AND PSYCHODRAMA

A list of current reading and reference materials dealing with group psychotherapy and psychodrama will be included in every issue of this Journal. Contributors and readers are invited to suggest articles which they think *should be included* here and add their initials. This list has our editorial endorsement and will replace the routine book reviews of journals which are rarely a satisfactory duplication of the contribution made by an author. We recommend their reading but this does not mean that we always agree with their contents and *conclusions*.

1. A Twenty-Year Experiment in Group Therapy, Edited by Joseph H. Pratt M.D. and Paul E. Johnson, PhD. The New England Medical Center, 25 Bennet Street, Boston, Massachusetts, 1950.
2. Origins and Foundations of Group Psychotherapy, by J. L. Moreno, Beacon House, 1950.
3. "Psychoanalysis of Groups," Alexander Wolf, American Journal of Psycotherapy, 1950.
4. Le Transfer En Psychotherapie Collective (Transference in group psychotherapy) by R. Diatkine, F. Socarras and E. Kestemberg. L'ENCEPHALE (Doin Et Cie, 8, Place de L'Odeon, Parie) 39:248-274, 1950.
5. Psychiatric Treatment of Institutionalized Delinquent Adolescent Girls Ralph M. Patterson, M.D., University of Michigan School of Medicine, Ann Arbor, Michigan DIS. NERV. SYSTEM, New York. 11:227-232, August, 1950.
6. Group Psychotherapy in Private Practice, Preliminary Evaluation by Lewis H. Loeser, M.D., William Furst, M.D., Ira S. Ross, M.D., and Thea Bry, American Journal of Psychotherapy, Vol. III, No. 2, pages 213-233. April, 1949.
7. Paul Torrance, The Role Concept in a Vocational Guidance Program.
8. Mental Health in Nursing, Edited by Theresa G. Muller, R.N., M.A.
9. Erika Chance, Group Psycho-therapy and the psychiatric social worker. Mental Health, London, 1948, 8, 8-12.

10. The function of the group. Donald A. Shaskan, Robert Plank and Helen H. Blum. Psychoanalytical Review, 1949, 36, 385-388.
11. Nathan Blackman. Group psychotherapy with aphasics. J. nerv. ment. Dis., 1950.
12. Psychodrama by Dr. E.A.D.E. Carp, 1949, Scheltema & Holkema's Boekhandel En Uitgeversmaatschappij N.V.—Amsterdam.
13. J. L. Moreno, Le Psychodrame d'un Marriage, in the September issue of Les Temps Modernes, edited by Jean Paul Sartre, Paris, 1950.
14. Florence Powdermaker and Frank Jerome, Group Psychotherapy with Neurotics, Amer J. Psychiat. 1948. 449-55.
15. Martin Grotjahn, The Process of Maturation in Group Psychotherapy and in the Group Therapist, Psychiatry, Vol. XIII, No. 1, 1950.
16. Victor W. Bikales, Drama Therapy at Winter Veterans Administration Hospital, Bull. Menninger Clinic, 1949, 127-133.
17. The other Side of the Bottle by Dwight Anderson. A. A. Wyn, Inc. New York, 1950.

The author of "The Other Side of the Bottle" is the Executive Secretary of the Medical Society of the State of New York. It is the best book by a layman on a mental topic since Clifford Beers "The Mind That Found Itself." This time it's the "alcoholic" mind. The author who found a cure calls himself a "dry" drunkard because he knows that he shall never be able to take a drink in safety—perhaps also because of his "dry" humor. Although autobiographic it is a good account of the therapeutic approaches to alcoholism. The book is recommended to physicians and laymen. (J.L.M., 1950)

ANNOUNCEMENTS

Upon the appeal of J. L. Moreno, about twelve hundred Fellows and Members of the American Psychiatric Association have joined in a petition for a Section on Group Psychotherapy within the Association. The Council will decide upon this issue during its November meeting.

A **symposium** on Group Psychotherapy is now in preparation for the next annual meeting of the American Psychiatric Association in May, 1951 at Cincinnati. The occasion will also commemorate the anniversary of twenty years of Group Psychotherapy within the Association since the first recommendations in its behalf at the Toronto meeting in 1931.

A Round Table Conference on Psychodrama took place during the American Psychological Association meeting at Penn State College on September 5th.

The Sociometric Institute at 101 Park Avenue is now carrying an extensive program of seminars and workshops in group psychotherapy, psychodrama, sociodrama and sociometry. The fall term began September 15th. Teachers of the New York City Board of Education are taking a course at the Institute on **Group and Action Methods** sponsored by the Board of Education. Teachers will get credit for taking the course and the Board of Education will extend salary increment to such teachers enrolled.

Forthcoming articles in **Group Psychotherapy**: Pierre Renouvier—"The Pioneers of Group Psychotherapy, An Appraisal"; Heinrich Teirich—"Group Psychotherapy in Austria and Germany"; Joseph W. Klapman—"Group Psychotherapy, Social Activities as an Adjunct to Treatment"; a symposium edited by Rosemary Lippitt on Family, School and Community Problems; A symposium edited by J. L. Moreno on Psychodrama and Sociodrama in Industry, containing papers by Delbert C. Miller, Ted Franks, H. Langenestrass, Theodore Jackson, Edgar Borgatta, John R. W. French, Alex Bavelas, including a complete protocol of Sociodrama of an Industrial Problem; and papers by all new contributing editors of this journal, S. H. Foulkes, Martin W. Grotjahn, Alexander Wolf, Wilfred Hulse, E.A.D.E. Carp, Rudolf Dreikurs.

Teaching and Training in Group Psychotherapy. The Sociometric Institute was incorporated by the State of New York in 1942 for the teaching and training of group psychotherapists, psychodramatists and sociometrists. It is located at 101 Park Avenue, New York City, and at Beacon, New York, and enrolls students throughout the year. It is the oldest school of this type and **the only one** with which this journal and its sister journal **Sociometry** are identified. Two professional societies are connected with the Institute: The Society of Group Psychotherapy and Psychodrama founded in 1943, and the American Sociometric Association, founded in 1945.

The New York State Dept. of Mental Hygiene, (Commissioner, Dr. Newton Bigelow) has started a new venture in Education for Mental Health, using the comic strip Blondie to teach good human relations.

SOCIETY OF GROUP PSYCHOTHERAPY & PSYCHODAMA (S.G.P.)

The rapid growth of the S.G.P. and the numerous projects under way make it auspicious to set a tentative date for its next meeting in November or December, 1950 in New York City at a place to be designated. Many of the leading contributors to group psychotherapy plan to be present: Dr. Joseph H. Pratt, Boston; Dr. Vernon C. Branham, Washington, D.C., Dr. Martin Grotjahn, Los Angeles, California; Dr. Wilfred C. Hulse, New York City; James M. Enneis, Washington, D.C.; Dr. Joseph J. Geller, Paterson, New Jersey, Dr. Lewis H. Loeser, Newark, New Jersey; Dr. J. L. Moreno; Dr. Joseph I. Meiers, and others. The purpose of the conference is to map out a nation-wide program which will try to coordinate the various branches of group psychotherapy. Membership in the American Psychiatric Association makes applicants automatically eligible for membership in the Society of Group Psychotherapy and Psychodrama. Dues: $3.50 per annum, including subscription to the journal **Group Psychotherapy.** Clinical psychologists, psychiatric social workers, and social psychologists are invited to apply for membership.

Since July, 1950, **one hundred and twelve** new members have applied for and been accepted for membership in the Society. Over 80% are members of the American Psychiatric Association:

ARNOLD ALLEN
Dayton, Ohio
DORIS TWITCHELL-ALLEN
Longview Hospital
Cincinnati, Ohio
GLENN C. ANDERSEN
State Hospital
Kalamazoo, Michigan
LOUIS A. AZORIN
New York City
ARTHUR J. BACHRACH
Univ. of Virginia Hospital
Charlottesville, Virginia
SONDRA BAKAL
New York City
BLANCHE M. BAKER
San Francisco, California
BYRON BENNETT
State Hospital
Little Rock, Arkansas
RAYMOND J. BENNETT
Tacoma, Washington
NEWTON BIGELOW
Dept. of Mental Hygiene
Albany, New York
GERALD W. BLANTON
Los Angeles, California
ALBERT J. BONER
Wisconsin Medical School
Madison, Wisconsin

EDGAR F. BORGATTA
New York University
Bronx, New York
LESTER D. BOROUGH
South Bend, Indiana
VERNON C. BRANHAM
Veterans Administration
Washington, D.C.
ANNA B. BRIND
Family Clinic
Los Angeles, California
WALTER BROMBERG
Talmage, California
ANTHONY BRUNSE
St. Elizabeths Hospital
Washington, D. C.
KARL A. CATLIN
Clarinda, Iowa
ARTHUR L. CHANDLER
Brentwood Neuropsychiatric
Hosp., Los Angeles, Cal.
WINSTON COCHRAN
Beaumont, Texas
FRED J. CONZELMANN
Stockton, California
H. O. COZBY
San Diego, California
E. H. CRAWFIS
Cleveland State Hospital
Cleveland, Ohio

MARJORIE B. CREELMAN
Western Reserve University
Cleveland, Ohio
CHARLES C. DAHLBERG
New York City
WALTER E. DEVINE
Vet. Administration Hospital
Bay Pines, Florida
IRVING I. EDGAR
Detroit 2, Michigan
FRANK G. ENGLER
Ashdown, Arkansas
JAMES M. ENNEIS
St. Elizabeths Hospital
Washington, D.C.
CLAYTON J. ETTINGER
Detroit, Michigan
ERNEST FANTEL
United States Army
Camp Cook, California
HARRY L. FREEDMAN
Director of Clinton Prison
Dannemora, New York
JOSEPH J. GELLER
Director Mental Health Ctr.
Paterson, New Jersey
NJUTY GREENBERG
Guidance Center
Wichita, Kansas

MARTIN GROTJAHN
Institute of Psychoanalytic Medicine for So. California
Los Angeles, California
ROBERT BARTLETT HAAS
University of California
BERT HANSEN
Montana State University
Missoula, Montana
GERTRUDE HARROW
Veterans Administration
Chicago, Illinois
C. D. HASKELL
San Francisco, California
VERN HAYS
Canton State Hospital
Canton, Illinois
FRANK R. HENNE
Harlem Valley State Hosp.
Wingdale, New York
R. HERNANDEZ
Bayamon, Puerto Rico
R. B. HOLMGREN
Univ. of Texas Med. Branch
Galveston, Texas
CONNIE I. HOOD
Yakima, Washington
LOUIS HOTT
Queens Village, New York
WILFRED HULSE
Long Island Coll. of Medicine
New York
PAUL E. JOHNSON
Boston Univ. School of Theology
Boston, Massachusetts
LEONA KERSTETTER
Hunter College
New York
AARON E. KOBLENTZ
Veterans Administration
Brooklyn, New York
LEONARD C. LANG
Buffalo State Hospital
Buffalo, New York
RUDOLF LASSNER
Child Study Institute
Toledo, Ohio
CECILIA S. LEE
Spokane, Washington
HENRY LIHN
Menninger Clinic
Topeka, Kansas
ROSEMARY LIPPITT
University of Michigan
Dept. of Neurology and Psychiatry
Ann Arbor, Michigan
LEWIS H. LOESER
Newark, New Jersey
HAROLD N. LUBING
Winneabago State Hospital
Oshkosh, Wisconsin
WILBUR M. LUTZ
Wernersville State Hospital
Wernersville, Pennsylvania
JEAN S. McILLWAIN
New Jersey State Hospital
Trenton, New Jersey
WILLIAM W. MAGRUDER
Highland Hospital
Asheville, North Carolina
HERMON S. MAJOR
Major Clinic
Kansas City, Missouri
OLIN R. MARTIN
Cambridge State Hospital
Cambridge, Ohio
JOSEPH I. MEIERS
New York City
J. A. MENDELSON
Dayton State Hospital
Dayton, Ohio
EMY A. METZGER
Inst. of Advanced Psychoanalysis, New York City
STAN MOLDOWSKY
Psychology Dept.
State Univ. of Iowa
Iowa City, Iowa
HARRY MURDOCK
Sheppard & Enoch Pratt Hospital—Towson, Md.
ELWOOD MURRAY
School of Speech
University of Denver
Denver, Colorado
VERONICA F. MURRAY
Veterans Administration
Lowell, Massachusetts
F. C. NEWSOM
U.S. Naval Hospital
Memphis, Tennessee
ROBERT P. ODENWALD
Child Center
Catholic Univ. of America
Washington, D.C.
E. MADISON PAINE
Green Bay, Wisconsin
MARY PALMER
Boston Psychopathic Hosp.
Boston, Massachusetts
EARL PARSONS, Jr.
Little Rock, Arkansas
OSCAR PELZMAN
State Hospital
Central Islip, New York
J. R. PETERS
Dayton State Hospital
Dayton, Ohio
ARTHUR L. PETERSON
Havertown, Pennsylvania
EDWARD PODOLSKY
Brooklyn, New York
JOSEPH H. PRATT
Boston, Massachusetts
WILBERT S. RAY
Trinity College
Hartford, Connecticut
LEON REZNIKOFF
Hudson Co. Hosp. for Mental Disease Weehawken, N.J.
KATHERINE K. RICE
Washington, D.C.
T. C. RODGERS
New York City
CHARLES T. ROOT
U. S. Army
Fort Custer, Michigan
SIDNEY ROSE
New York City
DAVID ROTHROCK
Florida State Hospital
GEORGE W. RUSSELL
Lakeland Hospital
Blackwood, New Jersey
HARRY M. SALZER
Cincinnati, Ohio
SOLON D. SAMUELS
Los Angeles, California
GERHARD SCHAUER
Veterans Administration
Brooklyn, New York
A. M. SCHNEIDMUHL
Spring Grove State Hosp.
Catonsville, Maryland
LUCY SCHNURER
Pittsburgh, Pennsylvania
ARTHUR J. SCHWENKENBERG, Beverly Hills Sanitarium, Dallas, Texas
DONALD A. SHASKAN
Vet. Admin. Mental Hygiene Clinic, San Francisco, Cal.
MAX A. SHERMAN
Vet. Admin. Mental Hygiene Clinic, Los Angeles, Cal.
ARCHIE SILVER
Verdun Protestant Hospital
Montreal, Canada
PHILIP E. STAHL
Santa Monica, California
MORTON M. STERN
Newark Community Hospital
Newark, New Jersey
ALEX STONE
State Hospital
Marlboro, New Jersey
LEONARD K. SUPPLE
Beacon Hill Sanitarium
Beacon, New York
RUTH H. THOMSON
San Bruno, California
ESTHER B. TIET
Los Angeles, California
ROLAND E. TOMS
Jackson, Mississippi
GEORGE J. TRAIN
Brooklyn, New York
ANNETTE devol TRUMBULL
New Jersey State Hospital
Trenton, New Jersey
CLAUDE UHLER
Dallas, Texas
SIDNEY VOGEL
New York City
RICHARD P. WANG
New Jersey State Hospital
Trenton, New Jersey
ISIDOR I. WEISS
State Hospital
Stockton, California
S. WILNER
Royal Victoria Hospital
Allan Memorial Institute
Montreal, Canada
DAVID C. WILSON
Univ. of Virginia Hosp.
Charlottesville, Virginia
MILLIE L. YOUNG
Pacific Colony
Spadra, California
MARK ZEIFERT
Fresno, California

STATEMENT OF THE OWNERSHIP, MANAGEMENT AND CIRCULATION REQUIRED BY THE ACT OF CONGRESS OF AUGUST 24, 1912, AS AMENDED BY THE ACTS OF MARCH 3, 1933, AND JULY 2, 1946

Of GROUP PSYCHOTHERAPY, Journal of Sociopsychopathology and Sociatry published quarterly at Beacon, New York for October 1, 1950.

1. The names and addresses of the publisher, editor, managing editor, and business managers are: Publisher, Beacon House Inc., Beacon, New York; Editor, J. L. Moreno, Beacon, New York; *Managing Editor, Zerka Toeman Moreno*, Beacon, New York; Business Manager, Zerka Toeman Moreno, Beacon, New York.

2. The owner is: J. L. Moreno, Beacon, New York.

3. The known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages, or other securities are:—None.

4. Paragraphs 2 and 3 include, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting; also the statements in the two paragraphs show the affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner.

Beacon House, Inc., J. L. Moreno, Editor

Sworn to and subscribed before me this 31st day of October, 1950.
Mary A. Walsh
(My commission expires March 30, 1951)

SOCIOMETRY MONOGRAPHS

No. 1. Developments in Social Psychology, 1930-1940, Leonard S. Cottrell, Jr., and Ruth Gallagher (List Price—$1.50)

No. 2. Sociometry and the Cultural Order—J. L. Moreno (List Price—$1.25)

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