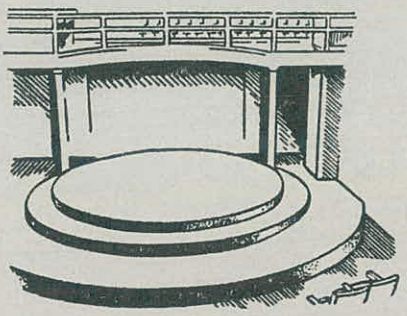
GROUP PSYCHOTHERAPY

A Quarterly



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AND PSYCHODRAMA

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FOUNDED BY J. L. MORENO, 1947

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INTERNATIONAL SECTION

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GROUP PSYCHOTHERAPY AND PSYCHODRAMA, A FOOTNOTE TO THEIR HISTORY

ANNA AND NAH BRIND

California Institute of Psychodrama, Los Angeles, Calif.

The definitive history of Group Psychotherapy and Psychodrama has not been written yet. It is, however, no great strain on any one's imagination to foresee that the history-to-be-written will try to elucidate the historical sources of Moreno's ample construct, the synchronic milieu, the gradual development of Moreno's own ideas, and the influence they in turn have exercised on contemporaneity and posterity. The history will also contain, to a greater or lesser extent, something of the struggle, despair and triumph woven into the personal, intimate lives of Moreno and his close associates.

The most celebrated couple modern psychotherapy has produced were on one of their many demonstration tours and had made a stop in California.

The Los Angeles audience which participated, Sunday, May 18, 1958, in a workshop headed by J. L. and Zerka Moreno had unexpectedly witnessed the making of a significant footnote to that future history, and this is a frankly non-reportorial account of the memorable incident.

On the surface of things, the all-day meeting, void of tensions and frustrations, was one of the more fruitful psychodrama workshops, one in which the audience has succeeded in exploiting Moreno's presence to the hilt.

There may have been perhaps, from the beginning, the added—rare—experience of watching teachers practicing their own teachings, as the very first performance of the day involved psychodrama in the family setting of the Morenos themselves.

But in the end the workshop was to offer even more than that.

By a concatenation of circumstances, the family situation chosen to be presented on the psychodrama stage touched upon ultimate human concerns. The theme of the performance was to be the actual acceptance of an intimate group of three—J. L., Zerka, and Jonathan Moreno—of the mutilation of one of its members.

J. L. himself, of course, was fully aware of what the performance was to imply. Indeed, unusually hesitant, he began: "I wonder if Zerka is willing to do it. You see there was recently a very threatening situation in the life of Jonathan. Mrs. Moreno, due to a needed operation, lost her right arm."*

* All quotations are from a tape recording of the session. The few added words, in parentheses, are self-explanatory.

Zerka was willing.

The ensuing performance—Zerka (just discharged from the hospital, one-armed) meeting Jonathan for the first time after the operation—had two clearly discernible levels of significance.

First, there was, to be sure, the business at hand, the necessity to convey to the Los Angeles workshop the efficacy of psychodrama techniques in confronting a most threatening situation.

It was, as it has always been, fascinating to watch Zerka—the most extraordinary Auxiliary Ego psychodrama has produced to-date—warm up to her task, to see her self-training for the job ahead, to observe the seemingly effortless flow of intuition and empathy.

Here is the core line of her brief monologue before meeting Jonathan.

"I wonder how he is going to act. . . . They tell me he cried last night *because he thought he would see blood. . . .*"

Then assuming the role of the absentee son:

"MOMMY! MOMMY!"

And again, Zerka-Jonathan, thinking aloud:

"I'd better not get close to (mommy) yet. I don't know if she's sore *up there.* I don't know whether I should *touch* her. I don't *see anything up there.* . . . I'll—I'll go over on *this* side." Then, "Well, Mommy, one arm on, one arm off."

As the performance went on, the members of the workshop participants became increasingly aware that they were watching a phenomenon surpassing group techniques, psychodrama, workshop, and all: They were watching sane, mature, creative coping with reality.

The following excerpt from Zerka's post-performance stream-of-thoughts, printedly pale as it is, illustrates the fusion of acceptance and transformation which is—or ought to be—human relation to all reality.

". . . I've discovered it is not as disfiguring as I had thought it would be. . . .

"About the worst response I got (was) from a psychiatrist who took this thing so desperately that— I dropped up at his office one day, and his secretary said, My, how nice you look, and you've got new things on. And I said, No, I haven't got new things on, but I decided to wear all my clothes now; I'm not going to have any 'good' clothes or intermediate clothes; *I'm going to wear them all the time.* And (the psychiatrist) came up with, Please don't talk like that. I began to realize that he was more upset than I was. . . .

"Some people (are) very threatened by this, and other people are very

wonderful about it. They say, After all, if you had been in an auto accident and come out the way you have, we would say, How wonderful, she's still here! . . .

"I didn't know there were so many people capable of . . . love and affection and esteem. . . .

". . . Before the operation I always used to project myself into the future as being alone (a widow) . . . and 'singlehandedly' fighting the world, supporting my child, and taking care of myself. And now, oddly enough, since the operation I don't see myself alone any more. I'm more in the cosmos. . . ."

Zerka—the Auxiliary Ego and the person—may have lost her arm, but she has made the most valiant attempt to convert her loss into an exceeding gain.

And Jonathan—and we—have gained with her.

THE "RELUCTANT THERAPIST" AND THE "RELUCTANT AUDIENCE" TECHNIQUE IN PSYCHODRAMA

ZERKA T. MORENO

Moreno Institute, New York

I

The psychiatric literature is replete with examples of patient-produced resistance to the therapeutic process and, particularly in psychoanalysis, this problem and its various approaches form a substantial part of such literature. In psychodrama this problem is met and dealt with in a head-on, direct manner. The resistance is systematically acted out, in psychodramatic episodes and interaction with the therapist-director, the auxiliary ego therapist and the audience carrying the load of hostility, aggression and negative warm up. Resistance may take the form of hostile silence, refusal to participate in the preliminary interview or to portray a role—his own or that of another person involved in his problem—inappropriate laughter, side remarks irrelevant to the situation to be portrayed, acts which are destructive of a cohesive warming up process leading to an integrating action catharsis. The literature of psychodrama too, is replete with descriptions of this type of resistance and how to assist the subject or patient to work it out in situ.

Sometimes the protagonist is not a single individual, but a group of patients and they may be resistant as a total group. Then it is the task of the director to work through the group's reluctance, to help clarify distorted perceptions and false expectations, before therapy can take place. The process of interaction in which the protagonist, single or plural, is engaged with the therapist who directs the session is like a subtle interchange between new-found lovers; there is a gradual process of seduction going on, which the director hopes will bring him to the goal of a psychodramatic production leading to total involvement.

II

THE RELUCTANT THERAPIST TECHNIQUE

Not so well acknowledged is the phenomenon of the "reluctant psychotherapist." It is met with very frequently and we believe that it occurs far more often than the therapist in the one-to-one therapy situation is aware or willing to admit. Since there are no observers of the proceedings, it is easy to ascribe the resulting interpersonal dynamics to the occurrence

of negative transference—usually on the part of the patient. However, the needs of the patient frequently fail to be met by the therapist and here we come to the part which the therapist plays, consciously or unconsciously, in the patient-therapist relationship.

Sociometry has taught us that transference is a one-way process, unilateral, based on projectional fragments carried into the present situation, and according to psychoanalytic tenets, patterned on parallel interpersonal experiences in the past. A transference relationship never meets the transference from the other person, even the so-called "counter-transference" is not a meeting of the transferences between two persons, but again, a unilateral relationship. According to Moreno, transference is the pathological aspect of a far more inclusive phenomenon which he called "tele." In contrast to transference, tele is a two-way mutual process which takes place between two persons, based on actual factors in the relationship, and it is tele which binds persons together, whereas transference disturbs and destroys interpersonal relationships. A group can never be built on transference alone, it is tele which cements and preserves true mutuality in the group. Tele, however, may also be negative in character, resulting in rejection, hostility, etc.

Therapists who are not aware of or refuse to face the fact that they may have "negative tele" for a patient are deluding themselves and the patient. How could it be otherwise? Sociometry has taught us how highly selective humans are in the choice of partners for innumerable daily activities —indeed, it has uncovered and studied such selectivity also for the subhumans (1)—and that this choice process is not a one-sided affair, but one in which both partners have equal responsibility. To continue filling books with lengthy descriptions of painful negative transference dynamics and to speak of counter-transference is to deny the existence of a vast sociometric body of knowledge, painstakingly gathered over a great many years. It is in the field of psychotherapy particularly where neglect of sociometric knowledge of the structure of human interrelations is doing damage to those who are seeking "expert" help. Without sociometry we are not filling that need. What would be the status of physical medicine today, for instance, without the use of the microscope? Yet, there are psychotherapists who continue to ignore the most up-to-date instruments in social science to uncover social microscopy.

The therapist—let us face it—makes choices too. He decides whether or not he likes a patient and whether he can give him of his best. When his decision is or becomes a negative one, it is the therapist who becomes

the reluctant participant in the therapeutic process, thus preventing the patient from deriving those benefits to which he is entitled. It would be more ethical to interrupt treatment at the point where this occurs, freeing the patient to find a more productive therapy situation for himself, at the same time making the therapist available for another patient with whom positive tele relations might be established. We know from sociometric research that a person may be rejected by one or another person, but wanted by someone else. We have ample evidence to note that a patient may be rejected by one or another therapist or carried in an unproductive relationship until not even a willing therapist is able to reach him. If a positive patient-therapist tele relation can be established early in the therapy-seeking, much harm can be avoided.

It has been especially Moreno who has pointed out the implications of this patient-therapist relationship (2). It was also he who had the courage to stand up to an audience of more than three hundred individuals who were filled with hostility and aggression, and to reject them as his protagonists in a psychodrama. It may be said that these were not unanimously rejecting individuals. Nevertheless, the positive relationships within the group were not sufficiently strong to carry the audience to a productive level. The director-therapist faced them with this fact and refused to be crucified by them (3). The writer was never faced by a group like it, it was a perfect, classic example of the enraged mob. The theme of the day which, parenthetically, had come forth early in the session was: "How can we help patients to face hostility in themselves?" Physician—Heal Thyself!

III

The Reluctant Audience Technique

A further elaboration of this theme occurs when, as is sometimes the case, an *audience* rejects a patient-protagonist. Such was the situation we faced with a patient whose exhibitionistic tendencies reached alarming proportions, in the course of his therapy. The patient suffered from a series of massive tics which involved the entire body, resulting in tonic and clonic movements. He had first developed these symptoms at the age of 7 and they had become progressively worse; he had been under psychotherapy on and off since the appearance of his symptoms but resisted the uncovering types of therapy. There had been but one fairly long period when his symptoms subsided, during his last year of high school. He was well accepted by his peers, participated fully in school life and gained particular recognition as a comic performer on the stage. After graduation he was admitted

to college and during the beginning of his freshman year developed an exacerbation of his symptoms which subsequently led to withdrawal from school and hospitalization. He was referred to us for psychodrama therapy because of his consistent preoccupation with fantasies which involved his inclination towards the drama, and because it was assumed that psychodrama is better suited to treat such psychomotoric disturbances than the verbal methods. Dick enjoyed the psychodrama sessions and appeared to benefit from them; he particularly relished the fact that he had an audience. The audience members began, in the course of his treatment, to develop very distinctive relationships to Dick and he found much warmth and responsiveness on numerous levels. His fear of failing, however, forced him repeatedly into the role of the clown, especially when this role was most inconsistent with the demands of the situation. For example, we placed Dick into a situation with an auxiliary ego in which he was being interviewed for a job. His enactment of the role of the prospective employee was so destructive of the correct warming up process that the audio-egos became more and more irritated with his performance. It was evident that he used the comic approach to cover up his own deficiencies and to deviate attention from this area. One could interpret this as resistance to therapy but that would be only the partial truth, for in fact, Dick loved his psychodrama sessions. He would feel rejected if he were not the protagonist in a session and was unable to sit through the performance of another protagonist as a spectator, though he was willing to participate as an auxiliary ego. He had been the exclusive subject in a number of previous sessions, when the audience finally became restive and refused to become the scapegoat for his narcissistic destructiveness. In other words, they were physically present, but emotionally absent. At this point one of Dick's most ardent supporters (she had frequently taken the role of his mother in earlier sessions) whispered to the Director "What would happen if he had no audience? What if we all left the auditorium, one after another?" The Director nodded his consent—it seemed the same thought had occurred to him as well as to several other audio-egos at about the same time—*and the audience quietly withdrew.*

Dick remained behind, together with the Director-therapist and the few auxiliary egos necessary. He reacted with a strong show of real emotion, resentment and hostility at the audience's fickle behavior, but for the first time during that session was able to go into a realistic portrayal of a job application. Whereas the mere perpetuation of permissive support produced no real heat in him, forcing him back into the action portion of the session without the gallery to play for was of essential therapeutic value.

The meaning of the "reluctant audience" technique is clear. If therapy is to be a true learning situation, no efforts should be spared to assist the patient in a re-evaluation of his behavior patterns, and to offer restraint where mere permissiveness would inhibit growth and integration. Permissiveness in such a situation would defeat its own purpose. The withdrawal of support at a crucial moment when the audience felt itself abused was a necessary step in the therapeutic process, thus interrupting a rigid behavior pattern which was bound to lead to disaster for the patient.

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MODIFIED GROUP PSYCHOTHERAPY, AN EXPERIMENT IN GROUP PSYCHODYNAMICS FOR COLLEGE FRESHMEN

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In keeping with its program of preventive psychiatry in the college setting, the psychiatry department of the student health service at Massachusetts Institute of Technology instituted "an experiment in group psychodynamics" for volunteer freshman students. The following is a report on the response of three freshman classes with regard to volunteering and attendance plus a more detailed analysis of a recent freshman class, 1955-56, with respect to academic ratings, personality ratings, withdrawals from school, academic disqualifications, and the use made of individual psychiatric help.

Group Psychodynamics and the Educational Process. Purpose of the Groups.

Preventive psychiatry in the undergraduate years must include as many elements of the educational process as it can in order to integrate effectively with the academic environment. For generations many brilliant and epigrammatic definitions of education have been composed. Almost without exception, there appears in them a reference to the educational process as a maturing experience. Since physical maturity proceeds in a fairly inevitable fashion, the maturing effects of education must appear in the mental and emotional qualities of the student. The factors in college that facilitate the emotional maturation of the student are not numerous or clearly defined. Hero worship and imitation of a mature teacher is one of the most powerful influences on the student. Fellow students whose personality and behavior are more mature and hence admirable are often emulated by the less mature late adolescents. The self-discipline exacted from the student by rigorous courses of study help the emotion maturing process. An organization of students and faculty that provides opportunity for increasingly wide independence and self-government will foster emotional maturation. And all social and extracurricular activities which encourage behavior at an adult level and encourage active use of the spoken word contribute to the students' emotional maturing.

The expression of feeling by use of the spoken word has impressed the senior author as a most effective and universal aid to maturing the personality. The effectiveness of this process is, of course, demonstrated in striking

fashion by the methods of psychoanalysis, psychotherapy, and various forms of counselling by lay individuals. But as B. D. Lewin[1] says, ". . . life often plays the analyst and gives people 'interpretations,' in the form of facts and ideas which they realize are true with their intellect but to which they cannot commit themselves emotionally." One of the opportunities to speak out and thereby become more emotionally committed is to be found in the intimate seminar and in group psychotherapy. In the latter experience, especially when led by a professional skilled in group psychodynamics, appreciable areas of the preconscious, if not the unconscious mind are uncovered in the talk of the participants. In doing so, increasing self-awareness is achieved and aids to the process of emotional maturation are provided. Ideally, the figure of Mark Hopkins on one end of a log and the student at the other could best be realized so far as emotional ripening is concerned if, in addition to all his other gifts, Mark had a working knowledge of psychoanalytic theory and its techniques.

In addition to such personal maturation that might occur it was hoped that the group experience would enhance the student's awareness and understanding of emotional human processes and relationships. It was anticipated, too, that in conducting such groups the medical staff would learn more about the social and emotional stresses undergone by freshmen at M.I.T.

Purpose of This Study

The groups were arranged on standardized patterns of group therapy. Each group of ten students with a psychiatrist as group leader met throughout the freshman year. During the seven years of experience with this program inaugurated by the senior author limitations have been encountered, and there have been necessary modifications of usual group psychotherapy techniques and objectives. One of the striking limitations has been the high incidence of drop-outs and variation in attendance. It is the purpose of the present study to get a clearer picture of the make-up of the groups and the trends in attendance as it relates to available data on all freshman students. This gives a clearer picture of how, by its voluntary aspects, this program selects certain students for varying amounts of time out of the crowded activities of the freshman year. By this knowledge it is hoped that the groups may be geared more closely to their realistic role in the freshman program. Thereby the groups may function more effectively within that framework to accomplish their intended purpose. Furthermore, it is hoped

[1] Lewin, Bertram D., *The Psychoanalysis of Elation*, p. 78. W.W. Norton and Co., New York, 1950.

that the data of this study will provide a baseline and springboard for additional investigation and work in this area.

It is not the purpose of this study to deal with the functioning and effects of the individual groups upon individual students. This important aspect is an appropriate subject for additional studies. Though these factors are of obvious importance in the attendance of groups, it is the purpose of this report to deal with the functions of this volunteer program within the freshman class setting. It has been strikingly evident that attendance and other group behavior patterns have been strongly influenced by the relatively low degree of motivation—even though approximately one-fourth of each freshman class volunteered for the experiment—the adolescent curiosity and unrealistic expectations of some of the volunteers and the severe academic pressure that accumulates as the year moves on.

Method

Method for Handling the Psychodynamics Groups

Freshmen were introduced to the "Experiment in Group Psychodynamics" by a brief announcement at one of their convocations during Freshman Week just prior to fall registration. The Chief of the psychiatric service made this announcement along with a short comment about the psychiatric facilities at M.I.T. Freshmen who wished to volunteer for this non-credit activity wrote their names and addresses on cards which were collected as they left the auditorium.

Taking the freshman class of 1955-56 as an example, of the 240 total volunteers a random sample of 95 students were invited to attend the group meetings. The remainder of the volunteers, the "control group," never received an opportunity to attend a group. By the time schedule complexities were worked out for the individual students and group leaders a total of 73 students, the "experimental group," were assigned to attend the meetings of some specific Psychodynamics Group. Of the original Freshman-Week volunteers a small number never actually registered in school and a few were classified as sophomores. These were deleted from the "control group" and the "experimental group" in this study. The several volunteers who were invited to attend a group but for various reasons did not pursue the scheduling far enough to work out an assignment to a specific Psychodynamics Group are not included in the experimental group of this study. For the most part these students made no response to the written invitation to check with the secretary for specific schedule arrangements. There were no instances known to the secretary where an interested student was abso-

lutely unable to arrange to attend one of the Psychodynamics Groups for reason of schedule alone. However, out of the experimental group there were several students who had to drop out of their specific Group reportedly due to late changes in schedules or the beginning of part-time work. These students may have attended no meetings or as many as 12 meetings when the schedule conflicts arose. Group attendance suffered heavily due to schedule complications which arose at the beginning of the second semester. Many groups had to be discontinued at this time.

The weekly group meetings have been for the most part one hour long. One and one half hours duration seems preferable, but institute scheduling does not permit it. Most of the meetings were held in informal settings in the Homberg Infirmary or adjacent seminar rooms.

The group meetings were essentially unstructured, which at times produced striking signs of frustration and borderline panic on the part of some students. However, an effort was made by the leaders to make the groups more structured and non-threatening than a typical psychotherapy group. The purpose of the group was introduced by each leader in terms something like "an opportunity for you to get to know each other better, to share your thoughts frankly and in this first-hand experience to learn something about how people get along together or why they sometimes fail to do so." Most of the leader's activity was oriented to the group interaction. Different leaders varied as to their participation in the discussion of subject-matter per se. Most limited their remarks to commentary that dealt directly or indirectly with the prevailing emotional processes. However, all leaders made an effort to be warm and personable, sometimes encouraging the use of their own first names. Occasionally, they engaged in some direct "educational" efforts in teaching simple emotional and social mechanisms with group activity as an illustration. This greater activity and intimacy of the leader as compared to the leader of a more intensive psychotherapy group seemed indicated by the adolescent age of the students, the comparatively low motivation for this voluntary activity in the midst of a severe academic schedule, the comparatively short duration of the groups and the values of a more personalized experience with the adult leader. This was confirmed repeatedly by leaders who came from experience with more intensive psychotherapy groups and found their comparatively remote and analytic approach too threatening for these psychodynamics groups. This is somewhat in contrast with experience in therapy-teaching groups involving psychiatric residents or students in allied fields where the group members are more strongly motivated and more nearly adult.

Within the group setting direct efforts were made to deal with attendance fluctuations by initially requesting and stressing the importance of regular and consistent attendance. The students were also encouraged to discuss frankly their reasons and feelings regarding absence and drop-out.

Group leaders were psychiatrists or psychiatric residents at the second and third-year level. Practically all had previous experience and training in group therapy, mostly in the setting of a psychiatric training center. Previous experience with this type of group was quite limited on the part of many, but all were under the supervision of the senior author, a psychoanalyst and experienced group leader who also served as leader for some of the psychodynamics groups.

Method of This Study

In an effort to get more factual data regarding the volunteers as well as those who were assigned to Psychodynamics Groups, a study was made of the data which is available on all the freshmen of 1955-56. This included:

1. *Predicted Rating*: A figure similar to the grade point or accumulated scholastic rating which is an approximate statistical estimate of the student's academic performance his first term at M.I.T. It is based on past scholastic performance in high school and performance on the college entrance board examinations. This composite figure is arrived at by the M.I.T. Admissions Office prior to admitting a student to M.I.T. It reflects individualized judgment according to the size and nature of the high school as well as a variety of factors in past academic performance. The figure has demonstrated a remarkably high degree of predictability when compared to the First Term Rating of the freshman student.

2. *Personality Rating*: Another figure compiled by the M.I.T. Admissions Office as a means of selecting students. It is based on letters of reference, individual interviews, past extracurricular activities and any additional significant knowledge available on the individual student.

3. *Term I Rating*: Grade average at the end of the first semester.

4. *Cumulative Rating*: Accumulated grade average at the end of the freshman year. Items 3 and 4 were made available through the courtesy of the Registrar's Office.

5. *Withdrawals* from school during the year, including academic disqualifications at the end of the first semester.

6. *Academic Disqualifications* at the end of the freshman year. This is essentially the same as academic failure but carries provisions for re-

admission at a later date. Items 5 and 6 were made available through the courtesy of the Office of the Dean and the Registrar.

7. *Individual Psychiatric Attention*: The number of freshmen who were seen individually by the psychiatric staff during the year for consultation and usually short-term psychotherapy.

The above data was compared for three groups, all within the freshman class for 1955-56.

1. Total Freshman Class.
2. Control group, defined above.
3. Experimental group defined above. For purposes of this study, the experimental group has been arbitrarily divided into three categories: those who attended no meeting, those who attended one to five meetings and those who attended six or more meetings.

The program has been in effect seven years. Records are available on the past three years, 1953-1956. During these three years there have been twenty different Psychodynamics Groups conducted—five, eight and seven groups respectively each year. Twelve different group leaders participated. Out of approximately 3000 freshmen entering M.I.T. during these years, there were 650 volunteers for the group psychodynamics experiment. Of these volunteers, 227 were assigned to groups. These proportions were roughly comparable for each of the three years save that there has been evident a gradual increase in the proportion of volunteers. The duration of the groups varied from four meetings to twenty-seven meetings. Eighty per cent of the groups had at least ten meetings and fifteen per cent had more than twenty meetings. The average for all groups was 13.3 meetings.

The usual number of freshmen assigned to each group was ten; but in the last year 12 to 15 students were assigned to compensate for early drop-outs. Of the total 227 students assigned to groups, 42 did not attend any meetings. Of the 185 who attended at least one meeting, 136 attended at least 3 meetings; 115 attended at least 6 meetings; and 45 attended at least 11 meetings. Some of these represented regular attendance throughout the first semester; others were scattered throughout most of the school year.

The data on the freshman class of 1955-56 is tabulated in the accompanying table. Percentage figures represent the percentage of total students in a given column. For example, in Item 19, Column III, the four students represent 25% of the 16 total students in the column.

In the case of predicted ratings and personality ratings, there were a few freshmen on whom these figures were not available; in such cases the percentage figure is adjusted to the smaller total.

It should be noted that the figures for the total class include the volunteers, both controls and experimentals. Hence, any comparisons of these smaller groups to the total class make the differences less striking than what they would be if comparing volunteers to non-volunteers. In the discussion some comparisons of volunteers to non-volunteers will be made.

Discussion

A glance down the two right hand columns of the table will show the close and consistent similarity between the *controls* and the *total freshman class*. There is one significant exception (Item 25), and there are some minor variations which will be discussed in the next paragraphs. But for practical purposes, in terms of predicted scholastic performance, personality ratings, actual scholastic performance, rates of withdrawal and disqualification, and the scatter of these qualities, the control group appears fairly representative of the total freshman class.

In comparing pre-admission data (e.g., Items 3 and 7), it would be more appropriate to compare the total volunteers (experimental group plus controls) to the total non-volunteers of the class. The mean average predicted rating of all volunteers is 3.62 compared to 3.57 for the non-volunteers (figures not given in the table). This difference is not statistically significant, but it is consistent with the trend whereby most of the differences between control-volunteers and the non-volunteers involve slightly higher ratings for the volunteers.

In scholastic performance during the freshman year, the controls averaged slightly higher than the average for the total class (Items 14 and 17). This higher performance apparently occurred in the median bulk of the class rather than at the extremes (Items 19 and 20). There is also a trend whereby in the Term I ratings the controls did not fall as far below their predicted average as did the class as a whole (Item 16). These differences in individual items are not statistically significant, though the consistency of the total pattern enhances the significance. Even if the trend is significant, the margin is quite narrow and of minor importance. An important point that is established by these data is that the volunteers as a group are no more in need of help (in terms of scholastic performance and personality evaluation) than their non-volunteer classmates. If anything, they are slightly less needy than their classmates as a whole. It is of further interest, then, that the most significant difference demonstrated in the comparison of the controls to the total class is the greater tendency of the controls to seek individual psychiatric help (Item 25). This is further discussed below.

M.I.T. FRESHMAN PSYCHODYNAMICS GROUPS, 1955-56

	Experimental Group (Volunteers who were assigned to groups)			Controls	Total Class
	Attended 6 or more meetings	Attended 1 to 5 meetings	Attended no meetings	(Volunteers who were not placed in groups)	Freshman Class of 1959
	No. %	No. %	No. %	No. %	No. %
1. Total number registered	35	23	16	166	954
2. Total completing the year	35	22	16	157	906
PREDICTED RATINGS ("P.R.")					
3. Mean average predicted rating (Range of P.R. 2.01 to 5.00)	3.74	3.64	3.81	3.58	3.58
4. Standard deviation of P.R.	.54	.52	.46	.52	.49
5. Number with P.R. higher than 4.00	14 42%	5 24%	6 40%	38 26%	200 23%
6. Number with P.R. lower than 3.00	2 6%	2 10%	0 0%	13 9%	78 9%
PERSONALITY RATINGS					
7. Average pers. rating	8.0	7.8	8.1	7.85	7.74
8. Range in pers. rating	7 to 9	7 to 9	7 to 9	6 to 10	6 to 10
9. Number with pers. rating 10	0	0	0	3	16
10. Number with pers. rating 9	5 > 15%	3 > 14%	5 > 33%	24 > 18%	160 > 20%
11. Number with pers. rating 8	23 70%	11 50%	7 47%	75 50%	391 45%
12. Number with pers. rating 7	5	7	3	46	297
13. Number with pers. rating 6	0 > 15%	0 > 36%	0 > 20%	3 > 32%	12 > 35%
TERM I RATINGS (T.R.) 2/56					
14. Mean average Term I rating (Range 0.00 to 5.00)	3.46	3.20	3.58	3.34	3.21
15. Standard deviations of T.Rs.	.86	.99	.70	.88	.87
16. T.R. compared to P.R., ave.	— .28	— .44	— .23	— .24	— .37

M.I.T. FRESHMAN PSYCHODYNAMICS GROUPS, 1955-56 (*Continued*)

	Experimental Group (Volunteers who were assigned to groups)						Controls (Volunteers who were not placed in groups)		Total Class Freshman Class of 1959	
	Attended 6 or more meetings		Attended 1 to 5 meetings		Attended no meetings					
	No.	%	No.	%	No.	%	No.	%	No.	%
CUMULATIVE RATINGS (C.R.) 6/56										
17. Mean average cum rating (Range 0.62 to 5.00)	3.42		3.29		3.52		3.36		3.27	
18. Standard deviation of C.R.	—		—		—		—		.88	
19. Number with C.R. *higher than 4.29*	6	17%	0	0%	4	25%	15	9.6%	88	9.7%
20. Number with C.R. *lower than 2.00*	3	9%	1	4%	1	6%	9	5.7%	53	5.8%
21. Number with C.R. *which exceeded P.R.*										
by at least 1.00 grade pt	0	0%	0	0%	0	0%	3	2.1%		
by at least .80 grade pt	0	0%	0	0%	0	0%	4	2.8%		
22. Number with C.R. *which failed to equal P.R.*										
by at least 1.00 grade pt	5	15%	2	9%	3	20%	17	12%		
23. *WITHDRAWALS*, including 27 disqual. Feb. 1956	0	0%	1	4%	0	0%	9	5.4%	48	5.0%
24. *DISQUALIFIED* at end of Term II, June 1956	2	5.7%	1	4%	0	0%	8	5.1%	46	5.0%
25. Individual psychiatric attention	8	23%	5	22%	2	13%	17	10%	64 Non-volunteers: 32	6.7% 4.5%

Regarding the *Experimental Group,* it was not particularly anticipated that the group experience would make a statistically significant difference in scholastic performance. It was felt that whatever the effects of the group experience, it would be individualized more according to emotional and social needs, and this merits special study in itself. On the basis of clinical impressions, it was felt that some individual cases were definitely helped toward better scholastic work during their freshman year. In other cases it appeared that a temporary unsettling might have lowered scholastic performance temporarily, hopefully to repay in extra dividends in the future. In most cases it was felt that there was not sufficient knowledge to estimate the effect of the group experience on academic work. Certainly, it has been the intent of the psychiatry department that no student's academic work should seriously suffer as a result of this experience. As safeguard in this respect, there were the clinical skills of the group leaders plus the availability of individual psychiatric help.

The *experimental group as a whole* had slightly higher predicted ratings and personality ratings than the controls. (Item 3: mean average predicted rating of total experimentals 3.71, of total controls 3.58.) This difference is not statistically significant and is presumably due to random chance in the random selection of experimentals. It is associated with their higher proportion of high predictive ratings and lower proportion of low predictive ratings (Items 5 and 6). The personality ratings are also slightly higher in the experimentals as a whole, presumably due to the same random chance.

These differences are presumably reflected in the higher average Term I ratings and higher cumulative ratings of the experimentals as a whole compared to the controls (Items 14 and 19). It is only in the context of this chance variation that one can look for significant differences in scholastic performance of the experimentals as compared to the controls. However, because of the selective process of attendance, there can be greater significance attached to variations between the sub-groups within the experimental group.

Within the experimental group in most ratings and in the percentage of withdrawals, there is an interesting parallel between those who attended at least six meetings and those who attended no meetings. This is somewhat in contrast to the lower ratings of those who attended 1 to 5 meetings, whose ratings and withdrawals more nearly resemble the control group and even more closely resemble the total class. There appears to be more evidence for the group attendance to function as the result of a selective process rather than for attendance to influence academic achievement in a statis-

tically significant manner. The highly rated students were apt to attend at least six meetings or no meetings at all (Items 5, 10, 11); the poorly rated students were more apt to attend 1 to 5 meetings (Items 6 and 12). This tendency is further reflected in the average predicted ratings and average personality ratings with the experimental group (Items 3 and 7). This trend is even more pronounced in the Term I ratings and cumulative ratings with respect to mean averages and high performers (Items 14, 16, 17 and 19). However, it does not hold up with respect to low performers (Items 20 and 22). In this comparatively small number of students the above variations are not sufficiently great to be of definite statistical significance, but the trend is a consistent one.

One question which one might ask of this data is whether group volunteering and attendance is related to the students' ability to keep their academic performance up to their predicted potential. There are a number of interesting comparisons of predicted ratings, Term I ratings and cumulative ratings within each column and comparisons of these trends in the different columns. (Compare Items 3, 14, and 17 within each column; note Items 16, 21, and 22.) However, there is no one consistent trend to indicate a significant over-all relationship. On a smaller scale it is interesting that in those more highly rated groups of students who attended at least six meetings or no meetings (Columns I and III), though they maintained higher average ratings than the other groups and had a higher proportion of top-notch performers throughout the year, their average ratings declined the second half of the year in contrast to the increase experienced by the other volunteers and the class as a whole. Also, these two groups have a comparatively higher proportion of those students who fell far below their predicted potential (Item 22). It is of interest that the two students in Column III, Item 25, who attended no meetings but later sought individual psychiatric help both were among the three who fell far below their predicted potential (Item 22). Since these trends involve both these groups rather than one or the other, to the degree that there might be any significance (there is no statistical significance in these small group differences), it again reflects a selective process rather than the effect of group experience on performance.

Those sixteen students who were assigned to Groups but did not attend any meetings merit special comment. Though their number is too small to be of great statistical significance in themselves, they serve a valuable function in pointing up the significance of the selective process in such a volunteer program. It tempers the readiness with which the investigators might

look to the influences of the group experience as the major determinant of the academic differences between those who attended few meetings and those who attended more meetings, which still might be so, but is not established by these figures. Also, it appears that we needn't be too worried about those who express sufficient interest to get lined up for Group meetings then decide not to attend. This group contained five top-notch students (more than three times the proportion found in non-volunteers) and no real academic casualties. Their proportion of high personality ratings is greater than in the comparable group of high performers who attended six or more Group meetings (Item 10). Of the three who were not performing up to previous standards, two found individual help in the psychiatry department. In the process of *having had the opportunity* to attend Group meetings, these non-attenders, perhaps less needy students as a whole, became distinguishable from the more needy students contained in the control group and in the non-volunteers. It remains for further study to confirm the validity of this apparently desirable distinction.

The low withdrawal rate (Item 23) of the experimental group as a whole is more nearly significant statistically than any influence of the groups on scholastic performance. The small numbers involved limited the degree of statistical significance, but the probability of such a low rate occurring by chance is .15 (15 times in 100). In comparing this with the average rate of academic disqualification at the end of the year (Item 24), one wonders if the group experience might have some influence in keeping the borderline students in school even though it may not significantly increase their performance. Of *those who attended at least six meetings,* despite their low quota of predictively poorer students (Items 6 and 12), there was a higher-than-average quota of low performers at the end of the year (Items 20, 22, and 24). This group's large quota of predictively better students (Item 5) did not have a correspondingly large quota of high personality ratings (Item 9), but they maintained their comparatively high proportion of high performers throughout the year (Item 19). Hence, it may be that in this group, while the low performers accumulated at a greater-than-predicted rate and at a greater-than-average rate, they tend to hang around until the end of the year, to be disqualified or continue another year rather than withdraw. It is noted that the group who decided not to attend any meetings has a similar pattern, but none of the comparatively low performers got so low as to be disqualified, as occurred in the case of two students in Column I. It must be remembered that all these figures and trends in the experimental group are prejudiced by the chance occurrence of potentially better students in the experimentals as compared to the controls.

The *most significant correlation is the relationship of volunteering and Group attendance to individual psychiatric attention* (Item 25). The control group had two times the incidence of individual psychiatric attention as that which occurred in the non-volunteers. Those who were assigned to Groups but did not attend had almost three times the incidence of that in non-volunteers. Those who attended any meetings, regardless of how many meetings, were over five times more likely to seek individual psychiatric attention than their non-volunteer classmates. One-half of the freshman individual psychiatric cases came from the 239 volunteers. No direct referrals were made by group leaders, and no conscious effort was made to use the Groups in a case-finding way. In fact, group leaders structured the groups in a comparatively non-threatening manner to avoid individual anxiety apart from its relevance to group interaction. Some of this movement to the psychiatrist seemed enhanced by the acting out of transference feelings toward the group leader. However, the individual therapists did not feel this was a prominent factor. In most instances, the individual therapists were different from the group leader of the student involved.

A variety of factors appear to operate in this association of volunteering and group attendance with a higher incidence of individual psychiatric attention. It is apparent that volunteers for the project are more likely to seek individual psychiatric help with their personal problems. On the basis of academic performance, these are not students with a greater need for help. Even on the basis of personality ratings, these students are not distinguished by their need for help. As a matter of fact, in all academic ratings and in personality ratings they actually average slightly higher than their non-volunteer classmates. It would seem probable that these volunteers are not distinguished so much by their *need* for psychiatric attention as by their tendency to use this method as a means of handling personal problems. One might assume that they are more aware of and interested in social and emotional processes, perhaps they are more introspective regarding their own emotional life. Regardless of which such factors are operative in the volunteering, it appears evident that additional contact with psychiatric facilities, and particularly the contact with the psychiatrist in the group setting, further lowers the threshold to utilizing psychiatric help as a solution to emotional problems. It is a clinical impression that those students who are not so introspectively oriented are among the early drop-outs from the group meetings. They appear to be more apt to handle anxiety by avoidance, rationalization and action rather than by inquiring into and verbalizing these feelings. We are not yet in a position to evaluate whether such differ-

ences in ego function are necessarily better or worse for the maturation of the late-adolescent student. But the existence of these differences seems important to recognize and deserving of further investigation, for such factors apparently are determinants as to which students can be helped in their maturation by present psychiatric techniques. This raises the question as to what other types of help are available and utilized by the needy members of this other group, the non-volunteers. Their academic performance as a whole is only very slightly worse than that of their more psychiatrically-disposed classmates. One wonders if their maturational process and emotional problem-solving is significantly worse.

Hence, though the groups may provide some equivalents of individual therapy, their over-all effect is associated with an increased flow of freshmen to the psychiatrist's office. Whether this is desirable or not depends somewhat on the basic orientation and available facilities of the psychiatric department. At M.I.T. the preventive psychiatric principles developed by Dr. Farnsworth and the senior author promote the establishment of readily available and acceptable psychiatric consultation and treatment, which by detecting emotional disorders in an earlier and milder form are able to forestall the incidence of serious casualties. At the same time there is the mental health objective of facilitating maturation of the "healthy," of promoting the emotional health of students, faculty and administration as individuals and as an academic team. The increased contact of freshmen with psychiatric staff is seen as consistent with this objective. In all this there is the question as to whether this psychiatric functioning accomplishes the desired objective. It means that the psychiatric contacts, once established, must function to promote emotional growth rather than foster dependency. This largely rests with the judgment and skill of the individual consultant as he deals with the late-adolescent student. It is also noted that as the psychiatrist's office becomes more acceptable and commonplace the stigma of "illness" and the connotation of "dependent help" become decreased.

Summary and Conclusions

1. A review is made of the use of modified group therapy, a voluntary "experiment in group psychodynamics," as a preventive psychiatry tool, an aid to student maturation, and an investigative technique in the freshman classes of M.I.T.

2. The selective processes of volunteering and attendance during the past three years are briefly reviewed and some factors discussed.

3. *A more intensive analysis of the most recent freshman class reveals:*
   a. There is a striking similarity between the 166 controls (volunteers who were not assigned to Psychodynamics Groups) and the 954 total class membership with relation to predicted academic ratings, personality ratings, academic performance at M.I.T., rate of withdrawal from school and percentage of academic disqualifications at the end of the year. Within the limits of this similarity there is a consistent tendency for the volunteers to average slightly higher in their ratings than the non-volunteers of the class.
   b. Of the experimental group (volunteers who were assigned to Psychodynamics Groups) those students who attended at least six meetings or no meetings at all had slightly higher academic averages and personality ratings than those who attended one to five meetings then dropped out. This appeared to operate more through a process of selection than as the effect of Group experience.
   c. For the volunteers the *opportunity to attend such a Group,* (i.e., actual assignment to a group) was associated with a decreased rate of withdrawal from school during the freshman year, even for those who chose to drop out after their assignment to a group. The higher rate of withdrawal for the remainder of the class was essentially the same for the volunteers as for those who did not volunteer for the Group experience.
   d. There is no statistical evidence that the academic performance of the Group members as a whole was significantly altered by group attendance. However, such a possibility is not ruled out by these data. Here is a clinical impression that the academic performance of individual freshmen may be either enhanced or temporarily impaired but in most cases is not detectably altered by the group experience.
   e. The Freshman Week volunteer for "an experiment in group psychodynamics" was over twice as likely as the non-volunteer to receive individual psychiatric attention during the year. If the volunteer was assigned to a Psychodynamics Group but never attended, he was three times more likely—and if he attended any meetings, he was five times more likely—than the non-volunteer to seek individual psychiatric help.

f. The higher incidence of individual psychiatric attention among volunteers, despite their lack of greater need (as indicated by scholastic performance, withdrawal rate and personality ratings), seems to indicate their greater tendency to use this method for solving their personal problems. This trend is further increased by contact with the psychiatry department through assignment to one of the Psychodynamics Groups. A question is raised as to what are the needs and what resources are utilized by the non-volunteers, who as a group appear to be equally needy but who are less apt to seek psychiatric help for their personal problems.

4. This type of study is of limited value as a method for evaluating the effects of the Group program on the students. It is more enlightening as to the process of selection which occurs in a voluntary "psychodynamics" activity.

CHARACTERISTICS OF IMPROVED AND UNIMPROVED PRISONERS IN GROUP PSYCHOTHERAPY[1]

JAMES L. JACOBSON AND ROBERT D. WIRT

The Minnesota State Prison and the University of Minnesota

The report I wish to discuss with you today is a segment of a larger program of research we have begun at the Minnesota State Prison with funds supplied by the State Mental Health Medical Policy Committee. We wish to express our appreciation to Douglas C. Rigg, Warden of the State Prison, and to Howard J. Costello, Associate Warden. Warden Rigg was instrumental in obtaining the research funds, and without the assistance of Warden Rigg and Associate Warden Howard Costello we would not have been able to maintain the adequate control necessary for the research we are conducting.[2]

I shall first sketch for you the outline of the Group Psychotherapy project.

We began with two major purposes in mind. First, we saw the program as an opportunity for training in group psychotherapy. Thus all of the groups were conducted by an experienced therapist who worked with a different co-therapist in each group. The co-therapists were psychologists and social workers from the prison Training and Treatment Department who had little previous experience in group therapy. Second, we wished to design our program in such a way that it would conform, as nearly as possible within the reasonable limits of adequate service, to scientific research methodology. In this we sought to determine the characteristics of an effective group structure in our setting and to determine, if we could, the characteristics of the men who most benefit from participation in group psychotherapy.

Our budget best fits a series of twenty weekly one hour sessions. We selected twelve men originally for each of these closed groups, with the expectation that since participation would be voluntary, the number remaining after the first few weeks would drop to about eight. Fortunately these budgetary considerations fit in well with clinical judgment for optimal

[1] Paper read at the annual meeting of the American Society of Group Psychotherapy and Psychodrama, New York City, January, 1958.

[2] Additional members on the Prison Research Committee include Nick Pappas, Classification Supervisor; Don E. Anderson, Clinical Psychologist; and Jack Julin and Ken Skelton, Social Workers.

frequency of meetings, length of treatment, and number of members. There is, of course, no research literature on these subjects and the best we could do, therefore, was to set such limits as appeared reasonable within our staff capacity and clinical experience as reported in literature.

Certain selection criteria were set. These were developed on the basis of judgment concerning the need to maintain some integrity within the groups by selecting members whose verbal skills would permit some degree of participation and on the basis of feasibility within the prison setting. For screening purposes, the following eight criteria were used: To be selected as appropriate for our purposes an inmate:

1. Had an I.Q. of 95 or above as measured on the AGCT;
2. Was under 41 years of age (i.e., this is above the median age in the prison by four years);
3. Was not eligible for release or Parole Board hearing before the scheduled end of the therapy program;
4. Did not belong to another therapy group such as AA, nor;
5. Had not received psychotherapy before;
6. Was not confined to cell halls where chronic disciplinary cases are housed which would interfere with regular attendance at the group meetings;
7. Did not have known brain damage; and
8. Was not considered frankly psychotic or incorrigible.

Before the beginning of the therapy session we screened recent admissions on the above criteria. When the new admission groups were selected we then took every other inmate's file with a view toward selection for the other groups. After 450 files had been examined, we found 175 cases which tentatively passed our screening criteria. These men were interviewed and told about the introduction of group psychotherapy in the State Prison and asked if they would be interested in participating. If they volunteered the interviewer filled out a biographical data sheet. They were told that not all volunteers could be selected at the time because of lack of staff.

Many possible groups could have been chosen from the 120 volunteers. However, we limited ourselves to three general types. The groups selected were those which had enough members in them to constitute an experimental (that is, therapy) group and a control (or non-therapy) group and those which appeared to be well defined and appropriate for our method of treatment. The groups selected were:

Group I. Cases incarcerated for sexual offenses.

Group II. Individuals clinically judged to have emotional problems other than the type of specific sexual problems characterized by Group I. These included inmates with problems which did not appear in specific symptom formation, but were expressed in a symptom picture of free-floating anxiety, inexpressible guilt feelings, excessive worrying or unsatisfactory interpersonal relations because of feelings of inadequacy, dependence, hostility, or persecution. Some were selected on the basis of deviant Minnesota Multiphasic Personality Inventory profiles which suggested neurotic conflict, even though overt expression of neurosis was not identified.

Group III. Inmates described as recent admissions to the State Prison. Only a small percentage of these were first offenses, however.

A number of comparisons were possible, both within and among the groups. It was possible to record changes in a given group for before and after the twenty weeks of therapy. The same group could be compared with its control group. Individuals selected as belonging to a particular group were randomly assigned to the therapy or the control group and are therefore comparable except of therapy. Groups were also compared with each other. Our measures included self ratings by the inmates, behavior ratings made by the therapists, tape recordings of the sessions, psychometrics (the Minnesota Multiphasic Personality Inventory and the Shipley-Hartford test of verbal ability) work ratings made by the prison supervisors and officers, and prison history information such as frequency of disciplinary infractions, visits to sick call, and recreation and educational activities.

Eventually we plan to compare the results of these analyses with follow-up studies of the inmates post-prison adjustment. Our further program of research in Group Psychotherapy includes an additional three years of study and the inclusion of some twenty-four groups. These will be selected first to be representative of the prison population as a whole, and then systematically selected to maximize in the group members those characteristics which our studies show to present the most appropriate and favorable prognosis with given approaches to group psychotherapy.

Thus far, the sessions have been conducted along eclectic lines. The therapists' orientation is sympathetic with the contemporary views of neo-analytic ego psychology.

I wish today to present a fragment of our results. I have chosen the aspects of our study which relate to the contribution of the behavior ratings to the therapists' judgment of improvement in the group members. Each week the therapists rated each member on each of the eighteen behavior rating scales. At the end of the twenty weeks all of the members were

ranked by the co-therapist from most improved to least improved. This ranking was then divided at the place judged by them to separate an *Improved* from an *Unimproved* group. We then graphed the average ratings of each of these groups against each week's ratings on each of the Behavior Rating Scales. The results of these analyses are on the ditto material which you have received. This method of presenting the data gives us some insight into the characteristics of improved and unimproved members and the changes in these traits as therapy progressed. Perhaps more interestingly, it suggests which of these characteristics are most heavily weighted by the therapist when he makes a global clinical judgment of improvement or non-improvement.

The solid lines on the figures in the graphs which you have are mean or average ratings for the Improved Group. The dashes in this line are between weeks in which the therapist was absent and an extrapolation of the trends in the curve for those periods when no rating was made. The dotted lines represent average ratings for the Unimproved group. It should be remembered that the groups are a combination of the individuals in all of the three treatment groups rated as improved or unimproved after twenty weeks of group therapy.

The line in the middle of each graph is at the 50% level. This shows the place along the rating scale where the median of the total rating was made. Above this level rating is generally in the "good" or more psychologically healthy direction; while ratings below the mid-line generally represent a judgment in the direction of psychological ill health.

Each scale is labelled on the ditto material and the extremes of the scales indicated. An immediately obvious characteristic of the graphs of most of the scales is a tendency for the ratings in the initial and early sessions to be low with a gradual slope upward, in the direction of greater maturity, as the therapy progressed. This, we believe, is a reflection of the general therapeutic value of the treatment. Both Improved and Unimproved groups showed some change; even those we labelled as relatively unimproved appear to have derived at least minimal benefit from the group experience.

The slopes of the Improved group tends on the average to be steep, however, suggesting that it is these men who showed the greatest change in the direction of improvement. The slope of the graphs for the Unimproved group is more nearly flat, showing a lesser degree of change.

One of the more striking features of the figure is a tendency on many of these scales to show the Improved group rather than the Unimproved group to be rated as less well adjusted initially. In the first session or two

the men who ultimately benefit most look less well integrated. We have interpreted this finding to suggest that it is to be recommended that group members be encouraged to continue with treatment even when early indications are that they do not seem motivated. As the initial apprehension of treatment fades away it is these men who begin to show the most favorable response. The Unimproved group gives an impression of greater social ease and spontaneity. Our findings indicate that these are superficial qualities which do not wear well and these men do not live up to their early promise. Rather they tend to remain relatively unchanged while the others overtake and pass them.

Some of the individual rating scales are of sufficient interest to warrant more detailed discussion. I shall discuss them in order:

Scale 1: How does each of the inmates in this group relate to the others?

This scale shows a general superiority of the Unimproved over the Improved during much of the treatment period. Nearly every week those later described as Unimproved appeared relatively more mature in their interpersonal behavior within the groups. This characteristic is apparently a reflection of their greater defensiveness and superficiality so that they appeared more mature because they behaved less affectively. However, by the end of the treatment the Improved group came to show greater maturity, as we would expect, reflecting greater growth as a result of group therapy.

Scale 2: How good is this inmate's judgment of the other inmates' behavior?

Here again we note the tendency describing most of these scales for a gradual slope upward indicating greater understanding by all of the participants. The chief difference between this and some other scales is the tendency of the two groups to show progressive divergence. Thus the groups received fairly similar patterns of ratings during the early and middle sessions, but as the more intensive period of therapy approaches—and near termination of treatment—the Unimproved group shows little further change, while the Improved shows markedly increased understanding of others.

Scale 3: How much insight does this man have into the causes of his behavior?

This turned out to be one of our very best scales for the discrimination of the groups. The graphs show no overlap, the Improved group is sub-

stantially more insightful about their own needs and motives from the very beginning. Neither group shows as much improvement on this dimension as we should like to see, of course; but a significant feature of these figures is the slight degree to which the Unimproved group became any more insightful at all compared to their first ratings.

Scale 4: How much insight does the man have into his present behavior concerning his awareness of his present needs and goals?

This scale is similar to the previous one in that it concerns the individual's judgment of himself. But while Scale 3 concerns introspection of a more basic kind having to do with one's personality and motivations, this scale has to do with current consciously held plans and desires. Here again we see the Unimproved group giving the better impression in the first session, but both show rapid increase in awareness of these aspects of behavior with the Improved group again showing the most marked change. By the end of treatment, the men seem to have a quite good grasp of what they want and of how they plan to go about getting it. Scale 4, as Scale 3, suggests they do not yet, however, have much insight into why they are motivated as they are.

Scale 5: The men's attitude toward group therapy was overtly hostile to extremely positive.

This is one of the more interesting patterns. The attitude of the Improved group at the beginning of therapy is one of suspicion and rejection; they express hostility toward the process and doubt its value. The Unimproved group is more polite. They begin by appearing mildly positive and remain that way. The Improved group shows a change of attitude as therapy progresses from one of disdain to one of interest, acceptance and quite positive feelings about their experience. The dip in ratings of these men in the last sessions we believe is a reaction to the termination of therapy and a return of some defensiveness and projection of their disappointment and anger at ending treatment. It suggests that some transference had taken place with the men in the Improved group; while little, if any, is obvious in the Unimproved group.

Scales 6 a and 6 b: These scales relate to the behavior of the group members toward the therapists.

As one might expect, the reactions to the experienced therapist became somewhat more extreme than the reactions to the co-therapists. It is also

with him that something of a more obvious transference nature is reflected in the slightly negative change near the end of treatment. It was he who was leaving these groups to start new ones, while the co-therapists were to remain. This would also account for the rise in positive feeling toward the co-therapists during this termination period.

After the twenty week evaluation period all of the group members were interviewed and those who expressed a desire to remain in treatment were continued under the leadership of the co-therapist with whom they had been working.

Generally all of the men expressed attitudes toward both therapists which could be characterized as more positive than negative.

Scale 7: How does each of the inmates in this group relate to the other inmates?

The evidence from this scale suggests that a more active, aggressive approach to others is prognostically better than a passive type of relating to others. The Improved begin and end treatment being rated more aggressive than the Unimproved group, and this difference is larger late in the treatment series. As a trend of the entire group, we note that the average group member begins treatment appearing rather reticent, quiet and passive in his relations with others, and becomes progressively more assertive. These data suggest that the greater involvement of this sort which occurs, the better the therapy outcome is likely to be.

Scale 8: How aware is the man of the consequences of his behavior?

The results shown in the ratings made on this scale demonstrate a clear trend for group members to steadily improve in recognition of the consequences of their behavior. We included a scale on this dimension because it seemed particularly germane to a study of prison inmates. This expectation was confirmed in the results shown here. The Improved and Unimproved groups are clearly separated on this dimension. The Unimproved group shows some increasingly better judgment, but begins with ratings indicating a profound lack of planning ability, suggesting that these are impulse ridden individuals with poor judgment and low frustration tolerance.

Scale 9: Investment in group activity.

Here again we see a good demonstration of the trends noted earlier. Initially the Improved group is rated below the Unimproved; both groups show some increasing investment in the group as they experience the effects

of treatment, with the Improved group showing a more rapid, more sustained interest; and it is the Improved group which appears to be more responsive to the therapist. They show a temporary lapse following the absence of the therapist around session nine and again during the termination phase of treatment.

Scale 10: Behavior toward other members of the group was extremely hostile or negative to extremely positive.

This scale is interesting on several counts, but not because it appears very much affected by therapy. Both groups begin and end with mildly positive behavior toward other group members. However, the intervening period shows an interesting reciprocal appearance. Those later considered Improved appear to be more positive toward others on days those later rated as Unimproved are relatively less positive in their group behavior. It is interesting that the Improved and Unimproved groups should co-vary positively with others who will have the same outcome and negatively with those who have an opposite result from treatment.

Scale 11: Does the inmate have tolerance for frustration at this time?

The results of ratings on this scale are perhaps the most unexpected of any. From beginning to end, with virtually no overlap, the Unimproved group is rated as showing substantially greater tolerance for frustration than is the Improved group. Ordinarily, of course, one would expect to find better control in the individuals who show the best treatment results. Some increase is shown in both groups, but clearly it is the Unimproved group which shows the greater frustration tolerance. In retrospect we believe this difference is a reflection of the emotional involvement in therapy which each group has. It is the Unimproved group which is more superficial in their relations with others, who are less motivated about treatment and participate least. They have less reason, therefore, to demonstrate low frustration tolerance within the group meetings since little occurs there which is frustrating for them.

Scale 12: How self-centered is the man? The opposite of this might be group-centered.

As well as any scale, this one is a good example of the trend for all group members to show increasing maturity during the course of treatment. The difference between Improved and Unimproved is not marked, though at the end the Improved group shows a slightly less egocentric orientation.

Scale 13: Anxiety.

There is relatively little total change over the 20 weeks on this important dimension, the only changes that are noted can best be explained as variations attributable to reactions within each session. There is, however, a striking separation of the groups; the Improved group is consistently rated as showing more anxiety than the Unimproved group, which displays few manifestations of overt anxiety.

Scale 14: Inmate's references to himself.

Here again we see the syndrome of low involvement in the group, little anxiety, and egocentrism manifested by the Unimproved group. They flatter themselves about as much at the beginning as at the end of treatment. The Improved group, however, comes from some degree of self-abnegation to greater self-respect.

Scale 15: During the session this man was generally active to . . . . very active.

Here we have a scale not only showing therapeutic movement but one which separates Improved from Unimproved from the very beginning of treatment, and during each session. Clearly it is those who participate most who gain most from group psychotherapy.

Scale 16: What is your general impression of this person's social skills?

During the beginning phase of therapy and for some time thereafter both groups are rated as having generally poor social skills. As treatment comes to have more intense meaning the Improved group clearly shows marked improvement in their social relations in the group, while the Unimproved show relatively less adeptness. This is a somewhat surprising finding, since one might have expected the Unimproved group to give the better impression in this area. They have less involvement and less anxiety and might be expected as part of their generally more superficial syndrome to be more socially adroit. We did not find this stereotype, however.

Scale 17 a: How much motivation does he have for exploring his own problems?

Again we have a scale in which the initial impression is misleading. In the first session the Unimproved group appears to have some motivation for self-exploration but this quickly evaporates and during the entire course of treatment these individuals display a remarkable lack of interest in looking

at themselves. On the other hand, the Improved group shows gradual increase in ability to explore their own problems.

Scale 17 b: How much motivation does he have for exploring the problems of others?

We find a similar trend on this scale. The Unimproved group is little interested in others, the Improved group more so. As seems logical, individuals in the Improved group do not begin to be able to display interest in others until after they have begun a more conscientious study of themselves.

Scale 18: Monopolizing.

The last scale is one we labelled monopolizing by which we mean not merely activity and group participation, but a tendency to use the group time exclusively for one's self. Ratings on this scale do not show large before—and after—changes and appear to be related in some degree to general activity level. The Improved group begins and ends treatment with more individuals of this type. They appear more assertive in this than the Unimproved, perhaps as a function of the average greater investment in therapy.

From these weekly ratings of behavior we can make some estimate of the characteristics important to a therapist in rating an individual as improved following therapy. In the first place, we find that low frustration tolerance and ability to bind anxiety are negative improvements. On the positive side, it is those, as Dr. Corsini has suggested, who show initial trepidation followed by acceptance of others and later on even altruistic feeling for others and some transference reactions who have the best treatment result. Probably the most important single characteristic of the Improved group is their motivation for treatment. In consequence, perhaps, it is these improved individuals who are rated as most insightful and as participating most in the treatment process.

These results confirm much clinical speculation regarding the therapy process. In our later research we plan to use these and other data as a basis for refining our selection of candidates for treatment and for evaluation of the treatment process and its outcome.

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CHANGES IN PATIENTS' ATTITUDES TOWARD SELF AND OTHERS DURING GROUP PSYCHOTHERAPY[1]

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PROBLEM

Many workers in the area of psychopathology believe that all neuroses are characterized by distorted self concepts and disturbed interpersonal relationships. The present authors believe that group psychotherapy offers a unique opportunity to observe and measure the changes in attitudes of the patients toward each other as well as toward themselves.

Accordingly, an experiment was designed to test the following hypotheses: (1) The attitudes of group members towards themselves and towards other group members will vary with the stage of treatment and the immediate anxiety of the group. (2) A rating scale can be used to measure these changes in attitude.

METHOD

The authors served as co-therapists with a group of eight psychoneurotic veterans of World War II who met semi-weekly for one hour sessions. Research data was collected for the first one hundred sessions, which covered approximately a year duration. Therapy was characterized by an emphasis on encouraging the patients to interact in a permissive atmosphere with the aim of working through their neurotic conflicts. A seven point rating scale on the hostility-friendship continuum varying from Very Angry through Very Friendly was administered every fourth session. The patients were instructed to rate themselves as well as every other member of the group. The therapists also made ratings at the same time the patients did. They attempted to judge from the activity of the session how each patient felt about himself and the other group members. In addition a diary of each session was kept by the therapists for the complete term of the research project. These diaries, written shortly after each session, were summaries of dynamics as well as content. The emphasis was on the description of the behavior, verbal and motor, of the patients during the session.

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Results

The results confirm the hypothesis that a rating scale can be used to measure patients' changes in attitude during group psychotherapy. The test-retest reliability of the scale as filled out by the patients was +.80, n = 18. The reliability of the therapists' judgments, based upon the scale, averages +.47, n = 22.

One measure of the validity of the scale is the correlation between the patient's ratings and the therapists' judgments of the patients' attitudes towards self and others. These correlations ranged from .0 to +.94. An analysis of the reasons for this variability suggests that the low correlations can be accounted for by those patients who were unable, in the early stages of treatment, to be free enough to express attitudes on the scale that they did express behaviorally in the group sessions. The responses of these patients to the questionnaire were determined in a large measure by their defensive needs. The therapists' judgments however were determined by their perception of the patients' behavior in the group sessions.

A second measure of validity, or sensitivity, is the range of acceptance that group members reported for each other as measured by the scale. This measure, which the authors have termed the "Acceptance Index" is the average of the ratings of all the other group members towards a particular patient. These indices varied significantly between patients when tested by an analysis of variance

A third criterion of the validity of the rating scale is that the attitudes of the group members as reflected by the average of their ratings, varied significantly during the course of treatment. These attitudes were related in an obvious way to the stage of treatment, as can be seen by Table 1.

The results indicated that the group process as far as patients' attitudes are concerned can be divided into two parts. The first ten weeks could be characterized as a honeymoon period. The members' ratings reflected extremely friendly feelings towards each other and anger only towards themselves. After ten weeks, the patients' ratings reflected less friendly feelings towards each other and less angry feelings towards themselves. These trends were tested by Chi-square technique (See Tables 1 and 2) but only the former was found to be statistically significant.

The authors feel that these findings accord with their clinical observations that the first task faced by patients beginning group psychotherapy is the formation of group unity. For this reason the expression of hostility towards each other and towards the therapist is unconsciously inhibited

during the first stage of treatment. When the patients come to feel a real sense of group cohesiveness and come to realize that the therapists genuinely are permissive, they are then able to begin expressing their hostility toward each other.

TABLE 1

RELATIONSHIP BETWEEN STAGE OF TREATMENT AND ATTITUDE TOWARD GROUP

Factors	*Attitude of Patients*	
Towards Group	Friendly	Hostile
Sessions 1-20	27	79
Sessions 21-40	2	68
Total	29	147

$X^2 = 13.8$, $p < .01$.

TABLE 2

RELATIONSHIP BETWEEN STAGE OF TREATMENT AND ATTITUDE TOWARD SELF

Factors	*Attitude of Patients*	
Toward Self	Friendly	Hostile
Sessions 1–20	8	9
Sessions 21–40	9	4
Total	17	13

$X^2 = 1.6$, $p. > .05$.

Throughout the treatment the patients' attitudes towards other group members remained more friendly than their attitudes towards themselves. The difference was found to be significant at the 1% level of confidence. Again it is felt that the explanation for this finding lies in the anxiety of the patient to maintain the feeling of group unity which they recognize, although perhaps unconsciously, as a prerequisite of therapeutic movement. This unity is maintained at the cost of suppressing, and possibly internalizing, part of their hostility towards each other. An example of this is that hostility towards absent members was clearly apparent to the therapists, but it was only with the greatest difficulty that the patients could be induced to verbalize their hostility.

Qualitatively, the data show that a communality of feelings based upon discussion of symptoms occupied the honeymoon period. The second, or working through period was characterized by a frequent discussion of the patients' interpersonal conflicts, both in the past and in the present.

For each patient, individual patterns of conflict derived behavior became apparent and were worked through, usually in terms of transference feelings towards both therapists and group members.

An analysis of the content of each group session reported in the diary suggests that each session was dominated by a specific theme (1). These themes were classified upon the basis of the major interpersonal attitude they revealed. Some of the themes were hostility towards authority figures, towards peers, and expression of need for help, etc. The authors believe that the themes represent a vehicle by which the patients were able to convert the anxiety they felt during the group session into a topic that would allow them to communicate their anxiety to each other and to the therapists. A theme was usually initiated by a group member's opening remarks at the beginning of a session. The anxiety underlying the theme spread through the group by the process of contagion. Each member would call forth from his own experiences or from his feelings towards the group members at the moment incidents that would serve to further develop the theme.

The authors observed from the data recorded in the diary that the principal sources of the patients' themes were their anxieties over interpersonal situations. These anxieties could be precipitated by experiences outside the group. The experiences most frequently involved their families, fellow employees and others with whom they have had affective contact. These anxieties were observed, however, in the group and developed into a theme only when the same interpersonal difficulty existed with some one or more group members or the therapist. Interpersonal relations within the group can act as a direct stimulus for a basic anxiety. The absence of one or more group members from a session is frequently seen by the group as a rejection. The content of the theme initiated by this situation might vary, but the experiences recalled and the feelings expressed were always in terms of hostility towards one's peers. Direct hostility towards the absent member could not be verbalized, however, without the help of the therapist. A validation for the authors observation that the theme of peer hostility in this situation was stimulated by the absence of a group member is the expression on the rating scale group attitude towards him. A comparison of the group's attitudes toward an absent member before and after the missed session, as measured by the Acceptance Index, revealed a marked increase of hostility towards the absent member. This is significantly greater than chance at the 5% level of confidence.

The activity of the therapists seems to affect group attitudes towards self and others in three major ways; understanding, usually communicated through an appropriate interpretation, seems to decrease hostility both towards self and others. Lack of understanding on the therapist's part increases the patient's hostility toward self, but may decrease hostility towards other group members. Expression of group hostility against the therapists results in less feeling of hostility toward self and also less hostility towards other group members.

Summary

1. A Rating Scale was used to measure the changes in the attitudes of members of a psychotherapy group towards themselves and other group members.

2. Length of time in treatment was found to have a significant relationship to patients' attitudes. Therapy seemed to fall into two major phases, a "Honeymoon Period" and a "Working Through" period.

3. The major anxiety of a group session also affects patients' attitudes. The absence of a group member, for example, did significantly decrease his acceptance by the other group members.

4. The activity of the therapists as exemplified by their interpretation, acceptance and understanding of group members, affected patients' attitudes in specific ways mentioned briefly in the body of this paper.

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TRAINING GROUP PSYCHOTHERAPISTS: A METHOD AND EVALUATION

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During the past years group psychotherapy has become a widely accepted and practiced form of therapeutic endeavor. Little study, however, has been made of the techniques for training therapists. After reviewing the literature a new training method was proposed. This paper presents the new technique as well as an initial attempt to evaluate it experimentally.

TRAINING METHOD AND PROBLEM

The usual format of training in group psychotherapy has been as follows: the trainee observes an experienced therapist until such time as he is considered able to handle a group himself, at which time he finds himself in a rather startling and new role. Use of co-therapists has been suggested as a training device (3, 4) but in the view of the present authors, as well as in that of others (1, 6) it unnecessarily complicates interpersonal relationships and patterns of interaction. Following from these considerations, it was proposed that a new method of training be formulated; one in which the trainee could take an active part as an independent therapist (after a minimum of observer experience) and yet one which would not be likely to produce or maximize complications between the trainee and supervisor. With this in mind, a trainee was assigned to a group as an observer, his supervisor being the therapist. Additionally, however, another group was formed with the trainee as its therapist and the supervisor as its observer. With such an arrangement both parties had opportunity to observe each other "in action" and discuss issues regularly. Over the period of four months during which this program was carried out, both the supervisor and trainee felt it was a worthwhile contribution to training method. In the role of observer neither the trainee nor the supervisor took an active part in the group meetings.

This technique was considered superior for training purposes, or at least assumed to be so, and, in itself, was not subjected to a study of its effectiveness. It could be argued, however, that the presence of a supervisor in the group as an observer would attract more interaction with the observer, thus detracting from the role of the therapist. This then was the purpose of the present investigation: given two psychotherapy groups, one in which

the trainee acted as observer and another in which the supervisor acted as observer, what differential effects might one expect relative to the groups' reactions to the observer? If significant differences between the groups' reactions to the trainee-observer and the supervisor-observer obtained, a reasonable objection to the use of this method would be posed. For the purposes of this study the null hypothesis was stated relative to these differences between the groups.

Method

Two psychotherapy groups on a 62 bed "exit" ward of a 1830 bed neuropsychiatric veterans hospital were used in the study. Group I was comprised of a maximum of five patients at any one time, all of whom were diagnosed schizophrenic; three paranoid, one acute undifferentiated and one chronic undifferentiated. Ages ranged from 22 to 40. The therapist in this group was the supervisor, the trainee the observer. Group II was comprised of a maximum of seven patients at any one time, with a total of nine patients having been treated during the time considered in this study. Diagnoses in this group ranged as follows: schizophrenic reactions, two paranoid and two catatonic; two passive-aggressive personalities, one manic-depressive reaction, manic type; one psychotic depressive reaction; one anxiety reaction, severe. Age varied from 20 to 50. In this group the trainee acted as therapist, the supervisor as observer. Both groups met for one and one-half hours twice weekly. During each session the observer recorded the presence and absence of group members and tallied the number of comments addressed to the therapist as well as the number addressed to the observer. Additionally, he tallied the number of references to the status or function of the therapist and the observer as well as the number of references to the presence of the observer. Immediately following the sessions the therapist and observer would meet and jointly make ratings for each patient on a number of five-point scales designed to describe the patient's activity in the group for that day. During these meetings the session was discussed, critical comments made if appropriate (by the trainee as well as the supervisor), and an attempt was made to study and analyze the group process. Data were gathered for two months following the inception of the groups.

Results

The several frequency tallies made by the observer during the group sessions were summed for each session and comparisons between the groups were made from these data distributed over sessions. The statistical technique used was analysis of covariance. Also, cumulative data on the five-

point rating scales, made on each patient for each session, were analyzed. The specific ratings analyzed were as follows: general spontaneity shown by each patient during each session; the amount of factual questioning by each patient of the therapist during each session; the amount of factual questioning by each patient of the observer during each session; the amount of factual questioning by each patient of the trainee (in either of his roles) during each session. The comparisons of group difference on these variables were also done by analysis of covariance. Results are presented in Table 1.

TABLE 1
ANALYSES OF COVARIANCE BETWEEN GROUPS

Variable	F	p
Therapist		
Comments addressed to[a]	6.68	.05
Status references to[a]	19.59	.01
Information seeking from[b]	13.01	.01
Observer		
Comments to and references to[a]	.23	—
Status references to[a]	3.45	—
Information seeking from[b]	1.00	—
Trainee, information seeking from[b]	11.06	.01
Spontaneity[b]	7.14	.05

[a]Data distributed over sessions and adjusted for number of patients present.
[b]Data distributed over patients and adjusted for number of sessions attended.

CONCLUSIONS AND DISCUSSION

By observation of the comparisons concerning interaction with the therapist, as noted in Table 1, it is immediately apparent that the behavior of the two groups differed considerably in this respect. This finding, which was consistent over the several comparisons, is an understandable one and would appear to be due primarily to two factors. It would hardly be expected that a trainee, beginning his first group as a routine therapist, would be able to generate as energetic patterns of interaction as could a more experienced therapist. In every case the significant difference was due to greater activity in Group I, i.e., the group in which the supervisor was the therapist. Perhaps this is most accurately reflected by the analysis of covariance regarding ratings of overall patient spontaneity as shown in Table 1. A second consideration, and one more difficult to handle, is that the groups themselves generally appeared to possess different characteristics, even from

the initiation of the treatment. This impression was gained primarily from their behavior in the early group meetings, i.e., the interaction among themselves and with the therapist. Lack of specific information about group differences, if indeed they are present at all, detracts from the "elegance" of the study and makes the results more difficult to evaluate. Problems such as response bias in the recorders were not evaluated.

The analyses concerned with differences in group interaction with the observer, despite the complicating differences in group characteristics, were consistently nonsignificant, however. Our sample gives us no evidence that groups respond differentially to trainee and supervisor in the role of observer. In this study this finding is made even more meaningful due to the fact that the supervisor had administrative responsibility on the ward for all but one of the patients in both groups. Although a patient may have been in the habit of coming to the supervisor with problems of an administrative nature outside of the sessions, this was not generalized to his behavior in the group when the supervisor was in the role of a passive observer. This is most clearly reflected in the analysis of information seeking from the observer.

It is possible the results could have obtained if Group II was as inactive toward the trainee as therapist as Group I was toward him as observer. Analysis of information seeking ratings for the trainee in both roles showed a significant difference in favor of his therapist role. This clearly shows he became more of a positive entity for this group.

This study provides no evidence that the training method here proposed provoked differential responses to the trainee-observer and the supervisor-observer. The initial differences between experimental groups mentioned above, however, does tend to obscure the clarity of this result. Additionally, this initial attempt at experimental evaluation made no provision for the assessment of interaction between the "main effects" of supervisor vs. trainee and therapist vs. observer. Finally, inasmuch as this result is consistent with the "null hypothesis," the study should be replicated using a larger number of subjects and a more complete design.

Although the efficiency of this technique in producing more adequate training in group psychotherapy has not been evaluated specifically, consensus is highly favorable. By using this method it is possible to overcome a number of difficulties in training group psychotherapists without producing untoward and possibly deleterious effects on group interaction. The trainee, after a minimum of observer experience, is able to gain actual experience as a therapist and yet have the benefit of extensive supervision. In addition to regular formal supervision the trainee is also able to observe a more ex-

perienced therapist at work with his group. Perhaps it might be better, as Bach suggests, if no observer was present at all, but even he concludes this is inescapable for training. The authors submit that the suggested training technique is superior to others that have been used in the past and have made an initial experimental attempt to demonstrate it does not produce special complications unique to it.

Summary

A new technique for training group psychotherapists was proposed. Specifically it was suggested that the trainee act as a passive observer in a group in which his supervisor was the therapist, and that the supervisor act as a passive observer in a second group in which the trainee was the therapist. Short discussion following all sessions would allow each to discuss his observations and impressions of the other. In such an arrangement the trainee would gain actual experience as a therapist while still in training, a situation that often does not obtain at present. Accordingly, two psychotherapy groups were formed. It was accepted that this technique would be a superior training device if it did not produce untoward responses of the group to the supervisor-observer who, in this case, was ward administrator for most of the patients in both groups. Data were gathered on the number and nature of comments addressed to each, the therapist and observer in each group. The data were evaluated by analyses of covariance. The two groups differed significantly on all measures concerning group interaction with the therapist. This is reasonable in view of the actual differences in the experience of the therapists. Additionally, the groups generally did not appear to possess equivalent overall characteristics, e.g., one generally was more spontaneous than the other. All measures concerning group interaction with the observer, however, were nonsignificant. This finding is consistent with the null hypothesis that the training technique does not provoke differential group responses to the supervisor-observer and the trainee-observer, and thus suggests that it may be a valuable addition to training programs for group psychotherapists.

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FORMER PATIENTS REPORT ON LETTER READING TECHNIQUE

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The letter reading technique in group psychotherapy (1) has been used by the writer fundamentally not for lifelong, chronic problems, but rather for symptoms of acute situational maladjustments. Its effectiveness in the chronic type conditions has not been explored as yet. The technique was chosen as the method of therapy out of mere expediency, inasmuch as it caused much more rapid interaction by the group members.

Within the past year and a half five former patients who were hospitalized in a general medical and surgical hospital, have written voluntarily to the writer as to their post-hospital adjustments, and their feelings and attitudes about the letter reading technique as they experienced it while a part of the group psychotherapy program. These former patients were members of a group in the original experiment with this technique. All of their symptoms at the time were of a situational type with psychosomatic manifestations. Most of them exhibited various anxiety symptoms reflecting a sense of insecurity and fear. Negative attitudes were revealed along with hostility and oppositionalism. Their thinking revealed evidence of a regressive tendency as manifested in preoccupation with their symptoms along with a decrease in social responsibility.

Each patient had received at least four months of group psychotherapy, three times a week. One patient received six months of therapy. The diagnostic classifications of these former patients were: anxiety reaction, depressive reaction, conversion reaction, schizoid personality, and psychophysiological reaction. The patients were in the same group with three or five other patients depending on the number assigned by the ward psychiatrist.

The attitudes and reactions of these patients toward their experiences varied. They revealed hostility, bitterness, and resentfulness; projecting feelings of fear, inadequacy, and guilt. Through the group experience tensions were reduced markedly. Patients who did not speak to one another became talkative, friendly and seemed less concerned with illness. The observation of patient reactions to the letter reading technique led the writer to believe in the effectiveness of such a therapeutic medium. This is further confirmed by the voluntary post-hospital responses received from the five patients who were instrumental in writing this report. The comments point up the advantages of this technique in group psychotherapy.

Generally, it is difficult to evaluate therapeutic techniques and most evaluations are made by the therapist based on some rating device. This would seem to fall short in appraising patient benefits. Naturally, it is unwise to belittle such ratings, however, an important and perhaps a major factor in evaluating the effectiveness of a therapy is the patient reporting his experiences. This becomes much more significant and valuable when such reporting is done without solicitation.

The writer has extracted from these letters pertinent statements relating to the feelings and attitudes of these former patients. Although the letters were predominantly favorable, there were some criticisms. These criticisms seem to be more in line with suggestions as to how much further this technique might be applied to certain problems and areas of disturbance, and not to spend too much time on any one analysis of a letter. It was interesting to note that one of the patients was continuing to use the technique on his own, to include wife, family, and friends. Intensive searching had been done to find proper letters for discussion. This patient wrote: "The letter seems to give us a starting point for our discussions and no one feels on the spot."

Perhaps a few short paragraphs extracted from the correspondence received might elucidate further the attitude toward the technique.

"When you came in and said we were going to try something new and something that was never tried before, I didn't know what to think. I thought the methods of psychotherapy were all cut and dried and all a psychologist had to do was put them into use. To tell you the truth I was like a lot of the other patients, I didn't want anyone trying experiments on me."

* * * *

"I had group therapy before, but this was sure different."

* * * *

"It sort of made you wonder about other people and the problems people had outside the hospital. Several of us felt that we wern't too bad off. Some of the letters showed that many outside the hospital have more serious problems."

* * * *

"I don't know whether or not you would approve or if it is ethical or not, but I have formed a small group as we had in the hospital."

* * * *

"Every person searches the magazines and newspapers to find columns where personal problems are discussed. We remove the identifying information as you did and then one of the group reads the letter. Afterwards, we discuss the contents. Frequently, we find ourselves spending an entire hour, and sometimes two or three sessions on one letter. It is

> surprising how much all of us become so involved in the problem and how our feelings come out into the open. . . . Last week one letter we read got under my skin. I guess I became quite talkative and concerned. One of the group afterwards asked me if I realized how excited I got over one of the issues brought up. At the time I did not realize this, but it must have been a good thing for me to let off some steam. If this wasn't possible, I don't know who might have eventually gotten this steam. Probably my wife, and I'm sure I would have been the outcast as far as she was concerned."

As with many group psychotherapy programs, there are a certain number of patients who get together after their formal sessions and discuss further the problems taken up during therapy. The writer feels that all groups should have professional supervision or direction, however, one wonders if such get-togethers at the desires of patients might offer some benefits even though professional control does not exist or is not available. It is probable that the previous experiences of patients in group psychotherapy would seem to act as a form of control within such self-established groups. Perhaps this subsequent formation is effective because in wanting to understand the problems of others, they tend to help themselves.

One patient stated, "I like this way of talking over problems. It seems more real. Sometimes I felt (while in the hospital) that I was seeing myself more clearly. I found myself comparing the feelings I had with the feelings of the people who were explaining their problems in the newspaper letters." "It wasn't too difficult for me to expose my mind once I got used to talking these problems out. . . ." "Whenever things don't go just right for me I think back about the discussions we had. I remember how much I wanted you to give me the answers to the things I brought up. I would get pretty angry with you as you probably knew. I can look back at this now and realize how foolish I was acting. Even today, I pick up the newspaper in the evening and almost immediately turn to the column by ————. I read the personal problems, study them, and then just sit back and think. They make me think more about myself than I ever did. My wife thinks that my reading of these personal columns is silly. I can't seem to make her understand that this is what you were doing and how much it helped all of us at the hospital. If only I could make her realize that this has some meaning and makes sense to me, and not that I read these things for curiosity—or as she says, 'Don't you have anything better to do?' "

The writer believes that psychotherapy exists in some form everywhere. If persons can receive help through such a medium as the letter reading technique or whatever technique is used, this has value for those individuals it

affects. The effectiveness of this technique may not be due to the personality of the therapist as in most therapies, and as claimed by some psychotherapists (2). The stimuli, the letters, appears to be the system by which the technique works. The therapist seems to be adjunctive and participating. Therefore, it appears that the emotional charge that suddenly emanates from the material read causes a more rapid participation which pushes the need to ventilate feelings and attitudes. The technique would seem to be a conscious attempt to create as real a situation as is possible in the therapeutic setting in which the pressing drives or need characteristics of the individual are released and made free to function. It appears that when the person comes to project himself into the letter content and can reorganize his perceptive patterns, that appropriate changes in behavior and thinking can occur. The altered pattern occurs automatically without too much conscious effort as soon as the perceptual restructuring takes place. It is not only from the realm of theory but also from the experimental laboratory that one finds confirmation of this line of thinking. There are parallel avenues of clinical observation and theoretical thinking, which point up the fact that for an effective psychotherapeutic technique there is the need for more complete understanding of the perceptive world of the person, and the need to develop methods and techniques that move into the world as experienced by the person. It has been seen that certain factors quite unrelated to psychotherapy have brought about changes and alterations in perception, insight, and behavior. To give an answer to this therapeutic phenomena seems an impossibility, but perhaps our skillful research colleagues may find the answers in this age of "space" research. This may lead to such studies as the effects of radiation and gravitational forces upon the perceptive powers of man. What psychotherapeutic significance this might have, or what answers might be derived from such near bizarre types of investigations may lead to most astonishing results.

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INTERNATIONAL SECTION

PSYCHODRAMA IN SPAIN

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History

Clinical application of psychodrama is of very recent origin in Spain. We are not referring to other dramatic techniques such as stage shows, festivals, singing sessions or poetic recitals which have long been performed in some mental hospitals and have been organized on the initiative of a doctor or an ex-patient. In these mental hospitals both patients and staff have cooperated. Probably this easy and useful form of stimulating the patients' social and competitive spirit has been put into practice by present as well as by former generations of psychiatrists.

Our aim, however, is to deal especially with the development of the method known as "Psychodrama." The first attempts within the clinical field were undertaken in autumn 1953 at the Psychiatric Clinic of the Barcelona University. There, at the request of the Professor of Psychiatry, Dr. R. Sarro, together with Drs. Gonzales Monclus and P. Turo, I organized a psychodramatic team consisting, in addition to the abovementioned psychotherapists, of three male and two female auxiliary egos. After a period of scientific, psychological and dramatic training, we were in a position to begin therapeutic work with hospitalized patients.

Theoretical Formulations

There have been several directions which have for over three years kept us aware of psychodramatic psychotherapy practiced on ward and ambulatory patients of the Psychiatric Faculty of Barcelona. They have been the following.

1. Spontaneity is essential in all psychodramatic situations except for the auxiliary ego in some given cases. The psychotherapist himself must act with as much spontaneity as possible without interfering with the therapeutic process. We should like to stress the importance of this *spontaneity principle,* which takes into account the individual's free will, and allows him to change his attitude when faced with either a problem of a private nature or his conception of the world in general. Far from considering it a bio-

logical factor, *spontaneity has for us an extraordinary value when it represents an attitude.*

2. We make use of some psychoanalytic concepts in our work: the psychodynamic assessment of personality, the ego's defense mechanism and certain specific findings which through studies of the human group, have become understandable to us and which allow us to anticipate certain individual or collective attitudes within the psychodramatic group.

3. The use of social psychotherapeutic groups, such as "discussion groups" incorporating the principle of the therapeutic community.

4. The study of human relations within the psychodramatic group. A person can never be isolated from the complex of interhuman relationships which surrounds him.

5. Incorporation of the concepts of social psychology, formation of the human being, study and value of various roles. Psychotherapeutic action of the changes of role as a liberation of the tensions arising from their social imposition. Interdependence and differences between psychodynamics and sociodynamics.

6. A new dimension is added by the existential study of the patients. These six stages have influenced our position in psychodrama.

We intend thus to find new starting points with which to explore and understand the patient's world as well as his existential projection.

Technique

The principal technique consists of the medical and social history stressing the analysis of the attitude which distinguished every period of the patient's existence, looking for the external events which determine the acquisition of psychological attitudes concerning himself and the world. In this way we succeed in establishing a list of categories through which his existence has developed. We may also use the report rendered by persons in the patient's social environment.

The patient himself has to understand that his attitudes towards the outside world have not been propitious for living within it. Change must be made desirable to the patient himself. The ideas which arouse interest in change may be based on: his desire for more happiness, possible increase in his abilities and social development, growth of self knowledge and of the world around him. Therapy tends to achieve characterological maturity; thus attained, it starts within the individual and leads through himself to others and towards the reason for being. The patient's recovery comes through meeting his own ego.

Stages in Dramatic Development

1. The *warming-up* process or the training for action, as we have called it. We have been able to make patients intervene as auxiliary egos.

2. The usefulness of the spontaneous attitude as a first step in the patient's progress towards leaving behind his morbid preoccupations. In this manner the patient gets his first inkling of the possibility of being different (change of perception or attitude).

3. The patient's report of his actual illness, during which he will try to obtain the assistance of other patients affected by the same morbidity and particularly of those patients who have either improved or recovered.

4. The account of the patient's life history supplied by himself, from two different sources: a. situations in which the patient has been an integral part of his world or environment and has received its physical or psychological impact; b. disposition of attitude, inner impressions, phantasies, dreams, changes in his concepts, evolution of his range of values. Attitudes which appear to the psychotherapist as morbid or apt to create barriers to the psychological development or to consist of possible sources of morbid attitudes will be specially pointed out to the patient for explanation and further understanding.

5. Temporality and spatiality constitute two new points of view for understanding the patient: a. the patient's adjustment to the temporality of human existence, his relationship to time, his manner or remembering and forgetting, planning and waiting; b. change in the spatial dimension of existence. Besides being qualitatively different the mental patient's connection with the world is very often more limited than that of the normal individual. This world reduction of the neurotic is secondarily related to changes in his interests.

6. The successive scenes are developed beginning with anecdotes which represent centers of tension, originating from special and morbid psychological attitudes.

7. The same scenes may be presented again in such a manner that the patient is enabled to adopt attitudes different from his former ones in order to render the new ones desirable and within reach.

8. Within the general psychotherapeutic framework a better knowledge of himself will be attained by the patient as well as the adoption of new attitudes which he will feel to be authentic.

9. Should the patient feel that his morbid attitudes are authentic, a further analysis of his motivations will be necessary; these will generally be found in the hypertrophy of some of his values.

10. In this process, apart from the auxiliary ego who is guided by the psychotherapist as to the general direction of desirable psychotherapeutic action, the patients who constitute the group may also intervene.

11. The free representation of scenes chosen by the patient who is also free to choose his auxiliary egos.

12. Final discussion with the participation of the directing psychotherapist. We want to point out that we gave special attention to the study of the patient's world image and the disparity which frequently occurs between this image and reality, as well as to the study of the situations which motivate anomalous attitudes or shocking behavior, revealing defense mechanisms with which he attempts to hide the insecurity of his ego. We are especially interested in the present and future projection of each patient and their psychodramatic exploration.

Clinical Experience

In the past five years at the rate of two one-and-a-half hour sessions per week we have treated 137 patients at the therapeutic theatre of the Psychiatric University Clinic of the Medical Faculty of Barcelona. Out of these 137 patients 106 have actively participated. In this group there were 24 schizophrenics, 5 alcoholic psychoses with demented features and 2 endogenic depressive psychoses, with whom we were not able to attain a continued and active integration in the group. From among the 106 patients who acted regularly and obtained variable although very evident benefits in most cases, we want to point out those who through the facility with which they displayed their symptoms and attained good social adaptation, deserve to stand as appropriate examples for our psychodramatic therapy.

In several cases of hysteria the cure has been both spectacular and permanent after two and a half years. In patients afflicted with anxiety neurosis we have had failures in some chronic patients and good results in a number of acute patients. After a number of failures occurred in some cases of obsessive neurosis we have lately succeeded in diminishing the anxiety from which these patients generally suffer in psychodramatic scenes in which only the obsessive patients participated. It was possible to modify satisfactorily their attitude while increasing the security of their ego. The best results have been obtained with the alcoholic patients and the great number of cured ones have made it possible for us to begin an ex-patients club in the spirit of the Alcoholics Anonymous movement.

Among adolescents suffering from disturbed neurotic behavior excellent results have also been obtained. We have had good results in immature,

shy, insecure personalities with inferiority complex and a tendency to social isolation; also in patients with abnormal and neurotic reactions to conflict situations as for instance, non-psychotic suicide attempts. We have treated several of such cases lately and have found it to be advantageous to treat several patients with the same mental syndrome at the same time.

As a matter of fact, because the patient's own defense mechanisms can be more easily objectified, in psychodrama, attitudes incompatible with the family, in marriage, in the work group, or antisocial attitudes in general can be very quickly modified. In several cases of syndromes of neurotic depersonalitation, success has been achieved after extensive psychodramatic treatment.

Psychodrama stands out as a fertile method in psychiatric therapy in both the actual neuroses and in alcoholism. We feel that it is also bound to yield excellent results in the problem of juvenile delinquency.

COMMITTEE ON GROUP PSYCHOTHERAPY
AND PSYCHODRAMA IN SPAIN

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RELIEF OF AN ANXIETY STATE BY A SINGLE PSYCHODRAMATIC SESSION

FRISSO POTTS

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This was the second psychodramatic approach of a neurotic patient at the "Dispensario de Higiene Mental del Municipio de la Habana" (a Mental Health Dispensary under the auspices of the City Hall of Havana).

The case: A white female, 32 years old, who came from the interior of the Republic, complaining of neurotic symptoms.

History: Married at an early age to a gambler, she soon began to suffer from her husband's temper and ways of earning a living, of which she was not aware before her marriage. He began to quarrel with her out of jealousy, although she stayed alone at home most of the time without social contacts, except for her mother's visits. From the beginning he was opposed to having children, confessing to her at last that he could not for biological reasons. Under those conditions, the home life of the patient became most distressing. She began to create a defensive pathoplastic reaction against her growing anxiety: nervousness, insomnia, tachycardia, epigastric pulse, shortness of breath and cephalae.

Development: We began the treatment with individual psychotherapy aided by an ataraxic drug; on this regime the patient improved only a little. She was transferred to one of our therapeutic groups. In the group the patient improved more than she had with the individual approach, and she began to think of divorce as the solution to her problem; but, at the same time, this decision produced a new outburst of anxiety supported by guilt feelings rooted in social and religious motivations.

At this time the patient made the acquaintance of a middle-aged handsome man, who proposed marriage to her. Although she was still full of anxiety, this proposal was her first ray of hope in many years. She started divorce proceedings against her husband. Some time later, however, she discovered that her lover was a married man with two grown up children. The shattering of her new illusion produced an intense recurrence of her anxiety state, and she became a mute member in the group. Then we decided to treat her by Psychodrama. Without letting her know our decision, we invited her suddenly to come upon the stage. "What do I have to do doctor?" she asked. "To express as vividly as possible all your thoughts and feelings about your present situation, as you have done many times

when alone by yourself," said I. She spoke first about her frustrating situation, about her guilt feelings, the social stigma in her native town placed on divorced women, some religious guilt feelings and her doubts as to what to do now. One of the auxiliary egos asked her "What about your marital life?" The patient assumed the role of her husband as well as her own in a discussion with him. Another auxiliary ego asked "What about your love affair?" She explained this relationship, even mentioning sexual relations (which she had failed to do during discussional group psychotherapy). At this point the patient was invited not only to assume her own role but also that of her lover, and she did it very well. She carried on the scene for about an hour, ending her production: "That is all that happened to me."

As she sat down, we invited the audience to discuss freely the situation of this patient, as if she were not present. The discussion lasted for another hour and everybody took part in it, centering upon three main points:

1. The social implications of her decisions.
2. The religious implications.
3. The human side of her problems.

In all these three aspects the patient was counseled and helped by the group.

At the next group meeting, the patient reported that she was not anxious at this time, that she was going to get a divorce, and with or without her lover, she had decided to begin a new life.

Conclusion: It is our opinion that the psychodynamics of this remission is based upon the following:

1. The cathartic power of spontaneity per se, as postulated by Moreno in his Stegreif theater.

2. The normal rechannelizing of disturbed emotions through dramatization and acting out.

3. The multiple roles assumed and lived by the patient which permitted her to introject her problems as a totality (a phenomenon of multiple telic empathy).

4. The help and support given her by the complex phenomena of Tele-Transference, relation to therapist and auxiliary egos.

COMMITTEE ON GROUP PSYCHOTHERAPY
AND PSYCHODRAMA IN CUBA

Dr. Jose A. Bustamante
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SOME ASPECTS OF THE INTERACTION OF PSYCHODRAMA AND GROUP PSYCHOTHERAPY

A Preliminary Report

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When we decided to separate group psychotherapy from psychodrama, a division somewhat different from Moreno's well-established procedure, we had various aims in mind. Our main interest was in observing the interaction between psychodrama and other forms of psychotherapeutic treatment. From previous experience and theoretical presumptions, we felt that the level of psychodramatic action differs a great deal from that of other psychotherapeutic methods. A patient taking part in a psychodramatic session is so busy with his performance and so moved by the actual experience, that he looses his intellectual defenses and, as Moreno points out, submerges into subconscious mechanisms. Of course, other forms of therapy also have the same effect, but since the patient relies on verbalization, a forced and sometimes premature intellectualization cannot be avoided. This lessens the effect of the emotional catharsis and the emotional discharge. Even the usual psychodramatic session, followed by an immediate discussion and/or interpretation, seems to have a lesser effect both on the episode preceding it and also on the following psychodramatic scene. Discussion brings out the therapeutic aim of the session annd thus arouses prematurely the patient's defense mechanisms. There are some themes, for instance, dream sessions, which seem to demand an immediate interpretation, but we decided to avoid verbal interpretation in all cases and to substitute for it a *staged* interpretation.

The sudden eruption of subconscious material, re-enacted in a psychodrama can produce a state of "shock" which is much stronger than that brought about by other forms of psychotherapy. Therapists working with out-patients have to lessen this "shock"; we, on the other hand, working with hospitalized patients, can not only risk shock, but can also prolong it for therapeutic reasons. This lapse of time between psychodrama and group or individual discussion augments the effect of both psychodrama and psychotherapy, each at its own level. The above assumptions were in accordance with the aim of our research—the investigation of the combination of different psychotherapeutic methods.

It is, of course, too early to draw a final conclusion, but some of our experiences are so striking that we feel that publication of this paper will encourage other workers in this field to conduct similar experiments.

We, therefore, selected three different types of patients, patients from an established psychotherapeutic group, patients under intensive individual therapy, and patients without any active psychotherapy.

1. Eight chronic Schizophrenics, both male and female, with varying symptoms, all belonging to a psychotherapeutic group. The group met twice a week under the direction of Dr. Kreitler and Dr. Bornstein. Psychoanalytically-oriented group therapy was used.

2. Two schizophrenic patients under intensive individual psychotherapy.

3. Two psychopaths with schizophrenic tendencies receiving no active psychotherapy.

The last two groups were later augmented so that the psychodramatic circle consisted of 16 members.

The psychodramatic group met once a week for two hours. It was directed by Dr. Kreitler, with the participation of Dr. Kleinhaus, Dr. Bornstein, Miss Lora Bloch, the Superintendent of Nurses, and two students of the Bar-Ilan University majoring in Psychology (Miss Ruth Yudelewitz and Miss Shulamit Elblinger). The members of the staff acted as auxiliary egos. The students maintained a protocol which was occasionally supplemented by a tape recorder. Staff members remained in constant contact with the director by whispering their ideas to him or spontaneously taking part in the drama. Generally, the themes were spontaneous productions of the patients themselves, supplemented only occasionally by the director. Participation was voluntary, but the patients came regularly and even punctually.

The benefits of psychodrama on the members of the psychotherapeutic group were felt quickly. Following are several typical case illustrations:

Case Report No. 1

Judith, schizophrenic, age 29, spinster, hospitalized for five years because of catatonic syndrome, hallucinations, etc., transferred to Beer Yaakov after receiving biological treatment, i.e., insulin, coma, largactyl, E.C.T.

Two months after her admission to the hospital, Judith joined the psychotherapeutic group as one of the original members. Here at first her behavior was the same as in the ward, autistic, her head always bowed to the floor. When she spoke, it was always in self-pity, demanding attention

and sympathy. Judith became the pet of the group which gave her the pity and attention she so much desired.

Her physical under-development and child-like body formation she ascribes to hunger and starvation during World War II when she was a refugee in Russia. Judith had been in love with a boy, but her mother refused to allow her to marry him. Her mother's choice, according to Judith, later raped her. Judith times the beginning of her symptoms with the illness (cancer of the breast) and death of her mother.

Because of her inattention to the problems of the other group members, Judith lost her position as pet of the group, especially when they had to concentrate on the more pressing problems of another female patient with overt lesbian trends. Judith began running away from the ward and soliciting attention of all available males. She began to demand biological treatment at every session. She was transferred to a closed ward. Once again the group endeavored to help her. They poured pity on her and even accepted the responsibility of watching her if she was transferred to an open ward again. She agreed to cooperate, but at the first opportunity she escaped once more. All the interpretational efforts of the patients in the group—and some schizophrenics may interpret better than the most experienced therapist—had no visible effect on her.

In psychodrama, which we began when the group was four months old, Judith continued her detached autistic behavior. Since we felt that guilt feelings in connection with the death of her mother played an important part in her present illness, we decided to bring her to "trial" for the murder of an old woman. For the first time Judith played her role actively, so much so that she spontaneously identified the woman as her mother, and, to our surprise, asserted that she had murdered her by knifing her in the breast. Despite the endeavors of the judge and defending counsel (both schizophrenics) and the evidence of Dr. B. acting as a pathologist, Judith was not to be convinced of her innocence. She insisted on punishment, but both the patients and the participating doctors were afraid of possible consequence of sentencing her to death. Instead she was sentenced to a protracted hospitalization.

This episode enabled the psychotherapeutic group to reassess Judith's mental situation and to work on her longing for punishment. She, on her part, accepted the closed ward as her punishment. Her demand for biological treatment was now correctly interpreted by the group.

In a later session Judith enacted her catatonic behavior in a previous hospital. These scenes in psychodrama acted as a catalyst for her to bring

forth a flood of hitherto undisclosed material to the psychotherapeutic group. Having worked on her guilt feeling for some time, we felt that she was improving and had her transferred to the experimental psychotherapeutic ward (Dr. Kleinhaus). Judith felt that the sharp contrast to the closed ward meant the end of her punishment. After 3 or 4 days she "raised her head" and "renewed contact with the outside world." She still heard voices but learned from the group and from psychodrama that voices are interpreted as our subconscious wishes. She was told by members of the group that the voices pushing her to immoral activities were partly her own drives and partly her desire for punishment. Gradually Judith ceased to suffer from hallucinations, became an active student in the dressmaking course (in O.T.) and began to revisit her family. After 10 months of group participating and 6 months of psychodrama she is a positive psychotherapeutic agent in both activities.

Judith's case shows the fruitful interplay between psychodrama (catharsis and wishfulfillment by punishment) and the socializing effect of the group. It also shows how the emotions aroused in the drama appear in the group in the form of new anamnestic material.

Case Report No. 2

An even more striking example of the psychotherapeutic value of the fulfillment of subconscious wishes in psychodrama is the case of Nathan, a chronic schizophrenic, male, age 25, hospitalized in different institutions for many years (received insulin coma therapy with little effect). Nathan came to the group and psychodrama from a closed ward in an extremely psychotic state. His main concern was his immediate release from the hospital and he made strong attacks on the members of the hospital staff. Little advance was made until a patient from the same ward enacted in psychodrama Nathan's childlike behavior when visited by his mother, which he categorically denied. We staged another visit by his mother. Our head nurse, playing his mother, was instructed to show her love and devotion even to the extent of feeding this child (6 ft. tall) at her breast. Nathan, without instruction, cooperated fully, playing the role of the suckling baby with evident release of tension. The scene was so funny that the audience started to laugh. Nathan arose from his trance-like state of infantile happiness, turned to the spectators and said, "Why laugh, this is the nicest thing in the world" and then returned to his "mother's" breast.

The next day he began showing appreciation of the problems of the other members of the group; everyone was struck by his immediate reaction.

Since he was more interested in others, the group on its part ceased to brush him aside as before and showed him more interest and tolerance. During the next psychodrama session he told of a dream in which he was an opera singer. He felt he could not play the dream; therefore, we staged a continuation of the dream in which the artist is acclaimed by his audience. He is besieged by autograph hunters and embraced by a pretty auxiliary ego. The whole group participated. Nathan gave autographs with great gusto and accepted the kiss in his stride. This scene was his wishfulfillment for success which he could not even dare to dream.

Nathan continued to produce more and more materials at group sessions, and at present, after five months of participation in the group, he is an astute interpreter with psychotherapeutic insight not only into others but also into himself. Psychodrama provided the opportunity for fulfillment of his subconscious wishes in an active way, but on the symbolic level of the stage. To achieve an equivalent effect using orthodox therapeutic methods would demand months of working through arduous transference situations.

Case Report No. 3

Benjamin, a foundling at the age of 3, never knew his parents. After a short and unsuccessful criminal career, he was hospitalized about three years ago and diagnosed as a schizoid psychopath, but despite all our therapeutic efforts, continued his antisocial behavior. Recently he was introduced to psychodrama. He presented a dream in which he stole from a shop and was caught. We staged the scene of this trial, providing the accused with an auxiliary ego to play his subconscious thoughts. Auxiliary egos of this type are usually played by a staff member, but to our astonishment one of the patients volunteered for the role and immediately brought out that Benjamin had stolen to revenge himself on society because his foster-father had told him suddenly and brutally at the age of 9 that he was not one of the family but a foundling. Immediately following the dream, we staged the scene in which Benjamin's foster-parents tell him the brutal truth. Benjamin played the role of the child with great emotion. He showed that he ran away from the family despite their willingness to keep him. The scene precipitated a "shock" that lasted several days. When the depression left, he hinted at his readiness to join the therapeutic group, an idea which he had rejected before and one not previously welcomed by the staff. He acknowledged that not only is the world to blame but that he too has personal problems which have to be solved. The hospital, on its part, was now prepared to risk the inclusion of a psychopath into a psychotherapeutic

group of schizophrenic patients after seeing the cooperation and development of Benjamin in psychodrama.

This episode is also important from another point of view. The auxiliary ego in the first of the two scenes produced the information he had gained from Benjamin with a dual purpose in mind. He not only wanted to help the scene along, but he had been similarly rejected in his youth by his own father. Although we remarked at the time on the aptness of his auxiliary ego function, it was only during the following group session that he explained his dual purpose. Thus we learned that patients can be used as auxiliary egos, bringing out the subconscious thoughts of the central figure and at the same time acting out their own problems.

We have shown the advantages of the parallel yet independent use of a psychodramatic session and a therapeutic group.

1. Psychodrama's catalytic effect on the production of new material in the group.
2. Fulfillment of subconscious wishes without the need to use verbal interpretation.
3. The effect of shock in psychodrama.
4. Opportunity of voicing patient's problems by having him act out the thoughts of another patient.

Finally, the success in role-playing strengthens the self-confidence of the psychotic patient and thus paves the way back to reality.

The authors wish to express their thanks and appreciation to Dr. R. Mayer, Director of Beer Yaakov Hospital without whose constant encouragement and advice the above work could not have been carried out.

ISRAELI SOCIETY OF GROUP PSYCHOTHERAPY
AND PSYCHODRAMA, EXECUTIVE COMMITTEE

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GROUP PSYCHOTHERAPY, PSYCHODRAMA AND SOCIOMETRY IN GREECE

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This review of the local efforts in the fields of group psychotherapy, psychodrama and sociometry, was stimulated by Dr. Moreno's coming to Greece. It can be but a brief one, because the things we have to report are very few.

Moreno came to Greece as a guest of the Greek Society of Child Mental Health and Neuropsychiatry. He gave to the interested Greek public an analysis of his research and work on group psychotherapy, sociometry and psychodrama, of which he is the founder.

Moreno made three public appearances. The first one took place at the auditorium of the Athens University Psychiatric Clinic mainly for medical personnel. The subject of this lecture was "Group Psychotherapy, Sociometry and Psychodrama, their Place in Modern Psychiatry." The second one was addressed to a larger scientific public, his subject being "Sociometry, Microsociology and the Social Order." This lecture was given under the aegis of the National Committee for Social Welfare. The third presentation by Moreno was given under the auspices of the Section for Mental Health of the Royal National Foundation and was addressed to a limited audience consisting only of psychiatrists, psychologists, psychiatric social workers. During this meeting not only the theoretical background of psychodrama was described, but also its practical applications. Under Moreno's guidance, demonstrations of psychodrama took place, the subjects used being problems that the members of the group were facing.

In addition to the above, Moreno had the opportunity to visit Psychiatric Hospitals. He presented his work at a press conference, which allowed extensive publicity through Athenian newspapers. He had the opportunity to have contacts with representative personalities of our country in the psychiatric and psychological fields.

Upon his departure, Moreno left behind him the nuclei of two committees: the one under the auspices of the Greek Society for Scientific Advancement of Psychodrama, Group Psychotherapy and Sociometry; the other one, under the aegis of the National Committee for Social Welfare. These Committees will have to undertake a very important task, because,

up to the present whatever does take place in these fields is due to the initiative and effort of isolated scientists.

In certain psychiatric hospitals of our country, more specifically at the Dromokaition Hospital, the group psychotherapy method has been used by Dr. Lyketsos and his associates since 1953. Some time later Dr. Rassidakis and his associates started a similar effort. The nature of the group psychotherapies used differs according to the orientation of the psychiatrist who applies it.

Dr. Rassidakis has published two articles based on his experience in group psychotherapy in Greek Medical Journals. An earlier attempt in the field of group psychotherapy was made by Dr. Matalas of Steckelian psychoanalytic orientation.

The experience of the Greek psychiatrists and psychotherapists in psychodrama is extremely limited. Some have been present at psychodrama sessions while visiting other countries. No one, so far as we know, applies psychodramatic techniques of any form. Some psychiatrists, psychologists and psychiatric social workers have attended and participated in psychodramatic sessions given in Athens during a seminar directed by the French child psychiatrist and psychologist Dr. S. Lebovici who had been invited to Greece by this group.

In the area of sociometry we are able to mention only the presence of one representative of this method, Mrs. Moustakas, who is conducting an intensive and systematic sociometric research with children of school age of various educational levels.

We hope that following the original impetus given by Moreno the rhythm of this whole movement will progress at a faster rate. This is why we think that the committees which have been organized will have a vast area of action.

Moreno's lectures and demonstrations served as a catalyzer, and have already been fruitful. On December 17th the first formal presentation of the subject of psychodrama, both its theoretical background and an effort at its practical application has been given at a lecture by the psychologist-psychotherapist Mrs. F. Karapanos. The lecture was given at a joint meeting of the Greek Society for Child Mental Health and Neuropsychiatry, and the Section for Mental Health of the Royal National Foundation.

It is certain that in the development and progress of this movement, Greek scientists will need the help of their foreign colleagues, both theoretical and practical.

GREECE

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THE DEVELOPMENT OF SOCIOMETRY, PSYCHODRAMA AND GROUP PSYCHOTHERAPY IN TURKEY

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Sociometry and psychodrama are comparatively new sciences for the world, they are even newer for Turkey where their application is not highly developed. However, their sporadic and non-organized application thus far promises a bright future for them in Turkey.

While sociometry and psychodrama are not as well established, it may be safely said that the nucleus of group psychotherapy has been organized and is gathering more strength daily. Sociometry was introduced for the first time to the general public in Turkey by an influential and widely circulated newspaper "Cumhuriyet." The first of five articles under the heading "New Questions of Science" was published on April 4, 1958. The first and second articles tried to explain sociometry, its philosophy and foundations. The headline of the third article read "The Treatment of Mental Patients by Dramatic Methods." This article dealt with psychodrama and sociodrama. The fourth article was devoted to a description of the application of psychodrama. The concluding article in the series dealt with a sociometric test.

After the visit of Dr. J. L. Moreno to Istanbul on September 20th, 1958, further articles on sociometry and psychodrama appeared in "Cumhuriyet" and other newspapers. Recep Doksat, M.D., wrote in "Milliyet" about Dr. Moreno, the fields he has founded and his conferences while in Istanbul. These articles were written in a most objective manner and tried to explain as to how and why sociometry was born.

In the course of his brief stay in Istanbul, Dr. Moreno gave a conference at the Psychiatric Dept. of the Medical School of Istanbul University, where he was a guest of Professor Dr. Ihsan Sükrü Aksel.

Persons in scientific circles who participated in these activities took a great interest in Dr. Moreno's conferences. Soon after Dr. Moreno's visit, psychodrama became the subject of discussion during the meeting of the General Assembly of the Third National Turkish Psychiatric Association. This was generally considered as a first step towards organizing the hitherto sporadic activities in sociometry, psychodrama and group psychotherapy.

I would like to point out that the first experiment in sociometry in Turkey was done by Dr. Moreno in person. Dr. Moreno considered "The

Bazaar" of Istanbul an excellent place for the application of sociometry. The Bazaar is a remnant of the middle ages and is maintained for its historic value. It consists of hundreds of small shops, all one story high and covered by one roof. These little shops are owned by individual shopkeepers and, therefore, each one of them can be considered as a unit. Thus the entire bazaar makes one sociological group, a nice place for the practice of sociometry.

The first application of psychodrama was organized in Istanbul on July 28, 1958, at Yedikule Mental Hospital. It was not exactly a psychodrama but more or less a beginning. The subject was taken from a play by Moliere, in which parts were rearranged and abbreviated for the patients. Three schizophrenics, four manic depressives, one epileptic, and one oligophrenic patient took part in this play. One paranoid patient refused to participate, stating accusingly that all these performances were done to cause his arrest. Another depressive patient changed his mood and had an attack of mania. On the whole, we believe that even this trial helped the patients to gain more self-reliance and better integration of personality. We strongly believe that this preliminary application is very encouraging and it has filled the doctors with hope.

This winter psychodrama and sociometry will be the subject of a number of academic lectures, when Dr. Kemal Zeyneloglu will lecture on these topics during his conferences at the School of Nursing.

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SOME DETERMINANTS OF THE SOCIOMETRIC STATUS AND SOCIOEMOTIONAL EXPANSIVENESS*

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Six sociometric studies of 3515 individuals in the school population, ages 9 to 20, carried out during the last few years in the Psychological Department of Belgrade University, are here summarized. Among different determinants of the sociometric status (SS) and socioemotional expansiveness (SE), the following factors were rather comprehensively studied: sociocultural status, size of family, family constellation, birth order, sex and age, intelligence and achievement, motives of choice, and the change of SS through living under more intimate conditions.

A positive correlation of different amount was found between the variable SS and the following determinants: sociocultural status, female sex, age, intelligence and school achievement (correlation for the last one being much higher than for the intelligence). Children living in institutions, foster children and those of extremely big families had a relatively low SS, the middle size family being the most favorable determinant. There is a tendency for the middle child's SS to be low and to increase with age, and for the eldest one's to decrease with age. Girls without brothers show high SS but low SE, boys with brothers but without sisters show the lowest SS. Positive interpersonal relations in general increase with age. Negative relations are more frequent in the groups of the same age in mixed groups of both sexes; less frequent in female groups and least frequent in male groups.

Children in unfavorable family situations: illegitimate children, those without one or both parents, step-children and those of divorced parents do not show appreciably low SS, *as foster children do,* but they all have low SE, i.e. they are chosen but do not readily choose others. SS changes through living under more intimate conditions in the group. Both likes and dislikes become more frequent, while indifference decreases through such communal living.

Motives of choice vary with age and situations: physical proximity and physical appearance, and school achievement are more frequent determinants at earlier ages; personal qualities, common social values and social attitudes

* Summary of report read at the XV International Congress of Psychology, Brussels, 1957.

being more frequent at older ages. In an intensive qualitative study some subjective factors of choice were analysed.

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SOCIOMETRIC INVESTIGATION WITH HUNGARIAN REFUGEES AS A BASIS FOR A MENTAL HEALTH PROGRAM

VERA FORSTER AND HANS STROTZKA

Vienna, Austria

During the two years following the Hungarian Revolution (1956-1958) the Austrian Society for Mental Health in cooperation with a number of other organizations tried to take care of the mental health of some 180,000 Hungarian refugees. This work was inspired by the World Health Organization (M. Pfister-Ammende and D. Buckle) and financially supported and supervised by the World Federation for Mental Health (J. Rees and B. Barton). A booklet containing a report on some of the work has already been published (1). We were asked by the Austrian Home Office to investigate the vocational abilities of 100 unaccompanied male juveniles between 14–18 years of age, housed in a special home. This work was carried out by two Hungarian psychologists, members of the working group for refugees of the Austrian Society for Mental Health.

The question was raised as to how much of the contact that we had with this home should be used for obtaining a better insight into the system of values and group dynamics of the Hungarian refugees. This seemed necessary and urgent for two reasons. First, the juveniles made great difficulties everywhere, due to their suspicious nature and ability to get repeatedly into trouble with authority. Second, we were faced with difficulties when applying certain basic principles of social psychiatry to Hungarian refugees.

By social psychiatry (2) we mean all measures for the maintenance and rehabilitation of the mental health of large groups. Its diagnostic methods consist of the empirical social sciences (sociometry, questionnaires, field work and social experiments) and its therapeutic methods consist of group work, group psychotherapy, change of environment, influencing key-persons and alteration of laws and regulations.

With the Hungarian refugees it seemed especially difficult to develop self-government and independent group structures. Both may be considered important items for theoretical reasons and from the practical experiences with other refugees. These phenomena are explained by three different causes. 1) The general apathy among refugees, typical for such conditions; 2) the transitional situation in Austria with its permanent insecurity as to further fate which prevent hierarchy-formation among refugees; 3) pre-

vious life in a totalitarian state where democratic thinking with its conceptions of group work and self-government had been systematically suppressed for years. As the recommendations about home and camp leadership which we were expected to provide depended on the result of such an investigation, the clarification of these problems was not only of theoretical but also of practical importance.

Even a relatively deep understanding of individuals, which resulted from therapeutic and personal contacts, was of no help in solving these questions since social interactions cannot be investigated on the basis of individual contacts. Extensive surveys were not possible because of the frequent change of inhabitants within the institutions, the lack of financial means, and above all, the suspicious attitude of the refugees.

However, the relatively small population of the home where we already had good contacts with the juveniles and the tutors made possible a sociometric investigation from which we obtained a satisfactory answer to our questions.

We used the modification introduced by Merei (3) because it allows evaluation not only of desired relationships by giving a choice of friends, arbitrators, treasurers, etc., but also the mental qualities ascribed to oneself and others, together with social roles which the subject assigns to himself and others in accord with these mental qualities and his personal likes and dislikes. With this method both the motivation for the choices and the value system of the community can be assessed. Forster has described the technique and the results of this work in detail in another publication (4).

The unaccompanied Hungarian juveniles show criteria typical for those of the inhabitants of an Austrian home for apprentices and for two classes of a grammar school for girls in Budapest to whom this test had already been given.

The refusals of the refugees to respond were most frequently a sign of a general oppositional attitude. Three refused to cooperate completely, 13 answered only the question "Who is your best friend?", 28% of the questions remained unanswered as compared to 9% and 0% on the tests given to apprentices and school girls respectively.

In the case of personal questions the refugees were especially reserved and very rarely answered negative questions such as "Who is the most unpopular among you?", which is a sign of solidarity.

The "dispersion coefficient" shows that the school girls have the most reliable criteria for mental qualities and social roles. Those of the Austrians are less reliable, and existing values of the refugees for both aspects vary

to the greatest extent. This gives the impression that the evaluation of personal qualities and above all of the competence of other inhabitants for different roles varies with the degree of harmony within the families from which the individuals come. The more disturbed family life is, the fewer normative rules can be established.

For the refugees the question "Who is your best friend?" has the highest correlation with the other questions about personal relationships. Friendship is much more essential to the refugees than to the other two groups. However, in contrast to the behavior of the Austrians, the leading roles (camp-leader, chief of delegation, etc.) are not given to friends. This finding seems to be the most important result of our investigation because it shows clearly to which extent such leading roles are considered with distrust, an attitude which results from the experience of the refugees.

"Relation" and "density index" show that the refugees have the smallest number of interpersonal relations whereas the school girls have the greatest. The relatively great number of negative egocentric votes is striking; i.e., relatively many refugees answered "myself" to the question "Who has most disagreements with the perfect?".

Among the refugees only three relatively loose group-like structures were seen without any expressed hierarchy connected by a common living-room or common professional training. Only treasurers and arbitrators are elected within these groups. Other leading and intellectual roles (i.e. publishing a newspaper) are given to persons outside the group. Thus in this case we do not deal with genuine groups in the sense of group dynamics but rather with "gangs." The boys with negative roles are either quite isolated or coupled with unimportant or in some other way negatively evaluated persons as well as appearing in isolated pair-connections without any friendship declarations from outside. The outcasts, juveniles who do not offer any friendship declarations and who got more negative than positive votes, always came from disturbed families.

The refugees form a community whose sole common quality is the negation of the adults resulting from the experiences of the revolution or of the flight. They are isolated socially as well as through language; therefore, friendship is very valuable to them. Their show of solidarity is only a pretence of genuine group structure. As a matter of fact, they have no positive relationship toward authority within their community. They are also very badly informed about their own motivations and qualities.

It is obvious that any attempt at democratic self-government has to fail under these circumstances.

It was typical that the tensions and revolts decreased the moment that an Austrian campleader who represented a strong and friendly father figure was appointed and the group experiments ceased. The new patriarchal regime was a great relief. It will take a while before attempts at a study of this kind can be made once more.

The publication of our experiences was made for two reasons. On the one hand, it was meant to be an example of how sociometry (in the modification of Merei) may form the scientific basis for satisfactory care of a difficult group. On the other hand, it should show that western terms like cooperation, freedom, etc., cannot be understood and accepted easily and without preparation by groups coming from other cultural and social systems.

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THE ETHICS OF SØREN KIERKEGAARD[1]

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If we contemplate a number of moral philosophers such as Kant, Bentham, Fichte and Stuart Mill and look at Søren Kierkegaard's production against this background, it is immediately conspicuous that Kierkegaard approaches the ethical problems in a completely different way. The said philosophers view mankind as a whole, and the individual only exists as a molecule among millions. For Kierkegaard it is quite different. The individual comes to the foreground, dominating the whole field of vision, and the innumerable multitude of human beings surrounding him only exists by virtue of the single member's relations to the individual.

Thus, when we are to characterize Kierkegaard's ethical philosophy, we gain nothing from comparing him with leading contemporary philosophers or those living shortly before him. But it may be done in another way.[2]

It may be done by centering our attention on the personal evaluations of good and evil of the person in question and his choice between values where the situation requires a choice. If we have obtained insight into an individual's personal system of values, and the means and methods applied by him to further the good and counteract the evil, we have the most important elements in his ethical ways and nature. However, the picture is not satisfactory unless we have previously got to know in which world or world-picture the person in question lives. Caesar could have no evaluation of America, since America did not exist to him. We all live with a limited picture of the world.

Where Søren Kierkegaard is concerned, the limitation of his world-picture was in particular due to his contempt of natural science, which he considered as a mere manifestation of human curiosity. When we read Kierkegaard and come across the word science, we must bear in mind that to him it signified only theology and scriptural research. But otherwise his world was by no means limited. Besides theology in which he graduated, and philosophy, which became his other main subject, he was deeply inter-

[1] Presented in slightly abbreviated form to the XII Intern. Congr. of Philosophy, Venice, Sept. 1958.

[2] The theoretical foundation for the following analysis is given in my book *Two Commandments,* Munksgaard, Copenhagen, 1950.

ested in poetry and the theatre, and he showed great interest in his fellowmen. It is in the drawing-room where the battle should be fought, he said. And after the drawing-room came Copenhagen, the urban community to which he belonged. Everyone knew everybody in the small capital (130,000 inhabitants). He walked in the streets of the town and on the ramparts which were still there at his time, he was on speaking terms with all of them, statesmen, actors, philosophers, poets, old and young. This also applied to the plainest classes, servants and poor people. He loved children and made friends with them very easily.

The young woman with whom Søren Kierkegaard fell in love, to whom he was engaged for about a year after which he broke with her, but whom he could never since forget, had a great place in his world-picture; but first and last it was dominated by the God who, in Kierkegaard's opinion, ruled over space and time. It will always be an essential factor in a person's world-picture whether it contains a God or not, whether there is a Holy Book or not. Even where the religious feeling is weak, a God and a Holy Book will always mean something to the person's evaluations. To Søren Kierkegaard they meant everything.

As to his personal life, the 14 volumes he wrote and published and the 18 volumes of papers he left give good insight into his spiritual world, and the biographical data about Kierkegaard are complete in almost every detail. This material tells us about his evaluations of good and evil, and if we then ask which were the cardinal values, or which was the cardinal value in his system of values, the answer is not difficult to find. The dominating cardinal value was without wavering and discussion salvation, the salvation which in the New Testament God promised the people who believe in Him, love Him and obey Him. And, correspondingly, the dominating evil was perdition. Kierkegaard depicts no paradise, nor does he depict a hell. He sticks to these plain words: salvation on one side and perdition on the other. By the way, Kierkegaard did *not* believe in the existence of a devil.

The means to reaching this absolute "telos," salvation, is faith, but a faith which also manifests itself in a striving to imitate the model given to us in the God-man as described in the New Testament. And faith must be passionate, one must feel contemporary with Jesus, His sufferings, insult and Crucifixion. The essential thing for man is to become spiritual instead of worldly, and the first step towards becoming spiritual is to become conscious of oneself as a "self," which can only be done by feeling as a self before God.

But when thus the essential thing is salvation, and man is a self, a

single individual before God's judgment, what then is the good of all this fuss around him about a community and the National Grundtvigian Christianity busying itself with lectures, meetings and folk songs? Or what is the good of the democratic commotion with freedom and votings and self-government? Kierkegaard's attitude to these movements was marked by contempt and indifference. He obstinately refused to form a party, a thing which people found it difficult to understand. When a man is in the opposition, as Kierkegaard was to the State Church, its ministers and the Christianity, which in his eyes only distorted the actual and original Christianity, the usual and natural thing for such an opponent would be to take over himself. But Kierkegaard looked quite differently at this. He was a critic of the existing Christianity and, like a Socrates of Christendom, he wanted always to remain a critic and, if possible, to help somebody possessing the character necessary to become a real Jesu disciple (in faith, poverty, suffering and renunciation). Monastic cloistered life was not real Christianity either. Through twenty years of personal experience Luther had learnt that this did not lead to faith either.

Thus, life ought to be an attempt at imitation, an attempt at imitating the model, and this again meant: to suffer, live in poverty and "die from the world." But how did Søren Kierkegaard himself cope with these demands?

As far as suffering was concerned, Søren Kierkegaard meant that he dared appear for the last judgment. He knew insult and persecution after a gutter-paper, "The Corsair," had made him its favourite victim, and street-urchins and apprentices shouted after him in the streets and ganged up and guffawed at him. He also knew the stings of physical suffering. He always had a weak stomach, and he suffered from pulmonary tuberculosis; he had a well-ascertained haemorrhage in 1840, which was not the first one. In his Journals are certain signs of febrile periods. To this was added a congenital depression, which was, however, hardly actual melancholy, but rather a specific defect of his emotional life with reduced and failing ability to be glad and feel joy. And last, but not least, there were economic worries. There was by no means lack of interested readers of his books, but it should be remembered that they were only published in small numbers, as a rule 500 or less, which, when it was larger, could pay no more than his house rent; and in 1848 when half of his inheritance had been spent, he clearly saw that his money would come to an end in 1856. He died in November 1855. He certainly had his cup of woe.

But he was unable to live in poverty like Jesus demanded of the rich

youth, and he regarded with admiration and penitence the "witnesses of truth" in the first centuries of Christianity who gave away everything they owned and took the beggar's staff. To a physician it is easy to see that if Søren Kierkegaard had carried through an attempt in that direction, if he had limited his excursions and recreation and put himself on a cheap diet, he would soon have died from his tuberculosis. Nature in him required her way, and she had it. But it pained him that he lived "lavishly," and this may very well have been the most essential reason why he dared not call himself a Christian.

As will be seen, the guiding principles mentioned here, faith and imitation, were directly derived from his cardinal value in connection with the enlightenments and instructions found in the New Testament. But also in the manifold ethical problems of daily life did Kierkegaard rely on God. The question that meets every man almost daily: what actually is good, and what actually is evil? was answered by Kierkegaard without hesitation: Good is that which is God's will. Thus, the same answer as in Duns Scotus and Martin Luther.

But if we go further into the matter, it was not easy for Kierkegaard either always to know what was God's will. Should he publish that book now or not? Should he continue his literary production or apply for an incumbency? Time and again Kierkegaard was immobilized for weeks or months while considering whether he should do this or that, because he could not find out what was God's will. As a matter of fact, he also says that in such uncertainty it may be necessary to act upon one's own best judgment, hoping that God's grace has been guiding one to the right decision. Very human and reasonable; but it has to be noted that in such cases purely human evaluations steal into the ethical conduct of life.

This also holds good of the strong feeling of piety marking Kierkegaard's attitude to certain personalities of strong character, in particular, his father, Bishop Mynster and Martin Luther. He clearly sees their faults, but his piety binds his admiration. It should be borne in mind that when in 1848 Kierkegaard began passionately to advocate the necessity of imitation, Luther with his doctrine of salvation by faith only—sola fide—actually became his chief opponent. Kierkegaard saw the contrast quite clearly, but still he limited himself to weak protestations. Here too we have a leaven of purely human valuations in Søren Kierkegaard's ethics. In this short analysis of Kierkegaard's personal ethics there is no space for critical observations. However, a single point should be mentioned, namely Kierkegaard's application of the notion *honesty* (redelighed). One of the news-

paper articles Kierkegaard wrote during the anticlerical campaign was introduced with the often quoted words: "What I want. Quite simply: I want honesty." (Works, XIV, 45.) But was that really what he wanted? and what did he understand by honesty?

According to ordinary Danish usage *redelighed* (honesty) and *unredelighed* (dishonesty) are especially concerned with the presentation of matters or conditions and demand that this presentation should express the actual conditions without distortions or concealments. Thus the word *redelighed* seems to be equivalent to one of the meanings of the English word *honesty*.

But did the ministers at Søren Kierkegaard's time distort or conceal the texts of the Holy Scripture? There is no reason to believe that, and least of all to believe that Bishop Mynster should have done so. But further down in the same article Søren Kierkegaard writes: "A teacher of Christianity (now) receives a salary of several thousand (rigsdaler)." Yes, in the first centuries of Christianity when the disciples lived in poverty, it was quite different, that is true. But there is nothing dishonest in it if only the ministers' salaries nowadays and the poverty of the first disciples are laid open to the churchgoers. There is a contrast, to be sure, but that is not dishonesty, that is lack of imitation.

Kierkegaard demands of the ministers that when they do not live like the first disciples, they must, at any rate, admit so. But, as a matter of fact, this confession has been made long ago. From the hand of Paul we have the following general confession, which has often been quoted: "For the good that I would I do not; but the evil which I would not, that I do" (Romans, 7, 19). Every churchgoer has heard these words from the mouth of the minister, and thus Kierkegaard is mistaken—or he is dishonest—when he says that it is dishonesty that he wants to stamp out. No, it is the lack of imitation which arouses his indignation. To his contemporary clergymen the difference existing between life in present-day Christianity and the life led by the first disciples, the "witnesses of truth" was either irrelevant, regrettable or sad, but to Kierkegaard it was revolting.

And here it must be remarked that the claim for accordance between words and acts, between evaluation and conduct, or however one wants to express it,—imitation as Kierkegaard says, is no particular Christian or scriptural claim. On several occasions (thus in Livsførelse (Danish, 1925) and in "Two Commandments," 1950) I have myself made this claim the object of a special investigation. And for the sake of clarity I have coined a special term for contrasts of this category, contrasts between evaluation and conduct, namely: ethical inconsequence.

The claim for ethical consequence is doubtlessly implicit in all that Jesus said; it is most strongly emphasized in the Epistle of James, and it is doubtlessly this claim for ethical consequence within Christianity which was the main thing to Kierkegaard in his mature years, in his 3 last books and in his iconoclasm. But it should be underlined for the sake of honesty that the claim for ethical consequence is not a specific Christian claim, it is a general human ethical claim. An honest Marxist or an honest Mohammedan will be just as agitated at ethical inconsequence in their ethical world as Søren Kierkegaard was in Christendom.

Finally I want to mention a special—and very much discussed—ethical problem in Søren Kierkegaard's life. Why did he break off his engagement to Regine Olsen?

Kierkegaard himself has diligently covered his deepest motive, as he says in a note in his Journal from 1843 (Papers IV A85): "After my death no one will find in my papers (that is my consolation) the writing in my innermost self that explains everything, and which often makes such events immensely important to me which the world calls trifles." He was, it should be remembered, a paradoxical mixture of reticence and pronounced inclination to communicate with others, and there is the possibility that he may have given himself away later. I think that is what has happened. At any rate, in his last book *For Self-Examination,* 1851, we can read the following passage near the end of the book: "So then think of a lover! He saw the object, and thereupon he fell in love. And this object then became his eyes' delight and his heart's desire. And he grasped after it—it was his eyes' delight and his heart's desire! And he grasped it, held it in his hand—it was his eyes' delight and his heart's desire: Then (so it goes in these old tales) there was issued to him a command: 'Let go of this object!' Ah! and it was his eyes' delight and his heart's desire."

Might this not be Søren Kierkegaard's own history? He has heard a voice saying to him: "Let go of her!" In support of this assumption serves that at another time of his life Søren Kierkegaard records that he has heard voices. It was in the night between 26th and 27th June 1849, a few days before the publishing of "The Sickness unto Death," and the voice or voices said among other things: "Who does he think he is?" and: "Now he wants his own ruin" (Pap. X^4 A299, 302 & 587). When a physician hears this, he will invariably ask Mr. Kierkegaard if he has not heard voices on former occasions, and it would be stranger if the answer was negative than if it was affirmative. Hearing voices is rather an ordinary phenomenon in the morbid state which is called psychasthenia (Janet), but it is also found in

otherwise sound and normal individuals under high emotional tension. Kierkegaard was under high emotional tension during the said days of June 1849, as he was in no less a degree in the days round his engagement; the conditions for hearing voices certainly were there. As he says himself later, he had 17 reasons for not marrying Regine and only a few reasons for doing so, namely that he was in love with the girl. This must necessarily cause high emotional tension, and to judge from his whole personality, there is reason to believe that he has taken the voice to be God's voice, just like it was in the tale in "For Self-Examination." What the rest of us might say to that, if it really was God's voice or not, that is another matter. If God really talks to a person, a psychiatrist will invariably take it to be audio-hallucination.

After all: Both the proposal and the broken off engagement were expressions of the struggle of passions in ethical man.

SUMMARY

An analysis is made of the ethics of Søren Kierkegaard; a sketch is first made of his world-picture followed by an examination of his evaluations of good and evil, his system of values. This is found to be ruled by one dominating cardinal good: salvation as laid down in the New Testament. The corresponding cardinal evil is: perdition. By deductions from these cardinal values and the conception of God (according to the New Testament) the life tasks are seen to be: faith and imitation, i.e. imitation of the God-man in the New Testament, and imitation is further characterized as a life in suffering, renunciation and a striving "to die from the world." It is shown that beside his religiously deduced ethics there are also leavens of purely human evaluations. Finally it is attempted to explain the decisive motive for Søren Kierkegaard's breaking off his engagement.

COMMENTS ON "CODE OF ETHICS OF GROUP PSYCHOTHERAPISTS"

D. LANGEN

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In Volume X of this journal, Moreno presented in an effective manner an ethical code for group psychotherapists. He emphasizes that one can call oneself a group therapist only if one has studied this method in an authorized institution. Therapeutic groups should be organized in such a manner that they represent a model of a democratic society. The Hippocratic oath is to be extended to all patients and it should bind everyone with the same responsibility. As every patient is bound and protected by such an oath, he can afford to express himself freely as to what he thinks of the others and how he feels. If one offends or disobeys the basic rule, he should be disqualified from continued treatment. The moment for taking this oath should be carefully chosen. It should depend upon the readiness of the group to appreciate the importance of such a commitment.

ROBERT R. BLAKE

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These remarks constitute an evaluation of Moreno's "Code of Ethics of Group Psychotherapists," as applied to training groups (1). Headings are phrases from Moreno's article, introduced to provide orientation for the ten points he discusses.

1. Objective is to render service

The principal objective of training group, by contrast with the objective of providing treatment in a group psychotherapy situation, is to create conditions from which members can learn how they relate and work with one another under the variety of circumstances that can exist within group situations.

Is this a service? In the sense that any learning situation like a classroom, for example, is a service it can be so regarded.

I would put another focus on the problem. Examined from the point of view of the recipient, both therapy and training come close to being a "right," in the sense that anyone possessing minimum mental and emo-

tional facilities for doing so can, by study and guided experience, exercise his "right" to health through increasing his knowledge and skill.

In other words, I would turn the problem around. While the therapist or trainer may be rendering a "service," the patient or trainee is exercising a "right"—seeking through knowledge and insight to claim his right to basic social, emotional, and mental health.

2. Method of Approach

In the training group situation, a trainer's obligation is discharged by the same orientation as guides a group psychotherapist—introducing learning methods founded on a scientific basis. Why? Because it's the most valid way known to achieve the objective. The motive is not idealistic, it's utilitarian.

3. Nomenclature and training of the person in charge

The nomenclature for the person in charge of a situation—whether he is engaged in treating, training, teaching, tutoring, or telling—ought, in the interest of valid communication, to be accurate. When the title is accorded on the basis of professional competence, then criteria of preparation need to be spelled out in specific and concrete terms. Today, the criteria are better developed for people who *treat* than for those who *train*. A very substantial measure of improvement is possible in both areas. Moreno's code is right!

4. Protection from abuse . . . respect for dignity

The clause on "protection from abuse and respect for dignity" defines a key distinction between therapy and training. The distinction hinges on differences in the subject-matter studied and the approach to it in the two situations. Protection in the therapeutic situation is mainly through the development of insight and awareness, while protection in the training situation is based on social management which avoids trends in the direction of destructiveness.

Abusive, destructive trends in behavior are, in one direction, what the group therapist is trying to treat. They are the hallmarks of pathology. "Protection" is possible through development by members of insights into the dynamics that provoke it and the reactions it evokes. The recipient then understands his attacker and, hopefully, the attacker is rendered "clean," or at least more constructive, through his own developing of wisdom into his actions. The group therapist is oriented to "manage" the abusive,

destructive behavior in the treatment situation in such a way as to resolve the pathology from which it stems.

Not so in a training situation. The appearance of provocation, abuses, or destructiveness means that a training situation is undergoing rapid conversion into a treatment situation, and in all probability—being a social scientist and not a physician—the trainer is incompetent to handle it. The target of training—to increase effectiveness in decision-making in groups has been revoked or abandoned when provocation, abuse or destructiveness protrudes. It means the trainer has failed in his primary task.

Under such conditions the trainer is obligated to introduce standards that prevent abuse, perhaps by edict through defining boundary limits of tolerable behavior. To use "authority" to prevent negative behavior trends is admitting failure as a trainer to have worked with the group to the point where it has developed self-regulating standards of conduct leading to respect for personal dignity, even when the group is confronted with opposition and engaged in conflict.

5. Group a model of democratic behavior

In terms of equality of status based on academic and economic, racial or religious dimensions, both approaches accord equivalent respect to individuals, regardless of differences springing from these sources.

A distinction arises from a different consideration in the sense that autocratic and laissez-faire as well as democratic procedures may be employed for experimental purposes in a training situation. A group arrangement with a single member exercising autocratic control might very well be tried out in order to experience it and to contrast its effects on group members with another situation operated, say, under laissez-faire arrangements. The situation now would be autocratic, then, laissez-faire, but neither time democratic. Such experimental arrangements are more common in training than in therapy situations because the training situation is concerned with exploring *procedural* aspects of group functioning.

Still Moreno's code fits both situations equally well. The reason is that, even in a training situation, the decision to experiment with autocracy is properly taken through democratic action, rather than on the face of the trainer's authority.

6. "Paying to Participate"

Same fee for all? The important answer is that there be a valid rationale for fees, whether the same for all or not, so that the fee angle is

not and cannot become a source of inequality. Arbitrariness is anathema wherever it occurs!

7. Patient free to choose the group in which he participates

The more valid statement for me here is, "Person (patient or trainee) is *free* to choose whether or not he will participate." Choice of a specific group is a matter conditioned by a host of administrative considerations and some psychological ones too, like time of meetings, availability of space, and so on.

8. Hippocratic Oath binding all

Perhaps "yes" for group therapy, that's moot. The answer is a firm "no" for group training, however. I will give reasons for the "no"; others already have commented on the "pledge" in group therapy.

Regarding the Hippocratic Oath in group training, I say "no" for several reasons. One is that it is unnecessary, for the simple fact that topics discussed are not of the personal kind that generate a need for secretiveness and the protection of communication. In over forty training groups with which I have had experience there has been no problem of protecting confidences. The situation is not one where "private" revelations contribute to the solution of problems dealt with in training for decision-making in groups.

There is another reason for "no." The modernized Western version of Christian ethics, as applied in work group situations is pretty well hammered out by this time. One goal of training is to operate intelligently, using *this* code, not the Hippocratic Oath, as a guide line for personal revelation or exposure. If a more stringent and binding code is placed in effect in a training group, it invites participants to become "cozy" and "personal," whereas the appropriate goal of training is for members to learn to talk to one another in terms that permit effective decision-making to occur. This is another way of saying that in training a goal may be to learn the conditions under which it is more appropriate "to keep your mouth shut," rather than to "flap it open." Until Hippocrates reaches committees and cabinets, it's a good idea to learn to apply Christian ethics to relationships even in training.

One other "halfway" answer is possible too. If "security" is needed the training group itself, rather than an arbitrary outside code, is the proper source of a specific standard to cover the situation. The reason is that people are more likely to support what they help create.

9. Patient is expected freely to divulge . . .

"Yes" in therapy, within the limits of his present defenses and insight; "no" in training, within the limits of "good sense," for reasons provided above.

10. Timing of the "pledge"

No issue: No pledge, no problem of timing.

So. What has been said? Moreno's code for group therapists applies to group training at certain points. There are key differences. Why?

The answer is that *fundamentally,* therapy *starts* with illness and focuses on pathology, aiming toward its resolution. Protection and freedom to explore private and subjective aspects of adjustment is indispensable to the objective of gaining health through the resolution or correction of defect. Not so with training. *Fundamentally,* training *starts* with a healthy individual and aims towards increments in diagnostic sensitivity and social skills of the kind which can increase personal effectiveness in group decision-making situations. Revelation, exposure, and confidences are inconsistent with the objectives of such training. A code suitable for the treatment of *defect* is given in the Hippocratic Oath; one appropriate for training is no more complicated than "love thy neighbor. . . ".

REFERENCE

1. MORENO, J. L. Code of ethics of group psychotherapists. *Gr. Psychother.,* 1957, 10, 143-144.

EARLIEST DEFINITIONS OF GROUP PSYCHOTHERAPY

J. L. MORENO

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

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

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

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

Definition 5: "Group psychotherapy treats not only the individual who is the focus of attention because of maladjustment, but the entire group of individuals who are interrelated with him." *Who Shall Survive?*, 1932, p. 301.

Definition 6: "A truly therapeutic procedure cannot have less an objective than the whole of mankind." Ibid., p. 3.

Definition 7: "Spontaneous formation of social groups based on the enthusiasm of the participants or on common interests and aims achieves often miraculous results, but cannot be called grouping in our sense as most of the interrelations remain unanalyzed." Ibid., 1932, p. 72.

RESEARCH NOTE ON TRANSFERENCE AND TELE

J. L. MORENO

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

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

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

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

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

BOOK REVIEWS

BILAN DE DIX ANS DE THÉRAPEUTIQUE PAR LE PSYCHODRAMA CHEZ L'ENFANT ET L'ADOLESCENT. S. Lebovici, R. Diatkine and E. Kestember. Paris: Presses Universitaires de France. 1958. 179 pp.

The little book is dedicated to me and has an inscription "With your 'enfants terribles' respectful compliments, S. Lebovici, R. Diatkine, E. Kestemberg". The three authors apparently want to apologize in this charming manner for a number of criticism they have launched against the classic methods of psychodrama. After reading the book carefully, I found that most of their criticisms are due to ignorance of the books and articles I have published in U.S.A. between 1937 and 1947 on the subject of psychodrama. They neglect, for instance, entirely the concept of tele, its relationship to transference and its influence upon the therapeutic process. The authors had to rest their arguments largely upon some articles which have appeared in French in LES TEMPS MODERNES and FONDEMENTS DE LA SOCIOMÉTRIE. Only these three of my articles have been listed in their bibliography. Had they studied carefully my American writings, they might have come to a different "Bilan". I have, therefore, sent to the three authors a complimentary copy of my monograph "Psychodrama and the Psychopathology of Interpersonal Relations" published in 1937, with an inscription "To enfants terribles from le *père terrible*".

Let us hope that within the next ten years les enfants and le père will harmonize their views.

J. L. MORENO

LE PSYCHODRAME ANALYTIQUE CHEZ L'ENFANT. Didier Anzieu. Paris: Presses Universitaires de France. 1956. 183 pp., 720 fr.

A scholarly book on analytic psychodrama as applied to children. It contains an extensive and thoroughgoing bibliography on the founder of psychodrama, J. L. Moreno, and a valuable bibliography on psychodrama and group psychotherapy in France. The author's emphasis is on symbolic psychodrama. He insists that in the treatment of children only symbolic situations should be used, actual situations being too traumatic. The author emphasizes that analytic interpretations after a session may be harmful to children. In true psychodramatic manner he thinks the therapist should "play" his interpretations rather than tell them.

ZERKA T. MORENO

DAS SOZIOGRAMM IN DER MODERNEN SCHULE. Otto Engelmayer. München: Chr. Kaiser Verlag. 1958. 72 pp.

Every American sociometrist interested in education should read this remarkable book on sociometry in the school. First it would reveal to them how wide-spread sociometry is in Germany and the fact that German workers are beginning to surpass the work done in the U.S.A. Until a few years ago U.S.A. was the only place in the world where sociometric work was done, but things are changing. The European countries are taking over our ideas and improving upon them.

ZERKA T. MORENO

SOCIOMETRY. Clio Pavlides. Athens. 1956. 75 pp.

This journal contains an analysis of sociometry, its relationship to psychodrama and group psychotherapy.

ZERKA T. MORENO

MUSIC IN DER MEDIZIN. H. R. Teirich. Stuttgart: Gustav Fischer Verlag. 1958. 207 pp., DM 22,–.

Dr. Teirich, the well-known pioneer of the group psychotherapy movement in the German-speaking countries, has prepared a delightful book on music therapy. It contains articles by various authors on the influence of music upon the ailing psyche. The book opens with a chapter on the pythagorean philosophy of music and describes the use of music therapy to psychosomatic disorders, psychoses, pedagogics, autogenic training, dance and psychodrama, daydreams and gymnastics.

I hope that this fine German book will find an American publisher. It should have a place in the library of every American psychotherapist.

J. L. MORENO

MULTIPLE COUNSELING, A Small Group Discussion Method for Personal Growth. Helen I. Driver. Madison, Wisconsin, Monona Publications. 1954. 280 pp.

This book contains chapters on group discussion, leadership, role playing, multiple counseling techniques, self appraisal devices, sociograms and interviews. It is well written and should be of value for social workers, counselors, group workers, pastors and students of human relations. It is an excellent practical guide.

ZERKA T. MORENO

THE AMERICAN SOCIETY OF GROUP PSYCHOTHERAPY AND PSYCHODRAMA

PRELIMINARY ANNOUNCEMENT AND CALL FOR PAPERS

The Eighteenth Annual Conference of the American Society of Group Psychotherapy and Psychodrama

* * * *

The Date: Saturday and Sunday, April 25-26, 1959.

The Place: Hotel Commodore, New York City and The New York Institute of Psychodrama and Group Psychotherapy.

Sponsored by: The Society.

An invitation is extended to all interested professional people working in the area of group psychotherapy, psychodrama and role playing to participate in our program. The program will consist of workshop seminars and orientation seminars in addition to the large scale meeting with authoritative speakers, panel groups and round table discussions.

The workshops and orientation seminars are designed for the purpose of an inter-change of ideas, methods, techniques and problems. By working together in skill and experimental groups participants will explore their own effectiveness. By evaluating results in terms of philosophy, methods, techniques and experiences.

A wide diversity of papers and workshop lecturers and instructors is hereby solicited from members and non-members in the related fields: education, correction, guidance, industry, medicine and social work. A 100 word summary of each proposed paper should be sent to the Office of the Program Committee to expedite program planning; a resume of each lecturer and instructor of a workshop seminar should accompany a 100 word explanation of techniques, skills and method.

Each workshop seminar will be limited to thirty-five enrollments. These workshops will be run on a two hour basis and will end in a joint conference for review. A Chairman will be appointed by the Conference Committee to start each group. The closing date for registration for these workshops is March 9, 1959. After this date inclusion in the workshops will depend on possible vacancies.

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J. L. Moreno, Chairman; Helen Hall Jennings, Co-chairman

Workshop 2—The Psychodrama and Role Training: discussion and training in acting out techniques and methodologies:
James M. Enneis, Chairman; Hannah Weiner, Lewis Yablonsky, Mary Angas, Assistants

Workshop 3—Group Psychotherapy with an emphasis on the Mental Health of the family life:
Zerka T. Moreno, Chairman; Asya Kadis, Co-chairman.

The conference is designed to bring about the broadest exchange of problems, experiences, pressures, principles and methods of group psychotherapy, psychodrama, role playing and group discussion methods.

Presentation length for papers—15 minute maximum

Deadline for receipt of papers—February 1, 1959

Address all papers and communications:

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PREMIERE JOURNEE D'ETUDE DE PSYCHOTHERAPIE DE GROUPE

Date: Dimanche 7 Décembre 1958

Lieu: Centre International d'Etudes Pedagogiques
I, avenue Leon Journault
Sevres

PROGRAMME

9.00h précises à 12.30h:

—Introduction de la journée (Dr Lebovici)

—Formation des psychothérapeutes de groupe en institutions
(Dr Raclot — Dr Kestemberg — Dr Tosquelles)

—Formation des psychothérapeutes de groupes de parents
(Mme Schutzenberger — Dr Diatkine)

—Formation des psychodramatistes analytiques
(M. Anzieu — Mme Kestemberg).

—Formation des psychodramatistes Moreniens
(Mme Schutzenberger)

12.30h à 14.30h: déjeuner en commun

14.30h à 18h:

—Formation des analystes de groupe
(Dr Blajan-Marcus, Dr Luquet)

—Formation des psychothérapeutes et des pédagogues par le groupe
(Dr Favez-Boutonier)

—Formation des animateurs dans l'industrie par le groupe
(M. Anzieu)

—Groupes de parents (M. Isambert).

Le Bureau: M. Anzieu, Mme Kestemberg, Mme Schutzenberger, Dr Blajan-Marcus, Dr Lebovici, Dr Smagghe, Dr Diatkine, Dr Raclot, Mme Testemale-Monot, Dr Favez-Boutonier

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