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SOCIOMETRIC STRUCTURE AND GROUP PSYCHOTHERAPY ON A MENTAL HOSPITAL SERVICE FOR CRIMINALLY INSANE[1]

BENJAMIN POPE, PH.D.
Spring Grove State Hospital, Catonsville, Maryland

There has been an increasing awareness that in a mental hospital therapy is only in small part that which goes on during the interview hour, and in much larger measure that which results from interpersonal relations on the ward. This has led to a series of studies about spontaneous ward associations of patients. A number of these have been based on sociological observations and interviews with mental hospital patients and personnel (10, 12, 14). Some of these have been concerned with determining the nature of social structure within the hospital (3, 12, 14), while others have stressed the patient interaction process as such, and how it may be studied (6, 7, 12, 14). The present study shall be primarily concerned with determining whether the patients on a mental hospital unit for criminally insane structure themselves into subgroups, based on spontaneous attractions and rejections of each other. The nature of group structure, if any, will be examined as well as the social behavior traits that determine a patient's position within this structure.

Several years ago, a psychiatrist in charge of the patient unit here under study set forth certain observations which have a bearing on the first aspect of this study (3). These he formulated as follows:

"In spite of the wide divergencies in ages and diagnoses, the average patient finds his level and makes a reasonably good adjustment with his fellow patients. Social groups which help to stabilize the situation form here as elsewhere. . . . In general, these little groups function as units independently. There is very little overlapping. . . ."

These observations will be treated as hypotheses to be checked by a sociometric technique. In addition, the nature of the prestige values in this group which make for acceptance and rejection will be investigated.

The findings of this study contain many implications for group therapy within a mental hospital setting. This is true regardless of whether

[1] The author is indebted to Dr. Albert A. Kurland and Dr. Jack E. Geist, the physicians on the unit, and Mr. Fred Cutter and Mr. Salvatore Cammarata, psychologists, for assistance in executing this study.

we are concerned with therapeutic ward management, or group therapy in its more formal sense. In either case, the staff will be aided greatly by a knowledge of such sociometric factors as group cohesion, sub-group formations, and the precise patterns of inter-personal acceptance and rejection. It will be important to know who the leading individuals are, the prestige they enjoy, and the values and standards of behavior that exist in the group. It will also be interesting to determine who the isolates are and how they can be socially integrated into the group.

The physician in charge of a hospital ward is frequently confronted with the problem of assigning patients to sub-groups, often organized for carrying out ward duties or for other administrative and therapeutic purposes. In this connection, he can be aided very much by a sociometric analysis of the spontaneous group structures that develop among the patients. The utility of the sociometric method in institutional group assignment was suggested by Moreno (15), and demonstrated by Moreno and Jennings (19).

Group psychotherapy in its more formal sense is also dependent on this type of sociometric information. It will be helpful to the therapist, at the point of organizing a group, to be aware of the inter-personal patterns that exist at the outset. He will wish to know which of the patients he selects are leaders within their groups, which are isolated, and which, actively rejected by their fellows. This will be important in order to estimate the degree of group cohesion that is likely to develop. Thus, Moreno (16) speaks of the disrupting effect of too many leader individuals within one group. It would also seem important to know how many isolates a group can tolerate and help along the path of greater social interaction. Of course, we may expect that patients will not necessarily occupy the same sociometric positions within the therapeutic group, as they do on the ward. In addition, dynamic changes in group status are to be expected as therapy proceeds. It is not our concern, here, to discuss the nature of these changes. But it is clear, that periodic sociometric analysis can be a valuable tool in increasing the therapist's awareness of them and in this way give some estimate of the effectiveness of group therapy.

The above considerations are especially pertinent to the treatment of the subjects encountered in this study, with whom group management and group therapy are the important treatment procedures. These subjects were patients in the Hillcrest unit of Spring Grove State Hospital, Catonsville, Maryland. Although there are approximately 65 patients in this service only 58 of these proved testable. In terms of diagnosis, the subjects are

distributed as follows: 16 schizophrenic paranoid type, 2 schizophrenic catatonic type, 4 schizophrenic hebephrenic type, 5 schizoid personality, 4 deteriorated schizophrenics of long standing, 3 schizophrenic reaction, 1 simple schizophrenic, 14 psychopathic personality, 3 mental defective, 3 psychotic depressive, 1 senile psychotic, 1 paretic, and 1 psychotic with convulsive disorder.

These patients are known to have committed the following crimes with the indicated frequencies: 13 murder, 7 assault, 1 manslaughter, 6 arson, 6 burglary, 4 armed robbery, 2 breaking and entering, 2 forgery, 8 larceny, 2 non-support, 4 rape, 2 sodomy, and 1 false alarm. Ages range from 18 to 69 with a mean of 38 and a sigma of 40. While the group is obviously varied in many respects it is probably fairly typical of the populations of similar wards in other state mental hospitals.

Method

Because of the kinds of patients involved, sociometric testing was a slow, laborious procedure. Many could not write; most would not respond to a written inquiry, and nearly all were guarded and suspicious about the purpose of the study. It was, therefore, necessary to interview each patient and use the sociometric inquiry as part of the interview. This was time consuming and necessitated extending the study over a three month period. In a sense, this will reduce the validity of the results, for group structure is not a static phenomenon. There no doubt was some shifting of group adherence in the three month period. Since we have no way of plotting these shifts, the findings must be considered as an approximation of the actual situation.

Each patient interviewed was told that the Psychology Department of the hospital was making a study of various wards in order to determine how the patients spent their time and how they got along with each other. The interview that followed had as its purpose the establishment of rapport with the patient rather than the gathering of anamnestic material. When the author judged that rapport was adequate, he would ask the specific sociometric questions. There were several cases in which it was fairly clear that the patient would not or could not give a valid response. Nevertheless, no interview was allowed to terminate without the sociometric questions being definitely put to the patient. The fact that the author was not part of the ward administration probably made it easier for the patients to respond. It was necessary frequently to reassure them about the confidential nature of the interviews, since fear of retaliation from other patients was often manifested.

Since the patients spend the bulk of the day on the sun porch of this division, association in this area was used as the criterion of sociometric choice and rejection. The patients were asked to list their choices in order of preference and their rejections in order of intensity of dislike. While they were not limited in their number of choices, statistical considerations made it desirable to use only the first three choices and the first three rejections.

Although there is no single, good external criterion against which to check the validity of sociometric scores, it was felt that the findings of this study would be more meaningful if they could be compared with other estimates of group status. Two physicians on the service involved were asked to rate the patients on a seven point scale, ranging from +3 to —3, indicating their judgment of the degree to which the patients were accepted or rejected by their fellows. After determining the reliability of ratings as between the two psychiatrists the correlation between their averaged ratings and the actual sociometric scores was calculated.

The two physicians' ratings show an adequate reliability with a Pearsonian r of .71 between their separate estimates. However, the r between their averaged ratings and the actual sociometric scores is considerably lower, though significant, at .322. This correlation is lower than the average of .595 reported by Gronlund (5) for teachers' judgments and grade 6 pupils' sociometric scores. It would seem that clinical familiarity with patients does not automatically imply a knowledge of the positions these patients occupy in the esteem of their fellows.

The reasons for acceptance and rejection given by the patients were used as the data from which prestige values were estimated. To begin with, the verbatim reasons given were placed on cards to facilitate categorization. In this way 19 categories of reasons for acceptance and 12 for rejection were derived. It was possible to carry this classification through without any a priori assumptions, for the reasons given were easily divisible into the obtained categories. These categories constitute the prestige values of this study, whose hierarchical structure within the group culture has been estimated from the sociometric choice and rejection scores that correspond to them. This estimation has been made by averaging the sociometric scores corresponding to the individual reasons which constitute a particular prestige value.

Because of the statistical procedures used with the sociometric data (2) it was considered desirable to transform choices into scores which could be placed on a continuum, with no negative values. For this reason the scheme

presented in Table 1 was used. In this table the row designated zero represents the unreciprocated choice and rejection scores. According to this method, a first unreciprocated choice was given a value of 11, a second a value of 10, and a third a value of 9. Conversely, a first rejection was given a value of 5, a second a value of 6, and a third a value of 7. To a neutral

TABLE 1
SOCIOMETRIC SCORING VALUES

	Choices			Neutral	Rejections		
Choices	1	2	3	0	3	2	1
1	16	15	14	11	10	9	8
2	15	14	13	10	9	8	7
3	14	13	12	9	8	7	6
Neutral 0	11	10	9	8	7	6	5
Rejections 3	10	9	8	7	4	3	2
2	9	8	7	6	3	2	1
1	8	7	6	5	2	1	0

sociometric situation between individuals, when there was neither attraction or rejection, a value of 8 was assigned. Table 1 indicates the manner in which these scores can be extended upward and downward for mutual attractions and rejections, without necessitating the use of negative values. Thus, all scores range from zero for a mutual first rejection to 16 for a mutual first choice with 8 as the neutral point. An isolate would receive a total score of 57x8 or 456. All individual sociometric scores above this point indicate that the patient is more accepted than rejected.

RESULTS

Distribution of Sociometric Scores

As is the usual tendency with sociometric scores, the distribution deviates from the normal curve in the following ways. The mean is 457.10, 1.10 points on the positive side of the neutral value of 456, while the curve is significantly negatively skewed and leptokurtic.[2]

[2] Skewness and kurtosis were calculated both for magnitude and significance by the methods suggested by McNemar (8, pp. 42 and 61).

In spite of gross, clinically observable, behavior pathology the group as a whole gives similar sociometric manifestations as do normal groups. There is a greater tendency to accept than reject one's fellows. The tendency for a few individuals to obtain eminence, or to be decidedly rejected occurs along with the clustering of the majority around the mean position of social mediocrity.

Group Structure

The complexity of a sociometric diagram depicting the attractions and repulsions between 58 subjects is not the only reason for avoiding its presentation at this point. The principal interest here is the examination of group formations, and their relation to the prestige value system of this particular culture. The data was plotted in a sociomatrix and sub groups separated out by an adaptation of Holzinger's B-Coefficient developed by Bock and Husain (2). Eleven sub groups were delineated, with seven residual patients and eight isolates.

TABLE 2
SOCIOMETRIC SUB GROUPS

Sub Groups	N	Mean Score	Range
A	7	464.7	453-491
B	2	464.5	464-465
C	3	462.3	460-464
D	3	462	456-463
E	2	459.5	458-461
F	2	457.5	456-459
G	2	457.5	452-463
H	7	457	453-461
I	2	456.5	456-457
J	7	455.9	445-462
K	4	455.5	449-459
L	2	455	455

Note—The neutral score, indicating neither acceptance nor rejection, is 456. The *Sigma* of the distribution is 5.80.

In Table 2 it will be seen that the sub groups are by no means homogeneous in terms of group status. In spite of this, however, we note that even in a forced society of such asocial individuals as psychotics and psychopaths a definite group structure develops, of a hierarchical nature.

Prestige Values

Tables 3 and 4 present the reasons for choice and rejection of others in the order of their weight within this culture. Two methods of calculating the sociometric value of each reason were used. According to the first, the

TABLE 3

SOCIOMETRIC VALUES OF REASONS FOR CHOICE

Reasons	Sum of Choice Values
Converses	177
Is friendly	158
Helps me	113
Plays cards	112
Feel sorry for him	103
Work with him	94
Is saner than rest	86
Is quiet	72
Is interesting	71
Understand each other	62
Is an old timer	51
Is intelligent	42
Like him	42
Is trustworthy	41
Has sense of humor	31
Knew him before	30
Knows the ropes	20
Is not obscene	11
Is new here	10

Note—The reasons for choice are arranged in rank order of sociometric value.

scores of all choices corresponding to a particular class of reason were totalled resulting in the sum values in the first column. Another evaluation was made by adding the sociometric scores of the individuals for whom particular kinds of reasons were advanced. The resulting rank orders of importance were almost identical, with a *Rho* of .996. With one small difference the same methods were used for determining the order of importance of reasons for rejection, with a *Rho* of .95 between them.[3] In the latter case the scores were weighted so that the reasons for the strongest rejections would be represented by the lowest scores. The method of weighting was based on the assumption that the most frequently mentioned reasons for rejection should draw the lowest scores.

TABLE 4

Sociometric Values of Reasons for Rejection

Reason	Sum of Rejection Values*
Aggressively domineering	.36
Psychotically aggressive	.72
Insane	.77
Homosexual	1.50
Unfriendly	1.50
Jealous	1.75
Untidy	1.77
Untrustworthy	2.75
Withdrawn	2.75
Old timer	5.00
Trouble maker	6.00
Syphilitic	7.00

* These sums have been weighted so that the most frequently occurring reasons would be represented by the lowest scores.

[3] Both these correlations are based on linear regressions, as determined by the method described in McNemar (8, 257-258). The significance of the r's was tested by the method suggested by McNemar (8, p. 257).

The rank order of values in Table 3 would suggest that we are here dealing with a prestige system, similar in many respects to that which we would expect to obtain generally in our culture. Thus, conversational ability, affability, friendliness, sociability, and the capacity to participate in organized recreation and joint work are general social behavior traits necessary for group acceptance. Two of the reasons, however, bear special reference to the special society with which we are concerned. These are the satisfaction gained by some of the better integrated patients in protecting the dependent psychotic members, and the general recognition accorded to these better integrated patients. The latter, however, simply emphasizes what is implicit in the entire hiararchy of prestige values. Even in this forced society of psychotics and psychopaths, those who have the greatest capacity for positive social interchange and adjustment are the ones granted positions of eminence.

Table 4 confirms what has already been suggested in Table 3. The most decidedly rejected individual is the one who is reputed to be an aggressively domineering person. The psychotically aggressive person whose hostile attacks are unpredictable is next in the degree to which he is rejected. Along with him comes the patient who is regarded as being frankly psychotic and disorganized. Although the homosexual is despised and sharply rejected, his deviate behavior does not occur at the top of the list because of the small number of patients who are recognized as homosexuals. In general, patients who are unfriendly and hostile antagonize their fellows in this group as in most others, although in this situation they are often viewed with considerable paranoid distortion.

Relations between the Sub Groups

Table 2 indicates that Group A is the sub group with highest sociometric standing. That it is the key group in the entire value system is further suggested by a *Rho* of .79 which its ranking of reasons for choice has with the overall ranking. In calculating this *Rho* the ranking of values presented in Table 6 was used in order that the value hierarchy within each group might be determined by frequency of occurrence of each reason, and not by the sociometric scores. This *Rho* is considerably higher than that attained by the other sub groups and is statistically significant.

Some insight into the bearing that sub groups have on the entire value system may be gained if we examine the inter-group attractions or repulsions between key Group A and the others, as well as their comparative standing on the various prestige values.

Table 5 presents a statistical evaluation of the choices and rejections that occurred between Group A and the other sub groups. The basic sociometric scoring system was used here, rather than the one presented in Table 1. Both positive and negative values occur, to demonstrate clearly inter-group attraction and repulsion. Thus, a first choice was given a value of plus three, and a first rejection value of minus three, with the other choices and rejections falling in between. The sums were weighted to compensate for the varying *N's* in the different groups.

The *Rho* between the sociometric scores of the sub groups and the inter group attractions is .42, a relationship short of significance. It would appear that the key group with the highest sociometric score does not always seek out, nor is it always sought out by other groups with like standing. Perhaps an examination of the prestige values accorded to these sub groups will throw some light on why A is often attracted to other groups of patients with considerably lower group status. Tables 6 and 7 present

TABLE 5

ATTRACTIONS AND REPULSIONS BETWEEN GROUP A AND THE OTHER SUB GROUPS

Group	Inter Group Attraction*
A	
B	21.00
C	—4.62
D	27.72
E	49.00
F	0.00
G	—56.00
H	—5.88
I	—14.00
J	11.76
K	—14.00
L	7.00

* The sums of the original sociometric values, before conversion according to Table 1, weighted to eliminate variable effect of *N*.

the relative weights of the various reasons for choice and rejection in the different groups. These are based on frequency of occurrence of these reasons. To equate for differences of N each frequency was averaged for its group and multiplied by 100.

TABLE 6

FREQUENCY* OF OCCURRENCE OF REASONS FOR CHOICE IN THE SUB GROUPS

Reasons	A	B	C	D	E	F	G	H	I	J	K	L
Converses	72	100	133	0	0	50	0	0	0	29	25	0
Is friendly	57	0	33	67	0	50	50	29	50	14	25	0
Helps me	86	0	33	100	0	0	50	0	0	0	0	0
Plays cards	72	100	0	0	50	0	0	29	0	14	0	50
Feel sorry for him	14	0	33	0	100	0	0	71	0	0	25	0
Work with him	100	0	0	33	0	0	0	0	0	0	0	0
Is saner than rest	72	50	0	33	0	0	0	0	0	0	0	0
Is quiet	29	0	67	33	0	0	50	0	50	0	0	0
Is interesting	72	0	0	0	50	0	0	0	0	0	0	0
Understand each other	0	0	0	67	0	0	100	0	0	0	0	0
Is an old timer	0	0	67	33	0	0	50	0	0	0	0	0
Is intelligent	43	0	0	0	0	0	0	0	0	14	0	0
Like him	14	0	0	33	100	0	0	0	0	0	0	0
Is trustworthy	14	0	33	0	0	0	0	0	0	0	0	0
Has sense of humor	0	0	33	33	0	0	0	0	0	14	0	0
Knew him before	29	50	0	0	0	0	0	0	0	0	0	0
Knows the ropes	14	0	0	33	0	0	0	0	0	0	0	0
Is not obscene	0	0	0	0	0	0	0	0	0	14	0	0
Is new here	0	0	0	0	0	0	0	0	0	14	0	0

* Frequencies weighted to eliminate variable effect of *N*.

A comparison of Group A with Group E, the sub group with whom there is the greatest inter-group attraction, indicates very little correspondence between their respective columns in Table 6. Group A is relatively high on conversing, helping and giving things to the more dependent patients, working together, and the general interest it holds for others. Group E, on the other hand, is low on all of these but very high on the tendency to evoke the sympathy and support of others, as well as on likeable-

TABLE 7
FREQUENCY* OF OCCURRENCE OF REASONS FOR REJECTION IN THE SUB GROUPS

Reasons	A	B	C	D	E	F	G	H	I	J	K	L
Aggressively domineering	72	0	0	0	50	0	0	0	0	86	50	50
Psychotically aggressive	0	0	0	0	0	0	50	43	50	0	25	0
Insane	0	0	0	0	0	0	0	43	0	0	0	0
Homosexual	0	0	0	0	0	0	150	0	0	0	0	0
Unfriendly	29	0	0	33	0	0	0	0	0	0	0	50
Jealous	29	0	0	0	0	0	0	0	0	0	0	0
Untidy	0	0	0	0	0	0	0	0	0	0	0	0
Untrustworthy	14	50	0	0	0	0	0	0	0	0	0	0
Withdrawn	0	0	0	0	0	0	0	0	0	0	25	0
Old timer	0	0	0	0	0	0	0	0	0	14	0	0
Trouble maker	0	0	0	0	0	0	0	0	0	14	0	0
Syphilitic	0	0	0	0	0	0	0	14	0	0	0	0

* Frequency weighted to eliminate the variable effect of *N*.

ness. It would seem that A's relation with E is that of a protector and supporter. It is noteworthy that this type of relationship evokes the strongest bond between any two groups.

Both D and B come next, and in this order. The picture of D that is suggested in Tables 6 and 7 is that of a somewhat withdrawn group that is friendly, affable, supportive of the more dependent patients, and understanding of them. It does not have the more outgoing, socially facile and aggressive traits of A, but nevertheless is not unacceptable to A's members.

The trend in Group B is one in which the friendly, supportive elements for which A is known are absent, but B is acceptable to A because it can join with it in conversation and recreation. This is true in spite of the fact that some patients, not in Group A, consider members of B to be untrustworthy.

If we now turn to the sub groups that are rejected by A, we find that foremost among these is G. From Tables 6 and 7 we may infer that in this group the members are homosexually related to each other. They are known to be quiet, friendly, withdrawn, but relatively more psychotic and unpredictable in their aggressive outbursts than A. In A's relation with G we see why the members of the key group can enjoy the prestige that is accorded them and still be known as aggressive and bullying. Apparently this society of patients is willing to accept A's aggression because it is directed against deviant members of the culture, such as the homosexuals.

Next in the degree of rejection by A are I and K. The reputation pattern of I points to a relatively psychotic withdrawn group. It is regarded as friendly by some, and unpredictably aggressive by others. In any case, it seems not to have the dependent qualities by which other psychotics evoke the protective support of Group A. Group K seems to be rejected by A because the only reputational trait that stands out is its aggressive bullying propensity.

Discussion

It is not the author's intention to advance values of group social behavior as the sole or even the major hypothesis of why certain patients achieve eminence, and others isolation or rejection. It is assumed that interpersonal relations are complex, involving all the nuances of the total personalities concerned. The objective of this study is simply to demonstrate that in the matrix of interpersonal relations are imbedded the prestige values of the group culture.

It would seem justifiable to refer to this mental hospital unit as a group with its separate culture. Davis speaks about culture as including ". . . all behavior which the human being exhibits in conformity with his family, his play group, his social class, his church, and all his other human groups" (4). To be sure the unit under consideration would constitute a very limited and special culture. But we have seen that it does develop a hierarchy of values and that those who conform to these are rewarded by acceptance, while those that do not, are punished by rejection.

The interesting thing is that a group that is so rebellious regarding social controls, and rejected by society, still clings to predominant social

values and punishes those in its midst that do not. The seven patients of Group A have been involved in the following types of crimes: burglary, forgery, arson, rape, assault, and murder. Yet the same patients are known for their friendly conversation, their helping of the more dependent members of the hospital community, and their ability to work with others. It may be assumed that a systematic error is present in that the interviewer was a staff member and the patients could not be expected to expose any propensities that they may have toward rebellious anti-authoritarian behavior. But this does not explain away such facts as the vehemence with which the group rejects the homosexual, the bully, and the psychotically aggressive individual. To be sure, the value system is not equally accepted by all sub groups. For instance, the two members of Group G, both homosexuals, are attracted to each other for this very reason. However, this forces them into a position of isolation. In the same way the members of Group K who are reputed to be both bullies and psychotically aggressive, are rejected by most of the other patients.

What emerges is a hierarchy of groups and prestige values, with the best integrated patients of Group A functioning as the arbiters of acceptable behavior. Although we have not gone beyond the groups to an individual analysis, in this report, it may be mentioned that one patient in Group A appears as the most powerful individual, functioning as the superego of the unit.

On the whole, Branon's (3) hypothesis about social group formation in this patient society has been borne out. However, his second hypothesis that the sub groups function as independent units is not entirely supported. For while there is considerable deviation within each group from the predominant value system, the prevailing tendency is for a group's prestige to be related to its ability to accept the overall values, most powerfully promulgated by Group A. It is also clear that there is considerable inter-group attraction and rejection.

At best, however, group explanations can only be partial. A clinical study of sociometrically deviate individuals, as well as the key persons within the various groups, would bring into the picture the individual dynamic material needed to add to our understanding of the group processes.

It is also hoped to put these findings to work in the therapeutic management of the ward. Future studies could be concerned with how best to do this. The work of Moreno and Jennings (9) may well suggest useful sociometric procedures for group organization in occupational therapy, ward activities, and perhaps group therapy.

SUMMARY

The purpose of this study is to determine whether the patients on a mental hospital unit for the criminally insane structure themselves into sub groups based on spontaneous attractions and rejections of each other. Further objectives are to determine the nature of the group structure, if it exists, and to discover the social behavior traits that are associated with prestige. Of the 65 patients in the unit, only 58 proved testable. A sociometric interview was carried out with every one of the subjects, using as a criterion, association with other patients on the unit's sun porch. The patients chose and rejected as many of their fellows as they wished, in rank order, but only the first three choices and rejections could be used with the statistical method employed. The data was plotted on a sociomatrix and sub-groups separated out by an adaptation of Holzinger's B Coefficient (2). Each choice and rejection was accompanied by a reason in the patient's own words. These reasons were used as the basic data for determining the prestige value hierarchy of this culture. The results follow:

1. This clinically pathological group gives the same kind of distribution of sociometric results as do normal groups. There is a greater tendency to accept than reject each other. Only a few patients obtain eminence or decided rejection, while most cluster around the mean.

2. Eleven sub-groups clearly emerge, with seven residual patients and eight isolates. These sub-groups are not homogeneous in terms of sociometric score, frequently including individuals with sharply contrasting group status.

3. Most of the prestige values in this group might well be found in normal societies. These include conversational ability, affability, friendliness, and the capacity to participate in organized recreation and joint work. Two of the values bear special reference to the present group. These are the satisfaction gained by some of the better integrated patients in protecting the dependent psychotic members, and the general recognition accorded to these better integrated patients.

4. The reasons for social rejection include aggressively domineering behavior, psychotic aggressiveness with unpredictable hostile attacks, and homosexuality.

5. Seven of the better integrated patients emerge as the key group in this culture. This group functions as the arbiter of values, accepting some of the other sub-groups and rejecting others.

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A COMPARISON OF TWO APPROACHES TO GROUP PSYCHOTHERAPY AND PSYCHODRAMA

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There are many theoretical and practical questions posed when the approach of a group psychotherapist is given careful scrutiny. In this paper, an attempt will be made to present the essential features of two methods which will be referred to as: 1) group psychotherapy for individuals and 2) individually-centered therapy in a group setting.

One manner of slicing this "approach to the group psychotherapy" pie is the emphasis placed on the centrality of a single patient participant. In some techniques there is, in effect, a continued "passing of the ball" from person to person. Each member defines his role by deciding how often *and for how long he will actively partake in the discussion.* The usual exchange might be likened to a snowball rolling down a hill heavily laden with snow. One member of the group makes some comment which stimulates the thinking of a second and may precipitate a remark. The process hopefully continues so that a sizeable segment of the group becomes involved. In such a situation, there is frequently a topical orientation. Of course, the topic can readily be, and frequently is, a certain member of the group and that person's experiences, but the tendency is to concentrate on considerations two or three rungs (on the abstraction ladder) away from the individual. It is likely that the participants will enter into a more intellectual discussion about, for example, marriage, love or aggression. This may be classified in a somewhat arbitrary manner as group psychotherapy for individuals.

The other phase of this proposed dichotomy, individually-centered therapy in a group setting, approaches treatment by directing attention to an individual's personality and seeks to unify the group around this member for any one meeting of the group. If the snowball analogy may be utilized again, we can construe the structure of the spheroid as an individual's make-up rather than some general idea or concept. As it rolls down the hill, it grows in size as the discussion or action concerning the central figure activates thoughts and hopefully subsequent comments about similar experiences in the other members of the group.

With these brief definitions of the two approaches in mind, it seems necessary to turn towards an oft-discussed theoretical notion—psychological climate. This is a useful concept and it underscores the importance of evaluating the superimposed structure that is established by the frames of reference of different therapists. When a number of unacquainted people assemble in a room, immediately some clarification of purpose is sought. Initially, the structure of the group is essentially amorphous. The definition reached is the cumulative resultant of the needs of the various members. Each person will reveal these needs by the comments he makes, by the attitudes assumed towards other individuals in the group, by his bodily positions, and other expressive activities. Essentially, this is the psychological climate. It might further be described as the atmosphere under which the members of a unit function. It is a concept defining the freedom or restrictions placed on the action that takes place in a group.

The centrality of any one person in the group is quite variable. When one idea is under consideration, a certain person may be the so-called leader, yet when a different area is being discussed, an individual who was relatively passive in the former circumstance might assume the authoritarian role. Nevertheless, the most consistent determiner of the over-all assumed climate is frequently the therapist or director. This is evident whether the leader remains silent or spends the entire period lecturing to the assemblage. In either of these extremes, the attitudes and feelings of the leader are perceived and recorded by the members. This brief preface on climate and the importance of the leader in its establishment is an attempt to set the stage for the crucial issues of this discussion. In this connection, Moreno's work on the "warm up" is especially relevant.

When the therapist is disposed to use a central figure or star, in psychodramatic terms, as the basis for discussion, he is, in effect, saying to the group,

> "Here is a person whom I feel represents your current interests so let us examine his problem areas and see how they might benefit all of us."

It is essential that a certain degree of group integration is achieved before the therapist can assume such a dictatorial position. An affectional relationship seems necessary between all the members of the group with at least the early roots of identification and a feeling of rapport with the therapist. The socially-endowed authoritarian position of the therapist, i.e., the role given to the therapist because of his experience and because he is being sought for help, does not seem to be sufficient to warrant such

a drastic step as this structuring apparently is. When this technique is used before the group is prepared, such intense hostility may be engendered that the therapeutic benefits are frequently hindered. The timing for the choice of a central figure seems to parallel the same process (timing) in any form of interpretation. In the group situation, it is even more difficult because the movement of many individuals must be taken into account. This will be discussed more thoroughly in a later section of this paper.

Such manipulation will frequently precipitate a feeling of rejection by the members of the group who are not chosen as the star. This sacrifice is consciously made to direct the thinking of the assemblage towards a specific entity. It is crucial that the star's immediate problem be representative of the preceding discussion since by this choice the therapist is imposing his will on the group. Utilizing this method of structuring requires the satisfying of alternate needs indicated by the other patients. In other words, since some affection is being withdrawn from the majority of the members, it is essential that the immediate problem of the star be coordinated with the area of interest indicated by a large segment of the group. The group's unity and continued productivity hinges on the appropriate choice.

This type of direction results in focusing on the make-up of a specific person and centers about his feelings and attitudes. This reduces to a remarkable degree seemingly tangential comments. It directs attention to the specific experiences of this central figure which are so frequently contributory to his emotional difficulties. This effort seems to direct the thinking of the participants towards personal rather than impersonal matters. As the central figure relates or enacts situations of his past or present, a process of generalization seems to take place. The experiences of the star stimulates similar thoughts in the others. In effect, each interested member of the group is reliving in his private world, the events that are being portrayed for public examination. Further, many of the more reluctant members are likely to "join the bandwagon" either during the immediate or some subsequent session. This two-fold method of stimulating *the material which many contemporary clinicians feel is most significant* in a therapeutic endeavor, seems unusually effective.

When the second of the two approaches, i.e., group therapy for individuals, predominates the scene, the therapist seemingly establishes an atmosphere in which general areas relative to mental health are emphasized. A discussion involving such topics is undoubtedly informative and useful in establishing a climate of esprit de corps; however, when an insightful

experience is the goal, this tack appears to underachieve. More impersonal comments are considerably easier to make since they are readily absorbed into a mold so formed. This is consistent with the usual approach in our society which favors the tendency to blend into a fixed and established matrix. After all, the group is just a small bit of society. A good "bull session" is certainly a socially approved form of expression and has rarely had any detrimental effects. It seems that many therapeutic hours of this sort may be described as such. The question that must be asked is, does it accomplish the desired effect? Is the group functioning so that the associates of the patient must be prepared. xtreme awareness of the whole members are examining themselves and their relationships with others? It seems that a therapist is playing into the defenses of the patient when this free discussion method is employed. The patient can maintain strong resistance to self-understanding by talking around significant material.[1] One technique utilized to attack this problem is interpreting this resistance to the patient. Although this is a perfectly acceptable and valuable method, the reaction is often one of alarm. Although the individual might be prepared for this interpretation, other members of the group might be disturbed by it. However, if the original and the continued structuring of the group prepares its members for personal discussion, the extent to which minutia is sought is substantially minimized and interpretations of the patient's immediate responses can be made more readily.

At first "blush", this discussion may suggest that the individually-centered approach is *the* panacea; that no such difficulties are confronted in using this technique. This would be a misconception. The defenses of the patients will still come into play to hinder the movement in therapy. This is found in any type or form of therapy. In fact, when this highly personal tack is utilized, the confidentiality of the material may call forth stronger resistances. However, since the atmosphere is established on the interests and make-up of the individual, it is more likely that the working through of these resistances will be hastened and enhanced. However, it is essential to take a relative attitude. There is not a real or qualitative difference between these approaches. The strength of this argument hinges on the quantitative differences.

One of the major criticisms of the individually-centered approach touches

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[1] Upon initial consideration, this may appear like an attack on the therapist's acumen; his ability to discern the changes in the patient. However, the entire set in writing this paper has been to divorce the technique followed by the therapist from the extent of his experience and how that experience is implemented.

it at its core. The bone of contention is stated in many ways, but usually implies that the therapist is being insensitive to the patient. The former seems to be pushing or probing to such a degree that the patient becomes unnecessarily disturbed. When the private world of a person undergoes intense scrutiny (especially in a group situation) it is more likely that a fear of exposure will be established. Anxiety of this sort seems to be the single most devastating factor underlying the discontinuance of a therapeutic program. In following this approach to group therapy, the initial sequence of sessions is crucial in that a feeling of security must be established. The patient must "warm" up to the situation at his own rate. In the early stages, even the observance of the open expression of the more advanced members will probably be disturbing to a newcomer. By the same token, the first person in a newly formed group to become the center of attraction will bear feelings of unrest and will instill these in the other members of the group. Therefore, careful timing must be utilized in every step of this integrating process. The most delicate decision of the therapist is determining the proper moment for selecting any one person as the central figure. The patient must have had ample opportunity to test the various members of the group so that he can establish limits within his own mind, even though they might be tentative. A feeling of belongingness and the realization that true affection exists in the setting seem essntial foundation blocks to the effective use of this technique. If this gradual process is followed, the previously mentioned criticism is unwarranted.

There are some adherents to this approach who subscribe to the view that quickly bringing some personal material to the foreground to achieve a sudden shock reaction is an important device in shattering tension systems. This is undoubtedly true; however, considerable care must be taken so that the anxiety level is not raised prematurely to such a degree that nothing more than an impediment to successful therapy is achieved. Although many of us have learned to appreciate the strength of the individual and the rather generally accepted principle that one trial learning is not readily maintained, such premature pressure can have an unusually potent deleterious effect. This is especially true considering the intensity of feeling that accompanies a therapeutic atmosphere. It is when this aspect of the approach is liberally employed that the aforementioned criticism might act as a guide or warning. Not only must there be considerable groundwork with the patient, but also the other professional personnel or close associates of the patient must be prepared. Extreme awareness of the whole

situation is an important "byphrase" in any such intense therapeutic endeavor.

In summary, it should be emphasized that the difference between these approaches are quantitative. In both techniques, the individual's attitudes and experiences, his personality make-up, is under consideration. The crucial issue becomes—which therapeutic climate will produce a more far-reaching and intense self-evaluation. The individually-centered approach appears to reach this goal more satisfactorily and more directly. Whether this issue should be given more or less weight than, for example, the individual differences amongst therapists, is not within the province of this paper. However, it seems that the various factors should be culled out, examined, and their relative importance be established. It is only through this constant teasing out process that there will be any real understanding of the state of psychotherapy—be it group or individual.

THE EXPERIENCING OF GROUP PSYCHOTHERAPY

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Whatever the inner experiencing, or emotional meaning, of group psychotherapy is to the people who look to it for help, it seems to be a realm of systematic ignorance to psychologists. And yet, there also seems to be an implicit assumption in discussing group psychotherapy in terms of observed behaviors that these behaviors *experientially mean* something to the people participating. It is on this assumption that group psychotherapists work; it is this experientially something that they are trying to facilitate. This study is an exploratory attempt to delineate this experience in some identifiable relationship to observed behavior. How clients experience group psychotherapy is interpreted from an incomplete sentences form in which clients express their feelings about therapy before, during, and after group meetings and their feelings toward the therapist and other group members. These interpretations will be compared to behavioral manifestations typified in the picture of the clients provided independently by the therapist. The latter includes relative amount of participation, behavior toward other members of the group, and apparent benefit derived from the group.

Six women, ages 19 to 49, all studying during a summer session at a large metropolitan college, participated. A group-centered therapy approach was attempted, best described by Hobbs.[1] The group met for five weeks, three times a week, each session lasting fifty minutes. After the ninth, twelfth, and fifteenth meetings, the clients were asked to fill out an incomplete sentences form devised by Armin Klein. They were told that their therapist, the co-writer, would not see the answers until after the group process was terminated. The clients knew that they were contributing to research in the field and willingly filled out the forms.

They were asked to complete the following twelve sentences "to express how you really feel."

1. Therapy is . . .
2. The other members of my group . . .
3. The therapist . . .
4. When I speak in the group, I . . .
5. When I am silent in the group, I . . .

6. The most significant moments in therapy seem to me to be . . .
7. At these significant moments, I . . .
8. I feel that what is most important about therapy to me is . . .
9. Away from therapy, I . . .
10. Before coming to therapy, I . . .
11. After leaving therapy, I . . .
12. It hurts in the group when . . .

The therapist describes client A as a matronly-looking woman of 34. She is the eldest of three children, unmarried, long submissive to a strong-willed mother and "just catching up with my adolescence, in terms of heterosexual adjustment, self-reliance and independence." In the year prior to therapy, she had moved to another town and had taken a position of responsibility and prestige. She was still, however, full of doubts and uncertainties. She was seeing a married man who was obtaining a divorce from his wife. Client A's mother harshly opposed the romance, but the client was determined to see it through, feeling that "marriage brings fulfillment." In the therapy sessions, she discussed her problems at some length at the outset, but after the first two weeks, her problems seemed to recede into the background as she became more concerned with the problems of the other members of the group. She took an active role in the discussions and made a genuine effort to be understanding and helpful. The therapist felt that client A had achieved, out of her group participation, a much greater emotional maturity and apparently had gained from the interaction a significant ability to manage her heterosexual relationships.

Her responses to the sentence completion form are:

1. Therapy is . . .
   a. (blank)
   b. helpful in understanding my own feelings and those of others
   c. an experience I'll never forget
2. The other members of my group . . .
   a. are very interesting people . .
   b. are extremely interesting
   c. are grand people
3. The therapist . . .
   a. is very skillful in gaining rapport and has a friendly personality
   b. helps to clarify feelings and ideas
   c. is very skillful in bringing out feeling
4. When I speak in the group, I . . .
   a. feel a sense of release
   b. feel that they are interested, though some may not fully understand

c. feel that everyone is interested

5. When I am silent in the group, I . . .
   a. am mentally evaluating the feelings of the others who speak
   b. am absorbed in what is being said and in relating it to my feelings
   c. am listening and trying to *feel* what the speaker feels
6. The most significant moments in therapy seem to me to be . . .
   a. those times when one of the members expresses a feeling that seems deep and possibly has never been expressed before
   b. those in which a person expresses a feeling which seems real and perhaps unexpressed before
   c. when a person suddenly looks at her own feelings objectively
7. At those significant moments, I . . .
   a. feel interested and stimulated
   b. feel rather excited
   c. feel a sense of achievement
8. I feel that what is most important about therapy is . . .
   a. a sense of seeing similarities in others' feelings to my own
   b. feeling free to express myself and hear some of my feelings expressed by others
   c. having a group of people who are interested in me and my problems
9. Away from therapy, I . . .
   a. look back and forward to the sessions with great enthusiasm
   b. usually forget it, but look forward to the next session eagerly
   c. think about it with pleasure
10. Before coming to the group, I . . .
    a. usually stop by a restroom and comb my hair, etc.
    b. look forward to it with pleasure
    c. scarcely think about it
11. After leaving therapy, I . . .
    a. feel like continuing our discussion with some of the members and frequently do, at lunch
    b. often discuss ideas with some of the group at lunch
    c. think about and sometimes discuss interesting incidents
12. It hurts in the group when . . .
    a. one of the members expresses a feeling as opinion which I can understand and appreciate (but do not agree with) but feel cannot be questioned or dealt with openly because of that person's emotional approach to it
    b. I feel that one is being critical or judging another's attitudes and feelings in a "moral" sense
    c. one person seems to have no conception of another's feelings

It would seem from this material that client A became increasingly *emotionally involved in the group. Just what this emotional involvement* means can be seen in items 4, 5, and 8, where the client responds emotionally, it is true, but egocentrically at first, and then subsequently includes everyone in her emotional reactions. Items 5 and 8 particularly show the development from a distant kind of intellectual participation with others to an emphatic involvement with the real group of people. The client, in item 10, seems to be expressing a change in her self-consciousness before the sessions, developing to a more secure relationship. At first, it really hurts for her, as judged from item 12, when she comes up against a member of the group whom she jarringly cannot understand; but her hurt changes to pain at the appreciation of the damaging effects of other members not attempting to understand such phenomena, demonstrating a real sensitivity to the group. Therapy becomes for client A "an experience I'll never forget"; and, we might interpret, one of real personal involvement with these people.

The youngest member of the group was client B, a 19 year old psychology major. Her written description of her problem on the application for group therapy states: "Emotional difficulties resulting from conflicts in parental and opposite sex relationships, lack of ability to be decisive, feelings of insecurity and instability." The client, according to the therapist, frequently expressed yearnings for independence and yet wanted to cling to old anchorages. She was bitterly disappointed with her mother who did not defend her against the father—a very authoritarian figure. The father had forbidden client B from seeing a boy of another religious faith on pain of withdrawing her from college and cutting off her allowance. The girl felt righteously indignant over this; that she was old enough to determine whom she should and should not see; that her parents were narrow-minded; that they did not understand her. The client also was disturbed about her inability to make decisions; usually by the time she does make up her mind about something, it is too late to carry the plan into effect. This was evident during psychotherapy, where she hesitated so long to speak about herself in the group that she requested an individual counseling session. The therapist felt that client B had insight into her problems but apparently felt so insecure that she could not work on them in the group. On several occasions the client assumed the role of the non-directive therapist and was quite conscious of her actions. Her participation was, however, primarily cautious and limited, but with good feeling.

Client B's completed sentence form follows:

1. Therapy is . . .
   a. a means of gaining insight thru self-expressing release rather than dependence
   b. a process for which I have the greatest respect and enthusiasm
   c. a very stimulating, fairly satisfying experience
2. The other members of my group . . .
   a. are intelligent women, who for the most part, seem to feel the essence of the process, but don't always get what they want out of it. Perhaps this is opinion on my part
   b. are very pleasant, cooperative, understanding
   c. seem to have been benefitted to various extent
3. The therapist . . .
   a. is very capable, does not make us dependent upon him and minimizes the leader-follower autonomy to increase the solidarity of the group
   b. is very capable and likeable; not at all threatening
   c. is very capable and understanding
4. When I speak in the group, I . . .
   a. am nervous but willing to talk
   b. feel very much at ease
   c. feel very much at ease
5. When I am silent in the group, I . . .
   a. am comparing the experiences of others with my own, or else thinking of suggestions to make to others without being offensive
   b. am listening to others formulating suggestions or comparisons to my own situation
   c. think of what or what not to say to the others
6. The most significant moments in therapy seem to me to be . . .
   a. the times when there is a "we" feeling attained through the realization that so many of us are faced with similar problems
   b. when one of us really seems to have gained insight through our discussions
   c. when one of us really achieves insight into her problems
7. *At those significant moments,* I . . .
   a. become very enthusiastic and feel quite satisfied
   b. feel elated to have been part of the process
   c. feel very exhilarated
8. I feel that what is most important about therapy to me is . . .
   a. the permissiveness, the feeling of acceptance, of knowing that three times a week there is a group of people to whom you can unburden your problems, or listen to others at

will, knowing that you will be understood and accepted
  b. the permissiveness of the situation, so conducive to facing a problem realistically, and being able to gain insight into it, not feeling threatened, on the defensive
  c. gaining the motivation to make adjustment to my difficulties

9. Away from therapy, I . . .
   a. think about the techniques, and about the problems of others, more than the relationship to myself
   b. think about it with very pleasant associations
   c. think about what has been said, and what may develop

10. Before coming to the group, I . . .
    a. anticipate each session with interest
    b. anticipate the session with great interest
    c. ibid

11. After leaving therapy, I . . .
    a. feel satisfied with group interaction as such, but sometimes feel that insight is slow in being achieved
    b. am usually tired, but satisfied
    c. will be sorry it is over.

12. It hurts in the group when . . .
    a. someone states their problem, and seems to miss the underlying principles—or scratch the surface, and I want to make suggestions and interpretations but feel that they may be incorrect, and even if not, the individual may not be ready to adopt them, would feel threatened, thus breaking the permissive atmosphere of the group
    b. I wish to speak my mind and can't do so because the other person may feel frustrated, or because I myself feel blocked
    c. someone feels threatened or upset by what has been said by others or frustrated by arriving at no satisfactory channel of solution

From the protocol in general, it would seem that client B's experience was a fairly positive and receptive one. There is a sensitivity to the experience of others, as shown in items 3 and 6. Her responses to the therapist and her descriptions of the high moments in therapy reveal a receptive involvement. However, item 12 indicates a marked insecurity in any active role in the group. Her experience, as expressed in this sentence completion form, seems to be a rather emotionally constricted one, but what is experienced is essentially a sensitive, receptive relating.

Client C was a 49 year old Negro spinster, whom the therapist describes as deriving a great amount of strength and comfort from religion. She is active in her local community and in a national religious woman's

organization. By profession, she is an educator. The client's mother is an ideal woman in her eyes, who could do, and did, no wrong. The client found considerable satisfaction in the fact that she always followed her mother's advice and "this advice invariably turned out right". This was particularly true in relation to client C's interest in men; three proposals of marriage were refused because of mother. "As things turned out, one man became blind, one was mean and nasty, the other died within five years of the rejected proposal." In the group, client C became a kind of mother-substitute for the others, all of whom experienced difficulties with their own mothers. This client was very friendly and quite active and consistently defended the other members' mothers, using her own experience as a moralizing force: Mother knows best.

The protocol of her sentence completion form is given below:

1. Therapy is . . .
   a. very interesting to help you find yourself
   b. a good way of solving personal problems
   c. very interesting and helpful in solving personal problems
2. The other members of my group . . .
   a. are very cooperative and jovial
   b. are very cooperative
   c. are very entertaining and happy
3. The therapist . . .
   a. has a very pleasing personality
   b. tries to help each one to solve their problems
   c. is so considerate in trying to help us
4. When I speak in the group, I . . .
   a. feel very much at ease
   b. at ease
   c. feel as if we are of one family
5. When I am silent in the group, I . . .
   a. am thinking of the problems of the group
   b. am thinking of some problems
   c. am trying to think and listen to others
6. The most significant moments in therapy seem to me to be . . .
   a. when one is relating their experiences
   b. when I feel that I can help someone
   c. when we all meet and have a very happy medium
7. At those significant moments, I . . .
   a. try to help them solve their problems
   b. try to express myself
   c. have a feeling everyone has been benefitted

8. I feel that what is most important about therapy to me is . . .
   a. the inward feeling of expression and sharing your experiences with them
   b. the freedom of expressing your problem
   c. group conferences and when problems are related and discussed
9. Away from therapy, I . . .
   a. often think of the group and their problems
   b. often think of the group
   c. am constantly reminded of the group
10. Before coming to the group, I . . .
    a. am very anxious to meet the group
    b. felt the need of therapy
    c. was wondering what it was all about
11. After leaving therapy, I . . .
    a. feel much better, when I think I have made a contribution
    b. have a very good sense of feeling
    c. feel that I have been helped by the contact
12. It hurts in the group when . . .
    a. when I am ill
    b. we leave a problem unsolved
    c. one looks sad

Client C's experience of the group seems to be one which is emotionally distant from the people involved. She describes them as objects and even as "entertaining and happy" (item 2), which would hardly indicate an emphatic understanding. The group meetings seem to be a social and inspirational gathering for her. Apparently, client C has an adjustive approach which denies depth of emotion and minimizes unhappiness. She is hurt by evidence of sadness (item 12); she wants to make everything "happy" and "for the best"; she feels everyone has been benefited (item 7) "when we all meet and have a happy medium" (item 6). In short, there would seem to be an extreme lack of interpersonal, emotional involvement.

The one about whom the therapist felt least hopeful was client D, a 23 year old college instructor. This client has been indulging in phantasies since the age of three or four and has found it "a comfortable mechanism to escape reality." She says in the group that she "detests" having close friends. When she feels friendship "closing in" on her, she breaks off. "I want to be alone, I want to be *entirely* alone, I want to be in my comfortable world of phantasies." Client D makes certain she leads a highly routinized, ordered life, marked by many obsessive-compulsive patterns. Noises, smells, certain parts of the anatomy, crossing thresholds of doors, all disturb her and arouses tremendous fears. The client is extremely articu-

late and makes effective use of gestures and facial expressions to dramatize her feelings. She would take the lead, turning to ask individuals their opinions, channelizing the discussion, originating topics, and asking theoretical psychological questions. In the first two and a half hours, the other members of the group were beginning to get restive with the client's unrelatedness to their own purposes in therapy, for she was far out-of-field. It *was only in the third session, halfway through, when client F flatly brought* up her "problem" that client D subsided. In the next one and a half sessions, she contributed nothing; but from the middle of the fifth throughout the sixth hour, she talked continually. "Don't any of you daydream?" she inquired with a charming, appreciative smile; and proceeded with a lengthy recitative of her phantasies, phobias, asocial and destructive behavior, and told it with the inspiration of a gifted story-teller who also enjoys the tale. The group was somewhat embarrassed by the intimacy and frankness of the revelations; when the client artfully suggested that she was, perhaps, boring them, they quickly protested. She asked to be excused from the next meeting; in the remaining eight meetings she participated only peripherally, perhaps feeling she had been carried away more than she intended or should have let herself. In an hour of individual counseling with client D, the therapist suggested that perhaps she might want to withdraw from the group in favor of private, more intensive help. She quickly refused the offer saying that this was the first time she had ever had such a "sustained friendship" and that it was invaluable to her. The therapist feels that while client D never approximated a friendship basis with any member of the group, it was the closest she could come to it. He believes that little apparent benefit accrued to the client from her participation in group psychotherapy, except perhaps a significant suspicion that people can be friends and that there might be some value in friendship.

Client D's protocol follows.

1. Therapy is . . .
   a. particularly helpful in talking myself out of tension
   b. helpful in building healthy interpersonal relations for me
   c. helpful in shifting some of my views about personality
2. The other members of my group . . .
   a. are very friendly and seem eager to help each other
   b. have helped clarify a few of my views
   c. have increased in their temporary importance to me
3. The therapist . . .
   a. is an expert in radiating a friendly-democratic attitude
   b. has begun to take a more active role in helping us explain our situations

   c. has provided the easiest and most receptive introduction to our statements

4. When I speak in the group, I . . .
   a. often deliver unstructured comments, which I later wish I had organized better
   b. feel that I am not always clear or always honest with the facts
   c. feel that I may not have given full sense to complicated situations

5. When I am silent in the group, I . . .
   a. try to consider implications of speaker
   b. try to consider the current problem and alternate solutions
   c. Think about the statements made by other members previously

6. The most significant moments in therapy seem to me to be . . .
   a. those high points of inspiration when group members agree or disagree sharply
   b. the points at which members help each other to understand a major block
   c. when we have shared a common experience

7. At these significant moments, I . . .
   a. feel greater unity with them
   b. forget my personal confusion or questioning
   c. believe myself united with them more than casually

8. I feel that what is most important about therapy to me is . . .
   a. that the members are able to reveal personal difficulties without strain and with sympathy
   b. the sensation of freedom and confidence in other's acceptance
   c. the knowledge of technique and the receptive atmosphere which I wish to cultivate

9. Away from therapy, I . . .
   a. seldom think of specific statements made but general remembrance seems to give me security
   b. have recently failed to remember or be concerned with statements and theories of other members
   c. have attempted to activate some of the principles successfully

10. Before coming to therapy, I . . .
   a. probably write out some of the statements which I now make orally
   b. made charts and wrote out my own problems
   c. am sure that I could not communicate as freely

11. After leaving therapy, I . . .
   a. have a sensation of release and acceptance by those present

b. hope to apply the principles to other counseling
c. will remember the varieties of testimony and problems

12. It hurts in the group when . . .
    a. statements are made with which I feel keen differences or which I think inspire nonconstructive pity
    b. we reach points which alienate 2 or 3 members and block their understanding
    c. a small group resented or felt bored before the speech of one member

This is a client who shows in her sentence completions an initial strong lack of involvement but who seems to have experienced some progress in that direction, which she is hesitant—or afraid—to acknowledge. This is seen in item 2, where the client initially expresses feelings of being outside the group to some tentative admission of the other members' importance to her; and in item 7, where she expresses some kind togetherness implying a previous need to be "casual". She seems to experience a need to protect herself by an orderly preparation of her participation (item 10). In item 6, the client shows an involvement which does not seem experientially deep when compared to the other protocols, but does give a feeling of movement for a person who seems in her initial responses to feel a detachment from the group.

It was not until the week before the group terminated its meetings that the therapist reported in his notes client E as taking a personally active role. Her behavior before then was marked largely by non-verbal, insouciant participation; but at the same time there was much evidence that she was listening and listening very carefully. When the group members touched on an area in which there was a related interest, the client warily and briefly contributed. In the last week, she aroused herself and complained, "I feel cheated. Everyone else seems to be helped and I haven't." Subsequently, although she had great difficulty verbalizing her area of concern, this 23 year old girl focused her problems on her overdependency upon her mother, her persistent indecisiveness, her complete lack of interest in anything including vocational objectives, and her feelings of incompetency and inadequacy for marriage and raising children. The client requested, and was given, two individual counseling sessions. In these two hours, she revealed her problems further, but with considerable effort. It would seem that the group experience, if it had been of longer duration, would eventually have facilitated such expression; as it was, it precipitated her, realizing that the terminal period was rapidly approaching, to express herself more intensely with the therapist. Finally, the client made three tentative de-

cisions which affected the three areas of primary concern; and she seemed much relieved that she was able to make these decisions herself. Her protocol follows.

1. Therapy is . . .
   a. a discussion of problems but very little solution is reached
   b. beginning to mean more to me
   c. most relieving and allows for a great deal of expression
2. The other members of my group . . .
   a. are fascinating
   b. seems to be of a sympathetic nature
   c. pretty nice people
3. The therapist . . .
   a. is a jovial guy
   b. is very understanding
   c. has been most understanding and constructive
4. When I speak in the group, I . . .
   a. am beginning to feel now at ease
   b. am nervous when talking about myself
   c. try to express my innermost thoughts
5. When I am silent in the group, I . . .
   a. sometimes think of other things
   b. listen to others
   c. listen with varying degree of interest
6. The most significant moments in therapy seem to me to be . . .
   a. when we discuss our innermost thoughts and feelings
   b. when I am able to discuss my own problems
   c. telling of some emotional conflict in my life
7. At these significant moments, I . . .
   a. most interested in the discussion
   b. feel something is being achieved for me
   c. become very tense
8. I feel that what is most important about therapy to me is . . .
   a. the feeling I get of sharing my trouble with others
   b. the capacity with discussing problems with those that have similar problems
   c. my ability to delve into areas of my childhood which had been depressed
9. Away from therapy, I . . .
   a. forget about it until I come again
   b. discuss and think about it
   c. usually talk and think about the problems presented
10. Before coming to therapy, I . . .
    a. usually think of something I want to discuss
    b. have no feeling
    c. anticipate the meeting

11. After leaving therapy, I . . .
    a. usually think about what was said
    b. was very much surprised at my reactions
    c. think about what the group said
12. It hurts in the group when . . .
    a. it never hurts in the group
    b. ibid
    c. ibid

There is definite development in client E's expression of herself in relation to the other members of the group. From an initial, shallow involvement, as shown in her first responses, she experiences herself as being much more able to express herself in relationship to the others and, thus, gain some real emotional exploration (items 1, 4, 6, and 8). Item 7 shows the emotionality of this involvement. However, she may well have some fear of hurt, as evidenced in her constant denial of any experience of pain (item 12). We might assume that the difference in this client's responses between the first two administrations and the last of the sentence completion represent a real change in her experience in group therapy.

The sixth member of the group, client F is described by the therapist as a 34 year old, unmarried college administrative employee. For the first several sessions, she brought a notebook to the group in which she had marked down her "troublesome" thoughts. She traced through her childhood, adolescence and adulthood, showing the dominating influence of her mother. The latter was portrayed as a rigid, overly-critical, strict martinet, who made the client feel self-conscious in everything she did. Client F's heterosexual relations reveal a deep immaturity. She has had but few "dates" in her life. She has been in love with several men, both simultaneously and separately, none of whom she has ever met. She has observed these men, thought they were the kind of men she would like to marry, but has never felt well enough about herself to approach, meet, or carry on social intercourse with them. Client F was extremely purposeful in attending therapy. Inevitably, she would cut the "small talk" at the beginning of the hour and say, "I have an immediate problem", forthwith beginning to discuss it. When, towards the end of the summer, one of the other members asked her how she felt about therapy, she stated that it was very much like going to a doctor; it was painful, but it was something that had to be done if you wanted help. Client F's behavior toward the other members of the group showed relatedness to them as a whole but not as individuals. This participation in group therapy was, seemingly, the first time she ever really exposed herself and let her feelings come to the fore; but she never

related at all closely with the people in the group, her participation always being within the framework of her singular purposiveness—to get help for herself. This she exploited and frequently at the expense of the substantive preceding discussion. The client seemed satisfied. The therapist, on the other hand, wonders if what she experienced in the group was not more akin to confession than to therapy; that the catharsis and satisfaction derived from this confessional would soon be dissipated and her anxieties and feelings of inadequacy would crop up again, but perhaps in a more menacing manner. Below are the three administrations of the incomplete sentences form for this client.

1. Therapy is . . .
   a. a form of healing for mental illness
   b. healing
   c. useful in helping one express attitudes and feelings
2. The other members of my group . . .
   a. are sympathetic
   b. are friendly
   c. are delightful people
3. The therapist . . .
   a. is skillful
   b. is understanding
   c. is helpful
4. When I speak in the group, I . . .
   a. feel the sympathy of others
   b. feel helped or relieved of tension
   c. feel their interest and desire to be of help
5. When I am silent in the group, I . . .
   a. am comparing experiences
   b. am unable to express my feelings
   c. am sometimes thinking about some of my difficulties
6. The most significant moments in therapy seem to me to be . . .
   a. 'the ones where the most emotion is felt
   b. those when I can tell about some emotional difficulty or hear another person tell about one which seems similar to mine
   c. the tense or emotional periods
7. At these significant moments, I . . .
   a. feel emotion
   b. am most alert and tense
   c. feel tense
8. I feel that what is most important about therapy to me is . . .
   a. that it helps me to be less angry and impatient with myself
   b. the pressure to discuss or think about my problems
   c. that I have verbalized difficult emotional attitudes

9. Away from therapy, I . . .
   a. recall what was said in the last meeting
   b. sometimes try to think about problems and sometimes try to forget them
   c. often *feel that I am unburdened by it*
10. Before coming to therapy, I . . .
   a. plan what emotional experiences I want to reduce tension concerning
   b. sometimes prepare for the meeting if there is some feeling I have formulated
   c. have not made any special preparation lately
11. After leaving therapy, I . . .
   a. am sometimes weak from the difficulty of discussing experiences which are embarrassing to me
   b. *recall the remarks made*
   c. recall things that were said
12. It hurts in the group when . . .
   a. I try to tell something which I feel that no one else has experienced and so can't understand my feelings
   b. I am not able to formulate my feelings
   c. my emotional repressions are expressed either by myself or someone else in the group

Client F, apparently from the beginning, felt the group as an emotional experience. This is markedly evident in the responses to the last seven items; and, yet, throughout these expressions of emotional meaning, one gets the feeling for a preoccupation with self, amounting to an exclusion of any responsive perception of the other members. This egocentric involvement is deep and constant throughout, and feelings of greater security in the group develop (item 10). It seems fair to sketch this person as someone who is frightened in the midst of these people (item 12) who seem to be sympathetic and wanting to help (items 2, 3, and 4); but she is so frightened that she is unable to give in any emotional way to them, unable to actually see them in any understanding way which would involve her with them.

Conclusions

What struck the writers in their attempts to interrelate their independent approaches to these six people was a compelling relationship between the nature of emotional involvement the clients experienced and the external perspective on their participation and derived benefit. Those who the therapist felt had benefited from group psychotherapy were those whose expressions of feelings about the experience showed a personal relationship, or interrelationships, with this group of people—that kind of relating or involvement which means a feeling for them as people and is

the necessary condition for an essential give and take. In the experiencing of those with whom the therapist independently did not feel safe in estimating any benefit, this element seems to be strikingly lacking.

One interesting illustration is client D, who for the first time in her life was involved in a group at all. From the perspective on her behavior provided by the therapist, she is seen to have gained something little, but significant to her: in the sentence completion forms, one sees a small but significant movement, or process, expressed in her perception of the group. It is interesting to note that in therapy, she completely rejected the idea that any one might be important to her; and yet as we view her experiencing of group psychotherapy, she came to admit, tentatively, the importance these people had to her.

Client C was clearly involved with the other members of the group. She was very active in her participation; and yet the therapist feels that she got the least out of the group. As one looks at her experiencing of the group as expressed in the sentence completions, it is seen that her involvement, although undoubtedly emotionally determined, is not interpersonally an emotional one. Rather, it shows a lack of emotional openness to the feelings of the other people, apparently a distance which she remained unable to diminish.

Client E is someone who is judged to have benefited from the group. She went through two phases during the time that the incomplete sentences test was being administered; and the difference in her participation is interestingly reflected in her experiencing of the group. It was only in the last few sessions, when she felt the group had little time left, that she became active in expressing herself; and it is during this time, in the last administration of the form, that she expresses a real emotional involvement with this group of people.

Three is a definite emotional involvement manifest in client F's feelings about group therapy; but it is, apparently, an involvement with a non-personal perception of the group. She seems to experience group psychotherapy as very frightening and with little emotional receptivity to the other members. When we turn to the therapist's description, we see her as participating in a kind of autistic manner, contributing very little to the others. One might say from these two perspectives that she came to therapy as one would to a medicine bottle; she took her dose but was too frightened to look at what was in the bottle. It is in this person whose emotional involvement with the group is real but does not fit the pattern of our personal, give-and-take hypothesis, that we find the therapist not

only not encouraged by her intense emotional participation but highly wary and concerned as to the benefit she derived.

Quite different is client B's experience which is definitely receptive to the feelings of the other members. This is paralleled by the therapist's feeling of the sincerity of her attempts to understand them and participate with them. On the other hand, her feelings about the experience show considerable constriction; matched by the therapist's description of her participation as hesitant, cautious, and limited.

The person whose experiencing seems to have grown into the most mature emotional involvement with the other members is client A; and she is the person whom the therapist judges to have benefited most from group psychotherapy. On the other hand, he describes her participation as the most sensitive, understanding, and constructive. Going back to the perspective afforded by the sentence completions, one sees her experiencing of the group growing from a friendly association to a deep, empathic interrelationship of real importance to her.

Such an investigation as this can hardly do more than suggest the relationship sketched above. More explicit definition of its nature looms as a large and complex field for further study; but it seems highly provocative and very important to our interest in understanding the process of psychotherapy. Immediately, it certainly appears significant in any consideration of the operational goals of the group psychotherapist.

Summary

An Incomplete Sentence Form was devised in an attempt to tap the emotional meaning which the process of group psychotherapy has for its participants—what the client experiences. The test was administered three times to one group over a period of five successive weeks, and the interpretation of what the group meant to the clients was related to the therapist's description of the clients and their progress.

PSYCHODRAMA WITH A CHILD'S SOCIAL ATOM*

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This paper discusses psychodrama in which the patients', in particular the child's, family members participate in the therapy. Our experience has included a wide variety of disturbances: bed-wetting, tics, aggressive destructive behavior, withdrawn autistic children, failures in school and the socially maladjusted child.

The child's social atom includes all who people his life situation, either in acceptance, rejection or neutrality. The primary relationships extend to members of the family with whom the child generally lives: this means mother, father and siblings, in some cases, it may be grandparents or other members of the family. The secondary group in the child's social atom is composed of the teacher, barber, school friend and neighbors. The size of the social atom of any particular person is difficult to assess, unless you study his whole community existence. The immediate family provides a network reaching out into every part of this secondary group, and the family provides resource people who can realistically portray the roles which will reveal the conflicts and disturbances that confront the child both within and without the home. The mother is generally in touch with the teacher, the sibling knows his friends and school mates, the father has other opportunities to become familiar with the child's experiences.

One of the problems in doing group psychotherapy with children, in private practice, is the difficulty in forming a group which will afford the child with a maximum of satisfaction in positive relationships. Psychodrama with the family group might well provide the solution to this type of problem in working with the disturbed child.

This approach, in which the interpersonal relationships may be observed provides the therapist the opportunity to diagnose the problem and facilitate its solution. This form of psychodrama in which the problems of the family are dramatized and shared focuses the learning process on reality situations and suggests actual solutions to different problems.

We may endeavor to recreate experience in this context, the child playing his own role and members of the family portraying either themselves or others concerned with the particular experience. The same scene may be

* Presented at the Eleventh Annual meeting of the American Society of Group Psychotherapy and Psychodrama, Los Angeles, California, May, 1953.

repeated to provide a release of hostility. The child, or the member of the family most particularly concerned may play the role in a presently desired manner; this is role-training. The child may take the role of his mother so as to provide both the experience of the other person's anxiety and a mirror of his own conduct. Because this is a shared experience and because it is a common problem blocks may be removed and spontaneity increased in the family group.

The initial sessions are diagnostic: to observe the choices and rejections within the group and, in general, the interaction of the family members. As his father, mother and siblings play out reality or fantasy situations, the scenes show how he manages sibling rivalry, his feelings toward the group, how he reacts to punishment, praise and criticism. When it appears the spontaneity of the child is increased as a particular member is inactive, a more satisfying family group can be provided at the following session by excluding that member of the family. As the child works through various roles, the reintroduction of that member of the family may be tried both to test and strengthen the child's role development. It is not the size of the group, but its composition which influences the child's reaction. Effort is made to select those members of the family that threaten the least and afford him the greatest opportunity to manifest his aggressions. As he progresses and grows, more roles are added to behavior, the challenging family group is similarly strengthened and so the process continues until adjustment with the total family group is confronted. It should be recalled that the experiences acted out are not only those touching the family relationship, but include the outside members of the child's world as well.

Very often, especially with autistic children, the family is the only group which will accept the bizarre and often disruptive behavior which they display. The withdrawn child will eventually warm up if the family act out scenes of everyday living or more pertinent material in front of him. The director can in those cases become one with the child and enter in as they sit together watching the family act out what has happened the day before. The double ego technique.

The director's goal is not interpretation or explanation of the dynamics of interaction, but rather to allow the action to supply it. When too much anxiety is exhibited by the disturbed child the psychodrama can be directed by the child. The group then acts out his dreams, daydreams or experiences, as he relates it.

Our experience indicates that while relationships with the secondary group in the child's social atom frequently come into play, the focus of conflict and disturbed behavior is to be found in family maladjustment. We

have on occasion introduced a member of the outside group into the psychodrama—such procedure is ordinarily unnecessary. Exception should be noted during later adolescence when family relationships weaken in favor of stronger outside ties.

> This is a case history of psychodrama in private practice.
> Stan, a nine-year-old boy, was quiet, withdrawn and friendless. He was a failure in studies and social adaptation. Psychodrama with a group of children around his own age produced no progress in social adjustment or school studies. The group did not provide him with the kind of support he needed, it would seem. His mother attended a separate therapy group. We then turned to family psychodrama. His mother and younger brother of six participated with Stan in the first session. The mother was openly hostile to Stan and her preference for the younger son was apparent. In this family group, Stan came to life. He gave his brother a physical going over; he spoke out in violent disagreement with his mother; he denied he had been staying up until midnight, or that he had neglected his work to watch television. The mirror technique was used: mother played Stan, the brother played himself. The director took the role of the mother. Stan watched. Stan's resistance lowered slowly. There was an element of fun in seeing his mother act as a nine-year-old boy. The mother was afforded an opportunity of releasing hostility at Stan and at the same time witnessing her destructive preference for the younger boy as realistically enacted by the director. One of the factors of sibling rivalry is thus felt rather than explained. During the discussion which followed, Stan continued to sheepishly refuse to see the role as played by his mother as reflecting his behavior. Yet, there was some loosening of his defenses and he was ready to participate in the psychodrama session, in something less threatening, that is, fulfilling future ambitions. He chose the tycoon of industry role. The mother, brother and director became auxiliary egos and supported his demanding attitudes. The mother, who was completely discouraged with having a son who wouldn't learn to read or study, was surprised at his show of ambition and the skill with which he could negotiate the role. This psychodrama gave the mother an encouraging insight into the future and permitted her to re-evaluate the present situation. After three sessions, there was marked improvement in his willingness to be tutored, a changed attitude toward the mother and brother. The mother's attitude was warmer and more friendly. Her nagging and over-protective attitude toward the children diminished and she showed good humor.

This is only one illustrative example from the multitude available.

Summary

The family psychodrama affords an opportunity for recreating life situations. It can give the child and family a chance to go back and do them over again as they would prefer to have done them, or to experience entirely new approaches. It may train members of the family to be therapeutic agents to each other, not at the intellectual level, but in the action process.

THE RESOLUTION OF PROFESSIONAL CLOAKS THROUGH AN INTERAGENCY GROUP EXPERIENCE

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How can two agencies that operate in the broad field of mental health join hands effectively; how can they strengthen their independence and still be dependent on each other; how can the people involved grow closer to one another wherein mutual needs can be satisfied and new capacities found and developed; how can these agencies become a unit which has greater strengths and potentialities than either group would have independently; how can this larger unit be used to help a community resolve some of its emotional problems? The struggle to find some of these answers, as we have lived it during the past year, is what we are writing about.

The Presenting Problems—Family Service needed psychiatric consultation. The Mental Health Clinic needed to re-define its role in the community and wanted to broaden its usefulness.[1] The solution to these problems began in March 1951, when Family Service requested a psychiatric consultation on a disturbed child.

The Group Process—The psychiatrist met with the Family Service professional staff for the first time. The social worker presented the problem and gave the background data. After this she wanted to know if this case should be transferred to the clinic. This led into the problem of what kinds of cases each agency should handle. The psychiatrist did not resolve that issue but rather encouraged the group to express its feelings about the matter. In the give and take that ensued he made it clear that he thought they had potential capacities to handle effectively many of the emotional disorders that came to them and wondered what they might like to do about it. This was a difficult case but the group decided that it might be worthwhile to struggle with it to see what could be done. The psychiatrist thought the group could gain something out of this even if

[1] Leonard T. Maholick, M.D. *The Mental Health Clinic As A Therapist in the Community*. This article has been accepted by Mental Hygiene but as yet has not been published.

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the specific social worker was not successful in the therapeutic management of this particular case. The psychiatrist was more concerned about the development of the group's total effectiveness rather than with being successful on one specific case.

The group responded positively to this. The members stated that they wanted this kind of help. From that point on the meeting developed into a group session. The social worker gave an interview by interview description of what took place during the time she was with the child. The group used that as a stimulus for further discussion. The social worker's attitudes and feelings were brought into the discussion. This encouraged others and they brought up their own feelings, ideas and attitudes. Through the group experience the social worker was able to get help in handling this particular problem very well.

After several meetings like this the psychiatrist and the executive director of Family Service discussed the possibility of having joint staff meetings. Both liked the idea as did their respective staffs so definite times were set up for the meetings. The group decided to meet once a week for an hour, one week at Family Service and the next week at the clinic. At this point the group consisted of the psychiatrist, psychologist, and psychiatric social worker of the clinic, and the executive director and three social workers of the Family Service. This group was inter-racial.

Nothing specific was on the agenda except when one of the members of Family Service presented a case in treatment. The clinic staff tried to keep the sessions on an emotional level and made constant efforts to get everybody involved emotionally. In this way real growth and learning took place. This was an experience in group living and as a result of going through a process like this the group began to resolve some of its personal differences. It was also possible for the individuals of the group to get help for themselves to some degree depending upon the limits set by the individual and by the group.

The burden of the work to be done was placed on the group as a whole. The clinic made no attempts to take over any Family Service functions. The clinic's aims were to help the group gain strengths so that the individuals could become more effective in coping with their problems as they arose in their respective areas. The clinic did not attempt to give specific advice nor to make decisions.

Techniques in working with people, psychotherapy, and psychopathology were discussed at various times. Occasionally requests were made for some diagnostic help through the clinic's psychological services. This

pattern was adhered to rather rigidly for about four months. Then the group became dissatisfied with what was taking place. Sibling rivalry appeared in some who felt that too much time was being given one particular person or case. Hostility was present but seldom expressed. Long hostile silences crept into the meetings. There was even some question about whether the group should continue. After this was brought into the open a new phase seemed to begin in which various members of the group expressed their inadequacy as therapists and wished to refer to the clinic all of their difficult therapeutic problems.

At this point the clinic staff became very aggressive and stated emphatically that it would not take over all of the cases, that Family Service could handle these therapeutic problems themselves, by and large, and that furthermore they did have the capacities to do that work. It was pointed out, rather bluntly, that until all members of the group could get to know one another as persons and express themselves the group couldn't make much more progress. *Only by getting into the sessions as individuals could* they break through this impasse and develop their capacities so that they could utilize more of themselves effectively in working with their clients on any level. Only as the group members could look into themselves and uncover some of their own emotional blocks could they expect to do better work. This was a very crucial point but the group had the strength to work through this and move on. The group realized it had been intellectualizing a great deal and was evading deeper feelings. Finally the members admitted they had been fencing for position and were afraid that in exposing their own inadequacies they would be hurt. When this was expressed the group seemed to solidify and movement took place again. At that time case presentations dropped out of the picture almost entirely and the group sessions became group therapy for everyone. The group members began to work on their own thoughts, feelings, attitudes, and behavior in an effort to get to know one another more intimately and to help each develop his capacities and abilities. One member of the group was having some personal difficulties which could not be handled in the group setting at that time so she asked for and received individual therapy.

Shortly after this the group tackled the problem of inviting guests to the meetings and came to the conclusion that newcomers could join only if they wanted to come into the group, stay in, and become a real part of it. This struggle revolved around the acceptance of a minister who was very interested in pastoral counselling and who wanted some help in this area. He had been attending meetings sporadically and the group resented this.

Finally he was forced to make a decision to stay or leave. He chose to stay and after that he attended regularly and became a real member of the group.

By this time the group had been meeting regularly for about six months and movement again slowed down. The difficulty centered around two members of the clinic staff who were concerned about their role in the group and felt they were not wanted. This was discussed openly. One member of the Family Service group did question the role of the psychologist and psychiatric social worker in the group. She did not feel they were making a contribution and thought that they were just staying out on the periphery of the group. Once again hostilities were discharged and and as a result the members were able to move one more step closer to each other.

Following this the group found itself again and the individuals were much freer in expressing themselves. Ideas were exchanged easily. Individual members of the group actively tried to help others in the group when they were in trouble. It became easier to talk about therapy, pathology, dynamics, and therapeutic cases. Members of the group became freer in asking for help and as soon as this was expressed the entire group responded immediately and worked together. It was amazing to see how capacities began to emerge and develop. More difficult cases were tackled with less anxiety.

It should be understood clearly that this group experience has not been completed. The need for this is a continuing one and the values are just beginning to be realized.

Dynamics—At the outset definite needs were expressed. Motivation to satisfy these needs was good. The clinic was able to define its role in such a way as to constitute no threat to the Family Service group. The clinic staff felt that the members of the agency had inherent capacities which could be developed to enable Family Service to do more in the area of psychotherapy and community mental hygiene. In order to do this, personal emotional blocks had to be removed. However, no attempts were made to push this because it would create too much anxiety and lead to group disintegration and a rejection of the entire group process.

The group's capacity to tolerate was not exceeded. The initial consultation was converted easily into a simple group discussion. As these discussions went on the members of the group became more comfortable with one another. The inability to express hostility was a major factor in inhibiting group movement. Gradually the group came to the point where it could look inwardly and realized that it had to do so if real

growth were to take place. If individual personal needs became too great for the group to handle, individual treatment was available. In this way group functioning was not impaired.

As the professional barriers among psychiatrist, psychiatric social worker, psychologist, social worker, and minister broke down, the individuals were able to relate better to one another in the group and were able to see each other in a new light which made it possible for more growth to take place. This resulted in the group's working together as a team and accomplishing much more than could have been possible working separately. The process is a slow and continuous one. The pace is set by the group itself and the amount of anxiety it can tolerate and work through.

The Role of the Leader—The functioning of the leader is a complex process in itself and will be dealt with in a separate paper. However, a few comments as they pertain to this experience would be appropriate. In order to dissolve the cultural cloaks which surround a group of professional people, the leader must first be able to do this with himself and share this with the group. He must be free enough to divest himself of his own God-like characteristics. This should take place spontaneously in response to the various members of the group. His responses must be affectively charged. He has to be able to "give" of himself in relation to others. The more he is able to become a person and "risk" himself the greater his chances will be to draw others into an emotional experience. In this way he can help the group members divest themselves of their cloaks and stimulate real growth.

To complicate matters the clinic staff acted as multiple leaders when the two staffs began to meet jointly. To work most effectively they had to define their own relationships and be able to "give and take" among themselves before movement could take place in the total group setting. This did not begin until the group had been meeting for six months indicating that the clinic staff had not become a real group in itself.

To confuse things even worse, Family Service was a group with its own leader. Thus initially, there were at least two groups, each having its leader, the director of each agency. As the group moved into therapy the clinic staff assumed the roles of multiple therapists. However, before the total group process can be completed every member should be able to take and receive help from each other as persons. The leader of the second group plays a vital role in making this possible. The threat of appearing inadequate, more so personally than professionally, can assume tremendous proportions. If this divesting process can't be completed it

will hinder group movement and produce group fragmentation. It can lead to a breakdown of communications and could eventually lead to a discontinuance of the sessions.

Results—The entire group*** did a self-evaluation of the project and the following is the essence of that discussion.

1. Individual development of the self was the most important result obtained for members of the group in their opinions. New insights were gained, new capacities were developed, and anxiety about doing therapy was reduced. In this connection in 1951 over the previous year Family Service noted an increase of 11% in the number of cases where the major problem presented by families was primarily emotional. Also during 1951 Family Service made no referrals for intensive psychotherapy to the Mental Health Clinic but rather used that source exclusively for psychiatric and psychological consultation. Family Service also reported improvement in the quality of its work which seems to be related to this group experience. In 1950 the service helped solve the problem in 71% of the total number of families helped. In 1951 this rose to 89%.

2. An increase in Family Service and Mental Health Clinic activities in the area of education for better family living developed. The group experience itself lessened the fear which so frequently prevents the therapists from working effectively with groups.

3. A better understanding and working relationship among psychiatrist, psychologist, psychiatric social worker, minister and social worker ensued. Cultural cloaks that surround individuals in these fields broke down through this group experience and enabled the members of the group to get to know one another on a personal basis; thus, a greater sharing of knowledge and experience took place which did not exist before. This experience was reflected particularly in contacts with other ministers. The minister also felt that real values were gained from this experience and has since set up a Seminar in mental hygiene for other ministers in the community. He reported that he is able to do a more effective job in his own pastoral counselling.

*** The group consisted of:

1. Mary Hankins, Social Worker
2. Claudine Hill, Social Worker
3. Gertrude Green, Social Worker
4. Rev. Jack Anderson, Minister
5. F. P. Baker, Executive Director of Family Service
6. Blanche Robertson, Psychiatric Social Worker
7. Marion Smith, Psychologist
8. L. T. Maholick, Psychiatrist

4. A closer identification of Family Service with the field of mental health in the eyes of the staff as well as in the eyes of the public resulted. No longer are there two groups struggling independently with the enormous problems of better family living and better mental health; but rather, there is now one group with more common understanding doing somewhat similar work. The particular job of each agency became clear through the group process without much conflict at a policy level. The joint activities of the Family Service and Mental Health Clinic demonstrated that our work was related and helped the laymen to see the connection between better family living and better mental health. This closer identification has strengthened both the Family Service and the Mental Health Clinic.

THE ROUND-TABLE TECHNIQUE IN GROUP PSYCHOTHERAPY*

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Missouri is noted for that hybrid product, that cross between a male ass and a mare, known around the world as the Missouri Mule. This remarkable creature, the Missouri Mule, is capable of doing worthwhile work, but, like some two-legged natives of the same state, it is characterized by defiant stubbornness and loud braying, neither of which characteristics contributes anything constructive toward the advancement of truth and knowledge. Furthermore, it is sterile.

Mention is made of the Missouri Mule because from Missouri there now comes another hybrid product, a cross between individual psychotherapy and group psychotherapy, known around State Hospital No. 2, at St. Joseph, as the Round-Table technique in group psychotherapy. This hybrid technique has demonstrated clinically that it has worthwhile possibilities. We are determined, however, that it shall not develop the characteristics of defiant stubbornness and loud braying. Furthermore, we are hopeful it will not prove to be sterile.

The technique which we call Round-Table psychotherapy has not yet crystallized into a set procedure of precise routines, nor do we want it to approximate that kind of maturity. Precise routines are dangerous because they are highly susceptible to that degenerative disease characterized by subtle metamorphosis into blind religious rituals, and full maturity in that sense always presages the onset of senile dementia and death. The technique has no existence as a technique per se. Instead, it exists as overt attempts to test empirically an hypothesis arising from a particular philosophy of life. It is an adventure in exploratory research which may lead to fertile fields or to barren wastelands, but no matter where it leads, we shall survey the area carefully and post our findings whether they be markers to encourage others to come our way or signs of warning to keep others out.

Round-Table psychotherapy is a point of view, a framework within which a variety of specific procedures may be tried. During the past year

* Paper presented at the Second Institute of the Midwest Section of the American Society of Group Psychotherapy and Psychodrama, Chicago, June 7, 1952.

our procedure has varied from that reported by McCann and Almada (1) in the article "Round-Table psychotherapy: A technique in group psychotherapy," which appeared in the December, 1950, issue of the *Journal of Consulting Psychology.* But the basic philosophy and the principles involved remain the same as when they were expounded for mankind some 2000 years ago. The hypothesis being tested also remains unchanged.

According to McCann's Hypothesis no mental condition, normal or abnormal, is a problem. On the contrary, all mental conditions are answers. They are the individual's answers to the problems occurring in his life. Answers that contribute to the individual's efficiency, happiness, and peace of mind are normal, or right, answers. Those that detract from any or all of these qualities are abnormal, or wrong, answers.

One advantage of this point of view is that it makes us sensitive to the complexities involved in determining the cause of any mental condition. The difficulty can be illustrated by simple arithmetic. Given the problem $2 \times 50 = ?$, anyone with an elementary knowledge of arithmetic can find the right answer. But suppose the answer, 100, is given and the requirement is to find the problem! That is the situation confronting the psychologist when he attempts to find the cause of a normal mental condition. For the psychotherapist attempting to find the cause of an abnormal mental condition the difficulty is much greater because he must work back from a wrong answer. For example, the wrong answer to a problem is 200, what is the problem?

It is the trickiness of this situation that leads the experts astray in their search for the causes of mental illness. That is why they list as causes a variety of problems for which the abnormal answer appears to be the right, or normal, answer. That is why no matter what experiences are listed as causes, there always are people who have had those or similar experiences and yet remained normal. Science News Letter for May 24, 1952, reports that Dr. Jean Walker Macfarlane, professor of psychology at the University of California, in commenting on her recently completed 24-year study of 250 families and their children said that the most rewarding part of the study was the evidence of the toughness and adaptability of the human organism. The report quotes Dr. Macfarlane as saying that many of the subjects "with many cards stacked against them who should have become delinquent or psychotic not only did not, but rather turned into substantial, mature and zestful adults."

Problems as they exist in reality do not of themselves determine the status of a person's mental health. On the contrary, the determining factor is the meaning, the significance, which the person reads into his problem.

To one person a particular problem assumes no important meaning or exaggerated significance, whereas to another person a similar or lesser problem assumes the proportions of a major catastrophe. The difference lies in the way in which the person orients himself psychologically toward his problems. In short, the individual's dominant attitude toward life determines whether he perceives his problems as they exist in reality, or whether his perception is so distorted by unrealistic meanings and significances that he misreads his problems.

Again simple arithmetic can be used to illustrate the principle involved. If 200 is the wrong answer to a certain problem, what is that problem? The patient arrives at an incorrect answer because to him the problem is $(5 \times 20) + (10 \times 10)$. Here the numbers represent incidents, the parentheses inclose situations, and the mathematical symbols indicate the evaluations contributed by the patient. Thus the first situation amounts to 100, the second amounts to 100, and the two combined amount to 200. Reason and logic cannot convince the patient he has arrived at the wrong answer because he used reason and logic in arriving at his solution. Certainly reason and logic are not the gods some people think they are!

To help the patient find the normal, or right, answer to his problem, therapy must accomplish two things. First, it must help the patient to develop a wholesome, realistic attitude toward life. This means that the patient must find himself, and the role that is his. Once such an attitude is acquired, the patient will experience a re-evaluation of the meanings and significances with which he endows his problem. He will then be able to perceive his problem not as $(5 \times 20) + (10 \times 10)$, but as $(5 + 20) - (10 + 10)$. Perhaps this is what some psychotherapists refer to as desensitization. When this change in attitude occurs, the remaining requirement of therapy is to induce the patient to face his problem. This is what we mean when we tell our patients they must face reality. The second thing therapy must accomplish is, therefore, as we see it, to require the patient to review his problem in the light of his changed attitude. This is what we believe the techniques of Round-Table psychotherapy are designed to accomplish.

The Round-Table psychotherapy technique described in this article is the technique used in our current investigation of the dynamic processes involved in this particular type of therapy. The investigation is a research project undertaken by our state hospital and the department of psychology of the University of Kansas City, Kansas City, Missouri. Professor William H. Cadman of the university faculty and the author, who is clinical psychologist at the hospital and clinical professor of psychology at the university, are co-directors. Mr. Donald V. Brown is our research assistant. The project

is financed by a grant from the Federal Security Agency of the U. S. Public Health Service.

Four wards in the Woodson Building were set aside for the research. Ward 1 for male patients and ward 2 for female patients were designated control wards; ward 3 for male patients and ward 4 for female patients were designated Round-Table therapy wards. The control wards were open to all types of treatment except Round-Table psychotherapy. Primarily, the therapy on these wards consisted of electroshock treatments and the standard state hospital practice of assigning patients to work at routine jobs, a practice which is euphemistically reported as "Occupational Therapy." On the Round-Table therapy wards no treatment was given other than a total of 50 Round-Table psychotherapy sessions. Recreational activity was provided for all the wards.

Inasmuch as the procedure was the same for the male and female groups, this description of the technique will be limited to the female group. These patients were selected without reference to diagnosis, except that seniles and those whose mental illness was considered secondary to a known organic pathology were excluded. The patients selected were paired as closely as possible for age, symptomatology, diagnosis, education, and length of time in the hospital. An index card was prepared for each patient. Mr. Brown then sorted these cards into pairs to represent the paired patients, and placed each pair of cards face down on a table. The author came into the room and selected one card from each pair. These cards, still face down, were placed in one pile and the remaining cards were placed in another pile. The author left the room while Mr. Brown moved the two stacks of cards to another table, after which the author returned and chose one of the stacks as the list of patients for the Round-Table therapy ward. The patients whose names were listed on the cards in the other stack were transferred to the control ward. Thereafter, when a patient was paroled from either ward, or became destructive to the extent of requiring transfer to a violent ward, the vacancy was filled by the next available patient from the receiving wards. Incidentally, only one male and one female, each from a Round-Table therapy ward, were transferred because of violence. This is not to say there were no violent patients on these wards. There were several who occasionally required restraint.

Not oftener than three times each week during the five month period from the middle of November, 1951, to the middle of April, 1952, all the patients on the Round-Table therapy ward were assembled for one hour in a room resembling a small broadcasting studio. The walls and ceiling of this room are draped for looks as well as for acoustics. At one end of the

room there is a large one-way mirror, and extending out from the mirror there is a semicircular table with chairs to accommodate six patients. Above the table hangs a microphone which leads to a tape recorder in the adjoining room behind the mirror. A loud speaker and an electric clock are located above the mirror, and on the table there are three small electric lights, one red, one amber, and one green. These lights are controlled by the therapist from his location in the room behind the mirror where he operates the recorder during the group sessions. The red light means silence, the amber one indicates a discussion period is about to begin or about to end, and the green one means the discussions are to proceed in full swing. The patients say the green light means they are "on the air", and it is here that an element of *psychodrama* is definitely present.

During the group sessions no one was allowed in the room with the patients. They were strictly on their own. Although they knew their discussions were being recorded, they did not know their actions could be observed through the mirror. During the first half of the hour the patients listened to the playback of the recording they made at the preceding session. During the remainder of the hour the six patients who sat at the table discussed one another's symptoms and problems, and attempted to help one another to find the right, or normal, answers. But the purpose of these discussions was not to use the patients as therapists for one another. The principle involved is that the patient who attempts to help others is thereby actually helping himself regardless of what influence, if any, he has on the condition of the other patients.

The six patients who sat at the table were called the Round-Table group, and the remaining patients were called the studio audience. At the first group meeting the patients decided among themselves who would occupy the six places at the table. Thereafter, the six elected to the table were given control over the table membership. By majority vote the Round-Table group could expell one of its members from the table, or recommend that one of its members be paroled from the hospital. An expelled member returned to the studio audience. A member recommended for parole was taken before the research staff within a few days for parole consideration. Before the research staff would consider any patient for parole, the patient had to be recommended for parole by the Round-Table group. Whenever patients would ask the doctor to let them go home they were told that they would be considered for parole as soon as, but not before, the Round-Table group recommended their release from the hospital. On the few occasions when the research staff had to deny a parole to a patient recommended for one by the

Round-Table group, the Round-Table group was advised as to the reasons for the denial.

When a vacancy occurred at the table the remaining table members elected a patient from the studio audience to fill it. The table members also had authority to expel from the room for that session any patient who was causing a disturbance. It was their responsibility to maintain order in the room. Obviously, these patients were given real rather than playlike responsibilities, and for them the drama was not psychodrama in the *technical sense* but the real drama of life itself.

Prior to each session the therapist had a ten-minute interview with each of the six table members. The purpose of these interviews was to encourage the patient to take an active interest in each of the other patients at the table. The patient was told that when it came his time to go before the research staff for parole consideration he would be asked about the other patients and their problems; that the advice he gave to the other patients would be used as evidence in determining the soundness of his judgment; and that his participation in the group meetings would be used as evidence in determining whether or not he was mentally ill. He was then given a friendly critique of what he did at the last group session, and an opportunity to plan what he would do at the next group session. As one patient remarked: "Even a crazy person will say there's nothing wrong with his mind, but this way he has to prove it!"

The techniques of Round-Table psychotherapy are founded upon two principles for wholesome living. The first principle may be stated as follows: He who would find himself must lose himself. By losing himself in the problems of other the patient interrupts the vicious circle of self-preoccupation which nourishes his morbid thought processes. We believe it is during these interruptions that he gets the flashes of insight which help him to gain a wholesome attitude toward life. Perhaps this is the same principle that enables one to recall a familiar name which at the moment is blocked from consciousness. Try as he will, he cannot recall the name. But once he turns his attention to other things, the name pops into his mind automatically.

The second principle may be stated in this way: He who would help himself must begin by helping others. When a patient attempts to help his fellow patients he shifts his dominant attitude from one that is subjective and hopeless to one that is objective and hopeful. When he tells his problems to the other patients in an attempt to show them he has suffered as much as they, he is in fact reviewing his problems in the light of his more wholesome attitude toward life. Thus he finds himself clarifying and solving his

own problems. He discovers that his major problem is not $(5 \times 20) + (10 \times 10)$, but $(5 + 20) - (10 + 10)$, and without further difficulty he himself finds the right, or normal, answer.

The data obtained during the research project recently concluded at our hospital are now in the process of being analyzed. The various instruments which we used in our attempt to measure the efficacy of the technique, such as the battery of tests given to all patients before and after the therapy period, are not being discussed at this time because it is the purpose of this article not to report the efficacy of the technique but to report the technique itself. We can say, however, that of the 22 female patients on the Round-Table therapy ward, five, or approximately 23 percent, showed a remission of symptoms. Four were paroled, and one was recommended for parole but her family has refused to take her from the hospital. Of the 22 female patients on the control ward, two, or approximately nine percent, showed a remission of symptoms and are now on parole from the hospital. Of the original 10 male patients on the Round-Table therapy ward, four, or 40 percent, showed a remission of symptoms and were released from the hospital. During the course of the winter seven additional male patients were transferred to this ward, and five, or approximately 70 percent, of these seven showed a remission of symptoms and were released from the hospital. Of the original 10 male patients on the control ward, one patient showed a remission of symptoms and was released. No additional patients were transferred to this ward.

A detailed report of the research project will be published as soon as possible. In the meantime, we refuse to draw any conclusions.

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GROUP PSYCHOTHERAPY IN A NAVAL PSYCHIATRIC SERVICE*

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Group psychotherapy has been one of many hopes of the military psychiatrist in his warfare against mental illness within the services. Unable often to predict the rate of patient admissions, the number of his associates or helpers, and the policies and demands of the armed forces as a whole, he must accustom himself to change, to frustration, and sometimes even to momentary failure. While there has been great progress in providing adequate care of many types in military settings, including, in recent years, somatic therapies, military psychiatrists have sometimes found there were not enough hours in the day to see their patients repeatedly in individual psychotherapy sessions. Hence the suggestion that they receive treatment in groups is frequently met with open arms. Two facts, however, have quickly emerged when group psychotherapy has been adopted: First, it is not necessarily more economical of time, although it may be in certain situations with limited goals. Second, it is not, in technique or results, simply individual psychotherapy writ large and spread thinly; it is something similar but different, often having unique values all its own.

Unfortunately, the benefits of group psychotherapy have not been extended in many cases to the rehabilitation of the physically disabled (and which of them is *just physically* disabled?). Neither has it made its fullest impact on the disciplinary, morale, and training sectors of the military, although aspects of it have been applied in certain instances to each area.

The aspect of military use of group psychotherapy techniques with which this author is familiar is limited to only two naval general hospitals. While the writer is familiar with the groups in session at the United States Naval Hospital in Philadelphia during the year 1951, the compass of this

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Delivered at the 11th Annual Conference of The American Society of Group Psychotherapy and Psychodrama, Los Angeles, California, May 5, 1953.

Editorial Note: A large number of articles are received which are reports of introduction or operation of group psychotherapy. We are able to publish those of more general interest.

paper will be narrowed to the series of groups which the author supervised during 1952 in the United States Naval Hospital, Oakland, California. Upon my arrival there, I found the group psychotherapy groundwork beautifully laid and an avid interest in group psychotherapy already present. In fact, a paper* was in press which covered the period prior to my arrival. Its conclusions, among others, were that patient selection criteria should include the following requirements:

"(1) Some ability or potentiality to verbalize with more or less rationality.
"(2) Freedom from severe psychopathic traits.
"(3) Freedom from extreme confusion or agitation.
"(4) Freedom from overt hallucinatory or delusional experiences."

While these conclusions were justified by the experience covered in that study, the groups we subsequently organized differed sufficiently in structure and purpose to justify violating all these criteria with more or less regularity. While our results were variable, they demonstrated that criteria of group membership need not be rigidly limited.

To demonstrate the variety of group constituency and techniques that were employed with variable degrees of success, I shall summarize the types of groups which met during 1952. There was already in existence on my arrival an insulin-coma group (Group I).** Two additional groups of this type were formed during the year (Group IA and VI).** Other categories of groups included three Officer Patient Groups, a Psychodrama group, a group of Negro schizophrenics, and four miscellaneous groups. Eleven groups convened for varying periods throughout the year. Five of the groups (I, IV, VI, VIII, and IX) were open-end in type. Most groups had more than one therapist at a time. Usually therapists were of different disciplines, e.g., psychiatry, psychology, social work. Most groups met once weekly,

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*Wolfe, Evan L. "Group Psychotherapy in a Naval Neuropsychiatric Center" U.S. Armed Forces Medical Journal, Aug., 1952.

**Roman numerals refer to individual groups which are designated and grouped as follows:

A. Insulin Coma Groups.
- Group I. Dr. N (Junior Naval Psychiatrist); Mr. X (Junior Civilian Psychologist); Miss S (Junior Civilian Social Worker).
- Group IA. Mr. X.
- Group VI. Dr. N and Miss S.

B. Officers' Ward Groups (included male and female officers and enlisted women).
- Group III. Dr. Q (Senior Civilian Psychologist); Miss W (Junior Civilian Social Worker).
- Group VII. Mr. E (Naval Psychologist—MSC); Miss W.
- Group IX. Dr. I (Senior Naval Psychiatrist); Miss W.

although some met twice weekly (III, VII, IX) or oftener (X). The duration of each meeting was usually one hour. Attendance at groups varied from two to fifteen members, the average approximately eight, at one time. Most groups ran for four to six weeks or less, except for the insulin-coma and insulin-sub-coma groups, the psychodrama group (IV), and one officer group (IX).

Therapeutic approaches varied from explanation, ventilation, and discussion, through education and activity, to analytic, interpretive, psychodramatic, and re-integrative therapy. In addition to variation *between* groups there was considerable flexibility in the activity of the groups between their inception and their termination. Variation occurred most markedly in the open-end groups with their changing populations.

Group I was the continuation of an insulin-coma group that had been begun by another therapist, Dr. U. The co-therapist, Mr. X, a clinical psychologist, continued, and Dr. N, the new medical officer for the insulin service, and Miss S, a psychiatric social worker, joined the team. The patients (usually nine or ten of them) met with their therapists in a pleasant room on their ward once weekly. The patients were at various stages in their courses of insulin-coma therapy (and in some cases combined insulin and electroconvulsive therapy). They were told that they could discuss anything regarding their problems, their treatment, or their future. They early expressed marked preoccupation with the duration, nature, and purpose of their insulin treatments, with many questions such as "How many more treatments will I have?", "What does insulin do to you?", etc. They evinced anxiety about the physical, mental, and social consequences of their disease and treatments. Fears of the service and authority, resentment of the doctors, and concern about "liberty," "Boards," "discharges," and Veterans Administration hospitalization were marked.

Techniques for dealing with reality questions and the infinite shadings from reality through emotional distortions to frank delusions were a subject of real concern to the therapists. The position of the Ward Medical Officer

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C. Psychodrama Group.
- Group IV. Dr. C (Naval Psychiatric Resident); Dr. F (Senior Civilian Psychologist); Miss D (Senior Civilian Social Worker).

D. Negro Schizophrenics.
- Group V. Mr. T (Senior Civilian Social Worker).

E. Miscellaneous Groups.
- Group II. Admission Orientation Group. Miss W.
- Group VIII. Insulin Sub-Coma. Dr. D (Naval Psychiatric Resident).
- Group X. "Two Psychotics." Dr. P (Naval Psychiatric Resident).
- Group XI. "Three Headaches." Dr. C.

as officer, physician, and legally responsible person led him to favor at times the giving of frank, factual replies, such as "You'll have thirty more treatments," "Insulin lowers the blood sugar and helps the brain to recover," etc. One of the non-medical therapists questioned this approach, and the other varied in her evaluations, tending with the physician to feel that the answer should vary with the questioner, the questioned, and the circumstances.

Despite their good therapeutic results with the patient population, as time went on the therapists' divergences in theory and techniques of therapy led to progressive friction in the conferences they held immediately after each group meeting. While this came up in individual and group supervisory sessions, it was solved only by the "apparently" spontaneous decision of the therapists to leave the group with *one* therapist, the other two therapists to form a new group among the next batch of arriving insulin patients. The patients in Group I were able to express their annoyance, consternation, and resentment of the Ward Medical Officer's "deserting" them for a new group even though overtly they accepted the explanation that "this way more people could be helped."

Group I was carried to termination by Mr. X. He later organized a similar group, IA, which ran for another six to eight weeks, when it too was terminated. Mr. X found that, while there was relief from the former tensions, the presence of multiple therapists was missed.

Group VI was the new group formed by Dr. N and Miss S after they withdrew from Group I. The co-therapists continued their custom of a post-meeting conference each week. Topics of discussion for Group VI were similar to those with Group I; the Ward Medical Officer tended to handle the "factual" questions "factually," while the social worker raised questions regarding the meaning or purpose of the question at the time of its being raised. At one time this group was faced with the expressed threat of a change in the Ward Medical Officer. The members were able to react to this openly, emotionally, and appropriately. This was seen as a sign of progress in these affectively impoverished or distorted schizophrenic men. On another occasion where the stimulus was a change in tone of the therapist's voice (defensive alarm), the patients froze into silence. Awareness of these nuances and their skillful handling led these therapists to continuing successful work with insulin patients.

All three therapists agreed that the group therapy sessions aided patients in accepting their somatic therapy, ventilating their service-connected resentments, and re-integrating their past and future. This is remarkable in the

face of the expected and encountered detrimental effect of post-shock amnesia. Nevertheless, there appeared to be fair carry-over of insight and persistence of group identification.

The Neuropsychiatric Service Officers Ward (SOQ) at USNHO contains provisions for the care of male and female officers and of enlisted women. Groups there tended always to have at least one or two women, and enlisted women were often included. While junior officers or enlisted personnel frequently felt intimidated because of their caste, occasionally a Wave of boatswain's-mate build and voice could out-argue a Marine colonel.

Techniques of working with the officer patients varied from educational-didactic and non-directive group discussion to group psychoanalytic approaches. In Group III, whose principal therapist was Dr. Q (a clinical psychologist who was also a former naval officer and professor of psychology), a motion picture, "Overdependency," was shown in the initial hour. Its topic and others were discussed in subsequent hours, with the therapist leading the group to conclusions, formulations, and summaries toward the end of each hour. Although he sought consciously and determinedly to avoid intellectualizing and didactic approaches, he had difficulty overcoming this penchant, which persisted during many of the twelve weekly sessions of this group. Four of the original nine patients dropped out, due to unexpected discharges or returns to duty (one of the perpetual handicaps to continuity in military therapy).

Topics discussed included anxieties around accepting responsibility, especially for the command and the lives of enlisted men; living the role of officer; dealing with the personality problems of aggressive enlisted men under their command; and using their authority.

In a more didactic vein (and I think as defenses of both therapist and patients) was the discussion of the "body-mind problem," hypnosis, faith healing, and psychosomatic medicine. These were interpreted at times as resistances. At times role-playing situations of applying for jobs were utilized in dealing with some of the fears around the patients' future acceptance as ex-NP patients. Therapists' remarks tended to be supportive and reassuring. There was some group interaction, and in two cases the group experience led to readiness to ask for and accept individual psychotherapy.

The chief leader, who had led two other officer groups in the preceding eighteen months, viewed this group as the most successful and rewarding. He acknowledged the benefit of support from his co-therapist (a social worker who worked with this and the two subsequent officer groups) and the weekly group therapy supervisory sessions.

Group VII, under Mr. E (another clinical psychologist, an MSC officer on active duty) and Miss W, contained seven officers and one enlisted woman who met for eight semi-weekly sessions. The second session was constituted by the showing of the Navy film, "Psychosomatic Medicine." During the life of the group, two members had to be moved from the officers' (open) ward to closed NP wards. One of these commenced insulin-coma therapy. Nevertheless they returned faithfully for the group sessions. Somatization was a prominent symptom, intellectualization the prevalent group defense. An attempt was made to record individual material and feed it back to the WMO, who met with the group therapists following each session.

Group IX also met twice weekly, under Dr. I, a senior officer who had considerable group psychotherapy experience and was a clinical associate in psychoanalysis, as well. The patients were confronted from the start with their resistances, transference reactions, and other psychodynamics and unconscious bases of their problems. Dynamic ideas and interpretations were advanced where appropriate. Everyone agreed, both in the group and in supervisory sessions, that the group "moved very fast." I was called upon to take the group during the absence of its principal therapist, and impressed first hand with its flexibility, group cohesion, and capacity for acceptance of an alternate therapist.

While several groups employed psychodramatic techniques in greater or lesser degrees, only one deserved the title "Psychodrama Group." Its leader, Dr. C, a physician who had been trained under experienced psychodrama therapists, had a good grasp of both the theory and the technique of this variety of group psychotherapy. He used a clinical psychologist, Dr. F, and a psychiatric social worker, Miss D, as stable auxiliary egos. The purpose of the group was the rehabilitation and preparation for discharge of neuro-psychiatric patients about to return to their homes. The men were concerned largely about the feared and anticipated reactions of relatives, friends, and employers to their hospitalization and discharge. They used psychodrama to test their handling of prospective encounters and threatening situations. A number concurrently augmented these experiences by job-seeking and had actual experiences with employment agencies and personnel managers. Dr. C limited the group's activities to catharsis, acting-on-the-stage, discussion of here-and-now and near-future problems of reality (as against rendering conscious deeper unconscious dynamics and exploration of parent-child relationships). Much tacit insight into deeper dynamics emerged, nevertheless, as evidenced by behavior and comments of many of the patients that they were greatly helped in preparing for life outside the hospital.

Perhaps partly due to the narcissism, immaturity, and psychopathic trends of many of the patients in this group, there was little interest in the jobs, once gotten. They seemed unrealistically confident that if only they could sell themselves to personnel managers, they would have no difficulty performing in any job, no matter how difficult it was or how ill prepared they might be. This was pointed out to the men, and in the wake of this interpretation came a flood of concern over performance and adequacy. Men began to ask for psychodramatic acting out of embarrassing situations on and off the job. They found themselves setting up situations where old employees questioned new workers, where nosy co-workers asked why they were discharged from the service, and where fussy foremen criticized poor work. They were then given the opposite role, while an auxiliary ego took their own, and had a chance empathically to experience both sides of the interpersonal clashes. Episodes of mistaken identity, being caught speeding, and being accused of car stealing or of un-American allegiances followed in turn. Group discussion grew spirited, with profound interaction both in the on-the-stage actors and in the participant observers. While resistances were not interpreted and men tended largely to examine the roles other than their own, they manifested their growing mastery of themselves in many ways—or fled the group entirely. There was no doubt that it shook people emotionally, and a number of visiting staff found themselves too threatened either to return or to participate in the drama as "egos."

Sessions were held on the lawn of an unoccupied ward, the porch being used as a stage. The director sat on the edge of the porch, and the auxiliary egos with the patients sat in a surrounding semicircle. Immediately following each meeting, the director and the "egos" met in his office to discuss the content of the meeting and the reactions of each of them. Notes were made then and incorporated into process recording of each session.

At one point, after steady progress of the group (whose population gradually and steadily changed) for about six weeks, a slump was noted. Interest fell off; men truanted or were tardy. If they came, they participated listlessly or not at all. It suddenly occurred to the staff that the situation called for re-structuring of the group. The goals and purposes were restated in the next session, and the patients took on an entirely fresh responsiveness almost at once. This underlines the importance of periodic re-structuring, especially in open-end groups.

Group V was made up of five negro schizophrenic patients housed on a locked ward. Mr. T (a white psychiatric social worker) was therapist, and Dr. O, the WMO, served as consultant. Prior to the first meeting, Mr. T saw each patient individually and invited him to join the group. The

expressed rationale was the patient's need to have the opportunity to express his feelings or ideas concerning the hospital and his therapy. The reason for the all-negro constituency of the group was that the negro population on the ward happened to be large enough at that time for such a group. When asked their preference, candidates rejected a mixed group in favor of all negroes.

Once constituted, the group was active, with lively interaction between members and little dependence for direction upon the therapist. The group took the opportunity of complaining seriously, and for a time "gripes" took precedence over all other forms of discussion. Hostility toward military doctors, electro-convulsive therapy, and sources of discrimination was marked and open. As the group gradually became satiated in this area, the persistent requests of some members that the group's purposes be restated were finally acknowledged by the group as a whole. At first the therapist saw these requests as evidences of suspiciousness. Later they appeared as signs of hostility. Finally they were interpreted as evidence that the group now desired something more satisfying than a "gripe session." In his restating of the group's purpose in the sixth session, the therapist therefore stressed the value of the group interchange and omitted entirely any reference to complaints. The subsequent hours proved the wisdom of this maneuver in their self-revelation by several members and the diminution of complaining.

Over and above the benefits of group catharsis, the members derived the valuable experience of discussing their social status and expressing hostility toward the dominant social group in front of one of its members without fear of censure or retaliation. This freedom (if not daring) was evidenced dramatically in the capacity of the group to tease or bait the therapist by references of a sexual nature to white women passing the windows of the therapy room. All this was deemed to have been salutary despite the fact that in only two patients was the racial question seen to be directly contributory to their breakdown.

Reactions to the all-negro composition of the group originated chiefly from without. Various staff members, including the ward nurse, saw the plan as undesirable, due to its opposition to general social trends in the United States against segregation. They feared undesirable reactions on the ward by various members. These did not transpire. After the fifth session the ward nurse began to evince overt positive interest, suggesting that a withdrawn, seclusive patient be added to the group. Only one white patient on the ward objected to the therapist to the negroes' "segregating themselves" in a group. He was an overt homosexual.

"Group II" was the designation applied to a series of single-session meetings held by Miss W, the psychiatric social worker on the admission ward. The "group meetings" were attended by one to three newly admitted patients. The purpose of the meetings was to orient the patients to the hospital, introduce them to the social service department, and permit them to ventilate, ask questions, and get acquainted with their worker and each other. As far as possible the attempt was made to select homogeneous patients, both in terms of general diagnostic categories and also in terms of degree of contact and cooperativeness. Excessively withdrawn or overactive patients were not included in these groups. The group continued to meet anew several days a week for about seven months.

Group VIII consisted of four to ten sub-coma insulin patients on an open ward meeting once weekly with their ward medical officer, Dr. D, who also supervised their insulin sedation therapy. Their physician's expressed goals were (1) to help the patients to learn more about their treatments; (2) to discuss reality problems which they would have to face (i.e., a medical discharge, the draft, discrimination against ex-NP patients); (3) to reassure newer patients through showing them how others with similar problems had already been helped.

This group was not supervised or controlled. Only certain impressions can be reported. These are that the group prospered at first, that therapist and patients were happy with it. Then interest waned, the number of patients on insulin sub-coma diminished, and the group died out, not to be reborn.

Group X "Two Psychotics," was begun by Dr. P in the fall of 1952. He had thrice weekly sessions with two paranoid schizophrenics. Remarkable strides were made in the content of the material produced, in the insight acquired, and in general improvement of behavior. Each patient seemed to catalyze the other, and movement was rapid, even into areas in which high resistances are to be expected. This group was individually controlled and was presented to the group psychotherapy seminar only after its termination two and a half months after commencing.

The patients had chosen to be in the group, although each chose blindly, not knowing who the "other man with similar problem" was. They grew to like and complement each other and accepted limitations in their own group which they refused individually or on the ward.

Group XI, "Three Headaches," was begun in October by Dr. C and was continued till his release from active duty in the Navy six weeks later. It consisted of three patients with similar backgrounds and identical complaints. It was not formally controlled individually or in the group seminar.

Soon after assuming responsibility for group psychotherapy supervision, I found that individual supervisory hours were valuable, but left much to be desired. The therapists came from different disciplines, represented different therapeutic philosophies and levels of training, and seemed to need some sort of over-all indoctrination and coordination of purpose, goals, and methods. It was therefore decided to provide a weekly group therapy seminar in which various group theories and techniques, clinical reports, and special problems could be discussed. These sessions were well attended and participation was enthusiastic. We met at first in the lounge of the officers' ward, sitting comfortably on easy chairs and davenports informally arranged. Later we used a comfortable group therapy room, similarly furnished, on the insulin therapy ward.

Once over the initial hurdle of pooling our ignorance and acquiring trust in each other and honesty with each other, we began to discuss a multitude of theoretical and practical questions: "How large should groups be?" "What is the ideal frequency and duration of groups?" "How should patients be selected, prepared, and oriented?" "What is the best combination of therapists, or is solo therapy preferable?" "How can movies and didactic presentations be used—or abused?" "Do they have any place at all?" "Is the psycho-analyzed therapist better off—or worse?" "Can people of different psychodynamic philosophies work on the same group?" "How can the problems of rank and military hierarchy be overcome?" Naturally there were no pat answers. One can imagine the depth and intensity of feeling and spirit that was periodically aroused in the course of the group of *therapists* learning to express their ideas and feelings around these topics! At times it was necessary to exercise suppression by verbal padding, authoritative answers, or diversion. At other times the group took the bit in their teeth and worked through some pretty knotty problems.

The procedure gradually evolved that each week the various therapy groups were presented—usually 3-4 sessions of material were shared in 1-2 meetings of the seminar. The dynamics of individual patients, group dynamics, and therapists' technique all came under question and discussion.

Therapists were encouraged (and usually succeeded) to present their material so vividly that the group "got the feel" of what must be going on in the group. Where groups had multiple therapists (some had two or three), the interaction between them was particularly important. At times during the discussions of their sometimes contrasting as well as complementary roles, tensions would mount and curious identifications and alliances would appear spontaneously between various members of the seminar. This was especially evident during the long period of chronic disagreement about

the handling of Group I (Insulin-Coma Group). The differences between the therapists were acted out psychodramatically on more than one occasion with benefit. On one occasion role reversal led to real insight on one therapist's part.

Younger therapists, particularly, continued to ask, "What do I do?" and "Did I handle this correctly?" This was most marked in terms of questions by patients into which therapists were sometimes inappropriately inveigled. The answers so often depended upon the limitations of the individual which the seminar seemed to sense and adjust to. They spontaneously supported, objected, corrected, or interpreted the therapist's needs to him. The supervisor seldom had to make either negative or positive suggestions, except sometimes in a rephrasing manner.

Sometimes there were arguments over the relative importance of talking, listening, reflecting, or interpreting. One therapist had a penchant for intellectualizing excessively with his groups. The seminar grasped this early, and unconsciously so did the therapist, since he perpetually protested how he sought not to be didactic. Frequently such insights or those of a countertransference type were slow in coming to individuals. The group, however, usually saw them early and worked them through bit by bit with the therapists involved, simultaneously learning other lessons themselves.

Current individual and group stresses among the military population appeared in the seminars in direct or disguised forms. One night at a group session one therapist appeared especially anxious. It came out in discussion that he had mistakenly received word that he was to be on an overseas draft. His anxiety was contagious and led others to fear the same—yet talking it out together eventually resolved the fear for all, including the victim of the rumor. At other times various therapists acted out resentment and hostility toward authority in the group seminars and, in the process of seeing what they were doing, acquired catharsis, insight, and relief of tension. This was generally reflected in improved insight into group phenomena on the therapists' respective wards and in their greater ease in handling nurses, corpsmen, and patients in general.

A number of techniques were experimented with, unfortunately to a degree insufficient to lead to valid conclusions. One technique was tape recording all or a portion of a group therapy session and playing it back to the group. At the end of a year's experience in group (and individual) supervision of group psychotherapy, there were still a number of unanswered questions:

(1) How often should structuring be done?
(2) Are 90-minute sessions preferable to 60 minutes?

(3) Should structuring include telling patients what a group is *not* for, as well as its purpose?

(4) What is the type of group most feasible for the Military? Should it be led by an officer or a civilian therapist?

(5) What are the most reliable and vivid methods of recording and reporting group meetings?

It was the staff consensus that group supervision of group psychotherapy gave the therapists something that individual supervision did not provide. Perhaps this was the sense of being in something like group therapy oneself.

Summary and Conclusion

I. During the year 1952, eleven psychotherapy groups were instituted at the U.S. Naval Hospital, Oakland, California. These were supervised by the author in individual sessions with the group therapists and in weekly group seminars.

II, Groups consisted of two to fifteen patients and included patient groups of many categories. The latter varied from psychoneurotic and character disorder patients to acute severe psychotic patients under insulin and electro-convulsive therapy.

III. Therapy techniques varied between supportive and orientative techniques, on the one hand, and interpretive, analytic, and psychodramatic techniques, on the other. Therapists came from a wide range of backgrounds and included the three disciplines of the classical psychotherapeutic team.

IV. Results varied, but generally substantiated the thesis that group psychotherapy is valuable for military patients and tends to fill a needed place in the program for their care. This was evident in general staff reactions to patient behavior, comparing those in and out of groups. There is some evidence that it had special value in enhancing the effectiveness of the total regimen for patients receiving insulin-coma therapy.

V. Supervisory sessions proved to be of teaching value to the therapists in a number of ways. They learned group dynamics, both theoretically and practically; they acquired a greater understanding of individual psychodynamics; they became aware of their counter-transference reactions in an especially keen manner as they confronted these feelings in what was for themselves a group experience. A freedom of interchange of opinion and feelings was encouraged in these sessions. This was felt to contribute to improved interpersonal functioning, both in the sessions and generally in other areas where the involved staff members interacted. In addition, there were opportunities to study the reactions of ancillary personnel to behavior

of patients through the observation of their reaction to the initiation of group psychotherapy on their wards as it changed from curiosity or suspicion through interest to deep appreciation or desire for further group experience.

VI. Representative data from a number of groups and their supervision have been presented as illustrative material both of the group techniques, particularly valuable in treating naval personnel, and also of the staff reactions to group psychotherapy seminars.

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REPORT OF THE 11TH ANNUAL CONFERENCE

The 11th annual conference of the American Society of Group Psychotherapy and Psychodrama was held May 4 and 5 at the Hotel Statler in Los Angeles.

Business Meeting:

Minutes read at the Business Meeting: The last business meeting of this society was devoted to the consideration of a revised constitution. The constitution was accepted. Copies of the constitution have been printed and are available at the address of the secretary of the society.

In accepting the constitution an option was passed allowing the current membership in good standing the temporary privilege of self-election to Fellow status. This expired with the mailing of the last ballot.

Elections were held and Dr. Moreno was elected president, Dr. Dreikurs president-elect, and Dr. Borgatta secretary-treasurer.

Old business: No old business was stated other than recommendations for creation of committees transferred to the new president.

New business: No new business was stated other than recommendations for creation of committees transferred to the new president.

Elections: Election by mail ballot gave the following:

President-elect: Helen Hall Jennings
Secretary-treasurer: Edgar F. Borgatta
New members of the council:
Raymond J. Corsini
J. L. Moreno
Abraham Schwartz
Leonard K. Supple

The president-elect, Dr. Rudolf Dreikurs, becomes president for the current year.

Correction: Inadvertently, the name of Esther G. Gilliland, an outgoing council member, was omitted from the ballot listing.

Transfer of office: During the year the office of the society was moved to Cambridge, Mass. The address of the office of the society is that of the secretary-treasurer until such time as the society is able to afford a permanent office.

Executive committee meetings: Two executive committee meetings were held in New York and minutes of these meetings were mailed to all council members not attending. Additional copies were made available to society members at the Los Angeles meetings.

Financial report: This financial report is correct and closes business for 1952. Further business and bills carried over will be considered 1953 business. Total funds received from all sources exclusive of payments for dues which are transferred directly to cover subscriptions of the society:

Total received		$1,646.87
Payments		
Secretarial assistance, billing, etc.	$ 102.00	
Stamps, incidental supplies	104.28	
Printing	153.00	
Phone calls, misc.	6.51	
Bank services, etc.	6.46	
Refunds and deficit assumed	305.66	
Advance payment of subscriptions	21.00	
Total	$ 698.91	—698.91
Total funds available		$ 947.96

Respectfully submitted by Edgar F. Borgatta, secretary-treasurer

Standing committee on membership: This is the only standing committee and it is required to meet at least once during the year (at the annual conference).

3 year terms: Edgar F. Borgatta, Sociologist, Cambridge, Mass.
Wellman J. Warner, Sociologist, N.Y.C.

2 year terms: Rudolf Dreikurs, Psychiatrist, Chicago.
Abraham Schwartz, Psychiatrist, Los Angeles.

1 year terms: Anna Brind, Psychologist, Los Angeles.
Raymond J. Corsini, Psychologist, Chicago.

Executive Committee: Executive committee members must be chosen from the Council and must include the officers of the Society.

Rudolf Dreikurs
J. L. Moreno, Psychiatrist, Beacon, N.Y.
Helen Hall Jennings, Psychologist, N.Y.C.
Edgar F. Borgatta
Robert Boguslaw, Sociologist, N.Y.C.

Program Committee: The program committee should have abstracts of the papers to be presented at the next meetings (May-Chicago, tentative date and place) by mid December. Initiative for the planning of the program should be taken by the chairman.

Helen Hall Jennings—Chairman
J. L. Moreno
Nah Brind, Psychologist, Los Angeles.
Wilfred Hulse, Psychiatrist, N.Y.C.
Dreikurs and Borgatta *ex officio* members.

Local Arrangements Committee:

Katherine W. Wright, Psychiatrist, Chicago.
Joseph Klapman, Psychiatrist, Chicago.
Adaline Starr, Psychologist, Chicago.

Others to be appointed.

Nominations Committees: Panel of nominations should be prepared before mid December. (Membership list will be published soon.)

Robert Boguslaw—Chairman
Gerhardt Schauer, Psychologist, N.Y.C.
J. W. Klapman, Psychiatrist, Chicago.
Zerka Moreno, Psychologist, Beacon, N.Y.
Rudolf Lassner, Psychologist, Ohio.

The secretary-treasurer would appreciate being informed immediately if any of the appointed committee members cannot serve.

ANNOUNCEMENTS

FIRST INTERNATIONAL CONGRESS ON GROUP PSYCHOTHERAPY,
TORONTO, 1954
(SECOND CONGRESS, PARIS, 1957)

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The International Committee of Group Psychotherapy was initiated and formed by J. L. Moreno in the spring of 1951 and the First International Congress on Group Psychotherapy announced as an aim of the Committee in *Group Psychotherapy*, Vol. IV, p. 126, 1951 and *The American Journal of Psychiatry*, 1951, and other scientific journals.

All individuals and groups interested in group psychotherapy and desirous of participating in the Congress are invited to write to the above address. The membership of the sponsoring committee is to be enlarged so as to include representatives of all varieties of group psychotherapy without discrimination. The aim is to have a real, all embracing Congress, in order to serve the development and integration of the entire field.

AMERICAN SOCIOMETRIC ASSOCIATION AND THE WORLD FEDERATION FOR MENTAL HEALTH

As a member society in the World Federation for Mental Health, the American Sociometric Association will participate in the Fifth International Congress on Mental Health, to be held at the University of Toronto, August 14-21, 1954. Members of the Association are invited to participate.

All those interested in participating in the above programs are invited to send an abstract of their paper of fifty words to P.O. Box 311, Beacon, N. Y.

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Section II (Coming February 1953)

A PHILOSOPHY OF SEX by JOSEPH FLETCHER, *Professor of Christian Social Ethics, Episcopal Theological School, Cambridge, Massachusetts.*

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Mit einem Vorwort von Leopold von Wiese

1953, *ca.* 400 *Seiten, Ganzleinen, ca. DM* 28,—

20 Jahre sind vergangen, seitdem Jacob L. Morenos Hauptwerk „Who shall survive? A new approach to the problem of human interrelations" in den Vereinigten Staaten von Amerika erschien. Durch den 2. Weltkrieg blieb es in Deutschland so gut wie unbekannt. 1948 wurde es im ersten Heft der neuen Reihe der „Koelner Zeitschrift fuer Soziologie" durch Leopold von Wiese eingehend gewuerdigt: (aus der Beprechung) „Selten hat die Beziehungslehre eine so starke Stuetze und Bekraeftigung ihrer Grundgedanken bekommen wie in der Soziometrik, dieser Schoepfung des Arztes Moreno . . . Es gibt gerade im grundlegenden und im Schlussteil Morenos wesentliche Abschnitte, die fast woertlich mit meinen Formulie-rungsversuchen uebereinstimmen. Voellig einig sind wir in der Auffassung, dass Soziologie in der Hauptsache eine Lehre von den Beziehungen zwischen Menschen ist, dass die sozialen Prozesse, durch die diese Beziehungen geschaffen werden, letztlich solche des Zueisander und des Auseinander und das soziale Gebilde Anhaeufungen von so entstandenen Beziehungen sind."

Das hier unter dem Titel „Grundlagen der Soziometrie" vorgelegte Werk ist die Uebersetzung der 2. Auflage dieses Buches, die gleichzetig in den Vereinigten Staaten erscheint. In den zwei Jahrzehnten zwischen diesen beiden Auflagen ist die soziometrische Forschung fortgeschritten. Manches, was damals noch unausgereift war, ist heute weiterentwickelt, verfeinert und gefestigt. Die Methoden sind vielseitiger geworden und der Kreis der Menschen und Menschengruppen, auf die sie angewendet werden, hat sich immer mehr verbreitert.

Im Vorwort zur deutschen Ausgabe schreibt der Verfasser selbst ueber die Soziometrik:

Die Prinzipien der Wahrheitsliebe und Naechstenliebe, auf denen sich die Soziometrie aufbaut, sind uralt. Neu sind lediglich ihre Methoden. Sie vermoegen gleich Roentgenstrahlen ins Innere des sozialen Organismus zu dringen und Spannungen zwischen ethnischen, oekonomischen und religioesen Gruppen zu beleuchten. Durch die soziometrische Methode koennen wir die allen Gruppenhandlungen zugrunde liegenden Gefuehle aufdecken, mit mathematischer Genauigkeit messen und spaeter im Sinne der Neuordnung lenken. Ist die soziometrische Geographie einer Gemeinschaft bildhaft klar geworden, so koennen viele soziale Spannungen durch Umgruppierungen geloest werden.

WESTDEUTSCHER VERLAG . KOELN UND OPLADEN