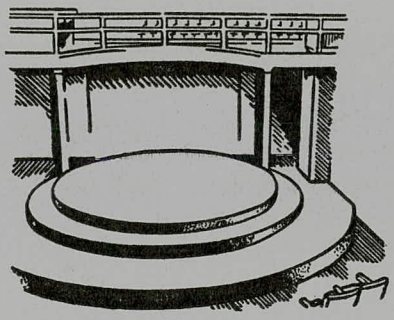
GROUP PSYCHOTHERAPY

A Quarterly



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Volume X SEPTEMBER, 1957 Number 3

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COMMENTS

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EDITORIAL

SECOND INTERNATIONAL CONGRESS OF GROUP PSYCHOTHERAPY

Zürich, Switzerland, August 28-31, 1957

The Congress was an outstanding success, by far surpassing the expectations of the members of its International Committee. The *official* report of the Executive Committee will be published in the near future, but here follow a few notations of a participant observer.

The total registration was 546 delegates from twenty-three different countries, including Poland, Czechoslovakia and Yugoslavia. The largest number came from the United States, 154 delegates. The next largest groups came from various countries in the following order: Switzerland, 80; France, 67; Germany, 63; Great Britain, 29; Italy and the South American countries, each 14; Holland and Israel, each 12. Other countries registered in smaller numbers. The Congress was held in three languages, English, French and German. It was organized with the assistance of Mrs. Gertrude Schneider, Stäfa, Switzerland.

The welcome on behalf of the City of Zürich was made by its President, Dr. E. Landolt. The Congress was officially opened by Dr. Wellman J. Warner (USA). The Chairman of the opening session was Dr. H. Binswanger (Switzerland). Announcements concerning the program were made by Dr. S. Lebovici (France), followed with a welcome by Dr. A. Guggenbuhl-Craig, the Chairman of the Local Arrangements Committee.

The Plenary scientific sessions were opened by Dr. J. L. Moreno (USA), who gave the first Presidential Address on "The Social Meaning and Scientific Significance of Group Psychotherapy". He was followed by Mr. S. R. Slavson (USA), who gave his Presidential Address on "The Era of Group Psychotherapy".

The Plenary session on the second day presented "The Influence of Group Psychotherapy on Psychiatry", by Dr. S. Hadden (USA), "The Place of Dynamic Concepts in Group Psychotherapy", Dr. J. Bierer (Great Britain), "The Place of Psychoanalysis in Group Psychotherapy", Dr. S. H. Foulkes (Great Britain), and "The Place of Psychodrama in Group Psychotherapy", Dr. R. Diatkine (France).

The Plenary session on the third day was chaired by Dr. H. R. Teirich (Germany), the Discussion was opened by Dr. W. C. Hulse (USA), and the various viewpoints developed during the Congress were summarized by its Program Chairman, Dr. S. Lebovici (France).

Besides these three Plenary sessions, the program consisted of Nine Sections: Analytic Group Psychotherapy, Group Psychotherapy with Children and Parents, Group Psychotherapy with In-Patients, Group Psychotherapy and Medical Practice, Group Psychotherapy and Sociometry, Group Psychotherapy and Psychodrama, Social Psychiatry, Group Psychotherapy and Group Psychotherapy Techniques, and Special Applications and Methods in Group Psychotherapy.

Among the features of the Congress which aroused outstanding interest were a "Demonstration of Psychodrama", the Workshop on "Acting Out in Group Psychotherapy", and a motion picture "Psychodrama", directed by Roberto Rosselini.

The Congress was climaxed by a banquet at the Grand Hotel Dolder, which was brought to a brilliant finale by Eduardo Krapf (Argentina), who introduced a representative from each country present, but two from the USA, Dr. Robert Drews (American Society of Group Psychotherapy and Psychodrama), and Dr. Nathan Beckenstein (American Group Psychotherapy Association). The various ideological and personal differences were submerged by a remarkable warmth and unity of conduct of the participants, a good omen for the forthcoming International Society of Group Psychotherapy and for the Congresses to come.

AN INVESTIGATION OF THE EFFECTS OF A "GROUP LIVING" PROGRAM WITH WITHDRAWN SCHIZOPHRENIC PATIENTS

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INTRODUCTION

The problem of treating withdrawn schizophrenic patients is perhaps the greatest one confronting hospital psychiatry to date in terms of sheer numbers, bed-space occupied and personnel required. A major difficulty from a treatment standpoint lies in the passive resistant behavior of such patients against engaging in interpersonal relationships or in participating in the group living activities from which better adjusted individuals appear to derive major satisfactions. One may become involved in rather complex theoretical considerations in regard to the underlying determinants of such passive resistant social behavior. However, a rather parsimonious view might be that such individuals have been severely disappointed in their attempts at social growth and have withdrawn to protect themselves against further emotional anguish. In addition, they have erected various delusional defenses to explain their behavior to themselves and others. It may be hypothesized that such disappointments in attempts at social growth stem from a number of psychological factors. These may be lack of adequate social learning opportunities and experiences, intense frustration by others in attempts at social growth, lack of meaningful gratification or reward when progress was made, and, as commonly observed, inability to share with others due to the anticipation of deprivation based upon past experiences.

Despite the withdrawal of these patients from interpersonal relationships, the existence of their social needs is obvious. To those observing patients closely from a psychological standpoint as an intensive group therapy, it frequently appears that initial steps toward the fulfillment of such needs stem from the opportunities for interpersonal and social experiences found in an understanding protective group environment. For instance in insulin therapy groups, such factors as sharing a common drastic treatment and living from day to day in a tightly knit group in which all hospital activities and the living situations are shared, may be more influential in improvement than the effects of the insulin therapy.

With the exception of the possible opportunity for shared group ex-

periences if several patients are undergoing insulin treatment at the same time, few opportunities are provided in the usual hospital situation for the development of intensive small group social relationships. Small groups of patients may meet periodically for O.T., group recreation, group psychotherapy, etc. but their meetings take up but a small share of the patients' time in the hospital. With the exception of group psychotherapy, they are not oriented specifically toward direct intensive interpersonal interaction.

The research to be described is an on-going attempt to evaluate the effects of an intensive group living therapy program for withdrawn schizophrenic patients organized into small closed groups in a hospital setting. The comparative therapeutic effects of such a treatment program are being evaluated against those of current somatic and pharmacological types of treatment programs, during a three year period. This group living research program is being carried out in an acute intensive treatment service of a general hospital in which the maximum hospital stay is six months.

Method

The subjects of this study are veterans hospitalized at the VA West Side Hospital. They are selected from those schizophrenic patients who, after going through the regular admissions and work-up procedure, are recommended by their case psychiatrist as candidates for insulin shock therapy or pharmacological treatment. In addition to the case psychiatrist's recommendation for such treatment the patients must meet the following criteria:

CRITERIA GUIDE FOR THE SELECTION OF PATIENTS FOR THE PROJECT

Schizophrenic—socially withdrawn type
Age 21 to 40 inclusive
No serious chronic physical illness or severe physical handicap which would preclude his taking part in activities
History of psychiatric illness (unable to carry on normal work and social responsibilities because of emotional problems, or under psychiatric treatment) of *not less than one year's duration* and *not more than five year's duration;* the duration of illness may be consecutive in time (example: the patient may have been ill two years, then in remission, and subsequently ill for another year, accumulating a three year duration of illness.)
Any previous treatment except lobotomy
Not chronically combative or assaultive (one or two incidents does not make him ineligible)
Not catatonic to point where he is unable to feed himself, is incontinent, etc.

Not mentally deficient
No indication that alcohol has been a *major* problem for him
Not a transient; permanent residence must be in the nearby area; this includes veterans living within a 50 mile radius of Chicago

Routinely when a schizophrenic patient is recommended for insulin or pharmacological treatment his name is forwarded to the project selection committee who review his case against the above criteria. Those patients who meet the criteria are assigned randomly to either the experimental group living treatment program or the insulin or pharmacological therapy program.

Patients assigned to the experimental treatment program are placed in a group of six to eight patients. The control patients are assigned to insulin or pharmacological treatment and the usual ancillary therapy programs. They serve as the control group representing the type of treatment that both experimental and control patients would ordinarily have received in the hospital program. Final results will be based on comparing 24 experimental with 24 control patients.

The experimental treatment program, involving six to eight patients at a time, consists of an intensive four month, closed group, activity program which is designed to maximize opportunities for social learning, sharing experiences and social gratification. It is known to patients as the group living treatment program and is voluntary. The intensive activity program is scheduled as follows:

8:00 A.M. Breakfast
9:00 A.M. to 10:00 A.M. Social and educational program. Several programs have been set up, each being assigned one period per week. They include the following:
Social dancing class—in cooperation with special services; the volunteer services of a dance instructor and dancing partners are available.
Music therapy—in cooperation with special services. Patients meet in one of the lounges together with a music leader. Records of the patients' choices are played and discussed, group singing is initiated, etc.
Current events—patients meet with the chief librarian; news digests, news broadcasts and current newspaper are utilized to activate group interest and discussion of what is going on in the external environment.
Sharing literature—patients meet in the library with the chief librarian; emphasis on the entertainment value of various types of literature as a vehicle for the development and sharing of interests.
The following three briefer programs are provided during the four month period.
Personal physical hygiene—the group meets with a physician to promote discussion and education regarding bodily functions and personal hy-

giene; the goal is to correct misconceptions regarding physical problems and to promote more adequate self care.
Vocational opportunities—practical questions of how to look for and apply for a job, what to look for in a job, etc. are raised in a group discussion with a vocational counselor.
Social activity planning—planning of group social activities and the preparation for these activities are carried out with the recreational leader.

10:00 A.M. to 11:00 A.M. Group Recreation
This hour is conducted by the recreational leader from special services. The emphasis is on team sports and recreational activities encouraging group interaction.

11:00 A.M. to 12:00 noon. Group Psychotherapy
Daily group psychotherapy sessions are held with male and female co-therapists. Orientation is of an analytic interview variety with primary focus on current relationships and problems.

12:00 to 1:00 Lunch

1:00 P.M. to 3:00 P.M. Work Project
The work project is under the supervision of O.T. The patients work as a group on the construction of toys for needy children. Although the material is diversified enough so that task difficulty can be geared to individual patient capacities, it still carries the recognition of an adult type work assignment. No one person in the group completes a whole toy; patients work on parts to a toy, and the combined products of the individual members are assembled to form the completed article. The patient group accepts responsibility in the actual distribution of toys to the children. In conjunction with their social activity program they plan parties for the children to whom the toys are distributed personally.

3:00 to 4:00 Psychodrama Clinic
Twice weekly psychodrama sessions are held directed toward encouragement of spontaneity in emotional and behavioral expression and centering around current interpersonal problems.

4:00 Relaxation period—regular ward activities

5:00 Supper

6:00 Relaxation period—regular ward activities

7:00 to 9:00 Generally the group participates in the regular on-the-ward evening recreation program. Later in the program special off the post outings are planned to attend interesting sports and cultural events. Similar outings are occasionally planned for week ends.

All group living treatment patients are initially assigned to a closed ward and move to an open ward as a group when group control is evident. Although they are assigned adjacent bed space, no other attempt is made to isolate these patients in terms of ward or nursing care. Meals are taken in regularly assigned dining areas. Participation in regular ward activities

certain hours of the day enables us to evaluate the extent to which any tendency toward intra-group socialization generalizes or extends to patients and personnel outside of the therapy group.

Orientation of the personnel directly involved in the group living program stresses the importance of an emphasis on group projects rather than individual ones and the encouragement of group interaction. The program is presented as a regular type of treatment program with as little emphasis as is possible on its experimental orientation.

Evaluation

The goals of the group living treatment program of this study might be described as an increase in patient responsiveness to his environment, increased interaction with others, increase in positive attitudes toward others, increase in social confidence and self acceptance, increase in expression of feeling and in general an increase in socialized behavior. Since the experimental treatment involves severely disturbed patients and is only of four months duration, we cannot be overly ambitious in our anticipation of a marked realization of these treatment goals and we have geared our evaluation methods accordingly.

The following evaluation techniques are utilized to evaluate progress toward the treatment goals. Pre- and post-treatment measures are taken, affording analysis of individual patient changes as well as group measures comparing experimental and control patients.

1. *Behavioral Ratings*

(a) *Ratings of ward behavior.*—Ratings are made on the standardized Hospital Adjustment Scale originated by Ferguson and McReynolds. Scores indicating "expanding" and "contracting" personality factors for items relating to communication and interpersonal relations, self care and social responsibility, and ward activities and recreation are obtained. Several measures are taken in an attempt to minimize possible bias on the part of the rater which might be created by his awareness of the patient's particular treatment program (experimental or control). Ratings by two aides and two nurses are made of all the patients on the ward in which the experimental and control patients as well as other patients are maintained. By rating all of the patients we hope to avoid the direction of obvious attention to the project patients. Interjudge reliability of ratings are computed, and in cases of item discrepancy the modal rating is utilized. Ratings are made covering ward behavior during the first two weeks of the treatment programs and the last two weeks.

(b) *Ratings of activity behavior.*—A descriptive behavioral check list of patient behavior during the first and last two weeks of the treatment programs is filled out by the various activity therapists. Although completed ratings for control patients are fewer because of their more limited activity program, ratings can be obtained from O.T. workers and recreational workers who have contact with the control patients.

(c) *Ratings by social workers of relatives' impressions of patients' social adjustment.*—Ratings of the experimental and control patients' social adjustment as described by relatives are made by social workers shortly after the patients are admitted, at the end of the treatment program, and six months after termination of treatment. The post-treatment ratings are made by workers from the out-patient clinic, based upon home visits. The rating form consists of eleven scales, each constructed of five items which give concrete descriptions of behavior. The rater selects the item under each scale which best fits the relative's description of the patient's behavior within the two week period immediately prior to the rating interview.

2. *Clinical Judgments*

Clinical judgments of patient behavior before and after treatment are obtained from ratings made by psychiatrists and psychologists on the Multidimensional Scale for Rating Psychiatric Patients (Lorr). Independent raters not associated with the treatment programs are obtained from the Mental Hygiene Clinic Service Staff. Ratings are based upon an evaluation of patient behavior exhibited and elicited in a forty-five minute interview. Four ratings of each patient will be obtained: two pre-treatment ratings and two post-treatment ratings. The two independent raters assigned to a patient conduct a joint interview with the patient, affording a common sample of behavior on which to base the rating and upon which to check the reliability of the two clinical judgments.

Similar clinical judgments, but not independent in the sense that the raters are familiar with the patients' treatment activities and in closer contact with them, are obtained from the individual patient's case psychiatrist and from the psychologist who administers the psychological tests described in the next section.

3. *Psychological Tests*

A battery of individual psychological tests is administered to experimental and control patients prior to and upon completion of their treatment programs. Both testings of an individual patient are conducted by the same psychologist to control possible effects of examiner difference.

The test battery consists of:

1) The Comprehension, Vocabulary, Similarities, Picture Arrangement, Block Design, and Digit Symbol subtests of the Wechsler-Bellevue Intelligence Scale. These are utilized as a measure of mental efficiency.

2) The Rorschach Test. The initial analysis of this test for research purposes will be limited to sign analysis.

3) Selected cards from the Thematic Apperception Test which depict scenes most likely to elicit feeling and attitude about interpersonal, social relations. The cards are 2, 6BM, 7BM, 3BM, 4, 7GF, 18GF, 13MP, and 16. Analysis will be categorical and quantitative in nature for research purposes.

4) The Social Insight Test by Sargent which presents descriptions of hypothetical social situations and asks for an expression of feeling about and possible action which might be taken in the situation by the patient.

4. *Self Evaluation*

Two self evaluation forms will be administered at the time of the standard psychological testing referred to above, but are described separately here because they are felt to represent a facet of evaluation different from the other type of psychological evaluation. They tap a more conscious attitude toward the self and its problems. The Taylor Manifest Anxiety Scale will be used as a measure of physical symptomatology related to feelings of anxiety. An adjective rating sheet involving rating of self, ideal self, and normal person concepts is used as a measure of attitudes towards one's personal worth and social relatedness.

5. *Time Sampling of Ward Behavior*

A short daily time sampling of the project patients' ward behavior is made during the first two weeks of their treatment program and the last two weeks along usual sociometric lines. The observer walks through the ward at the same time every day during one of the free hours in which the patients will be involved in regular ward activities. He notes, on a diagram of the ward, the physical location of each patient along with sociometric notations, regarding the patient's activity (interacting with other patient, isolated from other patients and inactive, etc.). Time samples of behavior will be analyzed to determine whether changes in the patient's ward behavior do occur and the direction of change.

6. *Follow-Up Evaluation*

The desirability of a follow-up evaluation of patient's behavior at a date at least six months subsequent to the termination of treatment is generally recognized. Patients participating in the project are limited to veterans living within a 50 mile radius of Chicago in order to facilitate follow-up contacts. An attempt will be made to contact patients six months subsequent to termination of treatment for re-evaluation. In addition to direct paient contact, there is a home visit made by a worker from the outpatient social service department who will interview a relative or close contact of the patient for information regarding the patient's post-hospitalization adjustment.

Obviously, as yet, no definitive results are available, but we might report the comment of a patient after one month in the group living program whose comment typifies the strength of interpersonal feeling generally found in the group—"It's too much like a God Damn family!"

GROUP PSYCHOTHERAPY OF HUSBAND-WIFE COUPLES IN A CHILD GUIDANCE CLINIC*

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Flint Child Guidance Clinic

That the role of each parent is important is a truism in our culture. It has been continually emphasized that the interpersonal situation in the family may be crucial in furthering or hindering the child's normal maturation, or in contributing to possible pathology. Yet in a vast majority of cases, at least as judged by experience in child guidance clinics, it is only one parent — generally the mother — who seeks therapeutic aid relating to disturbances in parent-child relationships. These disturbances, of course, also frequently indicate marital difficulties in varying degrees. Generally, too, there is an over-emphasis on therapeutic attention to the mother or child exclusively — the father being interviewed for diagnostic purposes only — which is not due merely to the reluctance of the male. The awareness of the need for direct aid in the father-child relationship exists, but on the one hand, there is an apathy regarding the father's potential for obtaining aid, and on the other, it is taken on faith that either the mother or the child will be the purveyor of the benefits that may be derived, and that basic modifications in the emotional climate in the home will ensue. But therapists are being constantly reminded through the direct complaints of the mother, or the projections of the child about parents and siblings, that such modifications are far from being achieved. The question naturally arises whether more could be accomplished were both parents to obtain psychotherapy.

At times, of course, each of the parents may obtain psychotherapy. It occurred to this writer, however, that group psychotherapy where candidates were admitted only if both husband and wife attend would prove especially beneficial. The proposed plan was to select in the intake process four or five couples who would be willing to participate in a group in one and a half hour, weekly sessions for a period lasting from 12 to 15 weeks. It was planned that a male therapist and a female co-therapist conduct these groups. Since June of 1954 these therapy sessions were held with four separate groups.**

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* Paper presented at the Annual Meeting of the American Society of Group Psychotherapy and Psychodrama, May 18, 1957, Chicago, Illinois.

** The first group, (June 1954-October 1954), lasted 14 sessions; the second group (June 1955-October 1955), 13 sessions; the third group (January 1956-July 1956), 23

The invitation to the parents for participation in a group usually resulted from a conference between the intake worker, who interviewed each parent, and the diagnostician of the child. Seventeen couples have attended the groups. In one instance both parents also obtained individual psychotherapy, and they attended two groups — the first and the third. The parents were of middle class or low middle class status. Six of the fathers were engaged in sales work, three in skilled labor, two in police work, and two in newspaper work. The others were two accountants, and two firemen. Only one of the mothers was engaged in full-time employment outside of the home, and only one other in part-time employment. There were indications of severe marital discord in six of the families. The referred children consisted of eleven boys and six girls. Eleven of the children were ages six through eight; three ages ten to twelve; and three age fourteen. The symptoms varied in degree of severity. Poor adjustment in school, enuresis and other forms of regressive behavior, withdrawal tendencies or acting out, and sibling rivalry were among the most frequent complaints. Epileptic seizures were reported in two cases, and speech defects in three others. One child was subject to a severe speech phobia, and another to a school phobia. Of the three 14 year old boys, one was referred because of poor school adjustment and emotional immaturity, one for minor delinquencies and one because of major delinquent acts. Eleven out of the 17 referred children were assigned for individual or group psychotherapy. In the case of the other six it was decided that psychotherapy with only the parents might prove adequate.

The immediate aim was to establish a permissive atmosphere where the group members would talk freely about the difficulties they faced with their children, about conflicts between the parents and outside the home, and would be aided toward self-evaluative attempts relating to areas of concern. It was hoped that the results would lead to more secure feelings about the

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sessions; and the fourth group (December 1956-April 1957), 14 sessions. The writer was the therapist in each of the four groups. Miss Patricia Pierstorff was the co-therapist in the first group; there was no co-therapist in the second group. Mrs. Sue Kallen was the co-therapist in the third group, and Miss Irene Fast, in the fourth group. The co-therapists were interns in clinical psychology under the supervision of the writer — Miss Pierstorff from the University of Wisconsin, and the others from the University of Michigan. The writer is indebted to them for stimulating discussions, stock-taking, sharing in the resolution of anxious moments and also in the pleasures derived from the unfolding of a highly rewarding experience. He is profoundly indebted to Dr. Paul H. Jordan, Director of the Clinic, who recognized the value of this project at its inception and whose continued encouragement and support have proved invaluable. He is also indebted to staff members of the Child Guidance Clinic for continued cooperation.

self, more positive attitudes in interpersonal relationships, some workable insights regarding self involvement, and better mental health practices in the home situation. It was thought that limiting the group activity to 12 to 15 meetings would avoid undue dependency and foster in the parents a consolidation of gains and a greater reliance on their own resources. The task was initially approached with some concern since there have been various warnings in the literature against having family members participate in the same therapy group.

The activities of the therapist were to aid in the unfolding of the group process. It appears, in retrospect, that the more they were in keeping with the following attitudes and approach the more effective they were. An empathic approach of feeling one's way in attempting to comprehend what a given member was trying to express, rather than of didacticism was essential. Relating what was said to feelings expressed by others followed naturally and often the whole group was stimulated to think about the common aspects involved. Much more sparingly, and usually only if questioned directly, the therapist suggested how a particular problem or an attempt at solution might be related to psychodynamic principles and general practices in our culture. It was important both to answer questions without evasion and to be brief in these responses. The aim was to stimulate thinking about constructive alternatives rather than to offer direct advice.

Group expression relating to an individual's statement or to a shared problem was given precedence over what the therapist had to say. At first, meetings which seemed to consist of "just talk" caused the therapists some uneasiness. We learned, though, that one or two such meetings generally occurred between the third and the ninth evenings, and that they were in the nature of immediate precursors to especially fruitful sessions, where parents would somehow feel more encouraged to search within themselves for dynamic factors in their background relating both to their disturbances and also to their strengths.

The aims in the therapeutic approach, and the role of the therapist were structured early in therapy. There was a need at times, though, for reiteration. At the sixth meeting of the first group, as an example, a father challengingly demanded of the therapists that since they have studied him and his wife for this long it was no more than just that they inform him of the results of the diagnosis. In redescribing the aims involved some group members, on such occasions, became auxiliary therapists in their own right. In each group too, there was a general consensus that assigned readings, or a

presentation of films were not germane for our purpose. It may be of interest that though we met around a table in a seminar room where a coffee break could be easily arranged, each group mentioned the idea but was actually initiated only during one evening. Most parents felt that it would distract them from their intent to make the greatest possible use of the time-limited therapy.

Simultaneous talking or tendencies to monopolize the hour were dealt with indirectly, often by means of a rather simple expedient. When the moment presented itself it was simply stated that what was being said seemed to have a bearing on what another group member had spoken of previously during this or another meeting. As a consequence, the member talking at the moment gained the feeling that what he tried to say was attended to and valued, and reluctant participants were more readily drawn in. Generally, though, resistance to active participation was permitted to work itself out. Reminders about wider aspects of particular problems, if not too frequently employed, also served towards helpful generalizations. Thus, for example, when the most intellectual couple in the first group confessed that it never occurred to them to take their children along when visiting with others, the group was moved to comment about the not unmixed blessing of the institution of baby sitting, and about the drawbacks of urban socialization. Rigid interpretations of mental health instructions in vogue received a balancing effect in the group. When insistence on just firmness or complete leniency or consistency at all costs was voiced it was explored by others for the attitudes that it may have covered up. At times the group's achieving a balance had an earthy quality. A mother reported to the group that a neighbor of hers, upon complaining to her physician that her children were too messy, received the advice to take such things philosophically. As a result, the children were allowed to eat in the living room whenever they pleased, scraps of food were left lying around for days, and everybody seemed happy. An unconvinced father immediately decided that the poor woman did not take the advice philosophically but "philoslopically". A mother chimed in that she must have taken it "filthysophically". It was then generally agreed that however she took it, the outcome was "filthyslopical".

An awareness of biases or possible counter-transference feelings was particularly important. A negative instance may bring this into relief. A father in the fourth group related how he dealt with his two pre-adolescents when their report cards showed particularly poor marks in citizenship. He merely asked whether they deserved these marks and when they answered in the

affirmative, he told them to come to the dinner table, and that they would be punished immediately after the meal. There was no further verbal exchange about the marks and a fairly harsh but swift physical punishment was meted out. The group took sides on the issue and before the therapist was actually aware of it he supported those who disagreed with this silent type of punishment. He even tried to explain it as a form of conditioning. He gave his opinion prematurely and the opportunity was lost of conveying to the parent the feeling that he was being understood and accepted regardless of whether one subscribed to this or another form of action. This parent failed to attend after this, his fifth meeting. Even though his wife had withdrawn on a previous occasion, it is likely that both parents would have attended the group again were it not for this incident.

The co-therapist in the fourth group observed that among the most prominent indications of possible transference feelings was the sibling rivalry for the therapist's approval or special favors. She further observed that "securing diagnostic interviews, showing greatest improvement, having a child in therapy in the clinic, attempting to exchange special smiles, looks, or comments in order to form a special in-group excluding the other group members were among the commonest maneuvers. These were most adequately dealt with when the therapist neither fell into the trap of reacting favorably to them nor responded with rigidity or rejection. Children were accepted for diagnostic interviews or therapy as this seemed useful in terms of the problem they presented. To avoid exaggerated accounts of progress, pleasure over evidence of improvement was shown, but improvements were examined in the same way as failures and problem situations to attempt to discover the causes and to foster further self awareness. Identification with the therapist, in his consistently non-punitive role, was evident in a number of group members and probably tended to diminish expression of sibling rivalry."

Therapeutic changes as perceived in the group and from the parents' reports will be summarized for the fourth group.* With the exception of the previously mentioned couple who withdrew early in therapy, all four other couples attended the group until termination. In the last two meetings the parents reported a radical, symptomatic improvement in each of the referred children, a general easing of tensions in the home situation, an increased regard for their children coupled with a renewed sense of fun, and an in-

* A research technique was used in this group and it is also planned for subsequent groups. The results will be reported at a late date.

creased confidence in their abilities as parents. At this stage they also readily perceived that the values accrued in the changing inter-personal relationships far outweighed the benefits of the symptomatic relief.

The most dramatic change occurred in the case of the Humphreys.** At the time when they sought clinic help because of their middle child, seven year old Mary, they were "at their wits' end." The child displayed symptoms of a severe school phobia, separation anxiety, vague fears, excessive sibling rivalry, and various forms of regressive behavior. The parents became helpless and immobilized with their three girls, but especially with Mary. They tended to shift from whippings to bribes. The mother gave permission to the young and inexperienced teacher at the parochial school to slap the child, and the father said, "I tried to make her mind with my hand and probably just outright meanness. I am usually tired and grouchy when I come home and I guess I took it out on the child." Mary stayed away from school for nine weeks. Mrs. Humphrey frequently used to summon her husband from work when she was overcome by feelings of losing control altogether. The husband, in turn, took an extra job, with the rationale that he needed the money, at the same time, though, becoming apprehensive about his feeling bored in his own home. The diagnostic data suggested suppressions fairly near the surface in a bright and imaginative child. She was even more anxious about her being away from her school than her parents. A change of schools, though, was indicated and after the parents gained in self-confidence, the child entered the new school without difficulty.

The Humphreys enthusiastically participated in the group. Their spontaneity was contagious. Thus, when a mother stated in the fifth meeting that she was puzzled about what to tell her child about the parents' regular absences from home on evenings that they attended the clinic, the Humphreys related that they simply told their children that they made the weekly 20-mile trips so as to become better parents. Their very leaving of their children with a friend became a festive ritual for all concerned. In the ensuing sessions they not only ventilated their self-perceived faults, but also related how they had been putting to work some of their own insights, and the constructive suggestions from the group. They were startled into recognition that their apportioning of privileges with due regard for age differences actually lessened friction, and joyfully noted the positive results when they now trusted their children to do on their own "things that before were taboo."

** The names have been changed throughout and identifying information removed.

The mother discovered: "I can be firm now and the kids know I am not being mean. Before I wavered back and forth." Mr. Humphrey stated, "I now have patience I never knew I had before, I play with Mary and take the children with me when possible, and I sure understand their problems, where before I couldn't take time to hardly talk to them. We are a family now." Mrs. Humphrey added: "Through my trips over the past few months to the clinic, I have learned a great deal how to be a better parent. I am not so demanding with any of the girls. Mr. Humphrey and I have taken a more equal share of responsibility. I feel less pressure and can relax with the girls easier. We are well on the road of a happy family. We feel that the time that we have spent at the clinic is possibly the best spent in many years." The Humphrey's delved less into the background of their difficulties than the others, but it was evident that it was no more boast on their part when they stated, "In the group, we learned to see ourselves." Mary, in turn, steadily improved, the symptoms practically disappeared, and she made rapid progress in school. Her individual therapy appointments were terminated upon the advice of her therapist soon after the parents group was discontinued. The mother's reaction was: "Knowing when the thing is ending, you get more accomplished. I hated to see it end, but I find things don't fall apart when we quit coming."

When the Carlsons referred six-year-old Ann to the clinic, the mother reported that the child was very shy and lacked in aggressivity, that she tended to be a worry wort, was a constant bedwetter and sucked her thumb. In school she was known as a very bright child who at times cried easily and seemed insecure. In the first few sessions both parents were more aloof and reserved than the others and gave evidence of being quite rigid in their middle class standards. When Mrs. Carlson began to talk freely about her irritations with Ann, Mr. Carlson was chagrined, but he too, in the contagion of the group process, came to participate more freely. During the 13th session, they volunteered the information that their marital difficulties diminished. However, it was not until after termination that Mrs. Carlson confided to the therapist, "Our divorce, I mean our marriage, was shaky." As a result of their participation in the group, she felt, her husband gained more respect for her and came to see that he doesn't have to take over the rearing of their two daughters. "Ann's difficulties were mainly because of what we went through," she added reflectively.

Because of his wife's temporary illness a year or so previously, Mr. Carlson began to take over a variety of duties with Ann and the younger

sister who was also adopted. He did not relinquish his control, though, even after his wife recuperated and attended to their baths and other routines, rationalizing that his wife was too strict and got the children upset. Early in therapy he must have perceived the dangers involved in his estranging the children from their mother, and in his contributing to Ann's oedipal attachment. Mrs. Carlson's ventilations in the group shed more light on their difficulties than the verbal attacks on each other in the home situation, and achieved two ends. The husband sensed that his undue attention to the children was in part an acting out of his own hostilities to his wife. More significant was their growing recognition of a sense of direction and of renewed regard for each other's intent and capacity for adequate parenthood. Mrs. Carlson received support in the group for her attempted correctives against rigid insistence on perfect performance. She became aware of changes within her that actually produced results. Thus, when she was wondering whether her reading to Ann at bedtime was responsible for the child's stopping her bedwetting, she quickly added, "But I always read to her — maybe I'm just more friendly." She was unusually sensitive in the instance when Ann reverted to regressive behavior following questions about her adoption. She felt encouraged in the group to be less controlling in spite of her high standards, and permitted Ann to be more independent. Ann's improvement, and the fact that after some explorative sessions with the child her therapist felt that further continuation of treatment was not indicated, encouraged the parents in their continued attempts at change. Mr. Carlson then stated that his wife "makes devoted effort to give Ann contentment, love, and a sense of well-being. Until four months ago, I made too much effort in showing love and interest in Ann. I now let her mother take over the major share in caring for her." Mrs. Carlson was over-confident when stating that in the group she and her husband "got to the root of the problem," and a bit too victorious in the feeling that her husband came to see things her way. On the whole, though, their progress appeared substantial.

The over-all experience with the four groups points to the effectiveness of group therapy with husbands and their wives. Inferences and conclusions drawn can only be suggestive; they are largely in the nature of reports of a phenomenological experience, in as much as they are based on observations within the groups and on spontaneously reported therapeutic changes.

The responsiveness of the members had been quite apparent. Fourteen out of the 17 couples who came to first meetings remained until their groups

terminated. A cohesive, in-group feeling developed early in therapy. There was usually an expression of concern when one or both marital partners were absent. In the first group it was unanimously agreed to have each Wednesday evening session succeeded by a Thursday evening session the following week, so as to accommodate the work-schedule of a fireman in the group. The presence of a male and a female therapist seemed to have contributed to the cohesiveness of the group. It was taken as "natural" and may have engendered more secure feelings through identifications with the therapist of the same sex and in less tangible ways. One male member put it simply: "Many things would not have been said if there had been only one therapist — either male or female. I don't mean that the female therapist was helpful only to the female members of the group, or vice versa."

Homogeneity in the group in terms of similarity of problems of the referred children does not appear essential, provided the problems are not extremely deviant or atypical for the given group. The focus of attention in one of the groups on the colorful reports of an adolescent's, "you-never-know-what-comes-next," delinquent acts tended to disrupt the therapeutic process. The parents of a brain-injured child, and the parents of a boy subject to epileptic seizures might have been more comfortable in a group where the problems aired by the other members would have been more specifically akin to their own. Neither is homogeneity in regard to the parents essential. However, a certain degree of sophistication appears to be needed in order to overcome initial apprehensions and resistances. Those candidates who agreed to come to the groups but failed to appear were usually of lower socio-economic and educational status.

The resulting economy in professional time need not be overlooked. Six out of the seventeen referred children were seen for diagnosis only. There were clear indications that without the parents' therapeutic experience the 11 children who obtained brief psychotherapy at the Clinic would have needed much more extensive treatment. This appeared to be especially true in cases of severe marital discord. The parents generally reported improvement not only in the children referred to the Clinic, but in the siblings as well. Such comments were increasingly frequent in the closing sessions and tended to replace earlier statements to the effect that a particular sibling "who is really the problem" or "who is really worse off" should be referred to the Clinic. In most instances the parents' awareness of the varying needs of their children in terms of sex, age and individual differences increased, and constructive changes followed. Actually, of the 17 referred children

only one was re-referred for psychotherapy, and only a single new referral was made from among their 38 siblings. Only two mothers and one father continued in individual psychotherapy at the Clinic, and only one father later obtained private treatment. The parents, indeed, seemed to have consolidated their gains and to have developed more reliance on their own resources. There were strong indications that the time-limited aspect of the therapy — each group was to last from 12 to 15 weeks — was a strong factor in this direction. In fact, even though in the third group the attendance was not stabilized for the first few weeks, the extension of the number of sessions to 23 did not appear to be an asset. Those in the group who requested an extension beyond the 15 weeks might have equally profited from a limited number of individual appointments.

The group members have been aware in varying degrees of the subtle changes in husband-wife emotional interaction, and of their acquiring new ways of relating to each other. A year after attending a group a wife stated:

> "I don't know why but I learned a new side of my husband during the sessions. Here was a place where we could talk easily and without embarrassment, and in front of others too. The weekly discussions never ended when we left the meeting. I thought we learned a lot about people and ourselves. We made some amazing discoveries in our talks after the meetings. I feel that in group therapy husbands and wives learn new ways and good ways to talk thing over. I am wholeheartedly in favor of husbands and wives present in the same group. I feel that there was nothing I could not bring up at the group sessions. Both of us spontaneously brought up things that the other probably never would have heard and — here — in the group — it seemed perfectly all right. I felt that things came out into the open both for us and other members of the group without any embarrassment and — here in the group we had understanding people to support us. Perhaps the value of two therapists — one male and one female might contribute to this in part."

A husband wrote:

> "I feel that participation of BOTH PARENTS simultaneously was of great importance and value and that many barriers were broken down — between husbands and wives — in good humor often. — One has to be a good sport in front of the group, so in spite of occasional embarrassment, the sessions were so skillfully directed that the delicate question was always understood without prejudice and parents went home happy. I know there are some things which are not expressed when husband and wife are both present — direct antagonisms, etc., but I believe these come to light obliquely through discussing other things and that one of the main values of the sessions is that we cannot verbalize some of our private feelings because we realize that they

are not true and we consciously and deliberately make a more charitable statement which is often much closer to the truth than our silent prejudice was. We discuss things that we didn't discuss at home because someone else has had the courage to verbalize a feeling we were afraid to mention. We achieve a feeling of *both working* actively, hopefully and with desire toward better family relationships and family fun. I feel that a very large measure of the success of these meetings was the result of husbands and wives both being present at the same time."

He descriptively added his observation about the sub-group that each couple appeared to form.

"On the few occasions when one spouse was absent there was much more limited participation. The spouse present would often speak very deferentially and qualify everything with — 'his wife might not feel the same way if she were here, but' but actually he felt unable to contribute meaningfully to a husband-wife group because the group had come to attach great value to expressions by BOTH SPOUSES."

Values, common to group psychotherapy in general, were readily perceived. The support gained through the dynamics of universalization is one example. As one mother put it: "Probably the greatest value of the sessions was learning that other people have problems. Mine seemed a bit dwarfed by the others." A father stated: "Often we felt we understood the problems of other parents better than they did and then came to realize that we were talking about a problem as it pertained to us."

The advantage to the couples who had severe marital difficulties were especially striking. As one wife puts it: "The sessions furnished the only opportunity for voicing our troubles — once out in the open they seemed different . . . some things were brought up that were never brought up at home." A couple who were considering divorce gained workable insights that led to an accord between them. The father meaningfully related his anxieties about his son's "slowness and immaturity" to specific disturbances in his own childhood, and the mother similarly related her compulsive neatness and overprotectiveness to disturbing factors in her background. In the case of another couple, the wife who had been brought up by a domineering mother, and later continued to be depreciated by her husband realized: "What I used to do is overlook any bad features; I fought my own anger." Her ventilations in the group contributed to more understanding and accord between them.

I should like to conclude with a summary statement of some of the dynamics in this group process. The outstanding value in the husband-wife group therapy is the very participation of both marital partners in the same

group. It became quite evident that their presence paved the way for a freer unfolding of their difficulties. Paradoxically, the newly gained freedom of expression increased in part because of self-imposed restraints. The paradox, though, is only on the surface. The group permissiveness stimulated individual search into the self, and also mutual explorations of discord in the home. Frequently areas of concern that had been suppressed prior to therapy were aired in the group, since the more primitive, self-defeating patterns of exploding at each other were avoided. There was the opportunity, to be sure, for an airing of conflicting, distorted versions of the same situation. Much more frequently, though, the mate's complaints received support from the spouse by means of telling examples and further insights. Of significance in this direction was the fact that both partners were in a position, in the intervening periods between the therapy sessions, to further share their newly acquired attitudes, and mutually test out in reality the insights derived from the group experience. The marital partner was no stranger to the aims crystallized in therapy when translated into action by his spouse. Such experiences raise questions about the frequent warnings in the literature against having family members participate in the same therapy group, even in brief forms of therapy. It is perhaps reasonable to hypothesize that these attitudes by therapists merely reflect, in part, the patterns of isolation in urban society. In general, the over-all experience with the four groups appears to warrant a wide use of group therapy with husbands and their wives.

A GROUP THERAPEUTIC APPROACH TO A CASE OF BED WETTING AND FIRE SETTING WITH THE AID OF HYPNO-ANALYSIS

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John (eleven years old) was referred to me because he was acting quite irritable with the other boys, was often moody and withdrawn, and had frequent outbursts of impulsive rage. In addition to this, he was a chronic bedwetter, wetting the bed almost nightly. Due to the fact that he was in an institution at a considerable distance from his home, it was impossible for me to interview the parents. I gathered from his social case history that his home life had been very unhappy; his father had deserted the family in John's infancy and John had had a very disturbed relationship with his stepfather, who knew only one form of discipline and that was whipping him severely with the buckle of a belt. His mother was apparently quite cool, displayed little sympathy or interest and was largely undemonstrative. There was evidence of strong sibling rivalry for her attention.

When I first saw the boy, he appeared to be very unhappy and seemed quite frightened. It was immediately apparent that he had a great hunger for love and understanding. There was a kind of pleading in his tone. His voice was subdued. At first he was rather guarded and afraid to talk freely. But gradually he began to warm up to the examiner. He seemed very reluctant to discuss his bedwetting; there was a great deal of guilt associated with the subject. It was easier to get him to talk about the fire-setting. He told of how he liked excitement and to see the fire engines and hear the sirens and see everyone running. His insight and judgment were limited.

I asked him why he liked the excitement and he told of how uninteresting and boring his life was at home. He was too afraid to retaliate directly against those toward whom he felt anger or rage. So he had found a way to strike back at those whom he resented, to set their house on fire.

GROUP THERAPY SESSION

The therapist made some introductory remarks in which he pointed out that the principal purpose of the discussion was to enable the boys, with the doctor and the cottage parents participating, to understand and help each other with their problem of bedwetting. It was further pointed out that the attitude of the staff persons present was sympathetic and in no way punitive

or reproachful and that they understood that bedwetting was due to factors over which the boys had no wilful control. Attempts were made to allay any embarrassment or guilt and to point out that bedwetting was a widespread problem. Fortunately, in this instance, the attitude of the cottage parents had not been punitive but on the whole understanding and sympathetic toward this problem. Their warm relationship with the boys made it easier to establish rapport and get the discussion under way. The general theme of the discussion was: *Why Do Boys Wet the Bed?* My immediate primary concern was John; however, I did not want to make a special target of him, but to permit him to enter spontaneously into the discussion, and project his feelings. Thus an attempt was made at first to have the discussion rather general and impersonal, permitting the boys to project their attitudes about bedwetting freely.

At first the discussion was on a rather superficial level with some effort to evade the subject. However, I guided them back by re-emphasizing the original theme of the discussion. Whereupon Glen led off with, "I don't like to interrupt my sleep to go to the toilet, and I didn't want to interrupt a good dream I had the other night."

Earl stated, "That night watchman, Mr. Simpson, he acts like he's mad. I don't like to look at his face. I don't like to get up for him. I guess I feel like spiting him."

James said, "Me, too."

Peter said, "Some boys don't want to get up because they can't fall asleep again very easily."

John said, "Some boys get mad at the night watchman because he wakes them up all the time. Every night they think that if they spite him and continue to wet the bed, he will stop doing this."

Michael said, "I wet the bed because the night watchman doesn't spank me." Most of the boys disagreed and felt that boys often wet the bed out of spite because someone made them mad.

John said that he believed he could get a transfer to another cottage if he wet the bed. Then he added, "I used to believe they might send me home to get rid of me if I wet the bed. If I created enough trouble for them."

James said, "I always wet the bed because I feel jealous of Mother's paying more attention to the other children."

John said, "I feel the same way."

Most of the boys agreed that they had experienced a similar reaction.

John then volunteered that he felt that bedwetting was a kind of protest against all the boys' in the cottage losing their privileges because one had

done something wrong. (This had been the practice at the cottage which had first received him, where his bedwetting had been more frequent.) Most of the boys agreed that bedwetting could be a form of protest. In a further development of this unconscious mechanism, the therapist cited the example of a boy who refused to eat in order to hurt his mother.

At this point James remarked, "I took a mirror, and I'm sure I let it drop and cut my finger on the glass in order to worry my mother because she had refused to give me something she had promised me. She got upset when she saw it bleeding."

The boys then admitted that they felt that boys could aggravate and express their spite and inner resentment against their parents, especially their mother, and at the institution, toward the night watchman, whom they all disliked, by wetting the bed repeatedly. This, despite the fact that they conceded that they did not enjoy the smell of the urine, lying in a wet bed or the shame and embarrassment which they felt afterward.

In the subsequent discussion the boys brought out that if the cottage parents replaced the night watchman they would not feel like wetting the bed because they liked them.

I asked why they didn't like the night watchman.

John said, "I don't like the way the night watchman looks at me."

"Does he remind you of someone?" I asked.

He paused. "He reminds me of my stepfather."

James said, "I don't like the way he talks to us. He talks too rough."

Earl said, "I don't think he likes us boys. He gets mad at us."

Michael said, "He makes us go to bed too early."

It was further established that three of the boys in the group had had difficulty in getting up at night to go to the toilet because they were afraid of the dark. Fear of ghosts seemed to predominate. These boys apparently had had persisting fears of darkness for some time. They brought out that in their home life there had been a great deal of supersitition, that they had been frightened by their parents and other adult persons to scare them into behaving. These boys all agreed that a night light would help them to get to the bathroom with less anxiety.

The discussion went on to a further elaboration of the masochistic protest reaction mechanism. It then began to center around the theme of the boys' suffering or getting into trouble in order to strike back at their parents or their teachers. Five of the boys promptly admitted that they had permitted themselves to get into difficulty so that they would be taken to court and punished in order to spite and humiliate their parents. One boy,

a truant, stated that he had cut school in order to hurt his mother, even though he didn't like to miss school and felt guilty about it. Another boy stated that he admitted to the police that he had stolen a bicycle and that this caused him to be sent to court and to Boys' Village. He further explained that it was because his father had promised him a bicycle and had not kept his promise. He added, "My parents were very upset when they had to go to court. I know they feel bad about me being out at Boys' Village. They didn't want to tell anybody. If they hadn't treated me like they did I wouldn't be here."

It was clearly established that many of the boys thus protested treatment which they received at home, masochistically hurting themselves for the rejection and lack of love, the excessive punishment and discipline they suffered.

In general there appeared to be two groups of boys: one group that reacted passively-masochistically and the other that resorted to more active, aggressive, direct, overt protest reactions. Such boys would put up a stronger fight against rejection, punishment, and apprehension by authorities. Then there were those who revealed an alternately sadistic and masochistic pattern.

In another session, Leroy said, "I often dream I'm going to the bathroom and am urinating in the toilet. But in reality I'm wetting my bed. One night the night watchman cursed me. He said he ought to hit me just on purpose. He called me 'the little bastard.' I felt pretty mad and the same night I wet the bed. Since then I've dreamt that I saw the night watchman when I was just going to go to the bathroom. But after I saw him, I felt afraid of him. So I stayed in bed and wet the bed."

Brady said, "I'm scared to be in the house alone when it's too quiet. I often dream that I'm in the bathroom and in reality I'm not and I wet the bed."

John: "I used to feel that boys would be sent hom earlier if they wet the bed. But I learned different."

Thomas: "I feel ashamed at being big and wetting the bed. Especially if boys laugh or tease about it."

Leroy: "I feel ashamed at being down here and wetting. It ain't like at home. Here I feel I'm wetting someone else's bed."

John: "It makes me feel ashamed when my parents tell me that my sisters don't wet the bed. It makes me mad when they tease me about it."

In later group sessions John proudly revealed the following:

"I now wet the bed only once a week. But I used to wet it almost every night. I had a bad time around last Christmas wetting the bed because they wouldn't let me go home. Maybe I felt that if I wet the bed enough they'd

want to get rid of me. But it didn't work. One thing I see is wrong now, that my mother would beat me with a belt every time I wet the bed. But that only made me mad and I'd wet the bed more. Now I feel too big to wet the bed and I feel ashamed to do it now. But when I feel mad I don't feel ashamed. Sometimes I think boys wet the bed to get even with their cottage parents."

"Why?"

"Well, like for putting their names on the scrubbing list. (To scrub the dining room.) Sometimes I get mad when we have to do detail every morning and that might cause me to wet the bed."

An attempt was made to evaluate this boy's current feelings under hypnosis. When asked how he felt about his stepfather, he said, "I don't like my stepfather. Especially when he's drunk. He gets mean; he yells at us. And I get scared because sometimes he just grabs a belt and hits me with the buckle. Sometimes he hits me in the face with the belt." As he said this, the left side of his face winced markedly.

I asked him why the left side of his face was wincing.

" 'Cause that's where he hit me with the belt," he said. "Once I set fire to the house he lived in. It burned some of his things up. I felt a little better after that."

When asked if he ever dreamed about his parents, he stated, "About a week ago, I dreamt my mother and stepfather were fighting and my mother stuck a knife into him." He denied that he felt upset about his mother's doing it to his stepfather. "It didn't seem to bother me much. My mother never married my stepfather."

"Do you think she should have?"

"I don't think Mother should. And it makes me mad because she lives with him."

I asked John about his speech difficulty.

He answered, "My mother used to say I was tongue-tied because I don't talk plain enough."

When asked if Mother hugged and kissed him, he said, "My mother hugged me and kissed me some, but she wouldn't hug me when I wet the bed. I like when my cottage mother Mrs. Hunt hugs me, but that ain't too often. I like the way Mother hugs me better because she hugs me tighter. I think if Mrs. Hunt hugged me more I wouldn't feel like wetting the bed so much.

"How do you feel about your stepfather now?"

"I don't feel so mad at him now as I used to."
"Why?"
"Because he comes to see me and brings me things."

Discussion of Fire Setting

Dr. Miller and Mrs. Scott (case worker) sat in. There was as little direction of discussion as possible. John B. opened the discussion by stating that some boys like to see fires and the color of fire. Russell remarked that some boys like to see people get hurt. Raymond stated that they get fun out of crowds and all the excitement. When the question of *Why boys set fires* came up, John remarked, "God tells a boy not to set a fire and the devil tells him to." Then John went on and said that maybe the boy gets mad at his mother and that's why he does it. "My mother would kill me if I got mad," he said. "So I don't let her know." Ferris remarked that boys get fun out of trouble and creating trouble. "Maybe they think that they can get away with everything. Maybe they think that they can fool people." Referring to why he set a fire, Ferris said, "The manager of a certain store threw a brick at me when I was stealing some candy and I got real mad. I made up my mind I was going to get even with that man. So I set a fire and ran away. Boy, was he upset too." At this point Ferris showed excitement and began boasting and some of the others followed suit. Ferris went on, "I also set a fire to get even with that principal for expelling me from school." Raymond: "Every time I played on that lot near our house, a man would chase me away so I got real mad. I got even that evening, too, by setting fires to the barrels on his lot." Earl stated, "The teacher smacked me on the side of the head when I was just playing quietly with a boy in class. She made me so mad I got some matches and set the teacher's house on fire. Once a boy beat me up because he said I stole a bike when I just took it for a ride. I got real mad and I set fire to his mother's house. Once I set fire to an apartment because I just wanted to see the firemen take the people out of the house. See how they did it." John remarked, "Miss Parker, the teacher, cursed me so I just set fire to the records in her desk." Raymond: "I built a hut in a lot and a big fat man tore down my hut, that's why I burned up his barrels on the lot." Ferris: "Boys get fun out of cops chasing them all the time. I want to show I am man enough to play hooky and to steal and set fires. You have got to have guts."

Report While Under Hypnosis

John was put under hypnosis and the following session occurred:
"John, how did you feel that morning when you set the fire?"

"I felt bad that morning."

"Were you angry that morning?"

"Yes."

"Who made you angry?"

"A man made me angry. The man was young."

"How did you start the fire?"

"I set the fire with matches and paper."

"Was there anyone with you when you started the fire?"

"Yes, Harry. He comes to play with me."

"What did Harry do?"

"He teased me and dared me to do it. He was laughing when I started the fire. I wasn't afraid."

"Why did you start the fire?"

"Because the man made me angry when he chased me away from the lot that I liked to play on."

"Was there any other reason?"

"I liked to see the fire engines and the excitement. The people running, and the sirens."

"How was life at home?"

"All right."

"How do you feel about your stepfather?"

His face was pained. "He whips me too much. He's always telling me not to do things. So I get mad and do them anyway. He'd tell me to wash the dishes and I'd refuse and I'd get whipped." John started crying. "Sometimes Mother stopped him from whipping me. I wasn't so scared of the beatings as I was of him."

"Do you want your stepfather to remain at home?"

"Yes."

"Does your stepfather take you places?"

"Sometimes he takes me to the park to a ball game."

"How does Mother feel when you wet the bed?"

"Mother gets mad."

"Do you wet in the bed here at Boys' Village?"

"Not all the time."

"When do you wet the bed?"

"When I have cottage parents who upset me. I get even with them by wetting the bed."

"How do you feel about your cottage parents now?"

"I like them."

"How often do you wet the bed now?"

"About once a week."

"And at home?"

"Every night."

"Who gets most upset when you wet the bed?"

"Mother."

"Has Mother said anything to you recently?"

"She said I should stay out of trouble down here. She wants me to come home soon."

"Did your mother love you, hug you and kiss you much?"

"No, she didn't. But she does more now. When she comes to visit me. I wish that my cottage parents would hug me once in a while to show that they like me."

This lad has improved greatly in his cottage and general institutional adjustment. His bedwetting has diminished markedly. The group discussions made it possible for him to better understand his sado-masochistic behavior. He now feels quite secure in his cottage, particularly since there is now a new night man who tucks him in in a kindly, fatherly manner. John no longer manifests the impulse to be destructive as he formerly did. Although when he first arrived at Boys' Village he stated that he enjoyed setting fires and found it exciting, he no longer expresses these feelings and denies that he would ever do it again. When asked why not, he states: "Because setting fires is bad and can do a lot of damage. It could hurt a lot of people who aren't to blame and have done me no harm. I know now it's a wicked thing to do."

Discussion

In this paper group psychotherapy has been applied primarily as a study method for such common disorders as enuresis and fire setting.

Bedwetting as well as fire setting are after all merely symptoms rather than true disease entities in themselves.

In many instances they represent the means of dealing with or giving external expression to deeper emotional conflicts.

The causes of bedwetting are certainly many. In the past, organic factors were primarily held responsible, as for instance cystitis, urethritis, balanitis, excessive fluid intake, cold as well as faulty habit-training, etc.

Today, emotional conflicts are generally conceded to be the most frequent etiological factor.

Here I should like to differentiate the following:

(1) Cases—where repressed anxiety is foremost.

(2) Cases—in which repressed hostility predominates.
(3) Infantile regression.
(4) Urethral eroticism.

Children may derive auto-erotic pleasure from wetting their pants or bed. (Fenichel)

Bedwetting has been found to be the most frequent masturbatory equivalent (unconscious conversion—displacement mechanism).

It is clear that the unhappy, emotionally impoverished child unconsciously seeks to recapture the blissful, carefree existence of infancy in which no responsibilities or inner controls are required. The bladder can be emptied freely; mother's attention sooner or later will be drawn to making baby comfortable again.

So we can understand the unconscious reaction, "I will secure the privileges of being a baby which you deny me."

This is frequently the child's reaction when he feels ignored in favor of younger siblings.

Thus, it may become an established unconscious attention-getting device.

Later, too, when mother gets quite disturbed at J's continued wetting, J soon realizes that this is a way in which he can revenge himself upon her for frustrating his desires.

Failure of ano-rectal control in children is often subject to direct, active and in some instances harsh punishment. On the other hand, enuretic children are usually made to feel ashamed.

Strong unconscious, ambitious drives can result as a defense and compensation against this shaming of the ego (wounded narcissism of the child). Further, this may result in a withdrawal and striving for self-gratification without consideration for others as revenge.

Why does the child select fire setting as an outlet for its vengeful-hostile reaction? This is a difficult question. There is divided opinion.

It is my view that the child here seizes defiantly upon the forbidden-tabooed method. There is an unconscious need to test his strength by violating a strong taboo which the parental authority had established, in the remark, "Johnny, you must never play with fire or matches, it is dangerous!"

Too, the small boy possessed by inner feeling of blocked rage and helplessness towards a more powerful authority seeks an undercover means of destroying or securing revenge on the threatening object.

The strict prohibitions against playing with fire tend to frustrate the natural curiosity of the child and result in consequent resentment and in instances defiance of the forbidding authority.

Significant is the fact that the hostility is usually displaced from the resented, often feared authority to the property belonging to him.

The hostility which could not be directly discharged has been unconsciously repressed and displaced.

It is to be noted that one boy pointed to the displeasure he felt at having his sleep interrupted, as well as his pleasurable dream. For this, he felt a need to spite the night watchman.

Most of the boys protested their treatment by the night watchman. Here, we see the need for the parental figure to tuck the boy in at night in a kindly, fatherly manner.

One boy, however, felt that he wet the bed because the night watchman didn't spank him, wasn't severe enough. This boy has developed poor inner controls, feels a need for submission to strong punitive authority, has learned to operate primarily driven by anxiety and may have passive masochistic character structure.

Evidence was gained to support the impression that bedwetting in certain instances represented an unconscious, passive resistance to authority.

Of interest was the fact that some boys felt that they would be rejected and could escape the painful situation by bedwetting.

There seems to be evidence to support my hypothesis that often there is an unconscious masochistic-protest reaction expressed in bedwetting.

EXPERIENCES WITH SMALL GROUPS IN TEACHING GROUP PSYCHOLOGY****

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This paper is concerned with the dynamic psychology of small groups as manifested in seminars convened for the purpose of studying group processes. Observations stem from a technique of teaching which works through the medium of management of the emotional needs of group members around a central figure or leader. The empirical data were drawn from upwards of ten groups of younger professionals in psychiatry, clinical psychology, and social work who agreed upon or contracted for weekly seminars ranging from fifteen to thirty-five in number. The procedure involved a modified type of free association where the criterion of "appropriate participation" rather than uncensored association is the rule. Size of the groups ranged from ten to fifteen members.

The pedagogic value lies in the opportunity to experience group processes as a participant observer and the challenge to understand as well as to observe the roles of the self, other members, and the central figures in the management of the issues and obstacles which arise.

The approach borrows from the methods of clinical research. It includes observations of personal interaction, reflection on associated inner experience (which colors observation), repeated review and re-evaluation of recorded and remembered experience—all in the service of seeing the process less subjectively. The procedure can be later rounded out through correlation with the experience of other workers in the field.

In our experience the method is invariably accompanied by some measure of personal discomfort, at times subjectively experienced as disappointing, or even tedious and monotonous. This is, perhaps, inherent in situations that do not lend themselves to rapid or ready solution.

In these groups the work of the central figure is not to create but to

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utilize existing emotional needs in a newly created learning situation. The leader helps group members become aware of their personal needs and encourages them to clarify the impact of these needs on the learning process. A framework of security is required that is not easy to establish because members tend to recapitulate earlier emotional problems at the same time exposing some childish styles of handling themselves. This is naturally associated with varying degrees of concern and embarrassment.

Before describing the management of these groups, some typical group phenomena are briefly reviewed. In early meetings members set about sizing up and testing out the central figure and each other, perhaps, to see what can be expected. Each member closely watches his associates' interactions with others and the central figure. Habitual ways of getting along with others gradually become evident together with capacities to fulfill certain roles, tolerance for anxiety, more specific defense mechanisms, and so forth. Also evident are attitudes toward and responses to authority and one's peers. The habitual quality of these attitudes and their associated behavior has led to the specification of a number of roles such as the usurper, the loyal lieutenant, the jester, and so on. All groups do not present consistently the same patterns of response and one person may fulfill more than one role. The emergence of particular roles seems dependent on the interplay of personalities entering into the group, yet there is some consistency in roles, once they have emerged.

However democratically the work of the group is agreed upon, there is inadvertent resistance to it. Disruption of the group in this regard takes on a variety of expression: absences, tardiness, silences, filibustering, proposals to change the meeting place or time or purpose, or membership of the group. Less tangible resistance is contained in a wide range of implied critical attitudes. Disruptive attitudes also gain expression in attempts to establish security or approval by clique formation or efforts at close affiliation with the leader through child-like goodness or ingratiation. Among members, attempts to learn from one another, at times, may give way to mutual admiration; members may resist clarification of group interaction lest it come at the cost of the pleasure of belonging.

Idealization of the central figure is not uncommon in these groups. Imputing great understanding to the leader regularly occurs possibly because the anxiety of not knowing to whom or what the discussion will turn next may be reduced by projecting omniscience onto the central figure. These phenomena seem relatively unaffected whether the persons composing these

groups come together for a course of instruction under institutional sponsorship or as individuals with a common interest.

In these groups a guiding framework is required for the central figure as well as the participating members. A foundation for techniques of leadership is laid in the making of a working agreement which clarifies what may be achieved together and how to work towards it.

A clear working agreement includes five elements explicitly stated by the leader at the outset. These are, in substance, (1) the structuring of the group detailing the when and where of meetings; (2) the purpose of the group; (3) the procedure through which the purpose is to be realized; (4) the responsibility of the members; (5) the responsibility of the central figure.

A few comments about these elements of the working agreement are in order since they underlie all considerations of technique. Regarding the structuring of the group, it is necessary to clarify the particulars of time and place and make explicit the self-commitment of members to attend on time, otherwise absenteeism and tardiness will not be looked upon as legitimate topics for discussion.

The purpose of the group may be generally stated as the study of group dynamics of group psychology. The procedure or method is conversational; exchanging opinions, ideas and personal experiences. Members are instructed to participate freely, according to their own personal judgment, with the idea of "appropriateness" acting as a guide and limit. The central figure introduces one or two items of work which are useful technical devices. First, in rotation, is the taking and reporting of minutes to be read at the beginning of each meeting. In addition to stimulating careful scrutiny of events in the group and providing continuity, the fact of recording itself induces a more business-like atmosphere. In addition to this individual chore from the outset, a later committee task requiring, in rotation, collaboration of three members may be assigned: each trio to review, summarize and report on their impressions of the earlier meetings. These committee reports can be correlated with the relevant literature on group psychology.

The responsibility of the central figure tends to be clarified by what he says and how he responds. In the beginning it can be left largely unstructured, beyond the presumption of his presence at meetings and his stated expectations of work from the group. Reference can be made to his style of participation in the group, namely as he sees fit, in accordance with the best interests of promoting the process. The role of the central figure is complex. Always he is an observer, sometimes a catalyst, sometimes a helper,

as when stalemates arise from intense resistance or intense differences of opinion. The more mature central figure also serves as a figure for identification, providing a model for members in their efforts to apply themselves to the task at hand.

The working agreement, so-called, provides a common point of reference for the group and the leader; its terms give a foundation in reality for the development of a working group with a common objective. The agreement, however, almost immediately becomes an issue, and around it invariably center the first as well as continuing manifestations of resistance and difference of opinion. It is the task of the central figure to represent consistently the terms of the agreement by noting deviations and helping the group understand these deviations as reactions to the difficulties involved in carrying out their responsibilities.

The unfolding of these reactions constitutes the "we-experience" of a new group. Individual and group reactions to the working agreement enable the central figure and members to discern and observe the playing out of feelings, attitudes, styles and roles of the members. The aim is to help all become aware of what is going on by watching for deviations and attempting to understand why they occur when they do. The central figure fulfills the reality testing aspect of his role, orienting the group to their difficulties in carrying out the working agreement. In this regard he uses the agreement as a reference point for the timing and phrasing of his comments.

Experience with such groups repeatedly brings to light concerns on the part of members over being criticized by one another, coupled with desires for reassurrance and respect. These concerns, perhaps, stem from finding themselves in a situation where a greater degree of personal intimacy or closeness through some measure of self-revelation is a requisite for achievement of the announced objective.

In pursuing a group or team objective then, individual members are subject to emotional responses which hinder the expression and interchange of ideas, opinions and personal experiences—the very medium through which learning from each other takes place. This hindrance most commonly takes the form of advancing one's own ideas or questioning those of others more with an eye to the potential prestige at stake or, in the opposite, namely reluctance to express one's ideas. The interchange in this sense can take on the coloring of a personal struggle, to the detriment of seeing and reflecting on the other person's point of view. This, naturally, has the effect of closing off issues from further discussion.

Analogous concerns and phenomena center around the leader. These usually take the form of one criticism or another of the style of leadership, including the necessity for recording each meeting, or starting with a summary at the beginning of each meeting. Verbalization of these anxieties perhaps serves the function of reality testing and apparently has the net effect, over a period of time, of allowing the members to feel closer without so much anxiety. This, in turn, is reflected in members advancing their views in a less dogmatic way, not feeling so hurt when these are questioned, and reflecting upon the opinions of other members, giving them due consideration as reasonable possibilities.

The problem of support is, in some ways, a matter for experienced judgment, more frequently subject to mismanagement in this type of work. The presence of a more mature, experienced person serves not only as a challenging stimulation, but as a support in itself—provided this person makes available his maturity and experience, not so much by giving, but through promoting learning and reality testing, encouraging group members to use their own resources.

Most people suffer at times from varying degrees of lack of self-confidence which hinders them in using their assets in an effective way. When the central figure concentrates on promoting interaction, support is apt to be felt as coming from the group rather than from any one individual. The boundary between helpful support and interference in the group process is not easy to delimit. A major difficulty experienced by persons conducting such groups lies in a tendency towards over-zealous support which verges upon interference that dissuades or disallows efforts of members to experience discomfort and learn for themselves. This tendency of the leader to do things for the members can deprive members of the satisfying experience of mastering difficult situations for themselves. Support encourages freedom of participation and license to verbalize inner reactions, as well as stimulation to examine the group experience as it unfolds. The task of the central figure at times of initial and repeated anxieties aroused by the emotional impact of working in a group is to stand by and offer security through helping the group face and grapple with the problems involved.

Some degree of objectivity in the person of the central figure is required. To unwittingly entertain favorites and concentrate attention on one or two would obviously discourage participation of other members. This situation is prone to develop in small groups where some members are apt, at first, to be silent and reluctant to participate. Lack of enthusiasm for the group is frequently the fate of the favored member (as well as the slighted ma-

jority) if the central figure does not avoid this situation by distribution of interest and by inducing more inclusive participation. It is predictable that some members will make a special effort to ingratiate themselves with the central figure. If he should prove non-objective in dealing with this he prevents the development of a situation of collective critical appraisal.

As teachers in the role of central figure we suffer from a temptation in common, the natural tendency to discuss and advance what we ourselves have found useful, forgetting that other ways of achieving the same goal may be equally appropriate, successful and personally rewarding. Pursuit of a familiar routine, though it has its place, may to some extent replace understanding of the interaction and in this sense be used defensively by the central figure in this seminar style of teaching. This not only deprives him of new experience and knowledge, but can also set a poor example for the group in the sense that they are not led to be curious, to question their own and other's experience, etc. Difficulty in letting people learn for themselves is frequently associated with the belief that the member is helpless and inexperienced—a conception that ignores the experience of people and their capacities which, if properly nurtured, can be brought to bear on the learning situation in a helpful manner.

One function common to the leader and the group is to keep active the member's appraisal and re-appraisal of his patterns of participation as well as those of others, in the hope that he may achieve increased understanding of the factors interfering with the process of learning from one another. Special conflicts and blocks in the pursuit of life goals will be reflected in members' preoccupations and productions in the group setting. The central figure, perhaps, does better to restrain himself from interfering except when situations develop that tend to close off further discussion and prevent it from working toward its goal. A good relationship in a teaching group does not depend on its potentialities for bringing about fundamental alterations in the personality or emotional life of the member, but on the creation of a sufficiently secure setting in which the interpersonal styles will not offer too great an obstacle to the group achieving its objective.

Beyond the critical points of establishing a working agreement, observing deviations from its terms, and minimal interference there are no hard and fast rules. It seems advantageous for the central figure to be flexible, passing an opinion now and then, stimulating a member to face an issue, encouraging reality testing, and lending a hand when intense difference of opinion arises.

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ON THE VALIDITY OF TREATMENT EVALUATION BY CLIENT ASSOCIATES

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THE EVALUATION FUNCTION OF TREATMENT

Inherent in any social practice undertaking, be it psychotherapy, social casework, groupwork or community organization, is a process of perpetual evaluation. Facts are assessed in terms of their validity, as measured by a specified criterion, such as their emotional meaning for the patient or his social adjustment. Treatment, be it social casework, a nondirective interview, a relief check, or a group participation, is examined in terms of evidence that it accomplishes the purpose for which it is undertaken. The outcome of a professional relationship is judged by professional criteria or patient expectations of what is "healthy" or "normal." The evaluation function will be found in any treatment process even when there is no well thought out research methodology. Without evaluation there is no rational basis for the existence and continuity of any professional helping process.

Numerous methods are used to accomplish this evaluation function. None can be employed singly. Evaluation of practice involves the application of logic to objective, subjective, projective and other data to build up a case of circumstantial evidence to support, throw doubt or disprove a fact, diagnosis or a treatment generalization. Some methods like observation, experimentation, index analysis, reliability, professional and client judgment are more trustworthy than evaluation on the basis of face validity or the training, experience and status of the therapist.

Often neglected in this stock-taking process is the knowledge, the judgment and the involvement of certain lay persons who are related to the treatment process by virtue of their personal knowledge of the client: his associates. This essay will be focused on the contributions and limitations of this method to the evaluation process.

THE "GENERALIZED OTHER" APPROACH

A man in physical pain needs no one else to tell him so. A social and psychological disturbance, however, is different. It rarely becomes acute for the patient without the participation of other human beings in the process of problem-definition. Individuals, groups and communities define

or evade problems for which help is needed in the market place of social interaction.

The author of *Mein Kampf* was a paranoid schizophrenic. Daily men are committed to mental hospitals for far less clear-cut evidence than the delusions, projections and maniacally aggressive emotions expressed by Adolf Hitler. He put them down for everyone to see in a book nearly a decade before he rose to power. Then it became Germany's Bible for thirteen dark, long years. How did he escape institutionalization?

His symptoms of pathology were shared by sizeable segments of the German population. As he grew into manhood in his native Austria, he learned to accept socially shared symbols of anti-semitism, nationalism and puritanism, etc. No matter what even half civilized men may think of his demonic spirit, if he were to be resurrected, millions of Germans and quite a few people in other nations would still vote him gloriously sane. They share his delusions and projections.

Like all social phenomena, social problems and their assessment involves the reciprocal interaction of many people. They communicate through the use of symbols which are significant for all—material artifacts such as lipstick or an expensively furnished office, gestures and language. These symbols, as George Herbert Mead has pointed out,[1] become significant only when they call out approximately the same response in persons who are communicating. People learn to take socially appropriate roles in these interactions, like the readiness to back up a check with cash. When they fail to live up to the expectation related to this symbol (the check), a breakdown of relationship is threatened. The police may be called, or the family will call a psychiatrist to ask: How can we keep father from writing these worthless checks?

When a client's associates view him as "well," it is more difficult to motivate him to expose himself to treatment than when they believe him to have a problem. The wives of mentally ill men are generally slow in defining their husbands' illness as psychiatric. In one study of 33 patients, early interpretations included such reactions as "nothing really wrong" (10%), "physical problem" (20%), or "normal response to crisis" (12%). Only about 25% inferred the presence of a serious problem. There are many ambulatory schizophrenic patients in the community. They are sufficiently ill to warrant hospitalization, but none of their associates know

[1] George Herbert Mead, *Mind, Self and Society* (Chicago: University of Chicago Press, 1934). It was he who coined the concept of Generalized Other.

enough, care enough or feel sufficiently concerned to get these people committed.[2]

The ideas of friends and relatives also affect the timing of the return to "health." Many patients in mental hospitals could be furloughed or discharged if someone in the community were willing to receive them. A study of 150 state mental hospital patients over sixty made by Western Reserve University social work students disclosed that the hospital was an optimum treatment setting for less than half of the elderly patients (45.3%). Lack of family and community resources and concern was largely responsible for the presence of the others. They might have been better cared for in a nursing home, in a hospital for the chronically ill, or outside of any hospitals but with some supportive custodial care by their own or a foster family.[3]

The participation of associates and people in the community in defining the need for service may be less dramatic in the child guidance field, old age assistance or group work, but primary and secondary group associates play a significant role in influencing the thinking of potential clients to ask for help from some source. They will also have a bearing on who is approached first: the corner druggist, the minister, the social worker, the Arthur Murray Dance Studio or the YMCA. The responsiveness to influence by "public opinion" about when to seek help on problems which most people expect to manage "on their own" is also a function of the individual's character-structure. People vary greatly in their psycho-social need to be accepted by some reference group—one with which they identify strongly. *Tradition directed* persons are quite responsive to the judgments of associates who share similar cultural values. They are the kind of persons who, as David Riesman suggests,[4] have learned to expend life energy largely in finding traditionally tried and approved solutions to problems. Associate judgments are even more crucial for persons for are *other directed.* Their morality is a matter of public opinion, particularly those reference groups with whom they wish to identify. They tend to change whenever there is a major shift in social role. They approach life questions in terms of "what do *they* think?" Those working with them in a therapeutic relationship need

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[2] Marian Radke Yarrow, Charlotte Green Schwartz, Harriet S. Murphy and Leila Calhoun Deasy, "The Psychological Meaning of Mental Illness in the Family," *The Journal of Social Issues,* Vol. XI, No. 4, 1955: 12-24.

[3] Helen M. Walker, "Evaluation of Special Services to the Mentally Ill in a State Hospital." Cleveland, Ohio, School of Applied Social Sciences, Western Reserve University (unpublished manuscript), 1954.

[4] David Riesman, in collaboration with Reuel Deunny and Nathan Glazer, *The Lonely Crowd* (New Haven: Yale University Press, 1950).

to know who the *they* are. The judgments of associates are least significant for autonomous individuals, whom Riesman has designated as *inner directed.* Like all people, they first acquire social ideals and goals by internalizing them from persons and groups with whom they grow up. But they make a highly personal integration of them. They are able to modify them without express support from membership groups. Inner directed persons are capable of charting their life's course with a high degree of autonomy. Their superego is a fairly personal and idiosyncratic "gyroscope" that is less dependent on traditional or group norms.

How Associates Evaluate

Much of social learning about significant symbols takes place in *primary groups*—the foremost link between a person and his social system. These usually include one's family, close friends, immediate work associates and some neighbors. They are the people with whom we have regular intimate face-to-face relationships, whom we know in many roles, and with whom we are emotionally as well as socially identified. In these groups one is likely to find many persons who "really" care for and who "really" know us. We speak their language, share many of their values, respond to the same fads in cooking, like to play some of their games, cherish common memories, and share mutual aspirations about that "home in the country with a running brook." These primary group associates represent the most interested reference group of any therapeutic or learning process. They are crucial in supporting the decision that professional help be sought and influence the client in his thinking about the outcome.

Much useful information about a problem can also be obtained from associates less intimately related, who stand in a *secondary group* relationship to the client. They include business associates, lodge brothers, classmates, and labor union brothers, who interact on a more impersonal basis. Such associations are rationalized more by convenience and utility than ties of affection. Their impact is likely to be much more environmental than psychological.

Secondary group associates are also part of the social matrix which evaluates treatment. They often are very important judges, as, for example, a client's employer. He can hire, promote and fire. He has power over the livelihood and self-esteem of a person in need of counseling. He sees him at work. He may have a vested interest in changes of behavior of the client that affect his capacity to be of use to the company. Many individuals become conscious of their need for help only when they are un-

able to relate themselves effectively to the expectations of some of these people in primary or secondary group relationships.

Theoretical Considerations

The facts of associate involvement are generally agreed upon, but their significance for the evaluation of treatment data is sometimes questioned on a theoretical basis by psychoanalytic psychiatrists, psychologists, and psychiatric social workers. They reason that personal problems can be dealt with best ("most deeply") in an absolutely private relationship of the therapist and the client. They presume that it is better *not* to know certain crucial facts about a client than to learn them from someone else.

This psychoanalytic hypothesis holds that the information could not be useful anyhow until the client is ready to volunteer it. Its validity has never been seriously put to test. The theory fits the preference of most professionals to work from their offices and see persons anxious to be with them because they are motivated. Somehow the office-centered approach is often modified when the client is a child or when there are external pressures for quick action, as is the case with impoverished clients. Then more systematic efforts are made to study the patient's total life situation, particularly his family.

Not many clients object to this consultation process of some of their associates, when this is done by social workers making collateral visits. This approach was emphasized during the early years of professional growth of the field of social casework. Mary E. Richmond, who wrote the first definitive casework test, suggested that the client's entire milieu, particularly his family, should be considered the basis of a social diagnosis and treatment.[5] This point of view was pushed in the background when social casework discovered the psychiatric approach during the 1930's, but it never disappeared entirely. In fact it is now receiving renewed emphasis under the symbol of the "Family-Centered" approach to casework.[6] This approach stresses the value of treating in a family context but tends to make light of the impact of other primary and secondary groups on personality development.

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[5] Mary E. Richmond, *Social Diagnosis*. Russell Sage Foundation, N.Y., 1917: 137.

[6] Nathan W. Ackerman and Raymond Sobel, "Family Diagnosis: An Approach to the Pre-School Child," *American Journal of Orthopsychiatry*, Vol. XX, No. 4, 1950: 744-753; Max Siporin, "Family-Centered Casework in a Psychiatric Setting," *Social Casework*, Vol. XXXVII, No. 4, April 1956: 167-174; Frances H. Scherz, "What is Family-Centered Casework," *Social Casework*, Vol. XXXIV, No. 8, October 1953: 343-349.

Comparative Validity of Client and Associate Judgments

Individuals defined as "problems" by their associates do have a problem. Minimally, there are communication difficulties. But no matter what the weight of public opinion may be, it is not conclusive proof that a person is in need of treatment. Often, it is true, as Elbert Hubbard has said, "Many a man's reputation would not know his character if they met on the street."[7] The associates rather than the client may be in urgent need of treatment. This is quite a common experience in child guidance clinics. Severely troubled parents, unable to manage their children to their own satisfaction, may be too threatened by their own inadequacy to accept help directly. Their "problem" child may be the healthiest person in the situation. Similarly, many an employee has been let go as "unable to get along" or "inefficient" without necessarily reflecting on his competency. His difficulties may reflect the incompetency of an immediate supervisor and an organization's poor administrative structure. Yet no matter how pathologically projective such judgments of associates may be, they are significant in the assessment process. They have reality consequences that must be dealt with.

Client associates' judgments thus have a double utility. Sometimes they are valid; they reflect a high probability of being correct in terms of other criteria, such as the opinion of professionals, objective evidence or the client's own view. Even if not valid by these measures, they may be relevant because they affect the client's life.

The significance of associate judgments is similar when applied to groups. What people think about a group may be important diagnostically. At least it will give a clue to why the group has difficulties or advantages. A street corner social club may be delinquent in terms of the activities in which it engages. But even if there is no objective evidence of delinquent acts, if they are a reflection of ethnic or class bias, the belief of neighbors that the club constitutes a "gang" will have important consequences. Members may be harassed by the police for "loitering" and some parents will try to keep their children from such "bad company."

Reliance on client judgment in evaluation is likely to be high when practitioners have an analytic approach to personality. An emphasis on client associate judgments is more common when practitioners are influenced by social psychology and Kurt Lewin's Gestalt or Field Theory. It is the theoretical

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[7] Elbert Hubbard, "Notes: Side Talks With the Phillistines: Conducted by the East Aurora School of Philosophy," *The Phillistine,* Vol. 14, No. 3 (February, 1897): 82.

outlook that led social workers to a *situational approach* emphasis. Workers prefer to see their client at home, meet his family, interview his employer, and make collateral inquiries from school officials and other agencies. Ada E. Sheffield, who advocated this approach, did so on the basis of the theory that the interpersonal "need situation" should be the concern of social casework,[8] in contrast to the more individual centered worker-client relationship approach that treats human problems primarily as if they were only intrapsychic phenomena.

The consequences of using one or the other orientation in casework was dramatized in the experience of one of the country's outstanding Family Service Associations.[9] Its social workers were highly responsive to a psychoanalytic point of view. When they were assigned to the job of helping a newly arrived group of Jewish immigrants, survivors of concentration camps, it was assumed that they would require a great deal of intensive therapeutically oriented casework. Few of the refugees responded to this service. Many of them made light of the psychological aspects of their adjustment problems. They wanted jobs, furniture and English classes.

In a psychoanalytic theoretical frame of reference, these people seemed to be "resistant" to facing their "real" problems. Many of the workers were quite concerned about what would ultimately happen to these sad victims of history's most calculated dehumanization experience.

A follow-up study three to five years later found an unexpectedly encouraging degree of adjustment. There also was evidence that the caseworkers' stress on psychodynamic aspects made them less interested in discovering and facilitating client resources that turned out to have been a significant element in the adjustment. Seventy-five per cent of the displaced persons had first degree relatives living in the city, and eight per cent had relatives to a lesser degree. They lacked the agency's financial resources, but often were able to help the new-comers to organize community resources that were able and willing to help the displaced persons find better jobs, housing and get otherwise acclimated in terms of their need to be independent and autonomous.

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[8] "Gestalt and the Case Study," *Social Forces,* Vol. IX, No. 4 (1931): 465-584. (A special issue dealing with social work problems, particularly the situational approach in casework.)

[9] Helen L. Glassman, *Adjustment and Freedom.* United HIAS Service and Jewish Family Association of Cleveland, Ohio, 1956, p. 29.

Reputational Surveying

Two methods are used in the assessment of client associate judgments: A qualitative and social-anthropological approach of the person's general social standing which might be called *reputational surveying* and a more quantitative measurement of status in a specific group, for which Jacob L. Moreno, who was first to use it, coined the concept of *sociometry*. The former is more focused on a person's social functions, whereas the latter relies more on the recording of group structure data.

Reputational surveying is widely used clinically in what social workers call "collateral visits." It has been employed in a number of treatment studies, including several aimed at evaluating the results of client-centered therapy. Names of close friends had been volunteered by each client for this purpose. They were interviewed about the client's maturity, job adjustment, and capacity to like other people, etc. before, during and after therapy. These judgments correlated in a good many cases with those of the counselors and with client self-judgments.[10] Similar consistency of client associate judgments was observed by Melvin Kohn and John Clausen. Relatives of adult schizophrenics were able to describe retrospectively the degree and kind of the patient's social isolation at the age of 13-14. Their accounts checked with a high level of reliability (26 out of 30 cases) with the recollections of the patients about this preadolescent period.[11] But this type of consistency cannot be taken for granted. Ratings of members of a Jewish fraternity of their own self-assurance and freedom from anxiety, intelligence, personal charm, Jewish appearance and Jewish cultural identification were not highly correlated with ratings of these traits made by fraternity brothers.[12] Engaged girls, their parents and their best girl-friend showed a

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[10] Carl R. Rogers, "Changes in the Maturity of Behavior as Related to Therapy," Carl R. Rogers and Rosalind Dymond, Editors, *Psychotherapy and Personality Change* (Chicago: University of Chicago Press, 1954): 215-237. Marian Bartlett and Staff, "Data on the Personal Adjustment Counseling Program for Veterans," Report of the Personal Adjustment Counseling Division, Advisement and Guidance Service. Office of Vocational Rehabilitation and Education, Veterans Administration (1948); Edward A. Hoffman, "An Investigation of the Relationship Between Attitudinal Changes and Reported Overt Behavioral Changes," *Journal of Consulting Psychology*, Vol. XIII (June 1949): 190-195.

[11] Melvin L. Kohn and John A. Clausen, *Social Isolation and Schizophrenia* (1954): 21-22 (mimeographed report).

[12] Wilse B. Webb, "Self Evaluation Compared with Group Evaluations," *Journal of Consulting Psychology*, Vol. 16 (1952): 305-307.

somewhat greater capacity to forecast when an engagement would end in marriage than the prospective groom and his closest male friend.[13]

Sociometric Analysis

Sociometry is measurement of how individuals are related to and are accepted by members of a group. It proceeds by asking each person to select group members with whom he prefers to be associated or not be to associated in a specific activity such as sharing a room or being on the same bomber flight crew. From the answers obtained, the choices each person receives can be added to give him a sociometric score. Cliques within the group can be recognized by mapping the pattern of attraction or dislike between individuals. This is generally called a *sociogram*. Leaders and social isolates within the group can also be identified in the same manner.[14]

Sociometric surveys have been used in the assessment of associate judgments. In a study sponsored by the United States Marine Corps, sociometric ratings made by "buddies" were found to be somewhat better predictors of subsequent combat efficiency (as judged by senior combat officers with whom the cadets served upon graduation) than personal inventories, psychological tests, and school grades.[15] In another study of preadolescent children, the youngsters were able to predict the power of each child to influence others in play, eating, discussion, and other aspects of camp life. This conclusion was drawn by Ronald Lippitt, Norman Polansky and Sidney Rosen, on the basis of evidence that boys in a camp were quite reliable in the judgments about each other. The opinions of the boys about "who is able to get others to do what he wants them to do" were consistent with the judgments of trained observers.[16] In a more general survey of 45 sociometric studies, Jane Srygley Mouton, Robert R. Blake and Benjamin Fruchter concluded that positive choices of group members were useful in predicting leadership, performance in industrial productivity, personal stability, combat effectiveness, and training potential. Negative choices or the absence of positive choices

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[13] Ernest W. Burgess and Paul Wallin, *Engagement and Marriage*. New York, J. B. Lippincott, 1953: 558-567.

[14] Mary L. Northway, *A Primer of Sociometry* (Toronto: University of Toronto Press, 1952): 1.

[15] Joseph W. Eaton, "Experiments in Testing for Leadership," *American Journal of Sociology*, Vol. 32, No. 6 (May 1947): 531.

[16] Ronald Lippitt, Norman Polansky and Sidney Rosen, *op. cit.*: 37-64.

was correlated with such variables as accident proneness, sick-bay attendance (in the Navy), and frequency of disciplinary offenses.[17]

The sociometric procedure produces a quantitative index that can be useful in group evaluation studies. Thus "morale" can be defined as the percentage of mutual positive choices out of all possible choices. Moreno used them in making residential assignments of girls in an institution for delinquent girls.[18] Henrik Infield found that this index was related to group harmony and striving to attain group goals, while negative choices were a fair index to tensions and group disintegration. He applied these quantitative data in counseling with members of cooperative group farms in the United States and in Europe.[19]

The fact that all group members must be asked about their feelings and thoughts about other group members also limits the use of sociometry in work with groups. Some members will prefer to maintain illusions about their group standing. Special interaction among members can become disturbed by too much exposure of latent feelings. As in all forms of social practice, the value of the knowledge to be gained has to be balanced against the anxiety resulting from such acquisition of insight.

Limitations

Inaccuracy. Client associates have no patent on wisdom. They are subject to stereotyped thinking and the many other limitations to perception. However, even when a judgment is erroneous, it can still be useful in evaluation. Evidence of inconsistency can lead to the formulation of questions about its meaning. For example, delinquents arrested for stealing from railroad yards will often be thought of as very honest by their friends. Such behavior is approved by the mores of the delinquent gang. The boys will rarely steal from each other. This contrast of society's and one group's evaluation of the act leads one to conclude that crime has an important normative dimension.[20] Client associate judgments is useful in evaluation,

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[17] Jane Srygley Mouton, Robert R. Blake and Benjamin Fruchter, "The Validity of Sociometric Responses," *Sociometry,* Vol. XVIII, No. 3 (August 1955): 181-206.

[18] Jacob L. Moreno, *Who Shall Survive?* New York: Beacon House, Revised Edition, 1953.

[19] Henrik F. Infield, "Cooperative Community Research and the Sociometric Test," *Cooperative Living,* Vol. III, No. 1, Fall 1951: 1-8; Henrik F. Infield, "Macedonia, the Case of a 'Clean Bill of Health'," *Cooperative Group Living,* Vol. VI, No. 2, Winter 1954-55: 1-12.

[20] Edwin H. Sutherland, *White Collar Crime* (New York: Dryden Press, 1949). For a good illustration of the subcultural relativity of crime and the theoretical im-

irrespective of its validity: but no more so than any other judgment can it be presumed to be valid in terms of other criteria, such as the professional worker's judgment or observed data.

Confidentiality. Confidentiality in relationships between a client and his counselor is a cardinal principle in all of the human relations professions. Many people would feel blocked against seeking help without the confidence that the privacy of their communication will be strictly adhered to.

In law, the ministry, and medicine, this principle enjoys a good deal of legal recognition. Consultation with associates of a client is generally undertaken only after express permission of the client is given. In medicine, such authorization is usually in writing. In most cases permission is freely given, since clients are anxious to do anything that might contribute to the relief of their problems. In social work the legal status of confidentiality is less clearly established. Practitioners are nevertheless often insistent on it, because consultation with associates requires some degree of disclosure to them that there is a problem. To the extent that it is an important element in treatment, the use of associate judgment data is highly circumscribed.

Exceptions to the principle of confidentiality are common in the treatment of children, persons who have violated a law, and individuals requesting a form of public assistance. Investigations often have to be conducted without the client's knowledge or consent, although professionally trained people hold that such investigations should be made with as much circumspection as possible to protect the client's privacy and self-respect.[21] Workers are sometimes received as law enforcement officers. This attitude is in contrast to the view held by certain public welfare officials. They en-

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plications of this fact, see Frank E. Hartung, *A Study in Law and Social Differentiation, as Exemplified in Violations of the Emergency Price Control Act of 1942 and the Second War Powers Act,* in the Detroit Wholesale Industry, University of Michigan, typewritten manuscript, 1949. Some of his findings have been reported in "White Collar Offenses in the Wholesale Meat Industry in Detroit," *American Journal of Sociology,* Vol. LVI, No. 1 (July 1950): 25-34.

[21] The emphasis on being considerate of client needs for respect, privacy and autonomy has been traditional in social work, even during its pre-professional period. This principle was among those stressed by the Charity Organization Movement towards the end of the 19th century. Its leaders advocated *Friendly Visiting* in place of investigation of clients. The focus of such visiting was to be on planning and therapy. This principle was in contrast to an approach based on the assumption that paupers tend to be dishonest and need to be approached from the viewpoint of repression of deceit, imposture and mendicancy. See Verl S. Lewis, *The Development of the Charity Organization Movement in the United States 1875-1900: Its Principles and Methods.* Unpublished Doctoral Thesis, Western Reserve University.

courage the use of procedures to verify evidence of eligibility and financial need that have more of a credit investigation than a therapeutic rationale. Their policies enjoy little prestige among persons identified with the professionally oriented practice jurisdictions.

Therapeutic Isolation. Not only the normal aspects of personality but the abnormal ones as well develop through interaction with close associates, particularly *primary group* members. As a result, the people who know a client best are often the very last persons who can help him. A son who is disturbed by the rigidity of his parents might be unable to accept help if he thought that they would be consulted in matters affecting his treatment. A gang would reject a leader who "ratted" about their activities to parents or teachers. Such consultation could prove equally threatening to parents because of an attenuation of guilt feelings about their role in the problem. Therapeutic considerations favoring isolation are sometimes overruled by legal requirements, as for example in the case of an unmarried mother applying for relief. Efforts must be made in some jurisdictions to get the father to contribute to the support of the child, although for the psychic welfare of both the child and the mother it would be better for the father to be kept out of the situation.

There is some need for therapeutic isolation in most helping services, but contact with client associates is not necessarily an "either-or" proposition. In most problems associates know that a client or a group is receiving professional help. The question the practitioner needs to face is not *whether* but *how* to involve associates in the helping process.

In one study of "The Wife of the Mental Patient and the Hospital Psychiatrist," the doctors generally accepted it to be one of their responsibilities to maintain limited contact with a patient's family. Two out of three doctors in a well staffed public hospital thought it was reasonable and proper for wives to come to them for information and to expect their questions to be answered. Requests to alter the course of hospitalization were regarded as reasonable and proper by only about half of the psychiatrists, with the notable exception of pleas to grant the patient home visit privileges which were thought reasonable and proper by 87 per cent. Most of the doctors wanted to get information from patient associates during the early phases of treatment. Thereafter, contacts almost always came at the initiation of the associates.[22] In another mental hospital study, a private institution depend-

[22] Leila Calhoun Deasy and Olive Westbrooke Quinn, "The Wife of the Mental Patient and the Hospital Psychiatrist," *The Journal of Social Issues,* Vol. XI, No. 4, 1955: 49-60.

ent upon fees, most of which are paid by relatives, there was considerable tension between the hospital staff and the relatives. Associates were often perceived as active factors in the etiology of a patient's difficulty, but there was uncertainty about how crucial they would be for its resolution.[23]

The problem of using associates in the treatment process is anything but simple. When it is perceived as an important matter and dealt with with the same degree of planfulness as the patient's own treatment, there is a probability for maximizing the contributions associates can make to the patient's improvement.

Expense. Home visits and consultations with client associates are time consuming and expensive. It is generally thought to be more effective to work directly with the people who are in need of help than to dilute one's efforts by including their associates in the helping process. Each hour spent with a relative could be spent with the client. A choice, therefore, has to be made about which type of contact is more likely to be productive for the client. The time and cost factors are particularly crucial in deciding upon the appropriateness of out of office contacts with clients and their associates. Social practice from behind the desk of an office has many logistic advantages. There is ready access to files, consultants and special equipment needed in treatment. Time that would otherwise be spent in travel to homes can be used for discussion with clients in the office.

This "efficiency" is sometimes purchased at the price of effectiveness. For example, at the New York Jewish Board of Guardians, one of the nation's best known child guidance clinics, it was found that the child and his mother were the main sources of diagnostic information and the most common unit of treatment. Fathers, siblings, relatives and other persons close to the child were less involved in the treatment than seemed advisable on the basis of a clinical review of cases. Practice took insufficient account of certain of the child's close associates towards whom his behavior was oriented.[24]

Conclusion

Client associates, particularly other than family members, are among the least used sources of information and validation. This fact need not be accepted as given but can become a departure for asking questions about

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[23] Alfred H. Stanton and Morris S. Schwartz, *The Mental Hospital.* New York: Basic Books, Inc., 1954.

[24] Otto Pellak and collaborators, *Social Science and Psychotherapy for Children* (New York: Russell Sage Foundation, 1952): 37-59.

the uses and limitations of this diagnostic treatment and evaluation variable. The reluctance of many therapists, be they psychiatrists, psychologists, social workers, or marriage counsellors, to include client associates in their work is in fact related to their predominantly psychodynamic theoretical orientation. When personal problems are thought of largely in *intra*-personal terms, there is little reason for extending one's horizon of action to the social dimension of living. Such practitioners ignore what insurance men and vacuum cleaner salesmen never forget: If you want to make a sale, see husband and wife together. They function as a unit on important decisions. Similarly, advertisers have discovered that many products, like cereal, can be sold most effectively to parents through their children. They approach the family as an interpersonal communications system of influence.

The present trend in the helping professions to give greater attention to social and cultural factors in behavior has already resulted in more thoughtful exploration of the degree to which practice can be improved through the use of client associates in the fact-gathering, diagnostic, and treatment phases of helping those with problems. There are probably many occasions when it would be cheaper, less time-consuming and more effective to leave the office and obtain information from the milieu in which the client or group lives. There are also many persons who cannot come to an office for physical or psychological reasons. The situation is analogous to that of the physician who practices most effectively in a hospital or his office. There he has nursing help and technical equipment. But could he safely abandon the occasional house call from his practice?

WHAT HAPPENS TO THE SOCIOMETRIC STRUCTURE OF SMALL GROUPS IN EMERGENCIES AND EXTREME CONDITIONS[1,2]

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Emergencies and extreme conditions obviously place unaccustomed stresses upon the sociometric structure of groups. Studies conducted by the author and his colleagues (14) suggest that the process of group adaptation under stress is much the same as Selye (8) has found for individual physiological adaptation to stress. In other words, groups appear to respond to increasing stress first by lag in response, then by overcompensatory response, and finally by collapse, if the stress continues without abatement.

In preparing groups to behave more effectively in emergencies and extreme situations, it is important that we know what types of group structure adapt most readily to insure rapid overcompensatory response when increasing stress is first encountered and continued adaptive behavior or will-to-survive as stresses accumulate. First, however, we need to know what happens to group structure in emergencies and extreme conditions.

In this paper, an attempt will be made to summarize and synthesize a number of findings concerning the sociometric structure of small isolated groups in emergencies and extreme conditions from studies conducted by the author and his colleagues during the past five years. Findings will be organized around the specific question, "In what ways does the sociometric structure of small groups change in emergencies and extreme conditions?"

METHODS

Three general approaches have been used in developing the findings which will be presented:

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[1] Papers prepared for presentation to the Fifteenth International Congress of Psychology, 28 July-3 August 1957, Brussels, Belgium.

[2] This report is based on work done under ARDC Project No. 7723, Task No. 77461 in support of the research and development program of the Air Force Personnel and Training Research Center, Lackland Air Force Base, Texas. Permission is granted for reproduction, translation, publication, use, and disposal in whole or in part by or for the United States Government. The opinions or conclusions expressed herein are those of the author. They need not be construed as necessarily reflecting the views or endorsement of the Department of the Air Force or the Air Research and Development Command.

1. Interviews with and personal accounts by survivors of emergencies and extreme conditions.

2. Field studies of groups in realistically simulated emergencies and extreme conditions.

3. Laboratory-type experiments.

The types of small groups studied include: aircrews downed behind enemy lines, on water, in the Arctic, in the desert, and in other extreme conditions; ship and submarine crews under fire or shipwrecked; groups in isolated and/or dangerous Arctic and Antarctic outposts; prisoners-of-war; evasion and escape groups; groups of secret agents; underground groups; infantry squads and platoons under severe enemy attack or exposed to extreme climatic conditions; and air-to-air fighter groups in combat. Nationalities included: United States, British, Canadian, German, Dutch, French, Australian, Polish, Scandinavian, and Belgian. The studies of groups in realistically simulated emergencies and extreme conditions have involved either aircrews undergoing survival training (6) or training groups of survival instructors. Research designs involved the administration of measures of sociometric structure obtained before and after the simulated survival experience, or intensive interviews with participants designed to reveal changes in sociometric structure and processes of adaptation. The laboratory-type experiments have involved aircrewmen, instructors and college students presented with some standardized group task.

A salient feature of the method employed has been the continuous interchange between the three types of studies. Studies of behavior in actual emergencies and extreme conditions have been used to generate hypotheses which were then tested in the field or laboratory, as well as to test hypotheses derived from field and laboratory studies. Although there are undeniably important differences in the three types of situations, we have obtained essentially the same types of phenomena in the realistically simulated survival situations and in the laboratory as those described by survivors of actual emergencies and extreme conditions. Panic and group disorganization occurring in the laboratory and in simulated survival situations are as clearly identifiable as in actual situations. Likewise, subjects in these simulated *situations discontinue adaptive behavior and resort to behavior analogous* to the loss of will-to-survive found in actual emergency or extreme situations. Only brief descriptions can be given of the studies from which findings are drawn.

Results and Conclusions

First, let us dispose of the question, "Does the sociometric structure of

small groups change in emergencies and extreme conditions?" In addition to a considerable body of observational data and the reports of survivors, empirical evidence exists to answer this question with reasonable adequacy (7).[3]

Eight hundred combat aircrewmen (310 officers and 490 airmen) composing medium bomber crews responded to a sociometric questionnaire both at the beginning and end of a fourteen-day survival training course in the winter of 1951-52. One phase of the course consisted of a seven-day simulated survival experience involving severe cold, snow, high altitude, travel over difficult terrain, living outdoors, and subsistence on limited rations. All of the groups had been functioning as crews for approximately four months prior to the training. A comparison of the pre- and post-training responses indicated that sociometric choices under stressful conditions are far from static. About 45 per cent changed their choices of "best survival leader." Over 50 per cent of the choices as "most desired survival companions" (two choices being permitted) were changed, and about 50 per cent of the nominations as "least desired survival companions" were changed.

In the same study (7), interesting variations in stability from crew to crew were found. Almost no changes occurred in some, while almost all choices were changed in others. This was especially true of choices of survival leader and least desired survival companion. Of the 70 crews studied, approximately one-third were dissolved during the next stage of training and were never assigned to combat duty. Significantly fewer choices of survival leader and of least desired survival companion were changed in the combat crews than in the "drop-out" crews. One-half of the combat crews were identified as "better combat crews" and the others as "poorer combat crews" on the basis of combat performance records and ratings by superiors collected several months later. The "better combat crews" made proportionately fewer changes in choices of survival leader than the "poorer combat crews." Percentage of members choosing the aircraft commander (the designated leader) as the most desired survival leader after training was also a consistent predictor of combat performance. This was not true of choices made at the begining of training.

Another study conducted in the winter of 1953 (3) provides insight into the nature of some of the changes which occur in the social structure of small groups under stress. The study was conducted in essentially the same setting as the 1951-52 study and involved 58 medium bomber crews

[3] It is assumed throughout this paper that changes in sociometric choices reflect changes in sociometric structure.

with the same crew composition and experience history as those of the previous study. All subjects were administered the Leader Behavior Description Questionnaire and the Crew Description Questionnaire (3) immediately before and after the nine-day field exercise. The Leader Behavior Description Questionnaire yielded two dimensions: The commander's tendency to take the lead in "structuring" interactions within the crew (Initiating Structure) and effort to maintain friendly and warm relationships between himself and his crew (Consideration). The Crew Description Questionnaire yielded four dimensions of structure: how well the men seem to know each other (Intimacy), how well they get along together (Harmony), how well they understand orders and procedures (Procedural Clarity), and the extent to which crew position or rank determines prestige within the crew (Stratification).

Leader behavior, as measured by crew members' responses to the Leader Behavior Description Questionnaire, was not found to change consistently during the stress experience, but the variation among leaders in behavior was greater when measured after the stress experience, than when measured before the experience. Apparently some leaders under stress exercised tighter control than usual while others "let things go" and did less to initiate structure than ordinarily. Similarly, some showed greater consideration under stress while others were less considerate than usual. The pre- and post-training means of the two dimensions, however, were not statistically different.

When the crew dimension data were analyzed, it was found that the stress experience apparently increased the variability of the Harmony, Procedural Clarity, and Stratification dimensions and decreased variability on the Intimacy dimension. The non-parametric T test showed that crew members' mean scores on Harmony, Intimacy, and Stratification are significantly different from pre- to post-training. There is significantly less Harmony, more Intimacy, and less Stratification after survival training. In other words, adaptation to the stress experience apparently involved getting to know each other better and becoming less aware of prestige differences, but getting along together less harmoniously. Viewed in the light of the variability data, it is interesting to note that the change toward greater intimacy is relatively uniform, while the other changes are accompanied by considerable variability. For example, some groups apparently adapt to stressful situations by becoming more aware of prestige differences while others become less aware of such differences.

From a matrix of the intercorrelations of the chief variables of the

study, two factors with loadings both on leader and crew dimensions were extracted. One factor, labeled *Esprit de Corps,* with significant loadings on all four crew dimensions, is described by Hites and his associates (3) as "good group feeling and relations, but with no laxity in discipline or military bearing." The other factor, *Organizational Effectiveness of the Leader,* characterizes a group which adheres to military procedure and whose leader follows SOP (Standard Operating Procedure), and makes duties and procedures clear.

It is well known that the formal structure of a group does not always coincide with the informal interpersonal relationships among its members. Accounts by survivors of emergencies and extreme conditions involving groups and observations of groups in laboratory and simulated survival experiences have repeatedly suggested that the official social structure tends to break down and give way to the informal social structure when emergencies and extreme conditions occur. In general, it has seemed that the more able members of a group tend to unite with the other more able members of the group, leaving the less able to fend for themselves. These phenomena were dramatically manifested in a group of 26 men studied intensively in the winter of 1955 (14). Prior to the stress experience (a blizzard in the High Sierras), the group had been divided alphabetically into three official subgroups each under a designated leader. Instruction was performed by a group of six experienced men. The group had been in existence for approximately three months. When the blizzard occurred and it became necessary for the group to halt and make shelters, the official subgroupings broke down almost completely. The data collected from group members included nominations of those best able to lead in a survival situation and those best able to "take care of themselves." When the subgroupings which emerged during the blizzard and the ensuing extreme condition were examined, it was found that those rated as best able to lead and best "able to take care of themselves" joined others similarly rated. Ninety per cent of the members' leadership choices were concentrated in two of the seven subgroups. Similarly, 85 per cent of the choices of "best able to take care of self in a survival emergency" were concentrated into these same two subgroups. This obviously left those least able to "take care of themselves" without strong leadership.

The following comment by one of the members of this group is typical of the explanations given for the subgroupings which emerged at the time of the blizzard:

"When something like a blizzard hits you, you work with the men

you can depend upon regardless of the group you are in. The three groups were not well integrated. They should have been grouped on some basis other than alphabetically. Each had a buddy in another group and had become disgusted with some of the members of his own group."

A phenomenon perhaps even more dangerous than the one just described is the failure of any kind of subgrouping or social structure to crystallize. This results in a lack of mutual support and an emergence of the "survival-of-the-fittest" philosophy or an apathetic loss of will-to-survive. This appears to occur when stress becomes most acute or when stresses have accumulated. In the blizzard study just referred to, this phenomenon became quite pronounced when stress was at its highest. For example, one man tumbled down a snow embankment of approximately 50 feet and man after man passed by without attempting to help him, laughing and showing no concern for his safety.

Discussion

It should not be difficult to accept the fact that the social structure of small isolated groups changes in emergencies and extreme conditions. Most operating groups are accustomed to functioning in relatively structured situations in which both goal and group structures are well defined. In a formal organization, each individual has particular functions and required relations with others in the group. These required relations are concerned with responsibility, authority, communication, and the like. They are specified in tables of organization, job descriptions, and standard operating procedures to some extent. If these do not exist, relations develop as a result of the various functions persons are given or take onto themselves and the relations these create with others. Each person then "feels" certain role prescriptions which affect the nature of his required (as he sees it) relations with others.

The degree to which one person likes another or is sociometrically chosen by another, then, is affected somewhat by the nature of his perception of the extent to which others will meet his needs in respect to getting done the job of the group. Other needs, of course, are also present. These concern more affect laden areas such as need for support, affection, and the like.

The nature of the needs a given person might have are greatly determined by the situation. The situation includes the goal of the group as well as other demands made upon the person. Tables of organization, job descriptions, standard operating procedures, and the like are established

to meet these needs. Demands change, however, when the group encounters an emergency. New needs arise in the individual and from the group as a group. The relationships described by tables of organization, job descriptions, and standard operating procedures are no longer effective and new ones are established.

As a result of setting up new relationships, both to protect the group and to protect the members, new patterns of sociometric choice are bound to occur. Individuals simply find themselves with new needs because of new conditions and find new people useful to them.

In attempting to understand the nature of the changes in sociometric structure which occur in emergencies and extreme conditions, it seems helpful to view them in the light of a conceptualization of group structure developed by the author in earlier analyses of approximately 200 interviews with survivors of groups exposed to emergencies and extreme conditions (11 and 12). Group structure was conceptualized as having four important aspects: *affect (liking-disliking), power, communications, and goal.* Each of these is a dimension of group structure on which a group may have built a stable linkage pattern. Under stress, these linkages between members may become confused and thus people do not know what they can expect of one another, with whom they can relate, how they can relate to one another, and so on. Thus we have the finding of Hites and his group that during a simulated survival situation group members came to know one another better and were less aware of prestige differences, but got along together less harmoniously. These findings should not be disturbing in the light of recent research evidence. Havron and his associates (2) found that the members of the more effective infantry squads know one another better than do the members of the less effective ones. Our research group found that willingness to express disagreement is associated with accuracy of group decisions (13 and 15), willingness to accept group decisions (13), and combat effectiveness (10). We have also demonstrated that awareness of status or power differences interferes with the expression of disagreement and reduces the accuracy of group decisions (13 and 15).

It is not difficult to explain why stability of sociometric choice is related to group effectiveness under stress, in the light of recent research. Perhaps the most direct attack on the underlying social psychological problem is found in Ewart Smith's laboratory study of the effects of threat induced by ambiguous role expectations on productivity and defensiveness in small groups (9). Smith found that the introduction of trained, silent members into small, short-term problem-solving groups produced large and

significant decrements in productivity, increases in defensiveness, and reductions in group satisfaction and group cohesiveness. Aircrews with unstable sociometric structures probably experience a similar kind of role unclarity to that engendered by the silent plant.

The finding that the more able members of a group band together under stress, leaving the less able without strong leadership is also in accord with an accumulation of observations of groups in actual and simulated emergencies and extreme conditions (11). Such a phenomenon is also to be expected from the finding of Hurwitz, Zander, and Hymovitch (4) that individuals of high status tend to choose, want to be with, and communicate with other individuals of high status rather than individuals of low status. Observations of aircrews and other hierarchical groups had led us to assume that this cleavage was due to the code that officers should associate only with other officers. The subjects of the blizzard study, however, were all of the same rank, suggesting that the basis for the prestige operating in emergency and extreme situations may possibly be related to the skills required for survival.

The failure of social subgroupings to crystallize is also compatible with stress research in other areas. For example, Keys, Brozek, and associates (5) found that food deprivation is accompanied by social withdrawal, narrowing of interests, apathy, and irritability. Boag (1) also observed that under severe conditions of cold "the individual's attention becomes restricted to keeping his body warm and putting food into it" and lack of communication with associates occurs. He observed that a well-organized group can thereby be changed to a mass of individuals each concerned only with looking after himself. The author would certainly concur with Boag in his recommendation for emphasis on efficient organization and leadership, clear definition of objectives and methods, adequate training in requisite skills, and the utilization of available methods of maintaining morale and good discipline.

Summary

In summary, it may be concluded with reasonable assurance that the sociometric structure of small groups tends to become unstable under stress; effective groups show greater stability in sociometric structure than ineffective groups; measures of leader and crew dimensions increase in variability under stress; group members become better acquainted with one another, less aware of prestige differences, and less harmonious; official social structures tend to give way to informal structures under stress; and in extreme stress, social structure tends to break down and tends not to be replaced by any structure.

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CODE OF ETHICS OF GROUP PSYCHOTHERAPISTS

COMMENTS

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In the last issue of GROUP PSYCHOTHERAPY there appeared a note by Dr. J. L. Moreno on a "Code of Ethics of Group Psychotherapists" (1) which has moved me to make some responsive comment.

We can only endorse Moreno's objective that group psychotherapy "render service to every member of therapeutic groups and to the groups as a whole." Similarly, we can esteem his belief that "a group psychotherapist should practice methods of healing founded on a scientific basis . . . .". Whether we are yet at a stage where the group psychotherapist's practices need the sanction of "official professional boards" is open to some question but certainly deserves serious consideration in a field where some unqualified individuals have undertaken to do group therapy. Moreno's emphasis on the need for proper training in the knowledge and techniques of this special branch of treatment is certainly worth advocating. His concern for the security of the group member against any kind of abuse, whether at the hands of the therapist or another patient, deserves full support. His advocacy of a democratic climate in therapeutic groups, so heterogeneously organized as to give equal status to all members regardless of "economic, racial and religious differences" inspires the same endorsement.

Moreno's question with regard to charging different members the same or varying fees and the possibility that disparate payments might "produce feelings of inequality and thwart the therapeutic aim" is an interesting one. However, in my own clinical practice, where members of the same group pay different fees, this partiality has not been an obstacle to therapeutic progress.

While the therapist is eager for patients to express their wishes freely, and while they may be encouraged to demonstrate their preferences, I cannot agree with Moreno that they "should be free to choose the therapeutic groups in which they participate as members." No one could disagree with him, if he means a patient should have the freedom to choose his therapist, providing the one selected is also in a position to accept the patient. But my impression is that Moreno rather implies that the applicant have the right to pick his group. In the first place, at least in private practice, applicants do not know the members of the therapist's groups, so that patient preferences can hardly be justified as valid, since they are not

based on any experience as yet with the other members. If the patient, after a period in a group, chooses to leave, asks for placement in another group and his reasons for requesting the change are not distortions, surely his wish may be granted. Secondly, while the therapist considers and respects the patient's choices, it is the therapist who is the expert, and who, as the specialist, must exercise his good judgment as to the most favorable milieu in which to place the patient. And finally, some patients may be so confused, irrational, psychotic or psychopathic that their freedom of choice may not at the time be in their own nor in the group's interest.

As to the therapist's being "free to accept or refuse to serve in behalf of a therapeutic group", such a contingency need hardly arise in the case of any professional who has chosen to qualify himself as a group therapist. Having initially accepted the medium in which to exercise his therapeutic skills, he will presumably prefer so to continue without feeling that he is under internal or external compulsion to carry on the practice. A possible exception might occur in the case of a therapist who has had no experience in conducting a group of children, a group of psychotics or some other special group with which he has little or no familiarity. Another exception that comes to mind is that irrational school of psychotherapy which compulsively drives the patient into further psychopathology and regards any form of conscious helpfulness on the part of the therapist as inappropriate (2).

I do not believe any patient should be compelled to join a therapeutic group against his wishes, even if the expert believes it would be in the patient's best interest. Good psychotherapy would first be directed toward working through his resistances to joining a group until such time as the patient himself expressed a desire to share his problems with other members.

While the Hippocratic Oath is binding on the majority of physicians "to keep all matters—of professional practice secret", there are enough exceptions among a less scrupulous minority to jeopardize the privacy of occasional patients. Ideally it would be most desirable in group psychotherapy that the Hippocratic Oath be "extended to all patients and bind each with equal strength not to reveal to outsiders the confidences of other patients entrusted to them." But it is difficult to conceive how seriously and consistently some patients would adhere to such a principle in practice, particularly when it is recalled that occasionally human frailty and compulsive protest lead to broken pledges. While one can only appreciate Moreno's zeal in feeling that "like the therapist, every patient is entrusted to protect the welfare of the co-patients", it seems to me that a thoroughgoing analysis of any member's readiness to gossip or otherwise betray another patient is a more practical and at the same time a more basically therapeutic means of

resolving this problem in ethics. In a fairly extensive experience of my own the matter of disclosing intra-group material to outsiders, though an occasional problem, has not been sufficiently seriously recurrent to warrant concern. Almost universally, extra-group revelations have been so nebulous or non-specific with reference to the actual identity of a given member as to preserve his anonymity. If any law is needed to protect the individual undergoing group therapy, I believe legislation that would prevent one group member from revealing in court confidential information about another acquired in the course of group therapy would be more in order.

I would agree that "the link of mass media of communication like television to group psychotherapy and psychodrama would produce 'leaks' of confidence—too difficult to control." As to Moreno's speculation that "open circuit television may become the major route for mass psychotherapy", I have expressed elsewhere (3) my feeling of the inappropriateness and irrelevance of group psychotherapy in mass conflict.

It seems to me that, while certainly a patient is entitled to the security that the privacy of his communications will be kept in trust, no reliable guarantee against the danger of betrayal is assured by subjecting the therapeutic group membership to a "pledge" of secrecy. Our life experience has not made us certain that we can surely always rely on the promised word, whether from the parent, the testimony under oath in the courtroom or the signer of an international treaty. Just as the individual patient tests the therapist again and again before he learns to trust and rely on him, so the group member repeatedly tests his peers until he begins to put his confidence in them. I believe the problem here is one of working through multilateral distortions in distrust and devious aggression rather than mechanically binding patients to a vow of uncertain security.

No matter how we may in minor respects differ with Dr. Moreno, he is to be congratulated for confronting us with a series of ethical principles of concern to the group therapist and patient alike. His speculations with regard to insuring proper safeguards in group psychotherapy will surely provoke further exploration and lead to the development of more conscientious and responsible group practices.

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It is not accidental that concern is being expressed regarding the ethical behavior and social responsibilities of group psychotherapists. Such concern is to be expected, since the practice of group psychotherapy has become fairly well institutionalized, and accompanied by various informal rules of conduct.

What is more significant, however, is the fairly explicit concern with the patients' ethics. This area is touched upon in sections 5, 7, 8, 9, and 10. It is most explicit in section 9.

Moreno's concept of the "Group Oath" and the "Group Pledge" makes explicit what in the best examples of individual psychotherapy evolves on the basis of the patient-therapist relationship, during that time in therapy when the patient and the therapist are capable of mutual confrontation of interpersonal distortions. This becomes more than a recognition of the need for therapeutic honesty: it specifies that a proper area for investigation between patient and therapist is what might be called unconscious therapeutic dishonesty.

Moreno's code of ethics attempts to impose structure upon an extremely elusive phenomenon. If only for this reason, it should be highly recommended. However, there are more specific, and less subtle, advantages to be gained by specifying rules of conduct for group psychotherapists. It is only necessary to mention areas of training, supervision, and evaluation of patient progress, to recognize that only such conscious efforts of control can lead to appropriate implementation of these areas.

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One of the criteria of any profession relates to its value as a contribution to man's physical, social, economic and mental welfare. The actual benefit which any person seeking aid from the helping professions receives is generally of a one-to-one relationship. Obviously, much depends upon the individual practitioner's professional training and skills. In a sense it is these phenomena which form the hard core relationships of professional reality.

Today, with the advent of the group method into many fields of endeavor, and particularly group psychotherapy, the codes of ethics which

have guided individual professional people in the past can help shed a good deal of light upon the present. But they need re-examining in terms of present experiences.

As group psychotherapists we have a tremendous professional responsibility. We are not only concerned with group members but with the multiplicity phenomena which operate in any group. This requires more than just a training in therapy. It requires a broad cultural understanding in many of the social, physical and biological sciences along with a knowledge of personality dynamics.

The group itself includes all of life in a microscopic fashion as it were. Therefore, the group psychotherapist is constantly beset with new challenges and demands upon the role he plays. Flexibility, understanding, acceptance, and firm-kindness are only part of the qualities demanded of him. He is working through problems and problems are working through him.

Because of much confusion now prevailing in the field there are as many different theories on group psychotherapy as there are group psychotherapists. It is true that the field is comparatively "new". Yet, it is not premature to concentrate on a code of ethics which would embody the best type of thinking and experiences gained from the various helping professions. Can we agree on certain concepts to be included in such a frame of reference? It is my opinion we can if we think of such concepts as principles rather than laws. Dr. Moreno, I note, refers to them as "standards in order to maintain a high level of ethical conduct".[1]

All professions have a body of knowledge and trained practitioners. There is no reason why group psychotherapy cannot eventually meet these characteristics in a refined manner. As yet, there are few facilities available for the training of group psychotherapy specialists. Only when this kind of training becomes more accessible and possible will we be able to meet board requirements, etc.

As to the question of fees, types of patients, selection, privileged communication and other pertinent matters one thing stands out. Dr. Moreno, by raising the question of a Code of Ethics of Group Psychotherapists,[2] has touched upon a most challenging and dynamic topic. Especially since group psychotherapy today is practiced by people from diverse disciplines in diverse settings.

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[1] Moreno, J. L., "Code of Ethics of Group Psychotherapists", *Group Psychotherapy,* Vol. X, No. 2, 143, June, 1957; also, see "The Group Oath", by J. L. Moreno, *Group Psychotherapy,* Vol. VIII, No. 4, 357, December, 1955 and *Progress in Psychotherapy* (New York: Grune and Stratton, 1956), Vol. I.

[2] *Ibid.,* "Code of Ethics of Group Psychotherapists", pp. 143-144.

We can assume that each practicing group psychotherapist is aware of a code of ethics as regards his own professional discipline. We can also assume that he will be aware of a similar code observed by his co-workers from other disciplines. Thus, we are confronted with a multi-discipline challenge. I believe a desirable example to follow at this time is that of the American Psychological Association in setting up its ethical standards for psychologists.[3] Large numbers of professional incidents were gathered before principles were evolved. At the same time there should be a continual interchange of ideas regarding ethical practices with psychologists, psychiatrists, social workers, educators, penal workers, group workers, industrial workers, and other group oriented peoples. In this process there can evolve much clarity regarding terminology, types of work each discipline is doing, the difference between intensive group psychotherapy and lesser forms of group work. There is certainly much which a national research committee can do.

At any rate, Dr. Moreno has raised a vital issue. Can we meet this challenge?

S. Lebovici, M.D.

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I quite agree with the Code of Ethics of Group Psychotherapists by Dr. Moreno.

In my opinion, the group psychotherapist has to behave as do other psychotherapists under all circumstances. A special problem has to be taken into consideration: I mean the existence of the group and the audience. It is necessary to advise each member of the group to be careful; each of them has to keep in mind that he is the doctor of his colleagues.

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The code of ethics, suggested by Dr. Moreno, is an important step toward the establishment of standards for group psychotherapists. However, the formulations as presented beg for revisions and amplification. Some points merely pose questions; some may encounter objections. At any rate, there can be no doubt that the advent of group psychotherapy and psychodrama introduced new perspectives which require new principles to guide the conduct of the therapist. The necessary change in the concept of privacy

[3] See *Ethical Standards of Psychologists* (Washington, D.C.: The American Psychological Association, 1953).

has been pointed out by Dr. Moreno in his "Group Oaths." A statement of this new orientation may have to be included in the formulation of standards.

The following are more specific comments to the various points raised in the presented outline of a code:

##1, 3, and 5 can well be accepted in principle. #3 could end after the first sentence—the rest is self-evident. #5 may benefit from some enlargement. The democratic nature of the therapy group requires equality of status for all members, not merely in regard to economic, racial and religious differences, but also in regard to symptomatology, personality and character traits. It implies a fundamental respect for every patient *as he is*. This should be stated explicitly.

Other points require considerable clarification. The question of protection of the patient, #4, is not clear. A special requirement or standard seems superfluous since the professional code of any therapist implies protection of the patient from abuse. If, on the other hand, this phrase means that the therapist should shield the patient from criticism, aggression and hostility of other patients, then such requirement would be contrary to the widely accepted principles of group psychotherapy. What the patient needs is not protection from abuse, but the ability to deal with aggression and hostility effectively. The respect for the dignity of every patient is implied in #5 with its provision for a democratic setting. Therefore, it seems that #4 could be eliminated altogether. #2 seems also to be superfluous; #3 covers the point adequately.

#6 raises implicitly the question of equality of status. In accordance with this requirement of #5, it seems preferable that all patients be charged the same fee. Attempts to do differently usually meet with objection on the part of the group.

#7 seems to be irrelevant. All decisions to join a group must meet with the patient's consent; but it cannot be left to him to decide which group would be best for him. This is a question of mutual agreement and communication between patient and therapist. Neither can force the other toward a decision to which he objects. But this requires no statement either in regard to ethics, standards or methodology. The choice of a group is part of the over-all *agreement between patient and therapist, necessary for* any aspect of psychotherapy.

##8, 9 and 10 belong together. They deal with the problem of privacy and protection of the patient's confidence. In the present formulation, this guarantee is neither clearly stated nor properly attempted. The Hippocratic Oath binds only the physician. It is questionable that a patient could be

bound by it, or that a pledge would guarantee protection for others. Such a pledge of secrecy does not prevent the patient from breaking it. There are other means by which consideration for the welfare of others can be evoked. The therapist should be acquainted with such approaches and use them; this could well form the content of a special point. It could explain the precariousness of the open and shared expression of intimate details within the group with the necessary discretion in regard to outsiders. The greatest guarantee against divulgence of private material is the sense of responsibility for the welfare of others, shared with and induced by the therapist, and the realization of a common benefit from the discreetness of each member of the group. A strong feeling of belonging and fellowship seems as well a basis for an effective therapeutic procedure in the group as a protection against loose talk outside of it.

The need to be frank and to talk freely about personal intimacies, normally not discussed with others, is part of the new form of therapy, with its revolutionary social orientation. The ability to accept this outlook and to communicate it to the patients may well be treated in a separate point of standards. Anyone who has reservations or objections to relinquish the heretofore accepted requirements of privacy in psychotherapy would, thereby, violate one of the basic standards of a code for group psychotherapy.

There may be other points to be considered which at the present time are not visualized. For this reason, I would suggest that a committee be appointed by the American Society of Group Psychotherapy and Psychodrama to study various suggestions in line with the first draft by Dr. Moreno. In line with my comments, I would like to submit for consideration the following formulation:

1. The objective of group therapy is service to every member of the therapeutic group and to the group as a whole.

2. The designation "group therapist" or "psychodramatist" should be used only by psychotherapists who have obtained training in recognized institutes of learning.

3. Therapeutic groups should be so organized as to represent a model of democratic relationships. Equality of status should be provided for each member regardless of economic, racial and religious differences, individual personality traits, symptomatology or other characteristics.

4. In line with the need for equality, the same fee should be charged for each patient, unless the whole group, including the patient, decide to make an exception.

5. The choice of the group should be made by mutual agreement between patient and therapist, except under conditions which make it im-

possible for the patient to make a choice (because of mental or intellectual deficiencies).

6. The group therapist must recognize the limitations of traditional concepts demanding privacy of communication. At the same time, he must offer protection against indiscretions of fellow patients to outsiders. The creation of a feeling of fellowship, of belonging and of mutual interest in the welfare of each member of the group is mandatory. It is the only safeguard against indiscreetness.

7. The therapy group must be so conducted as to promote an atmosphere of mutual respect and to stimulate complete frankness and willingness to help each other. The therapist must be acquainted with the knowledge and the skill to deal with psychodynamic as well as group dynamic processes.

PAUL E. JOHNSON

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A code of ethics is a timely subject for discussion among group psychotherapists. It is not time for laws, which crystallize rules of behavior prematurely in constrictive prohibitions. But the time has come to define standards in order to clarify aims and guide procedures in a new and pioneering form of human service. We are, therefore, indebted to Dr. Moreno for his well-considered suggestions toward such a code, in GROUP PSYCHOTHERAPY for June, 1957. Following discussion it is hoped a committee may give intensive study to the matter, and present a report to the annual meeting of The American Society of Group Psychotherapy and Psychodrama.

In considering the detailed statements of this code, there are some queries I would like to raise, not as dogmatic assertions but as questions for further discussion.

Overlapping appears between items (1) and (4), which suggests the need of uniting them into a clearer definition of what kind of service is to be rendered. The dignity of every patient is well to emphasize, but the term "abuse" is ambiguous. What constitutes abuse, and what exactly is to be avoided? Frank speaking is essential, and yet someone might feel abused to have his behavior described in the group.

The second item calls attention to the need for scientific research and professional standards. But if all methods are to be approved in advance by "official professional boards", what room will be left for experimentation and spontaneity? Are we ready to put this flourishing spontaneity under the rigid chains of authoritarian traditions?

The role of the leader needs further clarification. His titles are to be restricted in (3) and his training required, but what are his specific functions as group psychotherapist or psychodramatist?

The democratic behavior of such a group is noted in (5) and (6). Equality of status and fee may well be affirmed, but the practice of democracy begins with the leader. His status is not equal with that of the patients, yet he must exercise his authority wisely to develop growing responsibility in the patients. How is this to be done, and what is the role of the leader in democratic therapy?

Freedom of choice is affirmed in (7) for each person in the group, including the leader, at the point of beginning. But what shall we say as to leaving the group? Is anyone free to desert the group whenever he wishes, to absent himself intermittently or finally? What of open and closed membership, and of entering after a group is already well on its way? What shall we do about a terminal date in group therapy for one and all?

The keeping of confidences by each member of the group is well emphasized in items (8), (9) and (10). Such a pledge is basic to open communication and mutual respect. The timing of this pledge is of the essence in a group process, to emerge as the group is ready to face it. Television broadcasts are evidently contrary to the pledge, except for occasional demonstrations with full consent of each member of the group. Mass psychotherapy is another field, and may need to develop its own methods quite different from those of the small therapy group.

The question of when and how to disqualify an unethical member or leader is a difficult one. Is the group to decide or the leader? The philosophy of taking care of every patient must be upheld if we are truly to respect his dignity and worth. Removal from a group will not be a rejection of an outcast, but reassignment to other and more appropriate therapies for his present needs. This is to apply in prisons as well as in hospitals and clinics and churches, for the seriousness of his crime or resistance to treatment should increase the efforts and resources to heal the causes of his difficulty.

O. Hobart Mowrer, Ph.D.

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This seems to me an excellent statement of sound propositions and important, thoughtful questions. I wonder if the term, "physician", is used advisedly in the next to the last line, p. 144. Might not "therapist" be preferable, on the assumption that persons other than physicians may do group therapy?

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1. The principal objective of group psychotherapy is to render service to every member of a therapeutic group and to the group as a whole.

3. The designation "group psychotherapist" or "psychodramatist" should be used only by psychotherapists who have received specialized theoretical and practical clinical training in a recognized Institute.

4. A principal objective is to insure high professional standards, to protect the patient against abuse and to render service with full respect for the dignity of every patient.

6. Some patients cannot afford to pay as much as others. Payment in accordance with the fair standard of the ability to pay is generally accepted today. This should not thwart the therapeutic aim since it is basic that group members must recognize the problems and needs of other patients and the therapist as well as those of themselves.

9. With reference to extreme cases of improper conduct with reference to a therapist such matters should come up before the respective Council on qualifications and on practices.

Patients who are seriously disturbing to the group should be removed and given individual psychotherapy until they are ready to rejoin the group.

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I think that the need to impress group therapists with a code of ethics does not apply to the same extent in this country, where to my knowledge all group therapists are medical and bound by the Hippocratic Oath; at any rate they are likely to live up to such standards as society generally expects of doctors.

The second point I should like to make concerns the "pledge" to be demanded from patients. I think it would appear rather difficult to do this in a psychoanalytic type of group therapy, since it would establish in the patients some feeling of a collusive relationship between one another and the therapist, some secret relationship which would obscure the transference feelings one hopes to bring to the surface. I have often found that when one or another patient demanded from the others a pledge to keep secret the discussions taking place within the group, an interpretation drawing the patients' attention to the possibility that the people in front of whom they

were afraid to divulge their secrets were not outsiders but the other group members and in particular the hitherto idealized group therapist, almost regularly brought to the surface paranoid fears concerning other group members and the therapist.

The technique I personally find useful is not to allow any secrets between myself and a particular group member to the exclusion of other group members (e.g., I would read any letter sent personally to me at the next session of the group), with the result that patients know that what they are saying is bound to become the common property of at least all the group members, and may possibly be communicated by a group member to outsiders. This in the beginning may slow down the process of free communication, but whatever is being communicated sooner or later is done after overcoming various paranoid fears which would be merely covered up by a pledge of secrecy. In fact I found that in groups conducted on these lines (for more than eleven years) no case has become known where members of a group would divulge anything but trivialities to outsiders (including husbands and wives and "best friends"). And the respect for one another's secrets is the more remarkable since the same people may express considerable dislike towards one another in their sessions.

I have, of course, no idea how these remarks apply to groups conducted on different lines. I could well imagine that a "pledge" in non-analytic groups may be desirable if not unavoidable, but I have no personal experience with such groups.

R. J. Corsini, Ph.D.

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Probably the first question that should be raised to any consideration of a code of ethics for any professional group is: Is such a code necessary? Preliminary considerations lead me to a negative answer. The reasons are several.

1. Most such statements codify common sense, decency, and law—and in so far as they do, they are unnecessary.

2. Group psychotherapy is not a profession. It is a procedure in which people of different professions operate. Psychiatrists and psychologists, the two professional groups most common in this field, have their own extensive codes which cover them while operating in groups.

3. Short vague statements of good practice do not meet the problem of specific possibly unethical behavior, and the task of constructing a really

comprehensive code of ethics is a major one and outside the scope of possibility at the present time.

In short, I would argue that any attempt to establish a code is premature; that it is not necessary at the present time, and that unless a code can be used practically, it has little value.

Now that I have been destructive, let me try to be constructive. Assuming that a code is needed, then one must go to the grass roots, to the practitioners of group therapy to determine whether this is actually so. If I be representative of the community, then the answer is unequivocally "no". But, let us assume that there is a strong popular sentiment for a code, then it seems to me that the most proper procedure would be to tap the sentiments of the professional community in terms of specific items for codification, and that through a laborious working out of ideas a preliminary code be established.

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As the broad field of group psychotherapy continues to develop and increasingly make inroads into individualized approaches, practitioners must keep pace by formulating guiding principles as standards for practice.

These standards, in order to be useful and realistic, should be based primarily upon a solid foundation of systematic perceptions and observations of group psychotherapists and psychodramatists who have worked with many different kinds of groups under varying conditions for various objectives. As the field becomes older, more highly developed and specialized, practitioners will be able to focus with greater precision. As matters now stand, the few who are highly qualified and work directly with groups tend to find themselves in various areas of this work. For example, over the past decade I have directed group psychotherapy and psychodrama sessions with such diverse groups as mental patients, criminals, juvenile delinquents, juvenile gang members, narcotics addicts, police officers, institutional staff members, university students, "problem" families and parents, parolees, groups with interracial problems, and industrial groups in both institutional settings and the open community. This broad range is not unusual for most "specialists" in our field.

Unfortunately, the "doers", the few practitioners who have much to contribute from their vast experience, in general, do not write as extensively as some of our more "cloistered" and "contrived" small group researchers.

This applies particularly to many of the small group sociologists who work with contrived collectivities. The kind of data about how groups react to group methods can be presented most ethically and realistically by those who have personally experienced the many facets of group patterns and forms functioning *in situ*.

The obvious fact that in group approaches there are more eyes and minds viewing a problem is both stimulating and inhibiting to significant sessions. A tremendous creative potential is present in and out of the therapy group because of the great diversity of possible contributors available for helping to resolve interpersonal conflicts. On the other hand, certain material may not be presented because, in fact, the standards of the over-all community or this limited one are brought into a session and similar social controls which suppress the discussion of certain problems outside the session appear within the therapy group. For example, members of a group may feel guilt about discussing what they consider to be abnormal desires of homosexuality, bizarre sex behavior, or violence. Subjects may be more inhibited about discussing this in a group than with an individual therapist. Real problems of inhibition may be present, yet, it should also be pointed out that there are greater forces in the group for "opening up" on these areas because there are more "others" exerting influence in this direction.

At least one of the questions to be raised here is Can the members of a group "honestly" tell an individual to "open up" and then not judge him ever so subtly by external cultural standards which apply during or when the session is over? There is, perhaps, more of a possibility that the patient may find one therapist who will accept the individual without "judgment" than within a group of his peers.

Is this acceptance as important as other benefits which might be derived from a group? Here, in fact, is a slice of the community within the group. It may be a somewhat select slice, yet here is an opportunity for an individual to face up to his problems and discuss them with some of the eyes of the community looking in under ground rules which he can take part in establishing.

Another relevant problem is that in the group, as compared to one's role in an individual approach, the subject is faced with the dual and often conflicting role of co-therapist and member of the outside community. For example, in a session with a group of gang boys, one boy's sadistic pattern became manifest. He described his great enjoyment in shooting people "right between the eyes". He had possession of a .22 calibre rifle. The other boys

and myself in the group began to squirm a bit about the thought of walking through the neighborhood with this boy up on a roof sighting us through the gun-sight and perhaps pulling the trigger. Although similar problems arise in individual therapy, we were clearly members of this boy's community in this form of community-therapy; and we had not only his own therapy in mind, but the community's and its safety. This complicates confidentialness.

Certain inhibitions to discussing guilt laden or highly confidential material in a group may be overcome by promising to keep the discussion "professionally secret" *a la* individual psychotherapy. However, perhaps right at this point group psychotherapists and psychodramatists should break the stifling and often confining mold set for us by individual therapies. If we truly believe as Dr. Moreno has so aptly stated, "A truly therapeutic method cannot have less of a goal than all of society", then why should we inhibit or pattern our group approach to some obvious limitations of a secretive individual session which is a microcosm of our over-all societies' ills—*the closing out of one psyche's problems from another.* Group psychotherapists should recognize basic laws of human relations in their codes which are much broader in scope.

In the organization of a group psychotherapy project for "problem parents" the question of confidentialness arose. We had two choices (1) our therapy group of some 15 parents could maintain a high degree of confidentialness specifically so that other parents with problems in the community, although most interested, would not know what went on in the group; or, (2) whatever problem we would discuss in the group would be open to the community.

If we followed line one, the group members might feel freer with guilt laden, or what they considered to be "confidential", material. The gains are somewhat apparent; using the individual therapy tradition the flow of discussion might be deeper. (Although, this fact has not been proven either way.) However, as group psychotherapists dedicated to broader principles of community therapy we would be eliminating from the therapeutic process by this "silence" hundreds of others who fit into the small group's networks. The teachers, other parents, children, and many other members of the community would be closed out from participating in the total therapy process. Open discussions of the problems of the 15 would quickly indicate to others in their networks (*by definition these are the only ones who would hear of their problems*) how close and important the problem was to them. After all, Johnny's problem of delinquency does not rest with his family and school alone; by definition it is a community or social problem. Therefore, this community should have been and was allowed to participate.

To sum up, when we examine our approach, practices such as confidentialness and "long distance" research which, perhaps, were allowable in individualistic approaches, may upon a fuller examination prove contraindicated in the code of ethics to be established by and for group psychotherapists and psychodramatists.

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There is a special timeliness in raising at this juncture the ethical issues implicit in the practice of psychotherapy, and especially group psychotherapy. It does not suffice to carry over the traditional stand of the medical profession, with its definition of the relationship between the physician and the patient. A rationale of the ethical code here stems from a new set of conditions. The physician-patient relationship, although it tends to become less clearly so with the emergence of fresh psychological and sociological orientations, derived less from the requirements of the therapy procedure than from an affirmation of civil rights of the individual against public intrusion. In the enlarging scene of group psychotherapy, and in a lesser degree all psychotherapy—the need for definition derives first from the necessities of the therapy procedure itself, and only then can one assess the claim of the individual to protection against the tyrannies of public scrutiny.

It is expedient therefore to preface any formation of rights and obligations of the therapist-patient relationship by looking at the requirements of the therapy procedures themselves. Whatever their variability, there is one feature that is common to all of them. They deal with the relationships of the patient with other persons, and in group psychotherapy, every procedure is based upon the use of multiple participants through whom the dynamics of the communicating process are to be managed so as to produce the therapy result. At first glance this may appear to negate the whole ethical principle of privacy in the privileged relationship between physician and patient and one is tempted to make that facile jump of analogy. Nevertheless, although the group psychotherapy relationships are social, it is also true that there are certain rights to be defined and guarded and this task cannot be escaped by merely affirming that the rationale for privacy in the treatment of physical illness is here irrelevant. The code appropriate to this different situation is far less simple and more exacting. It must take into account a range of new considerations.

First, it is of the essence of the psychotherapeutic process that it deals with the relations between the patient and other persons. The therapist's necessary orientation to "reality" in his objective involves him in the moral questions constituting the reality with which the patient must come to terms. Is it the therapist's role, his duty, to be neutral here? Is it only his duty to see to it that the patient tests reality as he, the patient, finds it within or outside the treatment situation, or as the therapist perceives it? What if the therapist is neutral to the claims of "deviant" social norms? Does the therapist have any responsibility not to impose his private or perhaps deviant norms upon the situation for therapy?

Second, the whole range of present and potential techniques in group psychotherapy derives from the use of the resources of the groups of various kinds in both theory and in therapy method. (1) What is the role and responsibility of the professional therapist? Is he merely a manipulator of accessible forces or also subject to them? And how is the picture modified if there is more than one professional therapist involved? (2) What are the roles and what obligations do the lay participants have who are members of the therapy group? Is their participation a matter of passive instrumentality or are they responsible initiators? (3) What responsibilities derive from the role of observer participants in such therapy situations as the psychodrama? (4) What are the roles and obligations of the group itself in the situation of the so-called therapeutic community, whether the "patient" is the group itself or an individual upon whom the attention of the group is focussed? (5) With respect to each of these and other therapy roles, there emerges the problem of the kind and degree of responsibility of the professional therapist in defining and maintaining the standards of participation on the part of all the other members of the therapy group, whatever the specialized function of each. In the nature of the case, his power is limited and this obviously limits his choice of what he may defensibly do.

Finally, the rationale or philosophy of psychotherapy, and again especially group psychotherapy, injects still another set of relational issues into the problem of formulating ethical codes. What is the role of the therapist as one of the subjects of treatment? If the process is treated as one in which the therapist role is played in a variety of ways by all the members of the group, including the patient, there then emerges the question of the commitment of even the professional therapist in making accessible to the group the whole range of responsiveness that is his "private" life.

The standards of ethical practice in group psychotherapy which grow out of such basic and varied relationships cannot be reduced to a simple and

unambiguous code of rules enforceable by custom and professional sanction. Here is an instance where the skills of a marketable service cannot be disentangled from the nature of the moral commitment of the person rendering the service. Just because that linkage is so intimate, it becomes all the more important to spell out the standards which do condition the exercise of the skills. One set of standards will certainly relate to the measures of competence of the professional therapist. Another must focus upon the qualifications and obligations of other participants, or auxiliary lay therapists. And a third set of norms will derive from the tested conclusions cumulatively built up from the therapy process—and these will deal both with the values to be implemented by the instruments of method, and the way the instruments will be used in order to be the most effective. A fourth will spell out the rights and obligations of the "patient", both in the context of the therapy group and the larger community.

Dr. Moreno's formulation of "standards in order to maintain a high level of ethical conduct" is provocative and sensitive. Its value is greater because it does not undertake to be final or complete but to stimulate the kind of probing that is acutely needed during the period when the field is developing and consolidating. It well illustrates the differences between standards of principle and standards of vested interest which so readily disguise themselves as moral principles. Some of the standards referred to lie in the area of proper aspiration rather than present practicability, such as training, professional boards, and democratic behavior. At no point does Dr. Moreno bring into clearer focus a sharp issue than in those paragraphs concerned with the Hippocratic Oath. There is certain to be doubt about whether it is realistic to assume that it can be made to "bind each (of the participants of the therapy group) with equal strength," or whether "the therapist responsible for the group" can in fact make the "pledge" effectual by an act of ritual. But what this honest and insightful extension of the privacy principle in the physician-patient relationship to the group practice situation does is to focus the whole inquiry upon what the group is and how its forces become effective instruments of therapeutic processes.

TWENTY-FIFTH ANNIVERSARY OF GROUP PSYCHOTHERAPY MEETING IN PHILADELPHIA IN 1932

Herewith follow comments from original participants of the historical meeting. (To be continued.)

I

Amos T. Baker, M.D., Psychiatrist, Sing Sing Prison 1931-1932 (Retired)

I am very glad of the opportunity to state that in my opinion group psychotherapy during the past twenty-five years has increasingly proved its value in psychotherapy, psychiatry and allied disciplines.

II

Edgar A. Doll, Ph.D., Bellingham Public Schools, Bellingham, Wash.

The answer to the questions, "Has group psychotherapy in the course of 25 years established for itself a place as a valuable instrument of treatment within the framework of present day psychotherapy, psychiatry and allied disciplines?" is undeniably "yes". But I do not feel qualified to expand this answer into a detailed elaboration of it. My role has been that of an informed bystander, eager to support any legitimate means for improving the happiness and efficacy of our fellow man. It was in this role that I attended the original meeting and have followed developments since then, although not as an active participant.

In my professional capacities, I have had three major areas of interest in which I felt justified in promoting and supporting group psychotherapy. The first of these was as a member of the Board of Managers at the New Jersey Reformatory at Rahway, better than ten years ago. I feel justified in saying without reservation that this proved a feasible and useful method of correctional therapy—a method which cut across other procedures, utilizing without replacing them, and providing a more extensive and practical treatment system than was otherwise available in terms of helpfulness, practicability and cost.

My second association with this method was as Coordinator of Research at the Devereux Schools, at Devon, Pa. In this setting of dynamically and functionally disturbed adolescents and some young adults the same values noted above were re-experienced. This was about five years ago. While I had no direct responsibility for employing the procedure, nor of gauging its scientific validity, I did share as promoter and observer and felt that it justified its employment.

More recently we have used this technique in our special education program here at Bellingham, Washington. We use it informally and sporadically as a classroom aid to educational therapy. Perhaps more significantly we have employed it with the parents of our exceptional children,

particularly those of children with cerebral palsy and those with mental retardation for whom the consequences of their children's handicaps are so emotionally disturbing. These results have been so gratifying empirically that the sessions have seldom been long continued. We rely on them as an ever-present aid in times of crises.

I am afraid that these observations are not so "competent" as to be very helpful. You will note that they reflect a more utilitarian, lay or empirical evaluation and use than is for me customary. And yet this very shortcoming may make these remarks complementary to the more erudite and astute professional opinions of others.

I am grateful for your complimentary copy of the third edition of the *First Book* which I perused with some nostalgia (!) as well as profit.

III

Fredric Wertham, M.D., New York City

Many thanks for sending me the beautiful book *The First Book on Group Psychotherapy*. This is really a monument to you, and I send you my heartiest congratulations.

I remember vividly the discussions we had on group psychotherapy at the Association for the Advancement of Psychotherapy, which made me admire your originality, initiative and understanding. I wonder whether you ever came across my summary of group psychotherapy as a research method with adolescents. Some of my findings, and some excerpts from protocols, are published in my book *Seduction of the Innocent.*

IV

Pierre Renouvier, Ph.D., Manila, Philippines

Two things stand out in my memory about the Toronto meetings of the American Psychiatric Association in early June of 1931. One is Moreno's critique of psychoanalysis (the occasion was Dr. Brill's analysis of Abraham Lincoln) and the other is his coining of the terms, "group therapy" and "group psychotherapy".

He is justly honored all over the world as the founder of modern group psychotherapy. A systematic study of his German publications reveals that he has used group techniques since 1911.

I always believed that the conscious history of an idea starts at the moment when it receives its proper name. This is certainly true in the case of group psychotherapy as it was with the term, "sociology", 1830 and with the term, "psychoanalysis", 1896. By "proper", I mean that the name ex-

presses adequately the idea it represents. Moreno's original definitions are as valid today as they were when they were first used; they cover all methods currently practised under the label of group psychotherapy, from the analytic and dynamic versions to milieu therapy. The definitions I have in mind are, "one man as a therapeutic agent of another" from *The Application of the Group Method to Classification,* First Edition, 1932, page 103, and "Group psychotherapy treats not only the individual who is the focus of attention because of a maladjustment but the entire group of individuals who are inter-related with him in the community" from *Who Shall Survive?,* First Edition, 1934, page 301.

V

Olga Knopf, M.D., New York City

It was most thoughtful of you to send me the new edition of your book on group therapy. It vividly recalled the heated discussions we used to have and the good times nevertheless.

You have come a long way since and I wish to congratulate you. It is not often the "visions" of early years do come true as with you.

VI

Paul L. Schroeder, M.D., Atlanta, Georgia

Due to the fact that I have done no work in group psychotherapy in recent years, I feel it would be presumptuous of me to express my reaction. However, I want you to know that I am deeply pleased that you should want a statement from me.

VII

Calvert Stein, M.D., Springfield, Massachusetts

I didn't want to read your old book in the first place because it had your name all over the jacket; but when my staff threatened to bring it up in one of my classes and make me act it out, I decided to thumb my nose back at the little green-eyed monster. I knew I was licked. So, we dug it out of the bottom of the waste basket and then my wife told me my name was in it. I insisted that she must be mistaken; but that anyway, if it was true, then it *proved* that the book wasn't worth reading. When I said that, I didn't like the look in her eye either, so instead of pursuing the argument, I spent the weekend reading the book from cover to cover.

And now for your gracious letter and your kind invitation to write a few comments. At the risk of another challenge to act it out, I must insist that contrary to this being an honor to you, as you so graciously express

the thought, it is I who am honored by your invitation. After all, I was practically at the beginning of my psychiatric career in 1932, and only four years out of medical school. Thirteen years of training and experience in all branches of psychiatry were required before I began to step from the role of leading groups on a more didactic level to the role of therapist as we now understand group therapy. However, as a pioneer in the field in the Springfield area, I have naturally experienced many of your own tribulations. For instance, it is only in the past month that the nursing department of our Springfield Hospital has decided officially that group psychotherapy is here to stay. Although I have been conducting a group there since 1947, and scores of nurses have participated individually, this is the first time that entire classes of student nurses are being allowed to attend and to participate. It may be more than a coincidence that just before that decision, I had changed the bulletin board notice to read "Group Conference in Human Relations"—leaving the "Psychosomatic medicine" and "group psychotherapy" as subsidiary titles. After all, even medics are still "allergic" to anything that begins with "Psycho". As for persuading other physicians in the area to attend and train, either in the hospital group or in any of my three other private groups, I still have the same resistance that is so well described in your rebuttal and closing remarks on the 1932 meeting (pp. 126 to 131 of your book).

As to your specific assignment for a few paragraphs on a question that can only be answered with an emphatic "yes", I can do absolutely nothing, since you have covered all aspects of the subject most thoroughly. The fault is not with the method, but rather with the dearth of qualified leaders. Since these should come largely from the backlog of younger psychiatrists, the emphasis will have to begin in the medical schools. There is already a growing supply of potential lay leaders for group programs in industry and in education since more and more psychologists are leaning in this direction, and, in fact, are doing most of the group psychotherapy in our psychiatric hospitals.

In "The First Book" I think that the three discussions which shed the greatest amount of light on the problems of educators in our field today are: 1) Dr. Karpman's conventional attitude and presentation on pages 122 and 123, 2) Your own masterful closing remarks which I have already referred to, 3) Your postscript of 1956 on pages 133 to 136.

(This last paragraph will probably reveal more about myself than I intend, but perhaps it will amuse you.) As I re-read the proceedings of that 1932 meeting I kept thinking that you had missed a grand opportunity to put on a demonstration instead of the discussion. But now I recall my own

first efforts in the same direction at the Springfield Hospital where the response was even less charitable than at Philadelphia (1932). Repeated demonstrations however, and persistent efforts are gradually altering the attitude of the local profession. In Philadelphia you were wise enough to recognize the limitations of that group. Perhaps daily conferences with demonstrations at the next APA meeting would meet a happier reception. I also recall in the early forties, during the war, while stationed at Great Lakes, I attended a demonstration of psychodrama in Chicago. You may remember the case in which a young schizophrenic physician acted out a prepared manuscript, recounting his anxiety and conflicts over the birth of his wife's child. You were the principal discussant. I resented your discussion, and your criticism that it was "not psychodrama" since it lacked spontaneity and many of the other requirements which are now well recognized, but which at that time were considered picayune and a suitable outlet for personal resentments on your part. It was shortly after that, however, that I began doing acceptable group psychotherapy at the Naval Hospital at Yosemite. But not until my wife and I actually participated in psychodrama with you during a seminar at your Beacon Academy (just about ten years ago), did I discover that I had needed that experience to resolve personal resistance; and while it may be said that you sometimes talk too much, there is certainly no doubt about the quality and value of your remarks, and depth and breadth of your wisdom and experience, as well as the sincerity of your mission. My own feeling is that the most fruitful areas for future development of group psychotherapy are in the home and school; and that when more parents and teachers are taking the necessary time to iron out personality problems at their inception, we shall have a healthier and happier world.

VIII

F. Lovel Bixby, Ph.D., Director, Div. of Correction and Parole, Dept. of Institutions and Agencies, Trenton, New Jersey

As you probably know, since World War II we have been quite active in using a form of group psychotherapy, which we call guided group interaction, in our correctional institutions.

We have a special project known as Highfields where this form of treatment makes up the core of the program for about twenty boys at a time. It has been extremely successful, and the State Legislature has authorized the establishment of other such centers and actually appropriated the money for the second one.

BOOK REVIEWS

In honor of the Editor-in-Chief of this Journal and his *The First Book on Group Psychotherapy* (Beacon House, Beacon, N.Y., Third Edition, 1957, pp. xxiv, 138, $3.50), the Book Review Editor requested several authorities on the theory and practice of groups to submit their opinions from their respective points of view or schools of thought. Below, the reader will find two reviews about Dr. Moreno's book; more are to follow in the next issue.

I

I am glad to submit a brief comment on Moreno's *First Book on Group Psychotherapy* from the background of Burrow's phyloanalytic studies. The core of the book, written 25 years ago, proposes transforming a prison into a socialized community by selecting individuals through spontaneity tests and various forms of personality recordings, and assigning them to functional units. These interrelationships were to make possible a group therapy in which the problems of individuals would be spontaneously submitted to the regulating influences of the group itself. Authoritative opinions on Moreno's plan expressed at that time, and the discussion of his proposals at the 1932 meeting of the American Psychiatric Association, undoubtedly contributed greatly to promoting the group psychotherapy movement.

Moreno mentions that his action therapy was developed early in Vienna. He traces the rapid spread of group therapy in the 1930's to the influences of socialistic thinkers, of contemporary social philosophies, and of the growing mental hygiene movement. He could have added pioneers such as Edward Sapir who advocated the collaboration of anthropology, sociology and psychiatry. One misses also appropriate reference to Trigant Burrow who in his *group analysis*, beginning with 1918, had consistently investigated the *social neurosis* in the immediacy of group interaction, including the reactions of the observer or therapist himself. It is erroneous to place his studies with the "class" methods of Pratt, Marsh and Lazell. Burrow's work, reported in *The Social Basis of Consciousness* (1927) and in many papers between 1924 and 1930, undoubtedly helped to prepare a climate favorable to the development of group procedures.

Burrow's goal was not adaptation to the social norm but investigation of its noxious aspects. His studies showed that the trend toward autistic focussing upon the self-image is a common pathogenic denominator in the endless variety of personality formations and social structures. It would seem that unless we deal concretely with the social and physiological aspects of this attentional deflection as it is interwoven in patient, therapist and

community, we cannot expect our individual and group therapies to meet man's urgent need, and Moreno's "therapeutic society" must remain a hardly attainable ideal.

HANS SYZ, M.D.
The Lifwynn Foundation
Westport, Connecticut

II

This book helps to explode a myth of Moreno's phoniness. The principal new facts elicited from this book are that Jacob Moreno long ago had personal contacts with the great American psychiatrist, William A. White; further, that White, the father of modern American psychiatry, thought well of Moreno's ideas and gave his blessing to further explorations by the new heretic.

It is established by verbatim recordings in this book that Jacob Moreno was the first psychiatrist to see the potentialities of group psychotherapy, and to have a feeling for the use of group dynamic principles in treatment and in research. The recordings republished here give this reviewer the impression that Moreno is authentic and that his alleged pioneering role is actually genuine. I believe that this third edition was brought out to reaffirm and advertise his credibility, authority, and authenticity.

Now where does the widespread prejudice against Jacob Moreno arise? It is a fact that many psychiatrists think of Moreno as a counterfeit coin. One fountainhead of this anti-Moreno prejudice may spring from a resemblance between Moreno and the unconscious instincts. The dangerous instincts must be defended against; the defense mechanisms that are used in handling the instincts are also used in handling Moreno—denial, repression, reaction formation. Another fountainhead may be that Jacob Moreno becomes the humbled father figure who may be attacked as a kind of scapegoat to help therapists repress feelings of inadequacy in therapy.

Does Moreno stimulate and nurture the counterfeit myth? I believe he does; also, that he does it unconsciously. Here in this book we have grist for the prejudice mill. The book is entitled, "The First Book on Group Psychotherapy." The implication is that this is a primer on group psychotherapy. "Easy steps for little feet" it seems to say. However, the book is misnamed; more correctly it should be: "Group Dynamic Techniques in Prisons, Early Studies." The central core of the book written in 1932 contains extremely interesting ideas used in the continuing struggle to make prisons into therapeutic communities. It deals with prisoner assignment,

classification as to group type and outlined case histories with sociograms. This portion is an exemplary model for those who would do research in group dynamics and group psychotherapy. A formal discussion for the research plan developed by Moreno is presented. The discussants were attending the annual meeting of the American Psychiatric Association in 1932. The chairman was William A. White; most of the discussants were from the state hospital systems or prisons. The discussions were on a very high and useful level.

Along with being mistitled, the book gains untrustworthy flavor by starting with a 17-page "Introduction" in the Socratic style. But here the content is not that of Socrates with his student, but portrays the Great Father who has lived many battles and is bringing the ignorant son up to date. This new use of the Socratic method carries an implication that personal benefits may result from having Jacob Moreno play Socrates; a ready distrust of all advertising is prevalent in the land.

The book is mistitled; it is rendered less palatable by an appropriate dull introduction. Nevertheless, it is worth a quick review by all those doing work in psychotherapy because of its historical significance and its fine example of a forthright, exploratory approach. It is especially deserving of intensive study by those who work in large institutions, such as state hospitals and prisons.

ROBERT J. LINCE, M.D.
President, Group Psychotherapy Association
of Southern California, Inc.

HUMAN RELATIONS IN BUSINESS. By Keith Davis. New York: Mcgraw-Hill Book Company, Inc. 1957. 547 pp. $6.50.

If you are searching for new ideas, you will find none here. This is a sound text assembling fundamental concepts underlying human relations in management. The authors pulls many ideas found in the literature together in logical order. Throughout, Professor Davis' many first-hand experiences in this difficult field are cited.

Of particular interest to readers of this journal is chapter 12 on Role-Playing regarded in terms of role theory as conceived by Cooley and Mead. Some excerpts may illustrate: "Administration has a great deal in common with play-acting. The administrator, like the actor, has particular roles to play." (p. 210) "Since people take roles every day, they are somewhat ex-

perienced in the art, and with a certain amount of imagination they can project themselves into roles other than their own. This idea is not new, because dramatics is as old as recorded history but its application to human relations problems is somewhat recent. It was first used in psychological therapy and sociological analysis by J. L. Moreno, who called it 'psychodrama' or 'sociodrama'. It was later applied to human relations training in business by Alex Bavelas, John R. P. French, Jr., and others." (p. 213)

The author points out some weaknesses of role-playing as a training method, emphasizing the amount of time involved and the skill necessary to conduct sessions. "Most of these problems can be adequately subdued by an effective leader". (p. 218) In the section on Role-Playing Variations, no discussion of such techniques as *Role-Reversal,* the *Alter-Ego Technique,* or the *Mirror Technique* is found which weakens the chapter.

All things considered, this is a worth-while contribution to the literature of Human Relations.

WALLACE G. LONERGAN
School of Business
University of Chicago

HOSPITAL TREATMENT OF ALCOHOLISM. Robert S. Wallerstein, M.D. and Associates. New York: Basic Books, Inc., 1957. X, 212. $5.00.

This opus is the result of a two and one-half year research project conducted at the Winter Veterans Administration Hospital in Topeka, Kansas. Four treatment methods dealing with alcoholic patients are systematically appraised in relation to patients' personality structures.

A team of psychiatrists and clinical psychologists headed by Dr. Wallerstein employed and evaluated antabuse therapy, conditional reflex therapy, group hypnotherapy and closed ward milieu therapy.

It is to the credit of the author and his collaborators that they go beyond the processes of tabulation and comparing successful results. A serious attempt is made to answer such intriguing questions as: Does a certain kind of treatment lead to diverse results with patients of different personality structures? Why do certain treatment methods succeed better with specific kinds of individuals?

It should be kept in mind that the problem of alcoholism is the fourth ranking health problem in the nation. For a long time both the public and the medical profession shied away from many of the realities connected with alcoholism. It is indeed heartening to observe a rising scientific in-

terest in the problem. This book is a well conceived contribution and is to be welcomed as a booster shot for further serious research and consideration in the field.

ARTHUR LERNER, PH.D.
Los Angeles, California

THE FAMILY IN PSYCHOTHERAPY. By C. F. Midelfort. Blakiston, McGraw-Hill, 1957. Pp. ix, 203. $6.50.

According to the author, family therapy is a form of group therapy, which in turn is conceptualized as a procedure which is concerned with "less personal and more public matters", "encourages the growth of group actions . . . to prevent an individual from becoming too peculiar . . .", and makes "reactions objective." Despite the somewhat limited and naive conception of group psychotherapy, this little volume presents further discussion of a topic that increasingly is raising interest: the treatment of a natural group, or of an individual within his own cultural context, or of the other elements of the social atom in addition or even instead of the nucleus individual.

In Dr. Midelfort's concept of family therapy, bodily contact plays a great part. "It is possible for the therapist to show his feelings for the patient by sitting close to the patient, by touching and being touched by the patient, and by giving comfort in various ways, such as having the patient sit in his lap or holding the patient like a baby." In a chapter headed "Schizophrenia", one reads, "Usually body contact is necessary to draw the patient into a relationship that is positive and potentially creative." "The therapist, in giving his individual, social and cultural affection, may so stimulate the patient's potential to return love as to make the relationship of relative and patient a more fruitful one." In a case history, one reads, "During therapeutic interviews with the psychiatrist while the patient was reacting to insulin, the husband lay in bed with her in close body contact. . . ."

It is quite difficult to discern what major theoretical premises are behind Dr. Midelfort's conception of family therapy, but it appears to be a melange of ideas of the importance of love, expressed chiefly by bodily contact, simultaneous therapy and support by the therapist with various individuals in the family, and group interviews with the family members. This lack of clear-cut theoretical presentation plus a more or less undisciplined style of exposition reduces considerably the value of the book. The absence of corroboration or any mentioning of others who have worked in this area (such as Nathan Ackerman, Rudolf Dreikurs, J. L. Moreno),

or of personality theorists who have been concerned with the importance of love in psychotherapy (such as Nelson Foote, Sandor Ferenczi, Pitirim Sorokin and Wilhelm Reich) further weakens this nevertheless provocative volume.

RAYMOND J. CORSINI, PH.D.
University of Chicago

HYPNOTHERAPY WITH CHILDREN. By Gordon Ambrose. New York: John de Graff, 1956. Pp. 135. $2.50.

The author and his contributions are known in England where this volume first appeared. The primary value of this book is its introductory explanation to the solution of child problems via psychotherapy. The student, the general practitioner and child psychiatrist will benefit greatly from reading this well thought-out opus. The terminology and simple straightforwardness of the manner in which the subject is presented also makes it a welcome addition to the library of mental health workers in the field of child care.

ARTHUR LERNER, PH.D.
Los Angeles, California

CLINICAL APPLICATIONS OF SUGGESTION AND HYPNOSIS. Third Edition. William T. Heron. Springfield: Charles C Thomas, 1957. ix, 165. $3.75.

An indication of what this monograph "is not" will certainly explain its raison d'être. First, it is not intended as a compendium of knowledge about hypnosis and suggestion. The author believes there are several good books about these subjects and readers of this monograph should have already been acquainted with necessary background information.

Second, the monograph is not for general circulation. It is written solely for professional use and should be of tremendous interest to doctors of medicine, doctors of dentistry, psychologists, psychiatrists, neurologists, etc. Dr. Heron believes that the specific application of the principles involved in suggestion and hypnosis is the proper concern of the clinician and is not an entertainment medium.

Thus, the monograph is practical without falling to the level of a "how-to-do-it-yourself" approach. The experienced clinician will appreciate the cautiousness which the author reveals throughout this work. Group psychotherapists will be especially interested in Chapter IX dealing with "Group Hypnosis".

An excellent bibliography is appended which divides the use of hypnosis into three categories. These are: (1) prevention, (2) experimental tool, and (3) therapy. The entries under each category are appropriately listed as to their point of greatest emphasis.

ARTHUR LERNER, PH.D.
Los Angeles, California

MENTAL HEALTH IN ELEMENTARY EDUCATION. Dorothy Rogers. Boston: Houghton Mifflin Company, 1957. XI, 497 pp. $5.50.

The author is an educator who does not believe that children will operate effectively merely by filling their craniums with knowledge. She strongly contends that children are constructive beings and are not mere listeners. As such, the curriculum and the entire school experience should be oriented in the direction of developing a healthy personality in each child.

The approach to each topic presented is rather unique. First, there is an actual reporting of experiences. Each problem to be discussed is illustrated by statements presented by teachers, principals and others reporting school experiences. Second, research on each question is indicated and analyzed. Third, a realistic positive discussion is offered which is of great help to the teacher and administrator. Well conceived contributions of this kind will always have a vital place in the field of mental health.

ARTHUR LERNER, PH.D.
Los Angeles, California

METHODS OF GROUP PSYCHOTHERAPY. By Raymond J. Corsini. New York: Blakiston Division, McGraw-Hill Book Company, 1957. Pp. xi, 251. $6.50.

One can readily see with the Foreword, written by Dr. Klapman, that (a) Corsini has made a "commendable effort" to integrate into a single volume "the several dozen trends that merge into the concept of group psychotherapy;" (b) Corsini's "fairness to all the major schools of thought;" (c) the amount of scholarship that went into this book. It is these points that I wish to make, too. I wish to emphasize them, and I agree with Dr. Klapman that the author's book should be recommended "as primary reading for all who want an impartial and comprehensive view of group psychotherapy." Since, however, most reviewers are obliged toward their readers, their conscience (otherwise known as "ego"), and sometimes toward their better judgment to exercise some criticism, the following is offered, *always*

bearing in mind that I do not take issue with this or that omission of the author, with this or that bias (no matter how slight), *to which Corsini (as any author) is entitled, and to other shortcomings of the book.* I would say that Corsini has offered the best "nonpartisan" book in group psychotherapy so far, has tried to be a historian, theoretician, clinician, and researcher, and has been honest. That many readers may disagree from a non-eclectic point of view would seem to me their loss, as perhaps no author will be able to write a book for everybody. On the other hand, the individual schools and their students can but gain from Corsini's display and researches, showing different, and sometimes new, vistas, even though the book is not permeated to the core with, say, Freudian perfume. For those who wish to be indoctrinated into specific types of schools or view, the author has ample references, and other books—whether those written by Moreno or by Slavson—are on the market to fill their particular needs.

As to my critical comments, it should be pointed out that historically speaking the term, "group psychotherapy was introduced in 1932 by J. L. Moreno", according to William Alanson White, *Application of the Group Method to the Classification of Prisoners,* published by the National Committee on Prisons and Prison Labor, 1932; Winfred Overholser, *Group Psychotherapy Symposium Editorial,* Beacon House, 1945, p. 3; Pierre Renouvier, *Sociatry,* Vol. II, No. 1, New York, 1948; R. Dreikurs and R. Corsini, *American Journal of Psychiatry,* Vol. CX, pp. 567 to 575; Joseph Meiers, *Origins and Development of Group Psychotherapy,* Beacon House, 1945; S. H. Foulkes and E. J. Anthony, *Group Psychotherapy,* Penguin Books, London, 1957, page 41; etc.

As to historical developments, the writer did not have Bach and Illing's research before him, unfinished then at the time of Corsini's putting the finishing touches on his book. The root of *modern* group psychotherapy can be found in the writings of the early German sociologists, particularly Georg Simmel and Leopold von Wiese.[1] It was Simmel who, in the nineteen-nineties and in the early part of this century (his book *Soziologie* appeared in 1908), pointed out a direct "philosophy" of working "conflicts" out in groups. Following these sociologists, Corsini, in his otherwise excellent historical sketch, omitted the entry of the psychoanalytic movement into the

[1] Note of Editor, J.L.M.: This statement is highly questionable. A careful reading of Simmel and von Wiese shows that neither have made any major contribution towards the development of *modern* group psychotherapy; one could mention with equal justification dozens of other authors. However, they have been forerunners of the sociological aspect of sociometry.

field of group psychotherapy, particularly the contributions of Schilder and Wender, the former being mentioned with but two sentences (p. 19); yet, it is the psychoanalytically-oriented type of group psychotherapy which seems to be dominant[2] today and is most widely practised!

While, as already stressed, the author cannot give equal tribute to every school of thought, the psychoanalytic movement gets clearly the short end of it, and such seemingly all-important factors in treatment, as transference and counter-transference (the latter is not even mentioned), and acting-out are dealt with in a few lines. But the reader does have ample books available elsewhere, particularly those by Slavson, and, in my opinion, the lack of inclusion of the analytical material (except for one brief chapter) does not deter from the immense value of this book. Since this book is mainly designed to be a "primer" for students, rather than for experienced group psychotherapists, I would know of no book that would serve this all-around purpose as the one written by Raymond J. Corsini.

HANS A. ILLING

PSYCHOLOGY IN THE CLASSROOM. *A Manual for Teachers.* By Rudolf Dreikurs, M.D. New York: Harper & Brothers. 1957. Pp. xvi, 237. $3.75.

The author, a Contributing Editor of this journal, today is probably the foremost "Adlerian" in the world, but certainly in this country. While the author is candid about using Adlerian methods, in the classroom, in his private practice and elsewhere, it would seem to me that the methods which he demonstrates in this volume (nearly sixty case illustrations are presented) are such that, without knowing the author's background and school of thought, one would hold him to be an "eclectic" (a label which is nowadays used to fame as well as defame a person; here, of course, it is used in a laudatory sense). Each case illustration is appended with the author's "Comment," thus bringing another "classroom"—that of the lecturer—right into the living-room of the reader. I believe that Dr. Dreikurs did not address himself literally to the teachers. Regarding children, all of us, particularly parents, are teachers, and our "teaching" is a never-ending and

[2] Note of Editor, J.L.M.: *The Bibliography of Group Psychotherapy* by Corsini and Putzey, Beacon House, 1957, suggests that the most widely practised techniques of group psychotherapy are the "inter-actional techniques" which are *not* of psychoanalytic origin; it is true, however, that they are frequently combined with a psychoanalytically-oriented type of terminology and interpretation.

always ongoing process. We are even teachers when we (sometimes) fail and when our children/students "teach us a lesson." Two of the ten chapters of the book are concerned with "Group Discussion" and "Group Situations." These are for teachers primarily; yet, here too, the techniques developed are universal and actually are called, in this country, "social group work." However, Dr. Dreikurs had practised "group work" long before the name was even coined in this country. Yet, one never sees a reference in the social work literature to Rudolf Dreikurs! (Social workers are traditionally wary of teachers and vice versa; this attitude appears to be unscientific, unprofessional and, in the last analysis, is harmful to the child.)

The book also demonstrates an almost perfect blending of group work and of group psychotherapy. Of course, Dr. Dreikurs does not aim to make teachers into psychotherapists. However, the basic "psychology" is stressed time and again in his excellent comments underlying the case illustrations. For anyone working or living with children—and who is not?—this book will be a gold mine of sound and common sense, as all writings that I have seen by Dr. Dreikurs.

HANS A. ILLING

BEYOND LAUGHTER. By Martin Grotjahn, M.D. The Blakiston Division, McGraw-Hill Book Company. 1957. Pp. xvi, 285. $6.00.

The author, a Contributing Editor of this journal, is not only a well-known psychoanalyst, but proves here to be a fascinating writer, above and beyond his writings in the professional literature. While most busy book reviewers can only sample books under discussion, I can claim to have read this book from cover to cover and, although certainly not unfamiliar with psychoanalytic concepts, have learned psychoanalytic theory and practice anew and in a fresh perspective in every line of the book.

However, even those readers who are not particularly interested in psychoanalytic theory will gain, if nothing else, a great deal of enjoyment by learning new, and rereading old, jokes and have their meaning interpreted. Aside from the numerous jokes (particularly the Jewish jokes, as quoted by the Non-Jewish author), the reader will find a genuine enlightenment on such subjects as clowns, burlesque, circus, mystery and wild west stories, Ferdinand the Bull and Mickey Mouse, or Alice in Wonderland. These stories are related and interpreted; yet it seems to me even on a second reading Grotjahn never dissects the humor or, as the Germans say, *breittreten*. I can well imagine that patients (those of Dr. Grotjahn or of

other analysts) could read this book with profit and never-ending delight, especially when away from their analyst. I can also imagine that patients, after finishing this book, may write to Dr. Grotjahn, as follows: "Dear Grotjahn: I had a wonderful time reading your book. Wished you could be here to tell me why." (This story is not contained in the book, but may come under the heading of, what Grotjahn calls, *schlagfertig*.)

HANS A. ILLING

HUMAN PROBLEMS OF A STATE MENTAL HOSPITAL. By Ivan Belknap, Ph.D. Pp. 265. $5.50. New York: McGraw-Hill, 1956.

A generation ago psychiatry was very much concerned with nosology. Progress in institutional treatment did not extend beyond such formal considerations. Periodically, an uproar in the popular press revolved solely about a set of stereotyped, melodramatic criticisms about overcrowding and suspected cruel practices. All these, wherever true, are only symptoms of a much more fundamental, less obvious ailment. Repeated reforms along lines popularly suggested, but which took no account of the basic pathology, for obvious reasons, have always proved ephemeral. Whatever reforms were thus instituted were never effective in therapeutic progress, and moreover, after a relatively short space of time, the state mental hospitals usually drifted back to the status quo.

That alone would indicate a cryptic disease and pathology of state mental hospitals. Now, at last, the intense, searching light of more recently accumulated scientific data in sociology, cultural anthropology, psychology and psychiatry is being thrown on mental institutions. This book is a major force in the new attack.

The *anlage* of the disease process resides in the way the state mental hospitals were originally conceived by their state and local governments; in the idea of delegating authority from the governor down the line, which has caused a certain type of organization to be formed, which, in itself, is an obstacle to the treatment of patients. That state mental hospitals are charged with the functions of *safekeeping* and *treatment* of the mentally ill is in itself a contradiction. Forces "exterior to the state mental hospitals have tended to make a rigid and authoritarian internal organization of the hospital a necessity to render innovations in treatment or organization unlikely, to hamper or exclude efforts to widen preventive or rehabilitative activity of the hospital for its patients, and to hinder both professional and nonprofessional community relationships on the part of the hospital personnel."

It starts with the orders, directives, ukases and bulls issues by the state governmental agency in charge of mental hospitals. The whole institution is geared to carry out these directives, and the organization is a loose coalition of personnel strata. Theoretically, the authority descends from the superintendent (level I) downward to the attendants on the wards (level III). Actually the several levels are semi-autonomous. The arrangement is intended to carry out directives down to their applications to the patients on the ward and to reconcile the medical and psychiatric considerations with custodial and housekeeping necessities. These levels, Level I, superintendent, assistant, clinical director; Level II, the doctors, dentists, nurses, social workers; Level III, attendants, have little or insufficient communication with each other. Social distance is considerable, and mutual suspicion and some antagonism exists between them. The clerical personnel feel that Level II consists of drones, who are paid on a much higher scale, while they toil over records and the bookkeeping of the institution. Level III feel they are the most important working elements in the hospital, but are the lowest paid and least appreciated. It is obvious that the attendant corps (the most numerous of the employees) is a very strategic element in treatment as they have the 24-hour supervision of patients and through them psychiatric treatment must be implemented, at the same time maintaining the functions of the ward and the housekeeping. For this reason Level III (attendants) have developed a system of classification of their own which does not coincide and at various points contradicts the tenets of modern psychiatric practice. It could hardly be otherwise in view of the other defaulting systems. The attendant system is a covert one; it aims to get the housekeeping done—by patients as far as possible—at the same time maintaining social distance from and supremacy over the patients and regulating the patients by a covert system of rewards and punishments.

Departure from regulations is not tolerated. Thus the whole system sinks into an unimaginative, stereotyped routine. There is no room for spontaneity or creativeness on the part of employees and motivation for the job is at very low ebb. Any employee who feels cramped by this very constricted scope is either washed out or washes himself out. Turnover is very painfully large.

To this add the fact that everything associated with the mental hospital is tarred with the stigma of mental disease. To this also add the marked understaffing and low salaries and many other unfavorable circumstances.

Many other salient points are brought out in Dr. Belknap's study.

While the book is concerned with only one specific state mental hospital most other state mental hospitals in the United States will find themselves reflected in this study, either in toto or in part. The author also recommends a series of remedial changes.

This is no tempest in a teapot. Mental illness is fast becoming the No. 1 public health problem and no inconsiderable part of the population sojourns in mental hospitals at one time or another. If only for the sake of the taxpayer's wallet this concerns practically every citizen, to say nothing of the actual need to treat and rehabilitate so many patients.

We believe Dr. Belknap's 3-year study is in the vanguard of a new fruitful attack on the problems of state mental hospital treatment.

J. W. KLAPMAN, M.D.

AMERICAN SOCIETY OF GROUP PSYCHOTHERAPY AND PSYCHODRAMA

Annual Meeting

The Annual Conference of the Society will be held on January 3 and January 4, 1958 at the Henry Hudson Hotel in New York City.

Papers should be sent to Miss Hannah Brodie Weiner, 1323 Avenue N, Brooklyn 30, New York no later than November 30th.

The program chairman for the sixteenth meeting is Dr. Raymond J. Corsini.

The New York City branch of the Moreno Institute, 106 East 41st Street, New York 17, New York will hold an Open House on Sunday, January 5, 1958. The Institute will hold continuous workshops and will also fete the Society. It will be a fine opportunity to practice techniques and to ask questions.

Results of Elections

The results of the special ballot election for Council Members were:

1958	*1959*
Dr. George Bach	Dr. Nathan Ackerman
Dr. Robert Blake	Dr. Robert Drews
Dr. Michael Miller	Miss Marguerite Parrish

New Applicants for Membership

Laurence O. Anderson
Los Angeles, Calif.
Mary Mack Angas
Newport, R. I.
Dorothy W. Baruch
Beverly Hills, Calif.
Alexander Bassin
Brooklyn, N. Y.
Liberty R. Bergengren
Chicago, Ill.
Nathan Blackman
St. Louis, Mo.
Robert R. Blake
Austin, Texas
Robert Boguslaw
Pacific Palisades, Calif.
Martha Brunner-Orne
Boston, Mass.
Edwin Jack Chambliss
St. Cloud, Minn.
Gertrude B. Curtis
Chicago, Ill.
Mildred Dickinson
St. Charles, Ill.
Carolyn K. Diem
Oxford, N. Y.
Madeleine Dreyfus
Asnieres, France
Arthur Dunas
Chicago, Ill.
Henri F. Ellenberger
Topeka, Kan.
Theodore W. Franks
Chicago, Ill.
Mary E. Grier
Cleveland, Ohio

Robert W. Hyde
Providence, R. I.
Eleanor Jacobs
Buffalo, N. Y.
Glenna B. Johnson
Twinsburg, Ohio
Paul E. Johnson
Auburndale, Mass.
Patricia Jordan
Chicago, Ill.
James G. Kellett
Allen Park, Mich.
Walter Joseph B. Klavun
New York, N. Y.
John Mann
New York, N. Y.
Margaret M. May
Utica, N. Y.
Jerome Mayer
New York, N. Y.
Sophie Mishelevich
Van Dyke, Mich.
Margaret Hyde Moore
Akron, Ohio
Jane Srygley Mouton
Austin, Texas
Mary Orlando
Pasadena, Calif.
A. W. Pearson
No. Hollywood, Calif.
Ruth R. Reiman
Buffalo, N. Y.
Bina Rosenberg
Chicago, Ill.
Malcolm E. Shaw
Cincinnati, Ohio
C. Shooster
Chicago, Ill.
Forrest G. Shufflebarger
Chicago, Ill.
Bernard H. Shulman
Chicago, Ill.
Alexander B. Smith
Brooklyn, N. Y.
E. Mark Stern
New York, N. Y.
Rosalyn L. Switzen
New York, N. Y.
Richard W. Wallen
Cleveland, Ohio
Chester O. Watson
San Francisco, Calif.
Cecilia G. Wells
Detroit, Mich.
Joseph Wilder
New York, N. Y.
Alexander Wolf
New York, N. Y.
Kurt Wolff
Osawatomie, Kan.

Michigan Chapter

The Michigan Chapter held a meeting on Thursday, October 3 at the Pontiac State Hospital, Elizabeth Lake Road, Pontiac with a program conducted by Marguerite Parrish and her staff on the subjects of "Psychodrama with Patients" and "Demonstration on How Role Playing is Used with Relatives of Patients". For further information on this Chapter's activities, contact Sonia Rogolsky, Secretary, 19450 Canbrook, Detroit 21, Mich.

On November 20, 1957, Marguerite Parrish, Dr. Paul Jordan and Mr. Long will conduct a demonstration of psychodrama at the Michigan Welfare Conference at Grand Rapids (Hotel Pentland at 2 P.M.). The topic will be: The Use of Psychodrama in Family Case Work. At the same meeting Dr. Robert S. Drews will offer a demonstration of an Axiodrama. This chapter will also exhibit our literature during the Conference (November 18-20) with Henry Feinberg as Chairman of Exhibits.

North Carolina Chapter

Janet Haas and Roberta Lytle have set up a fine role reversal system of psychodrama. Janet is a Psychodrama Director at Butner State Hospital; her work is with mental patients; Roberta is the Psychodrama Director of a group of patients in the Alcoholic Rehabilitation Center. Each director acts as auxiliary ego in the other's session and consequently each is able to substitute for the other whenever it becomes necessary. Also on hand is Rev. Roy Barham who alternates with Janet. To date they have had 81 psychodrama sessions at the Alcoholic Center.

Ohio Chapter

Dr. Wiliam Earl Moore of Akron has started a local Ohio group that has been meeting about once a month and he has been instrumental in applying the following aspects of group therapy: Family Psychodrama, a weekly session for the entire families of patients currently in treatment; Group Psychotherapy and Psychodrama for staff nurses, physicians, aides, orderlies, and patients on the in-patient service of *Akron General Hospital* (started about 18 months ago and continuing weekly); Out-patient Group Psychotherapy at *St. Thomas Hospital* which can include in-patients on non-psychiatric services also (held weekly for four years with internes, residents, nurses and student nurses participating); Group Psychotherapy with Children, six to fourteen, while their parents attend church, with sociodrama and psychodrama for entire families of a fifth grade church school which meets for an hour each week before the class meets and with one set of parents attending the class weekly on a rotating basis.

California Chapter

Drs. George Bach and Robert Boguslaw are co-ordinators of a psychodrama group at the Institute of Group Psychotherapy in Beverly Hills. This group meets on Saturdays.

Creative action methods for groups and individuals; role playing, sociodrama, action dynamics, and creative self development are the tools Bobker Ben Ali applies to sessions at the Academy of Creative Techniques in Pasadena.

Buffalo Chapter

Dr. Abel K. Fink is setting up a Buffalo or upstate chapter. Contact Dr. Fink at Buffalo State Teachers College, Buffalo, New York.

New York Chapter

The New York City branch of the Moreno Institute at 106 East 41st Street will present workshops and seminars on Sunday, January 5, 1958 in connection with the Annual Meeting.

Changes in Constitution

AMENDMENTS TO THE CONSTITUTION AND BY-LAWS

(1) Change Article III, 1. from 1. "There shall be the following classes of members: Fellows, Members, Associate Members and Honorary Members."

To read: "There shall be the following classes of members: Fellows, Members, Associate Members, Student Status Members and Honorary Members."

Are you in favor of this proposed amendment? Yes.....
No.....

(2) Change Article III, 2. from 3. "A Committee on Membership of six Fellows shall be appointed by the President and approved by the Council. Each member of this committee will serve a three-year term and then be eligible for immediate reappointment. One member of this committee shall retire each year . . ."

To read: "A Committee on Membership of three Fellows shall be appointed . . ."

Are you in favor of this proposed amendment? Yes.....
No.....

(3) To delete through Article III, 5, Sections 1-6 the wording *"Group Psychotherapy* AND *Psychodrama* and substitute *Group Psychotherapy* OR *Psychodrama."*

Are you in favor of this proposed amendment? Yes.....
No.....

(4) ADD to Article III, 5. Section of *Student Status Membership*
"There shall be a student status consisting of graduate and undergraduate students. They shall have such privileges as granted by the Council including rates on publications. They shall receive abstracts, notices of meetings, and the Society Newsletter. They shall give proof of their college or university affiliation."

Are you in favor of this proposed amendment? Yes.....
No.....

(5) Change Article IV, from 1. "The President-Elect, the Secretary and Treasurer, and the appropriate number of Councillors shall be elected annually by mail ballot as provided in the By-Laws and in accordance with Section 7 of this Article."

To read: "The President-Elect and the appropriate number of Councillors shall be elected annually by mail ballot as provided in the By-Laws . . ."

"The Secretary and the Treasurer shall be elected for a two-year term by mail ballot as provided by the By-Laws . . . Each shall serve an alternate two-year term."

or

The Secretary and the Treasurer shall be appointed by the Council for an alternate two-year period.

Are you in favor of this proposed amendment? Yes.....

No.....

(6) Change Article IV, 2. from 2. "The President, President-Elect, Secretary and Treasurer shall hold office for one year. Councillors shall serve for three years."

To read: "The President and the President-Elect shall hold office for one year. The Secretary and the Treasurer shall hold office in alternate two-year terms as decided by the Council; Councillors shall serve for three years . . ."

Are you in favor of this proposed amendment? Yes.....

No.....

(7) Change Article VI, 5. from 6. "Any Member or Fellow nominated for office by a petition signed by 25 or more members shall be considered an eligible candidate . . ."

To read: "Any Member or Fellow nominated for office by a petition signed by 10 or more . . ."

Are you in favor of this proposed amendment? Yes.....

No.....

(8) ADD to Article VIII of the By-Laws "The official organ of the Society is *Group Psychotherapy.*"

To read: "The *International Journal of Sociometry and Sociatry may be* substituted for *Group Psychotherapy* upon request."

Are you in favor of this proposed amendment? Yes.....

No.....

ANNOUNCEMENTS

Henry M. Stratton, Publisher, Honored

On June 24, 1957, at the 500th Anniversary Commemoration and graduation exercises of the University of Freiburg, Breisgau, Germany, Henry M. Stratton of New York City was awarded an honorary degree of Doctor of Medicine. He is the first layman from the U.S.A. to receive such an award in the history of this famous University, one of the oldest, largest and most academically renowned universities in Europe.

Henry M. Stratton, president of Grune & Stratton, Inc., was educated in Vienna. His interest in medical research and medicine was stimulated by his uncle who was a well-known physician in Vienna. A pioneer in the field of medical publishing for more than thirty-five years, he has contributed importantly to the dissemination of original medical research and to the documenting of outstanding clinical medicine.

Group Psychotherapy Association of Southern California, Inc.

The Training Committee has arranged fourteen courses for the coming academic year. Each course will have 10 sessions with each session lasting 1½ hours. The meetings will be held on alternate weeks at a time and place to be agreed upon by the leader and course members. The charge will be $26.00 per course member, to be paid to the Association.

COURSES:

October 1957. 1) Experience-Sharing Course, Section I; 8-15 participants; Meyer Elkin, M.S.W. 2) Psychodrama, Section I; 15-30 participants; Nah Brind, Ph.D. 3) Professional Role Study, Section I; 8-15 participants, Theo. M. Brostoff, M.A. and Robert Small, M.D.

February 1958. 1) Group Psychotherapy in Institutions; 15-25 participants; Arthur Lerner, Ph.D. 2) Unconscious Aspects of Communication in Groups; 8-15 participants; Geo. Bach, Ph.D. 3) Psychodrama, Section II; 15-30 participants; Robert Boguslaw, Ph.D.

June 1958. 1) Introductory Course in Group Psychotherapy Principles; 15-30 participants; Helen Northern, Ph.D. 2) Experience-Sharing Course, Section II; 8-15 participants; Esther Somerfeld-Ziskind, M.D. 3) Participative Experience in Group Psychotherapy; 8-12 participants; Marvin A. Klemes, M.D. 4) Child and Adolescent Group Psychotherapy; 10-15 participants; Zelda S. Wolpe, Ph.D.

October 1958. 1) Case Discussions; 8-15 participants; Robt. J. Lince, M.D. 2) Participative Experience in Group Psychotherapy; 8-12 partici-

pants; Robt. Jones, M.D. 3) Experience-Sharing Course, Section III; 8-15 participants; Charlotte Buhler, Ph.D. 4) Professional Role Study, Section II; 8-15 participants; David D. Eitzen, Ph.D. and Richard A. Hogan, Ph.D.

Recommended Readings

S. H. Foulkes and E. J. Anthony, GROUP PSYCHOTHERAPY, Penguin Books, London, 1957.

Group Psychotherapy, edited by H. Hiltmann, K. H. Wewetzer and H. R. Teirich, with an introduction by J. L. Moreno, copyright Hans Huber Verlag, Bern, 1957.

Progress in Psychotherapy, Vol. II, Anxiety & Therapy, edited by Jules H. Masserman and J. L. Moreno, Grune & Stratton, 1957.

Didier Anzieu, *Le Psychodrame Analytique Chez l'Enfant,* Presse Univ. de France, 1956.

Raymond Corsini, *Methods of Group Psychotherapy,* McGraw-Hill Book Company, 1957.

Progress in Psychotherapy, Vol. III, Techniques in Psychotherapy, edited by Jules Masserman & J. L. Moreno, Grune & Stratton. Forthcoming, 1958.

Moreno Institute

THERAPY GROUPS, Rm. 327, 106 E. 41st St., between Park and Lexington Aves., New York City. These psychotherapy groups are under the supervision of J. L. Moreno, M.D., in connection with the Psychodramatic Institute, conducted with the assistance of Drs. Lewis Yablonsky, Martin Haskell and Miss Hannah B. Weiner. Application should be made by personal interview. Admission to these groups is restricted to suitable individuals.

BEACON WORKSHOP SCHEDULE, 1957-58. *Thanksgiving,* Nov. 28-Dec. 1 (four days); *Easter,* April 4-6 (three days); *Decoration,* May 30-June 1 (three days); *Independence,* July 4-6 (three days); *Labor,* Aug. 30-Sept. 1 (three days); *Thanksgiving,* Nov. 20-23 (four days). An accelerated program offering clinical facilities and lecture demonstrations on a seminar basis. Students participate in clinical practice sessions and group discussions. The Workshops take place at 259 Wolcott Ave., Beacon, N.Y., and begin at 3:00 P.M. on the first day. Room and board are included in the fee, which is $65.00 for a three-day workshop and $80.00 for a four-day workshop. Enrollments should be mailed to Moreno Institute, Beacon, N.Y., at least one week in advance of each conference. Telephone, Beacon 2318.

PSYCHODRAMA AND GROUP PSYCHOTHERAPY MONOGRAPHS

No. 2. Psychodramatic Treatment of Performance Neurosis—J. L. Moreno (List Price—$2.00)

No. 3. The Theatre of Spontaneity—J. L. Moreno (List Price—$5.00)

No. 4. Spontaneity Test and Spontaneity Training—J. L. Moreno (List Price—$2.00)

No. 5. Psychodramatic Shock Therapy—J. L. Moreno (List Price—$2.00)

No. 6. Mental Catharsis and the Psychodrama—J. L. Moreno (List Price—$2.00)

No. 7. Psychodramatic Treatment of Marriage Problems—J. L. Moreno (List Price—$2.00)

No. 8. Spontaneity Theory of Child Development—J. L. Moreno and Florence B. Moreno (List Price—$2.50)

No. 9. Reality Practice in Education—Alvin Zander, Ronald Lippitt and Charles E. Hendry (List Price $2.00)

No. 11. Psychodrama and Therapeutic Motion Pictures—J. L. Moreno (List Price—$2.00)

No. 12. Role Analysis and Audience Structure—Zerka Toeman (List Price—$1.75)

No. 13. A Case of Paranoia Treated Through Psychodrama—J. L. Moreno (List Price—$2.00)

No. 14. Psychodrama as Expressive and Projective Technique—John del Torto and Paul Cornyetz (List Price—$1.75)

No. 15. Psychodramatic Treatment of Psychoses—J. L. Moreno (List Price—$2.00)

No. 16. Psychodrama and the Psychopathology of Inter-Personal Relations—J. L. Moreno (List Price—$2.50)

No. 17. Origins and Development of Group Psychotherapy—Joseph I. Meiers (List Price—$2.25)

No. 18. Psychodrama in an Evacuation Hospital—Ernest Fantel (List Price—$2.00)

No. 19. The Group Method in the Treatment of Psychosomatic Disorders—Joseph H. Pratt (List Price—$1.75)

No. 21. The Future of Man's World—J. L. Moreno (List Price—$2.00)

No. 22. Psychodrama in the Home—Rosemary Lippitt (List Price—$2.00)

No. 23. Open Letter to Group Psychotherapists—J. L. Moreno (List Price—$2.00)

No. 24. Psychodrama Explores a Private World—Margherita A. MacDonald (List Price—$2.00)

No. 25. Action Counseling and Process Analysis, A Psychodramatic Approach—Robert B. Haas (List Price—$2.50)

No. 26. Psychodrama in the Counseling of Industrial Personnel—Ernest Fantel (List Price—$1.50)

No. 27. Hypnodrama and Psychodrama—J. L. Moreno and James M. Enneis (List Price—$3.75)

No. 28. The Prediction of Interpersonal Behavior in Group Psychotherapy—Timothy Leary and Hubert S. Coffey (List Price—$2.75)

No. 29. The Bibliography of Group Psychotherapy, 1906-1956—Raymond J. Corsini and Lloyd Putzey (List Price—$3.00)

No. 30. The First Book of Group Psychotherapy—J. L. Moreno (List Price—$3.50)

SOCIOMETRY MONOGRAPHS

No. 2. Sociometry and the Cultural Order—J. L. Moreno (List Price—$1.75)

No. 3. Sociometric Masurements of Social Configurations—J. L. Moreno and Helen H. Jennings (List Price—$2.00)

No. 6. The Measurement of Sociometric Status, Structure and Development—Bronfenbrenner (List Price—$2.75)

No. 7. Sociometric Control Studies of Grouping and Regrouping—J. L. Moreno and Helen H. Jennings (List Price—$2.00)

No. 8. Diagnosis of Anti-Semitism—Gustav Ichheiser (List Price—$2.00)

No. 9. Popular and Unpopular Children, A Sociometric Study—Merl E. Bonney (List Price—$2.75)

No. 11. Personality and Sociometric Status—Mary L. Northway, Ester B. Frankel and Reva Potashin (List Price—$2.75)

No. 14. Sociometry and Leadership—Helen Jennings (List Price—$2.00)

No. 15. Sociometric Structure of a Veterans' Cooperative Land Settlement—Henrik F. Infield (List Price—$2.00)

No. 16. Political and Occupational Cleavages in a Hanoverian Village, A Sociometric Study—Charles P. Loomis (List Price—$1.75)

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