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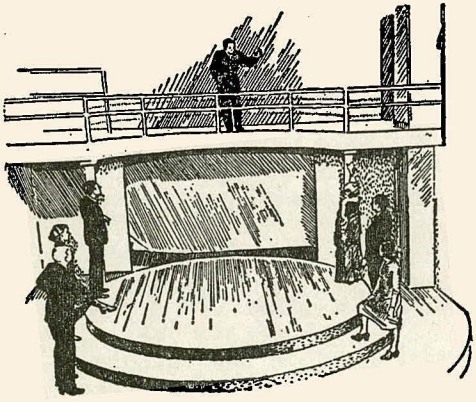
A Quarterly



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PSYCHOTHERAPY AND ANXIETY, A SOCIOMETRIC STUDY

HOWARD M. NEWBURGER, PH.D.

New York, N.Y.

Anxiety has been described at different times as the core of neurosis, as the cause of tension in back and shoulder muscles, or as a moving force that has lifted us from the stone age to the space age in the fantastically short time of fifty thousand years. For the purposes of the present study, I choose to view anxiety as the psychological parallel to physiological stress. The one does not exist without the other. Furthermore, anxiety and tension are essential for the smooth operation and development of our lives. Anxiety and its physiological concomitant, stress, when effectively and spontaneously functioning, see us enjoying meaningful and happy lives. When the anxiety is dammed up or denied constructive outlet, neurosis or delinquency result. In an earlier report on the effectiveness of group psychotherapy, modification of sociometric status of institutionalized delinquents was assessed.[1] At this time I would like to present some additional experimental data in that study with the aim of gaining further insights into the role played by anxiety.

The research population consisted of sixty consecutive admissions to the institution,[2] between the ages of sixteen and twenty-five, excluding those who were illiterate or brain damaged. A total of six groups was established on the basis of sociometric selection. Three groups comprised the experimental group, and three groups comprised the control group.

Since the entrance requirements to the institution are uniform, the research population was fairly consistent for such factors as social background, economic status, and extent of recidivism. No significant differences were found to exist between the two groups for either age or intelligence level at the outset of the study.

It was assumed that the period of three months, regularly allotted to group therapy within the institution, was adequate for the therapeutic procedures to motivate changes in behavior and attitudes, if they were to occur, and that the measuring devices used would detect such changes.

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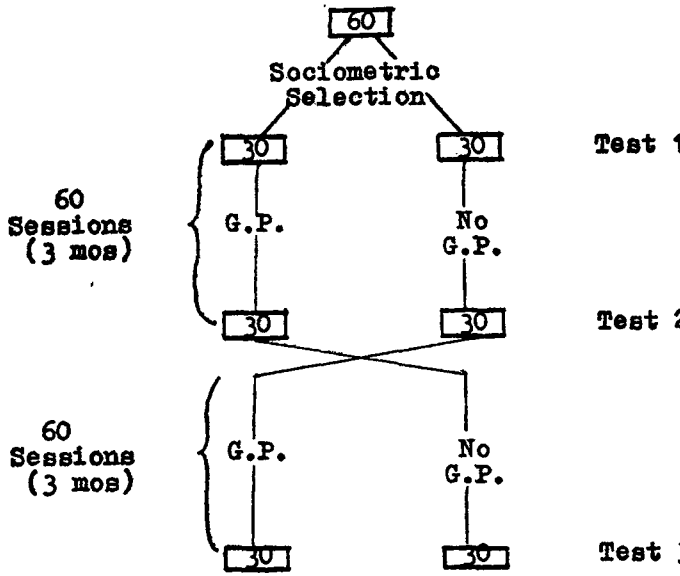
[1] Newburger, H., Schauer, G. Sociometric Evaluation of Group Psychotherapy, GROUP PSYCHOTHERAPY, 1953.

[2] This was done in order to allow for losses due to detention reports at the time of the testing, recalls by the court, and transfers to other institutions. Twenty-three subjects were used in the experimental group and twenty-four in the control group.

The behavior of the population was measured by means of the Haggerty-Olson-Wickman Behavior Rating Schedule, disciplinary reports, and work marks. The attitudes of the inmate toward himself, and toward others, was assessed by means of two special scales of the Minnesota Multiphasic Personality Inventory, interviews, and the Thematic Apperception Test. The attitudes toward certain social institutions were evaluated by means of interviews and the Thurstone Attitude Scales for Law, Treatment of Criminals, Constitution and Capital Punishment.

Experimental Design



At the outset of the study, the two groups were examined for significant differences between the variables. The groups were equivalent for all except two of the variables. The experimental group was significantly worse than the control group at the outset of the study on the variables of the Haggerty-Olson-Wickman Behavior Rating Schedule and the work marks. However, this difference merely served to emphasize the gains made by the experimental group, when compared with the status of the control group at the time of the first re-test.

At the outset of the study, groups were tested (Test 1) for the variables that were being measured. Then one group was placed in group

therapy, while the other had the same type of institutional program exclusive of the group therapy. Both groups were tested again at the conclusion of the therapy (Test 2). Then the activities of the two groups were reversed. The experimental group was removed from therapy, and the control group was placed in therapy. At the conclusion of the therapy, both groups were again tested (Test 3). This design had the advantage of allowing the scientific manipulation of groups without depriving anyone of therapy—or upsetting the institutional routine.

The group therapy utilized was a mixture of interview therapy and psychodrama. Psychodrama was used to accelerate growth during periods of great anxiety. Such a situation arose spontaneously at the very outset of the study. One of the boys had been arrested for stealing from a church. It must be understood that Mother's Day was a holiday of some significance in the reformatory. Special masses were held and gardenias were distributed to those who chose to wear them. The young man in question wore a tattoo of a heart pierced by a dagger, carrying the inscription of "Mother." As he related some autobiographical material and came to his activity of stealing from churches, a member of the group, who wore a similar adornment on his left arm, shouted out, "What the hell were you doing in church yesterday? You're nothing but a M——F——, anyway." With that he scraped his chair back as he rose to his feet. His victim got up and took his chair in his hands. We got well into our first psychodramatic episode.

The outcomes of the various experimental procedures are a source of interest and stimulation. Inter- and intra-group changes were examined. The effects of institutionalization, the effects of carry-over, and the relative advantages of giving group therapy immediately or after a delay, were evaluated.

Scores on the Haggerty-Olson-Wickman Behavior Rating Schedule appeared to be influenced positively by group therapy. The greatest gains accrued when the group therapy was administered without delay. Nor did time vitiate the highly significant gains. Institutionalization, without the support of group therapy, appeared to modify the behavior of the inmates negatively. An institutional program with group therapy administered at the time of admission appeared to influence more positive change than when the group therapy was administered after delay.

Group therapy, administered without delay resulted in significant improvement in work marks. When delayed, the work marks became worse and actually represented a loss from the gains in the experimental group. Carry-over from the early administration of group therapy appeared to

influence continued positive change at a significant level. An institutional program with group therapy in the first half appeared to influence significantly greater positive change in the work of the inmates than when the group therapy was administered in the latter half of the program; in effect, an adverse trend ensues.

Group therapy seems to have influenced significant improvement in the discipline of the inmates regardless of the time of administration. Greater benefits appeared to accrue from the early administration of group therapy as opposed to the later administration of group therapy. Carry-over was unchanged. An institutional program with group therapy in the first half appeared to influence greater positive change in the discipline of the inmates than an institutional program that offered group therapy in the latter half.

When the attitudes toward the self were studied, on the basis of the interview, it was noted that no significant changes appeared to be influenced by group therapy, institutionalization, or carry-over. However, changes were reflected in the Thematic Apperception Test protocols when they were rated for attitudes toward the self. Gain in the attitude toward self was noted in both the experimental and the control group. However, carry-over from the group therapy appeared to influence highly significant positive change, so that the attitude approached a normal amount of self-esteem. Group therapy, administered after a delay, demonstrated no significant changes in initial low self attitude. As measured by the Thematic Apperception Test, an institutional program with immediate group therapy appeared to be more effective in raising the low self attitude of the prisoners than an institutional program offering group therapy at a later date.

Significant change in attitudes toward self for both groups were reflected by the Minnesota Multiphasic Personality Inventory Scale. Carry-over from the early administration of group therapy appeared to influence no change in the increased self regard. However, when group therapy was administered after a delay, it was noted that further significant gains accrued. The advantages of administering group therapy without delay, as opposed to the institutional program that offered group therapy after a delay was not significant when measured by the Minnesota Multiphasic Personality Inventory Scale for self. It is not fully understood why the Minnesota Multiphasic Personality Inventory scale increased so greatly at the outset of the study for both groups.

Attitudes toward others, as measured by the Thematic Apperception Test, were not influenced by group therapy or institutionalization. Although improvement was noted when the group therapy was administered after a

delay, this was not significant when compared with the progress of the other group.

Attitudes toward others, assessed by interview, reflected no change in either group (at Test 2). Significant change appeared to accrue when the group therapy was administered after a delay. Carry-over was also successful in influencing positive change. An institutional program, offering group therapy in the latter half appeared to influence greater constructive change in the attitude toward others than a program offering group therapy in the first half. However, the difference was not fully significant.

Scores on the Minnesota Multiphasic Personality Inventory scale for attitudes toward others underwent a highly significant gain at the outset of the study for both groups. The reasons for this are not fully understood at this time.

The interview for assessing the attitude toward the U.S. Constitution reflected no changes as a result of group therapy, carry-over or institutionalization. Although the Thurstone scale for attitudes toward the Constitution reflected change influenced by the early administration of group therapy, this was not significant when compared with the control group for the same period. Other than this, no changes were reflected on the Thurstone scale for attitudes toward the Constitution as having been influenced by group therapy, carry-over or institutionalization.

The interview, assessing attitudes toward the law, reflected no change in the first phase of this research. However, carry-over and the delayed administration of group therapy appeared to influence, in a positive direction, respect for the law. Increased regard for the law appeared to result from the delayed administration of group therapy.

The Thurstone scale for attitudes toward the law reflected no changes due to the influence of group therapy, carry-over, or institutionalization.

At the conclusion of an institutional program, the interview, measuring attitude toward capital punishment, reflected a more humane trend on the part of those experiencing group therapy in the first half. However, this was not significant when compared with the progress made by those who had group therapy in the second half. Other than this, no significant changes were noted as having been influenced by group therapy, carry-over or institutionalization.

The Thurstone scale for attitudes toward capital punishment reflected a more humane trend at the conclusion of an institutional program that offered group therapy in the latter half. However, this was not significant when compared with the progress of the group that participated in the

institutional program that offered group therapy in the first half. Otherwise, results were found to be consistent with those reflected by the interview.

The interview for the attitude toward the treatment of criminals reflected no change in either group at the outset of the study. However, carry-over appeared to influence a very strong trend in favor of re-education to punishment. When the group therapy was administered after the inmates had been exposed to the conventional institutional atmosphere, it was noted that the interviews reflected a need for a more punitive attitude toward the treatment of the criminal. The fact that they, as criminals, were affected by this somehow managed to escape them. Subjective impression by the group therapists suggested that the prisoners in the second therapy group seemed to regard the expression of feelings as a sign of weakness.

The Thurstone attitude scale for the treatment of prisoners reflected no consistent changes as a result of group therapy, institutionalization, or carry-over.

Group therapy appeared to foster constructive modification of the prisoners' performance as measured by the Haggerty-Olson-Wickman Behavior Rating Schedule and the discipline within the institution. Work marks were similarly improved when the group therapy was administered at the outset of the inmates' incarceration. However, when it was administered after exposure to the institutional climate confusion resulted, and the work marks became worse. This confusion was also suggested by the performance on the interviews for the treatment of criminals. Widely deviant trends were noted that appeared to be due to the differential influences coinciding with the time of administration.

There is some evidence to suppose that when change in the prisoner's attitudes and behavior does transpire a sequential chain is activated. First his behavior, then his attitudes toward himself are affected, latterly his attitudes toward others and social institutions. This might tend to lend support to developmental theories in human maturation, such as the developmental aspects of ego differentiation and the relationship with overt behavior.

In general, carry-over induced no negative changes. However, institutionalization did not appear to meet the needs of the inmates as measured by the Behavior Rating Schedule. A slight hardened effect was also noted.

The early gains that were noted in the Minnesota Multiphasic Personality Inventory scales for self and others do not appear to have been primarily influenced by the group therapy. Rather, the many constructive factors present in the institutional climate appear to have been at least partially

responsible. The great extent of the change is not at this time fully understood.

Anxiety plays a central role in human development. When it is spontaneously generated and expressed in a constructive manner, meeting with adequate environmental response, an effective and happy person is the result. Adjustment to oneself, others, and certain cultural institutions, can be one measure of how a person's anxiety is serving him.

Delinquency is a failure in adaptation to the broader demands of a community. The mobilization of a delinquent's anxiety along redefined lines is an objective of group psychotherapy when it is administered within an institution.

The therapeutic process in itself can be a source of considerable unleased anxiety. This seems to be associated with the attainment of certain new insights. Anxiety and its physiological correlate of stress are then freed for retraining.

A method involving interview group therapy and psychodrama appears well suited for use with an institutionalized delinquent population.

OBLIGATORY COUNSELING WITH COLLEGE UNDERACHIEVERS

DONALD G. ZYTOWSKI, M.A.

Washington University, St. Louis, Mo.

It is the practice in most colleges and universities, when a student achieves grades below some given level for one or more semesters, that regardless of his potential, he is rendered ineligible to continue in the institution. Their acquired ineligibility may not prevent them from continuing with college level work, though it may prevent them from matriculating for a degree. Large university evening colleges and extension divisions often permit students to enroll for classes, but on a non-matriculated status. These divisions of indeterminate registration have become the hope of students who have become ineligible, to demonstrate that they are capable of adequate college achievement, by which they might be restored to degree candidacy.

Washington University recently formalized recognition of this group of students striving to regain academic eligibility by creating a formal program which includes a non-credit course called "Counseling and Study Skills." This course carried the implicit recognition that students who were enrolled in it lacked either or both skills and motivation to achieve in college, in spite of their having been previously admitted. The Student Counseling Service of the University was given responsibility for the administration of the course. Students were offered either counseling or study skills help, on the assumption that the low ability group needed skills most, and the low achieving-high ability group needed revisions in motivational factors.

Over the five-semester period this program has been in operation we have found it to be appropriate to permit the student to choose the treatment, skills or counseling, which he feels will be most effective. The skills section of the program emphasizes formal teaching of reading, language, and study skills from a variety of self-help workbook materials, but uses counseling approaches to examine motivation, and deal with other problems in the effective use of skills.

Students who are recognized as having high potential are invited to join counseling groups to examine the reasons for their non-achievement and attempt to stimulate higher grades. Since the choice of skills or counseling is available, there is some voluntary aspect to the program, but the brighter students find themselves in the counseling groups, to avoid what is to them a dull instructional class in skills they already know. These students, who are

generally labelled underachievers by the academic community, can be thought of as in an acute state of ambivalence about their situation. They are usually too embarrassed about losing their eligibility to ask for help directly, yet their presence in a program designed to help is taken as indicative of their wish for it.

This involuntary feature of the program presents a problem in resistance, which is exaggerated beyond that usually found in therapy groups constituted in ordinary ways. However, it is not unlike the problems of conducting groups constituted under the general rubric of legal or quasi-legal authority; prison groups, detention homes, state mental hospitals, public schools, and the like. Our experience is that the resistance generated by the involuntary referral is offset partially by the recognition of the common problem—that all the members of the group are suffering from some "run-in" with authority. However, it is usually necessary to point this communality out, and discuss it at length. We also find that with the non-voluntary circumstance, and the time limit condition under which we operate, that a single group member whose behavior is too deviant must be removed. That person who acts out in the group more readily, or the person who is too withdrawn or perhaps bizzare, or who is too nearly normal, must be asked to leave the group in order to not impede its progress. Most often this person is seen individually by a counselor.

All of the foregoing should sugest that the counselor or therapist will take a considerably more active role in the group than he might in more traditional treatment situations. This behavior is heightened even more by the time limit condition. Overcoming natural resistance, or the other side of the same coin, building sufficient rapport, can become the primary concern of the group for so many weeks that when and if a workable level is achieved, there may be little time left to achieve any benefits. Thus, it is apparent that this type of treatment calls for goals of limited depth, satisfaction with less rapport and transference to accomplish objectives, and more structure for the group activities supplied by the leader of the group.

The technique of providing structure which will override or reduce resistance has been a difficult one to develop effectively, since it is desired that the structure be the least necessary to gain the greatest movement. The techniques which we have evolved are idiosyncratic to the several counselors who lead our groups, and depend in part on their concept of what it is that is responsible for the underachiever's difficulty.

It should be understood that for us the diagnosis of these students is underachievement, and that we attempt to treat it, rather than the personal,

social or family pathology which they demonstrate. Most of the students in the counseling groups could be described as having mild character problems, variously called delayed adolescent reaction, immaturity, hysteroid behavior or dependent personalities. It might be recognized that each of these terms seem partly correlated with the other, so that they may just be different aspects of the genus, "underachiever."

There are three sets of dynamics associated with underachievement in the literature. The view with the greatest currency is that the underachiever suffers from inappropriately expressed hostility. This is well illuminated by a case presented by Kirk (1952), in which a demand for achievement from a father resulting from the disappointment in achievement from an older, brain injured sibling resulted in a persistent pattern of underachievement from the middle of his elementary school career. This individual exhibited many of the complaints given by underachievers: inability to concentrate, lack of a specific vocational goal, too much dependence on social gratification, procrastination, compensatory phantasy of grandiose achievement, family alienation, personal unsureness, and the like.

The same set of complaints are voiced by another general group of underachievers, which is the model next most accepted. This model sees the underachiever as suffering primarily from a deep dependency, and an occasional counseling client will demonstrate this picture vividly. It is entirely possible that these two types of underachievers are one and the same, exhibiting only different aspects of themselves.

The third explanation of underachievement might be keyed to the dynamic formulations of Erikson (1956) on the development of identity. Some prefer to describe the underachiever as not having achieved a sense of personal identity, or a concept of himself as a potent, autonomous individual. This explanation is most appealing to the counseling (as opposed to clinical) psychologist, since he views himself as a person who works with arrests of or incomplete normal development.

These differing views of the underachiever's problem stimulate differing approaches to the group treatment. One counselor begins his groups by drawing out the members for the purpose of each person getting to know the others better. He then discusses with them their situation: the lack of congruency between their goals expressed by being in college, and their present achievement. They are especially asked to describe their behavior in reaction to the discovery that they have lost their academic eligibility. From this point, discussion by the counselor of the defense mechanisms is given, gradually involving the members of the group as they demonstrate

their defenses in talking about their situations. One would view the counselor as remarkably didactic at this point, and hardly behaving in the passing, "counselor" fashion.

It is found that the members of the group begin to take over the functions of the counselor at about this point, pointing out the mechanisms of their co-members, and asking further questions of the counselor about them. They turn to the reasons for defensive behavior, and eagerly greet such concepts as anxiety, aspiration level, independence—dependence, etc. The members of the group usually call for even less impersonal discussion and more application to themselves. This brings questions about confidentiality and trust among the group members, and when this is resolved, the members begin to discuss their own needs and defense mechanisms on a high level of involvement. Participation is not entirely uniform; some present their behavior and invite comment on it, others comment on other's behavior, and relate it to their own, while an occasional individual will attempt to defend by contributing disruptive remarks.

An example is Ken—who was a quiet, passive individual, who feared responding in class and expressed his inferiority feelings. He was able to discuss his failure at an out-of-town school, which his parents sent him to, inspite of the fact that he was not fully sure that he wanted to go there. He was fearful of expressing himself to his parents, for fear of what they would say, but also felt guilty about letting them down by not getting good grades. Another individual, however, contributed nothing but disruptive remarks. When the group caused reasons for them to be analyzed, he left the group and did not return for its remaining meetings. While the loss of a member due to the anxiety created by his perception of his impending dismemberment by the group should not be permitted to happen in a more routine group, in the conditions of obligatory assignment with a time limit, this event becomes an example of the problem of dealing with the too-deviant member of the group.

A second counselor works at the level of perceptions and insights. He feels that most of his underachievers have not conceded to or are not sensitive to the rules of the game of achievement within the norms and strictures of the university community. That is, the students cannot accept the role required by the instructor who awards the grade. This view is easily incorporated into the resistance to authority perspective of underachievement. This counselor's technique is to almost lecture briefly on the values of the university or on some aspect of behavioral dynamics, which are not fully understood by his group. With the bright underachiever, this inevitably stimulates

discussion, which he guides gently by client-centered techniques (or selective reinforcement, if you like.) The depth of discussion goes further than it would in the normal classroom by reason of his manner of relating to the group; first names all around, personal references to the student's difficulties as the counselor has experienced them, etc.

A typical session might take up a common complaint—that the student suffers disabling anxiety when he is tested. After mention of the fact that if one is not fully prepared for a test one ought to be anxious about its outcome, the perception is presented of the university as a place where evaluation has a more unique function than anywhere else in life. Evaluation is described as one of the essences of the undergraduate education, and that fear of failure should be a natural concomitant. But the snowballing effects of fear (as Mowrer would have it), are described, and the idea presented that this is the unreasonable part of the fear, which can be effectively reduced by understanding.

Another problem taken up might be the "picayune" insistance on detail, orderly procedure and documentation which a freshman English composition paper requires, when the student knows that he could write the paper much more easily without being encumbered with these procedures. It would be typical of the underachiever to resist these requirements, in the hope that the merit of his final work will compensate for procedures which he does not do. The counselor presents for discussion the idea that the essence of scholarly work in the university community is just this kind of behavior, and that the instructor knows no world of the "easy way" and so will not accept it. Again, the skill of the therapist must be applied to the discussion which these value presentations stimulates, to maximize its usefulness to the group members.

A third counselor provides structure in a considerably different way, applying role-playing techniques to make material for discussion (see Moreno, 1956). The emphasis is not intellectual or didactic, but rather is on an action and participation level of hours of study, effectiveness, getting along with the persons who stimulate the interference with successful school achievement and the like. Typical sessions may have a role playing situation presented, such as a scene of the interaction between a student and his parents when it was discovered that he would be unable to return to his former school. Behavioral dynamics are thus revealed, but not named, and group members are generally anxious to comment on how the situation might have been better handled, or what the student might do to reinstate his status.

This group also is caused to form into natural subgroups of two's or three's. These coalitions are urged to take responsibility for each other, and agreements are made to call one's partner when it is known that study will be particularly difficult, or to provide tutorial assistance of a subject one is more expert in.

This counselor uses one unique procedure. This is the "behind the back" which is described in Corsini's (1957) book on group psychotherapy. Near the end of the semester, one counselee, who seems to need some insight into his or her own behavior to proceed further, and whose ego is judged to be in good enough condition to tolerate it, is asked if he would like to learn other's perceptions of him. The individual is asked to leave the group by turning his back, but staying well within earshot of it. The remaining members are called upon to comment on the individual as though he were absent. Depending upon the circumstances, they may be asked to go all around the group, speaking only about the absent member's assets, and withhold critical comments for the second circuit, or to mix their remarks together, but to be certain to include a good quality as well as a bad one. Each time this technique has been introduced a substantial number of the remaining members have asked for the same treatment, suggesting a very strong behavioral need of the adolescent.

It would seem an appropriate goal of this paper to attempt to identify some of the common operants in the three varied approaches to therapy presented above. While they must be tentative, the following factors I believe account for the movement which occurs, or the success which we have had.

First is the factor of *group support*. All of the students in our groups have received a shock which shakes their self-perceptions. This can result in further deterioration or can be capitalized upon. Which direction it goes, is probably a function of whether it is discovered that there are others in the same condition who are working on their situation. The remark, "My God, I thought I was the only one this ever happened to," frequently heard in individual therapy, is perhaps even more strongly felt in the group situation where the others are visible, rather than simply described. The reduction of fear which this realization achieves very likely permits the efforts of the therapist to be even more effective.

Second is a *group ego*. When an underachiever is tempted to believe in his own omnipotent phantasy, the other members of the group can effectively remind him of his and their achievement vulnerability. We observe this frequently, when one of the members comments on another, "Hell, you

know you can't always depend on making up your bad grades in a course on just the final exam." The freedom of the therapy group as compared with a classroom group permits this kind of remark to be made, and is much more acceptable from a peer in the group than from an individual therapist, especially in the stages before full rapport or positive transference is developed. This group ego may be actively promoted, or simply permitted to evolve, as it inevitably does. Occasionally too, a group super-ego may function for a single individual.

An extension of the second factor are the co-therapists which the group affords. The single adult counselor cannot be aware of every occasion on which he is being deceived or "conned," a favorite practice of the underachiever. The existence of individuals in the group who will and are permitted to take over the role of therapist, who are in classes with protagonist of the moment, or see him in the library or off campus, can be a strong asset in the control of grade achieving behavior.

The third factor is *information*, a goal of almost any therapy endeavor. A fair amount of the group material is taken up with such questions as how to deal with a given instructor—whether he requires his lecture material to be parroted back to him or whether he will give low grades for this behavior. Within the group, the presentation of material about the environment can be more frankly didactic, and the incorporation can be made readily through group interaction. However, it can also be gained at the level of participation without any labeling or specification. The co-therapists may also operate in extending the insight about the environment. Since the counselor inevitably represents the school authority, it is probably good that this kind of information not issue too exclusively from him.

The fourth and last factor should be labelled *insight* or *feedback* about the self. Whether the need is stimulated by the failure to succeed in the task of college, or whether it is a natural stronger need in the maturation process of the adolescent, the group members are eager for information about how they are perceived by others, and whether this agrees with their perception of themselves. Insight-making may be a deliberate process as in the last technique presented, or one which is permitted to occur as the counseling progresses as in the first. Nevertheless, the knowledge of one's typical reactions and defenses or whether one is having the intended effect on others, it well known to be highly facilitating in the change of behavior.

Insight about one's self should naturally stimulate the need to try new ways of relating or new sets of beliefs and behaviors. Thus we are returned to the first factor cited, group support, which may provide a secure environment in which to make the first tryouts.

It should be apparent that these factors do not operate equally in every group, but rather one or another gets more intense application within a group at a given time, while the remaining factors operate at a more or less unattended level. It may also be mentioned that these common factors are no less or different than the factors operant in varied types of individual therapy, and that their intensity and mode of facilitation only are altered by the group treatment situation. The obligatory quality of the relationship requires modifications in technique to be made at first, and the time limit feature, not common to many therapies, requires limits to be placed on who is acceptable for this type of treatment and inevitably the extent of the goals which can be held for them.

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ROLE PLAYING AS A TRAINING DEVICE IN PREPARING MULTIPLE-HANDICAPPED YOUTH FOR EMPLOYMENT

ROSE BRANDZEL, M.A.

Chicago Teachers College North, Chicago, Illinois

The use of role playing in training handicapped youth for job situations proved to be a highly practical and effective method of preparing them to get and to hold a job. Role play provided opportunities for gaining missing life-experience and practice, for anticipating requirements and demands of job situations, for establishing suggestive patterns in behavior and verbal response for meeting these situations more adequately. In addition it provided opportunities for developing competence and confidence. "Living through these experiences" in role play provided a different level of participation and involvement for these youngsters who for reasons of disturbance or retardation could not as easily be reached on only a discussion level.

This pilot project was conducted at the Jewish Vocational Center of Chicago with graduates of their ten-week program at the Vocational Adjustment Workshop. Prior to their entry in the shop, these youngsters had been judged "unemployable." The group included retarded, recently discharged mental patients, disturbed youngsters, as well as physically handicapped, all of whom had additional personal, social, and vocational problems.

There was some serious question as to whether such a disparate group could be handled together, but the "real-life situations" of the role plays turned out to be an effective way not only for each to learn some aspects of better functioning in his own role, but an opportunity for one member to help others. For some members, this was the first time they had the experience of being helpful to someone else. This was true of a bright, seriously depressed girl who could be lured out of her apathy only by the leader's obvious need for her services in the role play, and at such times she would show great sensitivity and creative helpfulness. Her reward came when she announced she had made a civil service list and the group broke into spontaneous applause. She broke into tears and said it was the first time any group had cared about what happened to her. This atmosphere of mutual helpfulness spread into the job-hunt. Members would call each other about opportunities, and three jobs were actually secured through such referrals, such as a slight boy referring a heavy-set boy for a job requiring heavy lifting, etc.

Role plays became important for revealing diagnostic clues to leader and counsellors that might not become evident in the ordinary course of counselling. In the case of an attractive young woman of 21, we were at a loss to find the reason for the failure of promising job interviews. As she role played her end of the interview, she handled herself well. When roles were reversed, she revealed the employer's shock at the mention of her illegitimate child. Her original version of the interview had completely omitted any reference to the child.

A similar type of emotional blocking of which the youngster was unaware, was exposed in the role play of application interviews of an epileptic youth. Although prospective employers were aware of the epilepsy, he managed to lose the prospect in the interview. We were at a loss as to the source of the trouble. One role play of an employment interview revealed a tightening and tenseness when the epilepsy was discussed which gave the impression of hostility. Roger indignantly denied that he got angry when questioned about his health. Fortunately, the role play had been recorded and was played back. Discussion revealed that Roger was still reacting to a question he had once been asked, "Do you have fits?" Everyone in the group was given the opportunity to ask and to answer this question. This process had many unexpected results, as alway with role plays, in addition to helping Roger work out his resentment to the point of finally achieving a successful application interview.

A similar process of practicing to meet a situation was initiated the following week by a spastic who had been floored by the question "What's your handicap?" During this process some of the group were taught special approaches. "Just give me a chance and I'll show you I can carry the job," etc. There was a great need among these youngsters who had been so limited in social interaction and verbal interchange to be taught patterns of possible responses to typical situations. Picking up suggestions from the leader, and more frequently from their peers, and with continued practice in the role play, they began to add to their repertory of interaction skills.

This practice for skill in meeting situational demands was also adapted to real and anticipated problems on the job. Each member took a turn in both making and answering such comments as "You're too slow—you'll have to speed up" or "you're too sloppy—you'll have to redo this." Not only did such practice provide them with patterns and ideas for meeting such situations, but the identification with the foreman role provided for some a way of understanding the reasons for the foreman's attitude, and hopefully, mitigating some of the terror and resistance authority figures inspired.

Role plays frequently exposed deficiencies in social experience and social awareness. Sharon was being slowly and carefully prepared for a baby-sitter's job. After a number of sessions she did a fairly acceptable job of approaching women at a play lot, offering her services as a baby-sitter, and discussing her qualifications, procedure in an emergency, etc. This time she was asked what she expected an hour, and answered seriously that she wanted $3.00 an hour. A detailed discussion on salary expectations was obviously needed. Salary expectations were discussed, as well as procedures for asking for increases. This did not prevent one of the boys who had been coached by the group that he was not to ask for an increase for at least three months, to role play a situation in which he asked for an increase, was told "We'll see," and immediately quit. With such retarded and disturbed youth carryover from one experience to a different situation must be carefully nurtured, and the "safe" experience of role playing was an invaluable educational device.

Role plays were used not only for diagnostic clues and for practicing patterns of response to new situations, but also as a conditioning experience for establishing self-confidence. Wanda was an anxious and frightened girl with an IQ of 51. There had been serious question about taking her into the group. Her positive assets were neatness and a pleasant appearance. She conscientiously practiced applying for a bus-girl job, and through special arrangements by the counsellor was placed on a training program for bus girls in a large chain restaurant. Her work was reported as satisfactory, but she felt anxious and insecure, and it was feared that she might "blow" at any time. The problem was how to help her develop a realistic feeling of confidence in her ability to do this job. A role playing scene was set up in which Wanda was asked to be the supervisor instructing a new girl in her duties. Wanda gave precise instructions—first wipe the table, put the sugar here, etc. When the group commented on the clarity of her instructions, she still expressed doubt. Leader then told trainee to perform duties as she had been instructed. She did everything correctly, to the growing wonder and amazement of Wanda, whose face lit up and who finally murmured, "I really knew what to do, didn't I?" Although other ways may have been found to help Wanda develop the security she needed to continue with her job, there is no question that this particular role play played a critical role in dramatically demonstrating to Wanda that she really knew her job. She continued to return to the group for many months after she was on the job, enjoying her status as one of the job holders helping the others.

Reverse role play providing a dramatic way of conveying other person's reactions, especially in situations where the individual was resistant to looking at the situation from any other viewpoint. There was the case of the twins who persisted, in spite of efforts of counsellors, to apply for jobs together. They were each set up in a role play as employers, and two applicants came in together for the same job. After analyzing the reason for letting both go and subsequently hiring a single person, one of the twins agreed that they were handicapping themselves by applying together.

In training children who have been socially deprived, role playing becomes invaluable for building in missing experiences and dramatically conveying consequences of actions. Sheldon did a good janitorial job, got jobs easily and lost them quickly. He consistently and beligerently maintained he had done nothing wrong on the job. He acted out some of his experiences on the job from which he had just been fired. He was told to watch as some other youngsters replayed the scene. Suddenly he said, "Oh, you mean I talk too much."

There was another dramatic instance of teaching possible consequences through living them out in role playing. After two weeks on a job as a messsenger girl, Marilyn announced that if the other messenger talked to her one more time like she had been, she would beat up on her. Reacting to the expression on the face of the leader (this had been a most difficult placement), Marilyn hastily modified and said that she wouldn't beat her up in the office, she'd do it outside the building. She was given a role play in which she beat up the other messenger, Gladys, and the boss walked in, and fired Marilyn. Se maintained she had justification and it wasn't fair. Everybody said the justification didn't matter, the boss would get rid of the trouble-maker and keep the older worker. This was a dramatic confrontation of consequences for Marilyn who had never doubted that her position would be understood and accepted. Marilyn was then asked to play the role of Gladys and when friendly overtures were made, ran away. Marilyn then explained that Gladys was old and crippled and "didn't know how to take it when somebody was nice to her." Various members of the group took the role of Marilyn being nice to Gladys. Marilyn insisted it couldn't be done, but came back next week to report that she had given Gladys a candy bar, and that things were a little better. Several weeks later Marilyn dropped out of the group saying she didn't need it any more. Four months later she called to inform the leader that on her own she had obtained a much better job and was getting along well with co-workers.

Role play situations were developed from the group. They developed

a keen sensitivity to their own needs for special practice, and an amazing ability to devise helpful role plays for others. Sometimes a new member would show a fear of involvement. Such a person was left alone to observe, and later given non-speaking roles such as being seated at a work-table. One member who had been standing behind a column for several sessions was unable to resist an opportunity to ride along in a station-wagon of his choice as a non-speaking helper. A favorite assignment was that of secretary, where unexpected incidents sometimes occurred, such as secretaries refusing to let applicants in, etc. The most sought after assignment was that of personnel director or foreman, and analysis of the behavior in these roles yielded many insights.

After a session of hard work on employment problems, the group would relax with role plays of social situations—introducing yourself to a new group and making conversation, telephoning for a date, asking for a dance, etc. Many of the members acquired real satisfaction from these experiences, saying, "It's the first time I've been for a dance," etc. Racial differences were ignored in the social patterns of the group. On one occasion when there was multiple calling for dates, it developed spontaneously into a situation in which a triple date was arranged. There was open cross-calling between the girls as to dress, and between the boys as to place and costs. It was obviously the first time that some of these youngsters had envisaged such a possibility. This particular session ended in hilarious spirits and with a strong sense of mutuality among the group, as though indeed it had been a highly successful triple date.

This social training also had some unplanned for consequences. The group named themselves the "Employment Club" and shared many of the attributes of the club. They went on trips together after the meetings, and planned outside get-togethers. Some of them reported that they role played at their evening get-togethers. As a consequence, one of the members indicated that as a result of her experience with this group, she was now ready to move into group therapy of which she had been fearful. Resources were developed into community centers, so as that these members became ready, they could move into other social groups.

The main objective of this pilot group was to determine whether this type of role playing training would prove helpful to these handicapped youth in getting and holding jobs. A study of the placement success of the Vocational Adjustment Center graduates indicates that the general factors affecting placement are: (1) severity, prominence and acceptability of

handicap; (2) the amount of tension in social contact; (3) fear, anxiety and inappropriate behavior; and (4) lack of positive work drive.

All of these problems were worked on in one way or another in the role playing sessions. The effect of these experiences on the statistics of placements were marked. Placements in the first three months rose from 50% to 91%.

Our experience indicates that role playing training with multiply-handicapped youth can be of great value as a diagnostic tool, a training method of teaching patterns of response to new situations and for developing sensitivity to possible consequences of behavior, as a tool for developing spontaneity and ease in social situations, and an opportunity for safe practice of "real life situations." Role playing training is a practical and effective method for helping the handicapped overcome some of the personal and social deficits of their lives, and for helping them to obtain and maintain employment.

PSYCHODRAMA IN INDUSTRY—PITFALLS, CAUTIONS AND REQUIREMENTS

JAMES G. GELDER

Diamond Electronics, Lancaster, Ohio

At least one authority on Management has identified "leadership" as the ability to recognize in others and self the needs and traits which motivate each individual to act; and, to structure the situation so that the individuals are moved to work voluntarily for the accomplishment of the desired goal.

This definition implies, as do so many others, that the manager must know himself, his superiors, his peers and his subordinates as individuals and be consciously aware of their needs. Further, he should foster mutual individual awareness among his subordinates; desirably, among his peers; hopefully, with his superior, not for exploitation but for greater operational efficiency.

Psychodrama would be less important or necessary if each industrial manager or supervisor were emotionally mature. One does not find adequate emotional maturity and self-understanding a consistent element in the managers and supervisors of any given company.

To be more to the point, it is not unusual to find wide variances in the emotional maturity of individuals of the same organizational level. To compound this situation is the awkward arrangement wherein there is an emotional maturity difference between those who work together but are at different organizational levels.

The situation becomes extremely awkward when the higher placed person has achieved a lesser emotional maturity than has his subordinates. Hopefully, it would be the other way around. The possibility of this "topsy-turvy" emotional arrangement should be kept in mind.

The value received from the intelligent application of Psychodrama is that Managers can become more able to deal with emotional exchanges which are the real components of human behavior.

Psychodrama is a powerful tool for creating emotional understanding. And, herein lies a potential problem for industrial users.

Industrial applications of Psychodrama as a training medium should be monitored with an awareness that: (1) each participant is in daily contact during the work day with the other participants; (2) the business must continue to operate; (3) Psychodrama stimulates strong emotional releases; (4) early sessions will tend to cause withdrawal by some, as they

tend to feel manipulated into giving emotional release beyond their intention; and (5) to promote exploitation by those who have observed honest participation by others but have withheld themselves.

These cautions cannot be discounted. It is true that during the Psychodrama the group is under the able guidance and control of a director; however, after the session the participants return to their jobs. There they are governed only by their personal ethics and morals which, even at the managerial level, vary considerably.

General requirements for the industrial use of Psychodrama would appear to be for the earlier sessions *not* to result in a deterioration of the company's performance during the Psychodrama period (here it is assumed that as awareness is achieved deterioration would not be a threat); nor, a debasement of a participant's ability, pride or position, as he may perceive it. Psychodrama should strive for knowledge of self through the re-adjustment of ego related values rather than for the destruction of egos.

A general caution would seem to be that the tenure of a Psychodrama series be governed only be the time required to recognize and effect the complete span of individual receptivity.

Insufficient tenure would appear to be a potential pitfall since the Psychodrama would be discontinued before the participants had been brought to near levels of emotional maturity. The revealing of non-uniform levels of emotional maturity could severely damage the company operations, heighten inter-position problems and result in a denouncement of Psychodrama as a valuable management training method.

With regards to specific pitfalls, cautions and requirements one might consider them as related to the environment within which the Psychodrama will take place.

Requirement

The "Boss" must have a sufficient understanding of himself . . . an understanding of human behavior . . . PLUS a tolerance for that behavior.

The Supervisor must have adequate psychological security and the capacity to absorb the emotional releases of both his superiors and his subordinates.

Caution

Care should be taken to develop an atmosphere conducive to a feeling of freedom to expose one's self without fear of retribution and of participating with impunity.

The pace of the Psychodrama should be neither too fast nor too slow or it will tend to increase the participants' feeling of insecurity.

The Director should constantly evaluate each participant for the answer to . . . Is he ready to be helped?

Pitfalls

The industrial management situation, almost by definition and definitely by operation, lacks a permissive atmosphere.

Ingredients contributing to the lack of permissiveness are the very structure of the organization with its different levels of authority and responsibility; the different work atmospheres; the daily interaction between job oriented people; and above all, the constant search by each man for the answer to the question . . . Does the *other* man "have it"?

The greatest pitfall would be the failure to develop the proper atmosphere for optimum results from the Psychodrama.

Some practical questions one might ask could be:

1. What grouping, within a company, of levels or positions and numbers can best avoid individual exploitation of co-workers after the psychodrama?
2. How can the optimum duration of the Psychodrama sessions best be determined?
3. What precautions can be taken to avoid deterioration of company effort during the Psychodrama period?

The answers to these questions can come only after extensive application of Psychodrama to industrial problems.

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THE USE OF SPECIALIZED GROUP PSYCHOTHERAPY TECHNIQUES IN A HOME FOR THE AGED[1]

STANLEY L. RUSTIN, M.S., AND ROBERT L. WOLK, PH.D.

Menorah Geriatric Guidance Clinic, Brooklyn, N.Y.

INTRODUCTION

During last year's meeting of the American Society of Group Psychotherapy and Psychodrama, Dr. Robert Wolk and Richard Brunner discussed group psychotherapy with geriatric patients in an out-patient clinic. Techniques described at that time for treating the aged patient with group therapy have been adapted and extended for use with geriatric patients living in a Home for the Aged.

Group psychotherapy, as it has been utilized with the aged, involves a more directive approach than therapy with other age groups. With the aged patient, the therapist must take an active role in offering information and in answering questions from group members. Because the institutionalized aged person is less likely able to manipulate the immediate environment, he is more likely to seek the support of the therapist to have him alleviate his difficulty through active intervention. At times, the therapist assumes an active role as a liaison between the patients, and their families, friends, and staff in the home, which frequently serves to further positive transference and foster confidence in the therapist. Problems unique to institutional living, such as psychological and physical dependency upon the medical staff, forced communal living with other aged persons, and isolation from one's family are raised by the group leader and discussed in the group. The group serves to emotionally support its members and helps through identification with each other's problems to further better interpersonal relations. In addition, the directive approach focusses upon the amelioration of anxiety by attempting to solve immediate problems. In contrast to other techniques, the therapist, employing the directive technique, attempts to alleviate anxiety by completing, within each meeting, specific areas or topics. The goal of directive therapy with the aged is to provide immediate relief from emotional stress with lesser emphasis upon emotional (personality) change or insight. In order to further adjustment in a Home, concrete

[1] Read at the annual meeting of the New York Chapter of the American Society for Group Psychotherapy and Psychodrama, November 18, 1961.

suggestions are offered with a great deal of support and encouragement to help facilitate greater sociability and interaction with fellow patients.

Criteria for Selection

Initially the patients selected for group psychotherapy were referred for psychological evaluation and treatment, by the Activities for Daily Living committee at the Home. The Activities for Daily Living conferences are attended by the heads of the departments of physiotherapy, medicine, social service, dietary, nursing, occupational therapy, speech and hearing, psychology as well as by the Administration. Patients who present adjustment problems in the Home are discussed by the committee and a suitable program for helping the patient is evolved. The geriatric patients utilized in this study were selected for group psychotherapy following psychological testing, psychiatric evaluation, and a thorough analysis of each patient's case history. Patients selected were of at least average intelligence, able to verbalize in English and in fairly good contact with their surroundings. Withdrawn patients were admitted to the group as seclusion presents one of the major adjustment problems in a Home for the Aged. Psychotic patients were admitted as long as they were in contact with reality at times, and were not overly delusional. One such patient was included in the group.

Composition of the Group

The members of the two groups selected were nine male, and three female residents who presented varied adjustment problems in the Home. The members ranged in age from 65 years to 88 years with a mean age of 75.6 years. One group member was diagnosed as psychotic with delusions of persecution, six of the members as reactive depressions, possibly caused by their admission to the Home, three members as passive aggressive personality-dependent type and two as anxiety neurotics.

Goals

Treatment goals for the patients centered upon creating better adjustment to institutional living, improvement of relationships with other aged persons in the Home, as well as members of the family, and strengthening of healthy defenses which would increase feelings of self esteem and self worth. Other treatment goals were to help develop new positive interests in activities in the Home such as physiotherapy, occupational therapy and recreation.

METHOD

Group Therapy meetings of ninety minutes duration were held once a week. During the initial meetings the members of the groups ventilated feelings of anger, depression, isolation, and rejection. The patients described themselves as "the living dead" and focused upon reports of their somatic complaints. In order to maintain rapport and lead the group into discussions of their problems, the therapist elicited from the members topics which they wanted to discuss. The members responded in a positive fashion and introduced for discussion, problem areas such as loss of memory, loneliness, fear of death, illness, and poor relations with children and other members of the family. The directive techniques of suggesting topics for discussion enabled the groups to express their feelings as is demonstrated by statements made by members of the groups. "No one cares whether I live or die," "I feel guilty. My guilt is my old age," "All I want is a kind word," "Before I was something, now I am nothing," "Sometimes I feel so lonely I wish I could end it all." By responding in this manner to the proposed topics the patients were able to express some of their repressed feelings.

Another directive technique, active intervention on the part of the therapist with other staff members, helped a member of a group to express his feelings regarding the frustration of his dependency needs. On this occasion the group member complained of not getting proper food for his diabetic condition. The therapist consulted with the dietitian who proceeded to revise the patient's diet. In meetings following the revision of the patient's diet, feelings concerned with impotency, inadequacy and resentment of forced dependency on others, were explored by the group.

A failing of the technique of active intervention was graphically illustrated when a group member requested the therapist inquire as to "why he was not getting a larger supply of nitroglycerin tablets." Upon inquiry, the therapist learned the patient was forming a psychological addiction to this medication and the dosage of medication had to be rationed. The therapist, in this instance, was therefore unable to interpret to the patient the reasons for the rationing of his medication, which led to a temporary regression in the patient's condition.

Another deviation from orthodox technique is the contacting of children when the therapist feels this is therapeutically necessary. On one occasion, contact with a patient's daughter enabled the patient to visit his daughter for a five-day period. In this instance the therapist's active role enabled the patient to overcome his withdrawal from family contact, and following his return to the Home, to relate in a positive fashion to other patients.

A special problem encountered in group therapy with the aged is the use of illness as a form of resistance to becoming involved in treatment. Frequently patients would not attend meetings using illness as an excuse. This was illustrated during one session when a patient left the group meeting following a discussion in which he allowed himself to become very angry. The patient stated he felt weak, faint and "ached all over." The patient in this case escaped from the threatening situation by withdrawing, using somatic complaints as a subterfuge. In the following days the therapist met with the patient for individual therapy and discussed his feelings in relation to his withdrawal from the group. Shortly after these individual meetings, the patient rejoined the group and was able to interact on a feeling level with the other members.

As reported in a previous paper the use of age and illness as a defense against coming for therapy is a particular problem since the therapist can not challenge the patient directly. The geriatric patient uses illness as a method for attracting attention, a form of adjustment and a method of control.

Other unique problems such as lack of sexual drive and preoccupation with death are handled in an accepting supportive manner in order to reduce the threat posed by the realization of one's impotency and nearness to death.

Results

In order to evaluate the results of the patient's involvement in group therapy, department heads of the different disciplines in the Home were consulted.

In general, the members of the groups appeared more outgoing than when first seen. The patient who had been diagnosed as psychotic, while he still maintains his delusional system, is now assisting wheel chair patients in physiotherapy. Four of the patients diagnosed as Reactive Depressions and two of the Passive Dependent patients seem less withdrawn, manifest less anxiety, involve themselves in some recreational activities, and also attend weekly counseling meetings held in the Home. The other members of the group have demonstrated little overt change, except for small weight gains due to an increase in appetite.

At present, retesting, utilizing psychometric techniques, is taking place in order to evaluate gains in treatment. These results will be reported at a later date.

Group psychotherapy in a Home for the Aged appears to be a valuable technique when utilized with patients with severe emotional disorders. The techniques described and offered have been found most useful in the administration of such treatment.

PSYCHODRAMA IN A CLINICAL PASTORAL TRAINING PROGRAM[1]

ISRAEL ELI STURM, PH.D.

Worcester State Hospital, Worcester, Mass.

A series of psychodramas with Protestant theological students and ministers took place as part of a Summer School of Pastoral Care conducted at a state mental hospital (Worcester) under the auspices of the Institute of Pastoral Care and a theological seminary. The objectives for the Summer School students were (*a*) clinical, to experience the special problems of ministering to the mental patient; (*b*) personal, to learn to understand themselves better; and (*c*) theological, to enhance their competence as clergymen in the community. For these purposes, then, the training program offered seven weekly psychodrama sessions which were conducted by the writer and at which attendance was voluntary. The purpose of this paper is to indicate some of the results of applying the psychodramatic method to the exploration of clinical, personal, and theological issues that are pertinent to such a pastoral care program.

CLINICAL ISSUES

The unique contribution of psychodrama in any clinical training setting would be that of providing the staff with the opportunity to assume the disturbed person's point of view. A recurrent sequence in the psychodrama series was therefore that of the students' re-creating the behavior of actual and hypothetical patients. The students thereby had opportunities to experience through role playing the phenomenology of the patient and the rewards and discomforts associated with different diagnoses and symptom patterns. The students also role played scenes where the patient complained that he was not understood by them, or that he was preached at, or that he was subjected to what the students had mistakenly though was "love." By becoming better able through role-reversal to perceive what the patient "really" thought or felt, the students were made aware of the pastoral techniques most suited to the patient's individual needs.

[1] The writer would like to acknowledge the contributions of Rev. John I. Smith, Chaplain-Supervisor at the Worcester State Hospital and Executive Secretary of the Institute of Pastoral Care, who suggested and participated in the psychodrama program, and Dr. Robert D. Palmer, who made helpful suggestions during the preparation of this paper.

Problems often arose when the students would use abstract theoretical terms in attempting to understand and discuss communications from these real or portrayed patients. The director attempted to gradually eliminate much of this inefficient terminology, the hard core of which included such terms as "give of the self," "move into the feeling level," "reveal self as a person," "relate," "accept," "reach," and "share." Gradually the students learned that they could apprehend behavior directly and more accurately without the inappropriate verbal labeling that would inevitably omit important aspects of the total message. The students learned from the psychodramas that interpersonal sensitivities could be refined to eliminate distortions and could be spontaneous, trustworthy, and free of the mediation of text-book terminology.

The psychodrama program also gave the students the opportunity to explore any theories they may have had concerning the effectiveness of a religious approach to "healing" mental illness. Reenacting their relationships with the patients on the ward suggested the likelihood that the problems of the patients should be viewed not as the manifestation of a "sickness of soul" but rather as the consequence of inappropriate behavior in a particular cultural context.

Personal Issues

One of the personal issues that received attention was that of the motivations behind the students' vocational choice. To the students the "call" to the ministry had been an experience of personal and spiritual significance but as a result of a growing awareness of psychoanalytic theories of motivation, some had begun questioning the spiritual validity of their choice. When role playing themselves at the time of their "call" they did not portray the motivations leading to their religious choice as particularly noble or "psychologically healthy" and this discrepancy was generating increasing concern. To counteract this uncomfortable dissonance, the director suggested that the spiritual value of any choice should perhaps never be evaluated in terms of the presumed "health" of its underlying psychological motivation but always in terms of its religious and ethical meaning alone. The students' concern over the weaknesses they felt sure they were compensating for may have abated somewhat, but prodding still was necessary to get them to acknowledge the socially desirable aspect of their choice.

In one case a student complained that he felt he was "going nowhere" in the church and had lost his sense of personal direction. In a psychodrama reenacting his "call" to the ministry he acknowledged that the only minister

he had as a personal model was a cold, aloof person whom he did not basically respect. It gradually became clear when scenes between him and "the minister" were enacted that the protagonist had chosen his vocation because he considered himself cold and aloof—deciding that if this other unpleasant minister could "make it," so could he. With the passage of years, however, the protagonist had become more effective in the ministry to the extent that it could no longer fulfill its original purpose of presenting an adequate vocation for someone with a "deficient personality." Growing personal adequacy had increased his self-respect and had paradoxically diminished the compensatory satisfactions from his position. After the role playing session the student's problem was one of deriving an additional set of satisfactions from his work, rather than one that questioned his entire theological perspective.

Throughout the psychodramas some students manifested a drive for accurate self-expression and frequently asserted that they wanted to ventilate feelings which were suppressed because of social or religious inappropriateness. Psychodramatic enactment made it clear to them that most of the feelings they hesitated to show could be expressed without retribution from director, recipient, or audience. Direct and even intense emotional expression was well-received by the group, and whatever discomfort or hostility was generated either by the object of the emotion or by the audience tended to be short-lived. The ease and directness by which even unpleasant emotions were expressed and received prompted the speculation by the group that, perhaps, the give-and-take of feeling is love and the withholding of it is remoteness and hostility. This new idea was in contrast to the theory that restraining emotional expressiveness is a form of benevolence.

Some students also alluded to feeling they were unable to communicate because of what they termed "repression" or a "communications problem." This reported disability was shown frequently to result from the students' preference for expressing those emotions they considered psychiatrically appropriate rather than those they genuinely felt. On one occasion, after having seen a young female patient run naked onto the hospital grounds, some students expressed concern because witnessing this event did not arouse sexual feelings in them. They viewed their neutral reaction as an indicator that they were undesirably repressed. It was suggested by means of brief role playing, however, that any sexual feeling generated by the sight of a disturbed naked female running at top speed would quite normally be counteracted by antithetical feelings of alarm and consternation, and that

a neutralized reaction was quite appropriate. In the discussion that followed, the group acknowledged the possibility that displacing an authentic response with one supposedly "healthy" is an improper application of psychiatric theory.

Another aspect of the communications problem was reflected in the students' distrust of their own interpersonal sensitivities. On one occasion while a student was in front of the group talking about his father and attempting to describe him, his audience gradually drifted off and became restless. The director inquired why this was so and several members of the audience responded that they thought their sudden detachment was due to authority problems of their own which prevented them from listening to the description of the speaker's father. The director suggested, on the other hand, that perhaps the group was uncomfortable because the speaker had drained from his words all emotion and feeling and that he was not really talking to them. The speaker then volunteered that he disliked his father and he didn't want to speak of him altogether. The group gradually acknowledged that they did feel the student was not involved in his description but they had been loath to blame him and preferred to attribute their discomfort to their own defenses. As a result of this psychodramatic incident the students, who are called upon to deliver sermons, became more aware that there is little communication without the personal concern of the speaker and that boredom is generated by the disinterest of the speaker at least as often as it is by the defenses of the listener.

Although the psychodrama sessions contributed to the solution, or at least elucidation, of some of the problems discussed, other personal problems the director felt were too complex to attempt to handle in the context of the training program. For example, on one occasion a student was surprised to find how uncharactertistically spontaneous and comfortable he was when playing a female role. It became apparent to him and to the group that his real-life masculine role was in some ways incompatible with the female role he considered as "much more myself." The director simply noted the problem and related it to the more general clinical issue of incompatible roles. The accepting atmosphere of the group permitted this personal problem to be raised and shelved without resolution and without apparent discomfort to the student. But a residual and perhaps beneficial effect of the psychodrama may have been present when several months after these sessions the student sought and entered private psychotherapeutic treatment.

Theological Issues

The psychodramas afforded an opportunity for the exploration of numerous theological issues. On several occasions the students enacted situations in which their roles involved behavior traditionally thought of as representing evil. Because the enactment of what might have been distasteful did not have an unpleasant effect, several theories of the nature of good *vs.* evil were examined and evaluated by the group. Considering the recent interest in reformulating mental health concepts in terms of moral issues, this discussion may be worth describing here and can be summarized by postulating a two-phase theory of salvation. In the first phase all elements of the personality are brought into expression for the purpose of self-awareness. For Moreno[2] and for a few members of the student group, the expression of the total personality based on this knowledge is all that is necessary for spiritual goodness, psychiatric health, and productivity; evil could not result from such total expression. Others of the group demanded a second phase, one more in line with traditional theology; they maintained that the first phase of total self-knowledge should indeed be achieved but to express it in real life would not necessarily result in morally desirable behavior. Therefore, they claimed, the true personality should be made apparent only so that the self-disciplining process toward perfection could proceed with efficiency. This issue, bearing on the great unsolved problems of behavior control, remained unsettled.

The private theologies of the students became publicly enacted and thereby subject to the critique of others. One of the psychodramas involved a reenactment of the Book of Job with the students portraying the various characters and attempting to answer some of the many problems it raises. Another portrayed the trial after death of a person who evaluated his deeds and who accused himself of overlooking many opportunities for self-expression, with prosecution and defense arguing before a jury. On several other occasions the students played God, the devil, angels, and many religious personalities. This aspect of the psychodramas encouraged the students to explore new facets of their personal theologies and, when confronted with inconsistencies, to formulate adequate resolutions.

In one session a student enacted, with the accompaniment of enormous emotion, a mystical (non-prophetic) religious experience he had had. This

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[2] Moreno, J. L. The theater for spontaneity. New York: Beacon House, 1947 (originally published 1923).

was a recurrent mystical religious experience that he had wanted to share with the group. The group observed but somehow did not come to believe in its meaningfulness, considering it to be largely what they termed "hysterical." This lack of belief in the face of a protesting experiencer who is absorbed in what for him is an incredibly valid event, may shed some light on the conflicts and problems of consensual validation that may transpire at the time of any new theological revelation.

Limitations to the Effectiveness of the Psychodramas

The potentially greater effectiveness of the psychodramas (or any alternative psychotherapeutic or "sensitivity training" method) may possibly have been circumscribed here by the students' personality characteristics, their theological background, the effects of a parallel group psychotherapy program, and the hesitancy of the director.

In comparison to other psychodrama groups the students were relatively guarded. It was a disquieting sight to see arms folded across chests defending against the beginning of each session. Although the students said that it was worthwhile to explore their underlying motivations, they understandably could not avoid resisting when confronted with unwanted feelings and thoughts. The typical student was moreover self-critical and intolerant of his weaknesses, and he expected his fellow-students to be equally critical of him. As a result of these processes, the mechanisms of suppression and repression were heavily reinforced and the amount of material hidden from awareness and considered unworthy was for the individual unusually large.

The students' defenses were reinforced by a religious culture that has traditionally had little encouragement for uncritical expression and exploration. This situation obtains at least in part because although it is written "ye shall know the truth and the truth shall make you free,"[3] it is also written that "whoseover looketh on a woman to lust after her hath committed adultery with her already in his heart."[4] The students were thus confronted with the dilemma of possibly being morally responsible for deeds as of the moment the potential behavior reached awareness, if not while it was still unconscious. While appearing to have assimilated psychoanalytic theory, then, the students understandably still adhered to "Victorian" dynamics of adjustment that were reinforced by the vestiges of puritanism in their backgrounds. This situation may have been mitigated somewhat

[3] John 8:32.

[4] Matthew 5:28.

by unusually long warm-up periods during which an attempt was made to encourage the group's perception of the director and the total situation as non-threatening.

An unknown proportion of the effectiveness of the psychodrama program may have been reduced by an unrelated twice-weekly group psychotherapy program which was conducted in smaller groups by various chaplain-supervisors. As a result some issues that had begun in psychodrama were concluded in the group therapy sessions and interesting interpersonal issues raised in the group therapy sessions were terminated before reaching the psychodramatic floor. This situation was beneficial for the students but it may have limited the content and continuity of the psychodrama program. A combined group psychotherapy-psychodrama program with the same participants would have permitted continuity and mutual reinforcement by the two interrelated systems.

The psychodramas may also have been limited by the cautiousness of the director who adhered to the principle that there should be no inquiry into the essence of the religious idea. In fact the director would get quite concerned when students would attempt to qualify or alter a religious belief or value on the basis of some mental health concept, on the grounds that such a procedure implicitly religious truths subordinate to psychiatric assumptions. The validity of religion was accepted as a premise by the director and the psychodramas never explored its meaning. Perhaps in systematically investigating the basic axioms of existence psychodrama will acquire a new frontier.

Conclusion

A program of psychodramas for theological students studying clinical pastoral care in a mental hospital was described. The technique was applied to clinical, personal, and theological issues. The experiences in the program provided the students with opportunities for increasing their self-understanding and their competence as ministers and theologians.

RELIGIOUS PSYCHODRAMA

RABBI ALVIN J. BOBROFF

Island Park, N.Y.

Religious Psychodrama is that type of group psychotherapy which deals with the personal problems of individuals associated with religious feelings. The director starts the group therapy session by asking for volunteers to suggest a religious topic that they would like to have discussed. Then the different members of the group are encouraged to give their points of view on the topic. When the director observes one of the individuals getting emotionally involved, he focuses the individual on some scene associated with his emotion.

In a characteristic session a woman raised the question "Why Doesn't God Answer People's Prayers?" In the discussion the woman became very angry and said, "God can be very mean at times," and indicated that God had forsaken her in time of crisis. The director asked her, "Was there ever a specific instance in your life when God disappointed you?" At this point the woman revealed that following childbirth she was very ill and had overheard her doctor saying that she would not pull through. She now felt that God had forsaken her and she became very angry. The director set up a scene between her and the Doctor where she learned that the Doctor had really said that she was not fighting hard enough. She passed the crisis and as the scene unfolded further she revealed that she became angry again with God when she prayed to him to help her recover rapidly so that she could return to her family, and instead it took a long time. The director asked her if she had ever received help when she needed it and a second scene was set up with her father when she was a young child.

It soon bcame apparent that father did for her what she should have done for herself. During a "role reversal" she as father realized all of this, and learned through the auxiliary ego who was playing her part how to become self-sufficient, instead of dependent.

She then played the scene all over again as the young child who was now self-sufficient and happy in her new found strength, and rejected the overprotectiveness of her father. She learned that she had accepted God as an overprotective father, and expected that God would protect her from all harm and grant every wish she made. In a further scene she prayed to God within her, asking for more strength and courage to be a better wife and mother.

In the group discussion we learned that different members of the group identified with this expectation that God would do for them what they were not ready to do for themselves. Because of their disappointment in God they neglected not only themselves but also their family. With this new understanding they expressed the desire to become more self-sufficient and allow their children the same privilege.

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PROBLEMS AND APPROACHES IN CHILD GROUP PSYCHOTHERAPY IN A PUBLIC SCHOOL MILIEU

B. J. Speroff, Ph.D. and Dan Simon, M.A.

East Chicago Public Schools, Indiana

The feasibility of group psychotherapy in an academic environment—especially with teen-age children—is a relatively unknown and primordial experience. While the concept of group counseling and/or guidance has received more than superficial attention, still less is known of the relative merits, problems, and issues involved in the applicability of the group psychotherapy process within a public school setting. While Moreno did much pioneering work with children, especially via psychodrama, group work with school children in a school setting per se is a comparatively rare and recent venture. (1, 2, 3, 4, 5)

Prologue

The impetus for an experiment in the use of group psychotherapy with school children came from the school administration of a city that was a leader in "innovative education." The socio-economic and ethnic conditions of the community are such that in this dynamic polyglot, formal and rigid didactic practices, dogmas and standards do not squarely meet the needs of the school community. The variegated personal and inter-personal problems engendered by the social milieu, the extreme differences in ethnic background, the diverse intellectual capabilities, and a host of other interdependent factors all focused upon the need for remedial assistance to those children who, for one reason and another, proved to be "problems" to the schools. In recent years, whether due to more efficient referrals by the teachers, lack of teacher effectiveness in dealing with sundry types of student behavior, the rapidly changing social values system, or what have you, an increasing and disproportionate amount of time was being spent by school administrators in dealing with "problem" pupils.

A review of this entire aspect indicated most of the so called "problem" pupils could be placed in one or a combination of three rubrics:

(1) those who created problems because they were under-achievers, (including marginal intellectual qualities, poor motivation, ineffective study habits, dislike for school and/or for teachers, etc.);
(2) those who created problems due to chronic excesses (including

tardiness and absences without good and sufficient reason, stealing and lying, horse-play, or causing distractions in class, etc.); and

(3) those who created problems due to personality deficiencies (including extreme shyness or aggressiveness, interpersonal conflicts, poor attitudes, insecurity, loss of self-confidence, etc.).

Part of the envisaged undertaking included an awareness and recognition of dealing only with the problems and situations immediately within the bounds of the background and training of the counseling staff and the time limitations available to them. By and large, the six full-time counselors at the two high schools had the background and the training requisite for individual counseling but no experience in group therapy approaches, techniques, and dynamics. (It was to the credit of the school administration that the six counselors were invited in the group sessions to act as auditors and later as group counselors as part of in-service training. In this manner, later in the training program, each counselor was assigned to his own therapy group.)

Since an examinoation of the available literature revealed a paucity of information existed (and then it proved contradictory oftentimes) specifically as to the guide lines to be used in setting up the child therapy groups, it was decided, inasmuch as this was a pilot operation, to experiment with the two high schools along dissimilar lines. At each high school a meeting was held consisting of the Assistant Principal, Dean of Girls, and the three full time counselors. The purpose of the meeting was threefold:

(1) to explain the underlying reasons and aims for the group psychotherapy program;

(2) to define the nature, scope, and characteristics of the therapy group (and in effect these were of two kinds):
   a. remedial
   b. personality; and

(3) to establish a modus operandi and referral system for conducting the therapy sessions.

At the outset, it was recognized numerous questions and issues would be encountered both from the counselor group and the counselee groups; also, it was recognized that the level of sophistication and experience at the one high school exceeded that of the other, consequently no hard and fast rules were laid down as to the exact composition of the therapy groups, except for two:

(1) no group should consist of more than six members; and
(2) the reasons for inclusion into a particular group should be as similar as possible, i.e., a commonality of problems should exist.

At both high schools the Assistant Principal, in conjunction with the Dean of Girls, drew up a list of individuals who would make likely candidates for group psychotherapy, and, on the basis of their own knowledge of these individuals and their problems, screen and establish two therapy groups. At the one high school, it was decided to create two groups, each group consisting of five individuals of the same sex. (The degree of problem commonality in the case of the girl group was exceedingly high; whereas in the instance of the boy group it was considerably lower.) At the other high school, two groups were established likewise, but each group consisted of ten individuals with a 50-50 mixture of the sexes. (The degree of problem commonality was especially low in each group.)

Problems and Issues

Prior to the initial sessions in both schools, each counselor was administered a Q-sort for the purpose of assessing the counselor's attitudes and feelings about himself (self sort) previous to undergoing in-service training. Of the three counselors at each high school, two were men and one was a woman. At the high school there were two therapy groups; a woman counselor met with the girl group, while a man counselor met with the boy group. The third male counselor acted as a "floater" between the two groups, but in practice he met with the boy group. At the other high school there were two groups also, but, in this instance, the two men counselors were assigned to the two groups, while the female counselor acted as a "floater" between the two groups. The modus operandi thereupon was simple: the therapist-trainer would meet with the assigned counselor and his group at a specific date, time, and place—usually for 55 minute periods on Mondays.

At the one high school, where the two groups were small and consisting of the same sex, the same groups met continuously for twelve weeks. In the case of the girl group particularly the degree of rapport and cathartic element were established and maintained throughout without much priming or resistance. This high degree of fluidity doubtlessly could be attributed to the fact that the girls all had similar social problems, knew each other fairly well, and were white Caucasians. The boy group, on the other hand, was slow to coalesce, difficult to motivate and keep talking (albeit there were several episodic exceptions), and the therapist had to continuously act

as the catalytic agent. This low degree of group cohesiveness probably could be attributed to the dissimilarity of the social problems, lack of vis-à-vis, familiarity with one another, and the mixed racial and ethnic backgrounds of the individuals.

At the other high school, where the two groups were large and composed of mixed sexes, it became evident after the third group session, that the groups in toto were too cumbersome and incompatible to work with effectively. At the beginning of the fourth session therefore each group of ten was broken down into two mixed sub-groups, called "A" and "B," and met with the therapist and counselor on alternate Mondays. But here, as in the case of the boy group at the first high school, the melding of the group was less than successful because of the same factors, viz., dissimilar social problems, a lack of interpersonal familiarity, and mixed racial and ethnic backgrounds. At the beginning of the ninth session, gleaning a page from the apparently more successful separate sexes approach utilized in the first high school, the groups were revamped so they now consisted of 8 boys in one group and 8 girls in the other group. (At this same time one male counselor worked with the boy group, the female counselor was assigned to the girl group, and the third male counselor became the "floater.")

Broadly defined, the purposes of these group sessions were threefold:

(1) to develop a permissive forum for exploring and resolving problems;
(2) to afford an opportunity for the "problem" pupils to learn from one another's experiences; and
(3) to provide a framework of support and socialized development.

At the initial meeting the general aims of the sessions were not spelled out to the groups purposely; rather the emphasis was placed on "getting together to discuss, examine, and even work out some problems, complaints, and gripes." The closed and privileged communication nature of the sessions was made abundantly clear as well as the roles of the therapist and counselor. (It is interesting to note that each of the four groups reacted quite differently and showed a remarkable correlation to their own cohesiveness; essentially, the higher degree of intra-group rapport and cohesion the more readily would they accept the principle of privileged communication.)

The actual nurturing and evolution of the counselor's role, both with respect to the therapist and his group, was left undefined for experimental reasons. Among the central reasons for leaving the role of the counselor undefined was to empirically test the relationship between the Q-sort cor-

relation and the length of time before the counselor moved from a passive to an active role in the sessions. A second hypothesis tested was that the counselor who early entered actively into the sessions was a more experienced and/or sophisticated counselor. A third hypothesis tested was that a counselor becomes less dogmatic, self-assured, or omnipotent in his personal convictions and/or deportment as a function of experience in group therapy.

Epilogue: Conclusions and Recommendations for Follow Up

As a result of this series of initial exercises in the use of group psychotherapy with children within the school environment, a number of important lessons were learned. As alluded to at the outset, a review of the available literature provided little definitive assistance as to pitfalls and problems to be encountered or to be dealt with. The guidelines developed from experience with adult group psychotherapy were found, in more cases than not, to be inapplicable. In large measure therefore trial and error (with revision and/or inclusion of new findings) proved to be the developing thread in these on-going sessions. What was learned—either positive or negative—in one session was transferred to the other group sessions.

As a result of the first phase of these experiences, several conclusions—that affected the selectivity, structure, and dynamics of the groups for the second phase (which shall form the basis for a future report)—became manifest.

I: Unlike adult groups, wherein age and sex factors are generally speaking minor considerations, in child groups (ages 13–18) age and sex play a preeminent part. Based on first phase experience, it was found the most cohesive and fruitful groups were those that contained:

(1) children of like sex;
(2) consisted of five to eight members;
(3) members who knew, or knew of one another prior to meeting as a group;
(4) children of the same or allied racial and/or ethnic backgrounds;
(5) children within the same grade levels (and not more than 3 years difference in ages);
(6) children with the same general problem backgrounds.

II: Groups should meet regularly at least once a week for approximately 50 minutes and preferably twice a week. (Originally the groups met on a fixed schedule—meeting the same day and during the same school

hour. Because most of the pupils were marginal, academically speaking, one of their chief complaints was they were "flunking" the particular course they were missing to be in the therapy groups.) Furthermore, these groups should meet on a rotating basis—meeting a different hour each week on any given day—so that no one class subject should suffer at the expense of the therapy session.

III: Due to the "chemistry" of the group, it may be deemed necessary, in the view of the therapist and/or counselor, to drop out a member of the group. Considerable care should be exercised thereupon that both the dropped-out member and his group be appropriately apprised of the reasons or causes for such action. (It is at this juncture extremely vital that recommendations in line with the above cited points be followed so that a compatible group replacement for the group can be found. While the matter of securing group acceptance before the entree of a new member takes place is most often desirable, this procedure is not really a requisite within the school setting, it has been found.)

IV: Adequate background—anecdotal, historical, academic and personality—is sorely needed both to aid in the proper assessment of each pupil as to acceptability for group therapy and in the selection and placement of that individual within an appropriate group. (The first phase experience revealed the paucity of background information possessed on the individuals who comprised the original groups; and, as a consequence, the school administration has initiated a cumulative records program aimed at rectifying this deficiency.)

In sum, it appears the initiation of an experimental project in child group psychotherapy within a public school milieu proved to be one replete with trial and error. With little definitive guidelines as to the problems and pitfalls to be encountered, specifically in a school environment, it was found the general procedures and practices of adult group therapy were not especially useful. This experience proved most beneficial in pointing out the complex and intricate avenues of the mechanics involved in working with young children within the public school settings; and, while this project may in some ways be viewed as a pioneering pilot, it has served as a true learning exercise from the standpoint of causing a thorough review and reformulation of the bases and rationale that were adapted in the second phase of this program (which shall deal with the dynamics of the group).

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EFFECTS OF GROUP PSYCHOTHERAPY ON ATTITUDES OF NURSING STUDENTS[1]

EDITH SCHULZE DECK, M.S., *UCLA Medical Center*[2]
SISTER JOHN BERNARD HURLEY, M.S., *Mount St. Mary's College*
EVELYN CRUMPTON, PH.D., *V.A. Neuropsychiatric Hospital, Los Angeles, California*

INTRODUCTION

The aim of the study was to evaluate the effectiveness of group psychotherapy in a teaching rather than therapeutic situation. It was hypothesized that nursing students who work out their own anxieties in group therapy learn more from a psychiatric ward assignment and become more effective in their relationships with patients. This hypothesis received support in a study of four semesters of nursing students assigned for practicum training to a V.A. Neuropsychiatric Hospital.

Each semester, one group of students received group psychotherapy; one did not. At the beginning and end of each semester, subjects were given psychological tests (California F and CMI attitude scales; adjective checklists for self, ideal self, and good nurse; and MMPI with instructions to respond as the "typical Brentwood patient" would respond).

Statistical analysis of results supported the following conclusions: The students in the psychotherapy groups became less rigid in their attitudes. They became more realistic in their conceptions of themselves and of psychiatric patients. The students came to the psychiatric ward to learn, and their own group therapy helped them to use the experience more effectively.

Eight nurses met in a small room to talk about fear. Seven were nursing students exposed for the first time to a psychiatric ward. One was an experienced psychiatric nurse training in group psychotherapy. Object: learning.

At the same time, a second group of nursing students carried on their

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[1] From the Veterans Administration Neuropsychiatric Hospital, Los Angeles, the School of Nursing and the Department of Psychiatry, UCLA Medical Center, and the Department of Nursing, Mount St. Mary's College, Los Angeles, California. The authors gratefully acknowledge the clerical and computational assistance provided by Miss Marie Brady and other workers of the NP Psychology Service Statistical Unit.

[2] Now at School of Nursing, University of California, Berkeley.

usual activities on the ward without themselves having the experience of taking the patient's chair in group psychotherapy.

These were our subjects. We believed that nursing students who work out their own anxieties in group psychotherapy learn more from their psychiatric ward assignment and become more effective in their relationships with patients.

To test our belief, we studied four semesters of nursing students assigned from Mount St. Mary's College to an acute intensive treatment ward of the Veterans Administration Neuropsychiatric Hospital in Los Angeles (known as Brentwood).

Each semester, one group received psychotherapy, one did not. Psychological tests were given at the beginning and end of each semester and the results evaluated statistically. The research team consisted of the nursing instructor, the group psychotherapist, and the psychologist.

The Instructor Sees the Problem—and the Solution

I was frustrated. Faced with a group of college seniors in their first psychiatric nursing experience, I felt as if there were a thick wall between us. They looked all right, but they were scared. But would they admit it? No! I was an instructor, a natural enemy. They had to find out what I wanted from them and give it to me. From their fifteen years of experience with teachers, they were sure that they had to be enthusiastic about the subject, that patients had to be accepted no matter how they looked or acted, that anything they said or did would be evaluated and would affect their grade.

To the students, the ward was large. There were 200 patients, all men. Many of them behaved strangely. A lot of the things they said didn't make sense. Some of them were dirty and disheveled. They were not physically ill; they were all up and walking around. The whole situation was very different from their experiences with patients who were in bed and for whom you could do things. There didn't seem to be anything to do for these patients.

Too, there were psychiatrists, psychiatric nurses, social workers, and psychologists around who spoke in a strange language and seemed to know a great deal about people. They could probably read students' minds, so they had better make their defenses even stronger.

The students would not talk about how they felt. They knew all about instructors. They had had lots of experience and had a system designed to

get the best possible grade. The semester would be over before I could get through that wall. I had to do something—and fast.

Then I thought of a solution. Why not ask the head nurse on the ward, who was experienced in group psychotherapy, to conduct a therapy group with my students? She had no authority over them. She would not be grading them.

I told the students that they needed to know something about group process and the way to do it was to have a group of their own. The group would not have anything to do with their grade, and I would not know anything about what went on.

I had some expectations about what the group might do for the students. First, if they could talk about their fears and ideas about mental illness, the patients and the hospital, their anxiety should decrease to the point that they could deal with patients more comfortably. The group experience should help them to recognize and accept their own feelings of fear, anger, inferiority, anxiety—to learn that it's all right to have feelings.

And, too, I noticed that the students readily identified with the head nurse. They wanted to be the kind of nurse she was. In the group, they might learn some of her techniques of working with people—patients, staff and each other.

After several semesters, we believed that the groups were helpful. We decided to set up a formal research project to find out.

The Therapist Meets With the Nursing Students

Group psychotherapy with normal people was new to me, although I had worked with psychiatric patient groups for several years. When I met with the nursing students, I told them we would be meeting once a week so they could talk about their feelings about the ward and the problems they have with their patients; also, if this brought up any other problems they might have, that this would be the time and place to discuss them.

Each time I started with a new group, I had about the same goals: that they learn to accept mental illness; that they know that there is a role for nurses; that they are able to help bring about a change in a patient; that there are many problems that we all have as people; and the important thing is to learn how to deal with these particular problems as they come up. These were the only expectations that I had of the groups—that they develop an interest in patients, in other human beings and a deeper understanding of themselves. I had no intention of trying to uncover "deep conflicts."

The first group reacted with, "Oh, we're used to groups, this isn't really anything new." But it *was* different.

Their first few sessions were always centered around particular patients. "This man is dirty, how can I possibly work with him—I can't even get close to him because he is dirty, he doesn't look like he's ever had a bath . . . what kind of nursing care is this . . . he's different from me."

At first they tried to look for the biggest differences they could find. It was as if they were afraid to look at the patient who was in remission or who was in good contact because he was much closer to the way they were—and this was very frightening.

The students came in with many preconceptions of what a psychiatric nurse was. "She is a custodian." "She isn't interested in taking care of people." "She runs into psychiatric nursing to get away from people." "If you have worked in a mental institution for more than three years, you cannot sit on jury duty."

What they were trying to tell me was, "You have been working here for three or four years; you must be as crazy as the patients are." And this, I felt, was an example of the distorted ideas that people in general have not only about the people that work with psychiatric patients but also about psychiatric patients themselves—that they are less than human.

Probably they were also telling me, "If we have to stay here for one semester, we, too, will be just as crazy as the patients."

When they first started talking about the patients, the students left themselves out. Their discussion referred only to patients. Next came descriptions of themselves and the patients—they were beginning to include themselves in this interaction process. Then they left the patient and became preoccupied with their own problems at school, authority, other students. Finally they were able to discuss what was actually happening in the group. They saw that they reacted in other situations the same way they related in the group.

They would switch back and forth: If a topic got too hot for the group to handle at a particular time, back would come the patient—always a safe subject.

Sometimes I would say, "I wonder why Miss X changed the topic?" It depended upon the strength of the group whether they were able to pick this up; sometimes they would let it drop—my clue to leave it alone. If some of the other members of the group could bring up their own feelings, they would pick up this with, "Well, I know why she changed the subject, she isn't able to express her feelings about this."

At first the students asked me questions. "How can I sit next to Mr. X, he never says anything?" "What do you do with Mr. X?" Sometimes I answered the question but usually I said, "Does anyone else feel this way?" Then they began to talk to each other.

When a student became frightened about the similarities between herself and a patient, the other students banded together and pointed out the differences. "Sure we use the same mechanisms, but we're not sick." Soon they began to think that the patients were not so sick either.

In nearly every group an example would be brought up about someone who had been discharged from a mental hospital. They realized their fears of catching schizophrenia were unfounded.

As they became more aware of their conflicts, they felt more confident about their ability to handle them.

I always thought it was a healthy sign in the group when the students began to talk about their lives outside the hospital. They were all young, still bothered by adolescent problems, and they were searching for their own values. Most of them felt that they had led too sheltered lives and that they really didn't know much about living. Yet they were concerned about how fast they were growing up. Would their nursing experiences make them different from the other "college kids"?

Most of the students had Sisters as teachers in parochial schools; now they had ambivalent feelings about the Sisters who were their fellow students. In each group they reached the point of "telling the Sister off," and she would be able to say, "All right, you're angry. But we're in this group; let's talk about it."

Not every group got this far. The first research group members felt that they were guinea pigs. I tried tape-recording, and it wrecked the group. They were immobilized by their anger. Whenever anything important came up, a complete silence would hit the group, it would frighten them so. They covered up with party behavior.

As the end of the semester approached, the students began to look ahead. They were college seniors and were concerned about what they were going to do about their future. They were psychologically leaving the group.

After my experience with the groups, I believe that we must reduce the anxieties of coming to a psychiatric ward before learning can be really effective. Group psychotherapy is important in the education of the nursing students.

The Psychologist Looks at the Results[3]

I put the girls through two hours of psychological tests during their first week at Brentwood and again during their last week. The instructor told me, "They were usually afraid of the beginning tests. They would say, 'They're trying to analyze us; they're going to find out all about us.' And then their last tests, they just groaned."

The instructor told them only that they would be given some tests and that the psychologist would explain them. I told them each time that we were evaluating the training program itself, never mentioning about one group having therapy and the other not having it. None of them seemed to connect the testing with the group therapy.

We expected the psychotherapy experience to have some effect on the attitudes of the girls toward themselves, toward others and toward patients in particular.

First I gave them two attitude scales—the California F Scale (Adorno *et al.*, 1950) which was developed as a measure of authoritarianism, and the Custodial Mental Illness Ideology Scale (Gilbert & Levinson, 1957), which was designed to bring out custodial, safety-oriented attitudes or treatment-oriented, humanistic attitudes toward patients. Then I gave them a list of about 200 adjectives (Fishman, 1957) and had each girl circle the words that described how she was, how she would like to be, and how she thought a good nurse should be.

Last came the Minnesota Multiphasic Personality Inventory, 373 statements to be answered true or false. I told them, "Answer as you think the typical Brentwood patient would." The students really groaned at this, but their conceptions of how patients would respond to these statements turned out to be surprisingly realistic, and became even more realistic at the end of the term.

The aim of the testing and statistical analysis was to find out how the students who were in the psychotherapy groups changed compared with the students who did not have group therapy. But everybody changed.

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[3] The description of results is based on statistical analysis of differences between the experimental and control groups at the beginning and end of the experimental period. Discrete variables were evaluated by means of the Chi Square test and the tables of the binomial probability distribution, continuous variables by means of the *t*-test. All findings reported are significant at the .05 level or better. The California F Scale, CMI Scale, and MMPI are described fully in the literature. Copies of the adjective checklist and more detailed description of results are available from the junior author.

Certainly no one could work in a psychiatric hospital for four months without having the new experience affect them in some way. The girls got to know patients, and they became more progressive in their attitudes and more realistic in their conceptions of patients. They became even less authoritarian in their general attitudes. (According to stereotyped ideas, girls who attend a Catholic girls' school should score on the authoritarian end of the F scale. But out of 28 items they agreed with only one authoritarian attitude: "Science has its place, but there are many important things that can never be understood by the human mind.")

But the group psychotherapy sessions did something over and above the intensive educational program and experience with patients to which everyone was exposed. Changes were similar but, on the whole, the girls who had therapy changed more.

On both total scores and the individual items the differences, for the most part, were about what we had expected. The students who had therapy either changed in the direction of more disagreement or showed no change on the F scale items, "Homosexuals are hardly better than criminals and ought to be severely punished," and "Nobody ever learned anything really important except through suffering." In contrast, the control group students agreed more with these attitudes at the end of the term. The experimental group students changed more than the control group, some of them disagreeing more, but some agreeing more on the item, "The wild sex life of the old Greeks and Romans was tame compared to some of the goings-on in this country, even in places where people might least expect it." The girls confirmed our prediction on the CMI item, "Once a schizophrenic, always a schizophrenic." Experimental group subjects changed to more disagreement; control subjects changed to more agreement.

The girls who had therapy crossed us up on two items. At the end they agreed with the CMI scale statements, "We can make some improvements, but, by and large, the conditions of mental hospital wards are about as good as they can be considering the type of disturbed patient living there," and "In experimenting with new methods of ward treatment, hospitals must consider, first and foremost, the safety of patients and personnel." In both cases the control group subjects did not change. We were surprised, since on the whole the girls who had therapy had become more progressive in their ideas about treatment than the ones who did not have therapy. We speculated that the students who had therapy might have been showing their loyalty to their ward merely because they like Brentwood better than the

other girls did. And we also wondered if perhaps we ourselves may think too much of our own safety.

There were many changes in adjective checklist ratings which occurred for the girls who had therapy but not for the controls, and again many changes which occurred for control subjects but not for the experimental subjects. Although the changes were not absolutely consistent, we had the impression that the therapy group members changed their self concepts in the direction of somewhat greater sophistication, and they set less rigid standards for themselves. The control group subjects on the other hand, tended to become somewhat complacement.

The two groups initially described themselves in much the same terms but after receiving group psychotherapy, the students no longer said they were: careful, hopeful, independent, intelligent, natural, rational and trustful. They no longer said they would like to be: moral, strong, and tender. They no longer said that a good nurse should be: affectionate, humble, and moral. Although they had not said so before, after therapy they said they were: gentle and normal; and they said that a good nurse should be: original.

At the end of the term, without having had group therapy, control group subjects no longer said they were: gentle, normal, truthful, and warm-hearted. They no longer said they would like to be: gay, humorous, real, and resourceful. They no longer said that a good nurse should be: cautious, humorous, and watchful. Although they had not said so before, at the end of the control period they said they were: ambitious, feminine, loving, rational, and self-conscious. They said they would like to be: genial, introspective, normal, peaceful, rational, satisfied, strong, and work-oriented. They said that a good nurse should be: desirable, expressive, introspective, lovable, peaceful and satisfied.

From the MMPI profile of scores, the students' patient would be described as a chronic schizophrenic, probably paranoid, or chronic undifferentiated in subtype, with considerable hostility toward authority and toward society, and with noticeable tension and anxiety. The "actual" patient (Crumpton & Wine, 1961) would be described in much the same way, except that the condition would be noted as fairly well stabilized with fewer blatantly psychotic symptoms and generally somewhat more effective ego functioning still present. By the end of the semester the students came to see the patients as not quite as sick as they had thought (but still a lot sicker than the patients really are), and as having a little more character disorder in their makeup. The students who had therapy did a somewhat

more realistic job of simulating the "typical Brentwood patient" on the MMPI than the students who had no therapy. Compared with the control subjects, they saw patients as more likely to act impulsively and as more likely to be obsessive worriers.

Now That It's Over

What do these results really mean? The students in the psychotherapy groups became less rigid in their attitudes. They became more realistic in their conceptions of themselves and of psychiatric patients. The students came to a psychiatric ward to learn, and their own therapy helped them to use the experience more effectively.

The experimental stages are over, but the psychotherapy groups continue, because now we know they are doing the job we wanted them to do. The student becomes more effective as a nurse when she is able to drop her professional defense and look at herself as a person.

SATIATION EFFECT IN VOCATIONALLY ORIENTED GROUP THERAPY AS DETERMINED BY THE PALO ALTO GROUP PSYCHOTHERAPY SCALE[1]

WALTER A. PRUITT

Jewish Family and Children's Service of Denver, Colorado

There is an adage in our culture that "one can't get too much of a good thing." In their own area, experimental psychologists have tended to dispell this notion through innumerable satiation studies; however, a search of the research literature has indicated that this idea is still accepted in psychotherapeutic circles and appears to be especially true in reference to group psychotherapy. For example, this writer was unable to find a single study concerned with the problem of how long group therapy should continue.

The present study therefore was initiated to determine if there might be an optimum period for the duration of group therapy. Specifically there was concern with emotionally disturbed, vocationally handicapped persons, undergoing a form of vocational group therapy. While we were aware that any significant findings would not necessarily have an across-the-board applicability, we did feel that this study might serve to stimulate further research in this area. Vocationally oriented group psychotherapy is defined here as a type of group therapy in which the content of the discussion is structured to include problems having no vocational implications. Any topic which is either directly or indirectly related to past, present or future vocational adjustment is appropriate for group discussion. Delusional and other bizarre material is excluded and intellectualization on the part of the participating members is also discouraged.

METHOD

Subjects

The *Ss* in this study were 19 emotionally disturbed and vocationally handicapped rehabilitation clients of the Utility Workshop of Denver. These *Ss* ranged in age from 16 to 60 years, with a mean age of 31.4 years. Twelve were male and 7 were female. The diagnostic break-down of these *Ss* is as follows; 13 schizophrenics, 5 character disorders, and 1 neurotic.

[1] This study is a part of a larger research project supported by a grant from the Office of Vocational Rehabilitation, U.S. Department of Health, Education and Welfare. Project No. 487.

Procedure

Over the 18 month period of this study, these *S*s participated in the group therapy for periods ranging from 16 to 108 sessions. The group sessions were an hour in length and were held twice a week.

The Palo Alto Group Psychotherapy Scale (PAGPS) (Finney, 1954) was the instrument used to measure the effects of therapy. The scale consists of 88 items which evaluate the group participation of members with special attention to bizarreness of behavior, level of participation, meaningfulness of contribution, and motivation for improvement. This scale was completed by the therapist on a bi-weekly basis. Each bi-weekly rating scale takes into account the behavior of the members during four sessions.

Statistical Treatment

As this study was concerned with an ongoing group over an 18 month period, (with new members being added and others dropped), the following procedure was adopted to handle the data. A mean was computed for all *S*s for their first rating period in therapy (first 4 sessions) and likewise through the subsequent rating periods up through 48 sessions. Note should be made that this treatment of the data disregards the actual group composition at any one time and is concerned only with the mean ratings for the *S*s during their first 4 sessions, their second 4 sessions, etc. The relationship between time in therapy and ratings was not computed beyond the twelfth rating period as only 6 members participated in more than 48 sessions. The Spearman Rank order Correlation technique was the statistic used to test the relationship between mean ratings and time in therapy.

In this study, the only hypothesis advanced was that, in general there is an optimum number of group therapy sessions, after which significant gain is improbable.

Table 1 shows the relationship results between time in therapy and the mean PAGPS ratings for the group.

Inspection of Table 1 indicates the positive relationship between mean ratings and number of sessions from 4 to 24 sessions. From 24 to 48 sessions the ratings tend to decrease somewhat so that the mean ratings after 48 sessions is slightly higher than after 8 sessions.

A Rank Correlation between mean ratings and total number of sessions was not significant (rho $= .45$, $p > .10$), however the co-efficient between mean ratings and the first 24 sessions is positive and highly significant (rho $= 1.0$, $p < .001$). Another Rank Correlation computed between mean

TABLE 1
PALO ALTO GROUP PSYCHOTHERAPY SCALE
(TIME IN THERAPY VS. MEAN RATINGS)

No. of sessions	Mean ratings	No. of sessions	Mean ratings
4	46.6	28	65.4
8	50.7	32	59.8
12	53.6	36	60.3
16	56.9	40	57.5
20	57.4	44	59.2
24	65.5	48	52.2

ratings and sessions from 28 to 48 was negative and also significant (rho = —.89, $p < .02$). These results indicate that, in general the group therapy members tend to benefit and reach a peak level of adjustment after 24 sessions. The decrease in mean ratings from 28 to 48 sessions would suggest that the therapeutic effects of the group diminished and that the additional sessions may have adverse effects upon the group members.

DISCUSSION

Examination of the above PAGPS data might be naively interpreted as indicating that each group participant showed perfect, positive, and consistent gain during his time in therapy—or at least during the first 24 sessions. While this is true for the group over the bi-weekly rating periods, there was considerable variability for *Ss* between sessions in each rating period. Theoretically, it would be possible for a group of members to sit silently during three sessions and participate actively during the fourth session and have a higher rating than another member who participated to some extent in all four sessions during the rating period. While the behaviors of the members did vary considerably from one session to the next, the general trend was positive for all participants during their tenure in the group meeting for 24 sessions or less.

In general the observed negative relationship between the number of sessions and ratings after 24 sessions holds for most individuals. Examination of the individual ratings of the *Ss*, however does reveal some exceptions. These appear to be for the members who were originally non-verbal and whose initial ratings were quite low. Clients of this type seem to make a slower gain but continue to gain beyond the point where the more verbal member's ratings begin to decrease. These facts

are interpreted to mean that, in general, vocationally oriented group psychotherapy participants continue to gain at their individual rates until a maximum level or saturation point is reached. After reaching this level, further vocationally oriented group psychotherapy is apparently of little benefit and may have debilitating effects. An analogy to this situation would be that of an athlete who trains for a contest until he is in his peak condition. The event is postponed and he continues training but, having reached his peak, he can make no further gains so, at best, he can only hold his own. If he continues his training longer there is the possibility that he may become too sensitive and irritable or, in the parlance of athletics: "overtrained." For the group therapy member, the purpose of the vocationally oriented group therapy has been to help prepare the members for competitive employment. If when ready, the group member cannot make this jump to a regular job, then, like the "overtrained" athlete, he may become "emotionally bound" and further group therapy may have debilitating effects rather than the rehabilitating effects as planned.

Another possible explanation for the general decrease in ratings after the *24th* is based upon the assumption that the earlier sessions are supportive and tend to facilitate the channeling of the *Ss* energies toward the solution of vocational problems. As therapy progresses, the possibilities of therapeutic processes tapping deeper conflicts increase. Should this happen, it would be expected that there would be a tightening of personality defenses and this, in turn, would be reflected on the Palo Alto ratings.

Other questions which are raised by the results of this study are: How applicable are these findings? Are these results a function of vocationally oriented psychotherapy, or a function of the type of subjects involved, or both or neither? Only further studies in different settings with other types of subjects will answer these queries. The results of this study justify our accepting the hypothesis that there is an optimum duration for vocationally oriented group therapy. The significant negative results after 24 sessions were not anticipated. It was assumed that at some point in group therapy a plateau would be reached where *no* further gain would be made. It has made us reevaluate our own thinking about the dynamics and processes involved in this type of therapy and has necessitated the decision to terminate members after 24 sessions unless clear evidence of continuing individual improvement is present.

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THE CITIZEN AS A DECISION MAKER*

ARNOLD H. DREYER, JR.

St. Louis, Mo.

It would be very difficult for me to add to J. L. Moreno's *Sociometry, Experimental Method and the Science of Society,* which was subtitled "An Approach to a New Political Orientation,"[1] for this forward looking work does, it seems to me, anticipate many of the things which are beginning to happen on the American scene today. Many of these things are happening under the pressure of necessity; necessity which is the consequence of a nation of human beings striving to survive in the context of advanced technology, automation, increasing population and over a century of expedient solutions to basic social problems.

Without reviewing the rapidly growing body of literature on decision making, I would like to call attention to some of the things which do in fact prevent the average citizen from being a competent, rational decision maker in affairs which vitally affect his own existence. If we conceive of decision making by the citizen as a process in which he selects or chooses from a number of proposed alternatives, then certainly some citizens are very much involved in decision making, for this is about what happens when the citizen casts his vote. If, on the other hand, we conceive of a more involved, more democratic and more rational level of decision making, one in which the citizen helps to work out the alternatives, evaluates the relative pros and cons of each, and then decides to select a particular course of action, then we are talking about a rare experience in today's society. The point is that on every hand the citizen is having decisions made for him. With the type of over professionalization developing in our country, more and more people are giving up more and more of their decision making responsibilities to one or another type of professional or quasi-professional. Teachers, doctors, lawyers, engineers, psychotherapists, aldermen, congressmen, senators, planning commissions, park boards, and an endless array of consultants offer to help us with our problems. Few really help us, and fewer still have any interest in such an enterprise. So we, finding it easier for others to do our thinking for us,

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* Presented to the 1963 Annual Meeting of the American Society of Group Psychotherapy and Psychodrama.

[1] J. L. Moreno, *Sociometry, Experimental Method & the Science of Society,* Beacon House.

and encouraged by the expert, avoid the struggle of thought, and withdraw to the temporary ease of a thousand ready-made diversions. Speed is a keynote in our society; and if one is in touch with our tempo, then one is likely to get the impression that we are racing toward some cataclysmic disaster with incredible speed. Perhaps we are not, in which case we need not hurry in our mission. But when we find unemployment increasing, clinics jammed to overflowing, large numbers of children and youths left to their own devices, and blatant dishonesty rampant, etc., etc., etc., it seems to me that is the time for someone to cry "wolf." In fact, I believe that we have almost completely lost control of our destinies, and that we are almost completely at the mercy of a whole host of forces and processes which are irreversible and beyond our control. If one feels this problem, he will understand the point; if not, he cannot be persuaded with rhetoric and logic, though he could be shown in a few weeks time. Or maybe he would show us that we are wrong and that we need not be concerned.

It is my view that the therapist has much to contribute to making some inroads on the chaos of modern America, and that the warm-up is now in progress. Soon, very soon, group psychotherapists, who have had to learn the lesson of what really constitutes a helping relationship in order to practice successfully, need to move into the open community; need to forsake the clinic, the institution, and the agency for the open community. Surely by this time we must begin to realize that the problems of and in the therapy session, both those of the patient as well as those of the therapist, are only symptoms of a much larger problem. For every disfunctional schizophrenic in therapy, there are a greater number functioning schizophrenics involved in businesses, government, school administration and the like. For every Napoleon on a back ward, there are several Adolf Hitlers in the open community. For every convicted sociopathic adolescent, there are a dozen sociopathic men in power positions. And on and on. If a therapeutic community or world order as conceived by Moreno has any validity, and I think that something of that type will be required for the species to survive, then the time is now for the group psychotherapist to get into action and to conceive of group therapy in the broadest possible sense. In so doing and in so practicing we will discover that the dilemma of the citizen as a decision maker is rooted in our social organization, or lack of it; in our interpersonal relations, or lack of them.

Now I would like to call your attention to what I think are some golden opportunities for group psychotherapists who are genuinely interested in helping people grow and develop in the open community. Medicine was one

of the original vehicles for psychotherapists; more recently welfare agencies, schools, YMCA's, churches and other such groups have been used as vehicles, though still generally oriented toward the problem person. All of these are certainly worthy opportunities for the group therapist if he can, and this is often very difficult, warm-up the group and get into action. When we talk about the open community, it seems to me that we should be talking about the groups and networks of the official and informal society which exert the dominant controlling influence on the citizen; the family, the neighborhood (almost completely unorganized in our culture), the precinct, the ward and the various departments of local, state, and national government, as well as business, educational, and other social institutions—all of these at the level where decisions regarding the lives of human beings are being made.

Today there are two groups of workers, more than any others, who have legitimized access to almost every facet of community life, not only on the local level, but on the regional, state, national and international levels as well. They are planners and community development practitioners. If these people do their work in a competent fashion, they are continually presented with opportunities to warm-up the open community to the possibilities of facing up to and attempting to solve some of the basic human problems of community life. Both in planning and in community development a technician is attempting to help a community arrive at its own goals within the context of existing conditions. Put another way, the main objective in planning and in community development is to get people to work together toward the solution of their problems—both present and future. The initial motivating problem may be industrial development, public housing, slums, urban renewal, or planning the city's future needs for schools, a sewage plant, or other capital improvements, but sooner or later the major stumbling block becomes getting people to work together. That is, it becomes a stumbling block if the solution to the motivating problem, and others like it to come, is to be an adequate one. Let me remind you that this nation has grown like Topsy; without plan, with little or no awareness of where we are going or why; without too much regard for the future; grown as if we didn't plan to be here tomorrow; most of today's problems began as yesterday's mistakes or as the expedient solution to yesterday's problems. This includes problem dodging at which we have become masters.

Now I seriously doubt if there are any practical human problems that are not directly related to an interpersonal referent. Certainly this is the case with the working together problem. Further, it seems that we are lacking to a great degree in interpersonal competence, of the type possessed by many

highly sophisticated psychotherapists, either because we ourselves lack self-awareness, or because those with whom we interact have not shared intimate personal growth experiences with us. In this society we seem to steadfastly maintain that we can reduce experience to words. Long ago Moreno referred to the American society as one of low cohesion; this is even more true today, because of our encapsulation from one another—we just don't have time to share our experiences even if we could overcome our fear of doing so. Yet it seems that in attacking the working together problem, no one knows quite how to personalize the issue without losing the protagonist or client.

Three major elements seem to be needed in developing interpersonal competence: emotional maturity, self-awareness, and an appreciation of the nature of what constitutes a helping relationship. It would further seem that psychotherapists are the most equipped, the most sophisticated, the best trained group of people we have to do this work. It is the psychotherapist who has braved the unknown aspects of man's being to "discover" some of the newest aspects of our world. And it seems to me that the therapist has more to offer man today than any other group. That is, he has it to offer, *if* he will only make an effort to offer it.

My experiences in the open community have persuaded me that two hours spent with the so called "normal" is worth 100 hours spent with the so called "abnormal," not because of the effect on any single individual, but because of the long range effect in warming-up a whole society. Now to appreciate the full significance of what I am saying I must digress into two critically important issues, and you must accept as fact that we are all related in some kind of complex influence system—that the acts of every person have an effect, no matter how small, on everyone else.

First, planning to be effective must in some measure coincide with the reality of things. For example, planning must itself be a process—it cannot be conceived as an end in itself. The planning process begins with a felt urge on the part on an individual or a group. In time this urge takes on a subjective form, and later direction, and still later artifacts result—new streets, zoning ordinances, living arrangements, etc. In order to plan adequately one needs a proper view of what he is about and how it relates to other processes. To this end it is of great importance that we understand those aspects of process which are deterministic and those which are not; that we understand that we may have our greatest impact on a process at the point of its inception and not after the process is underway. Here we must adopt an organismic philosophy—a philosophy which embraces some portion

of spontaneity, operating at the beginning of the process. A. N. Whitehead[2] has provided an excellent model for the deterministic aspects of a philosophy of organism, but with clear appreciation of the role of spontaneity omitted. Moreno conceived of spontaneity's role in the creative act. While I cannot take time to elaborate this point at length, I would like to point out that a synthesis of these two points of view can lead one to a much clearer picture of man's role in his interaction with the cosmos and points up a basic error in human thought. Let me give an example to illustrate the point. In Galileo's inclined plane experiment, it has always been assumed that Galileo discovered something about nature. Another view, however, might be more fruitful; that is, to say that he constructed this principle of motion—not created it, but constructed it from the given elements of reality, for clearly the formulation of the principle was not a given reality. We can now with this view reconsider all of philosophy under the title of constructive realism. What is the point? The point is that by so viewing the nature of things we can set ourselves free of many of the constraints of our history and move on to plan and develop our future. We now have additional philosophic license for the sociometric experiment as well as a whole range of other interpersonal experiments. The older systems have and are perishing—their course will not be changed. But clearly we can influence the future. The question is: where do we want to go? What do we want to do?

Planning is one of the most rational of human activities, or it should be. But to carry out such planning as we do is most difficult. We plan when we send a child to school, but if we are weak in our appraisal of the consequences of the various factors involved in his education, we end up preparing him for an unreal world. What we leave to chance, results in chance outcomes. We must control our freedom in order to maximize it.

If we continually deny the child the opportunity to think for himself, we deprive him of the ability to think at all; in fact, he becomes afraid of his thoughts. The same is true of feelings. Now we are back to the problem of professionalism and of the decision making abilities of the citizen. We are also back to the group psychotherapist, for it is clear to me that the person who prospers most in therapy is the therapist himself. What we need is more psychotherapists, not more "therapised" patients. Therapy itself is a process. If the therapy process ends when the patient discontinues his relationship with the therapist, then we have not done our job in therapy. The therapy process must go on through continual warming-up to even greater develop-

[2] A. N. Whitehead, *Adventures in Ideas,* The Macmillan Company, N.Y., 1933, p. 40.

ment in our skill and competence in our interpersonal relations with one another. This is the crying need of the open community—the need for more people who have the awareness of interpersonal life that the psychotherapist has. This is the route that we are going as we warm-up to sociometry and the therapeutic world order.

If we are to survive at all, we must develop an orderly process in human relations. We must come to this task with intention. That is with an awareness of what we are doing. I am amazed that Freud did not seize upon the curative powers of intentionality having discovered the disease of unawareness. Is it not clear that as man has increased his control over his environment, he has also increased his freedom? Is *this* not the objective, or underlying assumption, in the work of the behavioral sciences?

The urgent need of our time is to create situations in which the sociometric experiment can flourish—out in the open—in official society. And I earnestly implore group therapists to create opportunities for themselves in the open community—to ally themselves with the fields of planning and community development—to get personal in these areas—to show the open community that the Freud's, Sullivan's, and the Moreno's have something to offer to the entire human enterprise and not just a few unfortunate souls. The need for the warm-up is urgent. In all probability it will be the group therapist—the interpersonal therapist—who "renders clear to popular understanding some eternal greatness incarnate in the passage of temporal fact."

BOOK REVIEWS

JUVENILE DELINQUENCY: *Its Nature and Control*, Holt, Rinehart and Winston, Inc., New York, New York, 1960. 546 pages—$5.40. By Sophis M. Robinson, Ph.D.

As Dr. Robinson suggests in the concluding remarks of this ambitious text there have been some signs of progress in the understanding and controlling of delinquency, not the least of which is the acknowledgement of our ignorance. The heroic task of setting down in one volume much of what has been thought and done by the *experts* in the field (Has it become an industry?) of juvenile delinquency is fruitful for precisely the reason that it dramatically emphasizes the confounding hodgepodge of thought and action which now engulfs our methods of caring for a substantial segment of our young.

The author's broad experience permits effectively critical observations to be made of the many theories pertaining to the causation, treatment and prevention of delinquency. At times the reader may become frustrated as the research studies and opinions of sociologists, anthropologists and clinicians are one by one found to be wanting in one respect or another. It is only after absorbing the full impact of the difficulties involved in measuring and understanding this aspect of human behavior that the reader may come to anticipate a little less from the scientific method than this century has taught us to expect. One has the feeling that there will be no Julius Salk to arrive on the scene with the ability to isolate the Delinquency Virus and provide an antidote to it with the aid of the Ford Foundation or an NIH grant.

Included in the book is an extensive survey of court and police attitudes as well as an outline of the various types of institutions here and abroad. Dr. Robinson, like most optimists in this field, cannot resist making a number of practical suggestions for the days ahead. Group therapists will be interested to know that her opinions of the Highfields Project are particularly favorable.

ELY AMER

FREEING INTELLIGENCE THROUGH TEACHING, Gardner Murphy, The John Dewey Lectureship No. Four, Harper and Brothers $2.95

This little book is the fourth in the John Dewey Lecture Series and has a necessary relationship to formal education. Dr. Murphy, however, is suggesting a way of moving beyond the present day limits of achievement tests and personality quizzes. He uses the formula "love and reason equals reality" and seems to imply that this is the enabler that lends to education in its truest sense. He begins by revealing the three steps (relationship, stimulation and clarification) which result in a learning experience. Dr. Murphy then conscientiously points out the drawbacks to such a method of teaching such as the dearth of research into the elements of a meaningful relationship between teacher and student or of ways in which to make an assessment of the personality of the individual student. Having pointed the way Dr. Murphy leaves it to the educator to pick up the challenge.

Gardner Murphy has been associated with psychodrama for many years and, in this lecture, calls upon some of his experiences with Dr. Moreno to illustrate the process he outlines.

MARGARET AMER, MSW
Chatham, New York

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Nedlands, Western Australia

AUSTRIA

Dr. W. Doleisch
Karl Schweighofergasse 8
Vienna 7

Dr. Hans Hoff
Psychiatrisch-Neurologische Klinik
der Universitat Wien
IX-71 Lazarettgasse Nr. 14
Vienna

Dr. Traugott Lindner
Betriebsberatung
Viktorgasse 9
Vienna IV

Dr. L. Rosenmayr
Sozialwissenschaftliche Forschungstelle
Universitat Wien
Karl Luegerring 1
Vienna 1

Dr. R. Schindler
Bennogasse 8
Vienna VIII

Dr. S. Schindler
Schonbrunnestr. 111
Vienna V

Dr. H. Strotzka
Daringergasse 16/24
Vienna 19

BELGIUM

Dr. G. Bastin
Conseiller-Directeur du
Centre Psycho-Medico-Social de
l'Etat a Huy
16 rue Delloye-Mathieu
Huy

Dr. Rene Dellaert
Italielei 221
Antwerp

BRAZIL

Dr. W. Kemper
Rue Gustavo Sampaio 576
Rio de Janeiro

Dr. Gilberto de Macedo
Professor da Faculdade de Medicina
Senador Mendonca 180
Maceio, Alagoas

Dr. Walderedo Ismael de Oliveira
Praia do Flamengo 118, 6A
Rio de Janeiro, Brazil

Dr. A. C. Pacheco e Silva
Clinica Psiquiatrica
Faculdade de Medicina da Universidade de Sao Paulo
Caixa Postal 8091, Sao Paulo

Dr. David Zimmermann
Av. Sen. Salgado F 204 Ap. 21
Porto Alegre

BULGARIA

Dr. Nikola Shipkovensky
54 Patriarch Euthymius
Sofia

CANADA

Dr. Miguel Prados
1025 Pine Avenue West
Montreal, P.Q.

Dr. E. J. Rosen
Department of Psychiatry
University of Toronto
Toronto 5

CEYLON

Dr. W. G. Wickremesinghe
48 Buller's Lane
Colombo 7

CHILE

Dr. Ramon Ganzarain
Av. Paraguay 461 1°C
Santiago

CUBA

Dr. Jose Bustamante
Calle K Num. 309 Vedado
La Habana

Dr. F. Potts
Central State Hospital
Lakeland, Ky.

CZECHOSLOVAKIA

Dr. F. Knobloch
University Policlinic
Karlova nam 32
Prague 2

DENMARK

Dr. C. Jorgensen
Box 163
Copenhagen K

Mr. O. Martensen-Larsen
Alcoholics Treatment Center
35 Stormgade
Copenhagen V

Dr. Paul Reiter
Kommunehospitalet
Copenhagen

Dr. G. K. Sturup
Vingarde Alle 36
Hellerup

EAST GERMANY

Dr. B. Bauer
Medizinische Poliklinik
Bachstrasse 18
Jena, Thuringen

Dr. Hans Szewczyk
Humboldt-Universitat
Schumannstrasse 20-21
Berlin N.4

EGYPT

Dr. S. M. Tawadros
Institute of Education
Monira, Cairo

FRANCE

Dr. Juliette Favez-Boutonier
Faculte des Lettres et Science Humaines
Universite de Paris
Paris

Dr. Rene Diatkine
30 Rue de Miromesnil
Paris VIIIe

Me. E. Kestenberg
6 Rue Friant
Paris XIVe

Dr. Serge Lebovici
3 Av. du President Wilson
Paris XVIe

Dr. Simone Blajan-Marcus
4 Villa Eugene Manuel
Paris XVIe

Dr. Charles L. Pidoux
96 Rue Pierre-Demours
Paris 17e

Dr. Marcel Raclot
26 Avenue Perrichont
Paris XVIe

Anne Ancelin Schutzenberger
14 Avenue Paul Appell
Paris 14e

Dr. F. Tosquelles
Medicin des Hopitaux Psychiatriques
Saint Alban, Lozere

GERMANY

Dr. H. Heiss
Psychologisches Institut der Universitat
Freiburg i. Br.

Dr. E. Hohn
Schaffhausenstrasse 27
Tubingen

Prof. Ernst Kretschmer
Universitats Nerven Klinik
Osianderstr. 222
Tubingen/Neckar

Dr. D. Langen
Universitats Nerven Klinik
Osianderstr. 22
Tubingen/Neckar

Dr. J. H. Schultz
Bayern Allee 17
Berlin-Charlottenburg 9

Dr. Hildebrand R. Teirich
Mozartstrasse 48
Freiburg i. Br.

GREECE

Dr. G. C. Lyketsos
16A Roosevelt Street
Athens

Dr. Anna Potamianou, Director
Mental Health Section
Royal National Foundation
58 Notara Street
Athens

Dr. N. C. Rassidakis
The Public Mental Hospital
47 Omirou Street
Athens

HAWAII

Miss Rosie K. Chang
Nursing Director
Territorial Hospital
Kaneche

HUNGARY

Dr. Istvan Hardi
Pozonyi u. 21
Budapest

Dr. Z. Boszormenyi
Voroshads 116
Budapest II

INDIA

Dr. K. R. Masani
Silver Oaks
Warden Road
Bombay 26

Dr. Pandharinath H. Prabhu
Gujarat University
Ahmedabad 9

IRAN

Dr. E. Tchehrazi
Hospital Pahlavi
Avenue Shah Reza
Tehran

ISRAEL

Dr. H. Kreitler
Tel Aviv University
155 Herzl St.
Tel Aviv

Dr. J. Schossberger
Government Work Village
Kfar Shaul
Jerusalem

ITALY

Dr. Luigi Meschieri
Lungotevere Flaminio, 22
Rome

Dr. Giuan Franco Tedeschi
Viale Bruno Buozzi 109
Rome

JAPAN

Dr. Masaaki Kato
National Institute of Mental Health
Konodai Ichikawa Chiba

Taro Ogawa
12312 Fuchu
Tokyo

MALAYA

Dr. T. L. Green
Director, School of Education
University of Singapore
Singapore

MEXICO

Dr. Luis Feder
Leibnitz No. 1
Mexico 5, D.F.

NETHERLANDS

Dr. C. Van Emde Boas
Stadionweg 80
Amsterdam-Z

Dr. E. Carp
University of Leiden
Leiden

Dr. G. W. Arendsen Hein
Klomperweg 113
Ederveen

Dr. L. Hut
Dir., Mental Health
182 Oudegracht
Alkmaar, North Holland

Dr. M. L. Meijering
W. de Zwijgerstraat 27
Utrecht

Dr. J. Spanjaard
Paviljoenslaan 11
Haarlem

Dr. B. Stokvis
Psychosomatic Center
University of Leiden
Oegstgeest

Dr. Armand Sunier
Med. Supt.
Sinai Mental Hospital
Laan 1914, nr. 23
Amersfoort

NEW ZEALAND

Dr. Wallace Ironside
Prof. of Psychological Medicine
University of Otago Med. School
Great King Street
Dunedin C.1

Dr. R. W. Medlicott
Ashburn Hall
Dunedin

NORWAY

Dr. Finn Askevold
The University Hospital
Rikshospitalet
Oslo

Dr. Kjell von Krogh
Barnepsykiatrisk Institutt I
Munkedamsvn 84
Oslo

Mrs. Maison Mose
Barnepsykiatrisk Institutt I
Munkedamsvn 84
Oslo

Dr. Bjorn Urdal
Barnepsykiatrisk Institutt I
Munkedamsvn 84
Oslo

PERU

Dr. B. Caravedo
Medico-Jefe del Dpto. de Higiene Mental
Ministerio de Dalud Publica y
Assistencia Social
Lima

Dr. C. A. Seguin
Huancauelica 470
Lima

PHILIPPINES

Dr. Estefania Aldaba-Lim
The Philippine Women's University
Taft Avenue
Manila

POLAND

Dr. K. Dambrowski
Choroby Nerwowe 1 Psychiczne
Doroslych I Dzieci
ul. Gwiandzista 81
Warsaw

PORTUGAL

Dr. V. Fontes
Instituto Antonio Aurelio da Costa
Ferreira
Lisbon

Dr. Joao dos Santos
Praca Andrade Caminha 5
Bairro de S. Miguel
Lisbon

PUERTO RICO

Dr. R. Fernandez Marina
Clinical Director
Puerto Rico Institute of Psychiatry, Inc.
P.O. Box 127
Bayamon, Puerto Rico

Dr. Luis Manuel Morales
Box 12248
Santurce

SPAIN

Dr. Ramon Sarro-Burbano
Dept. of Psychiatry
University of Barcelona
Barcelona

Dr. J. L. Marti Tusquets
Doctor Amigant No. 15
Barcelona

Dr. C. Ruiz Ogara
Cardenal Vives y Tuto 40
Barcelona

SWEDEN

Dr. Hans Curman
Kungsholmsgatan 106
Stockholm K

Dr. Goesta Harding
Institute for Orthopsychiatry of
the Erica Foundation
Odengaten 9
Stockholm

Dr. Sven Larsson
Barrstigen 5
Bromma

Mr. Nils Lindgren
Parkvagen 5
Handen

SWITZERLAND

Dr. E. Burren, Director
Strafanstalt, Lenzburg
Lenzburg

Dr. Harry Feldmann
6 cours de Rive
Geneva

Dr. A. Friedemann
Psychohygienisches Institut
Institut d'Hygiene Mentale
Biel-Bienne

Dr. Adolf Guggenbuhl Craig
Untere Zuane 1
Zurich

Jakob W. Hug
Beundenfeldstrasse 18
Bern

Dr. Heinrich Meng
Larchenstr. 92
Basel

TAIWAN

Dr. Eng-kung Yeh
National Taiwan University Hospital
No. 1 Changte-Chieh Section 1
Taipei

THAILAND

Dr. Phon Sangsingkeo
Dept. of Med. Service
Ministry of Public Health
Bangkok

Dr. Prasop Ratanakorn
The Prasat Hospital for Neurological
Disorders
Phyathai
Bangkok

TURKEY

Dr. Ihsan S. Aksel
Taksim
Cumhuriyet Cad. Stadyum Palas No. 3
Istanbul

Dr. M. Sion
P.O.B. 484 Beyoglu
Istanbul

UNION OF SOUTH AFRICA

Mr. R. C. Albino
Dept. of Psychology
University of Natal
King George V Avenue
Durban

Dr. L. S. Gillis
Head, Dept. of Psychiatry
Groote Schuur Hospital
Observatory
Cape Town

U.S.S.R.

Dr. D. D. Fedotov
Academy of Medical Science
Psychiatric Institute
Moscow

Dr. Aina G. Ambrumova
Inst. of Psychiatrics
Ministry of Health of the R.S.F.S.R.
Sokolniri Poteshnaya
Ulites, Dom. 3
Moscow

UNITED KINGDOM

Mrs. M. L. Johnson Abercrombie
14 Park Drive
London, N.W. 11, England

Dr. Joshua Bierer
140 Harley Street
London, W.1, England

Dr. Donald Blair
St. Bernard's Hospital
Southall
Middlesex, England

Dr. H. Ezriel
Tavistock Clinic
2 Beaumont St.
London, W.1, England

Dr. S. H. Foulkes
22 Upper Wimpole Street
London, England

Dr. Maxwell Jones
Dingleton Hospital
Melrose
Roxburghshire, Scotland

Dr. T. Main
The Cassel Hospital
Ham Common
Richmond
Surrey, England

Dr. P. B. de Mare
St. George's Hospital
Psychiatric Department
15 Knightsbridge
London, S.W.1, England

Dr. T. P. Rees
47 Chelsea Square
London, S.W.3, England

U.S.A.

Dr. Robert S. Drews
12500 Broadstreet Blvd.
Detroit 4, Mich.

Dr. Helen Durkin
59 East 79 St.
New York, N.Y.

James M. Enneis
Director
Psychodrama Department
St. Elizabeths Hospital
Washington, D.C.

Dr. Martin Grotjahn
416 N. Bedford Drive
Beverly Hills, Calif.

Dr. Samuel B. Hadden
250 South 18th Street
Philadelphia 3, Pa.

Dr. Helen H. Jennings
470 West End Avenue
New York 24, N.Y.

Dr. Maurice E. Linden
Dept. of Public Health
Room 530 City Hall Annex
Philadelphia, Pa.

Dr. David Mendell
The Medical Towers
Houston, Texas

Dr. Jacob L. Moreno
Moreno Institute
Beacon, N.Y.

Mrs. Zerka T. Moreno
Moreno Institute
Beacon, N.Y.

Mrs. S. R. Slavson
321 East 18 Street
New York, N.Y.

Dr. Wellman J. Warner
Woodstock, Vermont

Dr. Lewis Yablonsky
University of California
Dept. of Sociology
Los Angeles, Calif.

VENEZUELA

Dr. Pedro Reyes
Avenida Cajigal No. 32
San Bernardino
Caracas

Dr. Rafael L. Araujo
Institute Medico Del Este
Caracas

YUGOSLAVIA

Dr. S. Betlheim
Neuroloskopsihijatrijska klinika
Rebro
Zagreb

Dr. Dimitrije Pivnicki
Allan Mem. Inst. of Psychiatry
1025 Pine Ave. West
Montreal, P.Q., Canada

Dr. Boroslav P. Stevanovic
Prof. of Psychology & Chairman of
Psychological Department
Faculty of Philosophy
University of Belgrade
Belgrade

THIRD INTERNATIONAL CONGRESS OF GROUP PSYCHOTHERAPY

OFFICERS

J. L. Moreno, President
S. H. Foulkes, Vice President
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A. Friedemann, Treasurer, European Co-chairman
J. Bierer
J. Favez-Boutonnier
E. E. Krapf
Zerka T. Moreno

General Manager

Enzo Spaltro
Via U. Hoepli 8
Milan, Italy

MEETINGS OF THE INTERNATIONAL COUNCIL OF GROUP PSYCHOTHERAPY

The International Council of Group Psychotherapy will meet on Thursday, July 18, 1963 from 5:15 to 7:00 p.m. and on Friday, July 19, 1963 from 5:15 to 6:00 p.m., if required. The attendance of the Council meetings is limited to the Directors and Members of the International Council. The Council receives and discusses all proposals made, but no final decisions are made at the Congress. All proposals will be decided via mail ballot by the entire International Council of Group Psychotherapy.

Agenda:

1. Constitution of the International Federation of Group Psychotherapy.
2. Time and place of the IVth International Congress of Group Psychotherapy.
3. Regional Representatives in various countries.
4. International Group Psychotherapy—A Global Review.
5. Publication of the Volume of Proceedings of the Third International Congress of Group Psychotherapy.
6. International Group Psychotherapy Research Foundation.
7. Specal items emerging during the meeting.

GENERAL INFORMATION

Congress Address:	Government Building Sala dei Congressi della Provincia, Via Corridoni 16, Milan, Italy
General Manager:	Prof. Enzo Spaltro, Via Hoepli 8, Milan, Italy
Official Languages:	The official languages are English, French, German and Italian. The papers in the Plenary Sessions in the morning and the Summaries in the final Plenary Session will be presented in one of these four official languages, as will the papers in the Scientific Sections in the afternoon. Simultaneous translation will be offered only in the languages listed above, and will be available in all Plenary Sessions. Papers in Spanish will also be accepted but no simultaneous translation of these will be given. The simultaneous translation will be handled by the Centro Congressi of Milan and Rome.
Time Schedule:	The official opening of the Congress is Thursday, July 18, 1963, at 9:30 a.m. Plenary Sessions take place every morning from 9:30–1:00 p.m.; a closing Plenary Session takes place on Sunday, July 21, 1963, from 4:00 to

	7:00 p.m. Scientific sections take place every afternoon from 4:00 to 7:00 p.m. Workshops and Panels will be announced, as time permits.
Attendance:	Because of the full schedule, participants are urged to be punctual, so as to make most effective use of the resources of the whole program.
Bulletin and Notices:	All members of the Congress should consult the bulletin board frequently for important information and notices concerning the various events.
Reception:	All members of the Congress and their associates are invited to an informal reception which will be the first gathering of the Congress. It will be held on Wednesday evening, July 17, 1963, at 7:00 p.m. at Sala dei Congressi della Provincia. Light refreshments will be served.
Congress Dinner:	The banquet of the Congress will take place on Sunday, July 21, 1963, at 9:00 p.m. Wives or husbands of registrants may attend. Reservations will be accepted at the office of the Congress at the time of registration.
Badge:	Members of the Congress are asked to wear the badge provided in the registration envelope. It will promote communication and facilitate organization.
Visits:	Visits will be arranged to centers of professional interest during the meetings.
Excursions:	Persons accompanying members of the Congress are invited to enjoy local excursions organized for them.
Exposition:	Publishers will exhibit a selection of books and periodicals relevant to the field of group psychotherapy.

ORGANIZATION OF THE CONGRESS

General Organization and Public Relations:	Aldo Chiappe, Via Santo Spirito 14, Milan, Italy, Tel. 780485, 705025.
Hotel Arrangements:	Wagons Lits Cook, Via Manzoni 10, Milan.
Congress Regulation:	In every plenary session there will be reports of thirty minutes' duration. The scientific sections in the afternoons will be opened by the Chairman, followed by papers lasting a maximum of fifteen minutes each.
Organizational Committee of the Congress:	Avvto. Adrio Casati, President of the Government of Milan, President Prof. Francesco Maria Vito, Rettore of the Catholic University of Milan, Vice President Prof. Caio Mario Cattabeni, Rettore of the State University of Milan, Vice President
Work Committee:	E. Spaltro, General Manager V. Robledo, Secretary; G. C. Trentini, Treasurer; F. Cocci, P. F. Galli, R. Guidi, E. Jannaccaro, G. Parmeggiani, D. Palazzoli Selvini, L. Spaltro, P. A. Achille, members.
Geographic Representation:	Argentina, Australia, Austria, Belgium, Brazil, Bulgaria, Canada, Ceylon, Chile, Cuba, Czechoslovakia, Denmark, East Germany, Egypt, France, Germany, Greece, Hawaii, Hungary, India, Iran, Israel, Italy, Japan, Malaya, Mexico, Netherlands, New Zealand, Norway, Peru, Philippines, Poland, Portugal, Puerto Rico, Spain, Sweden, Switzerland, Taiwan, Thailand, Turkey, Union of South Africa, U.S.S.R., United Kingdom, U.S.A., Venezuela, Yugoslavia.

PROGRAM SCHEDULE

Wednesday, July 17, 1963	Thursday, July 18, 1963	Friday, July 19, 1963	Saturday, July 20, 1963	Sunday, July 21, 1963
8:00 a.m.–6:00 p.m. Registration	9:30 a.m.–1:00 p.m. Plenary Session	9:30 a.m.–1:00 p.m. Plenary Session	9:30 a.m.–1:00 p.m. Plenary Session	9:30 a.m.–1:00 p.m. Plenary Session
	4:00–7:00 p.m. Scientific Sections	4:00–7:00 p.m. Scientific Sections	4:00–7:00 p.m. Scientific Sections	4:00–7:00 p.m. Summary Session
	5:15–7:00 p.m. Council Meeting	5:15–6:00 p.m. Council Meeting		
7:00 p.m. Informal Reception	7:30 p.m. Reception	Workshops Time to be announced	6:00–7:30 p.m. Film Exhibit	7:00 p.m. Meeting of Associazione Italiana di Psicoterapia di Gruppo
	Workshops Time to be announced		7:30 p.m. Business Meeting	
			8:00 p.m. Reception	9:00 p.m. Banquet
			Panel Time to be announced	

PLENARY SESSIONS

The Plenary Sessions are held each morning from 9:30–1:00; the Scientific Sections are held every afternoon from 4:00 to 7:00 p.m.

THURSDAY, JULY 18, 1963

Opening Plenary Session

Presidential Address

Chairman: Adrio Casati (Italy)

9:30 a.m.

Official opening of the Congress by the Government of the Province of Milano, by the Milano Universities, by the International Council of Group Psychotherapy, and by the Associazione Italiana di Psicoterapia di gruppo. Secretary announcements concerning the Program.

11:00 a.m.

"The Actual Trends in Group Psychotherapy" — J. L. Moreno

No Discussion

FRIDAY, JULY 19, 1963

IInd Plenary Session

Fundamental Processes

Chairman: J. L. Moreno (USA)

9:30 a.m.

Basic Concepts in Group Psychotherapy — S. H. Foulkes

10:00 a.m.

Development of Psychodrama — S. Lebovici

10:30 a.m.

The Concept of Self Government in Group and Social Psychotherapy — J. Bierer

11:00 a.m.

Operational Approach to the Formation of Groups — Berthold Stokvis and M. P. Bolten

11:30 a.m. to 11:45 a.m.
Intermission

11:45 a.m. to 1:00 p.m.
Discussion

SATURDAY, JULY 20, 1963

IIIrd Plenary Session

Basic Problems

Chairman: B. Stokvis (Netherlands)

9:30 a.m.
Therapeutic Communities — Maxwell Jones

10:00 a.m.
Group Psychotherapy with Physicians — A. Friedemann

10:30 a.m.
Le Depassement de la Conception Classique du Transfer dans l'oeuvre de Moreno — R. Sarro-Burbano

11:00 a.m.
Psychosomatic Medicine in Group Psychotherapy — Hans Hoff

11:30 a.m. to 11:45 a.m.
Intermission

11:45 a.m. to 1:00 p.m.
Discussion — J. Favez-Boutonier

SUNDAY, JULY 21, 1963

IVth Plenary Session

Applications

Chairman: A. Friedemann (Switzerland)

9:30 a.m.
The Impact of Social Psychology on Group Psychotherapy — Edgar F. Borgatta

10:00 a.m.
Family Therapy — R. Schindler

10:30 a.m.
Analytic Group Psychotherapy — G. Kuhnel

11:00 a.m.
Sociogenesis of Individuals and Groups — Z. T. Moreno

11:30 a.m. to 11:45 a.m.
Intermission

11:45 a.m. to 11:45 a.m.
Discussion

SUNDAY AFTERNOON

Vth Plenary Session

Summaries

Chairman: E. Spaltro (Italy)

4:00 p.m.
Summary, Plenary Sessions — Berthold Stokvis

5:00 p.m.
Reports, Scientific Sections — Section Chairmen (or Co-Chairmen)

6:30 p.m.
Closing Words — J. L. Moreno

SCIENTIFIC SECTIONS

Every Section has a Chairman and two Co-Chairmen in order to permit them greater flexibility of participation.

SECTION I—ANALYTIC GROUP PSYCHOTHERAPY
(INCLUDING PSYCHOANALYSIS OF GROUPS)

Chairman: S. H. Foulkes (Great Britain)
First Co-Chairman: Gian Tedeschi (Italy)
Second Co-Chairman: Curt Boenheim (USA)

FIRST DAY, THURSDAY, JULY 18

Stanley Lesse (USA)
The Influence of Unintended Phenomena on the Results of Psychotherapy

V. J. Bieliauskas (USA)
Shifting of the Guilt Feeling in the Process of Psychotherapy

Toyer Martin (Great Britain)

Cornelius Beukenkamp (USA)
A Rationale for the Treatment of the Homosexual Symptom

SECOND DAY, FRIDAY, JULY 19

Curt Boenheim (USA)
Expansion of the Group Psychotherapy Program in Mental Hospitals

Irving A. Goldberg and Gerald J. McCarty (USA)
Psychoanalysis in Groups: Separation Anxiety in the Alternate Session

Jean J. Kestenberg and S. Decobert (France)
Etude differentielle des phenomenes de transfert au travers des variantes dynamiques dans les groups dits stables ou instables

Norman Locke (USA)
Group Psychoanalysis: An Evaluation and Contribution

THIRD DAY, SATURDAY, JULY 20

Max Rosenbaum (USA)
Current Controveries in Psychoanalytic Group Psychotherapy

Pierre Jordi and Gilbert Genevard (Switzerland)
Contribution au probleme de la co-therapie en psychotherapie analytique de groupe

A. Marchesini (Italy)
Narcoanalisi Condotta de Coppie di Terapeuti

FOURTH DAY, SUNDAY, JULY 21

Summaries of Section Chairmen

SECTION II—PSYCHODRAMA (INCLUDING SOCIODRAMA, ROLE PLAYING, ROLE THERAPY, SIMULATION, PANTOMIME)

Chairman: Zerka T. Moreno (USA)
Co-Chairman: M. Berrini (Italy)
Co-Chairman: Anne Ancelin Schutzenberger (France)
Co-Chairman: Simone Blajan-Marcus (France)

FIRST DAY, THURSDAY, JULY 18

Daniel Widlocher, Bernard Jean and Yvan Tellier (France)
Audience Participation in Psychodramatic Therapy

Jaromir Rubes, Ferdinand Knobloch and Jaroslav Skala (Czechoslovakia)
Some Aspects on the Practice of Group Psychotherapy and Psychodrama in CSSR

Kohei Matsumura (Japan)
Some Aspects of Group Psychotherapy and Psychodrama

Simone Blajan-Marcus (France)
Indications et Contre-Indications a la Psychotherapie de Groupe

Allan N. Zacher, Jr. (USA)
Psychodramatic Techniques in Pastoral Therapy

S. Lebovici (France)
Analytic Psychodrama

N. N. Dracoulides (Greece)
The Most Ancient Therapeutic Psychodrama in the Wasps of Aristophanes

SECOND DAY, FRIDAY, JULY 19

Alvin Bobroff (USA)
Religious Psychodrama

Adaline Starr (USA)
Psychodrama and Group Living Research

M. Monod (France)
Introduction of Psychodrama in France

Heika Straub
Erfahrungen mit der Anwendung des Psychodramas im Rahmen einer Stadtischen Nervenklinik

Joseph Mann (USA)
The Incidental and the Planned Psychodramatic Shock and its Therapeutic Value

P. Lemoine (France)
Le transfert dans les Groupes de psychodrame morenien

Bela Galfi, I. Puskas, L. Schenker and Cs. Adorjani (Hungary)
The play-acting Therapy as a Method of Group Therapy of Chronic Schizophrenics

THIRD DAY, SATURDAY, JULY 20

Anne Ancelin Schutzenberger (France)
Psychodrama and non-verbal Communication

M. Mitscherlich (Germany)
Die motorischen Phanomene und ihre Bedeutung fur die Gruppentherapie

Hannah B. Weiner (USA)
Psychodrama and the Treatment of Alcoholics

Maria Mendes Leal (Portugal)
An Experiment in Group-Playanalysis with preadolescent girls receiving special education in Welfare School

Rose Garlock (USA)
Psychodrama in a Therapeutic Social Group Setting

Anna Potamianou (Greece)

Sylvia Ackerman (USA)
Group Cohesion through Psychodrama

O. Horetzky (Yugoslavia)
Individuelle Pantomimeaufgaben in der Gruppenpsychotherapie

John Hunting (USA)
Psychodrama: Objectives and Techniques

E. Jannacaro (Italy)
Psicodrama in Bambini Ricoverati in Ospedale Psichiatrice

M. Soule (France)
Le Psychodrame de Groupe Traitement Electif de l'Enuresis chez l'Enfant

FOURTH DAY, SUNDAY, JULY 21

Summaries of Section Chairmen

SECTION III—MENTAL HOSPITALS (INCLUDING MILIEU THERAPY, OPEN DOORS, HALF-WAY HOUSES)

Chairman: R. Battegay (Switzerland)
First Co-Chairman: G. Padovani (Italy)
Second Co-Chairman: Pierre Bour (France)

FIRST DAY, THURSDAY, JULY 18

R. Battegay (Switzerland)
The Group as Therapeutic Setting

H. Kleinsorge (DDR)

W. Derbolowsky (West Germany)
Multilateraler Widerstand in Patientengruppen

Gyorgy Hidas (Hungary)
One Characteristic of Group Psychotherapy in Hospitals

Horst Flegel (Germany)
Einflusse der Unterbringung auf das Gruppenleben einer Psychiatrischen Krankenhausabteilung

Werner W. Kemper (Brazil)
Zur Ausbildung des Gruppenpsychotherapeuten

M. Viviano (Italy)
Il rapporte psicoterapico di gruppo e la sua motivazione

G. Ceccarelli, G. G. Giacomina and C. Petro (Italy)
L'equipe multiprofessionale come istrumento di lavoro di un servizio di igiene mentale.

D. Napolitani (Italy)
Difese individuali e difese di gruppo nella psicoterapia analitica terapeutica extraospedaliera

S. Rusconi, G. De Simone and D. Napolitani (Italy)
Tre modalita di trattamento psicoterapeutico simultaneo di pazienti ambulatoriali e di gruppi di pazienti

G. Cavagnino, D. Napolitani (Italy)
Il controllo psicoanalitico in gruppo del rapporto tra assisente sociale e paziente psichiatrico

SECOND DAY, FRIDAY, JULY 19

Pierre Bour (France)
Echanges a la Faveur des Objets dans un groupe de Schizophrenes

Roger Amiel (France)
To be announced

R. Fichelet and Robert Meigniez (France)
Remarques a Propos D'une Intervention par Groupe D'Analyse Dans un Milieu Naturel

Shoug Inoue (Japan)
Group Psychotherapy in Chronic Schizophrenics

THIRD DAY, SATURDAY, JULY 20

Clifford Tetlow (Great Britain)
Group Organization of a Neurosis Unit in the British Health Service

Ehric Lange (West Germany)
Group Psychotherapy in Mental Hospitals

Bruno Pocciali and A. Maffei (Italy)
To be announced

Rene Portugaels (Belgium)
To be announced

Cornelio Fazio (Italy)
To be announced

Vincenzo Floris (Italy)
To be announced

Ralph S. Long, Jr. (USA)
The Development of a Sensitivity Training Program for Hospital Personnel

FOURTH DAY, SUNDAY, JULY 21

Summaries of Section Chairmen

SECTION IV—THERAPEUTIC COMMUNITY

(INCLUDING CRIMINOLOGY, DELINQUENCY, AUTONOMOUS GROUPS)

Chairman: J. L. Moreno (USA)
First Co-Chairman: F. Barison (Italy)
Second Co-Chairman: Maxwell Jones (Great Britain)

FIRST DAY, THURSDAY, JULY 18

Thomas Detre and Vincenzo Cocilovo (USA)
The Role of Group Psychotherapy in Resocialization

Giulio di Furia and Hayden L. Mees (USA)
Intensive Group Psychotherapy with Sexual Offenders

Sheila Rouslin (USA)
Interpersonal Stabilization of an Intrapersonal Problem

F. Napolitani (Italy)
Dinamico di Gruppo nelle Comunita Terapeutica

M. Fagioli (Italy)
La Coppia nelle Comunita Terapeutica

Joseph Andriola (USA)
Group Psychotherapy with Mentally Ill Offenders (Criminals)

Nicholas S. Ionedes (USA)
Three Years of Group Psychotherapy with Offenders

Richard R. Korn (USA)
Sociopathegenesis: Theoretical Issues and Alternatives

Max Ackerman (USA)
Co-Creative Group Psychotherapy

SECOND DAY, FRIDAY, JULY 19

Joost A. Meerloo (USA)
Emotional Interaction and Mutual Mental Contagion

Samuel B. Hadden (USA)
Treatment of Homosexuals in Groups

Nathan Cooper (USA)
Structure and Process in the Group Treatment of Two Male Homosexuals

Frank M. Buckley (USA)
An Existential Approach to Group Therapy Procedures: In Working with Members of the Helping Professions for Mental Health Purposes

Maxwell Jones (Scotland)
Therapeutic Communities

G. W. Arendsen Hein (Holland)
Progress in Group Psychotherapy

THIRD DAY, SATURDAY, JULY 20

Robert R. Benson (USA)
Principles of Interpersonal Therapy as Applied to Treatment of Chronic Delinquents

D. Fuchs-Kamp (Germany)
Die Konsolidierung einer poliklinischen offenen gemischten Gruppe

Rudolf Zimmert (Germany)
Poliklinische analytische Diskussionsgruppen der Allgemeinen Ortskrankenkasse Berlin mit einer Durchschnittszahl von 12 Gruppenmitgliedern

Herbert Holt (USA)
Existential Group Analysis

O. Martensen-Larson (Denmark)
Die Bedeutung der gruppenpsychotherapeutischen Behandlung beider Ehegatten, besonders von Alkoholikerfamilien

E. de Perrot, G. de Simone and G. Lai (Switzerland)

G. L. Van Dalfsen (Netherlands)

Liselotte Meier (Switzerland)
Gruppenpsychotherapie bei Sexualdelinquenten im Zuchthaus

Yves Roumajon (France)
Psychotherapie de groupe en milieu carceral

G. Grandi, D. Napolitani and S. Rusconi (Italy)
Organizzazione e funzione di una comunita terapeutica psichiatrica extraospedaliera

S. Rusconi (Italy)
Alcune osservazioni sull'attivita ergoterapica di una comunita terapeutica extraospedaliera

L. DiLucchio, G. Cavagnino and G. Grandi (Italy)
Possibilita e limiti dell'attivita dell'assistente sociale in funzione di terapeuta ausiliaria di gruppo

M. Lerma, G. Cavagnino and L. Cazzaniga (Italy)
Il servizio sociale di gruppo-Sue applicazioni nel settore psichiatrico

FOURTH DAY, SUNDAY, JULY 21

Summaries of Section Chairmen

SECTION V—FAMILY THERAPY AND MARRIAGE

Chairman: A. Friedemann (Switzerland)
First Co-Chairman: R. Rossini (Italy)
Second Co-Chairman: A. Potamianou (Greece)

First Day, Thursday, July 18

Virginia M. Satir (USA)
Family Therapy—An Approach to the Treatment of Mental and Emotional Disorder

W. Schindler (Great Britain)
The Role of the Mother in Group Psychotherapy

S. Decobert (France)
L'experience d'un groupe de Parents d'enfants psychotiques

Rudolf Lassner (USA)
Family Centered Group Therapy with Chronic Schizophrenic Patients

Miriam Proctor (USA)
Group Treatment for the One Parent Family

Second Day, Friday, July 19

Rachel B. Bross (USA)
Group Psychotherapy with Alcoholic Married Couples

Georgia Resta (Italy)
Group Psychotherapy with Mothers

Asya L. Kadis (USA)
Married Couple Group with Male and Female Co-Therapists

Howard E. Mitchell (USA)
A Therapeutic Approach to the Alcoholic and his Non-Alcoholic Spouse in Group Psychotherapy

Third Day, Saturday, July 20

William K. McKnight (USA)
Problems of Family Therapy

Leon Tec (USA)
Transformation of Parental Group Guidance into Analytic Group Psychotherapy

Aron Krich (USA)
Counseling the Married Couple

Francoise Dolto (France)
Family and Institution taken as a Group

FOURTH DAY, SUNDAY, JULY 21

Summaries of Section Chairmen

SECTION VI—GROUP PROCESSES

Chairman: E. Borgatta (USA)
First Co-Chairman: A. Masucco Costa (Italy)
Second Co-Chairman: Jose A. Bustamante (Cuba)

FIRST DAY, THURSDAY, JULY 18

Edgar F. Borgatta (USA)
The Ordering of Interaction Patterns in Groups

P. A. Achille (Italy)
La Psychotherapie avec des Groupes de Jeunes Delinquents en Internat de Reeducation, Les Difficultees du Demarrage

Leon Tec (USA)
Transformation of Parental Group Guidance into Analytic Group Psychotherapy

Joseph E. Garai (USA)
The Use of Classroom Discussion and Sociodrama for Student Guidance

A. Marchesini (Italy)
Di un Particulare Tipo di Psicoterapia di Gruppo

SECOND DAY, FRIDAY, JULY 19

Emanuel Chigier (Israel)
Group Psychotherapy in a School by the School Physician in Israel

Harold Leopold (USA)
Introduction of a New Member in a Group Psychotherapy Setting (Open and Closed Groups)

A. Ploeger (Germany)
Therapeutische Nuancierungen bei Männer und Frauengruppen

Eugene S. Uyeki (USA)
Organizational Behavior, Morale and Preventive Intervention

THIRD DAY, SATURDAY, JULY 20

J. Altrocchi (USA)
Martin Lakin (USA)
Group Psychotherapy, Group Sensitivity Training and the Necessary Group Conditions for Therapeutic Personality Change

Arthur S. Samuels (USA)
Improving Psychotherapy by Utilizing Complementary Balance of the Characterological and Dynamic Needs of Group Members and of the Therapist

John L. Brown (Canada)
Pairs and Triads

David R. Hawkins, Mary G. Clarke, John T. Monroe and Charles R. Vernon (USA)
Group Psychotherapy as a Method for Studying Affects

FOURTH DAY, SUNDAY, JULY 21

Summaries of Section Chairmen

SECTION VII—CULTURAL CONSTELLATIONS IN GROUP PSYCHOTHERAPY

Chairman: R. Sarro (Spain)
First Co-chairman: G. Jacono (Italy)
Second Co-Chairman: Henry R. Gold (USA)

FIRST DAY, THURSDAY, JULY 18

Henry R. Gold (USA)
Ethnotherapy and the Phenomenon of Scapegoatism

Henry Enoch Kagan (USA)
Changing the Attitude of Christian Toward Jew

Thomas F. Graham (USA)
Existentialism and Peace

Laurette Kirstein and Harold Klehr (USA)
A Group Therapy Program for Students of Varying National Backgrounds

SECOND DAY, FRIDAY, JULY 19

T. Conti and A. Marchesini (Italy)
Il Problema Psicologico, Sociale ed Economico delle Psicoterapia

Jose A. Bustamante (Cuba)
The Participant Variables in the Patient-Physician Relationship with Special Reference to Tele and Transference in Group Psychotherapy

Carlos Ruiz Ogara, A. Campo and J. L. Marti Tusquets (Spain)
Methods and Concepts in the Formation of Group Psychotherapy in Spain

R. Holmboe (Norway)
Group Psychotherapy and Psychodrama in Norway

Estefania Aldaba Lim (Philippines)
Group Psychotherapy in the Philippines

THIRD DAY, SATURDAY, JULY 20

Alberto Fontana (Argentina)
The Situation of Group Psychotherapy in Argentina

T. A. Baasher (Sudan)
To be announced

D. A. W. Rittey (Rhodesia)
To be announced

S. O. W. Daouda (Senegal)
Beginnings of Psychohygiene, group psychotherapy and psychodrama in Senegal

M. A. Eltawil (Egypt)
Varieties of Group Psychotherapy in Egypt

G. Resta (Italy)
Psicoterapia di Gruppo e Valutazione di Merito

FOURTH DAY, SUNDAY, JULY 21

Summaries of Section Chairmen

SECTION VIII—TEACHING AND TRAINING METHODS

(INCLUDING SENSIVITY AND DESENSITIZATION, SPONTANEITY, ROLE AND BEHAVIOR TRAINING)

Chairman: Milton M. Berger (USA)
First Co-Chairman: R. Canestrari (Italy)
Second Co-Chairman: A. Friedemann (Switzerland)

FIRST DAY, THURSDAY, JULY 18

Leon Fine (USA)
The Development and Program of the St. Louis State Hospital Training Institute for Psychodrama and Group Psychotherapy

Samuel Tenenbaum (USA)
The Problem of Teaching Group Dynamics in a University Setting

Samuel Slipp (USA)
Intrapsychic and Actual Separation of Young Adults from their Parents

Beryce W. MacLennan (USA)
Group Supervision as a Training Method for Group Psychotherapists

J. Ardoino (France)
The Symbolic Way of Expression as Language, between Psychodramatist and Participants and Group

SECOND DAY, FRIDAY, JULY 19

Jack D. Krasner and Arlene Wolberg (USA)
The Observation Group: A Training Technique for Group Psychotherapists

Milton M. Berger (USA)
The Role of the Therapist in Fostering, Developing and Maintaining a Working Psychotherapy Group

Eduardo Luis Cortesa (Portugal)
Training Group Therapists, a Review of a Nine Year Experience

Francois Gantheret (France)
To be announced

THIRD DAY, SATURDAY, JULY 20

Irving A. Goldberg, Gerald J. McCarty, Emanuel K. Schwartz and Alexander Wolf (USA)
The Absence of Face to Face Contact in Training in Psychoanalysis in Groups: A Model for Training

Helen Durkin (USA)
Training Standards

Jacqueline Rouquette and Anne Ancelin Schutzenberger (France)
Formation du Personnel Psychiatrique Par Le Psychodrame et la Dynamique des Groupes—Experience Institutionnelle et Image Ideale De Soi

H. H. Wolf (Great Britain)
Group Dynamics in a Supervisory Group for Medical Students doing Psychotherapy

FOURTH DAY, SUNDAY, JULY 21

Summaries of Section Chairmen

SECTION IX—SELECTION METHODS AND SOCIOMETRIC GROUP FORMATION

Chairman: Helen H. Jennings (USA)
First Co-Chairman: C. Fazio (Italy)
Second Co-Chairman: D. Langen (Germany)

FIRST DAY, THURSDAY, JULY 18

D. Langen (Germany)
Die Bedeutung soziologischer Faktoren bei der Entstehung und Behandlung von Neurosen

Helen H. Jennings (USA)
Sociometry and Group Formation

J. L. Marti Tusquets (Spain)
Sociometric Control in Group Psychotherapy

Mary L. Northway (Canada)
Sociometric Relationships of a Group of Ten Children from Kindergarten to Grade III

C. Ruiz Ogara (Spain)
Criterios de Intervencion terapeutica en los Grupos

SECOND DAY, FRIDAY, JULY 19

N. Kosemihal (Turkey)
Sociometry and Cybernetics

Floyd S. Cornelison (USA)
The Audio-Visual Record in Psychiatry

C. Jorgensen (Denmark)
Psychotherapeutics, Group Psychotherapy and Ethics

A. Bonzi and D. Kieser (Germany)
Therapiekontrolle durch das Soziogramm

M. Oezek (Turkey)
Sociometry in a Mental Hospital Setting

THIRD DAY, SATURDAY, JULY 20

L. Meschieri (Italy)

C. Giacomice (Italy)

Paulette Cahn (France)
Psychology of fraternal relations

Jeanne Jaquet (France)

Pandharinath H. Prabhu (India)
Sociometry in India

C. Sacchi (Argentina)

A. Madeddu and E. Jannacaro (Italy)
Ricerche Sociometriche come Criteri Selettivi par la Formazione di Gruppi Psicoterapici in Alcoholisti Espedalizzati

FOURTH DAY, SUNDAY, JULY 21

Summaries of Section Chairman

SECTION X—COMBINATION OF METHODS: INDIVIDUAL–GROUP–SOCIETY

Chairman: J. Bierer (Great Britain)
First Co-Chairman: L. Meschieri (Italy)
Second Co-Chairman: P. Senft (Great Britain)

FIRST DAY, THURSDAY, JULY 18

J. Bierer (Great Britain)
The Concept of Self-Government in Group and Social Psychotherapy

Z. Boszormenyi (Hungary)
Group Psychotherapy and Psychodrama in Hungary

Finn Askevold (Norway)

SECOND DAY, FRIDAY, JULY 19

G. Kuhnel (Germany)
Unterschied zwischen Einzel und Gruppenpsychotherapie

Friedrich Minssen (Germany)
Group Psychotherapy in Clinical Settings

Perez Morales Francisco (Argentina)

THIRD DAY, SATURDAY, JULY 20

Paul Senft (Great Britain)
Clinical Data to the Phenomenology of Reality and Society

George Vassiliou (Greece)
On a New Approach to the Use of Free Artistic Creation in Group Psychotherapy

Elisabeth Risler (France)

Charlotte Goldfarb (France)

Odile Salbreux (France)

FOURTH DAY, SUNDAY, JULY 21

Summaries of Section Chairmen

SECTION XI—GROUP PSYCHOTHERAPY IN INDUSTRY

Chairman: Enzo Spaltro (Italy)
First Co-Chairman: A. Winn (Canada)

FIRST DAY, THURSDAY, JULY 18

Enzo Spaltro (Italy)
Group Psychotherapy in Industrial Settings

Severino Rusconi (Italy)
Il Lavoro Economicamente Redditizio e la Libera Espressivita Artistico-artigianale come Momenti Dialettici dell'Attivita Ergoterapica di una Comunita Terapeutica Extraospedaliera

Selvini Maria (Italy)

Canziani Gastone (Italy)

F. Barison (Italy)
Psychological, Social and Economic Problems in Psychotherapy

A. Masucco Costa (Italy)
Industrial Psychology and Group Psychotherapy

SECOND DAY, FRIDAY, JULY 19

A. Anfossi (Italy)

G. Crosa (Italy)
Autogene Training and Group Psychotherapy

A. Winn (Canada)
The Training Group

C. Actis Grosso (Italy)
L'applicazione del Lavoro di Gruppo come Metodo di Addestramento dei Capi

P. A. Achille (Italy)
Group Dynamics and Training Problems

G. Trentini (Italy)
Techniche di Gruppo e Ricerche Motivazionali

THIRD DAY, SATURDAY, JULY 20

Flavia Zaccone (Italy)

Luigi Lapi (Italy)

Georgio Zanocca (Italy)

FOURTH DAY, SUNDAY, JULY 21

Summaries of Section Chairmen

SECTION XII—PSYCHOSOMATIC MEDICINE AND GROUP PSYCHOTHERAPY

Chairman: Berthold Stokvis (Netherlands)
First Co-Chairman: G. Canziani (Italy)
Second Co-Chairman: W. Schwidder (Germany)

FIRST DAY, THURSDAY, JULY 18

Berthold Stokvis (Netherlands)
To be announced

Daniel Cappon and Mario Bartoletti (Canada)
Group Dynamics in Sleep Deprived Patients and Controls

N. Schipkowensky (Bulgaria)
Psychische Auswirkungen des kollektiven Lebens in den Arbeitsgruppen bulgarischer Jugend auf pathologischen Entwicklungen, Reaktionen und Prozessen der Personlichkeit

Hans Szewczyk (Germany)
Sociometry of Psychosmatic Ulcers

SECOND DAY, FRIDAY, JULY 19

Max Cooper (USA)
Group Psychotherapy with Headache Patients

A. Peto (Hungary)
Bewegungstherapie

F. Baixas (France)
Psychodramatic Approach to Psychosomatic Problems

THIRD DAY, SATURDAY, JULY 20

Helmut Enke, G. Maass, P. Rotas and G. Wittich (Germany)
Gruppenpsychotherapie in der psychosomatischen Klinik

H. Gaertner (Poland)
To be announced

Julian Aleksandrowicz (Poland)
To be announced

Henry Tappen (USA)
Drug Induced Psychodrama with LSD-25

FOURTH DAY, SUNDAY, JULY 21

Summaries of Section Chairmen

WORKSHOPS

I. ANALYTIC GROUP PSYCHOTHERAPY
Chairman: Curt Boenheim

II. PSYCHODRAMA (Including Sociodrama and Role Training)
Chairmen: Hannah B. Weiner, Simone Blajan-Marcus

III. MENTAL HOSPITALS
Chairmen: Pierre Bour, H. Kleinsorge

IV. THERAPEUTIC COMMUNITY (Including Criminology and Delinquency)
Chairman: Lee Fine

V. FAMILY THERAPY AND MARRIAGE
Chairmen: Adaline Starr, Max Ackerman, Asya L. Kadis

VI. CULTURAL CONSTELLATIONS—Illustration of Group Psychotherapy
Chairmen: Jose A. Bustamante, Henry Enoch Kagan

VII. TEACHING AND TRAINING: DEMONSTRATIONS
Chairmen: Eduardo Luis Cortesao, Jacqueline Rouquette

VIII. PRACTICE IN SOCIOMETRY, MICROSOCIOLOGY AND SELECTION METHODS
Chairmen: D. Langen, J. L. Marti Tusquets

IX. COMBINATION OF METHODS, INDIVIDUAL, GROUP, SOCIETY (Illustrations and Practice)
Chairman: Paul Senft

X. APPLICATION OF GROUP PSYCHOTHERAPY AND PSYCHODRAMA TO LABOR AND INDUSTRY
Chairman: Enzo Spaltro

XI. PSYCHOSOMATIC CLINIC AND RESEARCH
Chairman: Helmut Enke

PANEL

UNRESOLVED THEORETICAL AND PRACTICAL PROBLEMS OF GROUP PSYCHOTHERAPY

Experts on the Panel are the Speakers on the Plenary Sessions: J. L. Moreno, S. H. Foulkes, S. Lebovici, J. Bierer, Berthold Stokvis, Maxwell Jones, A. Friedemann, R. Sarro-Burbano, J. Favez-Boutonnier, Edgar F. Borgatta, R. Schindler, G. Kuhnel and Zerka T. Moreno.

Participants

Helmut Lechnek (Austria)
Hector Wiltz (Cuba)

Yves Roumajon (France)
A. Racine (France)
Miriam Hoffert-Horani (Israel)
C. Van Emde Boas (Netherlands)
P. A. H. Baan (Netherlands)
D. A. W. Rittey (Rhodesia)
J. Bunuel and E. Gonzales Monclus (Spain)
I. Westmark (Switzerland)
Tamara Sternberg (Switzerland)
H. Szinetar (Hungary)
T. Asuni (Nigeria)
Henri Colomb (Senegal)
Georges Muller (Luxemburg)
Emanuel D. Kotsos (USA)

Name and Country	Affiliation
Dr. P. A. Achille Italy	
Dr. Max Ackerman New York, N.Y. (USA)	Dir., Psychodrama and Hypodrama, Moreno Institute; Exec. Council, American Society of Group Psychotherapy and Psychodrama
Mrs. Sylvia Ackerman New York, N.Y. (USA)	Dir., Psychodrama, Moreno Institute; Dir., Kew-Forest Psychotherapy Center
Dr. Cs. Adorjani Pomaz, Hungary	Institute of Occupational Therapy, Ministry of Health
Dr. Julian Aleksandrowicz Krakow, Poland	
Dr. John Altrocchi Durham, N.C. (USA)	Assoc. Prof., Medical Psychology, Duke University
Dr. Roger Amiel Paris, France	
Dr. Leonarda Ancona Milan, Italy	
Dr. Joseph Andriola Atascadero, Calif. (USA)	Chief Psychiatric Social Worker, Atascadero State Hospital
Dr. A. Anfossi Turin, Italy	Professor of Social Psychology
Dr. J. Ardoino Paris, France	Association Nationale Pour le Developement des Sciences Humaines
Mr. Finn Askevold Oslo, Norway	
Dr. T. Asuni Abeokuta, Western Nigeria ARO Hospital	
Dr. P. A. H. Baan Groningen, Netherlands	Psychiatric Clinic
Dr. T. A. Baasher Sudan, Africa	Sr. Psychiatrist, The Republic of Sudan, Ministry of Health, Clinic for Nervous Disorders

NAME AND COUNTRY	AFFILIATION
Dr. F. Baixas Paris, France	Private Practice
Dr. F. Barison Padova, Italy	Psychiatric Hospital of the Province of Padova
Dr. Mario Bartoletti Toronto, Canada	Research Psychologist, Dept. of Psychiatry, University of Toronto
Dr. R. Battegay Basel, Switzerland	Psychiatric University Clinic
Dr. Robert R. Benson Dayton, Ohio (USA)	Chief of Court Psychological Services, Montgomery County Juvenile Court
Dr. Milton M. Berger New York, N.Y. (USA)	Consultant and Lecturer in Psychiatry, Naval Hospital, St. Albans, N.Y.
Dr. M. Berrini Milan, Italy	
Dr. Cornelius Beukenkamp, Jr. Glen Oaks, N.Y. (USA)	Supervisor of Group Psychotherapy, Hillside Hospital
Dr. Vytautas J. Bieliauskas Cincinnati, Ohio (USA)	Chairman, Dept. of Psychology, Xavier University
Dr. J. Bierer London W.1, Great Britain	Director, Malborough Day Hospital
Dr. Simone Blajan-Marcus Paris, France	Consultant in Psychiatry
Dr. C. Van Emde Boas Groningen, Netherlands	
Rabbi Alvin J. Bobroff Island Park, L.I., N.Y.	Rabbi of Congregation
Dr. Curt Boenheim Columbus, Ohio (USA)	Director of Group Psychotherapy, Columbus State Hospital
Dr. M. P. Bolten Oegstgeest, Netherlands	Psychosomatic Center, Leyden State University
Dr. A. Bonzi Tubingen, Germany	University of Tubingen
Dr. Edgar F. Borgatta Madison, Wisconsin (USA)	Chairman, Dept. of Sociology, University of Wisconsin
Dr. Z. Boszormenyi Budapest, Hungary	Consultant Psychiatrist
Dr. Pierre Bour St. Venant (P de C), France	Medecin des Hopitaux Psychiatriques
Dr. Rachel B. Bross Los Angeles, California (USA)	Res. Assoc. Psychiatrist, Neuropsychiatric Institute, U.C.L.A. Medical Center
Mr. John L. Brown Ontario, Canada	
Mr. Frank M. Buckley Worcester, Massachusetts (USA)	Assumption College
Dr. J. Bunuel Spain	
Dr. Jose Bustamante Habana, Cuba	Director, Instituto di Investigaciones de la Actividad Nervosa Superior, Universidad de la Habana
Mlle Paulette Cahn Strasbourg, France	University of Strasbourg
Dr. A. Campo Barcelona, Spain	University of Barcelona
Dr. R. Canestrari Milan, Italy	
Dr. Gastone Canziani Palermo, Italy	

Name and Country	Affiliation
Dr. G. Cavagnino Italy	
Dr. Daniel Cappon Toronto, Canada	Asst. Prof., Dept. of Psychiatry, University of Toronto
Dr. Carlo Lorenzo Cazzullo Milan, Italy	
Dr. L. Carraniga Italy	
Dr. G. Ceccarelli Italy	
Dr. Emanuel Chigier Ramat, Israel	M.R.C.P.E., D.C.H., Municipal School Health Service
Dr. Mary G. Clarke Chapel Hill, N.C.	Assoc. Prof. of Psychology, University of North Carolina
Dr. V. Cocilovo Norwich, Connecticut	Sr. Psychiatrist, Norwich Hospital
Dr. Henri Colomb Senegal	
Dr. Tullo Conti Padova, Italy	Psychiatric Hospital, Province of Padova
Dr. Max Cooper New York, N.Y. (USA)	Community Guidance Service Inc.
Mr. Nathan Cooper Los Angeles, California (USA)	Assoc. Prof., Los Angeles State College
Dr. Floyd S. Cornelison, Jr. Philadelphia, Pa. (USA)	
Dr. E. L. Cortesao Lisbon, Portugal	Sociedade Portuguesa de Neurologia e Psiaquiatrie, Hospital Miguel Bombarda
Dr. Giuseppe Crosa Genoa, Italy	
Dr. G. L. van Dalfsen Hilversum, Netherlands	
Dr. S. O. U. Daouda Dakar, Senegal, Africa	Ministere des Affaires Etrangeres
Dr. S. Decobert Paris, France	
Dr. W. Derbolowsky Hamburg, Germany	
Dr. Thomas Detre New Haven, Connecticut (USA)	Assoc. Prof. in Psychiatry, Yale University School of Medicine
Dr. Francoise Dolto Paris, France	
Dr. N. N. Dracoulides Athens, Greece	President of the Psychological-Biological Association
Dr. Helen Durkin New York, N.Y. (USA)	Lecturer, New York University
Dr. M. A. Eltawil Minia, Egypt	
Dr. Helmut Enke Freiburg, Br., Germany	Psychosomatic Clinic
Dr. M. Fagioli Italy	

Name and Country	Affiliation
Dr. J. Favez-Boutonier Paris, France	Professor of Psychology, Sorbonne
Prof. C. Fazio Genoa, Italy	Clinica Malattie Nervose e Mentali, dell 'Universita
Dr. R. Fichelet Seine, France	Societe D'Etudes et de Recherches en Sciences Sociales, Le Kremlin-Bicetre
Mr. Leon Fine St. Louis, Missouri (USA)	Director, Psychodrama and Group Psychotherapy, St. Louis State Hospital
Dr. Horst Flegel Dusseldorf, Germany	Psychiatric Department, Dusseldorf Hospital
Dr. Vincenzo Floris Siena, Italy	Professor, Siena Hospital
Dr. Hans Floter Springe/Deister, W. Germany	Heimvolkshochschule
Dr. Alberto Fontana Buenos Aires, Argentina, S.A.	
Dr. R. Fornari Milan, Italy	
Dr. S. H. Foulkes London, Great Britain	Founder, Group Analytic Society
Dr. Perez Morales Francisco Buenos Aires, Argentina, S.A.	
Dr. A. Friedemann Biel-Bieune, Switzerland	Professor of Psychiatry, University of Freiburg
Dr. D. Fuchs-Kamp Berlin, Germany	
Dr. Giulio di Furia Steilacoom, Washington (USA)	Sr. Clinical Director, Western State Hospital
Dr. H. Gaertner Krakow, Poland	Third Medical Clinic
Dr. Bela Galfi Pomaz, Hungary	Director, Institute of Occupational Therapy, Ministry of Health
Dr. Francoise Gantheret Paris, France	
Dr. Josef E. Garai New York, N.Y. (USA)	Professor of Psychology, Pratt Institute
Miss Rose Garlock New York, N.Y. (USA)	Alfred Adler Mental Hygiene Clinic
Dr. Gildo Gastaldi Milan, Italy	
Dr. Canziani Gastone Palermo, Italy	
Dr. Gilbert Genevard Lausanne, Switzerland	
Dr. G. Giacomice Milan, Italy	Department of Psychiatry and Pedagogy
Dr. Henry R. Gold New York, N.Y. (USA)	Visiting Consultant in Psychiatry, Roosevelt Hospital
Dr. Irving A. Goldberg Seattle, Washington (USA)	Private Practice
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Dr. E. Gonzales Monclus, Spain	

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Mme. Jean Jaquet Mulhouse, France	
Dr. Bernard Jean Paris, France	Neuropsychiatric Children's Clinic, Salpetriere Hospital
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Name and Country	Affiliation
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Dr. A. Marchesini Italy	
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Dr. A. Masucco Costa Turin, Italy	Institute Italiana di Psicologia Sociale
Dr. Kohei Matsumura Tokyo, Japan	
Dr. Joost A. Meerloo New York, N.Y. (USA)	Attending Psychiatrist, Columbia Presbyterian Medical Center
Dr. Hayden L. Mees Ft. Steilacoom, Washington (USA)	Sr. Psychiatrist, Western State Hospital
Dr. Liselotte Meier Zurich, Switzerland	
Dr. Robert Meigneiz Seine, France	Consultant in Psychiatry

Name and Country	Affiliation
Dr. Luigi Meschieri Rome, Italy	Direttore dell'Institut Nazionale di Psicologia del C.N.R., Professore di Ruolo in Psicologia, Universita di Urbino
Dr. Friedrich Minssen Frankfurt, Germany	
Dr. Howard E. Mitchell Philadelphia, Pennsylvania (USA)	Marriage Counsel of Philadelphia, Division of Family Study, School of Medicine, University of Pennsylvania
Dr. M. Mitscherlich Dusseldorf, Germany	
Dr. E. Gonzales Monclus Barcelona, Spain	
Miss M. Monod Paris, France	
Dr. John T. Monroe Chapel Hill, North Carolina (USA)	Instructor in Psychiatry, University of North Carolina
Dr. J. L. Moreno Beacon, New York (USA)	Adjunct Professor, New York University, Graduate School of Arts and Science; President, International Council of Group Psychotherapy
Mrs. Zerka T. Moreno Beacon, New York (USA)	Professor of Research, Academy of Psychodrama and Group Psychotherapy
Dr. Georges Muller Esch-sur-Alzette, Luxembourg	
Dr. Diego Napolitani Milan, Italy	
Dr. F. Napolitani Italy	
Dr. Mary L. Northway Toronto, Canada	Director of Research, Child Study Center, University of Toronto
Dr. M. Oezek Istanbul, Turkey	
Dr. Carlos Ruiz Ogara Barcelona, Spain	Hospital del Generalismo
Dr. G. Padovani Milan, Italy	
Dr. E. de Perrot Lausanne, Switzerland	Universty of Lausanne, Psychiatric Clinic
Dr. A. Peto Budapest, Hungary	Professor of Psychology
Dr. C. Petri Italy	
Dr. A. Ploeger Tubingen, Germany	University of Tubingen
Dr. Bruno Poggiali Livorno, Italy	Clinica delle Malattie Nervose e Mentali dell'Universita degli Studi di Pisa
Dr. Rene Portugaels Dison, Belgium	
Dr. Anna Potamianou Athens, Greece	Director, Section for Mental Health, Royal National Foundation
Dr. Pandharinath H. Prabhu Ahmedabad, India	University School of Psychology, Gujarat University

NAME AND COUNTRY	AFFILIATION
Mrs. Miriam Proctor New York, N.Y. (USA)	Parents without Partners, Professor of Psychiatry; Medical Director, State Institute for Rehabilitation
Dr. I. Puskas Pomaz, Hungary	Institute of Occupational Therapy, Ministry of Health
Dr. A. Racine Paris, France	
Dr. Giorno Resta Genoa, Italy	Professor of Psychology, Genoa University
Dr. Elisabeth Risler Paris, France	
Dr. Max Rosenbaum New York, N.Y. (USA)	Clinical Psychologist, Private Practice
Dr. G. Rossini Milan, Italy	
Dr. P. Rotas Freiburg, Br. Germany	Psychosomatic Clinic
Dr. Yves Roumajon Paris, France	Private Practice
Dr. Jacqueline Rouquette Paris, France	
Miss Sheila Rouslin New York, N.Y. (USA)	Instructor, Graduate Program, Advanced Psychiatric Nursing, Rutgers University, New Brunswick, N.J.
Dr. Jaromir Rubes Prague, Czechoslovakia	Psychiatricka Lecebna V Praze
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Dr. C. Sacchi Argentina	
Dr. Odile Salbreux Paris, France	
Dr. Arthur S. Samuels New Orleans, Louisiana (USA)	Louisiana Group Psychotherapy Society
Dr. R. Sarro Barcelona, Spain	Professor of Psychiatry, Medical School, University of Barcelona
Mrs. Virginia M. Satir Palo Alto, California (USA)	Director of Training, Family Project
Dr. L. Schenker Pomaz, Hungary	Institute of Occupational Therapy, Ministry of Health
Dr. R. Schindler Vienna, Austria	Specialist in Neurology and Psychiatry
Dr. W. Schindler London, Great Britain	Private Practice
Dr. N. Schipkowensky Sofia, Bulgaria	Assoc. Professor, University of Sofia
Mme. Anne Ancelin Schutzenberger Paris, France	Director, Groupe Francais D'Etudes de Sociometrie —Dynamique des Groupes et Psychodrama; Social Psychologist
Dr. Emanuel K. Schwartz New York, N.Y. (USA)	Assoc. Dean, Postgraduate Center for Mental Health
Dr. Paul Senft London, Great Britain	Psychotherapist, University College Hospital

Name and Country	Affiliation
Dr. Eugenia Shere Framingham, Massachusetts (USA)	Cushing Hospital
Dr. G. de Simone Lausanne, Switzerland	Psychiatric Clinic, University of Lausanne
Dr. J. Skala Prague, Czechoslovakia	Psychiatric Clinic, Anti-Alcoholic Department
Dr. Samuel Slipp San Francisco, California (USA)	Assoc. Professor, San Francisco State College
Dr. Michel Soule Paris, France	Asst. Physician of Neuropsychiatry, Hospital St. Vincent de Paul
Dr. Enzo Spaltro Milan, Italy	Professor of Sociology, Catholic University of Milan
Mrs. Adaline Starr Chicago, Illinois (USA)	Consultant, Veterans Administration
Dr. Tamara Sternberg Switzerland	
Dr. B. Stokvis Oegstgeest, Netherlands	Director, Psychosomatic Center, Leyden State University
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Dr. Leon Tec Norwalk, Connecticut (USA)	Med. Dir., Mid-Fairfield Child Guidance Clinic
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Dr. Yvan Tellier	
Dr. Samuel Tenenbaum New York, N.Y. (USA)	Assoc. Prof., Long Island University, Brooklyn, N.Y.
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Dr. Eugene S. Uyeki Cleveland, Ohio (USA)	Department of Humanities & Social Studies, Case Institute of Technology
Dr. George Vassiliou Athens, Greece	Director of Athenian Institute of Anthropos
Dr. Charles R. Vernon Chapel Hill, North Carolina (USA)	Clinical Asst. Prof. of Psychiatry, School of Medicine, Dept. of Psychiatry, University of North Carolina
Dr. M. Viviano Italy	
Miss Hannah B. Weiner New York, N.Y. (USA)	Professor of Psychology, Fashion Institute of Technology
Dr. I. Westmark Switzerland	

Name and Country	Affiliation
Dr. Daniel Widlocher Paris, France	Asst. Physician of Hospitals
Dr. Hector Wiltz Havana, Cuba	
Dr. A. Winn Canada	
Dr. G. Wittich Freiburg, Br., Germany	Psychosomatic Clinic
Mrs. Arlene Wolberg	
Dr. Alexander Wolf New York, N.Y. (USA)	Assoc. Attending Psychiatrist, Flower Fifth Avenue Hospital
Dr. H. H. Wolff London, Great Britain	Consultant Psychiatrist, Maudsley Hospital
Dr. Flavia Zaccone Turin, Italy	Professor of Social Psychology
Rev. Allan N. Zacher, Jr. St. Louis, Missouri (USA)	Canon, Christ Church Cathedral
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Dr. Rudolf Zimmert Berlin, Germany	Zentralinstitut fur Psychogene Erkrankungen der Allg. Ortskrankenkasse

ANNOUNCEMENTS

SYMPOSIA FOLLOWING THE CONGRESS IN MILAN

ISRAEL (AUGUST 4–6)

Professor Kreitler, Chairman of the Department of Psychology, University of Tel-Aviv, and Dr. Silfan, Chairman of the Tel-Aviv Branch of the Israeli Society for Group Therapy, have devised the following program:

(A) Visits to institutions which are most active in group psychotherapy and psychodrama. These include the main prison, a mental hospital, and a clinic for ambulatory patients. (All institutions are in the environs of Tel-Aviv.)

(B) One evening of three short lectures by prominent participants of the Congress. The lectures, followed by discussions, will be held at a public hall with many participants.

(C) A second evening with two short lectures given by the Israelis concerning:

  (1) The Psychological Problems of Intercultural Interaction in Israel.

  (2) The Psychiatric Problems of Intercultural Interaction in Israel.

(D) A cocktail party in honor of visiting guests.

TURKEY (AUGUST 2–4)

Arrangements for a symposium in Istanbul may be made with Professor N. Kosemihal who will be at the Congress in Milan.

LAKE MAGGIORE, PALLANZA, ITALY

(A) Seminar directed by Dr. S. Foulkes, will be held from Monday, July 22 to Wednesday, July 24.

(B) Seminar directed by Dr. C. Beukenkamp will be held from Monday, July 22 to Tuesday, July 23.

(C) Psychodrama demonstration, directed by Zerka Moreno, will be held Monday, July 22, in connection with the World Academy of Psychodrama and Group Psychotherapy.

LECTURE TOUR OF J. L. MORENO

AUSTRIA (JULY 26–27)

Upon invitation of the Psychiatric-Neurological Clinic of Vienna University (Professor Hans Hoff), Dr. and Mrs. Moreno will give a demonstration in the newly built Theatre of Psychodrama on the Clinic grounds.

HUNGARY (JULY 29–AUGUST 1)

Upon invitation of the Hungarian Society of Psychiatrists and Neurologists, the Hungarian Psychologists Association, and the Sociological Research Group of the Hungarian Academy of Sciences.

CZECHOSLOVAKIA (AUGUST 1–4)

Upon invitation of the Psychotherapeutic Commission of Psychiatric Section of the Czechoslovak Medical Society at the Psychiatric Clinic of the Charles University of Prague. (Professor MUDr Otakar Janota, Chairman of the Psychiatric Section and MUDr Jaromir Rubes, Chairman of the Psychotherapeutic Commission.)

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