THE PRESENCE AND ROLE OF IDENTIFICATION IN GROUP PSYCHOTHERAPY (NON-DIRECTIVE)

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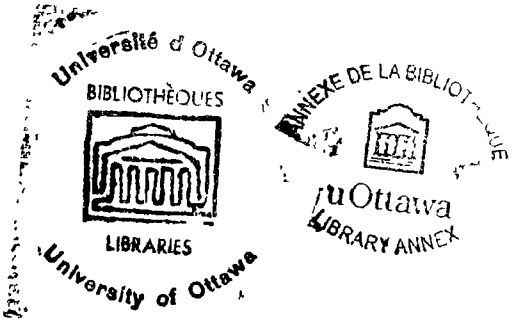
Thesis presented to the Faculty of Arts of the University of Ottawa through the Institute of Psychology as partial fulfillment of the requirements for the degree of Doctor of Philosophy in Clinical Psychology.



Ottawa, Canada, 1954

ACKNOWLEDGMENTS

This thesis was prepared under the guidance of the Director of the Institute of Psychology, Reverend Father Raymond H. Shevenell, O.M.I. Assistance was also received from Professors Maurice Chagnon and Lawrence T. Dayhaw.

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INTRODUCTION

Currently, there is an increased interest and attention being devoted to the treatment of individuals in a group setting. The case for the group approach was first constructed on the basis of an exigency measure because time and individual therapists of all professions were at a premium. Originally a time-saver, a placebo, or shock-absorbing measure, the group approach was discovered to possess something that yielded fundamental and lasting satisfactions over and beyond individual attention. Group psychotherapists became fascinated by this factor. They devoted a tremendous amount of energy to studying it carefully and to evolving from it critically delineated psychotherapeutic effects.

Although the literature disclosed a strong interest in why certain selected groups emerge with psychotherapeutic benefits, there has been insufficient crystallization, definition, and agreement as to what constitutes improvement in group psychotherapy. A fundamental axiom of any psychotherapeutic effort is the achievement of the maximum benefits that its technique allows. The conviction grew that it would be worthwhile to explore and establish criterion variables associated with effects, so that anticipations from group psychotherapy would not exceed the results or frustrate the psychotherapist.

The hypothesis is advanced that identification plays a crucial role in group psychotherapy. It is assumed that a patient who is positively inclined to treatment, and who declares his improvement, is an apt individual with whom another patient may identify. The second patient looks at the first and subliminally states: "He got over it. He's better. I'm the same. Therefore, I can look forward to something in life after all."

A distinction should be drawn between a "relationship" (the investment of external objects with emotional value) and "identification" (becoming like an object). A patient may tell his problems to several professional workers, but his status does not improve. He returns on a following visit, feeling worse than ever. Some relief may be obtained but it is temporary. It is like a visit to a psychic comfort station. The patient takes his enema but it does not prevent the constipation from repeating itself. He sees the doctor, but he does not carry anything substantial away.

To a certain extent, in every relationship to an object, a modified identification takes place. However, there are essential differences: identification is a more intense and a special type of relationship. It is more <u>intense</u> in that it places the experience on a permanent level which the patient carries away from the group. He appears actually to absorb

something from the group which he incorporates in himself. It is a special type of experience in that a young man might enjoy a relationship with his girl friend, but he certainly would not want to identify with her.

It is maintained in this thesis that insufficient emphasis has been assigned to the striking healing component of the identification factor. Some one psychotherapeutic effect, or conglomeration of effects, are usually stressed by various group psychotherapists without sufficient attention to actual results achieved, or sufficient consideration for the relationship of one effect upon another in the improvement process.

While there are basic historical reviews[1,2] available, Chapter I presents a reorganization of the material, with emphasis on the general aims of various frames of reference, the special aims of major contributors to group psychotherapy, and a discussion of their concepts of improvement in the light of the identification hypothesis.

Chapter II introduces the investigator's technique and philosophy of group psychotherapy. It has been influenced by the contributions of key figures in the literature, as well as

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1 Giles W. Thomas, "Group Psychotherapy", Psychosomatic Medicine, Vol. 5, 1943, p. 166-180.

2 J.I. Meiers, "Origins and Development of Group Psychotherapy", in J.L. Moreno, Editor, Group Psychotherapy, New York, Beacon House, 1945, p. 261-296.

five years of weekly seminars on the subject in the capacity of both student and supervisor. The explanatory framework is presented in detail because it was also the philosophy under which the group psychotherapists of this project were trained. The methodology of treatment is presented because it may affect the results that are reported and evaluated in Chapter III. A progressive schema of techniques is presented corresponding to a theoretical construct of progressive stages of identification.

Chapter III is the core of the thesis. It presents a statement of the problem, and the points of view of various theorists leading to the hypothesis that is advanced, to be checked later with the data. The design of the experiment is formulated with a description of the experimental and the control groups, the criterion instruments, and previous research conducted by other workers in similar studies. The theoretical constructs for Rorschach interpretation serve as a basis for analyzing the quantitative results. Three statistical comparisons are utilized. A questionnaire is evaluated for psychotherapeutic effects, subjected to a reliability test, and then related to discharge status. The results of both criterion instruments are discussed in relation to the basic hypothesis.

The third criterion measure for testing the hypothesis is reported in Chapter IV. The referrals of the group psychotherapy population are divided into continuing and non-continuing groups for the purpose of comparisons on face data information, crucial psychiatric intake variables, diagnoses, and adjunct individual psychotherapy.

The final chapter presents the summary, the outstanding features of the research, and the implication of the results.

CHAPTER I

HISTORICAL BACKGROUND

The group approach is not new; it has thrived as long as recorded history. The whole acculteration process as it is practiced in religious groups, social informal gatherings, and organizational groups such as the scouts, Masonic orders, professional organizations, can in some ways be called therapeutic in effect, although not in intent. Certain changes in attitudes may be brought about through the influence of such groups. However, these groups consist of a collection of emotionally unrelated individuals who are motivated not by illness and whose goals are not the alleviation of illness.

Despite the multiplicity and variety of groups, there still remains a large number of individuals who desire acceptance by others but have an aversion to joining a group. They are unable to find a group of people with similar problems, that permits the safe expression of their sufferings, vicissitudes and travail of isolation. Groups with such definitely structured objectives are relatively new. The earliest reference to their existence dates back to the turn of the century, with Pratt[1] as the pioneer of such efforts

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1 Joseph H. Pratt, "The Class Method of Treating Consumption in the Homes of the Poor", Journal American Medical Association, Vol. 49, 1907, p. 755-759.

in this country, and Moreno[2] as the promulgator of such endeavors in Europe. In fact, Moreno[3] claimed that he introduced the term Group Psychotherapy as a formal title in 1931.

A number of group psychotherapeutic methods have been used to influence the behavior of people in a favorable direction. A careful examination of the literature discloses that the methodologies of group therapeutic treatment can be broadly classified into three more or less distinct approaches: (1) suppressive frames of reference, (2) diversional frames of reference, (3) reconstructive frames of reference.

1.- Suppressive Frames of Reference.

Under this rubric are included the repressive-inspirational schools, so classified by Thomas[4] following the suggestion of Moore[5]; educative-orientational approaches; and the suggestive frame of reference.

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2 J.L. Moreno, Die Gottheit als Komoediant, Anzengruber Verlag, Vienna, 1911.

3 --------, Who Shall Survive, New York, Beacon House Inc., 1953, cxiv-763p.

4 Giles W. Thomas, "Group Psychotherapy", Psychosomatic Medicine, Vol. 5, 1943, p. 166-180.

5 Merrill Moore, "The Practice of Psychiatry", Harvard Medical Alumni Bulletin, Vol. 16, 1942, p. 53-58.

A.- Repressive-inspirational Schools.

The repressive-inspirational schools had their beginnings at the Boston Dispensary, represented by such men as Pratt[6,7] and Harris[8], and at the New York Kings Park State Hospital by Marsh[9]; and by such groups as Christian Science[10], Alcoholics Anonymous[11], and Recovery Incorporated[12].

The first publication that reported the value of groups in bringing about emotional improvement was attributed to Camus

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6 Joseph H. Pratt, "The Influence of Emotions in the Causation and Cure of Psychoneuroses", International Clinics, Vol. 4, 1934, p. 1-16.

7 --------, "The Group Method in the Treatment of Psychosomatic Disorders", Psychodrama Monographs, No. 19, Beacon House, 1946.

8 Herbert I. Harris, "Efficient Psychotherapy for the Large Outpatient Clinic", New England Journal of Medicine, Vol. 221, 1939, p. 1-5.

9 L.C. Marsh, "Group Treatment of Psychoses by Psychological Equivalent of the Revival", Mental Hygiene, Vol. 15, 1931, p. 328-349.

10 Mary B. Eddy, Science and Health, Boston, Christian Science Church, 1940, 231 p.

11 Alcoholics Anonymous, New York, The Alcoholic Foundation, 1941, 259 p.

12 Abraham A. Low, Recovery's Self-help Techniques, History and Description, Chicago, Recovery, 1943, 87 p.

and Pagniez[13], pupils of Dejerine[14] in 1904. Working at the Salpetriere, they discovered that ward patients in the Salle Pinel who experienced a communal social life and discussed their emotional problems together, improved more rapidly than wealthier patients who were isolated in private rooms.

Pratt[15], in 1905, observed similar emotional relationships among patients who met frequently in the waiting room of the Boston Dispensary. Klapman[16] referred to Pratt as the founder of group therapy because he consciously and deliberately directed efforts towards specific ends by using group influences. Beginning with ambulatory tuberculosis patients, Pratt extended group treatment to psychosomatic disorders and the neuroses. He felt that the appeal of the physician should be made to the emotions of the patient if he hoped to change their mental attitude. An uncooperative tubercular patient referred to Pratt as a Christian Scientist, or a professor of physical culture rather than a doctor.

Pratt described his procedure as a Thought-Control Class. At the present time, the name has been changed to a Class in Applied Psychology. The first thought-control class,

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13 J. Camus and P. Pagniez, Isolement et Psychothérapie, Paris, Felix Alcan, 1904, 407 p.

14 J. Dejerine and E. Gauckler, The Psychoneuroses and Their Treatment by Psychotherapy, Philadelphia, 1913, 389 p.

15 Joseph H. Pratt, op. cit., p. 755-759.

16 J.W. Klapman, Group Psychotherapy, Theory and Practice, New York, Grune, 1946, vii-344 p.

so named by one of its charter members, met on April 11, 1930. Since then over eight hundred patients have been referred to the class by the physicians of the medical clinic. Referrals occur following a careful case history and a thorough physical examination. Pratt hoped that this procedure would reduce the somatic entrenchment which patients placed on symptoms of psychic origin. He found that testimonials of improvement given by fellow neurotic patients carried more conviction than an explanation given by the physician in the privacy of the consultation room.

The mechanics of the Pratt technique was presented in the following sequence: (1) a relaxation session, (2) a short talk on a topic germane to mental health, (3) a request for written reports of progress from the patients, (4) an oral presentation by the therapist of statements of greatest improvement, (5) a recital of spontaneous testimonials (verbal statements of failure were forbidden), (6) a promotional arrangement in seat location, (7) an assignment of each candidate to an older member who explained the methodology of treatment in detail and who urged attendance at the following session.

Rhoades[17], Hauptmann[18], Johnson[19], Buck[20], Snowden[21], and Hadden[22] have followed along lines very close to Pratt in their treatment of the neuroses.

Harris[23] made the first serious attempt to formalize the psychotherapeutic elements operating within the Pratt type of group. He listed the psychotherapeutic components under the following five main categories: (1) loss of self-consciousness, (2) sthenic suggestions to the group, (3) establishment of rapport with the leader, (4) reinforcement of all factors, and (5) friendly relations established amongst members. Out of the total number of patients who attended group therapy, sixty-eight per cent improved. The benefits

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17 Winifred Rhoades, "Group Training in Thought Control for Relieving Nervous Disorders", Mental Hygiene, Vol. 19, 1935, p. 373-386.

18 Alfred Hauptmann, "Group Therapy for Psychoneuroses", Diseases of the Nervous System, Vol. 4, 1943, p. 22-25.

19 Paul E. Johnson, "Religious Psychology and Health", Mental Hygiene, Vol. 31, 1947, p. 556-566.

20 R.W. Buck, "The Class Method in the Treatment of Essential Hypertension", Annals International Medicine, Vol. 11, 1937, p. 514-518.

21 E.M. Snowden, "Mass Psychotherapy", Lancet, Vol. 11, 1940, p. 769-770.

22 Samuel B. Hadden, "Group Psychotherapy: a Superior Method of Treating Larger Numbers of Neurotic Patients", American Journal of Psychiatry, Vol. 103, 1947, p. 644-649.

23 Herbert I. Harris, op. cit., p. 1-5.

ranged from the alleviation of one or two of the most painful symptoms to a complete freedom from symptoms.

Marsh[24,25,26] treated neurotics and psychotics. He attempted to stimulate and inspire patients into a happier state of mind, much as a revival meeting does to religious feeling. He felt that mental illness was a social disease, that it was caused by the group and therefore should be healed by the same agency. His methodology was derived from the following principles: (1) mob psychology with reality as a motive, (2) concepts of salesmanship with sanity for sale, (3) cooperation and morale - Trudeau Sanitarium group method, (4) social service methods, (5) recreational and occupational activities, (6) soul winning as used by the Salvation Army, revivalists, missionaries. Marsh drew a distinction between his goals and that of the revivalist:

The revivalist:	Marsh's objectives:
(1) A conversion from sin to righteousness,	(1) A conversion from fantasy to reality,
(2) A salvation for a future life predicated on a conversion,	(2) A salvation for life predicated on a conversion,
(3) The acceptance of a given philosophy.	(3) The acceptance of principles of mental hygiene.

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24 L.C. Marsh, op. cit., p. 328-349.

25 --------, "Experiment in Group Treatment of Patients at Worcester State Hospital", Mental Hygiene, Vol. 17, 1933, p. 396-416.

26 --------, "Group Therapy and Psychiatric Clinics", Journal Nervous and Mental Diseases, Vol. 82, 1935, p. 381-393.

The leaders of Christian Science[27] state unequivocally and emphatically that the prime purpose of their meetings is a religious one. However, despite their attitude, there has been ample evidence that their services are in some measure therapeutic. Pratt adopted, essentially, the methods of Christian Science by the use of an impressive leader and by the use of testimonials of star patients.

Alcoholics Anonymous has an almost fantastic reputation in current events as reported in the newspapers, popular books, and the radio. The book entitled Alcoholics Anonymous[28], apparently written by the pioneers of this organization, depicts the general program and methods. It is a very popular but unsystematic presentation of orientation and goal. Some quotations from the book will clarify their frame of reference:

> There exists among us a fellowship, a friendliness, and an understanding which is indescribably wonderful. The feeling of having shared in a common peril is one element in the powerful cement that binds us. The tremendous fact for everyone of us is that we have discovered a common solution.

And again:

> We have had deep and affective spiritual experiences which have revolutionized our whole attitude toward life, toward our fellows, and towards God's universe.

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27 Personal communication.

28 Alcoholics Anonymous, op. cit., 259 p.

William James' book, Varieties of Religious Experiences, which appears to have been a source of inspiration for much of the work of Alcoholics Anonymous, was referred to a number of times. Most of the book, Alcoholics Anonymous, is devoted to numerous testimonials by various individuals who have claimed benefits from this organization. An outline of twelve steps constituted their program of recovery. These are stated briefly as follows: (1) admission of defeat, (2) faith in a Divine Power as Healer, (3) complete surrender to God, (4) fearless moral self-inventory, (5) public confession, (6) willingness to change under God's influence, (7) an attitude of humility, (8) make amends to persons who were harmed, (9) make direct amends unless injurious to these people or others, (10) continuation of personal inventory, (11) seek help through prayer and meditation, (12) disseminate a spiritual awakening to other alcoholics. They attributed the source of their difficulty to their own selfishness and self-centeredness.

Alcoholics Anonymous claimed 100% effectiveness with non-psychotic drinkers who had a strong motivation to make a change; 50% recovered almost immediately; 25% became well after suffering a relapse or two, and the rest were reported doubtful. This rate of success is exceptionally high. Dependable statistics for cures of alcoholics are lacking.

Low[29], founder of Recovery Incorporated in Chicago, introduced an example of firm leadership to a large group of psychotics. He sought to reduce the stigma of mental illness. He developed a hierarchical organization of patient units which extended outside the hospital. He utilized positive factors of relationship along with lecture methods. The presentation of problems, symptoms, basic fears, and feelings by patients were regarded as treason against the authority of the physician. By example and usage, patients learned that impulses can be checked; words can be harmful. A key language was developed to sustain mental health, such as danger, sabotage, authority.

B.- Educative-Orientational Approaches.

In this category may be included most of the group therapy accomplished under military auspices. The latter differed from most civilian group therapy in that the emphasis was more concerned with the improvement of group morale than amelioration of individual suffering. Representative reporters

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29 Abraham A. Low, op. cit., 87 p.

of this method were men like Sherman[30], Bion and Rickman[31], Jones[32], and many others.

The didactic approaches have also been used generally in state hospitals[33,34] and more specifically in interpreting the meaning of group therapy to the parents and relatives of psychotics[35,36]. This technique has been employed with mothers of school[37] and pre-school children[38]. Educational methods have been used to explain the nature of chronic

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30 S. Sherman, "A System of Combined Individual and Group Therapy as Used in the Medical Program for Merchant Seamen", American Journal of Psychiatry, Vol. 100, 1943, p. 127-130.

31 W.R. Bion and J. Rickman, "Intragroup Tensions in Therapy", Lancet, Vol. 14, 1943, p. 678-681.

32 M. Jones, "Group Psychotherapy", British Medical Journal, Vol. 2, 1942, p. 276-278.

33 Abraham M. Schneidmuhl, "Group Psychotherapy Program at the Spring Grove State Hospital", Group Psychotherapy, Vol. 4, 1951, p. 41-55.

34 Marguerite M. Parrish and Jack Mitchell, "Psychodrama in Pontiac State Hospital", Group Psychotherapy, Vol. 4, 1951, p. 80-81.

35 Margaret E. Brennan and Maxine Steinitz, "Interpretation of Group Therapy to Parents", American Journal of Orthopsychiatry, Vol. 19, 1949, p. 61-68.

36 W.D. Ross, "Group Psychotherapy with Patients' Relatives", American Journal of Psychiatry, Vol. 104, 1948, p. 623-626.

37 Betty Gabriel and Anita Halpert, "The Effect of Group Therapy for Mothers on Their Children", International Journal of Group Psychotherapy, Vol. 2, 1952, p. 159-171.

38 Abraham Fabian et al., "Parallel Group Treatment of Pre-School Children and Their Mothers", International Journal of Group Psychotherapy, Vol. 1, 1951, p. 37-50.

diseases and to minimize social ostracism[39]. Expectant mothers[40] found it a medium to ventilate their anxieties, and for a psychically healthier acceptance of the child. Mental Health associations have sent out psychiatrically-oriented personnel to attempt, through lectures and other methods, to reach people's emotions, attitudes, and prejudices[41].

C.- Suggestive Frameworks.

This method is used rarely as a total treatment, but more frequently as an adjunct. As a total treatment, it has been employed in Jacobson's[42] progressive relaxation technique. As an adjunct, suggestive methods have been employed by Pratt[43], Burrow[44], Schilder[45], and others.

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39 Albert L. Deutsch and Joseph Zimmerman, "Group Psychotherapy as Adjunct Treatment of Epileptic Patients", American Journal of Psychiatry, Vol. 104, 1948, p. 783-785.

40 Gerald Caplan, "Mental Hygiene Work with Expectant Mothers", Mental Hygiene, Vol. 35, 1951, p. 41-50.

41 Mrs. Melvin A. Glasser, "Group Therapy in the Community", Neuropsychiatry, Vol. 2, 1952, p. 74-77.

42 Edmund Jacobson, Progressive Relaxation, Chicago, University of Chicago Press, 1938, xvi-494 p.

43 Joseph H. Pratt, op. cit., p. 1-16.

44 Trigant Burrow, "Kymograph Records of Neuromuscular Patterns in Relation to Behavior Disorders", Psychosomatic Medicine, Vol. 3, 1941, p. 184-186.

45 Paul Schilder, Psychotherapy, New York, Norton, 1951, 396 p.

Singer[46] used post-hypnotic suggestion in order to maximize the participation of patients in, and use of, group therapy. Cahn[47] utilized benzedrine to accomplish the same purpose.

Simmel[48] combined individual hypnosis with parallel group methods in German military hospitals in World War I. His emphasis on abreaction of the traumatic neuroses anticipated Grinker's[49] spectacular use of intravenous amytal to bring about the same effect upon the battle scarred veterans of World War II. Simmel felt that repressed hostility of soldiers to their superiors was an important sector for treatment purposes. Unsatisfied with verbal catharsis, he used the ingenious suggestive device of inviting an acted out type of abreaction against an upholstered dummy wearing officer's insignia. He invited patients to brutally attack this symbolically hated fiture.

Critique of suppressive methods.- Characteristic of these types is an emotionally-led group that utilizes the

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46 William B. Singer, op. cit., p. 205.

47 C.H. Cahn, "The Use of Drugs in Group Therapy", American Journal of Psychiatry, Vol. 107, 1950, p. 135-136.

48 Sigmund Freud, Sandor Ferenczi, Karl Abraham, and Ernst Simmel, Psychoanalysis and War Neuroses, International Psychoanalytic Press, 1921.

49 Roy Grinker and John P. Spiegal, Men Under Stress, Philadelphia, Blackstone, 1945.

potential emotional forces residing in it. Suppressive therapies begin, first of all, with a leader who has a certain amount of dynamism about him. He has a flair for rabble rousing. This trait, constructively directed, makes him an ideal group leader. He infuses the group with a sense of optimism, with a feeling that the whole difficulty is nothing much to worry about, that it simply requires a firm and an immediate separation from one's conflicts, and that the patients can then go on to bigger and better things. The therapist is a definite leader for a group who follow him, a group that is very easily inspired and swayed by him. The leader makes recourse and appeal to the infantile or early emotional attitudes of many of the patients.

There is a strong appeal to the exhibitionistic tendencies in individuals. If it can be assumed that there is a considerable amount of infantilism in the patients who come for this form of therapy, there will be concomitantly a considerable amount of pleasure derived from exhibitionism. When the patients arise and give testimony they attract attention. A feeling of acceptance appears to be evoked, increases their rapport with their fellows, and strengthens a desire for the group.

Inspiration in itself is a type of reassurance. The group identifies itself with a strong figure. The leader

satisfies the needs of the patients, not in terms of resolving their conflicts, but in reassuring them to the extent that they are helped to suppress their conflicts to a level where they are no longer disturbed in terms of symptomatology.

There are a number of psychotherapists who have a strong antipathy towards this technique. It seems to them to be too anti-psychiatric. The clinical and incontrovertible facts are that these methods, often very unscientific, do help people. The question is: "How can so many unscientific methods produce therapeutic results?"

The problem has both theoretical and practical importance, but is of special import to the psychotherapist who, accustomed in his own work to attribute scientific validity to the pragmatic test of his therapeutic devices, finds himself faced with the dilemma of having to give credence to unscientific methods because they, too, have produced results. The tendency is to ignore or minimize the therapeutic effects of suppressive treatment for an anxiety neurosis as something akin to black magic or quackery, and let it go at that. Accustomed as the psychotherapist is to more rigid, scientific thinking, he cannot always comprehend the magical immature thinking of children and sick people.

Knight[50] pointed out that all children, because of their lack of knowledge and comprehension of the real world about them, indulge in primitive thinking which is fantastic, unscientific, and superstitious. As the child matures, he relinquishes this prelogical thinking for more scientific reasoning influenced by education and realities. Hardly anyone, however, entirely overcomes all his magical thinking. Each of us to some extent has private superstitions or rituals upon whose magical power we occasionally rely.

Studies by White[51] of the Harvard Psychological Clinic showed that in the more formal suggestive methods, like hypnosis, the ritual is gone through with the same magical effect. The patient's role is one of deference. White stated that successful hypnosis can occur only in those individuals who have an infantile need for love, a tendency for passive compliance, and the wish to participate in omnipotence.

So much emphasis has been placed upon the therapeutic effect of mental catharsis, that frequently something more basic in the patient's potential for recovery is overlooked. May not a psychotherapeutic effect be brought about by the therapist in such instances because he meets an unconscious need of patients by listening calmly and with equanimity, not disapproving, and by persisting in a kindly attitude?

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50 Robert P. Knight, "Why People Go to Cultists", Bulletin of the Menninger Clinic, Vol. 3, 1939, p. 139-148.

51 Robert W. White, "An Analysis of Motivation in Hypnosis", Journal General Psychology, Vol. 24, 1941, p. 145-156.

2.- Diversional Frames of Reference.

In this second major division may be included a large number of group efforts employing varied and extensive aids and adjuncts. Its therapeutic applications are dealt with in a more indirect fashion. However, they deserve a place in this review because one or another of them has been used as a total treatment by psychiatrists or ancillary professions, and because certain therapeutic advantages have been declared.

Diversional therapy is usually a medically prescribed activity for therapeutic objectives. It has been confined, for the most part, to behavior problems of children, delinquents, and withdrawn individuals.

"Diversional" is a term that is familiar to occupational therapists. It usually designates something that is used to increase physical and mental activity in order to prevent muscular atrophy, boredom, or more positively, "to increase physical and mental tone"[52]. Occupational therapy has too frequently, in the minds of the laymen, been associated with just busywork.

One of the most effective psychiatric tools is verbal communication. Often, however, one is confronted with non-

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52 Sidney Licht, "The Prescription of Occupational Therapy", New York State Journal of Medicine, Vol. 48, 1948, p. 1032-1034.

verbalizing patients. There are many psychiatric patients whose emotional and intellectual abilities have been so hampered by their conflict situations that verbal expression is impeded. This barrier interferes with the development of desirable relationships so necessary for psychotherapy. It provided a challenge, to find an appropriate expressive substitute for the patient's inability to communicate through the usual channels.

The objectives of diversional therapy are gained by the use of activities and tools. Most of these activities have, through usage, become associated with the word "therapy", and others have not. Actually they are not separate forms of therapy but rather different modalities of occupational therapy. The following list is suggested as an inventory of these activities:

A. Industrial therapies.

B. Recreational therapies:
   a) Introductory activities: games, trips, athletics, others.
   b) Artistic expressions: printing, lettering, painting, sculpture, others.
   c) Literary interests: bibliotherapy, reading.
   d) Dance kinetics: rhythmics.
   e) Musical applications: classical, traditional, others.
   f) Dramatic outlets: posters, films, puppets, psychodrama, etc.

A.- Industrial Therapies.

Up to the present, there have been no articles on group therapy that have dealt directly with this category of occupational therapy. Industrial therapy, a term used for more than a decade, has received two entirely different applications. As originally introduced by Bryan[53], it referred exclusively to those industries concerned with hospital maintenance, whether they be mechanical, such as the laundry; craft, such as carpentry; administrative, such as clerical; or custodial, such as grounds care. Recently, the commercial employment of patients has been introduced into some hospitals.

B.- Recreational Therapies.

Recently, the psychiatrically-oriented professions have invaded and emancipated the domain of the recreational therapies. No clearcut procedure has been recommended as to the selection of activity most appropriate to progressive levels of adaptation.

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53 William Bryan, Administrative Psychiatry, New York, Knopf, 1936, iv-314 p.

a) Introductory activities.- This treatment technique has been employed chiefly with psychotics[54,55,56]. Since these patients are the most withdrawn from reality, group experiences are very difficult for them. Daily contacts with one worker are usually utilized. Gradually, an activity is introduced in which the two alone can participate. After a while, the worker who initiates the activity steps out and another patient who has previously been in a similar therapeutic process steps in. In short, an attempt is made to wean the patient away from a solitary retreat. This phase of the work requires persistent effort before signs of acceptance and trust of the therapist appear. Activities usually involve some type of game like ping-pong, billiards, ring toss, etc. Interpersonal relations are strained and superficial. A continuous and consistent helping attitude of this type helps to bring about a shift of interest to others. As the patient moves closer in his contact with reality, he is able to use his relationship with his group worker as a tie to lead him

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54 Mortimer Schiffer, "Trips as a Treatment Tool on Activity Group Therapy", International Journal of Group Psychotherapy, Vol. 2, 1952, p. 139-149.

55 Arvilla D. Merrill, "Occupational Therapy with Maximum Security Patients: An Adjunct to Group Psychotherapy", Psychiatric Quarterly Supplement, Vol. 23, 1949, p. 205-223.

56 Louis Halle and J.F. Ross, "A Therapy Program for Schizophrenic Patients", United States Veterans Department of Medicine and Surgery, Information Bulletin, No. 10-13, July, 1951, p. 3-8.

into a group experience that is not too demanding. Group activities may then take the form of fishing trips, hikes, motor trips, and visits to various professional recreation centers. At this stage, the patient is ready to associate with a group around a common project. He is now getting better and is able to take his place in a group where he plans with others, helps the group make decisions, and carries some share of responsibility. The carefully planned and guided group experience affords the patient the opportunity to test himself in a reality situation, to develop latent capacities for participation or leadership, and to receive the recognition of others for his accomplishment. Unfortunately, no objective attempt has been made to measure these gains. Group discussions are then held several times weekly with a group therapist in charge to give the patients a chance to express themselves verbally, to ease tension, and to arouse group feeling and unity. During the summer months, if a gymnasium is available, various athletic activities may be utilized. Some of the patients may be undergoing shock treatment or insulin therapy concurrently with group psychotherapy.

b) Artistic expressions.- Slavson[57], Redl[58], and others have used this method in the treatment of behavior problems of children. Slavson's activity group consists of young children up to 10 years of age. Art, instead of verbalization, is used as the basic tool to liberate hidden and overt aggressions, fears, and confusion. Redl encouraged the use of artistic equipment with children in approximately the same age group as Slavson's. Redl's chief interest was diagnostic in nature. He attempted to find out, through the group medium, what the youngster was like. Detailed notes were taken of the child's behavior as well as group dynamics.

In the psychiatric treatment of adults, lettering was used by Wright[59] with psychotics in remission. She reported on an extramural clinic which served State Hospitals in the Chicago area. The twenty-six letters of the alphabet were used. The patient's response and reaction to writing them on the blackboard was noted. This procedure supplied diagnostic information to the therapist. The latter addressed her comments to the class and not to the patient.

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57 S.R. Slavson, "Differential Methods of Group Therapy in Relation to Age Levels", Nervous Child, Vol. 4, 1945, p. 196-210.

58 Fritz Redl, "Problems of Clinical Group Work With Children", Proceedings of the Second Brief Psychotherapy Council (sect. 3), Institute of Psychoanalysis, Chicago, 1944, p. 29-35.

59 Katherine W. Wright, "Group Therapy in Extramural Clinic", Psychiatric Quarterly, Vol. 20, 1946, p. 322-331.

Finger-painting has proved of value with psychotics. It has been the most popular outlet among the artistic expressions for the withdrawn patient. Napoli's[60,61] contribution to the psychotherapeutic use of this medium may be summarized in three points. The first constitutes the behavior observation of the patient in action including his physical performance, gestures, attitudes, mannerisms, etc. The second significant area is the analysis of the painting itself which includes such considerations as handedness, color, motion, rhythm, texture, order, composition, and symbolism. The third area is the verbalization which the patient attaches to his painting at any time during the process. Napoli's clinical and professional observations, however, were never followed up in an objective assessment of gains accrued.

Finger painting serves as an opening wedge in developing a positive relation between the patient and therapist. This type of activity is quickly accepted by patients in spite of their emotional and intellectual regression. This is due to the ready ease of manipulation, as well as the feeling of achievement that is attained without lengthy

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60 Peter J. Napoli and Beatrice Gold, "Finger Painting in an Occupational Program", American Journal of Occupational Therapy, Vol. 1, 1947, p. 358-361.

61 Peter J. Napoli, "A Finger Painting Training Course", United States Veterans Department of Medicine and Surgery, Information Bulletin, 10-16, October 1951, p. 21-22.

training. It has a psychic cathartic value. It tends to have a relaxing effect. It serves as an objective means for observing progress. Increased socialization has been noted.

c) Literary interests.- Bibliotherapy provides the patient with a more cheerful milieu. The library, with attractive furniture, books, perhaps flowers, is the setting. Menninger[62], Powell[63], and Schneck[64,65] found that discussion of books "helped to develop emotional maturity". Blackman[66] organized a literary club for schizophrenics. Kircher[67] applied bibliotherapy to the behavior problems of children.

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62 William C. Menninger, "Bibliotherapy", Bulletin Menninger Clinic, Vol. 1, 1937, p. 263-274.

63 John Walker Powell, "Group Reading in Mental Hospitals", Psychiatry, Vol. 13, 1950, p. 213-226.

64 M. Schneck, "Studies in Bibliotherapy in a Neuropsychiatric Hospital", Occupational Therapy Rehabilitation, Vol. 23, 1944, p. 316-323.

65 --------, "Bibliotherapy and Hospital Library Activities for Neuropsychiatric Patients", Psychiatry, Vol. 8, 1945, p. 207-228.

66 Nathan Blackman, "Experiences With a Literary Club in the Group Treatment of Schizophrenia", Occupational Therapy Rehabilitation, Vol. 19, 1940, p. 293-305.

67 C.J. Kircher, "Character Formation Through Books", Catholic University of America, Washington, D.C., 1944.

d) Dance kinetics.- Chase[68] and Bunzel[69] used rhythm, ballroom dancing, and free dance improvisation as a means of encouraging activity and interest in others. Psychotics tend to have a general lack of physical will-to-change, and often a profound resistance against any attempt to alter a body position or behavior pattern.

e) Musical applications.- Altshuler[70] presented a unique although simple method for initiating interpersonal relationships. Each patient was given a pair of wooden blocks or sticks. A march in two-four time was played and an instructor, holding a block in each hand, clapped them together in time to the music and invited the patients to do likewise. In a short time, the majority of the patients joined in. The next stage was started by playing the National Anthem. Some responded, approached the piano, and listened; some hummed. A patient was invited to sing his favorite song. This encouraged another patient to join the group. Chairs were placed in a circle and other patients were invited to join.

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68 Marion Chase, "Rhythm in Movement as Used in Saint Elizabeth's Hospital", in J.L. Moreno (editor), Group Psychotherapy, New York, Beacon House, 1945, p. 243-245.

69 Gertrude Bunzel, "Psychokinetics and Dance Therapy", Journal of Health and Physical Education, Vol. 19, 1948, p. 180-181; p. 227-229.

70 I.M. Altshuler, "One Year's Experience With Group Therapy", Mental Hygiene, Vol. 24, 1940, p. 190-196.

Mitchell and Zanker[71] restricted themselves to a small group of patients and concentrated on music as a possible method of group therapy. They decided to study the reactions of different clinical types to different musical styles. They found that romantic music, although it often produced emotional release, did not tend to facilitate group cohesion. A number of patients, especially of the inhibited type (mainly schizophrenics and neurotics) felt unable to integrate the thoughts and feelings aroused. Serious contemporary music was more effective than romantic and other music, in some inhibited schizophrenics, in bringing repressed emotional forces into consciousness. Classical music appeared to give more security, presumably due to its firm formal structure. Quite the most effective in increasing the harmony of the group were traditional and folk songs. Many examples of these were given from different countries. This type of music, based on the most deep-seated of human relationships, struck a universal chord which seemed to bind the people together.

Mitchell cites the remarks of two chronic psychotics. One patient listened to Bach's Air for the G String and said, "It's solemn and sad, but it does you good because it is so balanced". Another, after hearing Beethoven's Fifth Symphony,

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71 S.D. Mitchell and A. Zanker, "The Use of Music in Group Therapy", Journal of Mental Science, Vol. 94, 1948, p. 737-748.

said, "Now there was a man who overcame his great difficulties, and it shows you life is still worth while". The above authors felt that music encouraged self-expression, self-understanding, and improvement in interpersonal relationships.

f) Dramatic outlets.- This category may be subdivided into visual aids, military; visual aids, non-military; and psychodrama.

Military visual aids were employed in World War II to treat problems centering about adjustment to the new situation, early handling of the maladjusted, attitude conditioning, and adjustments necessary upon return to civilian life. For these purposes psychiatrists utilized charts and posters[72], motion pictures[73], and puppets[74,75]. The method was chiefly educational-orientational in nature, directed towards prevention psychiatry.

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72 Joseph J. Michaels and E. Omar Milton, "Group Psychotherapy for Neuropsychiatric Patients Being Discharged From the Army", Occupational Medicine, Vol. 1, 1946, p. 60-74.

73 Howard P. Rome, "Military Group Psychotherapy", American Journal of Psychiatry, Vol. 101, 1945, p. 494-497.

74 R.R. Cohen, "Mental Hygiene for the Trainee", American Journal of Psychiatry, Vol. 100, 1943, p. 62-71.

75 --------, "Visual Aids in Group Psychotherapy", Occupational Therapy Rehabilitation, Vol. 23, 1944, p. 324-329.

Non-military visual aids include plays, stories, puppets, and drama techniques. These methods have been used chiefly in the study and treatment of children with behavior disorders. Schilder and Bender[76], Bender and Woltmann[77], Despert[78], Axline[79], and others used these aids as attention-seeking devices when expressions of fantasy were difficult, and when "bad" fantasies had to be acted out. Puppets, rather than the use of dolls, were found to be more acceptable to boys.

Psychodrama represents the newest of the arts, but precedes in point of time the publication of other dramatic methods in the treatment of the emotionally ill individual. Psychodrama is largely the creation of one man, Moreno[80,81].

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76 Paul Schilder and Lauretta Bender, "Principles of Form in the Play of Children", Journal Genetic Psychology, Vol. 49, 1936, p. 254-261.

77 Lauretta Bender and Adolph G. Woltmann, "Use of Puppet Shows as Psychotherapeutic Methods of Behavior Problems in Children", American Journal of Orthopsychiatry, Vol. 6, 1936, p. 341-354.

78 Louis J. Despert, "A Method for the Study of Personality Reactions in Pre-school Age Children by Means of Analysis of Their Play", Journal of Psychology, Vol. 9, 1940, p. 17-29.

79 Virginia M. Axline, "Some Observations on Play Therapy", Journal of Consulting Psychology, Vol. 12, 1948, p. 209-216.

80 Jacob L. Moreno, "A Case of Paranoia Treated Through Psychodrama", in Proceedings of the Second Brief Psychotherapy Council, Chicago, Institute of Psychoanalysis, 1944, p. 47-54.

81 --------, Who Shall Survive, New York, Beacon House, 1953, cxiv-763 p.

It began in 1911[82], based upon an earlier history of therapeutic drama. A host of disciples and voluminous literature has since appeared on the subject. A complete presentation of Moreno's theory as well as technique falls, for the most part, outside the bounds of this thesis. However, of all the occupational therapies, his method has been the most elaborate to the point that it represents a distinct school, and he has developed a technique worthy of serious consideration.

Moreno[83] says:

> Psychodrama represents the chief turning point away from the treatment of the individual in isolation to the treatment in groups, from treatment by verbal methods to treatment by action methods . . . It is an effective combination of individual with group catharsis, of participation with action catharsis.

Spontaneity is a major objective. Spontaneity is defined "as the response of an individual to a new situation and the new response to an old situation". Spontaneity tests are conducted. The subjects are admitted individually and play a reacting role to the tester's previously determined one. Psychodrama is highly structured. Situations are formulated in advance, in which the subjects are asked to participate. Moreno sets the following specifications for the spontaneity test: (1) it must be a situation which could happen to any

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82 --------, Die Gottheit als Komoediant, Anzengruber Verlag, Vienna, 1911.

83 --------, Mental Catharsis and the Psychodrama", Sociometry, Vol. 3, 1940, p. 209-244.

one of the subjects; (2) it must be as simple as possible, yet present the subject with some sudden crisis which will necessitate some spontaneous reaction immediately; (3) the more fundamental the problem is, the more illuminating will be the reaction. For example, the subject is told by the director that "Your father has just been killed while crossing the street" or "You have just been stopped by a state trooper for speeding". He is then instructed to act out rather than to convey his feelings through verbal expression.

Results are determined by Moreno[84] in terms of the individual's sociometric status which is achieved by a score:

> A sociometric score is the number of times an individual has been chosen, rejected, or ignored by other individuals for a specific course of action . . . Sociometry is a neutral and objective agent; it does not imply that the sociodynamic effect is good or bad.

The higher the sociometric status of the individual, the higher will be the volume of words expected and accepted, the more frequently will he be allowed to monopolize the situation, and the more reciprocal will the warmth of others become. It was Moreno's opinion that "when the members find full realization of their choices within a group, the results do not require further validation".

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84 Jacob L. Moreno, Who Shall Survive, New York, Beacon House, 1953, p. 703-708.

Critique of diversional therapies.- Comments have been liberally interspersed on the commonly known occupational therapies. In this section, a more careful examination will be made of Moreno's efforts to improve upon the activity therapies. But foremost of all, what are his aims? Is the function of psychodrama to learn a great deal about people revealing themselves?

In reading the literature of psychodrama, one is greatly impressed with the fertility and ingenuity of Moreno and his disciples. One is equally impressed by their cultishness and esoteric language. The people who write in the field of psychodrama have become isolated from most of the other practitioners in the field of group psychotherapy. The mechanisms and tools by means of which the results are produced and measured seem to have become sidetracked from the original purpose of psychotherapy. When one clears away the maze that is spun over the work of Moreno and his colleagues, one thesis runs throughout: catharsis for the actor and catharsis for the audience are the cruces of the psychodrama as treatment, harking back to the old Greek ideas.

It is quite a revealing experience to a subject to discover how many of his characteristic attitudes he discloses in a fifteen or twenty minutes period of psychodrama. Is it possible to gain more insight into the dynamics of a patient's

personality through this medium than through the interview technique? The psychodramatic episodes do not appear to utilize a psychodynamic understanding of the patient. Moreno considers the activity of the group as an experimental sociometric measure.

His subsequent hours with the patient (in follow-up interviews) are based solely on a Dale Carnegie type of guidance and counseling, e.g., "You see, your trouble is that you are afraid to ride on subways. It's very obvious that you can ride on subways". Certain techniques may light up aspects of the personality, but one gets to a point where one asks: What therapeutic effect does psychodrama have on the patient? It suggests a situation in which an individual is put through a **maze**. If he cannot solve the maze, then it is indicative that he cannot solve life's problems.

The patient's conflicts may be opened wide from a diagnostic standpoint by the emphasis on catharsis in psychodrama. How is the material going to be treated? How will it be used? What is the therapeutic goal? Every diagnostic service must lead to a psychotherapeutic benefit. It cannot be an object in itself. Moreno has devised an intricate mechanical structure in his sociometric schema, but in doing so, has lost the patient.

In broad contrast with the suppressive methods which relied exclusively on verbal expression such as lecturing to the group and the reception of testimonials, the diversional therapies resort to the use of activities, expressive behavior, and dramatic devices. For the most part, the diversional methods affect the emotions rather than the intellect, and involve greater physical rather than verbal participation. The psychodrama of Moreno is an outstanding example of expressive activity in which the patient reacts with his entire body and thus obtains emotional release.

3.- Reconstructive Frames of Reference.

In this category are included schools of group psychotherapy that give clear recognition to factors other than inspirational and abreactive values. Four sub-divisions are suggested: phyloanalytical, psychoanalytical, sociological, and non-directive.

A. Phyloanalytical.

This school, like psychodrama, is the philosophy, essentially, of one man, Trigant Burrow. His first article in the field of group psychotherapy, entitled Group Analysis[85],

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85 Trigant Burrow, op. cit., p. 268-280.

appeared in 1927. His theoretical formulations involved learning a new and difficult language[86,87].

Burrow's major contention was that society is neurotic. He was not interested in analyzing the individual neurotic because neurosis is a social phenomena which no one escapes. It is not the result of cultural conditioning but is inherent within the biologic history of the race. An individual becomes symbol-dominated, which results in partitive behavior. In his reactions to other human beings, he is conscious of tensions that are usually centered about the eyes. It is through the eyes that symbols present an understanding of other human beings. Analyzing the past history of the individual is useless. Burrow analyzed symbols involved in immediate mood changes in response to other human beings. This leads to an understanding of reactions in such a way that primitive cotension (empathy) may be conceivably restored.

Each participant in the group offers for analysis his individual behavior and his mood reactions as part of a socially inadequate adjustment. Everyone is as much a therapist as any one else. Even the leader himself may be

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86 Idem, "The Social Neurosis: A Study in Clinical Anthropology", Philosophy of Science, Vol. 16, 1949, p. 25-40.

87 Hans Syz, "Phylopathology", in Encyclopedia of Psychology, New York, Philosophical Library, 1942, p. 519-523.

challenged by anybody present in the group and then analyzes his own immediate reaction. Any statement, question, or emotional response appearing during a discussion is utilized for the analysis of motives of the subjectively assumed position giving rise to it. In this way, the patient becomes aware of the conflicting tendencies he is expressing.

Burrow stated that the task of analysis is not the discovery of complexes but in the resolving of resistances. The essence of resistance is the sense of isolation in one's conflicts. In the exchange of the common nature of conflicts, the sense of isolation is gradually resolved. Burrow was very contentious about psychoanalysis, and had his greatest difficulty with analytically-oriented physicians or patients who insisted upon being reminiscent.

Only those people who are sufficiently intelligent, financially equipped, neurotic, and unsympathetic towards other forms of psychotherapy ally themselves with phylo-analysis.

B. Psychoanalytical.

The psychoanalytic frame of reference had its conceptual beginning in Freud's Group Psychology and Analysis of the Ego[88]. Freud's major thesis was that identification of individuals with group leaders bears many of the same variables operating in the father-son relationship. The members of the group take the leader as an ideal and want to grow and become like him. A mutual tie results because of a common bond with the leader.

Freud's interest, however, was in group psychology rather than group psychotherapy. No claim has been made by subsequent practitioners that they conduct mass psychoanalysis. Psychoanalysis, as it was originally conceived, can take place only between two people.

Those authors are assigned to the psychoanalytic category if they utilized basic psychoanalytic concepts[89,90] in their methods of observation and in their approach to group psychotherapy. The leaders of this school are represented by

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88 Sigmund Freud, Group Psychology and the Analysis of the Ego, translation by James Strachey, London, Hogarth, 1948, p. 134.

89 Edward Glover, "The Technique of Psychoanalysis", International Journal of Psychoanalysis, Supplement No. 3, 1928, p. 1-141.

90 E.F. Sharpe, "The Technique of Psychoanalysis", International Journal of Psychoanalysis, Vol. 11, 1930, p. 251-278.

Lazell (1921), Klapman (1941), Schilder (1936), Wender (1936), Wolf (1949), Foulkes (1944), Slavson (1940), Ackerman (1943), Redl (1942, and Powdermaker and Frank (1953). These authors will be discussed in terms of a similarity of emphasis and debt to predecessors, rather than in chronological order of first publications.

Lazell[91,92] is considered to be the first person to apply group psychotherapy to psychotics. He conducted his groups under the aegus of William White, American pioneer in the application of psychoanalytic concepts to psychotic patients, at St. Elizabeth's Hospital in Washington, D.C. Lazell gave a series of lectures on mental mechanisms, which he repeated many times, to a group of schizophrenic patients who were engaged in weaving baskets and many of whom were mumbling, preoccupied and seemingly oblivious to his presence. Although he referred to himself as a Jungian, he propounded Freud's complicated old libido theory (then popular with certain psychiatrists of the time) in an attempt to explain to them the meaning of their psychotic experiences. Lazell was surprised and gratified when a number of patients showed

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91 E.W. Lazell, "The Group Treatment of Dementia Praecox", Psychoanalytic Review, Vol. 8, 1921, p. 168-179.

92 --------, "Group Psychic Treatment of Dementia Praecox by Lectures in Mental Reeducation", United States Veterans' Medical Bulletin, Vol. 6, 1930, p. 733-747.

unusual improvement either immediately or some time later. He then stated categorically that "all early schizophrenics must be considered accessible to the correct method of approach". Lazell felt that group psychotherapy accomplished the following effects: (1) socialization of problems, (2) removal of the fear of the therapist, (3) increase of patients' accessibility.

Did Lazell's patients improve because of the uniqueness of his method, or did they improve because they were receiving unusual attention?

Klapman[93,94] is a later edition of Lazell. Like him, he used a class approach in his work in the Chicago State Hospital. He prepared a special brochure entitled Social Adjustment. His book gave a resume of psychodynamic principles in considerable detail, including the phases of psychosexual development and the mechanisms of repression and symptom formation. Klapman's psychoanalytic formulations were in accordance with Freud's ego psychology[95], in contrast to Lazell who worked at a time when Freud was publicizing his earlier libido theory. Each chapter was delivered as a lecture, followed by

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93 J.W. Klapman, op. cit., vii-344 p.

94 --------, "Clinical Practices of Group Psychotherapy with Psychotics", International Journal of Group Psychotherapy, Vol. 1, 1951, p. 22-30.

95 Sigmund Freud, The Ego and the Id, London, Hogarth, 1927.

questions and discussions. The patients were expected to study the material and show what they had learned through examinations. Case histories were presented which were discussed by both the therapist and the group, often with technical analytic terms and symbolic concepts. Klapman elaborated on the difficulty of establishing a relationship with a schizophrenic, explaining that in most cases the trauma occurred before the age of verbalization in the individual. The result of repeated early trauma is the withdrawal to the narcissistic, grandiose world of the psychotic. The schizophrenic views any attempt to return him to the world of pain with deep hostility, and erects barriers of delusion and hallucination to protect himself. Klapman avoided the presentation of psychotherapeutic effects because he felt there was no reliable method for doing so.

What Lazell and Klapman tried to do for psychotics, Schilder[96,97,98] attempted to do for a group with mixed diagnoses. Schilder conducted group psychotherapy at New York's

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96 Paul Schilder, "The Analysis of Ideologies as a Psychotherapeutic Method, Especially in Group Treatment", American Journal of Psychiatry, Vol. 93, 1936, p. 601-617.

97 --------, Psychotherapy, (Revised edition arranged by Lauretta Bender), New York, Norton, 1951.

98 --------, op. cit., p. 87-98.

Bellevue Hospital from 1934 to 1940. He was indebted to Wender whose publications followed his. Schilder symbolized, for those who pursued a psychoanalytic framework of reference, the most significant contributor to that method. He built a Herculean construct out of which he attempted to explore in an intensive manner his particular brand of psychotherapeutic methodology.

Schilder's patients were selected on the basis of preliminary interviews in which a brief history was taken and the principles of group association explained. Patients were instructed to write a detailed autobiography that could be subject to interpretation. Patients were introduced to a series of sessions already in progress. The group usually consisted of seven or eight members including severe neuroses, character disorders, and all classifications of ambulatory psychoses. Meetings were held weekly for a session of two to three hours, and each patient had two additional hours each week in individual psychotherapy.

> The sessions begin with the report of any one of these patients and is conducted in a way similar to individual psychoanalysis. Interpretation is given if the situation warrants it. Any one of the others can give his interpretations or add associations and experiences of his own. Demands to associate may be directed toward any members of the group. Whenever the material is sufficiently clear, a general remark about the mechanism involved may be added.[99]

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99 Paul Schilder, op. cit., p. 212.

Schilder believed that the appropriately described mechanism helped to reduce resistance, especially with material that was elicited in the group but was not offered in individual psychotherapy. "The fact that one patient brings forward material which another often hides lessens the resistance and brings forward conscious as well as unconscious material". He considered "transference-phenomena not less outspoken than in the usual psychoanalytic treatment and a serious attempt was made to bring the patient to an insight into the transference situation".

In drawing out dynamic material, Schilder made use of monumental questionnaires, not to be formally administered but as an occasional stimulus for discussion. He was aware that some people were opposed to group psychotherapy because it presented the facade of over-intellectualization. But he believed in the power of the intellect. He thought that patients had much to learn in every psychotherapeutic procedure. Though Schilder's orientation was psychoanalytical, no mention was made of Freud's triad of ego, id, and superego. In later years he became critical of certain orthodox Freudian concepts. It was conspicuous in his emphasis on the utilization of conscious intellectual processes.

According to Schilder, every experience has social significance. Therefore, individual goals will be clearer if

appraised by the group. Group treatment is a step nearer to reality. Patients are relieved in realizing that they are not excluded from the community for urges and desires that society does not openly tolerate.

Schilder felt that group psychotherapy was most effective with what he called the social neuroses, i.e., incompatibility in the presence of others, inability to concentrate, feeling of embarrassment and the center of attention. He indicated that the best results were obtained with the "social" and obsessional neuroses. He defined "cures" in terms of symptomatic improvement. He anticipated relapses, but stated that patients would get a better orientation to life, in any event.

Schilder breaks up a good deal of repressed material. How does this relate itself to a dynamic development in the members as individuals or as a group? Perhaps the psychotherapeutic good does not result from the fact that there is an intellectual interchange per se, but for the reason that here is a solidified group who have a common project and common things to talk about.

Wender's[100] approach differed from that of Schilder, his ingenious protegee, by emphasis upon the dynamic forces

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100 Louis Wender, "Dynamics of Group Psychotherapy and Its Application", Journal of Nervous and Mental Diseases, Vol. 84, 1936, p. 54-60.

operating in the group. He worked for a number of years with a group of non-psychotics at a private sanitarium[101], and at an evening psychiatric clinic operating on an out-patient basis[102]. He believed that the application of some of the methods of psychoanalysis in combination with intellectualization would lead to the release of certain emotional conflicts and a partial organization of the personality. Wender lectured on the psychodynamics of human behavior. These were illustrated by use of anonymous histories of patients in the group. Group discussions were usually initiated by the members of the group questioning the therapist. The group psychotherapist attempted to make clear unconscious emotional conflicts. Results were assessed only in terms of patients' testimonials. Wender presented the following dynamics operating in the group: (1) intellectualization of everyday behavior through a comprehension of emotional reactions, (2) patient to patient transference leading to abrogation of the role of the role of therapist, (3) catharsis-in-the-family through re-enactment of the family situation in a permissive

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101 Idem, "Group Psychotherapy: A Study of Its Application", Psychiatric Quarterly, Vol. 14, 1940, p. 708-718.

102 Louis Wender and Aaron Stein, "Group Psychotherapy as an Aid to Out-patient Treatments", Psychiatric Quarterly, Vol. 23, 1949, p. 415-424.

medium; and concomitantly, (4) group interaction with competition for the attention of the therapist by means of complaints, and health through the winning of new ego ideals and strivings.

Wolf's[103] technique was strongly influenced by Schilder in the following respects: the use of prohibitions, longitudinal approaches, minutiae, intensive individual therapy as a preparation for group, highly charged personal material, long term treatment, and patients as assistant therapists. Group psychotherapy was divided into the following five stages of treatment: (1) preliminary individual analysis; (2) rapport through free association and interpretation of dreams, fantasies, reveries; (3) interaction through interpersonal free association; analysis of resistance towards personal disclosures; the analysis of disturbed reactions in the group due to warped attitude towards people; (6) conscious personal action and social integration through the ability to deal with own feelings (transference investments) and the reactive feelings of others (counter-transference). The latter aspect is the highest of all objectives.

Foulkes[104] admitted his indebtedness to Schilder, and his early endeavor in group psychotherapy was definitely a

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103 Alexander Wolf, "The Psychoanalysis of Groups", American Journal of Psychotherapy, Vol. 3, 1949, p. 525-558; Vol. 4, 1950, p. 16-50.

104 S.H. Foulkes and Eve Lewis, "Group Analysis", British Journal of Medical Psychology, Vol. 20, 1944, p. 175-184.

modified Schilderian technique. Later[105], he digressed by avoiding (sic) the initiation of discussion, but did resort to "uncovering" for observation and investigation. He attributed the following factors to group: (1) socialization, (2) mirror-reaction (seeing one's problems and defences when pointed out in others), (3) activation and exchange (pooling of associations), (4) the group as a community forum (modifying the structure of the ego and superego by the group's rejection, tolerance, or approval), (5) the group as a support (intra-group transference). And still later[106], Foulkes wrote that "group analysis does not consider improvement based on support, release of guilt . . . as of equal value to . . . aims at lasting changes in the function of the ego, super-ego and the distribution of the libido". Foulkes gave no examples or proof of what constituted "lasting changes" in group psychotherapy. He gave no rationale as to why support and release of guilt differed from changes in the ego and superego. He supplied no evidence as to whether or not therapeutic or personality changes are achievable.

One of the most prolific writers on group psychotherapy today is S.R. Slavson. He has conducted and reported on group

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105 S.H. Foulkes, Introduction to Group-Analytic Psychotherapy, New York, Grune, 1948.

106 --------, "Group Therapy", British Journal of Medical Psychology, Vol. 23, 1950, p. 199-205.

psychotherapy throughout the entire age range of patient population[107,108]. Slavson groups treatment procedure on the basis of age and symptoms. He feels that the different phases of development call for a different role on the part of the leader. Slavson uses essentially three techniques of group psychotherapy:

(1) Activity group therapy.- This technique includes play groups for children under eight years of age, and activity groups for pre-adolescents from nine to fifteen years of age. Both age levels are encouraged to embark upon spontaneous activity, "a living out of impulses", but there is somewhat more restraint imposed upon the younger age group.

(2) Activity-interview group psychotherapy.- The age level is slightly extended. The chief addition is the introduction of verbalization and interpretation. It is a combination of the more specific children's approach with the adult interview.

(3) Interview group psychotherapy.- This technique is applied to adolescents and adults. The emphasis is on group discussion accompanied by "insight provoking explanations".

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107 S.R. Slavson, An Introduction to Group Therapy, New York, Commonwealth Fund, 1943, xvi-352 p.

108 --------, Analytic Group Psychotherapy with Children, Adolescents, and Adults, New York, Columbia University Press, 1950, 275 p.

Evidence of therapeutic changes in group psychotherapy are explained by the following dynamic factors:

(1) Transference dilution.- There is a reduction of negative feelings towards the therapist due to feelings spread towards the members of the group.

(2) Target multiplicity.- Aggression can be directed towards member of the group as well as towards the psychotherapist.

(3) Mutual support.- Group sanction and a less severe superego allows members to say things in the group that they could not say in individual therapy.

(4) Displacement.- Emotions are displaced from the psychotherapist to other members of the group.

(5) Escape.- This mechanism is accomplished by selective silence or change of subject.

(6) Deflection.- The evolution of insight occurs through the exploration of the difficulties of others.

(7) Catalysis.- Every member of the group is an activator.

(8) Identification.- This is the corrective effect upon one patient who identifies with another.

(9) Universalization.- Guilt is reduced by the observation that other people have problems similar to those of the patient.

Ackerman is the most renowned of Slavson's associates. In addition to capitalizing on Slavson's interview group psychotherapy, Ackerman formulated his own observations. He describes these in one publication[109] as therapeutic processes in the group method, and in another publication[110] as therapeutic aims in the group method. These processes or aims are enumerated as follows: (1) emotional support through group relationships; (2) release of anxiety and pent-up aggression, (3) reduction of guilt and anxiety, (4) testing social reality through a forum, (5) modification of the concept of the self in terms of increased recognition, (6) actual living out of drives in a multiple context leading to the development of insight.

In a Detroit Group Project, Redl[111], like Slavson, devoted most of his "group psychotherapeutic" efforts with children. Redl used the group primarily as a meeting for obtaining specific diagnostic insights, and for the purpose of facilitating the cooperation of the children for individual psychotherapy. He expressed much enthusiasm for group therapy and regarded it mainly as supportive treatment, either in

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109 Nathan W. Ackerman, "Some General Principles in the Use of Group Psychotherapy", in Current Therapies of Personality Disorders, New York, Grune, 1946, p. 275-281.

110 --------, op. cit., p. 559-570.

111 Fritz Redl, op. cit., p. 29-35.

preparation for, parallel with, or subsequent to individual psychotherapy. Redl's use of group therapy, however, was the study of residential or institutional treatment, of group situations with their implied dynamics, various group formations related to types of leader identity. In the above publication Redl stated: "Most of the therapy takes place in real life situations around eating, getting up, going to bed, playing, working, and every phase of daily life, rather than in selected individual or group interview situations."

Powdermaker and Frank's[112] endeavor in group psychotherapy represents the collective efforts of approximately forty collaborators. Their publication bares a strong imprint of the framework of reference of the major authors. Although most significant of the clinical contributions to date, it suffers from an overemphasis on the qualitative approach and "the judgment of the doctor". It is chiefly a report on the training of psychiatrists for group psychotherapy, described in the book under the phrase of "situational analysis".

Twenty-four patients were treated with group psychotherapy and one hundred with group and individual psychotherapy. Treatment ranged from nine to hundred and one sessions. Many

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112 Florence B. Powdermaker and Jerome D. Frank, Group Psychotherapy, New York, Commonwealth Fund and Harvard University Press, 1953, 615 p.

groups terminated early because the physician left the clinic. The group psychotherapeutic goals were the same as analytically-oriented goals for individual psychotherapy. Each patient was evaluated on the basis of conferences between the three professional disciplines and the observer. Weight was given most to the physician's judgment. Changes were evaluated on the basis of symptoms, social relations, and the patient's response to stimuli. Thirteen or 54 per cent improved with group psychotherapy alone, and sixty-two per cent improved with combined individual and group psychotherapy.

C. Sociological.

Abrahams and McCorkle[113,114] were the first to publish on group psychotherapy from a sociological frame of reference. Sociologists[115], interested in non-psychiatric aspects of group process, are beginning to show a curiosity towards groups of people gathered for psychological treatment.

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113 Joseph Abrahams and Lloyd W. McCorkle,"Group Psychotherapy of Military Offenders", American Journal of Sociology, Vol. 51, 1946, p. 455-464.

114 --------, "Group Psychotherapy of an Army Rehabilitation Center", Diseases of the Nervous System, Vol. 8, 1947, p. 50-62.

115 Robert F. Bales, Interaction Process Analysis, Cambridge, Addison-Wesley Press, 1951, xi-203 p.

Abrahams and McCorkle used a conglomeration of techniques: suppressive, diversive, and reconstructive. They worked in an Army Rehabilitation Center. The patient population consisted of soldiers who were incarcerated for six months to a year for some military offense. A trial period for restoration to duty, or dishonorable discharge was offered. The men were divided into honor and pre-honor companies. The pre-honor company engaged in military and vocational training and hard labor. The honor company had regular military and vocational training but no hard labor. Both companies received an hour of group psychotherapy six times weekly. The purpose of group psychotherapy was to soften up anti-social ideas and behavior, and to prepare them for future adjustment to army life.

Treatment ran for twenty-six weeks, consisting of a preliminary phase (nine weeks) of an educational nature, an analytical phase (twelve weeks) of a more realistic appraisal of problems, and a synthesizing phase (five weeks) devoted to establishing relationship between past offenses and actual group values and mores.

Patient population consisted of psychopathic, immature, and mentally deficient individuals. Greatest success was secured with the immature. The authors attributed improvement to the trauma of the penal situation, the fear of ostracism,

and the stigma of dishonorable discharge. There was a sharp increase in cooperation and a decreased need for discipline. The restoration rate was forty per cent. Adequate follow-up was difficult because most of the men were assigned to combat areas.

Other sociological efforts, to mention a few, have been made by Curran[116] with delinquent adolescents, Plowitz[117] and Illing[118] with hardened criminals, and Mueller[119] with prostitutes.

D. Non-directive.

Non-directive group psychotherapy is derived primarily from the Rogerian[120] non-directive individual psychotherapy.

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116 Frank J. Curran, "The Treatment of Juvenile Delinquency in Bellevue Hospital", Virginia Medical Monthly, Vol. 68, 1941, p. 74-81.

117 Paul E. Plowitz, "Psychiatric Service and Group Therapy in the Rehabilitation of Offenders", Journal Correctional Education, Vol. 2, 1950, p. 78-80.

118 Hans A. Illing, "The Prisoner in the Group", International Journal of Group Psychotherapy, Vol. 1, 1951, p. 264-277.

119 Edward E. Mueller, "An Experience in Group Psychotherapy in Japan, American Journal of Psychotherapy, Vol. 4, 1950, p. 293-302.

120 Carl R. Rogers, Client-Centered Therapy, New York, Mifflin, 1951, xii-560 p.

Its origins may be traced to Freudian analysis and Rank's[121] relationship therapy. Non-directive psychotherapy is a method of treating certain disorders of the personality which assumes that a person can gain insight or understanding of the causes of his difficulty without the use of interpretation. It also assumes that once understanding is achieved, the patient will be able to meet present and future emotional stresses on a sounder basis.

Baruch and Hobbs have applied the non-directive techniques to a collection of individuals. Baruch[122] stated that her orientation encouraged permissiveness and acceptance. She felt that resistance and guilt were common to the group as well as to the individual. Baruch took a more active role in the first session and defined her own non-advisory role. She used Roger's restatement technique based upon verbal and non-verbal clues. The aims of her group were admittedly exploratory:

> During the discussion sessions an attempt was made (1) to keep record briefly on what took place, (2) to analyze techniques of leadership, and (3) to tap the effects of the process through the expressed reactions of the group members.

She felt that the members of the group gained a "freeing" as a result of the experience.

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121 Otto Rank, Will Therapy, New York, Knopf, 1936.

122 Dorothy W. Baruch, "Description of a Project in Group Therapy", Journal Consulting Psychology, Vol. 10, 1946, p. 281-284.

Most of Hobbs'[123] experience has been with university students as in the case of Baruch. They were students who were "disturbed and unable to gain from life the satisfactions they desired." A verbatim transcript of part of a session was presented in the above publication. He discussed rather sketchily and in an eclectic fashion some details of organization and procedure: how groups get started, the development of a group and concept of themes, and the process as viewed by a group member. Finally, he reported on the results of several Ph.D. theses.

Critique of reconstructive approaches.- The general aim of the phyloanalytical, the psychoanalytical, and the sociological schools are presented as insight and maturity. The ultimate goal is the treatment of causes rather than symptoms. The mediate goals by which insight is finally gained are presented in a nebulous, ill-defined way. For example, Foulkes[124] mentions socialization as a constructive factor in group, but contaminated with this is a potpourri of other goals. There is an overemphasis upon arm-chair observations, with very little effort to apply quantitative methods for screening the chaff from the wheat.

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123 Nicholas Hobbs, "Group-Centered Psychotherapy", in Client Centered Therapy, op. cit., p. 278-320.

124 S.H. Foulkes, Introduction to Group-Analytic Psychotherapy, New York, Grune, 1948.

The non-directive group psychotherapists stress the autonomy and maturity of the patient. Their general aim is described as better self-perception and maturation. There is a deep respect for the integrity of the client and his right to select his own direction. Hobbs[125] stated that the group psychotherapist "generally says something to the effect that the objectives of the group are known to everyone and that the group can develop and follow its own leads." In the same publication, Hobbs wrote that the therapist attempts "to reconstruct the perceptual field of the individual at the moment of expression, and to communicate that understanding with skill and sensitivity."

The non-directive technique perhaps would be more appropriately called a non-advisory non-counseling method. The client is not given a prescription; and is led in a certain direction, but which is not sufficiently obvious to say, "This is it." It is a direction via indirection.

Client-centered group psychotherapy agrees with the other reconstructive approaches in the following ways: (1) it brings to awareness the patients' feelings, (2) it uncovers difficult experiences (one type of insight) freeing the client to progress in his thinking, and (3) out of such insight reconstruction occurs.

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125 Nicholas Hobbs, op. cit., p. 278-320.

E. Summary.

A review of the literature disclosed that many people were able to use the experience provided by a group and a psychotherapist to arrive at new and more satisfying ways of living with themselves and others. Pratt in 1906 attributed improvement to friendly relations among the members and freedom from physical symptoms. He became the father of the suppressive-inspirational methods. Moreno, the genius of diversional therapies, reactivated in 1911 the concept of the collective catharsis of Greek tragedy, - a catharsis for both the actor and the audience. Lazell, the pioneer of group psychotherapy with psychotics, contributed the aim or goal in 1921 of the reduction of the fear of the therapist as an individual. Behind the webb of obfuscation spun by Burrow in 1927 is the resolution of the sense of isolation in conflicts through the analysis of immediate mood changes. Marsh published his zealous attempts to return the psychotic back to sanity by means of revivalist methods, in 1931. His chief improvement criterion was the conversion of the patient's day-dreaming fantasy life into a sharper reality awareness. Chronologically, Marsh's unpublished attempts, in 1909 and 1912, in the use of group psychotherapy with psychoneurotics cut across the previous work of Pratt and Moreno. In 1938 Schilder, the monumental standard-bearer of the reconstructive

methods, published his views that patients had to learn many things in order to gain insight into the components of their illnesses.

Subsequent writers in group psychotherapy have used the psychotherapeutic effects described by the above authors in one way or another, either singly or combined.

Perhaps by holding up these several mirrors for view, gazing at approaches not one's own, there may emerge a more crystal definition of psychotherapeutic effects as they relate to the group process.

CHAPTER II

PSYCHOTHERAPEUTIC TECHNIQUE

The previous chapter presented a review of the literature with respect to the practice, theory, and effects of group psychotherapy as expounded by the major contributors to that field. Practice and theory were presented because they are not only logically primary but they may influence the criteria through which psychotherapeutic effects are reported and evaluated.

This chapter is an attempt to reconstruct the practice and philosophy of the group psychotherapy program towards which the present research project has been directed. It will discuss: (1) the mechanics of conducting the group, and (2) the structure of group dynamics.

1.- The Conduct of the Group.

The subjects were white, adult, male World War II veterans suffering from emotional disabilities. They were referred to group psychotherapy by the intake psychiatrists of a U.S. Veterans Administration ambulatory out-patient facility. The patients were assigned for the following reasons: (1) orientation to psychotherapy (45 per cent), (2) support (27 per cent), (3) witnessing other people's difficulties

(14 per cent), (4) socializing outlet for severe asocial patients (11 per cent), (5) expediency (2 per cent), and (6) stimulation of free association for individual psychotherapy (1 per cent). The groups met one evening a week over a period of sixteen weeks for one and a half hours per session.

Introductions.- The first session began by the patients being asked to introduce themselves by preferred names. Some of them were sensitive about names like Mortimer, Melvin, Wilbur, Percy, and Marion, and preferred nicknames like "Doc", "Pete", or "Smitty". Others used first names, family names, abbreviated names, or adopted names.

Catalysis.- The patients were given a brief orientation to the group approach. It was stated simply that group psychotherapy was a way of working through an understanding of emotional problems. The members of the group were then invited to talk about their thoughts, wishes, and feelings, but were told that they need not feel compelled to speak.

In every first session, the group psychotherapist is faced with a group of unknown people. The group psychotherapist does not know at this point what material, if any, he should introduce to the group. Anything he might say could alienate a member from the group. Some are prepared to fight, while others are prepared to leave. If the group psychotherapist is to convey a milieu of understanding and acceptance,

he will need to establish a relationship first, long before patients are encouraged to work through the emotional significance of their symptoms. In order to circumvent feelings of rejection and dissociation in patients, the group psychotherapist follows his introductory remarks with a stimulus statement that is worded in this vein: "Meeting with a group of unknown people always creates a new situation. Each one of us has certain feelings about a new situation. Would anyone like to express his feelings?"

Group anxiety.- The group <u>is</u> a new situation. Every new situation is accompanied by an atmosphere of electrified tension. Each patient feels uncomfortable. He does not know what to anticipate. He becomes alert to an attack for fear of being victimized, of appearing weak in some way. He may react against being afraid by aggressiveness and irritability. Another patient may reserve his thoughts. He may wonder what would happen if the group conductor should ask him to speak. Is he different from other people? Does he appear physically disfigured or intellectually inferior? Will the other members of the group laugh at him? He may fear rejection if he reveals too much of himself.

Therapist's role.- The group psychotherapist is keenly aware of the fantastically charged medium of implied self-deprecation. He is receptive but not passive. All questions

are referred back to the group. In this way the group proceeds at its own pace and level.

Material prematurely introduced into the group by one member is quickly shouted out of consideration by other members of the group. There is a shift to more innocuous subjects like baseball, or sub groups become mobilized. There is usually someone in the group who returns to the original topic.

The psychotherapist introduces no new material into the group. His chief task is to help promote group activity. In moments of stagnancy in group discussions, he may repeat significant words of a patient in question form. The therapist deliberately avoids the stimulation of additional anxiety by retorting to group provocations.

The progress of the group usually moves from a release of hostile feelings against authority figures to philosophical concepts. Discussions then center upon "I know a person who-", and before long the members of the group talk about themselves.

Group discussions begin as a reaction to the leader's summary of a previous session or his request for an expression of individual problems, as a reaction to current incidents in the news, at work, at home, to treatment, or by continuation of discussions spontaneously begun. Requests for anonymous suggestions on a slip of paper from the members of the group is used on occasion for assistance in assessing the needs of unusually passive and/or inhibited groups.

What to ask.- Prods towards the release of potentials for self-understanding come very late in group development. The attitudes and reactions of patients are constantly checked. Questions are sparingly introduced. Some of the most common questions are as follows: What sort of things happen that worry an individual inordinately? What happened to accelerate the problem at this time? Under what circumstances did the worry begin? Who was involved? Who else? What is the individual's feeling about the situation? Is this in line with similar feelings in another situation? Who else in the group has had a similar experience?

How patients are supported.- Some patients may require supportive remarks by the group psychotherapist. Examples such as the following appear to be of psychotherapeutic value: It's hard to talk about these things. It takes a great deal of courage to find out certain information. Sometimes we doubt that we have enough courage. Sometimes we don't feel strong. It's a real accomplishment to handle things by oneself. Non-verbal encouragements such as sympathetic gestures, glances, encouraging sounds are also used.

Whom to ask.- Not only is it helpful to know what to ask, but whom to ask. The psychotherapist has ample opportunity to gage a patient's readiness for self-understanding. There are a number of questions which the therapist reviews in his own mind. For examples: At what level can the patient

adapt in psychotherapy without peril to his homeostasis? Is there danger of a possible collapse of a successful facade? Does the patient possess assets for maintaining the facade? Is he the type of patient who so barricades himself that one may never be able to approach him? Is there a danger of a psychotic break, homocide, or suicide? What is the patient's predicament, his needs, his crises? How can the psychotherapist maneuver the other patients in the group so that they can be of help? What is his plan of action?

What to expect.- For every group there appear to be four major phases: (1) antagonisms, (2) beginning identifications, (3) working through period of feelings that each member has for the other, and (4) a breaking off period.

2.- The Structure of Group Dynamics.

Group psychotherapy is still in an experimental phase. In the review of the various methods that have been utilized, it became apparent that each proponent of a specific form of group psychotherapy applied ways and means which were consistent with his own training and experience. The suppressive therapies demonstrated skill in the winning and influencing of people. They capitalized on facile emotional swaying and inspiration, with a consequent appeal to early emotional attitudes. Their meetings are mindful of a mythical picture of

support directed towards the good of each one . . . leaping in tempo and significance as testimonies are elaborated. The diversional therapies stressed the "togetherness" of the group. When the individual mingled with others in a group, each occupied with an impersonal medium, a new situation was created with beneficial effects. The reconstructive therapies emphasized the content of the meetings. They presented intellectual formulations for a searching systematic recovery of thoughts and feelings. However, among the reconstructive therapies there was a difference in the delegation of responsibility. Non-directive therapy reported that the direction of treatment is placed on the client, whereas the other reconstructive therapies placed the therapist in a directive capacity.

There is probably an intermediate school of group psychotherapy that recognizes the value of inspiration, the aspect of togetherness, and the use of intellectual formulations; a school that is not based primarily on a philosophy woven by the therapist, nor so passive in structure that patients become shocked into exercising their rights for self-determination; a school that makes no attempt to cut away all defenses (does not elicit material that cannot adequately be dealt with at its current stage of development), nor so suppressed and protected that it passes by the problem of guilt (if a person has murderous impulses he should feel guilty);

a school that feels that abreaction is insufficient unto itself even if the patient does talk about his difficulties. Some patients repetitiously talk about their problems for years to willing and unwilling listeners, without particular benefit. The value of abreaction is significantly enhanced if it involves more than a casual relationship, if it is specific, if it is current, if it is a conscious experience in an appropriate group psychotherapeutic culture.

In the views to be presented, the author is indebted to many of the stalwarts of group psychotherapy: Pratt, Moreno, Lazell, Burrow, Marsh, Schilder, and others. Here also will be found Freud's concept of identification, as well as the Rogerian emphasis on the role of clarification. Since this thesis presents differences in the interpretation of the concepts discussed by the above authors, the latter cannot be held responsible for the use to which their contributions have been put in this version of group psychotherapy.

In the study, observation, and conduct of group psychotherapy, certain basic needs of the individuals emerge. The group psychotherapist may treat them with judicious avoidance or capitalize on their potentialities. He can create situations that would favor the actualization of appropriate reactions. The latter are classified under five general headings as follows: the initial emotional reactions of constituent

members; the emotional reactions of members to each other; the release of emotional interplay and discussion of conscious mutual difficulties; the increase of the awareness of egocentric patterns of behavior and immaturity; and the arousal of feelings of curiosity through explanations and subsequent insight through clarification.

A. Initial Emotional Reactions.

The raw materials at the outset consist of (1) a collection of malfunctioning individuals, who under usual circumstances, are not acquainted with each other; (2) a trained, psychotherapeutically-oriented figure; and (3) the belief by the members that there is something wrong with them. The group, as individuals, is unable to institute action without an appropriate common figure who is recognized as the leader. The members of the group are not yet emotionally related to the group psychotherapist or to each other. They may or may not see that their problems are psychogenic, or they may be giving a disproportionate emphasis to what they consider to be the nature of their troubles. It is extremely doubtful whether any significant psychotherapeutic effect could occur to a group of individuals without the attention of a group psychotherapist. In hospital or institutional set-ups patients eat, sleep, and carry out chores together, but these factors alone

are not curative. Patients need to be transformed from a collection of isolated individuals into an integrated functioning whole in order to effect favorable psychotherapeutic change.

Opening maneuvers.- Each member of the group has a strong need to prove himself adequate. Each individual has an intense feeling of insecurity unless he is on familiar territory. The group situation automatically sets up a control in the form of the group psychotherapist. It is a fundamental problem of patients to avoid experiences with someone else in control.

Members of the group use numerous maneuvers to keep the group psychotherapist talking and themselves silent. They may sit quietly waiting for the group psychotherapist to open the discussion. They may attempt to entice him into a debate concerning the efficacy of a dependency-weaning technique. They may seek to utilize the sessions for a question and answer forum. They may feel that they need to be asked questions, so that they will know what to talk about. They may request a schedule of subject matter for the entire series of sessions. It is as if only after being told what the subject matter will lead to, can they cooperate. At such times, the members see the group psychotherapist as an enemy who would push them into danger, rather than a reassuring figure who would guide them to the light in order to get a better understanding of the

dark areas. As one patient stated: "I expected to find in the group three executioners with machine guns who would fire away questions at me until I dropped."

Silence as a defense against criticism.- Trouble in speaking may sometimes occur for the following reasons: members of a group do not want to speak too much and with too much feeling; they are afraid no one will listen to them. They may want to speak but are unable to do so.

Some members of a group are unable to express their feelings whether they be love, hate, grief, or pain. They may be so inhibited by their fear, by their customary modes of isolation, that they find it difficult to verbalize their feelings. In order to maintain a certain degree of emotional equilibrium, a speech block occurs.

Oftentimes lack of confidence, and the feelings of not amounting to much, may have come from childhood. As children they really were not important persons. Their opinions may not have been accepted even when they were correct. Occasionally, they may have been scolded unjustly. They may have felt so badly about it at the time, that they could not speak.

Members of a group may want very much for people to like them, but there is a fear that people will not. Difficulty in speaking may be connected with the wish to have people whom we consider important come to like us.

Jockeying for the omnipotent role.- Patients have the tendency to reach out for the omnipotent position. Since they cannot be omnipotent, any evaluation of themselves falls short of their goals. Hence they become obsessionally motivated by an inordinate need to prove themselves adequate.

This need is again reflected in their inability to communicate with someone who has this fantasied omnipotence. Silence then relates to a particular person to whom they are speaking. Silence is associated with the authority role. If members of the group are silent, they force the group psychotherapist to comment. The moment he does speak, the members of the group who provoked the situation step into the authority position. Like the group psychotherapist they can remain silent and feel that they are not different.

Hostility as a defense against treatment.- An outstanding feature of the reactions of patients to group psychotherapy is their stormy initial hostility to treatment, and an unwillingness to accept illness in emotional terms. They feel that people do not believe that they have pains. They feel that they are regarded either as completely irresponsible or as obvious liars. They do not recognize the relevancy of their coming for psychological treatment. They are unable to face and accept the emotional nature of their disability without feelings of guilt, shame, or fear of punishment.

Anger and fear are equated. Some patients react against being afraid by becoming aggressive, irritable -- as if to trounce the threat confronting them. Not only do they fear being punished by the therapist as an authority figure, but they may also fear being victimized by emotions which they find difficult to control. As a result, they fear being hurt from without and within, and then become angry both at the group psychotherapist and at themselves.

B. Reactions of Members to Each Other.

Group psychotherapy is operationally defined as follows:

Group psychotherapy is the development of verbal and emotional interactions and part-identifications in a group of unrelated malfunctioning individuals, purposely motivated towards the common goal of the alleviation of reality problems on a conscious level.

A collection of ill individuals per se does not constitute a psychotherapeutic group. A major task of the interaction type group psychotherapy is the conversion of non-relating individuals into a functioning coherent whole. It is the development of a process of identifications: first to the psychotherapist and secondly, to each other. It is the

contention of this thesis that when identification does not occur, no substantial psychotherapeutic benefits result.

In order to bind individuals into a group, certain of their needs have to be fulfilled. This may be accomplished when patients identify themselves with other patients and thus acquire inflated values, strength, and morale. Membership in a group, in which an identification has been established, has a powerful effect. For example, all soldiers fear death, but they will not hesitate to storm an enemy hill with their buddies. The fear of death is not removed. It is the apprehensive, charged situation that creates a forced gravitation towards others, making it possible to cope with and temporarily overcome the habitual reaction pattern. The newly-formed emotional tie is greater than the fear of bullets. Similarly, if an emotional tie develops in group psychotherapy, it has the power to diminish the magnitude of crippling fears.

This is quite redolent of Aichhorn's[1] technique: only after satisfying needs and developing a special relationship was he able to do something constructive with his juvenile delinquents. Their needs were met and facilitated in terms of identification of one member with another -- not so much with people as with their symptoms, their illnesses, their emotional reactions, and their growing stabilities.

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1 August Aichhorn, Wayward Youth, New York, Viking, 1935, xi-236 p.

In group psychotherapy, there is a real attempt to combat the patient's own efforts at internalization. Group psychotherapy provides the opportunity to break down the patient's barriers against establishing a relationship, to work through his defense of withdrawing from people.

The complaints of patients represent a regression; their failings a neurosis. Reality becomes unattractive; emotional homeostasis is in peril. They are self-centered, often unloving individuals. They can surrender self-love and service of egocentrism if they receive something in exchange. They can love those people who are in their own image. They can love people whom they feel love them.

The need to be accepted will often force a person to turn to an inferior stratum, a new religion, or political movement. These categories differ from each other, but what is common to them all is their willingness to accept the stranger. Into which group the individual drifts is often a matter of chance. Demands are imposed upon the recruit for the privilege of membership, and there is a readiness to pay the price[2].

The maladjustment of neurotics is not due to a complete absence of identification with people. Rather they have over-identified with undesirable aspects of certain figures; they

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2 Gustave Le Bon, La Psychologie des Foules, Paris, Alcan, 1930, p. 17-18.

erroneously identify. Group psychotherapy provides a situation that encourages a correction of their old identifications. A new family relationship is approximated[3,4]. The patient is given a family experience, at more concrete levels, to correct his fantasies about significant figures in his own family constellation. The group framework is set up to assist patients to identify with real people in an effective and affective way. Hence the very significant value of group psychotherapy is in the many opportunities which multiple relationships provide[5,6,7,8,9].

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3 Louis Wender, "Dynamics of Group Psychotherapy and Its Application", Journal Nervous and Mental Diseases, Vol. 84, 1936, p. 54-60.

4 Louis Wender and A. Stein, "Group Psychotherapy as an Aid to Outpatient Treatment in a Psychiatric Clinic", Psychiatric Quarterly, Vol. 23, 1949, p. 415-424.

5 Nathan W. Ackerman, "Psychoanalysis and Group Psychotherapy", Group Psychotherapy, Vol. 3, 1950, p. 204-215.

6 L. Berman, "Psychoanalysis and Group Psychotherapy", Psychoanalytic Review, Vol. 37, 1950, p. 156-163.

7 S.H. Foulkes, Introduction to Group-Analytic Psychotherapy, Grune, 1948.

8 Jerome D. Frank and E. Ascher, "Corrective Emotional Experiences in Group Therapy", American Journal of Psychiatry, Vol. 108, 1951, p. 126-131.

9 L.H. Loeser et al., "Group Psychotherapy in Private Practice", American Journal of Psychotherapy, Vol. 3, 1949, p. 213-233.

Addendum.- The psychotherapist, too, as a member of the group, has his own emotional reactions. The psychotherapist, unlike the other members of the group, is expected to refrain from using his patients to act out his own catalog of personal disturbances. In training sessions and conferences, the following reactions of the psychologist group psychotherapists were noted: (1) anxiety, (2) feelings of hostility towards patients, (3) lack of confidence in group psychotherapy as an adequate treatment technique, (4) a need to compete with the patient for the omnipotent role, and (5) lack of sufficient empathy towards the group.

Although it would be interesting to expand on the reactions of the psychotherapist, and to give concrete examples, irrelevancy to the major topic of this thesis forbids entering into such details.

C. Release of Mutual Difficulties.

In the beginning of every psychotherapeutically-oriented group, the emotional reactions between the individual patients and the psychotherapist are paramount. As the group discovers a meaning and appropriateness to the sessions, interaction among members assumes substantial proportions. The latter process appears to move in three steps: (a) getting acquainted, (b) orientation into the group process, (c) amalgamation of the group by participation and interaction.

The power of the group not only resides in the emotional interplay of members of the group to each other, but there is also a significance to the verbal manifestations. There is some relevance to the content of their discussions in that the patients come for a common purpose, their symptoms are emotionally determined, and only pertinent material becomes incorporated in their understanding. Hence the release of mutual difficulties will be presented under the following topics: a) the emotional components, and b) the contential components.

a) Emotional Components.

Simple ventilation.- On this level, patients present their complaints in physical terms. The request is for a prescription: "This is what is wrong with me. Take care of me." It bears a marked dependency connotation. Two tasks are involved: overcoming resistance to group psychotherapy, and breaking down the feeling of isolation.

Resistances are usually manifested on a somatic basis, as a medical condition, as physiological expressions or physical symptoms, as to the value of treatment, and sensitivity about coming for psychological treatment. The group, in registering their complaints, break down their own isolation. Hence ventilation serves as a preliminary step in the direction of identification.

Catharsis.- In the use of catharsis with the group setting its own pace, the expression of emotionality bridges the gap between the external approach (stress upon testimonies of success characteristic of the suppressive and most of the diversional therapies) and the internal approach (discussion of pain and conflicts, typical of the reconstructive therapies). In catharsis spontaneously undertaken by the patient, there is no cutting away of all the defenses. The suppressive areas are more selective.

Catharsis is quite different from a simple ventilation. The latter is a complaining, passive aggressive manifestation, e.g., "Look, I'm telling you what's wrong with me. What are you going to do about it?" Simple ventilation provokes rejection. It is a demand for help. Catharsis is a purer expression of anxiety, e.g., "What shall I do?" Or it may be a release of sadistic projections, e.g., "Well, you never know, you might get killed." Cathartic expressions may thus be bivalvular: a release of anxiety and a release of unconscious fears. Members of the group can express both anxiety and sadistic fears without being rejected. They are accepted and it is safe, and in that safety there is reassurance.

b) Contential Components.

General topics to common topics.- Patients utilize the early sessions with "their lid off" and much of their anxiety and hostility are released. They then present theoretical and philosophical approaches to their problems. This type of content is frequently referred to by psychotherapists as intellectual in nature. For example, here is a list of terms that patients brought up in a ninety-minute session: personality, symptoms, complexes, frustration, fears, childnood, escape, unconscious, inferiority feelings, amnesia. These patients usually began with general ideas on personality. Each member gave his own ideas, and gradually moved in a more definitive direction.

Psychological discussions help the members of the group to postpone a presentation of personal problems until sufficient self-integration develops to tolerate them. The general approach helps to solidify the group and keeps it going.

Sessions usually begin in a rather low emotional tone - an impersonal view, but towards the end of each session, common feelings increase in tempo and there is an intense display of emotions. Discussions become a little more vital, less academic, less theoretical than at the start of the session.

Rationalizations by members of the group are allowed to proceed unchallenged, and even to gather momentum. They represent a sort of symbiotic resistance. Resistance is undermined by allowing the group to say what it wants without being criticized. The psychotherapist delays interfering with the group process in order to postpone the members' deeper self-understanding. The patients are allowed to test the group situation in a number of ways. The most successful dynamic psychotherapy is one in which patients obtain the feeling that they are making all the discoveries. They absorb from the group whatever is pertinent to their needs and purposes, as if the psychotherapeutic labors had been attained independently.

Common topics to personal topics.- At this stage of the treatment, the psychotherapist becomes alert to common denominators with the idea that he will eventually use them to understand resistances, increase objectivity, and intensify greater cohesiveness, because a common goal is being shared by everyone.

Here are examples of four common denominators observed in a single session:

(1) There was a presentation of problems on a somatic level. One patient complained of a pain, another of a nerve in his neck, a third wanted his heart checked, a fourth complained of headaches.

(2) Patients complained about problems concerning their voices. One member stated that he occasionally lost the power to use his voice. He could talk to his girl, but he could not talk to others. Another member commented that he did not like to talk. A third member remarked that he exploded verbally too often and too quickly.

(3) Complaints from several members centered about the problem of sleeplessness.

(4) Different patients utilized different methods to combat fear: some treated it as a physical ailment, some reacted to it as a form of a compulsion, and others behaved in a blind characterological fashion. One took a sedative, one had a bladder movement, and third member took a drink.

Individual problems.- The technique of channelizing broad topics into a more personalized direction is obtained from the patients by the simple device of asking for their feelings about these topics.

Heretofore, the group process was discussed in terms of functions of interpersonal reactions, levels of emotional release, topical progression, and delineation of common denominators. Subsequent sub-sections will treat: (1) the psychodynamics of anxiety manifestations and the technique for relating the anxiety to the present, as a means of increasing the patient's awareness of his egocentric patterns;

(2) techniques for arousing curiosity and increased objectivity, with the aim of obtaining the patient's acceptance of the emotional basis of his symptoms.

The assumption is made (but still open to empirical investigations) that patients become well on two radically different levels: (1) through initial stages of identification (based upon interpersonal emotional reactions), and (2) through intensified stages of identification (based upon insight: moving up to awareness of egocentricity and increased objectivity). The previous sub-sections dealt with initial stages of identification, and are characteristic of the suppressive frames of reference and psychodrama. The sub-sections to follow will be concerned with intensified stages of identification and are characteristic of the reconstructive frames of reference.

Group psychotherapy can be aimed at either level of identification. The literature proves that the patient still benefits, in either case. Even in the initial stages of identification, the patient obtains strength, and acknowledges this feeling. He feels stronger and better as he identifies with any strong member of the group. He becomes an integral unit of a self-sufficient body. He belongs. He no longer feels isolated by virtue of his neurosis, and it does not have the same crystal meaning for him.

D. Awareness of Egocentric Patterns.

Patients may have something they want to discuss but they are unable to talk about it. They may not be able to exercise initiative out of a feeling of guilt. If another member introduces the material, it is like a telepathic affair. It puts a stamp of approval on a topic that is close to the hearts of the inhibited members. When the subject has been introduced, it lowers the barriers of isolation in the patients. It is then a question of having the members of the group present their conscious motivations and feelings. This experience may be met by various reactions: much bickering, a shocked attitude, a creeping of understanding here and there, and a willingness to come to grips with personal material.

The increase in the patient's awareness of egocentric patterns of behavior and immaturity are developed in the following ways: by discussing outside danger versus inner feelings, and anxiety of the moment.

Outside danger versus inner feelings.- Patients tend to project their fears upon the environement. For example, one patient, in discussing his fears, mentioned visiting the home of a customer. There happened to be a knife on the table. He was afraid that the customer would attack him with the knife. The internal danger was attributed to an external

source. He was unable to draw a distinction between a real, external fear and a projection of his own sadistic anxiety reactions aroused by the perception of an external stimulus.

Some patients do not seem to realize that their attitudes are provocative. They are not aware of their own hostilities and aggressions; therefore, it is very easy for them to project their feelings onto the outside world in terms of being attacked. If reality is difficult for these patients, then they must be helped to see what it is that they bring to reality that makes it difficult. What are they doing to change themselves to adjust to reality? They tell the group what is done to them by others, but they fail to see or realize what their attitudes do to others, e.g., they talk with "chips on their shoulders", act domineering, express themselves too freely.

Anxiety of the moment.- At first, the anxiety of the moment relates to the group's suspicions as to what its members are going to get out of treatment. What kind of therapist do they have? Will he treat them right? Will he give them what they want? Will he answer their questions? Later, their anxiety ties up with their own feelings of inadequacy and helplessness. One patient told the group: "I'm in a sad condition." He cited a nervous condition that he had had five years previously. What circumstances are currently affecting this

patient that makes him displace his present difficulties onto the past? Another patient expressed the opinion that he had been a "sissy" in his childhood. What gives the man the feeling that he is inadequate today? What is he troubled about in his dealings with his fellow man, on the job, in school, or at home? What troubles the patient to the extent that old feelings of inferiority are brought back from out of the past into the current situation?

It is a difficult task to convince patients that there is a relationship between a present conflict and its concomitant symptomatic manifestations, in addition to childhood influences that have contributed to the current reaction pattern. Patients fixated on somatic symptoms find it prohibitive to speak about their emotional conflicts. The group psychotherapist may have to take a passive role with these patients for many hours, meeting their needs on an initiatory identification level only, lest they become seriously disturbed.

In general, when an appropriate situation occurs, the group psychotherapist should attempt to relate fears of the recent past to current feelings. For example, a patient complained of fears and insomnia. Subsequently, he told the group of a recent experience in which he witnessed the death of a fellow soldier, and was threatened with death himself. The patient was helped to see that he had had a real experience that

made him constantly on the alert to some catastrophic event that might befall him. At the same time the patient's experience was an excellent illustration to the group of how a traumatic incident could affect later actions. The psychotherapist is on the watch for additional disclosures made by other patients. He then helps the group to tie in similar connections between a conflict and its physical manifestations, so that solidarity is encouraged through the sharing of a common goal.

E. Curiosity and Insight.

Very few patients, who either voluntarily join a group or who are assigned to one, have any real acceptance of the nature of their illnesses. It requires a good deal of time to bring about a healthy insight, not necessarily on a deep level, but even on a recognition level. The group psychotherapist has to lead his group slowly, cautiously, and unhurriedly to the conviction that they have emotional difficulties and that emotions have an effect upon their bodies. They need to accept these convictions not only with their minds(intellectually) but with their hearts. They must acquire the feeling that they have emotional conflicts and not mental diseases. If the members of the group can really come to believe that emotional conflicts can produce symptoms, then the acme of group psychotherapeutic efforts have been achieved.

Explanations by the psychotherapist are frequently of value to whet the curiosity of patients for further exploration and understanding of themselves. The psychotherapist could stress that it is important to evaluate physical findings for treatment, but after these have been ruled out, the possibilities of emotional factors should not be overlooked. He could help develop an awareness to the fact that increased intestinal activity, for example, often accompanies fear and anxiety, and that the degree of physical pain is often closely related to the intensity of fear. When exciting emotional situations occur, there are certain physical sequelae: the blood pressure rises, mouths become dry, etc. The psychotherapist points out that headaches are real and not imaginary, but that self-observations tend to accentuate headaches or other symptoms. The group could be apprehensive in regard to many things in general, resulting additionally in a concern over health. The reason that patients observe themselves is that they have the feeling that something is wrong. The feeling that something is wrong ties up with the feeling of inferiority, feeling of inadequate masculinity, and the feeling of a lack of confidence in their capacities.

Explanation is directed towards educating the group; whereas clarification is directed towards a facilitation of establishing spontaneous connections and insight. There is

no question about the fact that even if the group psychotherapist is not directive the group quickly mobilizes the content of the sessions under their own impetus. However, the group process has so much more meaning to the members, if discussions can be tied up with the underlying dynamics of the inter-relations, the members of the group to themselves, the members of the group to the leader, and applied to a specific individual at a specific time in the group. In the use of context, the group psychotherapist has to exercise care that he does not disturb what is currently transpiring in the group or disrupt the solidarity of the group, that he does not accelerate or maximize patients' self-condemnations. Rather his task is to moderate the activity of their guilt feelings to the point where they look upon illness in a more lenient fashion. The goal is not so much a change of beliefs but to help patients to see more clearly behind their beliefs, feelings, conflicts.

As indicated above, group psychotherapy can be conducted at different levels. One can help the patient repress his aggressive feelings: "I don't want to kill. There is no malice in my heart." Or one can selectively suppress the aggression under conscious control: "I want to kill, but I won't." A propos, one of the ten commandments warns, "Thou shalt not kill." It does not say, "Thou shalt not think of

killing." However, there are situations when group psychotherapists may wish to calm disturbing drives and aid repressive forces by the adoption of less sophisticated levels of identification psychotherapy, especially when personality structures are too guarded, too rigid, or too weak to tolerate self-understanding and readjustment. Sometimes initiatory identification is the only type of psychotherapy that is appropriate, especially when time is at a premium, when the reality situation is hopeless, or with the elderly.

F. An Illustrative Session.

Patient C opened the hour by stating that he was rather nervous today. Yesterday he had gone to the barber shop to get a haircut. There was a judge sitting in one of the chairs. The patient felt the sudden impulse of hostility towards the judge "for no reason at all." The patient stated that in fact he had been quite friendly with the judge, although he referred to him as "an old senile." This in turn reminded him of episodes while in military service. The patient had been waiting in the barber shop for a haircut. An officer walked in and sat in the barber's chair before the patient whose turn was next. This infuriated the patient and instigated a discussion in the group about officers. Officers demonstrated their superiority over him when they actually had no right. He told

about a football game where an officer occupied his seat and an altercation ensued.

Now patient D began to shout his feelings about officers, how he hated them, how they mistreated him. He told about being subjected to a court-martial arising out of a mistake on the part of a commissioned officer. As he talked, his anger mounted and he rambled on over the mistreatment he endured under officers.

Patient C interrupted and wanted to clarify his views about officers. There were some officers who came out of the military service for whom he felt great respect, because these officers had sympathy and understanding for people. He looked at the group psychotherapist as he spoke. It seemed that he was feeling guilty towards the group psychotherapist, knowing that he too had been an officer.

Patient D attempted to neutralize his own outburst. He did not mean that all officers were bad. Patient C laughed and immediately pointed out to patient D that he was now on the defensive and was apologizing for his outburst. Whereupon, patient D apologized even further by stating that as he looked back upon his military career, he felt that he had enjoyed it. Patient B remarked that as for himself he did not feel any animosity against individuals, but was resentful of the system that brought about these injustices. However, patient B told the group that he had never felt important while in the service.

Both patients D and C expressed the feeling that the treatment accorded them in the service made them feel like little boys. Patient D mentioned that he was made to feel like a "five or six-year old." Patient B remarked that he hated the Army and wanted to get out. Patient C stated that perhaps an emotional break experienced by him in the Navy was an effort to get out. Whereupon, patient B indicated that he had attempted suicide in an effort to get out. This remark sobered the attitudes of the other members of the group. Patient C became introspective and moody and spontaneously stated: "That reminded me of my mother."

Inasmuch as the catharsis of hostility towards officers portrayed the group's reaction towards superior people and father figures, the group psychotherapist drew the group's attention to this possibility, suggesting that perhaps they had been aggressive towards their fathers and frightened as well. Patient C acknowledged difficulties that he had had with his father. Patient D recalled that his father had beaten him up "to an inch of his life". Patient B told about his father pushing his face into a plate of soup. Patient A remarked that he was always taken advantage of by his father. As the session came to a close, patient C commented that he should know enough to be able to act like a grown person, that he was determined to act grown-up and not to be aggressive and frightened.

In brief, the group psychotherapist used the group in the following ways: (a) he detected and delineated a key situation; (b) he tied up the complaint of a patient with the experience that the patient brought up; (c) he related a current situation and anxiety of the present to old relationships and feelings, and considered the current conflict a reality conflict and how it related to the past; (d) he utilized a personal problem brought up by the patient in the group situation and treated it as if it were a typical group problem, stimulating the reminiscences of similar situations which other members of the group had experienced in like manner.

In the latter situation the group psychotherapist introduced into the picture two important aspects: (a) the needs of a group as a group; (b) some explanation which sharpened understanding so that a tremendous vitality was imparted to a crucial situation that was fantasied as gigantic and brutalized, but that the group psychotherapist wanted the group to make more concrete, more actual, more real.

This chapter reviewed the methodology involved in the conduct of the group and reconstructed the dynamics which emerged out of the needs of the individuals who constituted the group.

Group psychotherapy was operationally defined as the development of verbal and emotional interactions and part-

identifications. Techniques were outlined for encouraging affective and cognitive development through two major levels of identification, namely: interpersonal emotional reactions and insight. It was maintained that the patient became well at either level, but that the group experience appears to have more meaning when the underlying dynamics is related to a specific individual at a specific time in the group.

The following chapter sets the experimental investigation of the basic assumption that identification is the crucial goal of group psychotherapy. Several criterion approaches will be utilized to effectuate the underlying psychodynamic rationale of this assumption.

CHAPTER III

PROCEDURE AND ANALYSIS OF DATA

1.- Statement of the Problem.

The rapid expansion of group psychotherapy, during World War II and since then, has exceeded an adequate understanding of the purpose of treatment and of what can be anticipated from the group psychotherapeutic experience. Each major author in the literature emphasized, for the most part, one particular manifest effect towards which psychotherapeutic efforts were directed. The question constantly arose: did these authors operate on the principle that there was a single basic psychotherapeutic mechanism, the result of which all psychotherapeutic effects occurred? Or, were the real needs of patients satisfied in a floating manner without this assumption as a guiding target? A review of the literature disclosed that patients became well regardless of frame of reference and psychotherapeutic treatment employed, and yet various authors differed as to the particular effect that was accomplished.

A. Theory Leading to Hypothesis.

The review of the literature in Chapter I noted that various group psychotherapists attributed improvement to some

manifest or overt psychotherapeutic change that occurred as the result of exposure to a series of psychotherapeutic sessions. The suggestion was made that the psychotherapist was meeting an unconscious need of the patient which really superceded the reported observed effects. In the theoretical framework as presented in Chapter II, group psychotherapy was defined as the development of verbal and emotional interactions in an increasing chain of part-identifications. It was maintained that the most powerful psychotherapeutic influence in the group is the mechanism of identification.

The function of identification has been given more or less recognition by various theorists. Rogers[1] warned the psychotherapist not to establish an emotional identification with the patient; the psychotherapist role was one of empathic identification. Apparently, Rogers did not use the term, emotional identification, in the converse relationship of patient to therapist. Moreno[2] equated identification with acceptance, a form of integration into the group:

> The lower the sociometric status of individuals the more are they exposed to injury from the powerful members and cliques of the group. . . The higher the sociometric status of an individual the more frequently will he interact with members of the group. . . and the volume of his interaction will tend to rise with acceptance (identification) with the norms.

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1 Carl R. Rogers, Client-Centered Therapy, Boston, Mifflin, 1951, p. 29.

2 Jacob L. Moreno, Who Shall Survive, New York, Beacon House, 1953, p. 703.

In a comparable sense Rogers[3], of the non-directive school, defined acceptance in the counseling relationship as follows:

> . . . as the client experiences the attitude of acceptance which the therapist holds towards him, he is able to take and experience this same attitude toward himself. . . Therapy consists in experiencing the self in a wide range of ways in an emotionally meaningful relationship with the therapist.

LeBon[4] stated that the individuals in a crowd sacrificed their personal interest to the collective interest through hypnotic contagion. Proceeding from LeBon's thesis, Freud[5] posited a type of identification characteristic of the group:

> . . . it may arise with every new perception of a common quality shared with some other person who is not the object of the sexual instinct. The more important this quality is, the more successful may this partial identifications become, and it may thus represent the beginning of a new tie.

In a critique of Freudian psychoanalytic mechanisms, Allport[6] commented:

> Another serviceable concept is that of identification, applied when one person develops an emotional tie with some other person to such an extent that he behaves as if he were that person.

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3 Carl R. Rogers, op. cit., p. 160, 172.

4 Gustave LeBon, Psychologie des Foules, Paris, Alcan, 1930, p. 17-18.

5 Sigmund Freud, Group Psychology and the Analysis of the Ego, London, Hogarth, 1948, p. 65-66.

6 Gordon W. Allport, Personality, New York, Holt, 1937, p. 185.

In a compendium of research on motivation for hypnosis, White[7] emphasized the relationship between the needs of a person and its effect on hypnosis. Needs were divided into manifest and latent. No relation to hypnosis was found in the manifest needs of sex, extraversion, and submission. A small but significant relationship was found in deference (the tendency to yield willingly to the wishes of a superior person), and the need for autonomy (reaction to the situation as a threat and the desire for self-direction). White postulated the following latent needs favorable for hypnosis: (1) the need for love (as that of a child towards his parents), (2) the tendency of self-compliance (in the presence of an elder), and (3) the wish to participate in omnipotence. White stated that positions in hypnotic rank could be predicated with success by examiners who knew their subjects. The need for love and the tendency for self-compliance were based upon Freud's Group Psychology and the Analysis of the Ego, while the thesis based upon omnipotence was attributed to Schilder[8]. Schilder maintained that the patient projected his infantile wish for omnipotence onto the hypnotist, "and thus

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7 Robert W. White, "An Analysis of Motivation in Hypnosis", Journal of General Psychology, Vol. 24, 1941, p. 145-162.

8 Paul Schilder and Otto Kauders, Hypnosis, (translated by S. Rothenberg), New York, Nervous and Mental Disease Publishing Co., 1927, p. 118.

participates, by the path of identification, in a magic power which he could not otherwise ascribe to himself" (underlining mine). White discovered that individuals who had either latent or manifest needs of aggression were highly refractory to hypnosis.

In summary, the theory which clears the way for our hypothesis is this: the amalgamation of individuals into a group has been linked with hypnotic contagion (LeBon); there is a partial identification with others, through a need for love and a tendency to self-compliance (Freud, White); identification is the acceptance of and by others in accordance with a sociometric status (Moreno); the deep feeling of acceptance is essential in the psychotherapeutic process (Rogers); acceptance is the satisfaction of a wish for omnipotence through identification by a deferent individual in a hypnotic-like relationship (Schilder, White).

B. Hypothesis.

It is hypothesized that the mechanism of identification is the latent and basic curative factor of personality adjustment in group psychotherapy. Three approaches or criterion measures will be utilized in order to test the truth of this hypothesis: (1) on the basis of a positive argument, that quantitative Rorschach signs will evidence the latent

identification component in personality structure; (2) on the basis of a positive argument, that quantified testimony of patients in a questionnaire will reflect evidence of manifest effects of identification; (3) on the basis of a negative argument, that in the case of improper referrals to group psychotherapy, there is an absence of adequate identification.

2.- Design of the Study.

This project had its inception shortly following World War II. It was an empirical survey of what eventually became eighteen groups of white adult male patients. They were referred for group psychotherapy to the Boston Regional Office of a United States Veterans Administration ambulatory outpatient facility for the treatment of emotional disabilities. The aim of this project was chiefly exploratory. After all the data was assembled, a preliminary investigation was instituted in order to formulate specific directions for systematic study.

The groups were conducted by dynamically-oriented psychologists under the writer's supervision, utilizing a group psychotherapeutic technique and rationale similar to that presented in some detail in Chapter II. As previously stated, the groups met one evening a week for sixteen sessions, each meeting of one and a half hour's duration. All patients had a minimum of eight sessions plus attendance of the final session

of the group, over a time span of approximately four months. Out of a possible total group psychotherapy population of 213 subjects, fifty-seven patients had completed the prescribed series of group psychotherapy sessions, without adjuvant individual psychotherapy. Forty-eight of these patients were available for post testing. Hence it was the latter who served as the experimental group.

A. Subjects.

Two groups of patients were used for this study. An experimental group of forty-eight white adult male veterans, diagnosed by the Neuropsychiatric Examining Unit as suffering from emotional disabilities and referred to the Mental Hygiene Clinic for psychotherapy. A control group of 10 white adult male veterans matched with the experimental group in basic face data information. Members of the control group had applied for treatment to the Boston Regional Office for emotional disabilities, but were denied assistance pending (1) examination by the Neuropsychiatric Unit and (2) adjudication of their disability claims. The rationale of having two groups, an experimental and a control, proceeded on the assumption that improvement could occur without psychotherapy, but that the use of psychotherapy might maximize the difference.

Table I presents the results of matching both groups for age, education and intelligence. The method for computing these variables was based upon the following consideration. Since the total number of cases varied markedly between the experimental and control groups, a more accurate measure of standard error was employed than would be provided by using the formula:

$$\sigma_{D_M} = \sqrt{\sigma_{M_1}^2 + \sigma_{M_2}^2}$$

The formula for the error, which involves pooling the variance of the two groups is as follows:

$$t = \frac{M_1 - M_2}{\sigma_{d_M}}$$

$$\sigma_{d_M} = \sqrt{\left[\frac{\Sigma x_1^2 + \Sigma x_2^2}{N_1 + N_2 - 2}\right]\left[\frac{N_1 + N_2}{N_1 N_2}\right]}$$

In this formula N's equal number in samples; Σx^2 is the variance sum of the series calculated for its arithmetical mean, the deviation of each item from the mean of the series, i.e. $\Sigma x^2 = (M-x)^2 + (M-x')^2 + (M-x'')^2 \ldots (M-x^n)^2$

An inspection of Table I discloses that the experimental and the control groups were matched for such face data as age, education, and I.Q. The mean age of the experimental

Table I.- Matching Both Groups for Age, Education and Intelligence.

Variables	Groups	M	σ	d_M	σ_{d_M}	$D\sigma_D$	P
Age	E	26.8	4.8	0.7	1.23	0.57	.40-.50
	C	27.5	6.3				
Education	E	11.3	2.1	0.8	.77	1.0	.30-.40
	C	12.1	2.6				
I.Q.	E	113.2	6.2	2.3	80.	.003	.90-.99
	C	115.5	10.8				

group was 26.8, and the standard deviation was 4.8. The mean age for the control group was 27.5, and the standard deviation was 6.3. The level of confidence was .40-.50. The mean years of education in the experimental group was 11.3, and the standard deviation was 2.1. The mean years of education in the control group was 12.1, and the standard deviation was 2.6. The level of confidence was .30-.40. The mean I.Q. of the experimental group was 113.2, and the standard deviation was 6.2. The mean I.Q. of the control group was 115.5 and the standard deviation was 10.8. The level of confidence was .90-.99. In each of the above three variables, the level of probability was based on fifty-six degrees of freedom.

Table II presents the results of matching both groups for marital status and religion. These variables were performed with the usual formula of chi square:

$$\chi^2 = \sum \frac{(f_o - f_t)^2}{f_t}$$

where fo is the observed frequency and ft the frequency expected by chance. In order to afford some measure of comparison between the two groups, chi square was calculated even though the theoretical frequency magnitude in the control group was low. The probabilities in both variables are so high as to make any significant difference unlikely.

Table II.- Matching Both Groups for Marital Status and Religion.

Variables	E	C	Both	Chi Square	p
Marital status					
Married	21	5	26		
Single	27	5	32		
				.013	.90-.99
Total	48	10	58		
Religion					
Catholic	38	6	44		
Protestant	6	3	9		
Jewish	4	1	5		
				1.904	.40-.50
Total	48	10	58		

The experimental group had twenty-one married and twenty-seven single male veterans. The control group consisted of five married and five single male veterans. The chi square was .013, interpreted for one degree of freedom, with a chance probability of .90-.99. The experimental group was made up of thirty-eight Catholics, six Protestants, and four Jews. The control group had six Catholics, three Protestants, and one Jew. The chi square was 1.904, interpreted for two degrees of freedom, with a chance probability of .40-.50.

B. Tools.

The Wechsler-Bellevue Intelligence Scale and the Rorschach Test were administered individually to both the experimental and the control groups. The pre-testing of the experimental group occurred before their first group psychotherapy session. The previously mentioned tests were administered by the writer, and involved comparatively few of his own patients in group psychotherapy. The Wechsler-Bellevue was administered strictly according to the procedure outlined in the manual[9]. The Rorschach test was conducted in accordance with the Klopfer technique[10]. However, no testing of the

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9 David Wechsler, The Measurement of Intelligence, Baltimore, Williams & Wilkins, 1944, p. 171-213.

10 Bruno Klopfer and Douglas McGlashan Kelley, The Rorschach Technique, New York, World Book, p. 27-191.

limits was undertaken. The inquiry was cautious so as not to encourage an elaboration that was not independently arrived at by the patient. One exception to the Klopfer System of scoring was employed: the calculation of F plus per cent in accordance with Beck's manual[11] on the Rorschach test. The rationale for the Rorschach test will be presented in a subsequent section.

In the week following the termination of group psychotherapy, the experimental group was retested with the Rorschach. The control group was retested approximately four months following the pre-audit. The diagnosis of the patients in the control group had not been determined. In all, 138 Rorschach tests and 77 Wechsler-Bellevue intelligence tests were administered.

In the final session of the group psychotherapy series, a Questionnaire was filled out by the patients for the purpose of self-evaluation of the group psychotherapeutic experience in accordance with a number of categories. The questionnaire was administered by a psychologist other than, and in the absence of, the group psychotherapist in the final session of the group.

Unfortunately, no follow-up study of the patients who were pre and post tested was possible.

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11 Samuel J. Beck, Rorschach's Test, Vol. I, Second Edition, New York, Grune, 1949, p. 207.

C. Previous Research in This Area.

The literature disclosed two pertinent reports of pre and post Rorschach testing involving group psychotherapy. One was by Walter Klopfer in 1945 and the other was a Ph.D. dissertation by Natalie Reader in 1948. Pre and post Rorschach testing reports on individual psychotherapy were made by Muench in 1947, Reader in 1948, Siegal in 1948, Carr in 1949, and others. There were numerous reports which involved pre and post testing of a single case following a period of psychotherapy, in the literature. The psychologists in the Powdermaker-Frank[12] project conducted pre and post Rorschach testing in group psychotherapy, but refrained from reporting their results. This was probably due in part to contamination by individual psychotherapy. Even in their group psychotherapy category alone, the patients had a maximum of five individual sessions as well. Their groups varied from a minimum of nine sessions to a maximum of ninety-eight sessions. Powdermaker and Frank[13] reported further that their sample was too small to allow for the use of statistical methods. The authors

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12 Florence B. Powdermaker and Jerome D. Frank, Group Psychotherapy, Cambridge, Harvard, 1953, p. 565-579.

13 --------, op. cit., p. 8.

presented a pessimistic view of quantitative methods:

> . . . preoccupation with controls and experimental design is premature and is based on the misapprehension that these methods in themselves lead to the discovery of significant relationships. . . the data were analyzed along qualitative rather than quantitative lines.

The paucity of reports on pre and post Rorschachs in group psychotherapy may be attributed to at least three factors: (1) most installations require a combination of group psychotherapy with individual psychotherapy; (2) since most group psychotherapists favor a group of from six to eight patients, allowing for discontinuing patients, it would require about ten groups to acquire a sufficient size population to work with; (3) if groups extend over a four-months period or more, and there is limited personnel, it would take several years before the data could be collected.

Muench[14] made a quantitative study of twelve cases that had non-directive therapy with pre and post Rorschach testing. He found four indicators of change following psychotherapy: FC, FC minus (CF plus C) Wt., M plus FC minus (C plus CF), and per cent R plus. Carr[15] repeated the experiment with nine cases regardless of length of therapy, and obtained no significant differences.

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14 G.A. Muench, "An Evaluation of Nondirective Psychotherapy by Means of the Rorschach and Other Indices", Applied Psychological Monographs, No. 13, Stanford University Press, 1947, 163 p.

15 Arthur C. Carr, "An Evaluation of Nine Nondirective Psychotherapy Cases by Means of the Rorschach", Journal of Consulting Psychology, Vol. 13, 1949, p. 196-205.

Walter Klopfer[16] gave the Harrower-Erickson Group Rorschach to nine soldiers in an anxiety state at a neuropsychiatric convalescent hospital, before and after a three-week treatment period. The program consisted of one hour of ward rounds, two hours of physical conditioning, two hours of educational conditioning, one hour of orientation, and one hour of an authoritative type of group psychotherapy. The Rorschach protocols were then analyzed qualitatively by Bruno Klopfer. The latter found the following signs of improvement: increased productivity, overcoming of rejections, increased use of color cards, increase in more integrated responses, variability of concepts, replacement of devitalized responses with more vitalized ones, rejection of inferior responses, and disappearance of disturbed content.

Reader[17] made the most extensive study to date in pre and post Rorschach testing before and after a treatment interval. She examined 56 patients: 17 who had individual therapy, 24 group therapy, and 15 individual plus group therapy. Her group had a twenty-five to forty-five year age range, thirty of whom were male and 26 female. Her control group consisted of fifteen

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16 Walter G. Klopfer, "The Efficacy of Group Therapy as Indicated by Group Rorschach Records", Rorschach Research Exchange, Vol. 9, 1945, p. 207-209.

17 Natalie Reader, "An Investigation into Some Personality Changes Occurring in Individuals Undergoing Client-centered Therapy", Unpublished Ph.D. Thesis, University of Chicago, 1948, 136 p.

individuals who did not request therapy, but were matched for age, sex, education, and socio-economic background. The individuals who had group therapy alone were "forced" on students as part of a course on client-centered therapy. The frequency of meetings varied from group to group: some once a week, some twice a week, while still others met daily. The group therapy treatment was of a nondirective type, and ranged from four meetings to thirty-five meetings. The control group of fifteen individuals were matched with the overall group of fifty-six patients in time of post administration, which varied from three weeks to four months.

Two methods were employed: (1) rating of records in accordance with the ten characteristics: quality of reality orientation, presence or absence of anxiety feelings, feelings of dependency-independency, attitude toward self, quality of affectivity, adequacy of intellectual functioning, spontaneity-flexibility, personality integration, attitude towards others, and quality of adjustment to emotional problems; (2) use of a variation of Harrower's neurotic signs in which pre and post neurotic signs are calculated and compared. The latter technique was employed chiefly to indicate that her control group was as comparably neurotic as her experimental group. Each of her ten categories was made up of a composite of Rorschach scores. Her experimental group showed small changes towards

better adjustment in nine of her ten characteristics. The greatest gain was in quality of affectivity at the .01 level of confidence, while other gains were at the .02 level, with the exception that her category of spontaneity-flexibility failed to note change in the direction of spontaneity-flexibility.

A number of points make it difficult to establish comparisons: (1) Reader used students for group therapy who were not sick (although they may have been neurotic) and who were not purposely motivated for psychotherapy; (2) there was a wide variation in number of treatments and intensity of treatment (from once weekly to daily); (3) one has to assume that her ten composite characteristics actually measure ten different, independent personality changes.

Siegel[18], working with children, attempted to correlate Rorschach findings with improvement. He used four gradations in rating of improvement from "considerable improvement" to "worse". Refusals, FC, W per cent, Fc, H, testing of the limits, O, and F plus per cent were found to be indices of improvement in descending order of importance. Since criteria for adults are somewhat different from criteria for children, it is doubtful whether findings for children who are emotionally and chronologically less mature, can be applied to adults.

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18 M.G. Siegel, "The Diagnostic and Prognostic Validity of the Rorschach Test in a Child Guidance Clinic", American Journal of Orthopsychiatry, Vol. 18, 1949, p. 119-133.

D. A Topographical Interpretation.

The quantitative approach was utilized for the analysis of the Rorschach results. In order to lend a greater objectivity to the use of the Rorschach as a research instrument, a qualitative study was omitted. Qualitative analysis introduced subjective elements that could not be controlled.

The quantitative results, however, will be subject to a topographical method of interpretation. For a clearer understanding of subsequent discussion of the Rorschach results, a number of empirical assumptions, or working hypotheses, will be presented below. They will appear in the form of (1) a simplified, theoretical construct, out of which (2) a Rorschach topographical view of the personality is portrayed.

a) Theoretical Construct.

Some organized concept of personality structure is necessary in order to evaluate mental health and psychopathology. We begin with Fenichel[19]:

> Stimuli from the outside world or from the body initiate a state of tension that seeks for motor or secretory discharge, bringing about relaxation. However, between stimulus and discharge, forces are at work opposing the discharge tendency. The study of these inhibiting forces, their origin and their effect on the discharge tendency, is the immediate subject of psychology. Without these counterforces, there would be no psyche - only reflexes.

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19 Otto Fenichel, The Psychoanalytic Theory of Neurosis, New York, Norton, p. 11.

The forces involve a number of constellations. Saul[20] stated:

> Just as in the body we observe certain systems such as the gastro-intestinal, the cardio-vascular, the respiratory, the genito-urinary, the skeleto-muscular, and the like, so the activities of the mind fall logically into certain systems.

The chief danger, as Allport[21] pointed out, is that they

> . . . may come to stand for an assembly of separate and self-active faculties, thought to govern behavior all by themselves, without interference . . . The basic principle of behavior is its continuous flow, each successive act representing a convergent mobilization of all energy available at the moment. . . . A single act may, and usually does, result from the mobilization of available energy through many channels.

The most fruitful approach to the study of personality structure is the dynamic one. It states that personality is an active, on-going process, and that the structure of this process is the main method of a psychological evaluation of the personality. Although our calipers are set to measure the present personality, the psychological scene embodies the entire historical background of the development of the personality. The present personality carries along with it the residue of the past history of the individual. A valuable approach to the study of the personality structure is an evaluation of the inter-relationship among tension systems --

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20 Leon J. Saul, Emotional Maturity, Montreal, Lippincott, 1947, p. 303.

21 Gordon W. Allport, op. cit., p. 312.

where each psychological system (artificially separated) must operate within an optimal charge or expenditure or energy, in order to maintain a healthy homeostasis. In this respect, Nunberg[22] quotes Freud: "The crucial point of the whole situation (i.e., health or illness) is the relative strength or weakness of the ego."

b) Psychic Structure of the Personality.

Figure 1 illustrates, in a visual form, a schematic representation of the major systems of the psyche. It is a concept of the psychic structure of the personality superimposed on the determinant graph of the Klopfer-Davidson Individual Record Blank, in order to correspond with the Rorschach factors. The arrows indicate the course and distribution of energy or power in the life system of the mind.

Psychological functions are more easily understood if they can be regarded from a topographical point of view. Certain crucial poles of reference, represented in spatial symbols are more clearly delineated and yet connected by a continuous life flow.

Drive-goal.- The left side of the Figure represents the internal world. It is said to have its impetus from a

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22 Herman Nunberg, Practice and Theory of Psychoanalysis, New York, Coolidge Foundation, 1948, p. 185.

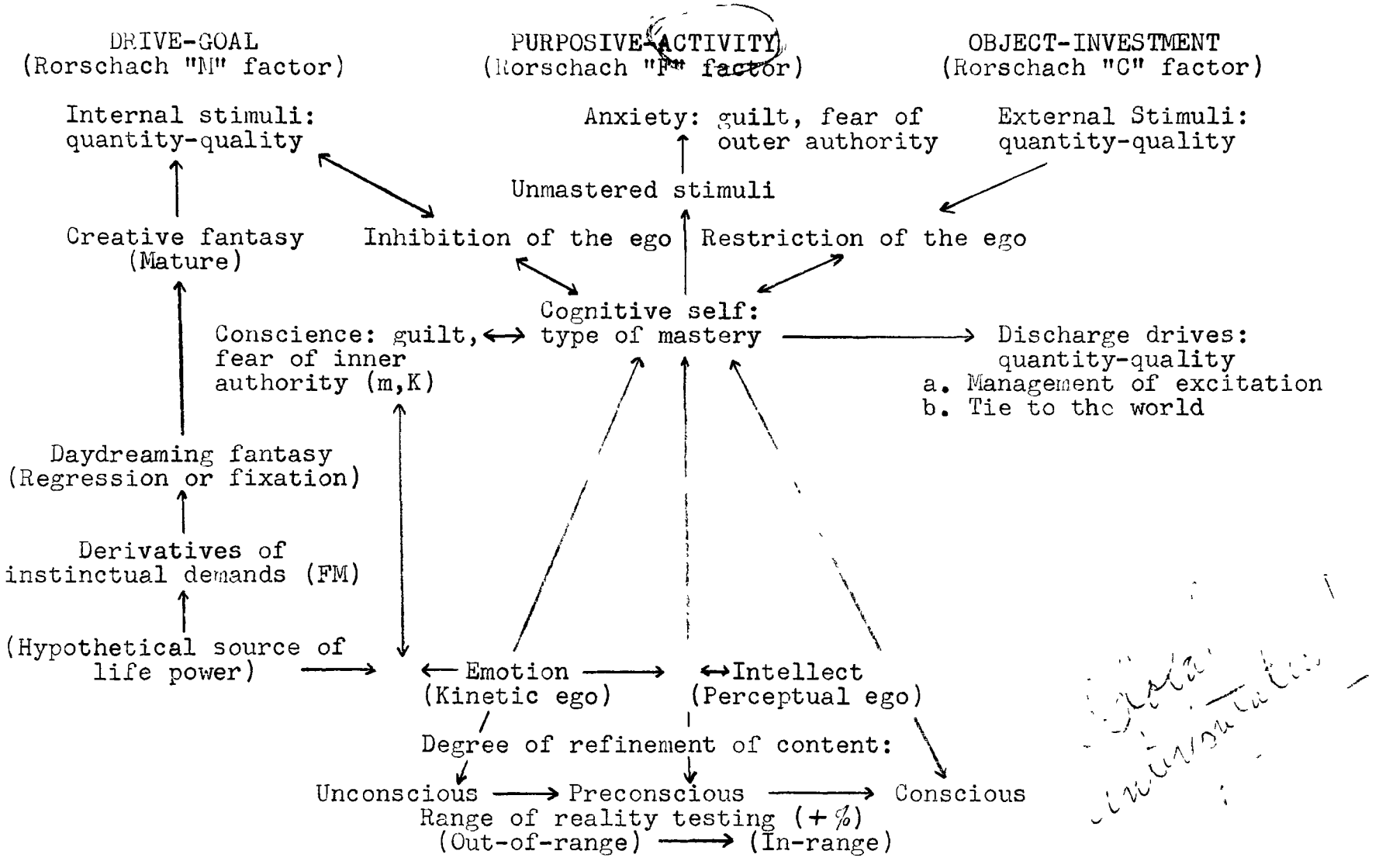

Figure 1.- Topographical schema of the Psyche.

metaphysical source of life power. According to the Aristotelian - Scholastic view, it is the principle from which all activity proceeds. It presupposes a multiplicity of actions and levels[23]. It provides the means for attracting and uniting the individual to the outside world. It has the power to contact and unite with objects. It may very well be the wherewithal that a person possesses in order to form an emotional tie with some other person (the concept of identification).

The writer is in strong agreement with Allport[24] in the following discussion of this point:

> . . . there are many meanings of the term personality other than the special psychological meaning . . . Metaphysically one might define personality as "the indestructible essence of individual being (the soul)." Such a definition would of necessity claim unity as an essential attribute of personality. This proposition, though it may very well be true, lies altogether in a nonpsychological realm of discourse. In deciding to dispense with the soul, psychologists cut themselves off deliberately from such speculative propositions of theology and philosophy. Unfortunately they fell at the same time into the rather shabby habit of declaring that all the metaphysical conceptions with which they refused to deal were ipso facto meaningless. It would be far wiser to concede that metaphysical unity may be the property of personality, while insisting that it is a different problem from the empirical unity that falls in the province of psychology.

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23 R.H. Shevenell, Lectures in Medieval History at the University of Ottawa (unpublished), 1953.

24 Gordon W. Allport, op. cit., p. 348.

The FM:M Rorschach factors represent levels of goal achievement. The Buhlers[25] stated that this ratio represents a balance between instinctual and cognitive led goals:

> The M and FM factors are called goal-directed pressure. While FM represents the tension resulting from unsatisfied drives, M seems to represent the tension which results from imagined, that is to say, intellectually conceived but deferred fulfillments.

Undeferred goals then are early derivatives which are expressed as primitive, unrefined, direct gratifications. The child, for example, is said to be unable to distinguish between his own needs and those consonant with the environment. The early life history of the individual is characterized by a day-dreaming, passive-receptive type of mastery. The child observes that he can use an intermediary, the parent, to control the environment for his own adaptation. Active mastery occurs late in the scale of emotional development. At this stage, the individual makes an active attempt to form a working relationship with others. Active mastery is the use of creative fantasy in an active orientation to the world. Goals, then, are present on various levels from an embryonic or arrested development, a recession in development, to the pursuit of

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25 Charlotte Buhler, Karl Buhler, and D. Welty Lefever, Development of the Basic Rorschach Score, California, Buhler, Buhler, Lefever, 1949, p. 36.

more mature, constructive life expressions. Piotrowski[26] has subdivided still further many types of M and FM with corresponding refinements in psychological interpretations of the drive-goal category.

Purposive-activity.- The center of Figure 1 represents the control center, the switchboard of the psyche, the cognitive self or the ego. Rapaport[27] discussed this function of the cognitive self or ego in relation to projective test data in the following way:

> The subject has an Ego which is the recipient of outside stimulation, and which may be inclined to take, to shirk, or incessantly to evoke stimulations. This Ego is also the executor of the intentions of the unconscious strivings, which in their particular constellation and strength are specific to the individual; as executor of these intents, the Ego may oppose them, subserve them without delay, or postpone them and by thinking prepare for their optimal realization. The Ego has a certain autonomy -- autonomous energy (bound cathexes), autonomous behavior (defense mechanisms), and autonomous thought patterns -- to govern perception, execution, and thought. The reception of stimulation by the Ego is not automatic but selective, and to some extent distorts the stimulation to meet the needs of the subject. The execution of intentions by the Ego is likewise not an automatic discharge of internal tensions, but an adaptation to the nature of the objects in reality which these intentions are aimed at or must cope with.

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26 Zygmunt A. Piotrowski, "Tentative Rorschach Formulae for Educational and Vocational Guidance in Adolescence", Rorschach Research Exchange, Vol. 7, 1943, p. 16-27.

27 David Rapaport, Diagnostic Psychological Testing, Vol. 2, Chicago, Yearbook Publishers, p. 11-12.

It is the Rorschach form responses which indicate the functions of the Ego according to Rapaport[28], Beck[29], and, in a modified form, the Buhlers[30]. However, all Rorschach writers are generally agreed that the F plus per cent measures reality testing for out-of-range or in-range adequate reality awareness.

The course of a stimulus (the object) is from the sense organs to the perceptive system (the cognitive self or ego), to the memory system (drive-goal) and then associative connections (through the cognitive self) are established. The aroused tensions are discharged into affects, emotions, and motor actions. Instead of conditioned reactions and reflexes, thinking takes place -- trial seeing, hearing, acting -- a test run from which plans are formulated for integrative action. Hallucinations result when the normal progressive flow is reversed and mental contents are directed in retrograde fashion from memory to the perceptive system. The memory content is given a sensory character which cannot be distinguished from the perceptions of actual objects. When such an intermingling of content occurs, we have projection[31].

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28 Idem, op. cit., p. 188-190.

29 Samuel J. Beck, Rorschach's Test, Vol. 2, New York, Grune, 1945, p. 19-21.

30 Charlotte Buhler et al., op. cit., p. 31.

31 Eduardo Weiss, Principles of Psychodynamics, New York, Grune, 1950.

The ego, although multiple in function[32,33], may be considered crudely as a two-faced Janus: one facing the external world and the other the internal world. Anna Freud[34] suggested broad mechanisms of defense for both areas: restriction of the ego for warding off unpleasnat external stimuli, and inhibition of the ego for warding off prohibited dangers or demands arising from internal sources. How much one broad defense category will operate depends upon the type of synthesis that is effected by the cognitive self or ego of the inner and outer world in the process of (a) assimilation and mediation, and (b) the dynamisms that are utilized to organize, refine, and blend individual stimulus components.

Failure in the mastery of internal and external stimuli results in "primary anxiety" (tension, dammed up state). According to Nunberg[35] and Fenichel[36], in psychoanalytic theory, there are two types of guilt. Feelings of conscience may be regarded as a special offshoot of primary anxiety, appearing as an anticipatory warning signal on what should or should not be done. It is directed more towards outer authorities and

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32 Robert Waelder, "The Principle of Multiple Function", Psychoanalytic Quarterly, Vol. 5, 1936, p. 45-63.

33 Gordon W. Allport, op. cit., p. 313.

34 Anna Freud, The Ego and the Mechanisms of Defence, London, Hogarth, 1948, p. 100-113.

35 Herman Nunberg, op. cit., p. 137-138; 143-147.

36 Otto Fenichel, op. cit., p. 103, 105; 132-134.

is linked with social fear. Guilt, as it is commonly known, stems from conflicts over renounced gratifications, and is an expression of fear of inner authority figures and pangs of conscience over past deeds. Feelings of conscience depicted by a fear of outer authority are disclosed by such signs as discomfort, dull inner tension, fear of loss of objects, and fear of loss of love from others. Guilt is expressed by fear of inner authority reflected by forebodings of disaster or fear of loss of self-integrity. Hence, the superego is the product of the ego arising out of insupportable inner and outer stimuli.

Conscience factors are admittedly the most difficult to isolate in the Rorschach determinants. The high F per cent would appear to approximate the descriptive terms of discomfort, dull inner tension, and fear of loss of love from others. Tension (m) and anxiety (K) would appear to approximate the descriptive terms of forebodings of disaster and fear of loss of self-integrity. The Buhlers[37] pointed out that Klopfer's high FK is called foreboding. The Buhlers, while denying that FK has this connotation, go on to speak about K as having "a signal function . . . a danger awareness . . . communicated to the ego." Since m has a similar function to K,

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37 Charlotte Buhler et al., op. cit., p. 31, 37.

both "interpret to the Ego its own pressures. . ." Klopfer[38] is even more specific:

> K and k seem to indicate a flight from the more sensuous shading effects, whenever these effects arouse so much anxiety and guilt (underline mine) that the subject is not able to accept them. . . It is understandable that K reactions have a tendency to associate with m. . . The inhibition of conflicts indicated by m are likely to create misgivings about any promptings from within.

The chief purpose of the cognitive self or ego is the constant attempt to align the tension systems through an equitable adaptation. Only the ego can experience anxiety. Only the ego can mobilize the appropriate defensive measure. When the ego no longer attempts to bring about mastery, then it is either overwhelmed by an excess of tension (guilt), or if a diffusion and disorganization occurs there may be a schizophrenic breakdown.

The refining function of the cognitive self or ego is the withholding of undifferentiated emotional experience by more differentiated cognitive experience. The role that emotive material plays in the amount and precedence of merger with the cognitive self provides another yardstick for gaging the degree in which the individual discloses out-of-range or in-range reality testing.

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[38] Bruno Klopfer and Douglas McGlashan Kelley, op. cit., p. 241.

For examples:

(1) If the cognitive sphere of the ego (externalized connections) is intact and the emotive sphere of the ego (internalized connections) is more or less adaptive, the person is either a normal neurotic (compensating, can realign) or a maladjusted neurotic (decompensating, unable to realign). The latter's undifferentiated emotive behavior is not condoned by his ego. It is ego alien.

(2) If the cognitive sphere of the ego (externalized connections) is intact, and the emotive sphere of the ego (internalized connections) of the ego fails to adapt, the person is a character disorder. His undifferentiated emotive behavior is condoned by his ego. It is ego syntonic.

(3) If the cognitive sphere of the ego (externalized connections) is severely impaired and the emotive sphere of the ego (internalized connections) is no longer adaptive, the person is psychotic.

Object-investment.- The nature of the discharged drives are reflected in the variations of the Rorschach C factors represented on the right side of the Klopfer psychograph. More specifically, they represent the type of emotional tie that the individual is able to form with the world: Fc (sensitivity), c (social insecurity), C' (caution), CF plus C (emotively driven with minimum cognitive control),

FC (cognitively directed emotion). Emotional tie to others is more significantly reflected in the FC factor, where the emotive component is utilized in a stable bond with an object in a partial identification with others. A predominance of FC over CF and C has been designated in the literature by Rorschach[39] as indicating an "ability to achieve emotional rapport"; by Rapaport[40] as an "empathy for the feeling of others"; by Beck[41] as a "capacity for friendliness that can be used adaptively" and "more fully introjected outside world".

In conclusion, three inseparable trends run throughout any assessment of the on-going function of the personality: the where of the tension system (structural aspects), the what that is transpiring in the equilibrium and interplay of tension systems (dynamics), and the how much in the approximate distribution of cognitive-emotive aspects expressed in the various tension systems (economics).

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39 Hermann Rorschach, Psychodiagnostik, English translators Lemkan, P., and Kronenberg, B., New York, Grune, 1942, p. 29-35.

40 David Rapaport, Vol. 2, op. cit., p. 241.

41 Samuel J. Beck, Vol. 2, op. cit., p. 29-30.

E. Analysis of Rorschach Variables.

Twelve Rorschach signs (10 formal and two content variables) were selected for quantitative analysis. The choice was based upon the frequency of their occurrence in Rorschach protocols, the vital meaning that they have in the personality constellation, and because Rorschach workers have found them sensitive as adjustment indicators.

Previous experimental data in pre and post Rorschach testing, utilized with an interval of non-directive individual psychotherapy, especially by Muench[42], provided a number of Rorschach factors which could be formulated as specific hypotheses for group psychotherapy. The analysis of the Rorschach will be presented under the captions of method and results.

a) Method.

The design of the Rorschach experiment provided for three statistical comparisons: (1) between the pre and post means of the experimental and the control groups for Rorschach scores on number of R, M, FC, CF plus C (Wt.), FC minus (CF plus C) Wt., M plus FC minus (CF plus C), and H; (2) between the pre and post means of the experimental and control groups for Rorschach percentages on expanded F percent

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42 G.A. Muench, op. cit., p. 154.

(FK, Fc plus F), F plus per cent, W per cent, D percent and A per cent; (3) between the pre means of the experimental group and the pre means of the control group on two Rorschach score variables, K and c.

The first two statistical comparisons were utilized for testing the hypothesis that the experimental group would be distinguished from the control group by a change in post-test Rorschach scores and/or percentages in the direction of a more stable emotional flow in object contact. In other words, if treatment has been helpful, there should be evidence in the Rorschach of more adequate emotional identification with others in post-test than in pre-test status.

The third statistical comparison was constructed to determine whether the experimental and the control groups were equally favorable for psychotherapeutic change. With this type of comparison, the results could indicate one of several possibilities: (1) the experimental group could be favorable and the control group unfavorable for psychotherapy, (2) the experimental group could be unfavorable for psychotherapy and the control group favorable, (3) both groups could be unfavorable for psychotherapy, (4) both groups could be favorable for psychotherapy, (5) both groups could be neither significantly favorable nor significantly unfavorable for psychotherapy as measured by these scores.

The Rorschach score K has been designated by Klopfer[43], Rapaport[44], and others as free-floating anxiety. This type of anxiety is universally accepted as a sine qua non for successful psychotherapy. The Rorschach score c has been by Klopfer[45] as "absence of adequate control of contact impulses", a "hazy desire for contact", and by Beck[46] as a "depriving experience" of affect hunger. This type of relationship is universally regarded as unfavorable for psychotherapy.

Seven of the Rorschach variables involved scores, whereas the remaining five Rorschach variables involved percentages. Hence two different methods were utilized to determine the presence of significant difference between pre and post observations.

a) Method employed with Rorschach scores.-

(1) The pre and post means were calculated.

(2) The standard errors of these were determined by the formula:

where is the standard deviation of each series from its mean.

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43 Bruno Klopfer and Douglas McGlashan Kelley, op. cit., p. 242.

44 David Rapaport, Vol. 2, op. cit., p. 279.

45 Bruno Klopfer, op. cit., p. 286-287.

46 Samuel J. Beck, Vol. 1, op. cit., p. 128.

(3) The standard error of the difference between means was calculated by the formula:

(a) $$\sigma_{D_M} = \sqrt{\sigma_{M_1}^2 + \sigma_{M_2}^2 - 2r_{12}\sigma_{M_1}\sigma_{M_2}}$$

where r is the simple linear correlation between pre and post observations.

(b) The coefficient r was calculated by the formula:

$$r = \frac{N\Sigma XY - (\Sigma X)(\Sigma Y)}{\sqrt{[N\Sigma X^2 - (\Sigma X)^2][N\Sigma Y^2 - (\Sigma Y)^2]}}$$

where X equals the pre series and Y the post series.

(4) The t test was calculated by the formula:

$$t = \frac{D_M}{\sigma_{D_M}}$$

where D_M is the (non-algebraic) difference between the pre and post means.

b) Method employed with the Rorschach percentages.-

(1) The pre and post percentage means were calculated.

(2) The standard error of these were determined by use of the formula:

$$\sigma_p = 100\sqrt{\frac{pq}{N}}$$

where p equals the proportion recorded in the score, (e.g. 45 = .45) and q = 1 - P (e.g. 1 - .45 = .55).

(3) The appropriate standard error of the difference between percentages was computed by the formula:

(a) $$\sigma_{d_p} = \sqrt{\sigma_{p_1}^2 + \sigma_{p_2}^2 - 2r_{12}\sigma_{p_1}\sigma_{p_2}}$$

where r again is the simple linear correlation between pre and post observations.

(b) The coefficient r was calculated by the formula:

$$r = \frac{N\Sigma XY - (\Sigma X)(\Sigma Y)}{\sqrt{[N\Sigma X^2 - (\Sigma X)^2][N\Sigma Y^2 - (\Sigma Y)^2]}}$$

In the σ_{D_p} calculation, the correction element $(-2r_{12}\sigma_{p_1}\sigma_{p_2})$ was only employed where r was itself significant by the usual test. The r significance was tested by the table with forty-six degrees of freedom for the experimental group, and eight degrees of freedom for the control group. The standard error of the r being a function only of the number of degrees of freedom in the series being correlated. For the experimental group of N = 46, r must equal .29 or greater to be usable (i.e. to be significant at least at the .05 level). For the control group of N = 8, r must equal .63 or greater to be usable (i.e. to be significant at least at the .05 level).

(4) The level of significance was calculated by the formula:

$$T = \frac{D_P}{\sigma_{D_P}}$$

where Dp is the difference (non-algebraic) between the pre and post percentage means.

In addition, a third statistical comparison was utilized, involving the experimental-control difference in Rorschach factors K and c. These factors were tested by the t test, as described above, for age, education, and intelligence.

b) Results.

The pre-test and post-test ratings on the Rorschach scores for R, M, FC, CF plus C (Wt.), FC minus CF plus C (Wt.), M plus FC minus (CF plus C) and H are presented in Table III. The pre-test and post-test ratings on the Rorschach percentages of expanded F per cent, F plus per cent, W per cent, D per cent, and A per cent are presented in Table IV.

The t test is a test of the hypothesis that the true difference between the mean of the pre and post test observations is zero. The probability determined is the probability that a difference between the means as high as observed could occur as the result of chance if the true difference were zero.

Table III.- Pre-test and Post-test Ratings on Rorschach Score Variables for Both Groups.

Rorschach Factors	E	Pre & Post	M	σ	σ_M	d_M	σ_{DM}	D_{σ_D}	P
R	E	Pre	18.75	8.23	1.19	.31	.94	.33	.70-.80
		Post	19.06	7.48	1.08				
	C	Pre	15.5	4.06	1.28	.60	.94	.64	.50-.60
		Post	16.1	5.42	1.72				
M	E	Pre	2.90	2.19	0.32	.40	.30	1.35	.10-.20
		Post	2.50	1.89	0.27				
	C	Pre	2.30	1.84	0.58	.30	.34	0.88	.40-.50
		Post	2.60	1.95	0.62				
FC	E	Pre	0.77	1.21	0.17	.08	.15	0.53	.50-.60
		Post	0.69	1.10	0.16				
	C	Pre	1.0	1.05	0.33	.40	.22	1.80	.10-.20
		Post	0.6	0.84	0.27				
CF-C (Wt.)	E	Pre	1.2	1.31	0.19	.30	.16	1.86	.05-.10
		Post	0.9	1.02	0.15				
	C	Pre	0.9	0.99	0.31	.50	.31	1.63	.10-.20
		Post	0.4	0.70	0.22				

Table III.- Pre-test and Post-test Ratings on Rorschach Score Variables for Both Groups.

Rorschach Factors	E C	Pre & Post	M	σ	σ_M	d_M	σ_{d_M}	D_{σ_D}	P
FC-CF-C (Wt.)	E	Pre	-0.75	1.40	0.20	.29	.20	1.45	.10-.20
		Post	-0.46	1.09	0.16				
	C	Pre	-0.40	1.17	0.37	.30	.26	1.14	.20-.30
		Post	-0.10	0.70	0.22				
M-FC-(CF-C)	E	Pre	0.74	2.12	0.31	1.16	.38	3.04	.001-.01
		Post	1.90	2.26	0.33				
	C	Pre	1.90	1.73	0.55	0.60	.43	1.40	.10-.20
		Post	2.50	2.21	0.70				
H	E	Pre	2.90	2.08	0.30	0.40	.35	1.13	.20-.30
		Post	3.30	2.24	0.32				
	C	Pre	3.30	1.57	0.50	0.10	.32	.32	.70-.80
		Post	3.40	1.35	0.43				

Table IV.- Pre-test and Post-test Ratings on Rorschach Percentage Variables for Both Groups.

Rorschach Factors	E C	Pre & Post	M	σ_p	d_p	σ_{Dp}	ρ_{σ_D}	p
F+%	E	Pre	83.56	5.4	3.02	7.3	.41	.60 - .70
		Post	86.58	4.9				
	C	Pre	89.7	9.6	5.5	15.	.37	.70 - .80
		Post	84.2	11.5				
F%	E	Pre	61.94	7.0	3.4	10.	.34	.70 - .80
		Post	58.52	7.14				
	C	Pre	55.2	15.73	0.6	6.1	.09	.90 - .99
		Post	54.6	15.74				
A%	E	Pre	43.7	7.16	1.4	5.15	.27	.70 - .80
		Post	42.3	7.13				
	C	Pre	42.3	15.62	7.2	7.7	.93	.30 - .40
		Post	49.5	15.81				

Table IV.- Pre-test and Post-test Ratings on Rorschach Percentage Variables for Both Groups.

Rorschach Factors	E C	Pre & Post	M	σ_p	d_p	σ_{D_p}	D_{σ_D}	P
W%	E	Pre	38.35	7.0	3.06	5.1	.60	.50 - .60
		Post	35.29	6.9				
	C	Pre	54.9	15.75	5.0	7.98	.63	.50 - .60
		Post	59.9	15.49				
D%	E	Pre	53.94	7.21	1.98	4.97	.40	.60 - .70
		Post	55.92	7.14				
	C	Pre	41.9	15.59	1.0	6.61	.15	.90 - .99
		Post	40.9	15.56				

Of the twelve Rorschach variables, all but one showed a pre-post difference of such relatively small order that it could have easily occurred by chance if the true difference were zero. Therefore, in eleven of the Rorschach factors, the null hypothesis must be accepted. In the twelfth factor, M plus FC minus (CF plus C), the pre-post difference in the experimental group is too great to occur by chance and the null hypothesis must be rejected. The t test for the significance between the means of pre and post tests for the experimental group yielded a probability level of .001-.01 for M plus FC minus (CF plus C) with forty-seven degrees of freedom. While the difference between the means of pre and post tests for the control group on the same Rorschach variable was not significant.

Table V presents the results of the t test employed to test whether the experimental and the control groups were alike or not alike in respect to K and c Rorschach determinant scores. An examination of Table V indicates that the experimental group and the control group were alike with respect to K and c. But a t test on such data may be of limited reliability, inasmuch as the number of individuals receiving scores more than zero was relatively small. However, there is no evidence that the groups differed with respect to K and c even though the recording of scores for many individuals on these factors were

Table V.- Test Ratings on Rorschach Variables K and c for Both Groups.

Rorschach Factors	E C	M	σ	d_M	σ_{d_M}	$D\sigma_D$	ρ
K	E	0.23	4.84	.27	49.	.001	.90-.99
	C	0.5	2.02				
c	E	0.12	.30	.02	.045	.44	.60-.70
	C	0.1	.39				

not more than zero. Hence both the experimental and the control groups were neither significantly favorable for psychotherapy nor significantly unfavorable as measured by these scores.

F. Analysis of Questionnaire.

The second criterion measure for evidence of the latent process of identification, as a basic curative factor in group psychotherapy, is a questionnaire. The latter will be explored for manifest effects of identification in the forty-eight male veterans with whom Rorschach pre and post testing was completed in the experimental group.

The questionnaire was devised to explore the following areas: (1) the patient's condition generally, and his physical and emotional status; (2) the patient's attitude toward the self and environment with relation to people, family, and work; (3) the patient's feelings of his relationship to the group psychotherapist; (4) the patient's feelings of his relationship to the group; (5) the patient's feelings of the value of group psychotherapy. Areas 2, 3, and 4 were specifically aimed at relationships, whereas areas 1 and 5 purported to measure the effects of the relationship experience.

a) The Patient's Condition.

General condition.- Table VI shows that despite the guarding that usually accompanies initial statements in a questionnaire, a substantial percentage of patients indicated that they improved. Twenty-five or 52.1% of the patients stated that they felt better as the result of the group experience, seventeen or 35.4% felt the same, and six or 12.5% felt worse. The report of improvement was substantial in view of the special factor that a number of the veterans were jeopardizing the per cent of compensation they were already receiving for a neuropsychiatric disability by recording their current emotional status.

Physical complaints.- Table VI discloses that a majority of the patients reported no improvement in this category: twenty-three or 47.9% remained the same, six or 12.5% felt worse. Nineteen or 39.6% indicated that they had improved. The percentage of patients who stated that they were physically better is 12.5% less than those who felt generally better. The physical expression of conflicts seem to be more difficult to yield to psychotherapy. Relief from physical symptoms appears to be a more difficult psychotherapeutic effect to attain than general overall improvement.

Table VI.- General Condition, Physical Complaints, and Emotional Aspects as Reported in the Questionnaire.

Categories	Status							
	Better		Same		Worse		No Comment	
	No.	%	No.	%	No.	%	No.	%
General condition	25	52.1	17	35.4	6	12.5		
Physical complaints	19	39.6	23	47.9	6	12.5		
Emotional aspects								
Sadness	10	20.8	21	43.8	1	2.1	16	33.3
Lack of pep	12	25.0	24	50.0	1	2.1	11	22.9
Irritability	11	22.9	21	43.8	5	10.4	11	22.9
Tension	13	27.1	26	54.2	2	4.2	7	14.6
Lack of self-confidence	14	29.2	22	45.8	1	2.1	11	22.9
Forgetfulness	6	12.5	23	47.9	2	4.2	17	35.4
Ability to concentrate	9	18.7	24	50.0	3	6.2	12	25.0

Emotional aspects.- The classification of emotional aspects in relation to improvement is difficult to assess due to the various meanings that emotion in general has for different people. For this reason, an attempt was made to obtain an overall impression of emotional feelings of change in the group, by specifying meaningful adjectives which describe various aspects of feeling emotional change. The patients' reports of improvement in the affective components (presented in Table VI) took the following descending order: (1) increased confidence, fourteen or 29.2%; (2) decreased tension, thirteen or 27.1%; (3) increased pep, twelve or 25%; (4) decreased irritability, eleven or 22.9%; (5) decreased sadness, ten or 20.8%; (6) improved concentration, nine or 18.7%; and (7) less forgetfulness, six or 12.5%. An interesting feature is that the highest frequency of improvement was reported in increased self-confidence.

A large percentage of the people (40-50%) experienced no change in emotional aspects as measured by these specific traits. Also there was a slightly higher percentage of patients who did not register their status as compared with those who reported improvement. Perhaps the varying percentage of people falling in the "no comment" category was the result of unawareness of affective disturbance and its translation into physical terms, or the specific adjectival description did not apply to their particular conditions.

b) Attitude to Self and Environment.

Table VII reveals that the greatest number of patients in this category, sixteen or 33.3%, reported improvement in attitude toward self; fourteen or 29.2% indicated better adjustment to people; and thirteen or 27.1% improved relations to the family. The work component was reported least affected (six or 12.5%), and it is in this area that the largest number of veterans made no comment.

c) Feelings Toward Group Psychotherapist.

The questions in this area were devised to obtain both the direct feelings of the patient for his group psychotherapist, as well as indirect feelings of the patient for his group psychotherapist, via projections. A test for the latter was attempted in questions which explored the patient's feelings of the leader's relationship to the patient, as well as the patient's feelings of his own relationship to the leader. Table VIII reveals that forty-two or 87.5% of the group liked their group psychotherapist, thirty-one or 64.6% felt that he answered their questions fully, twenty-two or 45.8% felt that he talked enough, forty-two or 87.5% of the group were satisfied with the amount of self-expression permitted, and forty-five or 93.7% of the patients felt that the group psychotherapist liked everybody.

Table VII.- Self-other Relationships as Reported in the Questionnaire.

Relation	Status							
	Better		Same		Worse		No Comment	
	No.	%	No.	%	No.	%	No.	%
To people	14	29.2	23	47.9	1	2.1	10	20.8
To self	16	33.3	22	45.8	2	4.2	8	16.7
To family	13	27.1	24	50.0	1	2.1	10	20.8
To work	6	12.5	25	52.1	2	4.2	15	31.2

Table VIII.- Feelings About Group Psychotherapist as Reported in the Questionnaire.

Categories	Responses No.	Responses %
Relationship to psychotherapist		
Liked him	42	87.5
Indifferent to him	4	8.3
Disliked him	0	0.0
No comment	2	4.2
Answers by psychotherapist		
Complete	31	64.6
Incomplete	11	22.9
None	2	4.2
No comment	4	8.3
Speech of psychotherapist		
Talked too much	0	0.0
Talked enough	22	45.8
Talked too little	3	6.3
No comment	23	47.9
Permitted self-expression		
Satisfied	42	87.5
Dissatisfied	2	4.2
Unable to use opportunity	4	8.3
Leader's relationship to patient		
Liked everybody	45	93.7
Had favorites	1	2.1
Was indifferent	2	4.2

d) Feelings Towards the Group.

Table IX shows that thirty-five or 72.9% felt that the psychotherapist and the group paid favorable attention to the patient and his problems. Twenty-seven or 56.2% felt they could talk more easily as a result of the group experience. Twenty-four or 50.0% felt that they became friendly with other members of the group after a while, twenty-six or 54.2% felt that the group's interest did not develop until after a similar interval of time, whereas twenty-three or 47.9% of the patients felt that their own interest in the group was immediate.

e) Catalogue of Gain.

Eight specific indices of improvement were constructed on the basis of the patients' reponses to the questionnaire on the value of group psychotherapy. Their written comments were catalogued in accordance with certain indices of improvement; and, on the basis of clinical experience and by definition, were assigned an ascending order of importance portraying various levels of group participation in a chain of increasing relationships, and part-identifications: (1) information, (2) social-participation, (3) loss of isolation, (4) loss of fear of emotional expression, (5) reassurance, (6) symptomatic relief, (7) intellectual insight, and (8) increased psychotherapeutic receptivity.

Table IX.- Patient's Relationship to the Group as Reported in the Questionnaire.

Categories		Responses	
		No.	%
Patient's ability to speak	Easy	27	56.2
	Difficult	19	39.6
	Unable	2	4.2
Group's (and Psychotherapist's) attention to patient	Favorable	35	72.9
	Unfavorable	8	16.7
	No comment	5	10.4

Development of relationships	Responses									
	Immediate		Retarded		Closing		Absent		No comment	
	No.	%	No.	%	No.	%	No.	%	No.	%
Sociability	10	20.8	24	50.0	7	14.6	5	10.4	2	4.2
Group's interest in patient	4	8.3	26	54.2	5	10.4	9	18.7	4	8.3
Patient's interest in group	23	47.9	16	33.3	3	6.2	5	10.4	1	2.1

Definitions.- The psychotherapeutic benefits are defined as follows:

(1) Information is the acquisition of new knowledge. It is a level of isolated factual gain without advancing any meaningful encroachment upon the individual's understanding. Examples: "I learned a few things I did not know before." "Just gained some valuable knowledge - nothing more."

(2) Social-participation is the intellectual participation by an individual without becoming part of the group's emotional relationship to a significant degree. It is the initiating level to possible further interaction. Examples: "They were a fine bunch of fellows." "I am more sociable to people without resorting to sarcasm."

(3) Loss of isolation is the presence of a common factor conveying emotional feeling in the individual with some members of the group. It heralds the return of the patient to a competitive social orbit. Examples: "These feelings are not just mine; the group decided that for me." "Others have the feeling I do."

(4) Loss of fear of emotional expression is defined as the expression of conscious feelings without the fear of leader or group. This category includes two aspects:

(a) Loss of speech inhibition which refers simply to the increased ability to talk. Examples: "I talk more openly

and unguardedly and not as carefully as I used to." "The doctor was O.K. He let us talk about anything we wanted."

(b) Abreaction which refers to the increased ability to ventilate with affect. Examples: "Expressing things out in the open are not as magnified as when bottled up inside." "Blowing off helped."

(5) Reassurance is a loss of feelings of inadequacy either partially or totally. Examples: "Confidence has improved. I have a little more security." "I feel more at ease. I have gained strength."

(6) Symptomatic relief is the patient's statement that he feels better emotionally or physically. It may occur with or without insight. Examples: "The rash I had on my legs is gone." "My crazy thoughts do not come as often."

(7) Intellectual insight is seeing one's self more objectively through the similarity between the experience of others in relationship to one's self, and the common factor that repeats itself in others. Examples: "I have a greater capacity to understand my problems." "I now realize how certain thoughts can affect me physically."

There is sometimes confusion between <u>information</u> and <u>intellectual insight</u>. Information is understanding a subject and/or understanding others. Intellectual insight is more specifically understanding the self.

Intellectual insight may also include increased objectivity where there is a dissociation of the self from emotional attitudes. It is seeing the self in two pieces. Example: "I have been able to face myself."

(8) Increased psychotherapeutic receptivity is the expression of the desire for further help with emotional problems. Examples: "I would like to continue this treatment." "I want more help."

Reliability.- The question arose: how well could these variables be identified a second time? Provided with a definition of the criterion variables, could others learn them and identify them? For this purpose, a four-fold point correlation was obtained between the two ratings by the same judges of a random sample of twenty-five cases. The formula for this purpose was the phi coefficient:

$$\phi = \frac{\alpha\delta - \beta\gamma}{\sqrt{pqp'q'}}$$

The two ratings were independent, but the judges worked together both times. Table X presents the results.

Table X shows that speech inhibition is more difficult to identify than abreaction, and was correctly placed under the broader category of the loss of fear of emotional expression. Symptomatic relief could not clearly be differentiated from reassurance, and increased objectivity could not clearly be differentiated from intellectual insight. There were more

Table X.- Reliability of Identifying Manifest Effects of Group Psychotherapy.

Effects	Ratios	
1. Information	1.0	
2. Social-participation	1.0	
3. Loss of isolation	1.0	
4. Loss of fear of emotional expression	.78	
a. Speech inhibition		.51
b. Abreaction		.84
5. Reassurance (including symptomatic relief)	.76	
a. Reassurance alone		.68
b. Symptomatic relief		.56
6. Intellectual insight (including increased objectivity)	.76	
a. Intellectual insight alone		.68
b. Increased objectivity		.51
7. Increased psychotherapeutic receptivity	.85	

scorable statements for identifying reassurance and intellectual insight than there were for identifying symptomatic relief and increased objectivity. It seemed therefore appropriate to subsume symptomatic relief under reassurance and increased objectivity under intellectual insight. The categories of speech inhibition, symptomatic relief, and increased objectivity may be really different from the categories with which they were merged, but the patients in the above sample were vague in communication or were unable to verbalize these manifest psychotherapeutic effects.

Perfect correlations were obtained with information, social-participation, and loss of isolation. There was a high degree of reliability in recognizing increased psychotherapeutic receptivity from the statements that patients made.

Relation between manifest effects and discharge status.- The reliability table suggests seven clearcut manifest effects of group psychotherapy: information, social-participation, loss of isolation, loss of fear of emotional expression (speech inhibition plus abreaction), reassurance (including symptomatic relief), intellectual insight (including increased objectivity), and increased psychotherapeutic receptivity. The next step seemed to be to tie up these manifest psychotherapeutic effects with the patient's discharge status, e.g., improved or unimproved. For this purpose a chi square comparison was made

between these indices of improvement and psychiatric discharge. Twenty cases were selected at random from the improved and the unimproved groups. The most common formula for chi square was used:

$$\chi^2 = \sum \frac{(f_o - f_t)^2}{f_o}.$$

The results are presented in Table XI.

Information and social-participation did not discriminate between the improved and unimproved groups. The loss of isolation, the loss of fear of emotional expression, and reassurance were highly significant for the improved group. No chi squares could be performed on the categories of intellectual insight and increased psychotherapeutic receptivity due to the low theoretical frequencies in a number of the cells.

3.- Interpretation of Results.

An analysis of two criterion instruments, the Rorschach and a Questionnaire, in relationship to an experience with a series of group psychotherapy, has been presented. It seems appropriate now to apply the results of the criterion instruments to the presumed curative process of emotional identification, the basic hypothesis of the research problem. This will be discussed on the basis of evidence from the Rorschach and on the basis of the evidence from the Questionnaire.

Table XI.- The Relation of Manifest Psychotherapeutic Effects to Discharge Status.

Effects	+	-	Both	Chi Square	p
Information					
Improved	14	6	20		
Unimproved	10	10	20		
				1.66	.20
Total	24	16	40		
Social-participation					
Improved	3	17	20		
Unimproved	8	12	20		
				3.12	.05-.10
Total	11	29	40		
Loss of isolation					
Improved	13	7	20		
Unimproved	4	16	20		
				8.32	.001-.01
Total	17	23	40		
Loss of fear					
Improved	11	9	20		
Unimproved	1	19	20		
				11.78	.001
Total	12	28	40		
Reassurance					
Improved	16	4	20		
Unimproved	5	15	20		
				12.10	.001
Total	21	19	40		

A. Evidence from the Rorschach.

In evaluating the results of the Rorschach tests, the question might be raised as to whether or not the significant difference on the M plus FC minus (CF plus C) could have arisen by chance, since it represents only one significant difference out of a total of twelve differences. However, the fact that the difference between the means of the pre and post tests of the experimental group yielded a probability level of .001-.01 with negative difference between the means of the pre and post tests of the control group, the fact that it is a composite of several Rorschach signs, plus the fact that an investigation by Muench had previously found this configuration significant of change following individual psychotherapy, would suggest that the obtained difference actually represents real difference of favorable change as a result of the group psychotherapy experience.

One might ask why this one Rorschach configuration, M plus FC minus (CF plus C), was found to significantly differentiate those individuals who had a group psychotherapy experience, while the same Rorschach configuration failed to show a significant change with individuals who did not have the psychotherapeutic experience. One possible explanation is that a significant increase in M plus FC minus (CF plus C), between

the pre and post means, is specifically related to a healthier emotional identification with others.

The psychodynamics of the Rorschach signs was presented in a previous section. The Buhlers[47] stated: "Rorschach [. . .] related movement and color responses to the unconscious, while form responses seemed to represent conscious functions." The writer is in agreement with the Buhlers in their interpretation that M

> . . . is also a goal-directed Ego organizer. Essential is the intellectual factor of imagination and of deferred action, whether the delay is due to the objective impossibility of carrying out the idea, the insight into objective difficulties, or the inhibitions and repressions in the sense of the superego. The conclusion after studying the M [. . .] is that they represent to varying degrees a goal factor and an imagination factor without executive tendencies. Depending on these factors, the M sometimes represents actual "self determination" towards some future goal and sometimes only fantasies which are unrelated to action.

Whether or not M serves in an integrative fashion will depend upon its role in an economic, dynamic, and structural sense in the topographical dynamisms of the psyche.

A predominance of FC over CF plus C is designated in the literature by Rorschach[48] as "affective adaptability [. . .] a strong desire for empathy [. . .] an ability to achieve emotional approach to the environment [. . .] the expression of

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47 Charlotte Buhler, et al., op. cit., p. 36.

48 Hermann Rorschach, op. cit., p. 29-35.

the desire to adapt"; by Beck[49] "feeling in tune with others, understanding of others through the medium of feelings (. . .) likely to be frequent in healthiest adults"; by Shafer[50] as "passivity and deference." Klopfer[51] stated:

> It is one of the best proved and validated assumptions that the percentage of FC indicates the degree of emotional adjustment to outer reality. This emotional adjustment can be accomplished in many different ways and these different ways are all clearly reflected in different constellations within the determinant graph.

The FC minus CF plus C represent the two extreme poles of love for others versus self-love, acceptance of equality versus need for superiority, social feeling versus hostile feeling, altruism versus egoism, object primary versus object secondary, emotional restraint versus incapacity for moderation and delay, a longing for proximity versus a feeling of aversion, a process of emotional identification versus emotional rivalry.

A color response is interpreted by Rorschach[52] as indicating the "urge to live in the world outside oneself." The coupling of a form response with color, designated by an FC score, can readily be interpreted as the use of this "urge" in a partial emotional identification with others. The combination

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49 Samuel J. Beck, Vol. 2, op. cit., p. 29.

50 Roy Schafer, The Clinical Applications of Psychological Tests, New York, International Universities Press, 1948, p. 30.

51 Bruno Klopfer, op. cit., p. 282.

52 Hermann Rorschach, op. cit., p. 29-35.

of M plus FC minus CF plus C could be said to be a measure of a latent or unconscious goal-directed urge in an adaptive, deferent, partial emotional identification with others.

The quantitative empirical Rorschach finding confirms the theories of Le Bon, Freud, Moreno, Schilder, White, and Rogers, discussed previously under theory leading to hypothesis, with regards to the role of the identification process in effecting an adequate relationship with others. Favorable results in group psychotherapy have been found by Slavson[53] with those patients who have "social hunger, a yearning for emotional interchange with other persons, a desire to belong to people and a capacity for being influenced by relationship experiences." Abrahams and McCorkle[54] observed that those patients with a positive sense of national obligation have more favorable group psychotherapeutic prognosis than patients with a deep-seated lack of "social intelligence."

B. Evidence from the Questionnaire.

The results of the Questionnaire indicated that a strikingly high percentage of patients developed a positive relationship to their group psychotherapist. The development

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53 S.R. Slavson, Introduction to Group Therapy, New York, Commonwealth Fund, 1943, p. 15.

54 J. Abrahams, and J.L. McCorkle, "Group Psychotherapy of Military Offenders", American Journal of Sociology, Vol. 104, 1948, p. 613-617.

of a relationship with the members of the group was a gradual process. A small percentage of patients stated that they were able to form an immediate relationship. A much higher percentage of patients indicated that relationship to members of the group did not develop until later. This is a graphic report that the group's organization into a functioning whole, with increasing relationships, is a gradual progression.

In an analysis of the patients' comments of the value of group psychotherapy, a number of manifest indices of improvement emerged. A reliability test indicated that at least seven indices of improvement could be clearly differentiated. These were then subjected to chi square comparisons to determine which psychotherapeutic effects appeared to be related to the discharge status of improved or unimproved. Loss of isolation (sharing a common emotional feeling with other members of the group), loss of fear of emotional expression (the ability to talk with a decreased fear of leader and group), and reassurance (increased confidence and/or relief from physical symptoms) appeared to be significantly related to discharge as improved by a clinic psychiatrist. Statements made by patients indicative of intellectual insight and increased psychotherapeutic receptivity occurred too infrequently to draw a comparison between the improved and unimproved groups.

Information and social-participation, which were not significantly related to improvement, would appear to be mild and ineffective psychotherapeutic effects that could probably occur when a collection of people gather for the purpose of attending teaching groups, social groups, etc. There may be social stimulation but no interstimulation. There may be an intellectual exchange but no emotional tie. The external experience does not invade their internal orbit in a positive sense; it does not become part of their emotional constellation. They are unable to relate their experience emotionally to themselves, the leader, or the group. They may take the roles either of the spectator or the rebel.

The purpose of group psychotherapy in the cases where only information and social-participation are obtained end a series of sessions with no meaningful encroachment for the patients. Such individuals often remark at the completion of group psychotherapy, "I still don't know what to make of the group!"

However, once patients move into a feeling of a loss of isolation, the factor of identification has already begun its healing process. Identification is not with the psychotherapist but with the other members of the group (sibling identification). They feel they are all in the "same boat" (sibling rivalry has decreased). There are others who have a

similar emotional difficulty. There is a badge of membership. Although some members appear to be sicker than others, the fact that they are walking around serves as a sign of good health despite their label of ill health. The other manifest psychotherapeutic effects follow pari passu with the onset of identification. They can talk, act; their terror does not become mountainous. They become confident. There is a reorientation of their concept of the self in relation to this new experience. There is increased objectivity and a greater readiness to accept the concept of emotional illness on a conscious level.

C. Summary.

A wide variation was observed in group psychotherapy literature as to what constituted the curative factor in group psychotherapy. In the formulation of the research experiment, it was hypothesized that identification is the basic healing mechanism in group psychotherapy. It was maintained that the various manifest psychotherapeutic effects, reported in the literature either as single or multiple concepts, are reflections of increasing relations and part-identifications.

In order to test the initial formulation, evidence of identification was presented from a quantitative analysis of the Rorschach protocols of two groups of patients. One, an experimental group of forty-eight white adult veteran male

patients were pre and post tested, with an interval of group psychotherapy extending over approximately four months. Two, a control group (matched on face data information) of ten white adult veteran male patients were pre and post tested over a similar period of time, without the benefit of psychotherapy.

A second criterion measure was utilized in the form of a questionnaire, administered to the experimental sample in the final session of group psychotherapy, to show evidence of the presence of identification from its psychotherapeutic manifest effects. These effects were defined, ranged in an ascending order of importance, tested for reliability, and related to discharge status of improved or unimproved.

The presumed relationship between identification and group psychotherapy has been suggested quite often in literature. However, the results of two positive approaches to the research problem provide experimental evidence that such a relationship does exist, and furnishes some information as to the degree and nature of that relationship.

The final step in this experiment is to analyze the initial referrals to group psychotherapy, as a basis for a negative proof of the hypothesis, namely: in the case of an inadequate consideration of individuals referred for group psychotherapy, there is an absence or abortion of the process of identification. This will be discussed in the subsequent chapter.

CHAPTER IV

EVALUATION OF INITIAL REFERRALS

In the conduct of research in group psychotherapy, it was observed that there were important elements overlooked in the assignment of patients. Routine processing factors were never fully evaluated. Such menial tasks were usually delegated to a technician who unfortunately was limited in his ability to assess the overall situation, and who was unable to select what was important and relevant. He lacked the broad awareness of the psychodynamic factors involved in interpersonal relationships. As a consequence many patients did not appear to be failures of group psychotherapy, but rather failures due to improper referral. An awareness of certain dynamic considerations could prove to be of paramount practical value in the appropriate assignment of patients.

In the light of these considerations, this chapter will describe the picture in the following areas: (1) the characteristics of the overall population of referrals to group psychotherapy; (2) the pertinent variables from the intake psychiatric interview; (3) the relation of diagnostic categories to the completion of group psychotherapy; (4) an analysis of the relationship of adjunct individual psychotherapy with group psychotherapy in respect to patients who completed a series of group psychotherapy sessions.

1.- Characteristics of Overall Population.

The veteran was seen by the intake psychiatric social worker following his interview with the intake psychiatrist. The duties of the intake psychiatric social workers were to determine the source of referral, the legal eligibility for treatment, the identifying data, a brief history of the veteran's complaints, and the significant facts in his family history.

The social history served as a major source for the evaluation and the use of face data in the initial patient population. It furnished the descriptive material, particularly the basic characteristics, that were necessary with which to compare the continuing and non-continuing patients in group psychotherapy. Certain supplementary information on the patient's military history and his compensation status were obtained from other sources, such as his Medical Folder and his Adjudication Claim Folder.

Description of the continuing and non-continuing groups.- Table XII shows that the sample group psychotherapy population appeared strikingly similar in many characteristics. The age range of the continuing group was from nineteen years to forty-four years, with a mean of 27.0 and a sigma of 5.2. The non-continuing group disclosed the same age range, a mean of 26.9 and a sigma of 5.4. A t test (Table XIII) disclosed a level

Table XII.- Characteristics of the Continuing and Non-continuing Patients in Group Psychotherapy.

Characteristics	Continuing (N = 105)	Non-continuing (N = 108)
Age		
40 - 44	4	3
35 - 39	4	7
30 - 34	18	16
25 - 29	43	40
20 - 24	35	41
15 - 19	1	1
Education (years)		
15 - 17	2	0
12 - 14	58	51
9 - 11	22	28
6 - 8	11	8
No information	12	21
Religion		
Catholic	66	71
Protestant	21	16
Jewish	6	6
Greek Orthodox	1	2
No information	11	13
Marital status		
Single	63	49
Married	41	52
Divorced	1	6
Widowed	0	1
Work status		
Employed	58	56
Unemployed	26	29
Student	21	20
No information	0	3
Military service		
Army	74	61
Navy	24	29
Marine Corps	4	9
Coast Guard	3	4
No information	0	5

Table XII.- Characteristics of the Continuing and Non-continuing Patients in Group Psychotherapy, (continued).

Characteristics	Continuing (N = 105)	Non-continuing (N = 108)
Length of service (months)		
72 - 93	1	1
60 - 71	2	0
48 - 59	19	2
36 - 47	29	17
24 - 35	26	44
12 - 23	19	19
0 - 11	5	8
No information	4	17
Type of service		
Combat	63	61
Non-combat	39	43
No information	3	4
Rank		
Enlisted man	104	108
Officer	1	0
Previous neuropsychiatric hospitalization		
No	56	52
Yes	40	50
No information	9	6
Type of discharge		
Medical	42	51
Non-medical	54	53
No information	9	4
Per cent pension		
90 - 100	1	2
80 - 89	4	0
70 - 79	4	2
60 - 69	2	4
50 - 59	12	4
40 - 49	7	6
30 - 39	20	19
20 - 29	5	3
10 - 19	21	23
0 - 9	27	37
No information	10	0

Table XIII.- Continuing and Non-continuing Groups in Psychotherapy Compared.

Variables	C / N-c	M	σ	σ_M	σ_{D_M}	D_{σ_d}	P
Age	C	27.0	5.2	.51	.28	.4	.60-.70
	N-c	26.9	5.4	.52			
Education	C	11.2	1.9	.2	.63	0	.90-.99
	N-c	11.2	1.7	.6			
Length of Service	C	35.7	15.2	1.52	1.99	4.6	<.001
	N-c	28.7	12.3	1.29			
Percent Pension	C	32.8	23.0	2.4	3.2	3.4	<.001
	N-c	21.8	21.6	2.1			

of probability of .60-.70. Education range was from six years to seventeen years for the continuing group, a mean of 11.2, and a sigma of 1.9; six years to fourteen years for the non-continuing group, a mean of 11.2, and a sigma of 1.7. A t test showed a level of probability of .90-.99. Religion and work status were obviously alike for both groups. The chi squares for these categories were not presented due to low theoretical frequencies. However, if chi squares were calculated, no significant statistical differences would occur. The predominant religion of both the continuing and non-continuing groups was Catholic, which is also characteristic of the population of Boston and vicinity. Marital status was divided into single and others (married, divorced, widowed). A statistical comparison (Table XIV) established a chi square of 4.81 with a significant difference occurring at the .05-.02 level. It may be that the married men were pressed more for time and/or had other responsibilities which forced them to be elsewhere.

The patients came from the same geographical and cultural areas, had a similar socio-economic status (lower middle class), and a comparable distribution of occupations in the broad classifications of laborers, clerical workers, and students. There was insufficient information to form a comparison on such variables as marital and occupational adjustment, early broken home, criminal record, and number of siblings in the family.

Table XIV.- Continuing and Non-continuing Groups in Psychotherapy Compared by the Chi Square.

Variables		C	N-c	Both	Chi Square	p
Marital Status	Single	63	49	112		
	Others	42	59	101		
					4.81	.02-.05
	Total	105	108	213		
Previous NP Hospital	No	56	52	108		
	Yes	40	50	90		
	?	9	6	15		
					2.11	.30-.40
	Total	105	108	213		
Type of Discharge	Medical	42	51	93		
	Non-med.	54	53	107		
	?	9	4	13		
					3.51	.30-.40
	Total	105	108	213		

Characteristics associated with military history were compared for the continuing and non-continuing patients in group psychotherapy. Chi squares were not calculated for branch of military service or type of service, due to the low theoretical frequencies in some of the cells. However, a glance at Table XII reveals that both the continuing and non-continuing groups were similar in regard to branch of service: most patients came from the Army, considerably fewer came from the Navy, and a very small number came from the Marine Corps and the Coast Guard. Service in combat areas (Table XIV) was not a differentiating characteristic: chi square was .24, with two degrees of freedom, and a level of confidence of .80-.90. Likewise, previous neuropsychiatric hospitalization was a poor criterion for predicting which of the patients would remain or separate from group: chi square was 2.11, with two degrees of freedom, and .30-.40 the level of probability.

However, the groups did differ with regards to length of service and per cent pension. Table XIII shows a mean length of service of 35.7 months for the continuing group and a sigma of 15.2; and a mean of 28.7 months for the non-continuing group and a sigma of 12.3. A t of 4.6 was found with a level of confidence beyond .001. A greater length of service related significantly with the completion of group psychotherapy. The length of service can be viewed as an

experience of regimented group adaptation. One might speculate that veterans with fewer years of service were unable to tolerate a controlled, passive, dependent existence. Likewise, a higher per cent pension related significantly to patients remaining in group psychotherapy. Table XIII discloses that the continuing group had a mean per cent pension of 32.8 and a sigma of 23.0; while the non-continuing group had a mean per cent pension of 21.8 and a sigma of 21.6. The appropriate t test disclosed a level of probability beyond .001. This finding may indicate that the sicker patients tended to remain in group psychotherapy.

The presence of a lone officer among so many enlisted men can perhaps be explained by the fact that officers were generally retired and did not come for treatment. Information was too sparse on the number of those who were absent without leave (A.W.O.L.) and on military adjustment in general.

2.- Intake Psychiatric Variables.

The intake process was a reflection of the general scientific approach of the clinic as a whole, consisting of the total evaluation of the patient resulting in a planned disposition. The intake process was one of the most difficult and challenging problems of the clinic. The proper selection and disposition of patients who came to a veteran's facility

for help required the exercise of extensive clinical experience and judgment. In order to maintain treatment potential and motivation, a total evaluation of the patient had to be made expeditiously and the treatment initiated as soon as possible. Insufficient recognition was given to a patient's ambivalence toward treatment. The veteran's request for psychiatric treatment did not neutralize all his negative feelings about its desirability or value. A waiting period only enhanced a patient's doubts. However, the attrition of veterans on a waiting list did not necessarily indicate that those who did not appear for their initial psychotherapy sessions were all poor treatment risks nor that those who eventually received treatment were entirely favorable for psychotherapy.

The veteran was interviewed by a psychiatrist upon entering the clinic. The intake psychiatrist had a four-fold task: (1) to evaluate the patient's reasons for coming for help; (2) to make a diagnostic survey; (3) to estimate the treatment potential; and (4) to initiate a course of treatment.

There were several courses of treatment open to the intake psychiatrist in the assignment of patients: (1) they could be scheduled with the medical internist for a physical evaluation, emotional support, and reorientation towards psychotherapy; (2) they could be placed on a waiting list for psychotherapy with a psychiatrist, a psychologist, or a psychiatric social worker; (3) they could be designated for both

individual and group psychotherapy; (4) they could be assigned to group psychotherapy alone.

The psychiatrist appraised the patient under the following major headings: verbal-emotional participation, symptoms, and attitude toward treatment. Under verbal-emotional participation, he then recorded whether the patient was or was not spontaneous in verbal interchange, and whether he did or did not disclose the following affect components in his emotional participation: alertness, composure, friendliness, flexibility. Under symptoms, the following list was supplied for checking the patient's complaints: fearfulness, tension, confusion, insomnia, forgetfulness, depression, fatigue, headaches, stomach pain, diarrhea, vomiting, backache, and heart-pain. Under attitude toward treatment, the psychiatrist recorded whether (1) the patient refused treatment immediately and/or was ambivalent; (2) he accepted treatment without pressure. Since the foregoing information was not recorded consistently in every clinical folder, twenty-six intake protocols of patients who continued group psychotherapy and twenty-six non-continuing patients were selected at random from the group psychotherapy population.

Nineteen variables were considered for chi square analysis, with one degree of freedom by the usual formula. The significant findings, which statistically discriminated between the two groups on crucial intake variables, are illustrated in

Table XV. Significant variables relating to patients continuing group psychotherapy were as follows: (1) the spontaneous-friendly (chi square 18.64, p beyond .001); (2) the tense individuals (chi square 5.56, p = .01-.02); and (3) those who accepted treatment without pressure (chi square 21.74, p beyond .001). Significant variables relating to non-continuing patients in group psychotherapy were as follows: (1) the spontaneous-composed (chi square 5.00, p = .02-.05); (2) those who complained of insomnia (chi square 4.20, p = .02-.05); and those who complained of headaches (chi square 3.82, p = .05).

The chi squares on the following variables were insignificant: spontaneous-alert (chi square .30, p = .50-.70), and spontaneous-flexible (chi square 2.78, p = .10). Due to the low theoretical frequencies, chi squares were not completed on the following symptoms: fearfulness, confusion, forgetfulness, depression, fatigue, stomach pain, diarrhea, vomiting, backache, and heart pain.

For purposes of discussion, the crucial intake variables will be elaborated upon in the order that they were originally constructed for exploration, namely: surface traits observed in verbal and emotional participation, symptoms presented, and attitude toward treatment.

Table XV.- Continuing and Non-continuing Groups Compared by Chi Square of Intake Psychiatric Variables.

Variables		N^{C}_{N-c}	+	—	Both	Chi Square	p
Verbal	Spontaneous-alert	C	13	13	26		
		N-c	11	15	26	.30	.50-.70
Emotional Participation			24	28	52		
	Spontaneous-composed	C	3	23	26		
		N-c	10	16	26	5.00	.02-.05
			13	39	52		
	Spontaneous-friendly	C	17	9	26		
		N-c	2	24	26	18.64	<.001
			19	33	52		
	Spontaneous-flexible	C	15	11	26		
		N-c	9	17	26	2.78	.10
			24	28	52		
Symptoms	Tension	C	9	17	26		
		N-c	2	24	26	5.56	.01-.02
			11	41	52		
	Insomnia	C	5	21	26		
		N-c	12	14	26	4.20	.02-.05
			17	35	52		
	Headaches	C	8	18	26		
		N-c	15	11	26	3.82	.05
			23	29	52		
Accepted treatment without pressure		C	17	9	26		
		N-c	1	25	26	21.74	<.001
			18	34	52		

Verbal-emotional participation.- There was a statistically significant number of patients in the continuing group who were spontaneous and friendly in the intake psychiatric interview. These patients were cooperative and talked about their difficulties. They were anxious to present their problems and sought eagerly to establish a relationship. There was an urgency to form a better self-other adaptation. Some of these patients were alert and good contact was noted.

The non-continuing patients presented two extremes: (1) those who were spontaneously hostile, and (2) those who were placid and required prodding. The hostile patient was variously described as suspicious, unsmiling, sullen. The placidly reactive individual did not appear anxious, was colorless, and emotionally flat and shallow. Still others were recorded as serious and solemn.

Presenting symptoms.- Tension was a characteristic of the continuing group of patients who were inhibited in their aggressiveness. It was probably indicative of overcontrol. These patients found it difficult to relax. Tension was related to unmastered anxiety. It was usually a characteristic of the "good" type of person. A number of patients complained of fatigue. The expenditure of energy was directed towards warding off their conflicts.

In sharp contrast, there were patients in the non-continuing group who disclosed their "functional" disorders

in the muscular realm by extreme lack of motor control. They acted out their aggression. They were reported as restless and irritable.

Insomnia and headaches appeared to be the chief symptoms that patients presented who subsequently discontinued group psychotherapy. For the most part, they were spontaneously-composed. They showed pronounced lack of affect. A discrepancy was frequently noted between no overt show of tension and complaints of terrific pains.

Actually, slight sleep disturbance is encountered in every neurosis[1]. In the non-continuing patients, insomnia was more intense and chronic than that reported by the continuing patients. The clinical folder disclosed that some of these patients postponed sleep due to fear of nightmares involving scenes of dying or death from which they would be unable to escape. Sleep and death appeared to be equated. Other patients feared sleep because they were unable to control the apprehension and desires that they ordinarily warded off in a wakeful state.

An examination of the case folders disclosed that the headaches of the non-continuing patients were for the most part diagnosed as migraine. During a clinical examination, these

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1 John A.P. Millet, Insomnia: Its Causes and Treatment, New York, Greenberg, 1938, iv-274 p.

patients did not show outward signs of perturbance. There was an air of indifference - a disparity between their behavior and the nature of the presenting complaint. They had considerable difficulty in describing their illnesses. They were reported by the psychiatrist as being either vague, circumstantial, or circuitous.

Attitude toward treatment.- There appeared to be a strikingly similar relationship between the number of patients who were desirous of treatment and those who were spontaneously-friendly in their initial contacts with the psychiatrist. Those who sought psychotherapy were more or less interested and enthused. Some were hesitant but willing to try. A few were content with help in arresting their illnesses, but did not want to be subjected to psychiatric exploration.

The patients who failed to appear for treatment were portrayed as negativistic. These individuals did not see any connection between their complaints and psychotherapy. They had difficulty with interpersonal relationships, and could not make friends easily. They felt that only "whacky" people were candidates for psychotherapy.

3.- The Role of Diagnostic Categories.

Table XVI presents the psychiatric diagnoses of patients who referred to group psychotherapy by the intake

Table XVI.- Psychiatric Diagnoses of Continuing and Non-continuing Patients Assigned to Group Psychotherapy.

Diagnoses	Continuing (N = 105)	Non-continuing (N = 108)
Psychoneurotic disorders		
Anxiety reaction	47	46
Dissociative reaction	3	2
Phobic reaction	1	1
Conversion reaction	1	10
Somatization reaction		
Psychogenic gastrointestinal reaction	7	9
Psychogenic asthenic reaction	2	3
Obsessive compulsive reaction	2	0
Neurotic depressive reaction	14	8
Character and behavior disorders		
Immature reactions		
Emotional instability reaction	2	6
Passive dependency reaction	16	7
Passive aggressive reaction	3	3
Aggressive reaction	1	1
Immaturity with symptomatic habit reaction	1	1
Pathological personality reactions		
Schizoid personality reaction	2	2
Schizophrenic disorders		
Schizophrenic reaction, latent	1	1
No information	2	8

psychiatrist. The nomenclature of the American Psychiatric Association was utilized in establishing a differential diagnosis.

Initial diagnostic classifications did not show dynamic configurations and defenses, but rather broad descriptive nosological components. Diagnostic typologies varied according to the emphasis placed on symptoms by the examining psychiatrist. Hence, complaints of an emotional nature were generally classified under anxiety reaction. If the anxiety involved self-depreciation, it was classified under the neurotic depressive reactions. However, there is an acknowledged variation among psychiatrists in arriving at initial diagnoses. For example, diagnoses of physical complaints varied from conversion hysteria to psychosomatic and hypochondrical reactions, depending upon the chronicity and severity of the complaint as it was conveyed to the psychiatrist. It was extremely rare that a psychiatrist confused an emotional reactive configuration with a physical reactive configuration. Therefore, in the psychoneurotic disorders, the continuing and non-continuing patients in group psychotherapy were classified in Table XVII according to two major divisions: (1) diagnosis of emotional reactive disturbance or (2) diagnosis of physical reactive disturbance. The relationship between the physical reactive disturbances and non-continuing group psychotherapy was significant just below the .02 level (chi square 5.31, with one degree of freedom).

Table XVII.- Significant Re-grouping of Psychiatric Diagnoses in Relation to Continuation in Group Psychotherapy.

Diagnoses	C	N-c	Chi Square	p
Psychoneurotic disorders (Emotional reactions)				
Anxiety reaction	47	46		
Dissociative reaction	3	2		
Phobic reaction	1	1		
Obsessive compulsive reaction	2	0		
Neurotic depressive reaction	14	8		
Total	67	57		
(Physical reactions)				
Conversion reaction	1	10		
Somatization reaction	9	12		
Total	10	22	5.31	>.02
Character and behavior disorders				
Passive dependents	16	7		
Total	16	7		
Others				
Emotional instability	2	6		
Passive aggressive	3	3		
Aggressive	1	1		
Symptomatic habit reaction	1	1		
Schizoid personality	2	2		
Total	9	13	3.74	>.05

It has been pointed out in the discussion of attitude toward treatment that those patients who presented physical complaints, and who conceived of treatment only in terms of the tangible and concrete, were unable to accept the fact that their symptoms may have had an emotional basis and that "talk treatment" could help. Consequently, it was not too surprising to learn of a statistically positive relationship between physical reactive complaints and non-continuing group psychotherapy.

The character and behavior disorders were divided into two major categories: (1) passive-dependents, and (2) others. The relation between passive-dependents and completing group psychotherapy was just below the .05 level (chi square 3.74, with one degree of freedom). The diagnostic nomenclature of the American Psychiatric Association defined the passive-dependent reaction as follows:

> This reaction is characterized by helplessness, indecisiveness, and a tendency to cling to others. The clinical picture in such cases is often marked by anxicty reaction which is typically psychoneurotic, but it may be characterized by a type of emotionally immature personality developments. There is a predominant child-parent relationship in reaction.

An examination of the clinical folders disclosed that a small number of terminations occurred for the following miscellaneous reasons: (1) the patient moved to another community; (2) he obtained a job conflicting with the treatment hour; (3) his plans for treatment did not take into consideration

the impending opening of the school he would attend; (4) treatment for his physical ailment took precedence over a presumed emotional disturbance; (5) it was necessary to hospitalize the patient for an acute psychosis before ambulatory treatment could be instituted.

4.- The Relationship of Adjunct Therapy.

Table XVIII shows that a statistically significant number of patients discontinued group psychotherapy if they had received prior and/or parallel individual psychotherapy. The probability value was at the .001-.01 level (chi square 9.29, with one degree of freedom). More patients discontinued group psychotherapy under a "total push" program than those patients who had group psychotherapy alone. Although 108, or 50.7 per cent, of the patients discontinued group psychotherapy, twenty-seven, or twenty-five per cent, did not break simultaneously with the clinic, but continued in individual psychotherapy.

Table XIX presents a breakdown of the relationship of prior, parallel, or no individual psychotherapy to group psychotherapy, with regards to attendance in group and subsequent continuation in individual psychotherapy. An analysis of Table XIX reveals the following observations and corollaries:

(1) Of fifty-eight patients who, during individual psychotherapy, were transferred to group psychotherapy, none

Table XVIII.- Continuing and Non-continuing Patients with Adjunctive and Non-adjunctive Group Psychotherapy Compared by Chi Square.

Group Psychotherapy	C	N-c	Both	Chi Square	p
Adjunctive	47	70	117		
Non-adjunctive	58	38	96		
				9.29	.001-.01
Total	105	108	213		

Table XIX.- The Effect of Prior, Parallel, or No Individual Psychotherapy on Continuation in Group Psychotherapy and Subsequent Continuation in Individual Psychotherapy.

Individual therapy N:213		Completed group therapy 105	Continued & individual therapy	Broke group but therapy 108	Continued individual therapy
Prior to group	58	0	(0)	58	(2)
Parallel with group	67	47	(39)	20	(19)
None	88	58	(0)	30	(6)

completed a designated series of group psychotherapy sessions; and only two, or 3.4 per cent returned for additional individual psychotherapy. Hence, the transfer of patients from individual psychotherapy to group psychotherapy is a deterrant not only to attendance in group psychotherapy, but also to subsequent individual psychotherapy.

(2) Forty-seven, or 70 per cent, of a total of sixty-seven patients treated in group psychotherapy parallel with individual psychotherapy, completed a series of group sessions. Thirty-nine of the forty-seven, or 83% of the patients, continued with individual psychotherapy following the completion of group psychotherapy; and nineteen out of a total of twenty, or 95%, of those who discontinued group psychotherapy, continued with individual psychotherapy subsequently. It is recommended that patients who have had prior individual psychotherapy when assigned to group psychotherapy should continue with parallel individual psychotherapy, in order to increase the likelihood of group attendance, and decrease the possibility of severance from the clinic following the patients' discontinuation of group psychotherapy.

(3) Of eighty-eight patients assigned to group psychotherapy alone, with no exposure to prior individual psychotherapy, fifty-eight, or 65.9%, completed group psychotherapy. Of the patients who discontinued group psychotherapy six, or

20%, of a total of thirty patients sought additional individual psychotherapy. It is quite probable that if patients are assigned to group psychotherapy alone, with no prior individual psychotherapy, a substantial majority would complete a series of group sessions.

(4) The number of non-continuing patients in group psychotherapy alone with no prior individual psychotherapy (thirty out of eighty-eight, or 34.2%) did not appear to be significantly greater than the number of non-continuing patients in group psychotherapy who had parallel individual psychotherapy (twenty out of sixty-seven, or 30 per cent). It seems that attendance in group psychotherapy is maintained as well with no prior and/or parallel individual psychotherapy, as it is in group psychotherapy parallel with individual psychotherapy.

(5) Of the 213 patients who were assigned to group psychotherapy, sixty-six, or 30.9%, remained with the clinic for additional individual psychotherapy. If the aim of the referring psychiatrist is short-term treatment as well as discouragement of a dependency relationship, then it appears that the patient should be carried in group psychotherapy only.

The adverse relationship of prior individual psychotherapy to the successful completion of group psychotherapy can be understood in terms of the patient's relationship to the psychotherapist in prior individual psychotherapy and to

the group. When the relationship to the psychotherapist in prior individual psychotherapy was strongly positive, the patient's ability to make a good group relationship was impaired. When the relationship to the psychotherapist in prior individual psychotherapy was negative, or conversely, when the relationship of the psychotherapist to the patient was unfavorable, the patient's relationship to the entire psychotherapeutic program of the clinic was negative and retarded the development of intense group attachments. For example, the assignment of a patient to group psychotherapy by transfer from individual psychotherapy was clearly perceived by the patient as a rejection. The patient in such cases severed his connection with the clinic.

Other factors for patient discontinuing group psychotherapy may be involved, such as personality homeostasis, the composition of the group, e.g., siblings assigned to the same group, non-whites in a predominantly white racial group, a group with passive participants only, etc., the personality of the psychotherapist, and/or the group psychotherapy technique.

Summary.- This chapter presented the third criterion for the evidence of the identification hypothesis. Its strength was found in the negative argument that patients failed to continue in group psychotherapy due to barriers of isolation towards, or weakened drives for, the liberation of appropriate

identification with others. To this end, we investigated the relationships of face data characteristics, psychiatric intake variables, nosological syndromes, and individual psychotherapy, to the patient's continuing or non-continuing in group psychotherapy.

SUMMARY AND CONCLUSIONS

1.- Summary.

This research was undertaken because the literature does not provide a clearcut or uniform conception of what constitutes improvement in group psychotherapy. A hypothesis was proposed that identification is the curative factor in bringing about a decisive change in personality adjustment. A nomothetic approach was utilized, where results derived from a quantitative study of patients from many groups were applied as generalizations to a single group or individual.

The design of the experiment employed three criterion measures to test the role of the identification hypothesis: (1) a quantitative evaluation of the Rorschach test scores for latent signs of identification; (2) a quantitative analysis of a questionnaire for manifest expressions of identification; (3) a study of the failures in the initial parent population who discontinued group psychotherapy, as negative evidence of the absence or arrest of identification.

The subjects for the experiment consisted of an experimental and a control group of white adult male veteran patients, suffering from ambulatory emotional disabilities. The purpose of the two groups was based upon the assumption that a favorable change in status could occur without treatment, but that

the benefit of treatment would maximize the change. The experimental group was comprised of forty-eight patients who completed approximately four months of moderate reconstructive group psychotherapy. The patients came from eighteen groups led by five psychologists with varying amounts of group psychotherapy experience. A control group of 10 patients was matched with the experimental group for essential face data.

The experimental group was administered the Wechsler-Bellevue Intelligence Scale and the Rorschach test prior to group psychotherapy, while the Rorschach test alone was given following the termination of group psychotherapy. In the final session of the group psychotherapy series, a questionnaire was distributed for the purpose of a self-evaluation of the group experience, and the patients were requested to write out their responses. The questionnaire was filled out and delivered to a person other than the group psychotherapist to lend a greater objectivity to the procedure. The control group was given the Wechsler-Bellevue Intelligence Scale and the Rorschach test, and reexamined with the Rorschach test approximately four months following the first administration, without the benefit of an interval of psychotherapy.

Rorschach variables, sensitive to adjustment, were subjected to three statistical comparisons: (1) between the pre and post means of the experimental and control groups for seven Rorschach scores; (2) between the pre and post means of

experimental and control groups for five Rorschach percentages; (3) between the pre means of the experimental group and the pre means of the control group on two Rorschach scores indicative of readiness for psychotherapy.

The questionnaire was evaluated for the patient's estimate of manifest change with regard to his symptomatic status, social factors, feelings about the psychotherapist, the group, and the value of the group. The patients' written comments were then catalogued in accordance with certain indices of improvement which were screened from the group psychotherapy literature. These indices were redefined, arranged in an ascending order of importance, subjected to a reliability test, and related to discharge status.

Initial referrals of patients for group psychotherapy from the parent population, consisting of 105 continuing and 108 non-continuing patients, were evaluated with regards to face data information, variables associated with military history, intake psychiatric variables, diagnostic categories, and the use of adjunct individual psychotherapy.

2.- Conclusions.

The conclusions, outstanding features, and interesting aspects, which appeared to be a significant outgrowth of the investigation of the effects of identification in group

psychotherapy, will be presented under the following criterion measures: the Rorschach test, the questionnaire, initial referrals.

A. The Rorschach Test.

(1) Eleven of the Rorschach variables disclosed no significant pre-post differences in the experimental group as determined by the appropriate t test formula. A twelfth Rorschach variable, M + FC - (CF + C), successfully reflected a favorable change in the post examination, following an interval of a series of group psychotherapy sessions over a time span of approximately four months.

(2) None of the twelve Rorschach variables showed significant differences between the pre and post test observations for the control group over a comparable period of time.

(3) The most inclusive Rorschach variable was more significant than single signs or less complex Rorschach variables. The combination variable is in a better position to describe personality changes, from a topographical point of view, than dependent, separate single signs.

(4) The discriminating Rorschach variable was interpreted as a positive argument for the hypothesis that a favorable latent change in the topography of the psyche will reflect a more adaptive, goal-directed urge in the service of a part-emotional identification with others.

(5) The Rorschach variables K (free-floating anxiety) and c (hazy desire for contact), usually indicative of readiness for psychotherapy, were not significant in favor of either the experimental or the control groups.

B. The Questionnaire.

(1) Over 52% of the patients stated that they felt better as a result of the group experience. The physical complaints were slightly more recalcitrant to change than the overall condition. Among the affective characteristics explored, an increase of confidence was checked by the greatest number of patients, which is also consistent with their reports on improved relationship to the self. An overwhelmingly large number of patients indicated a favorable relationship with the psychotherapist and the group. Feelings of friendliness were reported as having developed after the group was under way. While these measures were not charted at the beginning of the series of group sessions, they do appear to disclose the gradual development of increasing relationships.

(2) Seven distinct indices of manifest improvement were reliably differentiated on the basis of the patients' comments on the value of group psychotherapy: information, social-participation, loss of isolation, loss of fear of emotional expression (speech inhibition, abreaction), reassurance (including

symptomatic relief), intellectual insight (including increased objectivity), and increased psychotherapeutic receptivity.

(3) A chi square comparison of manifest psychotherapeutic effects with the independent variable of discharge status disclosed that information (p = .20) and social-participation (p = .05-.10) did not distinguish between those patients who were reported psychiatrically improved from those patients who were reported psychiatrically unimproved. Loss of isolation (p = .001-.01), loss of fear of emotional expression (p = beyond .001) and reassurance (p = beyond .001) significantly differentiated those patients who were psychiatrically improved from those who were unimproved, in favor of the former. Patients' statements indicative of intellectual insight and increased psychotherapeutic receptivity occurred too infrequently to be subjected to statistical calculation.

(4) The improved self-other relationships reported by the patients in the questionnaire, and levels of manifest psychotherapeutic effects (established by definition and related to psychiatric discharge status), were interpreted as positive arguments for the identification hypothesis in favorable psychotherapeutic progress.

C. Initial Referrals.

(1) A comparison of the characteristics of the continuing and non-continuing patients in group psychotherapy revealed that the veteran who was not married (p = .02-.05), who stayed longer in military service (p = beyond .001), and who had a higher per cent pension (p = beyond .001) related significantly to remaining in group psychotherapy.

(2) In the psychoneurotic disorders, the veteran patients who had emotionally reactive diagnoses, as contrasted with those who had physically reactive diagnoses, related significantly (p = just below .02) to continuing in group psychotherapy.

(3) In the character and behavior disorders, veteran patients diagnosed as passive dependents did not quite approach the .05 level of significance (chi square equalled 3.74 instead of at least 3.84 for 1 degree of freedom).

(4) The spontaneous-friendly (p = beyond .001), the tense (p = .01-.02) and those who accepted treatment immediately (p = beyond .001) were significantly related to continuing in group psychotherapy; whereas, the spontaneous-composed (p = .02-.05), those who suffered from pathological sleep disturbances (p = .02-.05), and those who complained of migraine headaches (p = .05) were significantly related to non-continuing in group psychotherapy.

(5) In a review of routine referrals, several recommendations emerged for avoiding non-continuing patients in group psychotherapy. Prior individual psychotherapy is a deterrant to (a) attendance in group psychotherapy, (b) continued individual psychotherapy following group psychotherapy, and (c) continued stay with the clinic, if it is not continued parallel to group psychotherapy.

(6) Group psychotherapy without adjuvant individual psychotherapy appeared to be best recommended if the following purposes were desired: (a) the greatest reduction in the loss of non-continuing patients ($p = .001-.01$), and (b) short-term treatment and the discouragement of the dependency relationship (very few request additional individual psychotherapy following completion of group psychotherapy alone).

The above observations present the negative argument for the basic hypothesis, that in the case of improper referrals to group psychotherapy, there is an absence or arrest of desirable potential for identification.

3.- Implications.

The psychotherapeutic effects characteristic of individual psychotherapy are seldom delineated. If it has not been possible to reach an agreement as to what constitutes improvement in individual psychotherapy, one can readily see how much more difficult it must be to establish criteria for

improvement in group psychotherapy with its increasing number of variables and complexities.

A basic requirement in the practice of psychotherapy is the formulation of aims and goals. The plan of treatment that a psychotherapist has will depend upon the actual psychotherapeutic effects that a technique, patient population, and/or a situation permits. The setting up of realistic sights gives the group psychotherapist a feeling of confidence in what he is doing and what he can anticipate from the group psychotherapeutic process. This thesis is an embryonic attempt to present such a guide. Although identification has been suggested quite often in the literature of group psychotherapy, it has been assigned a peripheral role to some other major problems that have interested its authors.

The contributions made by this study are as follows: (1) empirical evidence for favorable topographical change in the psyche due to exposure to group psychotherapy; (2) a structural theory of Rorschach interpretation; (3) the notion that psychotherapeutic change is due to an increasing chain of interactions and identifications; (4) the presentation of a group psychotherapeutic technique with the latter as a basic assumption; (5) an attempt to set properly the group psychotherapist's perspective between aspiration and actual attainment, by proposing a series of aims and goals associated with psychotherapeutic effects; (6) the establishment of a significant

statistical relationship between a number of characteristics of initial referrals to group psychotherapy and continuing group psychotherapy, and recommendations for the proper use of parallel psychotherapy.

The literature discloses that the chief guide to a plan of treatment, even by experts in group psychotherapy, has been an intuitive dynamic understanding of the individual patient and/or the group process. This may be facilitated further, by testing the validity of clinical observations on an empirical basis, through extensive investigations into the geography, the obstacles, and the uncertain boundaries of pre-constructed goals. This research effort is a minor step towards the scientific evaluation of a difficult clinical concept.

There are certain deficiencies in this experimental design:

(1) It falls short on the idiographic approach, where attention is focused on individual cases. The personal dynamic fulness, with all its brutalized vicissitudes, is absent.

(2) It lacks an accumulation of more extensive data on the role that identification and its particular figures serve in restoring emotional equilibrium. Perhaps a pre and

post administration of Murray's[1] Thematic Apperception Test, or still better, a specially-devised identification test would have filled one gap: it would have provided a measure of the kind and quality of reactions which occur in growing identifications, and the kinds of persons with whom patients identify in a curative way.

(3) Although one measure, the Rorschach test, was obtained from status quo ante, a questionnaire administered before the onset of, as well as at the completion of group psychotherapy, would have provided a more reliable indication of patients' terminal self-evaluation.

(4) A study of the group interaction process with the Harvard-Bales[2] technique would be another valuable instrument. However, Bales sociological descriptive categories should be substituted by more appropriate on the scene, psychiatric, dynamic categories charting the development of leader and group identifications. The chief obstacle in such studies is the problem of establishing reliability of observations among observers.

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1 Henry A. Murray, Manual for the Thematic Apperception Test, Cambridge, Harvard University Press, 1943, 20 p.

2 Robert F. Bales, Interaction Process Analysis, A Method for the Study of Small Groups, Cambridge, Mass., Addison-Wesley, 1950, 203 p.

(5) A larger control group would have imparted more convincing force to the results of the comparisons between the experimental and control groups.

(6) A follow up Rorschach examination would be of value to determine if the topographical changes noted in post observations are maintained or lost after a period of time.

Some implications for further research can be drawn from this exploratory venture:

(1) Is group psychotherapy a change from (a) rivalry with the therapist to identification with the therapist, (b) rivalry with members of the group to identification with members of the group?

(2) Does the patient accrue less and/or different psychotherapeutic effects if he identifies with the leader only?

(3) Is group psychotherapy a cross-sectional approach as contrasted with a presumed longitudinal approach in individual psychotherapy?

(4) Is group psychotherapy a true multiple relationship as contrasted with a presumed one to one relationship in individual psychotherapy?

(5) Is the essential difference between individual and group psychotherapy one in which identification in the

former is with the psychotherapist mainly, while identification in the latter is chiefly with the members of the group (siblings)?

(6) Does reconstructive group psychotherapy introduce the patient into deeper stages of identification (with subsequent benefits) as contrasted with presumed initial stages of identification in repressive group psychotherapy?

It is likely that the various problems raised by this study will serve as a useful guide to budding group psychotherapists, as a thought-provoking stimulus to the expert, and as another starting point for further research by workers with similar interests.

BIBLIOGRAPHY

Abrahams, Joseph and Lloyd W. McCorkle, "Group Psychotherapy of Military Offenders", American Journal of Sociology, Vol. 51, 1946, p. 455-464.

This is the first article on group psychotherapy to appear in a sociological journal. Delinquent and inadequate soldiers were sent to an Army Rehabilitation Center for a course of mass therapy and ultimate restoration to duty or transfer to a disciplinary barracks. The result of treatment was portrayed as a gradual development and increase in emotional stability, a sense of national obligation, and an eagerness to return to duty. The restoration rate was forty per cent.

Ackerman, Nathan W., "Some General Principles in the Use of Group Psychotherapy", in S. Glueck, editor, Current Therapies of Personality Disorders, New York, Grune, 1946, p. 275-281.

There are three therapeutic aims: (1) to improve social adaptation, (2) to relieve acute emotional distress, (3) to induce personality change. Group therapy is directed toward a reorganization of conscious aspects, or release of unconscious mechanisms for subsequent insight and personality change. The value of the group method is the reintegration of ego patterns with better organized and controlled emotional drives.

Aichhorn, August, Wayward Youth, New York, The Viking Press, 1935, xi-236 p.

The role of pathological identification, the lack of affection and undue amount of affection are presented as primary causes of dissocial behavior. The teacher offers traits for identification that "bring about a lasting change in the structure of the ego-ideal."

Altshuler, Ira M., "One Year's Experience With Group Psychotherapy", Mental Hygiene, Vol. 24, 1940, p. 190-196.

The patient proceeds through three stages: indifference, empathy, integration. A case example is presented illustrating this therapeutic progression. Eurhythmics, musical influence and participation, and group discussion meetings are the major techniques. Group psychotherapy is held to have a socializing value. With a State Hospital population, seventy-two per cent improvement rate was reported.

Baruch, Dorothy W., "Description of a Project in Group Therapy", Journal of Consulting Psychology, Vol. 9, 1945, p. 271-280.

This is the first paper that has been published on non-directive group psychotherapy. Baruch presented her ideas under the following headings: process and analysis of techniques, listing of techniques of leadership in therapeutic group discussion, and group members' statements as to the effects of the therapeutic experience. Her paper is a report of twelve sessions of therapeutic group discussion in a college course on techniques of therapy with a mixed professional group of both sexes.

Berman, Leo, "Psychoanalysis and Group Psychotherapy", Psychoanalytic Review, Vol. 37, 1950, p. 156-163.

This author saw very little difference between individual therapy and group therapy. Even in individual therapy, the patient acts as if there were a third person present. Berman offered the following examples as proof of his contention: the telephone call, verbal exchanges with the secretary, chance meeting with other patients, cigarette stubs, warmed up couch, persons mentioned in analytic treatment, and the symbolic figures represented by the analyst.

Burrow, Trigant, "The Group Method of Analysis", Psychoanalytic Review, Vol. 14, 1927, p. 268-280.

Unrecognized destructive features of the normal social background are expressed in neurotic manifestations. Neuroses and psychoses are exaggerations of the accepted norm of social behavior. Due to the inadequacy of social adaptation, the patient has surrounded himself with a wall of special symbolizations which are merely a variation of the symbols and substitutions about him. Burrow, therefore, urged group analytic research experimentation as a prerequisite for the treatment of neurotic disorders. The participants in these investigations are invited to disregard the accepted symbolic outlooks and to offer for analysis their own individual behavior and mood reactions. Instead of a detailed study of reminiscences, this method analyzes the phenomena of the present moment, the immediate mood reaction, and the actual social relationship.

Carr, Arthur C., "An Evaluation of Nine Non-directive Psychotherapy Cases by Means of the Rorschach", Journal of Consulting Psychology, Vol. 13, 1949, p. 196-205.

This author attempted to repeat the experiment, used by Muench, in the analysis of pre and post therapy Rorschach protocols. Nine non-directive psychotherapy cases were examined for evidence of change following therapy. No significant statistical changes were noted within the limits of the quantitative and qualitative signs explored.

Foulkes, S.H., Introduction to Group Analytic Psychotherapy, New York, Grune, 1948.

The goals of group psychotherapy are equated with the goals of individual psychoanalytic treatment. A group analysis does not indicate that psychoanalysis occurs in groups. The stress is upon insight. The following constructive factors are attributed to group: (1) socialization (including abreaction, loss of isolation, and intellectual insight), (2) mirror-reaction (seeing one's own problems and defenses when pointed out in others), (3) activation and exchange (pooling of associations), (4) the group as a community forum (modifying the structure of the ego and superego by the group's rejection, tolerance, or approval), (5) group as support (inter-group transference).

--------, "Group Therapy", British Journal of Medical Psychology, Vol. 23, 1950, p. 199-205.

Group psychotherapy aims at basic personality change in the functions of ego, super-ego, and the distribution of the libido. Support, release of guilt and anxiety through sharing, encouragement, etc. are not considered signs of improvement.

Frank, Jerome D., and Edward Ascher, "Corrective Emotional Experiences in Group Therapy", American Journal of Psychiatry, Vol. 108, 1951, p. 126-131.

Emotional experience interrupts habit and accelerates biological adjustment by change of attitudes, facilitated through support, stimulation, and reality testing.

Freud, Anna, The Ego and the Mechanisms of Defence, Toronto, Oxford University Press, 1948, 196 p.

This is a book frequently referred to for information on the mechanisms of defence which the ego brings into action in order to deal with repressed impulses.

Freud, Sigmund, Group Psychology and the Analysis of the Ego, (translated by James Strachey), Toronto, Clarke, Irwin, 1948, 134 p.

Three meanings to the concept of identification were presented:

> First, identification is the original form of emotional tie with an object; secondly, in a regressive way, it becomes a substitute for a libidinal object tie, as it were, by means of the introjection of the object into the ego; and thirdly, it may arise with every new perception of a common quality shared with some other person who is not the object of the sexual instinct. The more important this common quality is, the more successful may this partial identification become, and it may thus represent the beginning of a new tie.

It is Freud's third type of identification that is of concern to this thesis.

Glover, Edward, "The Technique of Psychoanalysis", International Journal of Psychoanalysis, Supplement No. 3, 1928, 141 p.

Three stages were utilized: (1) relaxed watchfulness of the super-ego; (2) analysis of super-ego development and structure; (3) preparation of the ego to effect adaptations.

Halle, Louis and J.F. Ross, "A Therapy Program for Schizophrenic Patients", United States Veterans Administration Department of Medicine and Surgery Information Bulletin, IB 10-13, July, 1951, p. 3-8.

These authors postulated four levels of reality relationship and readiness for socialization in a psychotic population: (1) those who are most withdrawn from reality, (2) those who are secure enough to mingle with others in some form of diversional therapy, (3) those who are ready to identify within a group around a common project or goal; (4) those who, for the most part, are oriented and in good contact but whose interpersonal relationships are strained, fruitless, and superficial. The major purpose of the article was to describe a therapeutic program rather than a study of the dynamics and results of group action.

Harris, Herbert I., "Efficient Psychotherapy for the Large Outpatient Clinic", New England Journal of Medicine, Vol. 221, 1939, p. 1-5.

The author presented a sketchy picture of the history of group therapy, but attempted for the first time, to outline the principles of group therapy and to offer some simple statistics, inadequate though they were.

Hauptmann, Alfred, "Group Therapy for Psychoneuroses", Diseases of the Nervous System, Vol. 4, 1943, p. 1-4.

Each patient has a preliminary interview, and those who do not improve by the group method are offered parallel individual psychotherapy. The patient becomes anchored, by his testimony, against future failure or relapse. Transference does not become fixed in group as it does in individual therapy. It is not what the group psychotherapist says, but how he says it. Extraverts are cured by suggestive factors, whereas introverts are cured by intellectual conviction.

Hobbs, Nicholas, "Group-Centered Psychotherapy", in Carl R. Rogers' Client-Centered Therapy, New York, Mifflin, 1951, p. 278-319.

The techniques of client-centered individual therapy, such as clarification of feeling, reflection of feeling, restatement of content, simple acceptance, are applied also to group therapy. However, "in group therapy, a person may achieve a mature balance between giving and receiving, between independence of self and a realistic and self-sustaining dependence on others." The effectiveness of group therapy has to be based chiefly on an overall clinical appraisal and on the individual's own estimate of his growth; but behavioral changes noted in verbatim protocols of group therapy, and ultimately quantitative assessment of the effectiveness of group therapy are the more rigorous methods.

Klapman, J.W., Group Psychotherapy, New York, Grune, 1947, vii-344 p.

The literature is reviewed and a series of lectures on group psychotherapy are presented. Preference is shown for a clinical assessment of the results of group psychotherapy in terms of the patient's previous history, his personality structure, and psychic conflicts. The author felt there was no reliable method for assessing the results of group psychotherapy with an objective, scientific plan.

Knight, R.P., "Why People Go to Cultists", Bulletin Menninger Clinic, Vol. 3, 1939, p. 139-149.

The thesis was presented that very few adults entirely overcome the magical thinking of childhood. They are ripe for the curative promises of patent medicines or for the suggestive approaches of cultists who speak reassuringly and authoritatively. What the cultist does unscientifically, physicians often fail to do with their mechanistic science.

Lazell, E.W., "Group Psychic Treatment of Dementia Praecox by Lectures in Mental Reeducation", United States Veterans Medical Bulletin, Vol. 6, 1930, p. 733-747.
The author was a pioneer in group psychotherapy with psychotics in 1919. The patients' problems were socialized. A decrease in the fear of the therapist was reported. The neurotic and psychotic were regarded as educational problems and best approached by the lecture method. Seventy per cent social recoveries were reported.

LeBon, Gustave, Psychologie des Foules, Paris, Alcan, 1930, ii-187 p.
LeBon outlined the general characteristics of the crowd under three categories: (1) loss of restraint and responsibility through the power of numbers, (2) sacrifice of personal interest to the collective interest through hypnotic contagion, (3) influence of suggestibility by the crowd's feelings and ideas.

Marsh, L. Cody, "Group Treatment of the Psychoses by the Psychological Equivalent of the Revival", Mental Hygiene, Vol. 15, 1931, p. 328-349.
A highly charged inspirational approach was utilized, accompanied by diversional techniques in a total-push program. The aim was to "extravert" the individual at a "social level".

Mitchell, S.D. and A. Zanker, "The Use of Music in Group Therapy", Journal of Mental Science, Vol. 44, 1948, p. 737-748.
The authors made a systematic study of the reaction of the patients to different styles and periods of music. The traditional and folk songs were found to be the most effective in increasing the harmony of the group as a whole, and in fostering the integration of individual personalities.

Moreno, Jacob L., "A Case of Paranoia Treated Through Psychodrama", in Proceedings of the Second Brief Psychotherapy Council, Institute for Psychoanalysis, Chicago, 1944, p. 47-54.
Four versions of the psychodramatic technique are described in a succinct and pertinent manner. A case study is presented, and subsequently discussed by psychiatrists Alfred P. Solomon and Thomas M. French of Chicago.

Moreno, Jacob L., Who Shall Survive, New York, Beacon House, 1953, cxiv-763 p.

The book presents the history, techniques, research, and theoretical constructs of Psychodrama. The best summary of the results of research can be found by the reader on page 696-717 under the topic General Hypotheses and Recommendations for Further Research. Catharsis is the chief activating agent. Results are determined in terms of the sociometric status of the individual in the group.

Muench, George A., "An Evaluation of Non-directive Psychotherapy", Applied Psychology Monographs, No. 13, 1947, p. 9-163.

Twelve cases, of non-directive therapy on patients who had four to thirty interviews with five different therapists, were evaluated for the study. The Rorschach, Kent-Rosanoff Free Association Test, and the Bell Adjustment Inventory were administered to each client before and after an interval of non-directive individual psychotherapy.

The Rorschach scores were tabulated in three columns: the sum of the pre-test scores of each case, the sum of the post-test scores of each case, and the sum of the end-test minus pre-test scores of each case. The scores of each column of cases were then summed, means were obtained, and a Fisher's t test was performed. The sum of the following Rorschach scores were found to be significant at the .01 level: %R+,FC, FC-CF+C (Wt) and M+FC-(C+CF). The %R+ was interpreted as a keener perception of things. The other three factors were emotional adjustment factors: FC, emotional adaptability; FC-CF+C(Wt.), emotional stability; and M+FC-(C+CF), maturity of emotional development.

Napoli, Peter J., and Beatrice Gold, "Finger Painting in an Occupational Therapy Program", American Journal of Occupational Therapy, Vol. 1, 1947, p. 358-361.

The Psychotherapeutic values of finger painting are presented as follows: (1) a tension-releasing agent, (2) a medium for establishing rapport, (3) a means for socialization.

Powdermaker, Florence B. and Jerome D. Frank, Group Psychotherapy, Cambridge, Harvard University Press, 1953, xi-615 p.

This is a report of a group psychotherapy research project with U.S. World War II veterans who were Mental Hygiene Clinic patients and hospitalized schizophrenic patients. The purpose of this study was to investigate objective methods for developing psychotherapeutic techniques. The authors stated that the use of controls and experimental design were

premature, and that quantification is merely a guise for science. Hence, the data was analyzed qualitatively, for the most part. Out of a total of 124 patients treated, twenty-four were assigned to the classification of group therapy alone. However, thirteen out of the twenty-four patients had five individual sessions or less. One group had eight group meetings, another twenty-nine meetings, and a third group ninety-eight meetings. The results were evaluated on the basis of a group conference on each patient pre and post by the patient's doctor, psychologist, social worker, and group observer. Changes were evaluated with reference to (1) symptoms: physical, mental, emotional; (2) social relations; (3) characteristic response to stimuli. They used a 1 - 6 range of improvement based on slight or marked improvement in one or more of the above categories of improvement. Thirteen of the twenty-four patients (54%) improved. Although Rorschach tests were administered pre and post, the data was reported qualitatively in terms of an individual patient and in the context of a personality tension area.

Pratt, Joseph H., "The Influence of Emotions in the Causation and Cure of Psychoneuroses", International Clinics, Vol. 4, 1934, p. 1-16.

Historical data were presented as a basis for the argument that the appeal to the emotions is a factor in the change of mental outlook. Although the strength of the emotional impact of the doctor upon the patient was emphasized, the testimony of patients was regarded as more convincing than statement of the physician. Pratt stressed the need of replacing bad mental habits with good ones. Hence, only the good habits were permitted expression. Disappearance of symptoms is the criterion of improvement.

--------, "The Group Method in the Treatment of Psychosomatic Disorders", Psychodrama Monographs, No. 19, Beacon House, 1946.

The author felt that Dejerine's faith cure never made the impression on the medical public that it deserved. Psychotherapists were too fascinated by the views of Freud. Pratt stated that Dejerine was the first to recognize the role of emotions in psychosomatic disorders. No change in Pratt's technique was reported in its fifteen years of existence.

Reader, Natalie, "An Investigation Into Some Personality Changes Occurring in Individuals Undergoing Client-Centered Therapy", unpublished Ph.D. Thesis, University of Chicago, 1948, 136 p.

This is a study of fifty-six cases of pre and post Rorschachs on patients who had a wide range of exposure to non-directive psychotherapy. Seventeen had individual psychotherapy, twenty-four had group psychotherapy, and fifteen combined individual therapy plus group therapy. A control group was matched for age, sex, education, and socio-economic background. Favorable changes were found in nine of the ten personality factors (by grouped constellations of location, determinant, and content Rorschach scores as representative of each of the author's categories of a personality process), and a small, but statistically significant difference in overall results in the direction of a better adjustment on the post-test. A control group of fifteen cases showed none of the changes manifested in the experimental group.

Redl, Fritz, "Problems of Clinical Group Work With Children", in Proceedings of the Second Brief Psychotherapy Council, Institute for Psychoanalysis, Chicago, 1944, p. 29-35.

The Detroit Group Project, which was an experiment with groups of children, was described. Redl's chief concern was to discover forces in group psychotherapy that induce behavioral changes. He hoped to create certain group climates that would favor psychotherapeutic purposes. Group work was combined with individual case work. It was used chiefly for "support". Redl expressed the opinion that the group climate could "at least make a dent in drive pattern, superego content and strength, as well as in the power of the ego and its techniques of synthesis."

Rogers, Carl R., Client-Centered Therapy, Boston, Mifflin, 1951, xii-560 p.

Throughout this revision of his previous principles of non-directive therapy, Rogers stressed his objection to the use of clarification in the description of the counselor's role. The clarifications of clients' attitudes imply a declarative statement, a judgment, a diagnosis. Reflection of attitudes presents the difference between a declared and an empathic attitude. Client: "I feel as though mother is watching me and criticizing what I do. . ." Counselor: "You resent her criticism. . ." Rogers felt that the new principle left the person freer to choose and reject inaccurate reflections of attitudes. However, not only does reflection of feelings refer to things said by the client but to things which are not said.

Schilder, Paul, "Results and Problems of Group Therapy in Severe Neuroses", Mental Hygiene, Vol. 23, 1939, p. 87-98.

The goal of group therapy is insight (ability to appraise the self and the world and to act accordingly). "Cures", however, are spoken of in terms of symptomatic relief. Even in cases of relapses, the patient obtains a better orientation to life. Schilder reported that best results were obtained with social and obsessive neuroses.

--------, Psychotherapy, (Revised), New York, Norton, 1951, 396 p.

The author's technique of group psychotherapy was presented. Silent members were not allowed to remain in the group. The group setting decreased resistance in the repressed and inhibited. Problems lost their magnitude in public "confession". A monumental questionnaire was used as a psychiatric construct of areas and problems to be explored.

Sharpe, Ella Freeman, "The Technique of Psychoanalysis", International Journal of Psychoanalysis, Vol. 11, 1930, p. 251-278 and p. 361-387.

The psychoanalytical task is the analysis of complexes, the exploration of feelings, the reasons for actions, and the barriers to self-expression. These are approached by unravelling the past, recalling past incidents and phantasies, and discovering the sources and models of present behavior. Resistances are resolved by bringing to consciousness unconscious id wishes and the nature of the superego threats. Transference plays a shifting role: id against superego, superego against id, and ego against id or superego. The analyst brings to light these various projections upon him.

Simmel, Ernst, "War Neurosis", in Psychoanalysis Today, edited by Sandor Lorand, New York, International University Press, 1944, p. 227-248.

The military ego must show blind obedience to the commander of the unit. The indoctrination process regresses the soldier to a child-parent relationship. The Infantry connotes a group of infants. Army experiences frustrate the soldier's attempt at identification. Personal discriminations, disappointments, denials, make the soldier feel like a child deserted by his parents. A stuffed dummy, representing an officer, was introduced into a therapy situation while a patient was under hypnosis. The discharge of repressed hatred and destructive energies against the dummy brought about a dramatic change. Patients were helped but no cure was claimed.

Slavson, S.R., An Introduction to Group Therapy, New York, Commonwealth Fund, 1943.

The emphasis is on social adjustment and overt social behavior. Those children benefit from activity group therapy who have a social hunger, a yearning for emotional interchange with people, and a capacity for being influenced by a social relationship. Various psychotherapeutic techniques for different age levels were presented. The types of children were listed who are accessible or inaccessible to group therapy.

--------, Analytical Group Psychotherapy, New York, Columbia University Press, 1950, 275 p.

Group psychotherapy is facilitated by the following dynamics: transference dilution, target multiplicity, mutual support, displacement, escape, deflection, catalysis, identification, and universalization. The goal of therapy is to prepare the individual to accept reality.

Thomas, Giles W., "Group Psychotherapy", Psychosomatic Medicine, Vol. 5, 1943, p. 166-180.

This is a pioneer attempt to present a broad review of group psychotherapeutic efforts.

Wender, Louis, "The Dynamics of Group Psychotherapy and Its Application", Journal of Nervous and Mental Diseases, Vol. 84, 1936, p. 54-60.

This is Wender's first paper on group psychotherapy. It is a report of six years experience at the Hastings Hillside Hospital in New York. Patients attempted to compensate for the loss of their family groups by identifying the hospital as a substitute family group. The goals were the release of certain emotional conflicts, partial reorganization of the personality, and increased capacity for social amalgamation. Group psychotherapy requires unimpaired intellect and retention of some degree of affect. Techniques were described. Basic concepts were intellectualization, patient to patient transference, catharsis in the family, and group interaction. The results showed positive social adjustment and freer discussion of problems. No statistics were presented.

--------, "Group Psychotherapy: A Study of Its Application", Psychiatric Quarterly, Vol. 14, 1940, p. 708-718.

Wender described group treatment in a mental hospital. The diversional approach was utilized before actual group psychotherapy. "Open" groups were instituted. Wender's approach was indirect. A disguised case was utilized. Psychoanalytical mechanisms and specific defenses were discussed with patients. Group was used as an adjuvant to individual therapy. The goal of therapy was social reorientation.

Wender, Louis and Aaron Stein, "Group Psychotherapy as an Aid to Out-patient Treatment in a Psychiatric Clinic", Psychiatric Quarterly, Vol. 23, 1949, p. 415-424.

Experiences on out-patient basis were reported. Eleven out of 14 patients experienced a cessation of symptoms and improved social adjustment. Results are contaminated by parallel individual psychotherapy.

White, Robert W., "An Analysis of Motivation in Hypnosis", Journal of General Psychology, Vol. 24, 1941, p. 145-162.

This article is a summary of White's research on the relationship of the needs of a person to hypnotic influence. There are manifest and latent needs. The manifest needs, unrelated to hypnotic susceptibility, were found to be sex, extraversion, and submission. The manifest needs that had a small but significant relationship were deference (the tendency to yield willingly to the wishes of a superior person), and need for autonomy (the desire for freedom and self-direction with a feeling of threat by the hypnotoc situation). Latent needs favorable for hypnosis were found to be the need for love from a parental figure, the tendency of passive compliance in the presence of an elder (Freud), and a wish to participate in omnipotence (Schilder). Both manifest and latent needs of aggression were contraindications for hypnosis.

Wolf, Alexander, "The Psychoanalysis of Groups", American Journal of Psychotherapy, Vol. 3, 1949, p. 525-558; Vol. 4, 1950, p. 16-50.

The stages of treatment are as follows: (1) preliminary individual analysis, (2) rapport through dreams and fantasies, (3) inter-action through interpersonal free association, (4) the analysis of resistance, (5) the analysis of transference. A criterion of discharge from the group is insight: the patient's ability to adequately cope with transference and counter-transference reactions. Groups are of the open-continuous type.

APPENDIX I

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There has been a dire lack of crystallization and definition as to what constitutes improvement in group psychotherapy. A discrepancy was observed between the level of the group psychotherapist's aspirations and the group's achievement of goals. It seemed worthwhile to investigate a clinical observation that the identification process is the crucial healing factor in group psychotherapy. Through an emotional identification with other members of the group, the patient develops an automatic course by which he can operate.

The theory and practice of the major schools of group psychotherapy were reviewed with particular reference to concepts of improvement. A progressive schema of techniques, dynamics, and manifest effects in group psychotherapy were developed corresponding to a theoretical construct of progressive stages of identification. Three criterion measures were employed to test the truth of the identification hypothesis: (1) on the basis of the positive argument, that quantitative Rorschach signs will evidence the intensification of the latent identification component in the topography of the psyche; (2) on the basis of the positive argument, that

quantified testimony of patients in a questionnaire will reflect manifest psychotherapeutic effects of identification; (3) on the basis of the negative argument, that in the case of improper referrals to group psychotherapy there is inadequate potential release or arrest of identification.

Two groups of patients were used for the core of the study: an experimental group of forty-eight white adult male veterans suffering from ambulatory emotional disabilities, and a control group of 10 white adult male veterans matched with the experimental group in basic face data. The control group was on a waiting list for processing, pending admission for treatment. The Wechsler-Bellevue Intelligence Scale and the Rorschach test were administered individually to both the experimental and the control groups. The experimental group was retested with the Rorschach following the termination of sixteen weeks of moderate reconstructive group psychotherapy, under the leadership of five dynamically-oriented psychologists. The control group was retested with the Rorschach approximately four months later without the benefit of an interval of psychotherapy.

The design of the Rorschach experiment involved three statistical comparisons: (1) between the pre and post means of the experimental and the control groups for selected Rorschach scores; (2) between the pre and post means of the

experimental and control groups for selected Rorschach percentages; (3) between the pre means of the experimental group and the pre means of the control group on two Rorschach scores indicative of readiness for psychotherapy.

The questionnaire, which was administered in the final session of group, was evaluated for self-other relationships and manifest psychotherapeutic effects. Patients' written comments were catalogued in accordance with indices of improvement. The latter were subjected to a reliability test and then related to discharge status.

Routine factors involving initial referrals to group psychotherapy were reviewed with regards to face data, military history, intake psychiatric variables, diagnostic categories, and the use of adjunct individual psychotherapy.

The Rorschach analysis disclosed one combination variable that revealed a significant favorable change in post group psychotherapy examination, while no significant changes were found in the control group. The significant Rorschach variable was interpreted in accordance with a topographical construct as a more adaptive, goal-directed urge in the service of a part-emotional identification with others.

The evaluation of the questionnaire showed improved self-other relationships. Seven distinct manifest indices of improvement were reliably differentiated. A chi square

comparison of manifest psychotherapeutic effects with discharge status disclosed that there were no significant differences between the improved and unimproved groups with regard to the indices of information and social-participation, while the indices of loss of isolation, loss of fear of emotional expression, and reassurance significantly related in favor of the improved group. Patients' statements interpreted as intellectual insight and increased psychotherapeutic receptivity occurred too infrequently to permit statistical comparisons. The improved self-other relationships, and achievement of higher levels of psychotherapeutic effects, were interpreted as manifestations of a favorable increase in part-identifications.

In the study of initial referrals, a number of characteristics emerged which were typical for continuing and non-continuing veteran patients. Those veterans who were not married, who had a longer record of military service, who had a higher per cent pension, who were diagnosed as emotionally reactive, who were spontaneous-friendly, who were tense, and those who accepted treatment immediately were significantly related to continuing group psychotherapy. Those who were spontaneous-composed, those who suffered from pathological sleep disturbances, and those who complained of migraine headaches were significantly related to non-continuing group psychotherapy.

In a review of routine referrals, it was observed that prior individual psychotherapy is a deterrant to attendance in group psychotherapy, to continued individual psychotherapy, and to continued stay with the clinic, if it is not continued parallel to group psychotherapy. Group psychotherapy without adjuvant individual psychotherapy is indicated for the reduction of the number of non-continuing patients, for short-term treatment, and the discouragement of the dependency relationship. Veteran patients who do not possess the above favorable characteristics or who are injudiciously assigned following acceptance for individual psychotherapy, are pathognomonically blocked or arrested in their potentials for identification.