AN EXPLORATION INTO THE SHORT TERM EFFECTS OF THREE THERAPEUTIC METHODS

by

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CHAPTER I

INTRODUCTION

The growing number of hospitalized mental patients results in steadily increasing expenditures of governmental and private agencies which are concerned with the care of psychiatric cases. This situation vividly illustrates the necessity not only for scientific investigation of psychopathology, but also for the evaluation of the various psychotherapeutic techniques.

The scientific investigation of this field is, however, beset by enormous difficulties which have discouraged many research workers. Among the different obstacles and methodological problems which the investigator faces is also the problem of personal bias. One can hardly work in the field of Abnormal Psychology without feeling the need to lean upon some sort of stable frame of reference. With the increased feeling of confidence and security derived from the association with a more or less established, consistent approach to psychopathology, one is only too apt to acquire simultaneously the defensiveness against the impact of findings which appear to threaten this balance. Findings, which are not in accord with one's frame of reference, are all too easily overlooked, or disposed of as "biased," an expression of "resistance," of personal inadequacy of the investigator, and so forth instead of being taken as a serious challenge for investigation. This holds for both the study of etiological factors as well as that of the effect of psychotherapy; within the latter realm a crucial problem arises in the question of how to define the therapeutic effect in quantitatively measurable terms. Investigators have frequently relied upon the judgments of the therapist. But, obviously, this introduces a bias since

the therapist is consciously or unconsciously involved in being successful in discovering signs of improvement in the condition of the patient whom he is treating. Jerome D. Frank (28, 1) remarks:

> "Psychotherapists report their cases without raising the question as to how correct their observation of what went on in psychotherapeutic interviews really is. Actually comparison of retrospective reports of interviews with recordings of them shows that even the most unbiased and objective psychiatrists make significant errors of omission and distortion. The psychiatrist may fail to observe important events or observe them accurately. He may forget or incorrectly remember what he observed. Such errors might be expected to be the greatest at those points in the interview most important for the study of psychotherapy, where the therapist's own emotional participation was greatest. Almost all descriptions of psychotherapy, moreover, are presented to illustrate the writer's particular method and to demonstrate its effectiveness. This leads to a selective bias which may result in further distortion. Just as the therapist cannot produce a full and undistorted report of what went on in the therapeutic interview, so he cannot form a completely unbiased judgment of the effects of therapy....having a personal stake in the outcome, he cannot be regarded as strictly impartial."

Reliance upon the judgment of the patient also introduces a number of possible errors, thus his judgment may be influenced by his desire to terminate or to continue the therapeutic relationship; his judgment may also be distorted due to a false conception of the purpose of the survey and, finally, with certain groups of patients this approach will be impossible due to the fact that they may not be able to relate verbally or to perceive their situation adequately.

The most promising solution under those circumstances appears to be the appraisal of the patient by a group of experts who are not directly involved in the patient's treatment, or the introduction of non-participating observers. Both of these methods, however, are costly and introduce a number of new variables such as the meaning and importance of the

presence of the observer or the interview with the expert. The difficulty of measuring therapeutic effect or progress has thus led to various attempts but to no conclusive solution.

Another difficulty encountered by research in psychotherapy is the fact that it is impossible to make repeated observations or repeated measurements of the same phenomena.

> "Obviously no two people are alike so that one cannot repeat the same observation on different people. The same observation, moreover, cannot, strictly speaking, be repeated on the same person because the situation has inevitably been modified by the preceding one. Also the fact that one is working with human beings makes it impossible to maintain a rigid experimental design. One seldom can wait for just the patients needed to fill out a preconceived plan...." (28, 3)

Modern research tends to resort to statistical methods in an effort to isolate the significant relationships when it is not possible to control the variables experimentally. But, in an investigation of therapeutic processes, exact quantification can easily become an artifact which tends to veil rather than reveal the underlying complexities.

If, in spite of all these deterring factors and difficulties, this research was undertaken, it is largely due to the conviction of the experimenter that one can not wait until a scientific framework has been constructed which will permit the use of flawless investigative procedures, but that pilot studies may pave the way for the gradual emergence of such a framework. The study to be described may be classified as such a pilot-attempt. The objective of the research was to compare the short-term effects of three different therapeutic methods. In short,

these were:

1. Individual Psychotherapy
2. Group Psychotherapy
3. Social Process Centered Activity Therapy.

All these will be described in greater detail in the following pages.

It was hoped that even if such a pilot study would contribute nothing else but cast doubts upon the existing traditional percepts of psychotherapy it might be provoking by introducing other than the established alternatives. Beyond this the experimenter hoped that the research might achieve a twofold goal:

In the first place, he thought that the practical use of different treatment procedures in comparable settings would tend to deepen the understanding of the therapeutic process and might lead to greater efficiency in the use of established and potential therapeutic resources.

On the other hand, it appeared also to be desirable to further clarify differences existing between the theoretical frameworks upon which the three treatment procedures under investigation appear to be based.

Plan of Presentation

In the description of an investigation of such complexity as the one here under discussion one has to choose from among the many components of the research context those which most adequately produce a picture of the total situation.

In order to achieve this goal an attempt is made in the following pages to present:

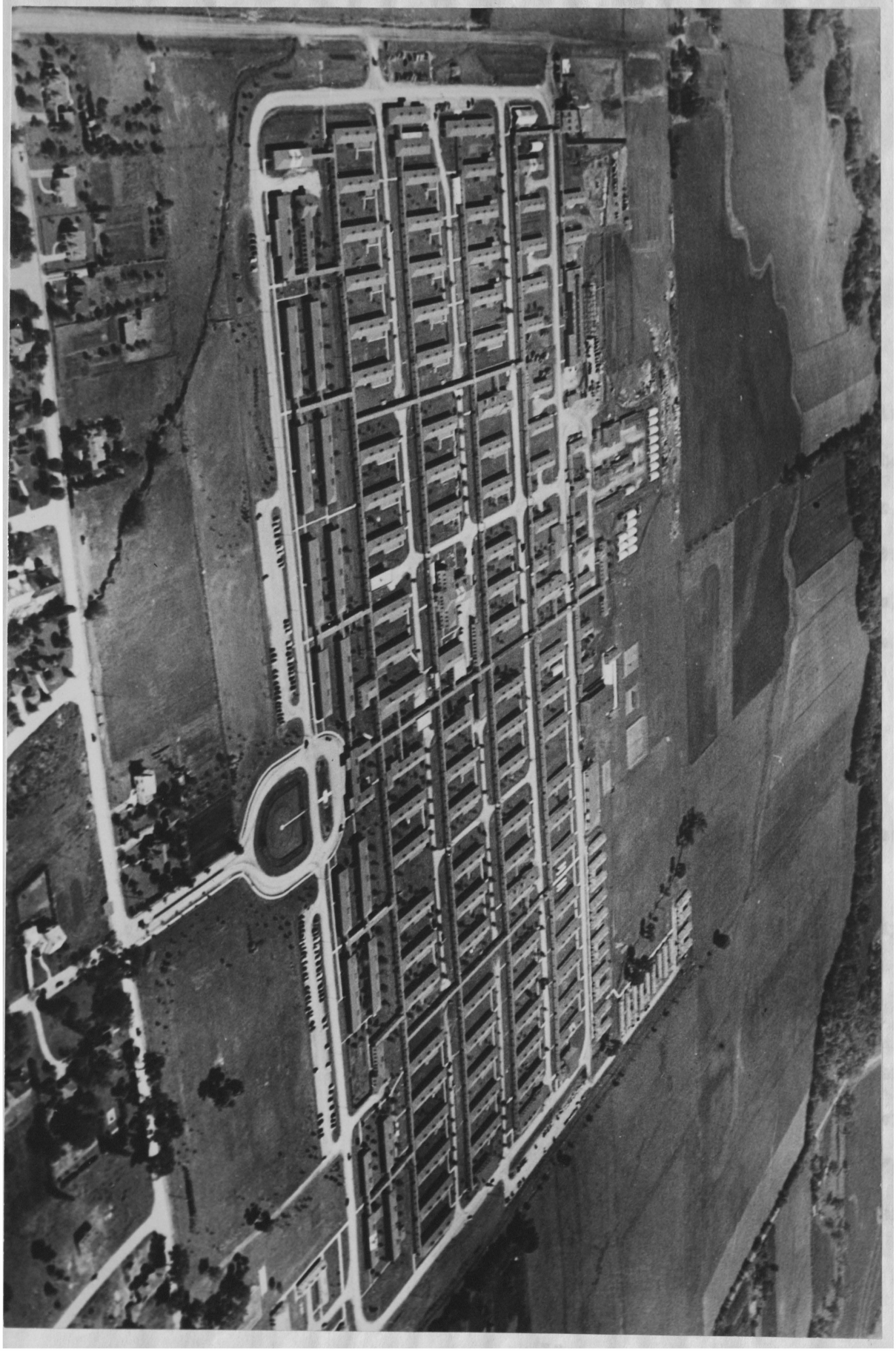
1. Some relevant aspects of the physical lay-out of the hospital in which this research was undertaken.
2. Common dynamics of the "chronic hospital patient" who served as subject in this investigation.
3. Theoretical reflections of the experimenter which led him to choose the specific therapeutic methods for comparison.

It is believed that on the basis of these observations an understanding of the motivations and convictions which led to this research project will be obtained. By exposing his beliefs at the stat the experimenter hopes to be able to prevent it from interfering with the results.

A Short Glance At The Hospital.

In order to see the research project to be described in its proper light it is advantageous to be at least superficially acquainted with the layout of the hospital in which it was undertaken.

Winter Veterans Administration Hospital is located near the city limits of Topeka, Kansas. As a result of the pooling of the resources of the Veterans Administration and the Psychiatric philosophy and know-how of the Menninger Foundation, it developed into an outstanding

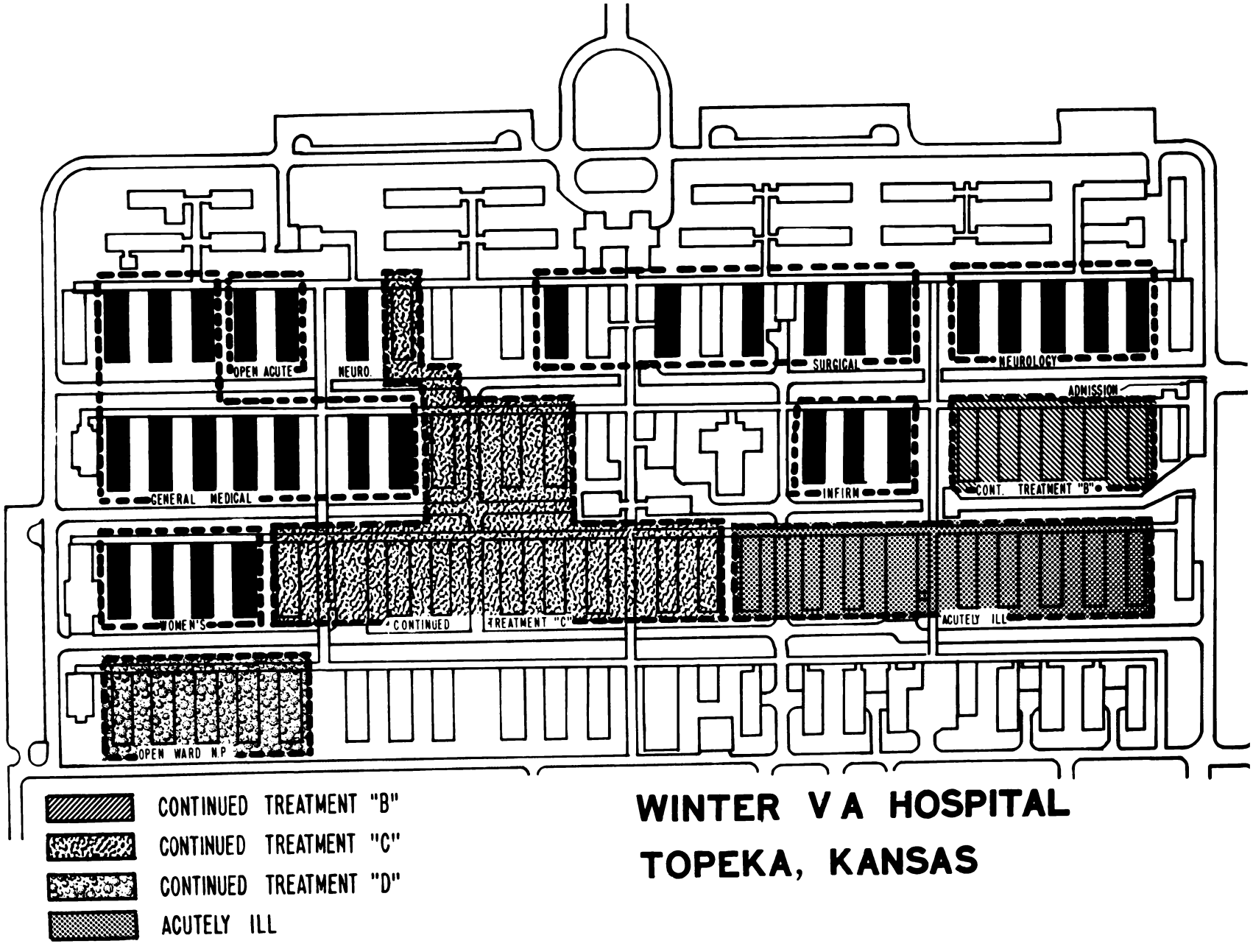


psychiatric teaching institution. As a result of the influx of numerous medical doctors who wanted to specialize in psychiatry, of psychologists working for the doctorate, of psychiatric social work students, etc., the hospital has a relatively large staff.

The physical plant of the hospital, taken over from the Army, consists of a multitude of one story barracks, the hospital wards, of which are connected by long corridors.

The hospital is divided into various sections and services. Since the present research is concerned with male neuropsychiatric patients it is superfluous to describe the function of the Women's NP Section, the Psychosomatic Section, the Neurological and Medical Services, etc. Concentrating upon the four main Neuropsychiatric Treatment Sections, one can distinguish the "Acute Section," the Continued Treatment "B" Section, the Continued Treatment "C" Section, and the Continued Treatment "D" Section.

The average patient who comes into the hospital in an acute psychotic state is admitted to the "Acute Section." Here he receives various sorts of treatment such as Hydrotherapy, Insulin Therapy, Electro-Shock Treatment or Milieu Treatment. His movement is rigidly guided and supervised. All wards on this section are locked wards and are in addition provided with special security measures and more numerous personnel in order to be able to handle disturbed and dangerous patients. When the psychiatric staff of the "Acute Section" is convinced that the patient has obtained maximal benefit from the treatment offered on this section he is transferred to one of the Continued Treatment Sections.



WINTER V A HOSPITAL
TOPEKA, KANSAS

Admission

Acute Section

Continued Treatment "B" Section	Continued Treatment "C" Section	Continued Treatment "D" Section

Continued Treatment "B" Section consists of four locked and one open ward. It offers in the main milieu treatment. It is the primary transfer station for patients who have completed a course of Insulin or Electroshock Therapy as well as for chronic and ambulatory schizophrenics, who have not responded or not received Insulin or Electroshock therapy.

Continued Treatment "C" Section, the largest treatment section serves as transfer and receiving station for severely chronically impaired schizophrenic patients and post-lobotomy retraining. This section comprises 12 wards of which one is an open ward. Therapy consists, where it goes beyond custodial care, in the, what has been called elsewhere, participation in hospital industries, such as the Laundry, the Furniture Rebuilding Shop, etc.

Continued Treatment "D" Section comprises 5 open wards and serves as a waystation for those patients who are considered to be greatly improved and/or thought to be capable of deriving benefit from a more individualized treatment and the potentialities of greater freedom of movement. Treatment on this section is primarily given in the form of psychoanalytically oriented individual and group psychotherapy.

One would normally expect that a much greater percentage of patients would be able to leave the Continued Treatment "D" Section

than the Continued Treatment "B" Section, since the latter served as receiving station for those patients who appear to be more severely ill. This expectation is however not borne out by the statistics. In spite of the relatively greater impairment of its patients a larger percentage of patients is returned to the community from the Continued Treatment "B" Section than from any other Neuropsychiatric Section in the hospital.

Yet, in spite of these continuing discharges one observes a progressive accumulation of patients who have remained for long periods in the hospital without apparent change. Such long time residents begin to affect by their presence the treatment program on Continued Treatment "B" and "D" Sections, not to speak about the Continued Treatment "C" Section, where such long term hospitalization is anticipated. Such patients who "know all the ropes" not only make life difficult for the young residents who are reassigned and rotated every six months but also exert a demoralizing influence upon patients who in the process of remission are housed on the same ward with them, and become themselves progressively more dependent upon supervision and care. It was with an eye upon these patients that the present research project was undertaken.

The Dynamics of the Chronic Hospital Patient.

Regardless of the original illness, that brought a patient into the hospital, a prolonged stay in a hospital appears to bring about changes in the patient which show a remarkable similarity and which

have jokingly been called "hospitalitis." Barker, Wright and Gonick have shown some of the underlying dynamics of this process when they write:

> "Every person who has experienced long illness and slow convalescence will have some motivation for clinging to the simple, secure world in which he has been dominant. The problem which faces him is in many respects like that which faces the adolescent. Just as the latter wants adult freedom, the convalescent wants to return to the satisfactions and freedom of the healthy. On the other hand the world of the healthy adult now seems new and strange and the convalescent is filled with the conflicts and resistance which are felt by anyone entering into an important new situation. The pressures to cling to the familiar and safe, though unadventurous life of the invalid are unavoidably strong, just as the pressures upon the adolescent to cling to his childhood role are strong." (3, 243)

Of the many instances of spontaneous expressions of patients in which this aspect has been elaborated, the following discussion between two patients which took place in one of the group therapy meetings is characteristic:

First patient: Coming back on the bus from my pass last Monday I did start to think about..uh..uh. When I was home over the weekend I was thinking about getting out of the hospital and doing a lot of packing and making plans for the...leaving Topeka and thinking about what I was going to do in the future and everything...and the thought was almost frightening and then I stopped and asked myself what am I frightened about and it was this...I believe it's a tendency that if you are in a particular situation or some circumstances you know what you've got, you know what you feel...and to explore anything new is always going to be frightening because of the uncertainty involved. It's too damn easy to stay in the old rut. That's an easy way up to a point and then you become unhappy with the old rut and then you're really in a crossfire...you hate to explore the new and you're tired of the old rut...goddamn, you don't know <u>which</u> way to go.

Second patient: Isn't that sort of what I said a while ago. If I sit down and talk.. I feel that I'm just a big f...bluff, which I am, and if I sit down quietly I get the feeling...what the f...is this, I get the feeling that the others are thinking that sort shouldn't be up here because he is sitting there like a f...monkey. What good can he do for anyone? See it hits me both ways. See...I can't hit no damn medium.

First patient: So...you've got to do something about it.

Second patient: But what can I do about it...right there...?

First patient: Well for one thing instead...Now I'm not picking on you because I've gone through the same thing myself...all was calm you were protected, you had security, problems were thought out for you.

Second patient: That's the way it was.

First patient: And there is no going back. There have been lots of times when lots of us fellows would have liked to go back to the old ways. But there is no going back you can only go ahead. So instead of feeling about the good old days, they are trying to say "you old rep, you've got to explore the new and the quicker you start exploring the new such as talking, going to town, getting a job and going ahead on your own two feet, the quicker you're going to find a new way of life."

It is this problem which appears in a variety of situations, the inability of getting over the difficulty of the first step into the unfamiliar, unknown, which in the opinion of the experimenter constitutes a clue to the growing numbers of chronic hospital patients who are functioning adequately as long as they are assured a permanent stay in the hospital. The research was designed to attempt to cope with this problem.

It is thus decidely not the aim of the research to investigate the effect of various forms of treatment in acute schizophrenic breakdown. The condition with the treatment of which the present

study is concerned is well known to clinicians and appears to warrant the status of a specific syndrome. It is characterized by the following:

1. The patient is not in a state of acute anxiety.

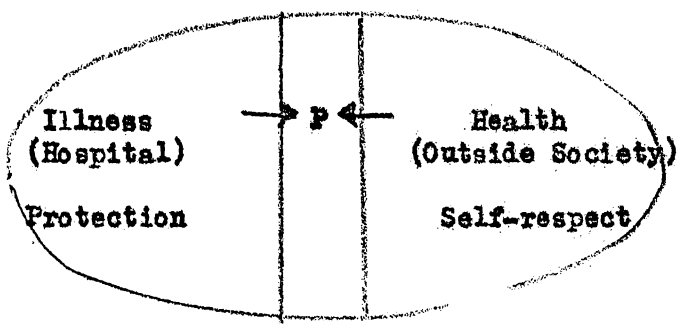
2. Distortion of perceptual processes and loosening of thought processes if present are no longer progressive.

3. The patient has comfortably settled down to the hospital routine.

4. The idea of leaving the hospital is deeply disturbing and conflict-arousing. On one hand, the patient desires to leave, to assert himself, to regain his self-respect, to be independent. On the other hand, he is afraid of further defeat and harm. He feels that it is dangerous to leave the protective environment of the hospital (and as a matter of fact it is harder for the reconvalescent mental patient to regain his place in society than for most other people separated for one reason or other temporarily from the social process.)

5. This conflict is also reflected in his phenomenal view of his illness, he is torn between the feeling that he is really ill and the belief that he is an imposter who is deceiving himself and others by simulating illness.

The dynamics of this conflict may be illustrated by a drawing:



This illustration clarifies the reasons for which such patients demand to leave the hospital the more ardently, the more they are assured that their demand will not be taken up, under these conditions they are sure of protection and the more distant goal becomes more enticing. Vice versa, as soon as they are advised that they may leave the hospital as soon as they feel capable of doing so, they develop all sorts of

illness symptoms and begin to demonstrate to themselves as wellas to the medical personnel in numerous ways that they are not ready yet to leave the hospital.

By no means should the impression be created that these patients are just smart egotists who know how to squeeze the most protection and care out of their environment. Such a view would overlook the very real feeling of inadequacy, of being a "flop" of which these patients are very much aware. It would overlook their real desire to be strong and healthy. In dealing with these patients one cannot avoid the impression that they are "caught" in this conflict between security and protection which the hospital offers them on one hand, and the desire to be well and strong, and independent like other men. They are "caught" and unable to extricate themselves. And therefore they need as much assistance and help as any severely ill person.

The present research was designed to study the success of various methods of therapy in helping such patients to get out of their dilemma.

In back of the investigator's mind was the thought that an understanding of the problem of these patients might well lead to a further understanding of the problem of schizophrenia, since there seems to exist a special affinity between schizophrenia and this condition of "chronic hospitalitis." It cannot be accidental that the overwhelming majority of patients suffering from this condition have at one time or other been diagnosed as schizophrenics. Indeed, it might frequently be difficult to distinguish between "Chronic Schizophrenia" and "Chronic Hospitalitis." But an exploration of this relationship must remain

clearly a task for the future. For the present the goal is to investigate the effect of different treatment procedures upon patients who are caught in the dilemma of leaving or staying in the hospital.

THEORETICAL REFLECTIONS

Numerous techniques are used at present for the psychological treatment of psychiatric disorders. Scientists have attempted to classify these methods in various ways. Knight (49, 100)mentions nine different classificatory systems.

1. With regard to the preponderant attitude taken or influence attempted by the therapist, e.g., suggestion, persuasion, exhortation, intimidation, counselling...
2. With regard to the general aim of the therapy, e.g., supportive, suppressive, expressive, cathartic...
3. With regard to the supposed "depth" of the therapy - superficial psychotherapy and deep psychotherapy.
4. With regard to the duration - brief psychotherapy and prolonged psychotherapy.
5. With regard to its supposed relationship to Freudian Psycho-analysis as for example, orthodox, standard, psychoanalytically oriented psychotherapy, etc.
6. With regard to the ex-Freudian dissident who started a new school of psychotherapy. (Adler, Jung, Rank, Stekel)
7. With regard to whether patients are treated singly or in groups.
8. With regard to whether psychotherapy is "directive" or "non directive."
9. With regard to the adjunctive technique which is coupled with psychotherapy, e.g., narcotherapy, hypnotherapy...

From a somewhat different perspective, it appears meaningful to classify therapeutic techniques according to the "Clinical Philosophies" expressed in their personality theories and conceptions of the role of the therapist.

These "Clinical Philosophies" do not necessarily separate into rigidly defined contrasting systems. They appear to fall rather

along a continuum from almost exclusive emphasis on individual therapy to emphasis upon group centered therapy which primarily aims at affecting the patient's socio-cultural standing. Within this continuum two major poles are discernible:

On one pole one finds personality systems which consider the individual and specifically his biological constitution as the main determinant of his developmental potentialities and consequently also of his maladjustment. Either faulty heredity or personal reaction tendencies become an obstacle to the individual's normal development and may lead to pathology. Treatment then is focussed primarily upon the individual. Henceforth this approach will be designated as the "Individual Centered" Psychological Approach. For convenience it will be abbreviated IC.

On the other pole one finds personality systems which consider the social process of which the individual forms a part - particularly the degree of his participation in cooperative working relationships - as the main determinant of his development and also of his maladjustment. An individual, who has become separated from the cooperative endeavor of his social group will be hemmed in his development or may lack integrated behavior. Treatment consists in re-establishing the connection between the isolated individual and his society. This approach will be designated as the "Social Process Centered" Psychological Approach which will be abbreviated SPC.

Although there are considerable differences between the various IC approaches as well as between the various SPC positions, the present

study will focus upon the differences between the two "poles" and neglect the finer shadings in the transition from one to the other along the continuum.

Orthodox Psychoanalysis represents probably the most consistent prototype of the IC approach. In view of this, and in consideration of the widespread influence which Orthodox Psychoanalysis exerts in American Psychiatry and clinical psychology, it will be presented here as the model of an IC system. Other IC schools have in some respects approached somewhat the SPC position. This also holds true for some of the more recent developments of psychoanalysis e.g., Hartman's Ego-Psychology and Erikson's "Relativity in Human Existence."

There appears to be at present no system of equal completeness and renown in American psychiatric thought which might serve as the model of the SPC approach. There are, however, numerous individuals and groups whose thinking appears to approach such a common theory, the outlines of which become increasingly more distinct. In presenting the SPC approach as a more or less unified system, this paper attempted to integrate findings and viewpoints of investigators who appear to be working in this direction, although they themselves have not explicitly said so.

The "Individual Centered" (IC) Psychological Approach

The Organism and Personality Formation:

Some of the most influential psychological theories regard the formation of personality essentially as the resultant of the interaction

of inherent biological impulses or drives. These may be furthered or thwarted as the case may be by environmental factors, but they are regarded as the fundamental dynamic components of human development. Freud (30) expressed this when he wrote

> The permanent character traits are either interchanging perpetuations of original impulses, sublimations of them or reaction-formations against them.

Fenichel (24, 6) makes this position even clearer by attacking those who think otherwise:

> At first glance, it looks as if the stressing of cultural factors because of their significance for mental development, expressly brought about an emphasis on reality; but actually this viewpoint denies reality by denying man's biological basis...The culturally determined desires are merely variations of a few biological basic needs.

K. Horney (42, 283) summarizes this point of view:

> The implicit theoretical presupposition underlying this train of thought is a belief in the existence of biologically determined human nature...

It is noteworthy that among the adherents of psychoanalysis there have been repeated attempts to enlarge the psychoanalytic conception regarding biological and "intrapsychic" determinants of individual development. These efforts were directed frequently towards conceding greater importance to socio-cultural factors and thus one might well say that they led in the direction of a SPC theory.

In spite of these repeated attempts at revision and enlargement of the psychoanalytic framework, which seem to indicate an awareness of a deficiency in this area, few if any of these psychoanalysts appear to have gone beyond a token recognition of socio-cultural

influences. All such revisionist movements start out by criticizing Freud for overlooking the importance of social factors, and yet they all seem to end up by placing exclusive emphasis upon the subjective element in people's inner conflicts. Beaglehold (6, 76), speaking for the Washington School of Psychiatry which puts such emphasis upon the impact of interpersonal relations, writes:

> To give up the concept of human nature, as referring to a continuous and primary set of biological and psychological needs inherent in the structure of man, the human animal, is to give social psychology over to the changing winds of a cultural relativism, to be blown here and there, anchorless and ultimately boatless as well.

Not only open dissenters, but also faithful disciples of Sigmund Freud have attempted to do justice to socio-cultural factors in personality theory. One of the latest undertakings of this sort is found in the writings of Erik H. Erikson (22, 32). Speaking of personality development he says:

> We are speaking of three processes, the somatic process, the ego process and the societal process...These three processes have belonged to three different scientific disciplines - biology, psychology and the social sciences - each of which studied what it could isolate, count, and dissect: single organisms, individual minds, and social aggregates...Out thinking is dominated by this trichotomy...Unfortunately, however this knowledge is tied to the conditions under which it was secured: the mind surrendered to experiment or interrogation, the organism undergoing dissection or examination, social aggregates spread out on statistical tables. In all these cases then a scientific discipline prejudiced the matter under observation by actively dissolving its total living situation in order to be able to make an isolated section of it amenable to a set of instruments or concepts.

The author then advances a relativistic interactionism by stating:

> The meaning of an item which may be "located" in one of the three processes is co-determined by its meaning in

> the other two. An item in one process gains relevance by giving significance to and receiving significance from items in the others.. I hope we may find better words for this relativity in human existence.

It is remarkable that orthodox Psychoanalysis can be stretched to include this point of view. However, it appears that the author in spite of his almost SPC-like formulation, remains thoroughly IC. Thus, Erikson emphasizes the "fears based on the structure and growth of the organism because they are the most pervasive and the least conscious themes of fear." One will look in vain for the author's recognition of social processes in his account of those fears. He writes (22, 367)

> This fear of being left empty and more simply that of being left seems to be the most basic feminine fear, extending over the whole of a woman's existence..."

And Erikson deduces from it that

> Lest their men discard and abandon them in the periodical pursuits of competition, conquest and war, women are apt not to question these pursuits... They pretend that they really believe in war...where actually they have merely learned to accept as inevitable a martial excitement which is essentially outside their comprehension.

To the woman's biologically given fear of "being left empty" corresponds according to Erikson the man's fear of castration (22, 365):

> In the center of the boy's locomotor phallic fears lurks that of castration...the anxiety of being immobilized and imprisoned...here is the infantile origin of (the man's) need for an enemy so that he may arm himself against and fight a concrete adversary and thus be freed of the constant anxiety of unknown enemies.

It would be hard indeed to discover consistency of the author's avowed psychosocial thinking in his statement that "women pretend that they really believe in war" although this "is essentially outside

their comprehension" and men "need an enemy." A study of Erikson's work makes it evident that this latest in the series of attempts to integrate psychoanalysis and a wholistic psychosocial approach has ended like earlier efforts in a sophisticated subjectivism.

The fact that so many theoreticians in the field of psychopathology have attempted to go beyond the Freudian position of biological determination of individual development and have been unsuccessful in their efforts, seems to indicate the existence of conditions which need further investigation. A later chapter will offer some suggestions regarding this problem area. At present it is necessary to round out the representation of the IC approach.

Individual and Society.

A theory of personality will have to deal with the question of the individual's relation to society. Emphasis upon intra-personal determinants of human development, the IC approach, tends to coincide with a depreciation of the role of society and culture. This is most clearly expressed by Freud (32, 60) and his followers:

> Liberty has undergone restrictions through the evolution of civilization.

Individual and society appear to be in opposition. Freud states his position unambiguously when he says (32, 136):

> The two processes of individual and of cultural development oppose each other and dispute the ground against each other.

He states further (32, 61):

> Man will always defend his claim to individual freedom against the will of the multitude.

Geza Roheim (75, 236), expressing the same point of view, says:

> In general, we have no cause to deny the hostility of analysis to culture. Culture involves neurosis which wetry to cure. Culture involves superego which we seek to weaken. Culture involves the retention of the infantile situation from which we endeavor to free out patients.

Freud (31, 134) reduces altruism (Gemeingeist) and esprit de corps to "its origin envy." He discovers the same core in the anecdote of the judgment of King Solomon: "When the child of one woman has died the other one is not supposed to have one either." Scheerer (79) points out that in his deduction Freud completely neglects to deal with the positive aspect, the willingness of the real mother to sacrifice the child so that it might live.

IC theoreticians tend to stress the negative, the pathogenic aspects of socio-cultural processes upon the individual or to dissolve the totality of socio-cultural influences into interpersonal relations of a very direct character. Thus, Beaglehole states (6, 60)

> A society may be validly conceived as a collection of two groups and three groups, real or illusory or a blend, and of larger, less durable integrations of two groups and three groups, having members in common.

By thus reducing the whole into its parts the theoretician is freed of the necessity to comment upon the influence of society and culture upon the individual.

Consciousness

IC clinical systems have been relatively little concerned with the investigation of those processes by means of which the individual becomes conscious of the nature of his surroundings and the effect of his activity. Heidbreder (40, 19) seems to have in mind this state of affairs when she writes:

> It has been customary in psychology for the last two, three decades to emphasize the non-cognitive determinants of behavior and indeed the non-cognitive determinants of the cognitive processes themselves...It is curious that the term dynamic psychology is often used today to denote a field with which the psychology of cognition is contrasted.

Orthodox Freudians have been concerned mainly with investigations of the manifestations of the "Unconscious." They were intent upon getting an understanding of the irrational forces which appeared to interfere with the rational behavior of their patients. In their enthusiasm over the newly found explanation which seemed to fit so well, they did not show great concern with an inquiry into the process of rational behavior. Fenichel (24, 17) says:

> The portion of the conscious that is best known is the "repressed" that which is unconscious because strong, dynamic forces hinder the becoming conscious.

The obvious insufficiency of a psychological system which relegates conscious processes to a role hardly worth investigating has lately become apparent to orthodox Freudians. The last fifteen years have seen as a consequent of this awareness of inadquacy the growth of a new psychoanalytic tendency which has been called by its authors (Hartmann, Nunberg, etc.) "Ego-Psychology." "Ego Psychology" aims to make room within the psychoanalytic framework for more adequate presentation and investigation of the role of conscious (conflictfree) processes. Heinz Hartmann (36, 71) originator and one of the foremost representatives of this trend remarks:

> Learning to think and learning in general is an autonomous biological function which exists next to and partly independent of the problem area impulse and defense. Orderly thinking is immediately or mediately turned towards reality...Presenting such a phenomenon as a defense mechanism does not completely define it; it also has to be characterized according to the rules by which it contacts outside reality and furthers adjustment to it...

In spite of the new stimulus for investigation of conscious processes which "Ego-Psychology" represents, there has to date been relatively little systematic investigation in this area on the part of psychoanalysis, with the possible exception of D. Rapaport and his co-workers.

Although not as outspoken as the earlier psychoanalysts in rejecting the investigation of the consciousness, other theoreticians have nevertheless shown little inclination to study the processes by which the individual gains a knowledge of the surrounding world. There has been far more concern in clinical circles with the investigations of distortions and projections. Rogers (74, 496) as well as the theoreticians of the William Alanson White Psychiatric Foundation have been greatly concerned with the exploration of the phenomenal field of the patient.

> It is possible to achieve to some extent the other person's frame of reference because many of the perceptual objects have counterparts in our own perceptual field and practically all the attitudes toward these perceptual objects...have been present in our own world of experience.

This convergence of one's own perception with other or consensual validation is not further explored with a view to finding the bases of the far reaching agreement; it is simply taken as a given fact which is important only because it permits the therapist to infer a portion of the patient's perceptual and experiential field. Indeed, Rogers (74, 485) postulates:

> It seems unnecessary to posit or try to explain any concept of "true" reality. For purposes of understanding psychological phenomena reality is for the individual his perceptions...We do not need to solve the question as to what really constitutes reality.

It is unusual that psychological investigation, specifically in this field, has been principally concerned with the study of distortions in

perception and cognition, with what might be called divergence between reality and psychic representation, while there still exists only scanty information about the normal process of convergence between psychic phenomena and reality.

Looking at the various systems of the IC approach, one is impressed by the numerous attempts to broaden this framework, to include fundamental aspects of the SPC position. It is certainly remarkable that many of these attempts at revision have stumbled over their inability to deal with the problem of mind - body, individual - society. IC theoreticians today are convinced that one cannot separate mind and body, individual and society, and yet their basic approach appears to make it impossible for them to overcome the dualism of their thinking. Erikson (22, 19) has recognized this dilemma. He writes:

> In recent years we have come to the conclusion that a neurosis is psycho and somatic, psycho and social and interpersonal. More often than not, however, discussion will reveal that these new definitions too are only different ways of combining such separate concepts as psyche and soma, individual and group. We now say "and" instead of "either-or", but we retain at least the semantic assumption that the mind is a "thing" separate from the body and a society a "thing" outside of the individual.

This dualism is regarded by SPC scientists as a reflection of the mechanistic thinking of the psychoanalysts which conceives of change merely in terms of re-distribution of energy caused by the conflict between antagonistic forces (e.g. ego:id, Ego:Superego, Thanatos: Eros, etc.) This thinking is unable to comprehend that something new can arise out of the fusion of interrelated conflicting aspects. More generally, it is unable to grasp the fact that a whole can be difference from the sum of its parts and that the whole determines the character of the parts.

Problems of Therapeutic Practice

The IC psychological systems view psychopathology as an outgrowth of a faulty constitutional foundation, a consequence of severe environmental obstruction which has prevented normal maturation of the biological capacities, or has a combination of both these conditions. Under stress, which is too great to permit the patient's biological capacities to cope with it in a healthier way, the individual resorts to a more rigid, stereotyped, and successively less adequate way of behavior. This process becomes increasingly more maladjustive and is accompanied by compensating distortions of the patient's perceptual and cognitive field which make a return to normal behavior more difficult. Under these conditions, it becomes the task of the therapist to help the mental patient in achieving a healthier, i.e., more appropriate and successful behavior.

In order to do this, the IC psychotherapist deals primarily with the psychic life, the phenomenal field of the patient. He may attempt to help the patient to get a fuller, less distorted view of his situation. He may show him by various means how the patient's situation appears to others, e.g., to the therapist, the group, etc., how it is in "reality." He may help the patient see choices of which the patient himself has been unaware. The therapist may have to resort to long-term or to short-term treatment. A meaningful distinction (49, 107) is also made between those techniques

> which aim primarily at support of the patient with suppression of his symptoms and his erupting psychological material and those which aim primarily at expression.

Regardless of the specific clinical theory to which the therapist adheres treatment is focussed upon the individual. It is then only consistent when psychiatrists admonish their patients not to be concerned with other patients, to behave in accordance with the instructions of the therapist and to have confidence that he, as well as the others, will be taken care of.

In adjunctive therapy equally, the patient is the focus of the attention of the adjunctive therapist. He develops his skill, and makes some object which will be a "source of narcissistic gratification."*

Group Therapy

The IC clinician may treat the patient either in individual consultations in the doctor's office or in group therapy meetings. The fundamental goal remains the same in either case. The aims of the group therapist, as Dr. Ackerman (1, 357) summarized them, are hardly different from those of the therapist who works with the individual patient:

1. To provide a continuous flow of emotional support through the group relationship.
2. To activate emotional release in the area of specific anxiety ridden conflicts.
3. To reduce guilt and anxiety.
4. To provide opportunity for the testing of various forms of social reality as personified by individual members of the group, the therapist, the group as a whole.
5. To provide opportunity for the modification of the concept of self in the direction of increased self-esteem, and recognition of constructive capacities which in turn tends to increase the acceptance of other persons and tolerance for frustrating experiences.
6. To foster development of insight arising from actual living out of emotional drives in the context of multiple interpersonal relationships within the group.

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*In order to be permitted to work in an adjunctive therapy shop the patient needs his doctor's orders to the adjunctive therapist. These say frequently as prescription: "Provide source of narcissistic gratification."

Due to a number of factors, such as the small, insufficient number of trained therapists, the expense of individual treatment, etc., more and more agencies and institutions have begun to enlarge the therapeutic relationship from the individual patient-doctor relation to that of the group setting. In its concentration upon the problems of the individual patient this group therapy nevertheless remains within the limits of the IC framework. The patient is still seen as a primarily self-contained individual who has all his potentialities within himself. It is an interesting fact that many of the advances of group therapy were an outgrowth of economic considerations, the scarcity of doctors, lack of availability of individual treatment, and only secondarily encompassed the notion that the group setting might be a therapeutic factor.

In practice, it was found that the airing of individual problems in a group setting might help the individual to gain a different perspective and to see his problem in a new light. He might thus find a way to overcome his inflexible mode of coping with frustrations which had become a major obstacle in his development. Beyond such direct help "talking things over" in the group may demonstrate to other group members that they are not alone with their difficulties and fears and may thereby counteract the widespread feeling of personal inadequacy, create a greater degree of self-confidence which can become the basis for more successful efforts.

Occasional criticism has been leveled by group therapists against the Psychoanalytic Technique. This criticism appears at first glance to place its author into the SFC camp. Thus Meiers (62, 264) writes:

> Group psychotherapy treats individuals in groups and can be contrasted with the concept of individual psychotherapy in which the person is treated as an individual only... centered upon the individual alone...

Moreno (69, 46) repeatedly stresses

> that no person is an island apart from the mainland of social relations.

One finds here an attempt to enlarge psychotherapy in the direction of a SPC approach; however, as previously when this tendency appeared in personality theory, so also here in its practical application does one find that in general (with the possible exception of the psychodrama) these therapists are unable to deal with the pathogenic social relations and restrict themselves, as do the psychoanalysts, to treating the individual.

Efficiency

It is generally believed that IC treatment is able to help more patients to recover than would in all probability recover spontaneously. The question arises: By what means is the therapy accomplished? Is it the IC technique or is it possibly another factor? Denker (16), in one of the few studies dealing with this question found that general practitioners were superior in the treatment of neurotic maladjustment to psychiatrists, and that the latter were superior in turn to psychoanalysts.

Paul Schilder (81) writes:

> The statistics so far available show that the method (psychoanalysis) is not always successful. We have the

> statistics of the Berlin Psychoanalytic Institute and the reports of Hyman and Kessel. It is astonishing that the statistics of state hospitals show almost the same percentage of cures and improvements as Hinsie pointed out in a paper read at the N. Y. Psychotherapeutic Society. In the same paper he pointed out the social inefficiency of the method, since only a very limited number of patients have so far been treated and the number of analysts is very small.

To this account Schilder adds:

> I am inclined to believe...that the cure of the patient by psychoanalysis is not the same as the so called cure by a state hospital. The psychoanalyst comes much nearer to the ideal cure.

One does not have to be concerned with the defensiveness which attempts to weaken findings which do not seem to be in accord with one's frame of reference by reiteration of confessions of faith or by attacks against the "biased" or "resistant" investigator. It seems warranted, however, in the light of the above investigations and in view of the almost complete absence of statistical data from even the most famous institutions for the treatment of nervous disorders, to raise the issue of hidden variables in the treatment of mental illness. It is well known that Freud himself expressed his conviction that psychoanalysis had not more to offer for the cure of neurotic illness than the "Virgin of Lourdes."

I. D. London (55, 234) expresses this opinion:

> True both psychoanalysis and Christian Science can argue their usefulness and pragnatically may be defensible. Their cures, however, and their insights are testimony not to their respective theories, but to us through whom these theories act. We are the essential constituents and mediators of these theories because their symbols operate not through themselves but through us, for we are the indispensable supplementers of their inadequacies. In brief, it is we who are the intervening variables.

Any evaluation of the therapeutic efficiency has to take these pertinent considerations into account. It is well known that not only modern treatment has been successful. Licht (53, 6), speaking of the eighteenth century reports:

> The superintendents of the insane had become frantic in cruelty..some..wished for machinery by which a patient just arriving at an asylum and after being drawn with a frightful clangour over a metal bridge across a moat, could be suddenly raised to the top of a tower, and as suddenly lowered into a dark and subterranean cavern; and they avowed that if the patient could be made to alight among snakes and serpents it would be better still... Among many cruel devices, an unsuspecting patient was sometimes induced to walk across a treacherous floor; it gave way, and the patient fell into a bath of surprise, and was there half drowned and half freightened to death.

And institutions like Bedlam (St. Mary of Bethlehem)(53, 5) insisted that "sum ben restoryde unto hyr witte and helthe a-gayne."

An investigation of therapeutic efficiency of a psychotherapeutic system has to be aware of the possibility that it is not so much what the therapist does as what he is, that may be a curative factor. Also the fact, that the patient finds a sharply defined relationship to the therapist, a relationship in which he knows "where he is at."

In IC centered therapy the patient may find in the therapist a person who will permit him to establish a meaningful and trusting relationship to him; he finds a patient and understanding listener, somebody who takes him seriously, a "friend"who will not betray him. There is further the possibility that the regularity of the therapy hour may be a meaningful organizing factor or the fact that the talk with the therapist is the only highpoint in an otherwise drab and unexciting existence. Each one of these factors may actually be more

therapeutic than the therapeutic technique proper. Pierre Janet (51, 161) expressed this same idea:

> The psychotherapeutist who understands the patient well and who knows how to use psychological stimulation succeeds with any method that he cares to use.

These reflections are pertinent because in any comparison of therapeutic systems numerous IC theoreticians tend to fall back upon the fact that their particular method achieves cures and thus has been "proved" correct. It is clear on the basis of the foregoing that such an argument is not valid, even where it has been proven that a specific system is able to produce a higher percentage of cures than other methods (which has not been done so far.) It would still be necessary to show that it was the systemic variable rather than other hidden factors which made the difference. As it is, the IC clinical techniques have to rest upon the consistency and adequacy of their theoretical frameworks and cannot adduce therapeutic efficiency as a realistic argument in their favor.

Degree of Direction in Therapy.

IC therapists frequently advocate that, within a well defined framework of limits, the therapist should remain aloof, avoid taking sides, and be not overtly directive.

Healy, Bronner and Bowers (38, 434) say:

> Freud says the analyst should play the mentor as little as possible. It is desirable that the patient should make independent decisions. Only in the case of very young or very helpless persons the function of the physician and educator may be combined...Analysts are not reformers.

Foulkes (27, 25) writes:

> The psychoanalyst must remain undefined as a person, in order to enable the patient to project upon him as on a screen, the unconscious images of his inner-most self, to relive with him the vicissitudes of his long forgotten emotional relationships with his paternal figures and other persons of his past life.

It is well known that the Rogerian school, although for different reasons, adheres to this non-directive permissiveness. Dr. Meiers, in his historical survey of Group Psychotherapy, comes to the conclusion that the non-directive group therapy "comes to the foreground and gains momentum." In the group setting, the IC therapist has the job to accept and interpret what is going on in the group and what the individuals are trying to express. He helps the group members to understand the feelings and needs which lie behind the expressed contents. A group of this type does not need a rigid framework and strict regulations. It is a loose formation. Group members may be working in different places and even live in different localities. They have no common goal beyond that of finding relief from their individual difficulties. In the hospital setting it is therefore perfectly reasonable that such groups be scheduled for their therapy hour as the individual is scheduled for his hour with the doctor, and that the individual members of the group be left free to do whatever they choose during the rest of their time.

In summary, one might say that the main focus of attention of the patient as well as of the therapists, is directed towards the alleviation of the individual's problems. The inner life and

personal difficulties of the patients constitute the primary focus of group discussions as well as of individual consultations. Discussions about other subjects are regarded as manifestations of veiled needs and desires and are at appropriate moments interpreted.

The "Social Process Centered" (SPC) Psychological Approach*

> Human nature is something social through and through, and always presupposes the truly social individual. Indeed any psychological or philosophical treatment of human nature involves the assumption that the human individual belongs to an organized social community, and derives his human nature from his social interactions and relations with that community as a whole and with the other individual members of it. George H. Mead. (60, 229)

The Organism and Personality Formation.

SPC Psychology rejects the onesided belief in the exclusive biological interpretation of human personality but at the same time opposes with equal vigor the denial of the importance of biological factors. To speak of an individual human being as if he were a self-contained genetic entity appears from this point of view as indulgence in fiction. To regard the single personality as the primary unit of society or of the family seems to be in this perspective an unrealistic abstraction. No human organism can become "human" or maintain himself as such for any length of time without contacts with and roots in a social community. The physiological

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*The term "Social Process Centered (SPC) Psychological Approach" has been employed in the present paper in an attempt to express the essential common characteristics of the position developed in these pages; as far as the writer knows it has not been used elsewhere.

organism "homo sapiens" left to his individual resources in social isolation is condemned to a level of adjustment and functioning which is less "human" than the behavior of some domesticated animals. (84)

The SPC approach, next to stressing the social interdependence of the individual, recognizes the fact that physiological structure and function of the organism are necessary conditions for the development of social processes. Thus, it has been found that in the absence of the normal biological avenues of communication, e.g. in physically handicapped or subnormal children, social-psychological adequacy can be attained only when adequate measures of training and retraining are provided by the human environment. Thus Mead (60, 234) says:

> In fact we find that in the case of the deaf and dumb, if no care is given to the development of language, the child does not develop normal human intelligence, but remains on the level of lower animals.

Novikoff (71, 81) expresses the same idea in more general terms when he writes:

> Thought, speech, labor are impossible without a highly developed brain and a hand. It is his unique biological constitution which makes possible the development of truly social relations among men...Animal societies never rise above the biological level...only man's society is truly sociological.

However, to recognize the importance of biological - and for that matter physical and chemical factors - is not equivalent to saying that the human character of the personality is based solely upon biological components, or that it can be analyzed into a basic contribution of biological factors plus their modification by

socio-cultural events. SPC psychology holds that the man's individuality is an irreducible whole which, as everything else, is not a static unity but is itself in a process of continual change. Thus Novikoff continues:

> Man's behavior differs from that of other animals because of his possession of body structures, notably the highly developed nervous system, which make thought and speech possible and whose functioning is profoundly affected by social or cultural influences. Man possesses a unique head and hand, and he is able to confront nature not only with his body but with tools devised and wielded by him. The crude tools of primitives give way to the more complex technology characteristic of modern society. As the technological forces change the social and economic relations of men change, and with them man's behavior. Socio-economic or cultural forces thus come to dominate biological factors in directing man's actions. Man's social relationships represent a new level, higher than that of his biological make-up.

He quotes Bartlett's conclusion that:

> The biological organism, by its existence in society has become a "new biological species"...New laws of motion have come into being which are neither biological nor sociological, but the subject of study of a different science, psychology.

The specific human character of a person arises only in the process of social activity which aims to understand, change and control nature, including human nature itself in order to achieve increasing independence from the "blind elements." In this social endeavor communication becomes pertinent; with its development a new level of give and take relationship between people, of deepening affective experience and conceptual thinking arises. Wortis (93, 6) writes:

> It is in the final analysis, social structure that determines human behavior together with the ideals and ideologies which motivate behavior. Without some form of social organization, personality as we know it would have no meaning or existence. Patterns of behavior, language, ideas and personalities all owe their

> being to the social context in which they arise and cannot claim an independent existence. Man has no fixed instincts of social behavior. Not even the pattern of normal sexual activity can be regarded as instinctive and innate.

Mead (60, 235) says similarly:

> It is only in human society - only within the peculiar complex context of social relations and interactions which the human central nervous system makes physiologically possible - that minds arise.

And Vigotsky (91, 1077) says:

> All higher psychologic functions, including speech and conceptual thinking are of social origin. They arise as a means of rendering mutual aid, and gradually they become a part of the person's every day behavior.

It is clear that these scientists regard social endeavor not only as the achievement of material goals, but also as having far-reaching implications and involving changes on the social, the physiological and the psychological level. The psychological processes involved appear to have defied so far any atomistic analysis. People participating in a common task or concerted action experience with their total being - emotionally, conceptually and conatively - that they are part of a larger group in which they have a specific function or responsibility, an importance, and a direction. They gain from this participation self-confidence and the freedom to venture into creative expression:

> When participating (writes Allport (2, 130)) the individual discovers that his occupational manipulations grow meaningful. His community contacts are understood and appreciated. He becomes interested in shaping many of the events that control his life.

SPC psychology considers personality as a new emergent, a higher level organism. Schneirla (83, 273) says:

> In man, culture and intellectual heritage as selective agencies have so thoroughgoing an influence that even sustenance and security adjustments may become rather completely controlled and modified by factors of prestige, dominance, social approval and the like.

It would lead too far, were one to go into a detailed discussion of how corresponding newly emerging forms of perception, learning, emotionality and cognition would have to be postulated from this point of view. Schneirla has attempted to outline some of these concepts. He differentiates, for example, between the levels of conditioned response learning observed in the small child and higher order animal and the selective learning and anticipation of the socialized individual. He shows similar progress in the area of adaptation, which in the lower animal "is more and more directly conditioned by organic factors," but in the human child is developed by means "of much gradually accomplished learning through experience" into the capacity to act persistently and appropriately with reference to anticipated results." Be it remarked, parenthetically, that learning, as well as perception and cognition, are never regarded as purely psychological reactions but are seen as an outcome of the action and total involvement of the organism.

Individual and Society

A theory of personality defines explicitly or implicitly the relations of the individual to his society. The IC approach offers a conception in which individual and society are somewhat

antagonistically opposed, and in which society itself is largely negatively defined as an institution restricting the freedom of man's impulses. The SPC approach views the social organization of man as a continuously developing and changing process of interaction by means of which humanity has made great strides toward the conquest of nature and the achievement of freedom.

SPC psychologists may be aware as much as their IC colleagues of the detrimental influence of social conflicts and dislocations. They do not, however, generalize from specific conditions to all social processes. Cooperative work, they hold, has made it possible for man to develop the means by which he is able to be free and independent of the dangers of life which resulted from natural catastrophes, adverse climatic conditions, wild animals, diseases, etc. The immense pathogenic contradictions of our present-day society are not denied, but they are not generalized into a universality which makes them appear almost as natural laws; instead they are seen as a temporal stage in a dynamic development. SPC psychologists, far from viewing the social process as an external limitation of individual freedom, recognize the advance, the tremendous increase in freedom which has resulted for individual and group from socio-cultural interaction. One outgrowth of this process is the development of language. Mead (60, 69) says:

> Words are the essential elements in elaborate social processes and carry with them the value of those processes.

Vigotsky has shown in his ingenious investigations (92) the close relationship which exists between speech and thought, and the

contribution of language to the development of concept formation and consciousness.

Not only language and the ability to think abstractly are developed in the course of social interaction, a new quality of emotionality, a humanized emotionality arises which is as qualitatively different from the animal emotional response as human language differs from the language of the parrot or the chatter of the monkeys. Schmeirla (82, 19) discusses this aspect:

> Because of the similarities in the external and internal aspects of emotional response in man and lower animals analogies from human consciousness are tempting, such as inferring an experience of pleasantness when the emotional reaction involves approach or acceptance of an object...There is little to be gained in discussing whether...ants licking their queen and a human mother patting her infant experience "love" in the same sense.

In contrast to the reasoning by analogy, SPG psychology recognizes various qualitatively different levels of emotional response even among higher animals (82, 19):

> Simplest of all is the direct conditioned emotional reaction as when a punished dog pulls back, trembling and whining at first sight of a whip. It is characteristic of the lower mammals and the very young child alike that dealing with objects tends to be dominated by such emotional reactions that the perception of the given object cannot be divorced from its emotional elements.

The author then describes the development of a higher, qualitatively new, emergent level of emotional reaction:

> In man rather fully and in the chimpanzee to a far lesser extent the process of socialization and special training leads to a greater freedom from direct impulsive emotional reactions.

It has been mentioned previously that in the process of social interaction man similarly achieves new levels of perception, purposive striving and thinking. As a result of this development, man achieves a new level of capacity for "variable and plastic adjustments."

Various investigators (83, 269) have explored aspects of this human level of flexible adjustment, e.g., Goldstein and Scheerer in their study of abstract and concrete thinking and performance, the Lewinian investigations of regression and de-differentiation to name but a few representative works. Summarizing Mead's view C. W. Morris (60, XXVI) states:

> Through a social process then, the biological individual of proper organic stuff gets a mind and a self. Through society the impulsive animal becomes a rational animal, a man. By virtue of the internalization or importation of the social process of communication, the individual gains the mechanism of reflective thought (the ability to direct his action in terms of the foreseen consequences of alternative courses of action...) becomes a moral individual with impulsive ends transformed into the conscious pursuit of ends in view.

Consciousness.

It is an interesting fact that IC systems in general regard the spiritual and mental life of the individual as well as that of society as the principal determining factors of development, and that they single out the unconscious or irrational forces as the dominant component of mental life. SPC psychologists in contrast to this point of view tend to look upon mental life as the outgrowth of a high level of biological development. Mind regarded as a potentially powerful agent of development is itself the product of an advanced stage of this genetic process. Once emerged, mind - according to this view -

goes through various phases of development. (Ontogenetic as well as phylogenetic) Consciousness, viewed as the highest level of mental development, arises only in a context of advanced social life; it constitutes the most dynamic and potentially most powerful mental state. Mead (60, 18) emphasizes the dependency of the genesis of consciousness upon the social process. He writes:

> Consciousness is an emergent...far from being a precondition of the social act, the social act is a precondition of it... the social act in its more elementary stages or forms is possible without, or apart from some form of consciousness.

In the course of participating in social activity the biological organism "homo sapiens" is transformed into a new, a human individual, his intrapsychic processes change in character and in their interrelationship. The emergence of the new qualities of feeling, purposeful striving, reflective thought and, one might add, self awareness from the rough material of autonomic reaction, instinctual adaptation and conditioned response learning in a context of social participation has been mentioned previously. As these changes take place the total mental context - according to this view - changes, i.e. the relationships among these functional qualities themselves are altered. At the lowest level of social participation and experience one finds a knowledge which is strongly pervaded by the impact of the external impression of objects. Immediate sensation and emotional reaction appear in the foreground of perception, cognition and reaction. Purposive behavior is still dominated by immediate needs and stimuli. (This stage corresponds roughly to the lower Concrete Level described by Scheerer and Goldstein.)

At a higher stage, that is one in which social practice has progressed beyond a certain level, functional aspects of objects are understood, common characteristics are recognized, emotional reaction is delayed and logical reasoning, deduction and judgment begin to develop and to overshadow in overt behavior the influence of autonomous factors. Social influences in interaction with biological needs begin to develop strivings for specific human goals.

At the highest stage, a new smoothly functioning unity has emerged. Reason and inference based upon a recognition of the laws of development have come to the fore as the predominant aspects of the psychological context, which in this emergent form is called consciousness. In emergent consciousness emotion still plays an important, a necessary, but no longer a dominant role, it has, to use gestaltist terminology, changed from figure into ground, while reason now stands out as the figure in the context of human consciousness. Vigotsky (91, 1064) found:

> that the most important development of thought in adolescence is the change from "complex" associative types of thinking to conceptual types of thinking - a change which not only revolutionizes the intellectual processes but determines the dynamic structure of the personality, i.e., the consciousness of the self and of the environment.

The SPC approach holds that development of these stages of psychic life takes place only as a result of active social participation and experience; it does not "mature" automatically or in the contemplating asocial organism. It represents a valuable achievement which is liable to break down under stress, such as may be produced by weakening of the organism, disease processes, or social contradictions. Here the

investigations of the Lewinians particularly those of T. Dembo and those of Barker, Dembo and Wright provide insight into the ways in which this breakdown may occur. Goldstein, Scheerer, Vigotsky and others examined the corresponding stages of regression or readjustment on a lower level which occurred as a result of organic disturbances.

SPC psychology regards reason, rational thought, as the predominant aspect of psychic life in the adult personality. Not the abstract rationalism of the area of enlightment, but a reason imbedded in the emotional and purposive consiousness of the present day adult who is in close touch with the social life of his community.

This consciousness is only distantly related to the introspective, essentially passive consciousness which constituted the focus of psychological investigations in the last century. It is not merely the awareness of relatively meaningless sensory aspects but concerns the symbolic representation and reflection of external reality as it develops in the course of social activity, and is in turn reflected in the increasing impact of rational thought upon society and the growing scope of human freedom.

The SPC View of Change and Development.

Examples for the mechanistic approach of Psychoanalysis to individual and social phenomena have been given previously. SPC psychologists such as Sherif and Cantril (85, 488) point out that:

> Social change can best be seen as a series of successive stages with each new stage derived from or heaved up by what have proved to be the limitations or contradictions of an earlier stage. Because of this failure to recognize that emergence can and does take place on the psychological and social level as well as on the physical and biological level, analysts have been forced

to create their various abstractions and to account for individual and social behavior with circuitous derivations.

The developmental conception of SPC thought might be characterized for those acquainted with Gestalt Psychology as a special type of wholistic approach. It tries to explore temporal or historical, as well as contemperaneous, organic as well as inorganic "Gestalten." It has become known under the name "Concept of Integrative Levels." It may be defined by the following principles (87 and 71):

1. Nature and Society are in a continuous process of development.

2. In the process of this development new forms and levels of organization emerge. "Quantitative changes may suddenly give rise to remarkable qualitative changes or emergents."

3. What were wholes on one level become parts on a higher level.

4. Each level of organization possesses unique properties of structure and behavior...The laws describing the unique properties of each level are qualitatively distinct.

To illustrate this concept one might mention for instance the development of the organism through the mammalian series. Throughout the mammalian phylogenetic development there is a continuous increase of the organism's capacity to adapt to new situations, which is largely dependent upon the development of the brain and of the hand. In man, this development has reached a degree of perfection, which makes possible the emergence of a social organization.

With his organization in a society the adaptability of the human organism has reached a new level, at which the organism in increasing

measure begins to change nature in accordance with his needs instead of passively adapting to the changes of nature. On the mammalian level the organism is to a greater extent a self-sufficient unit, a whole. On the higher level, i.e., the human level, the organism has become a part of society. While an understanding of the laws of behavior at the mammalian level is possible in terms of the organism, at the human level a complete understanding of the laws of behavior of the individual organism can only be obtained by a knowledge of the new laws which describe the unique properties of the social level of which the individual is a part.

Problems of Therapeutic Practice

The SPC approach regards psychological disturbance and mental disease as a consequence of a pathogenic malfunctioning in the organism - society interaction. Heinrich Schulte (84, 369) has investigated certain aspects of this interaction. He postulates that people living and working together must experience themselves as a community a "we."

> It is known that very few human beings can continue a healthy existence without some kind of "we" association.

Ashley Montagu (64, 277) says:

> The "individual" is a myth. A creature apart from a social group is nothing but an organic being. The member of a social group is a person, a personality developed under the molding influence of social interstimulation.

Schulte has studied the mental processes of people who were separated from their social group. Speaking of a prisoner of war who

found himself in a POW camp in which nobody was able to understand him and in which he was unable to understand anybody else. Schulte (84, 366) writes:

> In a few days he began to have delusions of persecution. He believed that he was being pursued by his ward companions and that his life was threatened. These psychotic phenomena disappeared, however, as soon as an interpreter was found who could re-establish language communication with him.

Not frequently is one able to trace back psychopathology to such a specific obstacle to social interaction. Many of the barriers which prevent the individual from participating actively in the striving of his group are not as obvious. They may be hidden in the intricate complexities of organism environment interaction.

It is the task of SPC psychotherapy to help in re-establishing the individual's contact and interaction with his social community. This task can be achieved only in conjunction with medical correction of primary pathogenic or secondary pathological disturbances of organismic functioning. SPC psychotherapy regards this process as an intensive effort to bring about social living, social working, social interest and the development of consciousness which can only arise in this context. To do this, SPC psychotherapy must find the means to engage the patient in a meaningful task at which he is capable of working as a member of a group.

Patients who are in good contact with reality will usually be seen first by the therapist in individual interviews in which personal contact is established and the patient's interest in the group activity is stimulated. In patients with more severe disorders

verbal communication may be less effective and the patient may have to be introduced to prescribed work in a group setting without more than a hazy preparation and motivation.

One might condense the SPC approach to therapy in the form of three basic principles:

1. Group activity must be in line with the patient's physical capacity. For this purpose the specific physical condition of each patient must be determined. The physically exhausted needs another regime than the person with apparently unlimited energy.

2. Activity prescribed must be meaningful or potentially meaningful, i.e., it must make a contribution which affects other people beneficially and gives the patient a feeling of his worth and human dignity by enabling him to discover that through his activity he is contributing to something which other people need, wants or consider worthwhile. His status as a contributing member of the group should contribute also to increase his own feeling of worth. The prescribed activity must also offer an opportunity for the application and creative development of a variety of skills and personal capacities.

3. It must take place in a context of cooperative group activity which is so organized that it not only involves contact with others but necessitates a high degree of mutual dependency of "helping and being helped" relationships.

It is apparent that any therapeutic relationship, be it IC or SPC, includes elements of all three SPC principles. It has been suggested by SPC psychologists that the presence of these therapeutic factors in IC therapy might constitute a major hidden source of the therapeutic success of the IC method.

It is interesting to note that the above mentioned therapeutic principles are foreshadowed by the pronouncements of a number of early workers in psychiatry. This fact may be illustrated by means of the following quotations extracted from a source book recently published

by Licht (53). Pinel (53, 7) wrote (1801) that

> rigorously executed manual labor is the best method of securing good morale and discipline. (53, 21) Those patients who are able to work are divided into separate groups each morning and a supervisor is placed in charge of each group to assign their work project as well as to direct and watch over them. The day passes in continuous activity interrupted only by the rest periods; and the fatigue of the day induces tranquil slumber at night.

Benjamin Rush (53, 8) advised (1810) the Board of the Pennsylvania Hospital

> that certain kinds of labor, exercise and amusement be contribed for them, which should act at the same time upon their bodies and minds. The advantages of labor have been evinced in foreign hospitals as well as our own in a great number of recoveries.

The importance of social interaction was specifically recognized by Leuret (53, 63) (1840):

> In several hospitals the need has arisen for assembling patients for meals. This serves to improve their eating habits. It also helps to instill in them a consciousness of society and at the same time is a diversion.

In 1844, when visiting European hospitals, I. Ray (53, 9) found:

> The employment of patients in some form of useful labor is practized in all the institutions I have visited, and in some to an extent quite unparalleled in this country.

Returning from a similar survey P. Earle (53, 11) reports of the Charity Hospital in Prague:

> Superintendent Dr. Reidel says that labor often effects a cure when all other measures both physical and moral have failed.

Many more examples of this trend of thought among nineteenth century psychiatric workers could be given. Toward the end of the century, this way of thinking in psychiatric circles receded into the

background. Among the factors which contributed towards the advance of IC psychotherapy, which began to replace to some extent the way of thinking represented by Pinel and Rush, three may be mentioned:

In the first place, there had always remained a considerable opposition against Pinel's methods. Licht (53, 7) reports:

> In France the resistance came from the physicians of private hospitals where manual labor was not considered appropriate for patients who paid for their keep and care.

Dr. Leuret (53, 67) wrote in 1840:

> At Charenton there is no work. There is nothing for the men to do except walk and play...The patients at Charenton are for the most part from the upper classes and their families object to their being placed at manual labor.

Next to the low esteem in which manual labor was held in leading families another factor contributed to pushing these precursors of SPC treatment into the background: When after the discovery of paresis, the idea began to spread that it might be possible to cure mental illness by medical means, psychiatry became more concerned with the individual patient (69, 77):

> The premise of scientific medicine has been since its origin that the locus of physical ailment is an individual organism, therefore treatment is applied to the locus of the ailment, as designated by diagnosis...When in budding psychiatry scientific methods began to be used, axioms gained from physical diagnosis and treatment were automatically applied to mental disorders as well...In psychoanalysis the idea of a specific individual organism as the locus of psychic ailment attained its most triumphant confirmation. The group was implicitly considered by Freud as an epiphenomenon of the individual psyche.

The initial spread of psychoanalytic thinking brought with it a decline of work-therapy. This process came to an end during the last few decades, which saw a reviving of all sorts of activity therapy, frequently prescribed in conjunction with IC psychotherapy. The increasing scope of Occupational Therapy and similar methods for rehabilitation are indicative of the widely felt need for an inclusion of appropriate physical and social activity in the treatment program. Hoffman (41, 272) writes:

> One should not be blinded by the glamour of more spectacular and more widely publicized newer forms of psychiatric therapy to the extent that one neglects the treatment opportunities, particularly for chronic patients which exist in a properly conducted hospital industries program.

However, one finds that in spite of the recognition of the necessity of using these work-treatment procedures, IC treatment centers appear to suffer from the lack of proper emphasis upon social interaction: In a penetrating study of a new community work project in Winter Veterans Hospital in Topeka, Kansas, Kaplan and Stein (47, 23) found that:

> Although the patients were physically close to each other there was practically no interaction. It appeared as if each patient existed in isolation.. In the original focus of this project it may have been felt that through communality of work projects and activities a greater degree of socialization would spontaneously occur. Certainly... this does not appear to be the case. Very seldom if ever did we see patients spontaneously talking to each other or mutually engaging in a single task.

Of a series of pertinent suggestions made on the basis of their observations by Kaplan and Stein (47, 26) only the following is cited:

> The possibilities for initiating tasks that would require the cooperative efforts of two or more patients were noticed. One might begin to develop a team of two and when the patients work well and build up some semblance of a team a third patient might eventually be introduced.

Dr. Barton (4, 78), Superintendent of the Boston State Hospital, comes to a similar conclusion:

> Any job may be broken down into situations that will help foster constructive relationships with one another. For example, if one wants to unload bricks from a truck patients can saunter up to the truck and each one takes a couple of bricks and deposits them in a pile or patients with schizophrenia may be organized into a chain.. the group works as a team..a sense of awareness of others has been established.

Comparing such work projects with the routine occupational therapy projects, as they are undertaken in many hospitals one finds advantages and disadvantages on both sides. The patient working in an average O.T. shop is not brought to interact with his fellow patients in the manner described above. On the other hand, he has more of an incentive, he works for a definite goal, be it for himself or for a hospital ba$_2$aar, in which he can develop a real interest. In the community projects of the sort described, the patient frequently is not aware of the goal and if he is, it is meaningless as far as his personal interest is concerned.

SPC therapy aims toward integration of the positive aspects of both methods of rehabilitation. It has the task to organize a group activity with the goal to achieve something which has importance for each of the patients, because it is of social importance.

The practical execution of this task is beset with many difficulties. It must avoid the danger that the productive and

therapeutic labor of the patient be changed into exploitation which would produce the opposite effects. Well intentioned legislation passed to protect the patient in the VA hospital has, however, also restricted the area of functioning of the SPC therapist.

In the present study a practical attempt was made to cope with these difficulties within the restricting framework of protective legislation. Another more generous effort in the same direction has been reported recently in the local press. The article (94) described that patients from Topeka State Hospital, during the great flood in Kansas, had volunteered to work on the dikes and to do other emergency chores. After mentioning the admiring and grateful comments of the people of North Topeka the article goes on to say:

> It soon became apparent that work outside of the hospital was valuable for the patients, Dr. Anderson reported. Patients who had not talked spontaneously for years began to talk more freely. Other patients who could not previously be taken off their ward except by force were waiting at the door to get started in the day's work. One patient who had been in treatment for a year and a half, had little confidence in his ability to adjust outside the hospital. This new link with the outside let him prove to himself that he was able to leave the hospital...Dr. Anderson said, "We have always known that work properly used could be extremely helpful for patients, but we have never seen anything like this." (my emphasis)

One aspect of the SPC group therapy is particularly worth stressing, since it constitutes the fundamental difference between this kind of approach and that practiced in some hospitals and penal institutions which occupy their inmates in institutional industries.

Allport (2, 123) points out this important characteristic of therapeutic group activity which is frequently overlooked in the setting up of work programs:

> For most people there is plenty of ego-relevance to be found in teamwork provided the composition of the team and its identity of interest are clearly understood. (my emphasis)

The SPC therapist must attempt persistently to interpret to the patients the meaning of their activity within the larger framework of social progress. He must try to arouse a deep interest in the relevant problems of the community, not by lecturing or teaching in an abstract style but by continuously pointing out the intimate connection between the patient's individual experience, his personal conflicts, and the developmental conflicts in the social life of his community.

The SPC therapy group represents a total effort to re-integrate the patient into the cooperative striving of his society. Accordingly, group life is organized to a much greater extent than IC group therapy. Besides the common periods of work, it includes discussion hours and common recreational activities. This communality is not restricted to those hours which have been established by verdict of the therapist. The group must gain the feeling that any changes and extensions of the group which they might want to suggest would be welcome.

Group discussions, where they develop, will be guided by the leader towards the primary goal of clarifying the role of the individual as part of the developing community.

Leadership.

It is held by SPC therapists that the therapist, as soon as he has succeeded in establishing rapport, cannot afford to maintain a non-directive neutrality and distance, or to remain emotionally uninvolved. The therapist, it is assumed, has achieved a degree of emotional integration, i.e., a deepening of his emotional experiences under the controlling influence of purposeful reasoning which can only be achieved on the basis of his strong identification with the social values of the community. As such, he has a personal, moral and emotional stake in the recovery of the patient which he does not have to hide. The expression of feeling on the part of the therapist is not the pouring forth of uncontrolled reactions set off by the autonomous nervous system, but the indication of conscious involvement and awareness of social obligations; it is not experienced as degrading, debasing, authority undermining personal weakness which should be suppressed, but as a sign of humaneness and of strength of conviction.

Concludingly one might say that the SPC psychological approach is focussed upon re-integrating the patient into the social activity of his group. Meaningful group activity is regarded as the primary therapeutic factor which has to be combined with psychological influences such as the interpretation of the unity of individual and social conflicts, the personal example of the leader, etc. It is felt that a re-integration of the patient into the active striving of his group constitutes the basic contribution of psychotherapy which together with the medical efforts to restore adequate physiological functioning can achieve an optimum of recovery from mental illness.

This first chapter was devoted to a description of some of the important features of the structure of the hospital situation, an analysis of the specific difficulties of the chronic mental patient, and a presentation of the theoretical foundations of two contrasting psychotherapeutic approaches. The actual research project, to be described in the following chapters, was developed against the background of these reflections in an attempt to explore the possibilities by which patients with this sort of difficulty might best be helped.

CHAPTER II

THE RESEARCH PROJECT

1. The Research Plan

Twenty-one chronic mental patients were to receive treatment under experimental conditions on an open ward specially vacated for this purpose. The patients were to be divided into three treatment groups with each group receiving a different specific treatment. By this procedure, it was hoped to gain an understanding of the differential effect of the three specific therapeutic methods. In order to magnify if possible the effect of the differences of these three therapeutic methods the whole experimental ward was to be managed with a view toward providing a maximally therapeutic common environment. It was assumed that the members of each group would be able to benefit to an equal degree from this common overall structure and ward atmosphere.

The psychiatric authorities were to select patients unable to benefit from a further stay in the hospital but apparently equally unable to ever leave the hospital. Patients in this dilemma settle down into the pattern of "lifetime hospital patient" although they themselves are unable to face this fact. The patients selected by the psychiatric staff were to be notified individually that an "Intensive Treatment Program" leading to discharge from the hospital at the end of three months was to be conducted. They were to be acquainted with the exact nature of the project and to be advised of the fact that they

had been selected as patients who in the opinion of the psychiatric staff would be able to derive maximal benefit from such a program. It was then made clear to each patient that only those patients who, besides being selected by the staff, would volunteer in writing could be accepted for the treatment program. It was emphasized that refusal to volunteer would not entail any difficulties for the patient.

After an initial week of psychological evaluation and appraisal by the psychiatric ward-team, the total research population was to be divided into three groups which were to be matched according to the following criteria:

a) Handicap (Severity of illness))
b) Self-confidence) As determined by ratings of the
c) Popularity) psychiatric personnel

Group 1 was called the IC Individual Therapy Group. Each member of this group was to see the therapist, a resident psychiatrist, individually in his office for two one-hour meetings every week.

Group 2 The IC Group Therapy Group was to meet as a group with the experimenter as therapist for two one and a half hour meetings every week.

Group 3 the SPC Group Therapy Group was to engage in a meaningful group activity for three two-hour meetings per week under the leadership of the experimenter, and two two-hour group meetings without the leader.

A re-evaluation at the end of the three months treatment period was to indicate the opinion of each member of the psychiatric personnel regarding the patient's present condition, specifically with regard to the three matching criteria.

All patients were then to be given an opportunity to receive a discharge from the hospital. A follow-up study by questionnaire inquiry was to be conducted at the end of three additional months. Changes produced by the treatment were to be measured by:

1. The patient's ability to make use of his discharge.
2. The patient's adjustment in the three months following his discharge.
3. Changes in the three matching criteria.
4. Judgments and opinions of the psychiatric workers and the patients themselves regarding the effect of the treatment.

This was the overall plan. The following is a more detailed description of its execution, the obstacles which were encountered and the modifications which became necessary as a result.

2. The Research Population

a) Selection

After a briefing session with the medical staff of the Continued Treatment "B" Section in which the experimenter explained the scope and the details of the research project, he asked the Psychiatric Residents from the four wards of this section which house chronic mental patients to submit a list of those patients whom they considered to be capable of benefiting from the program. It was stressed that patients should be capable of living on an open ward. Approximately 30 names were suggested by the psychiatrists. These 30 names were submitted for approval to the section staff including the Chief Nurse and the Charge Aide. The section staff approved 26 chronic patients as capable

of being carried on an open ward, but made it clear that three of these patients were so difficult to handle that they were apt to wreck the program. These three patients happened to be among those with whom the experimenter had previously been working in group therapy on one of the more disturbed wards of this section. He expressed his willingness to try to include these patients into the program and although the staff felt without exception that these three patients were detrimental to the program and would not be able to benefit from it to the point that they would ever leave the hospital, the inclusion of these patients was approved.

The 26 patients thus approved were seen by the experimenter in individual interviews of approximately an hour and a half average length. They were informed of the details of the intensive treatment program. Only nine patients of these 26 decided to volunteer (including the three patients mentioned above).

Those who declined advanced various reasons. Some said that they would not volunteer as long as they were barred from freedom; others expressed the hope that they would be out of the hospital before the three months were up. Some felt that they would not be ready to leave in three months, that this was too soon, while still others insisted that they were not in need of any treatment. Although a certain number of refusals had been anticipated, it had been hoped that the temporal distance of the discharge date (three months) together with the attraction of being able to live on an open ward would be able to help a greater number of patients do the first step toward their eventual discharge from the hospital, that is, to make them volunteer for the

program. The fact that only about 30 percent of the patients approached volunteered even under these conditions is a vivid demonstration of the seriousness of their dilemma.

With only nine patients instead of the required 21 signed up at the time at which the project was scheduled to start, the whole study appeared to be endangered. The Section Chief of the Continued Treatment "B" Section approached the Section Chiefs from other NP treatment sections, acquainted them with the aim of the project, and asked them to suggest patients from their sections who might benefit from the program. He also suggested that the experimenter talk to additional patients on the Continued Treatment "B" Section who had not been previously considered because it had been felt that they were too little in contact with reality to be able to profit from such a program. The inclusion of these patients in the program was authorized provided the patients themselves were willing to give it a try.

In this manner two additional patients from the Continued Treatment "B" Section were recruited.

From a group of six patients suggested by the staff of the Acute Section four patients volunteered.

Of eight patients cleared for the project by the staff of the Continued Treatment "C" Section, two patients volunteered. The others explained that they saw no reason for speeding up their discharge from the hospital. Of two patients approached upon the suggestion of the Chief of the Diagnostic Appraisal Unit, one patient volunteered.

At the end of two additional weeks of recruiting the research ward (B-15) was composed as follows:

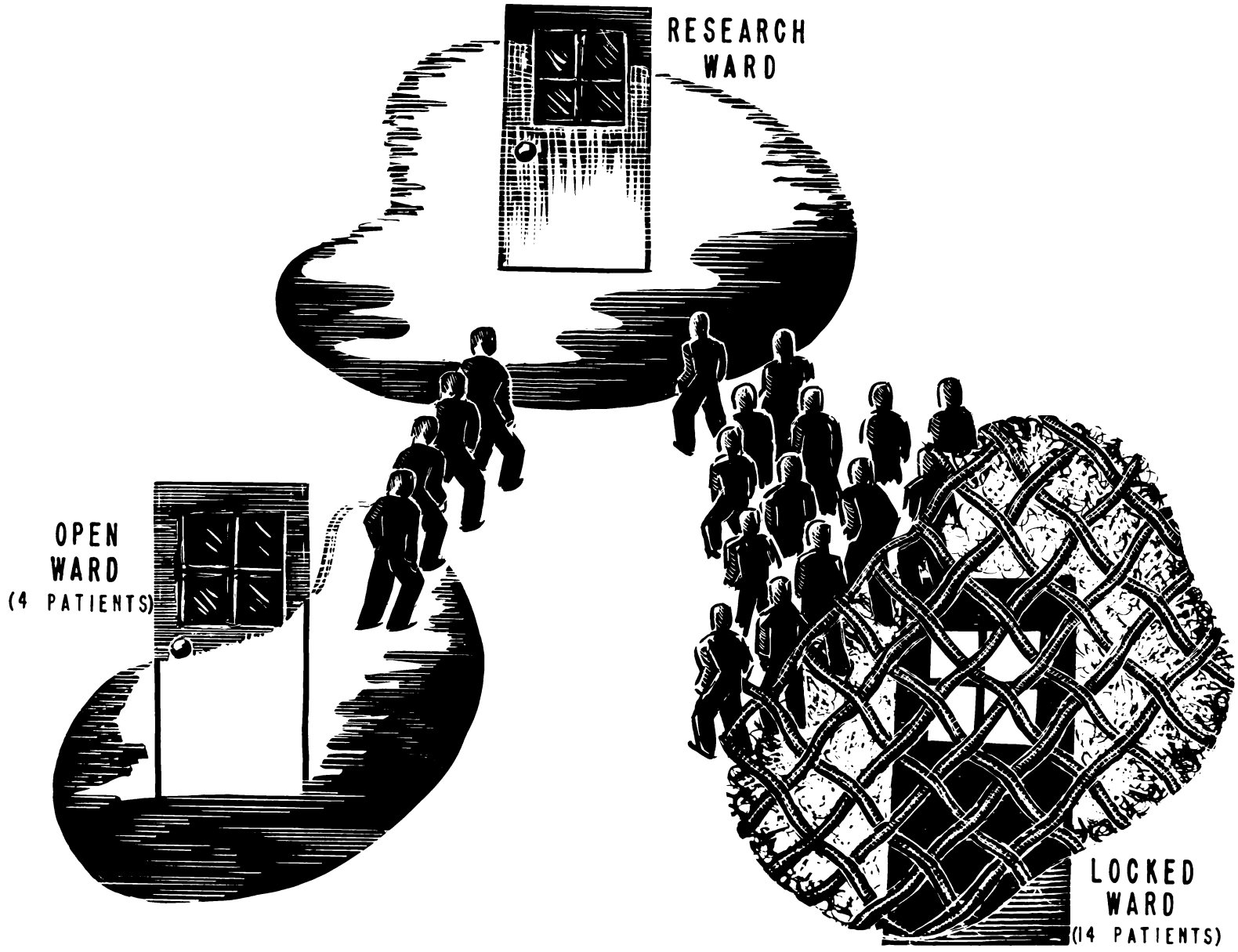
9 patients	From Continued Treatment "B" Section	The Originally approved group
2 patients	From Continued Treatment "B" Section	Additional
4 patients	From the Acute Section	Additional
2 patients	From Continued Treatment "C" Section	Additional
1 patient	From Appraisal	Additional
18 patients		

Four patients of the total research population had come from open wards; 14 had volunteered from locked wards.

Most of the nine additional patients showed a considerably higher degree of thought disorganization and active delusional thinking than the original group. Only 18 patients instead of the projected 21 patients had been recruited by this time in spite of the considerable liberalization of the selection criteria. Since this recruitment had already taken two weeks more than had originally been set aside and since the patients who had moved into the ward began to show signs of restiveness over the initial delay, it was decided to start the program with groups of six patients instead of seven patients as had originally been planned.

b) Assignment of Patients to Treatment Groups

During their first week on the ward all patients were interviewed by the experimenter and the ward psychiatrist. On the basis of their clinical impression, they rated each patient on a rating scale with regard to the severity of his handicap, his self-confidence and his popularity. Similar ratings were obtained from other therapists who had worked with the patient previously.


RESEARCH
WARD
OPEN
WARD
(4 PATIENTS)
LOCKED
WARD
(14 PATIENTS)

(See Appendix for Rating Scales) On the basis of these ratings the patients were divided into matched groups: e.g., the patients were ranked on the basis of their mean handicap rating and then distributed in the order of their rank:

Group 1.	1	6	7	12	13	18
Group 2.	2	5	8	11	14	17
Group 3.	3	4	9	10	15	16

After the groups had been established on the basis of the Mean Handicap Ratings of each patient, the Mean Self-confidence and the Mean Popularity rating of each of these three groups were computed. Some changes were necessary in order to obtain a maximal equality in the Mean Group Ratings in all three criteria. In assigning the patients in this manner to the three treatment groups the experimenter hoped to achieve greater equality in the composition of the three groups than would be achieved by randomization. To what degree such matching is actually better than randomization depends however upon the relevance of the matching criteria which can be determined only after the termination of the project. (For a discussion of this aspect see Chapter III, Findings. See also Appendix for Individual Ratings and Analyses of Variances)

3. The Therapeutic Goal

It has been mentioned previously that the original research plan envisaged a research population for which discharge from the hospital constituted in the opinion of their doctors the "next" psychological step forward. Patients who in the opinion of their doctors were unable

to derive further benefit from a prolonged stay in the hospital. Such patients are discharged by a procedure technically known as "Maximum Hospital Benefit Discharge" (MHB).

It is a frequent misconception that patients discharged MHB are of necessity healthy and capable of functioning on the level of normalcy. A well known V.A. Installation (76, 335) advises the relatives of lobotomy patients who have been discharged MHB:

> ...you may find that he (the patient) does not act as he did before he got sick or before the operation... He may do these things:...He may still hear imaginary voices or people or may repeat over and over foolish actions...Like a young child he may say "I won't" to everything you suggest. He may not want to get up in the morning and may even want to stay in bed all day. He may not go to the toilet in time and soil and wet his clothes...Once he gets to the toilet he may want to sit for hours...He may lock himself in the bathroom. He may not wish to dress. He may put on only part of his clothes. He may not be modest about himself. He may not care about his looks. He may be willing to wear any "old rag" or insist on buying more clothes than he needs or can afford.

Fortunately the patients who entered the research project did not generally exhibit overt maladjustive tendencies of such severity. A number of patients were overtly delusional and in precarious contact with reality. Their doctors, however, felt that a prolonged hospital stay had nothing further to offer them but on the contrary entailed the possibility that the patient would become more self-centered and dependent upon others. Previous attempts which had been made with nine of these patients to encourage them to leave the hospital had ended in failure, the patient had returned generally in less than a month's time. It was therefore felt that success in helping the patient to leave the

hospital would forestall the formation of an exaggerated concept of his illness, thus preventing the fixation of attention upon his disability and would in this sense be therapeutic, even though the patient might still exhibit a number of maladjustive symptoms. It was also the hope of the experimenter that some of the patients might be strengthened further as a result of successful new experiences on the outside.

The aim of the therapeutic program was therefore explicitly not to achieve a "cure" but to bring about a discharge of the patient. To the uninitiated this may appear as an easy administrative procedure not worthy of the name of "therapy." In actuality, however, this is by no means so. A chronic hospital patient, of the type chosen for this project, frequently defeats all efforts to discharge him from the hospital. There was, for instance, one patient in the research population who upon receiving his papers after three months of preparation for his discharge, went straight to the State Capitol Building and asked for "Adolf Hitler" which, of course, resulted in an immediate request to the hospital to pick him up again.

In a recent report from Topeka State Hospital the same problem is described. The patients were ready in the opinion of the staff to leave the hospital. Lacey and Katz (50, 22) found, however, that:

> The very mention of "discharge" evoked bitter resentment and opposition, even panic, in some of them. Take Mrs. O., for example. She had been hospitalized for 13 years. Despite real progress in her recovery from illness she clung to her hospital "home" with the frightened intensity of a child. At each mention of "discharge" she

became physically ill and took to bed. There was Mrs. F. who said she wanted to leave and for whom discharge plans were actually made. When interviewed by a boarding home owner she became utterly mute, too frightened to speak. She was obliged to remain in the hospital.

In the face of this problem, it was the therapeutic goal to enable the patient to accept his discharge. In order to do this it was necessary not only to convince the patient that discharge was in his own interest and to mobilize him to active participation, but it was necessary also to help him to deal more adequately with the internal conflict aroused by the possibility of his leaving the protective "home." Each of the three treatment procedures had the task to help the patient face this internal conflict.

It had originally been planned to select patients who upon "discharge" would be able to enter into the work-process without overt handicap. As a result of the small number of volunteers from the original patient group from the Continued Treatment "B" Section this plan had to be abandoned. Even patients who were quite obviously incapable to enter the competitive labor market and who thus presented additional problems were included in the research population. This complicated the problem of defining the criteria by which the therapeutic success was to be measured. From all that has been said so far it is clear that the patient's ability to leave the hospital and to adjust on the outside had to be measured. But neither the act of leaving, nor the adjustment during the follow-up period can be considered as genotypic or phenotypic equivalent criteria. There are patients who want to leave the hospital because they have a clearly formulated plan and are eager to prove to themselves their capacity to go through

with it. There are other patients who demand a discharge in constant rebellion against rules and authority in order to "show them." Others want to leave because "nobody wants to stay in a place like this." They feel they must assert their manliness and compliance with group expectations by asking for a discharge. When they are told, however, that they cannot leave or when they are brought back in after an abortive escape or an unsuccessful Trial Visit they feel relieved and at ease. Obviously discharge cannot be regarded as an unambiguous criterium for therapeutic success, not even with patients for whom discharge, in the opinion of their doctors, appears to be the big hurdle.

One might assume that a patient who is discharged from the hospital well prepared psychologically and ready to face the outside world will be able to adjust better on the outside than the patient who receives his discharge psychologically unprepared. This, however, is not always the case. The circumstances under which a patient has to start his life over on the outside may vary greatly and adverse situational factors may well account for the breaking down of the better prepared patient, while fortunate circumstances may contribute to a prolonged borderline adjustment of an ill-prepared one.

In spite of these inadequacies, the lack of appreciation of the phenotypic event, which is inherent in the use of such criteria as "discharge" and "ability to remain outside the hospital during the follow-up period" these two indices have been chosen in advance as the primary measures of therapeutic success with this patient population.

In order to compensate at least partially for the obvious deficiencies of these two measures and in order to gain a better understanding of the effects of the therapeutic process, additional information was to be collected. The members of the psychiatric team as well as the patients themselves were to rate the patients on the matching criteria rating scales. (See Appendix) at the beginning and also at the termination of the project. The patients were to complete also a preference questionnaire (See Appendix) from which an index of the changes in popularity of each patient and of group cohesion could be obtained.

Aside from these quantitative measures the personal impression of all members of the psychiatric team who were in daily contact with the patients was to be consulted by questionnaires. The patients' own feelings were to be tapped by interviews and questionnaires. One of these was to be completed at the end of treatment and the second one after the lapse of a three month follow-up period. (See Appendix for Questionnaires)

4. Ward Management

The management of the ward is legally the responsibility of the ward physician. However, the ward psychiatrist had made it clear from the start that he was eager to comply as much as possible with all aspects of the projected research setup. As a result of the perfect understanding and complete cooperation between the ward doctor and the experimenter a number of principles of ward management were

developed and closely adhered to. In doing this it was the goal to intensify as much as possible all therapeutic factors which were not directly the object of the investigation. As was stated previously, it was assumed that a maximally therapeutic milieu on the ward would affect the patients in the different treatment groups to an equal degree. Besides the additional help which it was hoped this milieu might provide for the patients, it was also anticipated that it would make the study more sensitive by increasing the range of observable changes.

The following therapeutic conditions were envisaged and largely realized for the ward as a whole:

a) Patients were to "know" what to expect.

Even before the patient had entered the project he had been thoroughly informed of the various aspects of his living under the projected setup. The experimenter had discussed with each patient in great detail what his daily routine would be if he should decide to enter the intensive treatment program. The patient, as was previously mentioned, had also been acquainted with the main ideas underlying the three treatment procedures, as well as with the ways in which his assignment to a specific treatment group would be decided. All through the program, a special effort was made to let the patient know at all times "What's up." This approach is essentially in harmony with the ideas advanced by Barker, Wright and Gonick (3, 233):

> Understanding the physician's actions and their purpose is of particular importance in dissipating the strangeness of diagnostic and treatment procedures. No matter how familiar the instruments and the general techniques

> may be, the physician's program of action is likely to be unknown to the patient unless care is taken to inform him of it. The physician may be sure that when he fails to reveal his plans to the patient, the latter will develop his own conceptions which are often much worse than the actuality...Most medical doctors apparently solve the problem by adopting the general policy of informing the patient of as little as possible, and then only in general terms. This would appear to insure a general maximum of anxiety in patients, for most medical procedures are not in themselves sources of anxiety, but the unknown always is.

b) Patients were to be given a feeling of their responsibility within the framework of the hospital. "Areas of Freedom of Movement" in which the patient's choice and decision counted were to be emphasized, although no effort was made to minimize or underplay the realistic boundaries imposed by the institutional structure.

The ward management attempted to foster the idea that the patient, although he has to live within the restrictive structure of a hospital, still has a large area of freedom available in which his own decision counts. The patients were made aware of the fact that they could look upon all members of the psychiatric "team" as allies in any attempt to enlarge the legitimate areas of their movement. For example, the patients knew that they themselves could decide what activities they wanted to engage in, they knew that their decision would be honored and that the ward doctor would write a medical prescription for the activity of their choice. During a ward meeting, the patients pointed out that on other wards they had been sent to activities without being asked what they themselves wanted to do. Similarly, the patients soon realized that they could have weekend passes into town or to visit

their folks by just asking for them. Indeed, some of the patients began to feel apologetic for not asking for passes and expressed their feelings. A point was made to encourage any spontaneously developing group activity. The suggestion to have a show of psychologically interesting films on the ward on Saturday morning was taken up and the Saturday morning movie - hour with a following "bull session" - became a standing institution. A series of fishing trips on which some of the patients went together was remunerated by procurement of better tackle and the provision of the necessary frying materials. Numerous other occasions could be mentioned in which the ward personnel went out of their way in order to accommodate patients with initiative.

Weekly "ward meetings" helped to give the patients a heightened feeling of their responsibility and importance. In these ward meetings complaints against any member of the "team" as well as against fellow patients could be and were frequently voiced, as were requests for explanations and demands for changes. Although it was occasionally attempted by the ward doctor or the experimenter to deal with the feelings expressed, these ward meetings were focussed in general upon the content of a patient's statements, thereby hoping to heighten their feelings that "they could get things done." How successfully this goal was achieved was illustrated in some of the later ward meetings in which the patients repeatedly pointed out the lack of a necessity for further ward meetings since all their requests had been granted, and there "was nothing left to bitch about."

c. <u>Opportunities for passive withdrawal into a world of fantasy were to be minimized</u>.

Each patient was expected to select during the first two weeks of his stay on the ward one or more activities among the numerous possibilities which the physical rehabilitation and therapeutic work-shop facilities of the hospital offered. He was expected to arrange it so that an average of four hours daily was taken up with this activity.

Actually only about two-thirds of the patients kept to this obligation, the rest required the special efforts of the ward personnel to make them comply. Two patients never went beyond a token compliance.

Among the enforced ward rules (of which the patients had been advised before they volunteered) was the obligation to get up before 8 o'clock in the morning on weekdays and a ruling against laying down on their beds in daytime, except between 12 and 2:00 p.m. and on weekends.

d. Living within a structure set by a short-term goal and a definite time limitation was fostered.

On entering the program, the patients had been advised that the intensive treatment was designed to facilitate their discharge at the end of three months. The fact that all patients would be discharged from the hospital during the first week of October was emphasized throughout and became a principal focus which progressively helped to organize the thinking, planning, and acting of most patients.

It may be worthwhile mentioning that the period of three months was not an arbitrary selection. It was necessary to select a time boundary which on the one hand was not so far distant as to become

meaningless, but on the other hand also not so immediate as to constitute a threat for the patient on entering the program, and thirdly, it should enable the social worker in connection with the therapist to make realistic preparation for the patient's living on the outside.

e. Consistency in the application of the previously described principles of ward management was considered an important factor.

In order to achieve this aim, it was necessary to acquaint and imbue the whole ward personnel with the importance of these ideas.

A weekly "team meeting" brought together aides, nurses, the ward secretary, the social worker, the ward doctor and the experimenter. These meetings lasted approximately an hour and a half. Practical problems which had come up during the week were discussed. Suggestions which had come from the patients were discussed. The behavior of patients who appeared to constitute a problem was reviewed.

In these meetings it was demonstrated on the basis of practical problems what was meant by "emphasizing the patients' initiative and responsibilities." Thus, when an aide whom one of the patients had approached with the request to get his civilian clothes from the clothing room asked how he should react to such a request, it was made clear that it was one of the ward management principles to encourage the patients to wear their civilian clothes as much as possible within the framework set by hospital regulations.

It was observed that nurses and aides were eager to use this approach. They went out of their way in order to encourage any

spontaneously arising initiative. Thus, when some patients asked for sports equipment the nurses and aides got it for them. When some patients suggested the starting of a common fund for the buying of coffee, the nurses were quick to realize the beneficial potentialities of this proposition. They saw to it that the "coffee piggy" was never empty and that patients always had the possibility of finding company or joining in a discussion by going into the kitchen "for a cup of coffee." Examples of this sort could be multiplied.

On the otherhand, the impression should not be given that everything was rosy for the patients, that there were only rights and possibilities and no limitations. It was a clear policy on the ward to enforce the ward rules as well as the general hospital rules. In ward meetings the experimenter repeatedly made it clear that no violation of hospital rules would be tolerated and as a matter of fact two patients were transferred to locked wards, one because he was unwilling, the other because he was incapable of complying with ward and hospital rules. In each of these cases it was, however, made clear to the patient at least two weeks before any sanction was taken, that his lack of compliance with the regulation was considered by the "team" as an expression of the patient's desire to leave the project and that unless he would change in the following week action upon this assumption would be instituted. After the patient had been transferred, the experimenter made it clear in the ward meeting that this transfer - the reasons for which were obvious to all patients - (in one case they consisted in the patient's repeated AWOL and drunk sprees, in the other in the patient's lying on his bed all day) had only been undertaken after giving the patient two weeks advance notice and a chance to change.

4. Treatment Procedures and Treatment Groups

The primary independent variable which the project was set up to explore was differences in the psychotherapeutic approach to the patient.

It was described previously how the patients had been distributed into three groups in such a manner as to match the groups with regard to the severity of the patient's condition, presence or lack of self-confidence and popularity.

Each of these groups had then been assigned at random to one of the three treatment procedures.

A. IC Individual Therapy

Each member of this group had two individual psychotherapeutic sessions per week with the ward psychiatrist. The average length of these sessions was about an hour. In these therapy hours the patients were treated according to the best current hospital practice. In general, even a training hospital like Winter V.A. Hospital, with its greatly enlarged hospital medical personnel can provide this sort of treatment to a very small percentage of its patients and consequently only the most promising cases are selected for this treatment. In the framework of the project no selection was undertaken and all patients of this one group received this treatment.

The therapist had the goal to help the patient to overcome the most disturbing adjustment difficulties, to give support and to prepare him as well as possible to face life on the outside at the end of three months.

(For a detailed report of the progress of the various patients in this group and their behavior in the treatment hour see Appendix.)

The IG Individual Therapist, a competent psychiatrist in his last year of residency, asked for and received the assistance of two senior staff psychiatrists. One, a senior consultant of the Staff of the Menninger Foundation, the other a Chief of Section of Winter V.A. Hospital. The IG therapist saw these consultants weekly and discussed with each the problems encountered in the treatment of three of the patients in his group.

B. IG Group Therapy.

The members of this group met, as a group, with the experimenter twice a week in group therapy sessions of one and a half hours duration for each session. In these meetings, the patients were encouraged to talk about their difficulties, to express their feelings. The experimenter attempted to foster the development of insight by giving the patient an opportunity to become aware of his way of dealing with reality problems in the specific context of the interpersonal relationship existing in the group. He attempted to further acceptance of other persons and tolerance of frustrating experiences. He finally attempted to structure the group relationship so as to provide emotional support. Where the experimenter succeeded and where he failed will become more obvious on reading the detailed description of the group process. (See next chapter)

This therapeutic approach, like the one described previously, focussed treatment upon the personal problems of the individual patient.

They were also alike in that each patient had two weekly sessions of therapy. This was done because in the opinion of psychiatric advisors two hours per week constituted the optimal condition for either of these two types of therapy with these patients.

C. SPC Group Therapy

The members of this group met every weekday for two hours. Only during three of these five weekly meetings the therapist (the experimenter) was able to stay with the group; twice a week he had to leave the group in order to attend the meeting of the IC group therapy group. The patients of the SPC group were lead to engage together in a common, meaningful activity, the production of a puppet-play which depicted some of the adjustment problems of a discharged patient. In contrast to the two other therapeutic techniques therapeutic activity in this group was not focussed upon the individual problems of the patient but upon the achievement of a common group goal. Talking became secondary to doing.

The experimenter had no previous experience in this sort of group therapy and therefore felt initially insecure and handicapped. In addition he did not have the technical "know how" required for the production of a puppet-play.

5. The Variable of Time Spent in Psychotherapy.

It was mentioned previously that the three groups spent differing amounts of time with their therapists. This may of course be an important factor in the patient's improvement. The fact that the SPC Therapy Group met two hours daily stood in marked contrast to the two

hours per week which the members of the IC Individual Therapy Group spent with their therapist. It is evident that the patient in the SPC Group spent two to three times as much time with his group leader than the patient of either of the IC groups spent with their therapists. In the framework of the present investigation no attempt will be made to extract the therapeutic contribution of the differential time element. It is therefore not possible to determine in this study how much of the relative effectiveness of either psychotherapeutic method is due to the amount of time spent by the patient with the therapist and how much is due to the effect of the method proper. This question is considered to be an academic one in view of the fact that a therapist using the IC individual approach needs 12 hours of his time in order to spend two hours with each of his patients, while the therapist treating his patients by the SPC Group method only needs six hours of his time in order to be six hours together with his patients. From a practical and financial point of view that therapeutic method is most adequate which achieves the best results with the least amount of time expenditure on the part of the therapist and in this latter respect the IC Group Therapy appears to be leading.

Time Differences of The Three Therapeutic Methods

	Total of Therapist's time spent with six patients	Time spent by the Therapist with each of six patients
IC Individual Therapy	12 hours	2 hours
IC Group Therapy	3 hours	3 hours
SPC Group Therapy	6 hours	6 hours - in groups

Thus if it should be found that all three therapeutic methods are equally effective in the achievement of their goal, the IC Group Therapy would have the advantage of greater economy, which in view of the lack of trained therapists must be an important consideration.

CHAPTER III

FINDINGS

1. The Overall Effect of the Therapy Project

A. The Average Day of the Patient on B-15

7:00 am.	The patients were awakened. They had time to turn over, get dressed and go to breakfast.
7:30-8:30 a.m.	Breakfast was served in the Dining Room for Open-Ward patients. This dining room was approximately ten minutes walking distance from the ward, a fact which aroused numerous complaints and was repeatedly mentioned as a shortcoming of the project.
8:45 a.m.	The ward doctor made rounds and examined patients who had physical complaints. The experimenter visited with each patient on the ward.
9:00 a.m.	Patients were supposed to report to their shops for activities. (O.T., woodwork, ceramics, etc.)
10:00 a.m.	The patients of the SPC group had to leave their individual activities and report for the group meeting which lasted until 12 o'clock.
10:30 a.m.	Twice a week at this time the patients who belonged to the IC Group therapy group had to leave their activities and report for their group meeting.
11:00 a.m.	End of shop activities for most patients.
12:00 Noon	Lunch
12:00-2:00 p.m.	Quiet on the ward. Patients are permitted to stay on their beds.
1:00 p.m.	Some patients had to leave for their shop activities.
2:00 p.m.	All patients at shop activities.
3:00 p.m.	Some patients returned from shop activities. Coffee prepared in the kitchen. Start of "bull session."
4:00 p.m.	Most patients returned to the ward, got washed and cleaned up and joined "for a cup of coffee."
5:00 p.m.	Dinner served in the Dining Room.
10:00 p.m.	Lights out on the ward; dayrooms still available for reading and chess (Piano room locked).
12:00 a.m.	Bed check.

Besides their daily routine which kept the patients occupied on weekdays until dinnertime at five o'clock in the afternoon, the hospital offered them an extended schedule of evening entertainment.

Regular Special Service Events
for Open Ward Patients

Monday:	5:00	Gymnasium and tennis court open.
	7:00	Informal dance and games in the recreation hall.

Tuesday:	4:00	Swimming pool open
	6:00	Movie (35 mm. First run in town)
	8:00	Television show
Wednesday:	5:00	Gymnasium and tennis courts open
	7:00	Dance, stage show, quiz program in rotation
Thursday:	4:00	Swimming pool open
	7:00	Bingo game night
Friday:	6:00	Movie (35 mm. First run in town)
	8:00	Television show
Saturday:	7:30	Stage show
Sunday	3:15	Stage show
	6:00	Religious movie show
	7:00	Regular movie show

The movies shown on Tuesday, Friday and Sunday were never the same and were in general shown in the hospital a week before they arrived at the "first run" movie theaters in Topeka.

Their general schedule was, of course, flexible. On Mondays, for example, all patients instead of going to their shop activities assembled for ward meeting at 8:30 a.m.

Patients who refused to get up in the morning were approached at 8:45 by the doctor and the experimenter. After the former had made sure that there was no need for the patient to stay in bed, the experimenter would remind him of his obligations under the terms of the contract. (The patients had signed that they would comply with the ward rules, and it was a ward rule that patients were not to stay in bed in the daytime except for the hours from 12 to 2 p.m.) With three or four patients staying in bed became the preferred way of withdrawal. It was pointed

out to them that this could not be tolerated and that their staying in bed would be taken as a silent request to be transferred back to another ward. Three patients were given notice that if they would not change from this pattern within the next week there would be no choice on the part of the ward management but to transfer the patient and to consider the contract expired. Two of the three patients changed; the third one refused to leave the bed except for meals and had to be transferred to a locked ward.

Besides the well structured and restrictive aspects of the daily schedule, elements of free movement were not at all lacking. Thus, the patients were encouraged and began in increasing number to ask for passes to go into the city after 5:00 p.m. or on weekends. Saturday and Sunday no ward activities were scheduled and the patients were not required to get up or leave their beds at any particular time. There was, however, no meal served on the ward and thus many patients got up for breakfast on their own. The ward management arranged it that coffee was served on the ward on Sunday morning, so that the patients could rest a little longer. Upon the request of a number of patients on Saturday morning at 10 a.m. a series of 16 mm. films were shown on the ward. One of these films was usually a short on a psychological or mental hygiene theme selected by the experimenter. This frequently led to a discussion during the following "break for coffee."

B. <u>The Development of the Ward Community</u>

In some respects, it is much more difficult to achieve a community feeling on an open ward than on a closed ward. The 24 hours of forced

togetherness on the closed ward create a feeling of familiarity, in spite of, or maybe because of the many frictions which arise. In an earlier group therapy venture on a closed ward the experimenter had noticed how easily this familiarity can be molded into a feeling of communality. On the open ward, however, it is possible for a patient to disappear at will, to remain all day by himself in a part of the hospital where others patients from the ward are not likely to meet him, or to stay in bed whenever patients get together in the evening or at weekends. Thus, withdrawal from social contact is much easier on the open ward. As a matter of fact the social worker, who had also previously had her office on the ward and had been able to observe the patients housed there prior to and after the start of the research wrote: "Formerly patients complained from time to time about the difficulty of striking up friendships on the ward." The ward meeting, at which attendance was mandatory, was probably a weighty factor in promoting a feeling of belongingness and cohesion, but the importance of the "bull session" over a cup of coffee and the movie shows on Saturday mornings should not be minimized.

It is of course impossible to reproduce within the frame of this report the complete transcription of all 12 ward meetings which were conducted during the three months in which the research project was in progress. All these meetings were recorded on Sound-Scriber discs. (A transcript of one meeting alone extends over 18 single spaced typewritten pages.) The experimenter also summarized his impressions after each ward meeting in process notes, which he wrote during the day at which the ward meeting had taken place. He similarly summarized the impressions and

conclusions of the other members of the psychiatric team as they were expressed during the weekly "team meetings."

After listening again to the recordings of the ward meetings and consulting his own process notes of ward team meetings, the experimenter feels that the following observations express the opinion of all members of the psychiatric team.

In a survey of the total process of interaction as it took place between the participants in the 12 ward meetings held between July 12 and September 24, one may distinguish roughly three phases of development. The First Phase reached from the first ward meeting on July 16th to the ward meeting on August 13th, 1951. It was apparent that in most patients skepticism and cynicism about the "new" treatment was mingled with the sincere hope that they might somehow be helped. The anxiety aroused by the newness of the situation, the fact that they had "signed up", etc. found expression in, at first cautious, then more and more overt attacks against the people in charge. The following recorded passage from a ward meeting may serve as an example:

Patient X: (addressing experimenter) You are talking about cooperation, why don't you say that you mean "You do all we tell you to. And not only do you do what we tell you to but you keep quiet about it. You don't say anything about it. If you say anything about it that is a sign that you are really upset and in that case you have to do even more what we tell you to." That's cooperation.

Patient Y: That's a lot like it used to be.

Patient X: Then why use that word? Do you want people to do what you ask, come right out and say that. Say, "You do what we tell you to. We know more than you do, we have all these statistical averages over a number of years and therefore you have to do what we tell you to."

Experimenter: Is that actually our attitude? Do you all feel that way? Do we really say, "We want you to forget about thinking and do what we tell you to, 'Cadence Count' or whatever military command we want to give."

Patient Y: If you tell me to do a certain thing, I cooperate to the extent that I think it ought to be done.

Experimenter: Well, Mr. X. feels that we demand absolute obedience. What do you think? Is that sort of an attitude on our part good?

Patient X: Well, I cooperated too. (bitter and cynical) I swallowed every bit of pride that I had and I pleased the whims and wishes of these...maniacs and did what they told me to do and then..when nothing happened, when I did not improve, they told me that I was not cooperating. (Imitates) "You think you are cooperating but you really aren't. You are unconsciously resisting." (laughs excitedly)

It did not take very long for the patients to find out that they could not only express their feelings without fear of being punished for it, but that they were apt to encounter an understanding warmth which remained not only restricted to the verbal expression of empathy, but led, where this was at all possible, to the correction of real faults. The experimenter attempted to deal not only with the feelings expressed but was seriously concerned with the content of the patient's expression. Thus, for instance, when the patients complained about lack of hygiene on the ward, this was not treated simply as an expression of general dissatisfaction with the way things were going, but gave rise to a discussion at the following meeting of the psychiatric team in which serious self-criticism was expressed by a number of people. The following day the aides on duty began with a thorough clean up and indeed went to work with so much energy that a number of patients commended them very highly during the next ward meeting. Thus, the patients soon began to recognize that by "speaking up" they could get things done.

At the end of this period, in the beginning of August, a nurse who returned from a two weeks vacation commented upon the amazing change on the ward. She felt that the patients had become much friendlier toward each other and showed a greater "esprit de corps"; also that they could be seen together in groups much more frequently. During this same week, Patient X, whose "frankness" has been illustrated in the above quotation from the ward meeting, remarked in a "bull session" that this ward was really "the best ward in the whole hospital."

At the end of this first phase a definite feeling of confidence toward the staff and of cooperation among the patients had been established. The patients had learned to feel at ease and to regard the ward meetings as a constructive feature of the program, in which they could "blow off steam" and by which they were able to accomplish changes which they desired. The Second Phase, starting in the middle of August, extended over a period of three weeks. One might well call this phase the "period of crisis" and of shying away from dealing with the problem of approaching discharge. The ward meeting had outgrown its function as a sounding board for complaints and feelings. As three patients commented somewhat regretfully "there is nothing left to bitch about." At the meeting of August 20 nobody seemed to have anything of importance with which to start the meeting. The experimenter repeated half jokingly the remark which a patient had made at the previous ward meeting, that there really were no more complaints about the ward, that everything was o.k. One patient replied laughingly but seriously this was true, the way life in the

hospital was at present, was just perfect and as far as he was concerned he was so well satisfied that he wanted to stay here. Immediately one of the "sophisticated" patients made the motion to adjourn the meeting. Since the ward meeting was mandatory this was something unheard of. Another patient seconded the motion. The experimenter called for a vote and registered a majority of seven votes for adjournment. Without further comment he declared the ward meeting terminated ten minutes after it had started.

This meeting presented in many ways a turning point. The patients had made an unprecedented active effort to avoid the problem of discharge which had been posed by the sincerity of one patient's admission of his preference for life in the hospital. Instead of opposing this evasion the experimenter accepted it like any initiative which the patients had shown.

The following week saw an increase in the tendency to avoid responsible facing of the problem. Two patients returned drunk from passes. A third one was observed openly bringing alcohol into the hospital which, of course, resulted in a search in which the alcohol was discovered and confiscated. The next ward meeting started out with rebellious protests against the search of the patients' lockers. The experimenter pointed out matter of factly to the patients that they were free to choose their own way of action, that they were treated on the ward like responsible adults, but that, if they behaved irresponsibly and openly flaunted the hospital regulations, it was necessary to treat them like irresponsible children. (Hospital regulations forbade the drinking or keeping of alcohol on the premises.) After this start of the meeting the patients began to attack

the project from all sides. One patient maintained that it was not at all planned to discharge all patients at the end of the treatment. Another one wanted to know how one could even think of such a thing as preparing in advance for discharge from the hospital. How could anybody "dream of getting a job for a month from now, who would want to rent a room for that long a time in advance," etc. Others demanded to know whose idea the whole project had been anyway. How did one know that it would work? Then the question was raised "Do you and the ward psychiatrist think that we are getting better?" Some patients asked if it would be possible for them to leave a few days earlier in case they were fortunate enough to find a job at that time. Others wondered if it would be possible to stay a little longer in case they had not found a job by the time they were to be discharged. The experimenter remarked that all these questions arose as the understandable and healthy reaction against the vagueness of the approaching discharge and the fear of doing a step forward into a uncertain and unknown situation. He mentioned that it had been one of the purposes of the three months time structure of the project to help the patients to get organized, i.e., to prepare planfully for dealing with the problem of discharge. He requested the patients to express their opinions about the effectiveness of rash impulsive moves, such as asking for discharges against medical advice or complete passivity until the last moment. After some discussion about these "ways out" the experimenter remarked that it seemed to be difficult to plan ahead and to work with a definite goal in mind and that there was always the tendency to take the "easy" way out. The definite time

structure of the program had been set up in order to help the patients to plan ahead. It would be adhered to. There would be a leeway of one week, the first week in October. Nobody could be discharged before or after this week, but within this period personal wishes would be taken into account.

In summary, it appears that during this second phase the problem of discharge began to come up in many oblique ways. It was at first actively avoided and denied, then cautiously and defensively explored.

In the Third Phase, starting in the beginning of September the patients began actively and more directly to face the problem of discharge. It became apparent that, with the approaching date of discharge, they became more and more convinced of the reality of it. Vague references to the discharge date, such as a remark like "It's only six weeks until October" had been made during the previous phase; now they had more specific questions such as "What could the Vocational Guidance Service of the hospital do for a patient who wanted to find a job?" The use of various hospital resources such as Vocational Guidance, Social Service, etc. was discussed. Five patients began to make derogatory remarks about these agencies and expressed the opinion that they would hardly do any good, after the experimenter had announced that it would be possible to invite the guidance counselor over to the ward to ask him directly how he could be of help to the various people. Two patients, however, noted that one should not make up one's mind in advance, why not first see what these people could do before judging them. The experimenter voiced his opinion

that it was quite normal for people who needed help to minimize in advance the possibility of such help. By doing this one protected himself in a way against later disappointment.

Although during ward meetings the problem of discharge remained in the center of the discussion by no means all patients had begun to prepare consistently for the day of discharge. During one of the meetings - shortly after Labor Day - one patient suggested that one should make plans for common activities on the ward for future holidays. Other patients reminded him cynically that he was to be discharged and that he would not be in the hospital on future holidays. It became clear from the patients' behavior on the ward that eight patients not only had not taken the initiative to prepare for their discharge but on the contrary began to fall back into increased despondency. In contrast to the previous months, it happened that frequently four to five patients were found in bed during all hours of the day. This problem was mentioned in the ward meeting. Immediately the patients began to attack the examiner for looking at it from the outside, for not seeing it like they who lived on the ward for 24 hours. They accused him of jumping to conclusions and of not seeing that those who were unable to sleep at night had to get some rest in daytime. Another patient mentioned the hay fever epidemic (six patients on the ward had hay fever) as a reasonable cause for some people to stay in bed. It soon became clear, however, that the hay fever victims were not generally the ones who stayed in bed unduly. Two patients began to point out that the examiner might be right and that some of the things

that had been said were just excuses. The experimenter then suggested that it was perfectly o.k. and normal to want to escape from a new step into an unknown situation or from a frightening decision by forgetting about it, or by going to sleep and "putting one's head into the sand." He said there was not the slightest reason to feel bad about doing this, because everybody would do the same thing at times. But by being aware of what one was doing one might possibly realize that one had a choice in the matter and was capable to overcome this "ostrich policy."

During this third phase of the ward meetings, the patients had voiced some of their ambivalence about leaving the hospital and had encouraged each other to take a number of responsible actions in preparation of discharge.

By the end of September, the ward appeared to be a place in which faces and schedules were familiar and friendly. The "bull sessions" in the kitchen became more crowded and more lengthy and frequent. Patients who had been quite undemonstrative began to display feelings of friendliness and liking for staff members. "Bull sessions;" showed an increase in discussion of reality problems.

The clinical advisers had predicted that the approach of the discharge date would go hand in hand with an increase of destructive and defeatist behavior. Five patients began to show a noticeable increase of bizarre and anti-social acts, however, their behavior never became unmanageable. Thus one patient who had previously had his own fishbowl on the ward suddenly developed a flair for more pets; he acquired in short succession a chamelion, two turtles and a large dog all of which he housed

in the immediate neighborhood of his bed. When the presence of the dog on the ward finally led to a ruling restricting his zoological aspirations, he submitted in dignified silence. Another patient began to show a great increase of autistic behavior such as talking to himself, excited gesticulating, and inappropriate running. He also could be reached by friendly talk and it was possible to pull him at least temporarily from his autistic world by realistic requests, provided that he felt capable to cope with such demands successfully. Two patients began to remain in bed for most of the day while the acting out behavior of another patient took on the form of active destruction of the group project of the SPC group. (For detailed description see Process Notes of the SPC Group Therapy.) These maladjustive tendencies exhibited during the last month of the therapy project were more than balanced by an increasing amount of constructive, spontaneous group activity among the other patients on the ward. Thus five patients went together to the Hospital Radio Station and volunteered to help in the reorganization of the program. Another group of four patients prepared a miniature golf course on the hospital grounds adjoining the ward. They organized golf matches among themselves and against teams from other wards. Beyond this there was of course the organized group activity which kept the members of the SPC group increasingly occupied during the last month.

B. How Did Life on the Research Ward Affect the Patients

1) A Survey of the Problem[1]

One might conceptualize the problem to be analyzed in this investigation of therapeutic efficiency in the following manner:

TREATMENT (Stimulus)	PATHOLOGY (Intervening Variables)	CHANGES (Response)
Overall "Common" Therapeutic Components of the Exp. Ward-Structure	Character Structure of the Individual Patients	Ability to Accept the Discharge from the Hospital and to Remain Outside during "Follow-up"
"Specific" Treatment Given in the IC and SPC Groups	Character and Degree of Individual's Illness	Overt Behavorial Changes on the Ward
Character Structure of the Individual Members of the Psychiatric Team	Phenomenal Aspects of the Interaction between the Personalities of the Patients and their Pathological Conditions	Phenomenal Experience of The Research Project
Interaction of the Personalities of Team Members	Normal (Spontaneous) Changes to be Expected in any of the Above Factors	Phenomenal Experience of the Changes Taking Place
Hidden Variables	Interaction of all the Above Factors	Interaction of all the Above Factors
Interaction of all the Above Factors		

One glance at this model will suffice to show that its intricacy is not yet open to scientific investigation, not only because many of the components still escape scientific determination, but also because there exists

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[1] The ideas expressed on this and the following pages were developed under the impact of the stimulating paper by Edwards and Cronbach (89)

an interaction between any two components, a triple interaction between any three, a quadruple interaction between any four components, etc. Each of these may well have an effect which is different from that of its components.

As was mentioned initially, the present research cannot aspire to produce exact conclusive results. It aims to screen out those factors which might serve as hunches for promising subsequent explorations. At the same time the present findings may point to ways by which hypotheses might be subjected to further more stringent tests. In order to make statements about the effect of any one of the above mentioned "stimulus components" - and it is with these that the present research is primarily concerned - it would be necessary to know the effect of all other components as well as the "intervening variables" and the "responses." Of course, a complete knowledge of these factors is a Utopian dream, at least for the present. In this research the evaluation of therapeutic changes results not in an exact quantitative measure. It works rather with an estimate which is based on the patient's ability to make use of the discharge from the hospital as well as on the impressions of the members of the psychiatric team and the patients themselves, as they are expressed in answers to questionnaires, interviews and ratings. These measures are relatively unreliable since the influence of extraneous factors cannot be controlled. Under such circumstances it appears meaningless to "analyze" that total estimate of therapeutic changes into "refined" components corresponding to the various treatment components, since they would in actuality only represent additional guesses and approximations.

In order to simplify the conceptual model in conformity with the approximate characteristics of the measures of change the following assumptions were made:

1. Basic Character structures of the members of the psychiatric team, their interaction and impact upon the patients as well as the impact of other "hidden" variables was assumed to play no different role on the experimental ward than on other Continued Treatment wards in Winter VA Hospital, on which patients with this degree of chronicity are treated and from which they are discharged.

2. The personality variables of the research population were equally assumed to be not different than those found on the wards from which the patients had come.

On the basis of these assumptions - it was then possible to reduce the intricacy of the experimental design in accordance with the following model:

TREATMENT	PATHOLOGY	CHANGES
Overall "Common" Therapeutic Components of the Exp. Ward-Structure "Specific" Treatment i.e. IC Indiv. IC Group SPC Group	Not Different Than That On the "average" Ward[1] of the Continued Treatment "B" Section	Difference to Changes Observed on the "Average" Ward of the Continued Treatment "B" Section With Regard to: 1. Ability to Accept Discharge from Hospital 2. Ability to Stay Outside 3. Overt Behavioral Changes

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2) Treatment Variables

Before attempting to examine the various measures of change, it may be worthwhile to review some of the components of the "common"

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[1] In comparing the research ward with the "average" ward of the Continued Treatment "B" Section, the experimenter used of course an abstraction. In an alert dynamic teaching institution like Winter VA Hospital there are no two wards alike. New techniques are continuously explored. One can therefore speak of an "average" ward on the Continued Treatment "B" Section only with reservations. Yet such a comparison appears to be warranted by the fact that the research ward was distinguished from all these wards by "common" therapeutic factors.

overall therapeutic structure of the experimental ward. It is also necessary to determine if the "specific" treatment groups are actually comparable before an evaluation of their relative therapeutic effects can be undertaken.

a) An examination of some components of the "common" therapeutic factor.

With a view toward gaining a better understanding of the factors contributing to the therapeutic change and of possibly finding hypotheses which may be put to the test of more stringent investigations one may view the components of the "common" overall therapeutic structure of the experimental ward against the background of the corresponding features which are encountered on the "average" ward. Four such components have previously been mentioned:

i. A conscious and consistent effort was made on the research ward to encourage the patients to develop their own initiative, and to foster cooperation among them.

On many wards of the Continued Treatment "B" Section emphasis is placed on passive submission of the patient under a routine regime. The patient is made to feel that all his physical needs are taken care of and that he does not have to do anything on his own initiative. This regime is frequently successful in eventually getting the patient to the point at which he is literally "fed up" and begins to organize, to plan in order to "getout of it." Many of the patients in the research project had previously lived under those conditions but they had been the ones who seemed to be insatiable and did not get "fed up" with the pampered life. The approach used on B-15 combined many single features which are also found on other wards such as ward meetings, free choice of therapeutic activity, encouragement to go on pass, fostering of undertakings initiated by small groups of patients under a consistent explicitly formulated ward policy, of which the patients were constantly reminded.

ii. All members of the research population had been notified of the intention to discharge them three months after the start of the treatment,

i.e., in October 1951. (See patient's Statement of Voluntary Enrollment" in the Appendix)

> In general, such questions as date of discharge are dealt with on an individual basis. Doctors, confronted by psychiatric patients with the question "How long do you think I will have to stay in the Hospital?" are apt to give an indefinite answer or to point out that it is still too early to discuss this question. As a result, it would be hard to find any ward in which more than a very small minority of patients are aware of the date of their discharge.

iii All members of the research population had volunteered in writing for this treatment.

> It is an important fact that some patients of most psychiatric hospital wards had come of their own accord, i.e. voluntarily, to the hospital and whereas others had been brought in against their will. While it is true that some of the research population had equally been brought into the hospital under commitment and restraining orders, the fact that they had all volunteered for the treatment program and that only volunteers had been taken constituted a new feature.

iiii All members of the research population were aware that they were participating in a research project.

> Studies in industry, specifically the "Western Electric" study reported by Roethlisberger and Dickson, demonstrated that the awareness that one is participating in a research study and is under more constant observation may become an important motivational factor.

Since these four factors are distinguishing features of the research project, it may be helpful to examine each one of them for their probable therapeutic contribution, even though no attempt can be made here to present evidence from this research project. In order to show possible connections and effects and to develop plausible hypotheses other therapeutic investigations in which these factors have been used in various combinations will be examined.

Unfortunately, no study has been done in which only one of these therapeutic agents has been employed. Two research projects have been conducted at Winter VA Hospital. Both have used a definite time structure - i.e., the patients in both cases knew that their treatment was to be terminated at the end of three months. In both studies the patients had volunteered for the treatment and were aware of its research character. In contrast to the present study, neither of these treatment procedures stressed specifically the necessity for the patient to develop his initiative and cooperation.

The presence of three of the four "common" factors has not prevented one of the therapies from resulting in failure. The patients in this case were to receive the Carbon-Dioxyde Treatment discovered and described by Meduna (61). They had - in order to receive this therapy - to volunteer for this program knowing that it would last three months.

Of the total of nine patients who volunteered for the treatment:

6 patients (66%) dropped out before the end of treatment, unimproved

2 patients (22%) completed the treatment but showed no improvement

1 patient (11%) completed the treatment and showed improvement [1]

Even if it were assumed that the administration of Carbon-Dioxyde functioned essentially only as an impressive placebo one would certainly conclude that the therapeutic effect of the time structure and of the volunteering for the research was minimal.

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[1] Dr. Francis M. Moriarty, Personal Communication

Both these components, short term structure and volunteering for research, were present also in the framework of the Alcoholic Treatment Research undertaken at Winter VA Hospital under the direction of G. L. Harrington, M.D. In this case the treatment procedure had been used previously without a definite time structure and without the necessity to obtain the written request from the patients expressing their desire to participate in the research project. The investigator is thus qualified to evaluate the weight of these two factors since he saw a treatment program before and after their introduction. According to him (14) a comparison of the treatment process before and after the introduction of these factors makes it evident that they served essentially as focussing devices. In other words the investigators in the Alcoholic Treatment Research found that prior to the introduction of a definite time structure patients tended frequently to avoid facing their problems by speculating and exploring how much longer they might have to stay in the hospital. After the introduction of the three months treatment structure the patient's energy was focussed more upon the essential difficulty. Similarly the investigator said that before the voluntary recruitment of patients a large amount of time was taken up in handling the patient's rebellion against the restrictive aspects of the therapeutic set-up which was frequently compared to a jail. After the introduction of the rule that only volunteers could be admitted to the program this problem appeared to be no longer relevant.

Observation in these studies also suggests that the knowledge that one is participating in a research project is not apt to elicit in chronic patients the same rise in motivation which has been observed in industrial relations research.

These admittedly sketchy comparisons appear thus to suggest that all these factors - Definitely limited short term structure, Admission of volunteers only, Knowledge that one is participating in research - do not themselves exert a direct therapeutic influence, but act more or less as catalysts, i.e., they aid and enhance the impact of genuine therapeutic agents. If the therapeutic agent is weak or non-existent as seemed to be the case in the CO_2 treatment as it was undertaken in Winter VA Hospital, the presence of these factors will not prevent failure of the treatment. On the other hand if the treatment is partially effective, as I understand the various Alcoholic Treatments were, the presence of these additional factors will tend to heighten the therapeutic effect.

If such reasoning is correct - and the hypothetical character of it at this stage should be kept in mind - one would conclude that the specific character of the ward management constituted the direct "common" therapeutic agent which was reinforced by the presence of the "catalytic" structure.[1]

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[1] From an administrative point of view it is important to note that the three months time limit appears to be facilitation of administrative duties, since it permits careful planning and full use of all psychiatric and secretarial workers. The necessity to admit only volunteers on the other hand, as the experimenter found out, not only puts an added load and pressure on the therapist during the first weeks but it also restricts the program and tends to exclude a number of patients to whom it might be most beneficial. Dr. Chotlos writes: "On a structural level, the difficulty of getting patients is the greatest shortcoming. This means mainly that some patients are unable to accept the contract and under such condition the therapeutic methods never reach them.

b) An examination of the methods by which the "specific" treatment groups had been equated.

In order to be able to evaluate differences in therapeutic efficiency of different "specific" treatment groups it is necessary to determine first if these groups can actually be compared. The question arises: Have the groups been matched in all relevant variables prior to the start of the treatment? In order to answer this question it is necessary to examine in how far the matching procedure used in the research project actually accomplished this goal.

If one were dealing with larger experimental groups one might be well satisfied with an equation of the groups produced by randomization. In groups of the small size of the treatment groups randomization would not offer sufficient guaranty against an accidental factor favoring one group to the detriment of the others. The present study strove, therefore, to increase the equation of the treatment groups by using a matching procedure. This procedure has been described in detail in the preceeding chapter. It is, however, not sufficient to show that a correct matching procedure has been used; one must also show that the matching variables were relevant. Only if this is the case does matching produce an equalization of the groups which is more refined than randomization. Ideally, the groups should be matched on the basis of <u>all</u> relevant variables. A comparison of the pre-treatment ratings of the therapeutic "successes"[1] with these of the therapeutic "failures" might show the

[1] Therapeutic "successes" are those patients who were able to make use of the discharge and to adjust after the treatment outside of the hospital. Therapeutic "failures" are those patients who did not leave the hospital at the end of the treatment or who returned before the end of the three months "Follow-up" period.

relevance of the matching variables. This comparison (See date in the Appendix) shows that the "therapeutic successes" appeared in the pre-treatment rating on the average 20% less handicapped, more self-confident and more popular than the therapeutic failures. Although this trend is found inall three matching variables, it attains statistical significance only for handicap ratings. It is therefore necessary to treat the three groups as randomized rather than matched groups.

The experimenter takes some comfort in the fact that other investigations of therapeutic success have apparently come up against similar difficulties. Jerome D. Frank (28) writes:

> Matching presupposes that we know what are the important attributes to match, which we do not. Attempts to match patients in terms of diagnostic categories, for example, run into two methodological difficulties. Aggreement between trained clinicians as to which category a patient belongs in is very low because almost all patients have features of several diagnostic categories. Furthermore, diagnostic categories often seem to bear little relation to behavior under therapy...Matching with respect to those aspects of people which are relevant to psychotherapy is not yet possible.

3) Discharge Data

Turn to the findings which are indicative of the changes which took place on the ward as a whole during the period of the Therapy Research Project and one will focus first upon two criteria of change:

1. The ability of the patient to make use of the hospital discharge.
2. The ability of the patient to remain outside the hospital during the "follow-up" period.

As has been previously mentioned, the patients chosen for the project were, according to the best judgements of their psychiatrists,

incapable of deriving further benefit from an additional stay in the hospital, yet they seemed to be condemned to a more or less permanent hospitalization, not because they were potentially dangerous but because they just seemed to be incapable of facing life outside of the protective walls of the hospital. The psychiatric chief of the Continued Treatment "B" Section stated:

> People with this degree of illness can be cared for for the rest of their lives.

In spite of this condition, it was possible to make the following arrangements for the 18 patients who had constituted the research population:

At the End of the Treatment Period (October 1951)

Total number of patients who remained in the hospital[1]		4
Total number of patients who left the hospital		14
Number of patients who left the hospital on trial visit[2]	7	
Number of patients who left the hospital with a permanent discharge (MHB)	7	

Three Months Later at the Time of the Follow-up Study

Total number of patients hospitalized		6
Number of patients who had remained in the hospital	4	
Number of patients who had returned to the hospital after Trial Visits	2	

[1]These patients had made it clear in words and actions that they felt unable to leave.

[2]It had originally been planned to discharge all patients MHB; however, while the project was already in progress a new VA ruling was announced which made it impossible to discharge outright any patient who received an institutional award, i.e., pension while in the hospital.

Total number of patients who remained outside 12

Number of patients who remained on Trial Visit 3

Number of patients permanently discharged (MHB) 9

In order to gain an understanding of the number of discharges which might have been expected regardless of the ward structure and the specific treatment, the "movement" of patients on the same ward during the corresponding period of the preceeding year - when no research project was in progress - was taken as control measure. At this time B-15 had also been an open ward, which was used as transit station for recuperating chronic patients who were on their way out. The patients then on the ward were not volunteers and did not know the exact time of their discharge in advance. Ward management did not attempt to encourage initiative and responsibilities of the patient. The patient body as a whole had however been selected by a slow continuous process of screening the most advanced cases from the section and transferring them to B-15 in contrast to the selection of the research population which had proceeded quickly and under pressure of time.

A Comparison of the Disposition of Patients on B-15

For the Corresponding Periods of 1950 and 1951

	1950		1951	
July				
Total	16	100%	18	100%
October				
Hospitalized	13	81%	4	22%
Trial Visit	1	6%	7	39%
MHB Discharge	2	13%	7	39%

January of the following year				
Hospitalized	7	44%	6	33%
Trial Visit	7	44%	3	17%
MHB Discharge	2	13%	9	50%

The relative efficiency of the Research Project with regard to the achievement of discharges was also determined by comparison with other therapeutic units which had similar goals. Robert A. Solow (88) writes about a group work project which was organized on two adjacent closed wards of the Continued Treatment "C" Section. The patients of that study appeared to be in general more apathetic and therefore more difficult to treat than the majority of the B-15 group. Over a period of 22 months (April 1948 - February 1950) a total of 60 patients were admitted to these "Community Wards." Solow states that the average period spent on the ward by the 21 patients who left the ward later was seven months. Unfortunately, Solow does not break down his figures beyond the category "Sent to open ward, trial visit, and discharge" so that no differentiation between trial visit, return from trial visit and final discharge is possible.

The problem of discharge and preparation for discharge is a focal problem in all three "Continued Treatment" Sections. Thesection with the highest number of discharges is the "Continued Treatment 'B' Section". It was possible to obtain data for the turnover on this section for the six months period from January until July 1951. It must be kept in mind that neither for the "Community Ward Project" nor for the Continued Treatment "B" Section is any "Follow-up" study available.

A Comparison of the Number of Discharges Effected by Various Therapeutic Units

Unit	Time Surveyed	Hospitalized		Trial Visit		Discharge	
Community Ward	22 mos. period	(39)	65%			(21)	35%
Cont. Treatment "B"	6 mos.	(87)	57%	(35)	23%	(31)	20%
B-15 1950	3 mos.	(7)	44%	(7)	44%	(2)	13%
B-15 1951 (The experimental ward)	3 mos. 3 mos. follow-up	(6)	33%	(3)	17%	(9)	50%

This comparison makes it clear that with respect to the achievement of discharge from the hospital (and Trial Visit) the Research Project is at least equal to if not superior to the other methods.

4) Observed behavioral changes

Most striking among the behavioral changes observed by the members of the psychiatric team on the research ward were certain immediate changes which resulted from the transfer to the ward: One patient who had been incontinent on his previous ward never exhibited the slightest sign of this difficulty on B-15. Another patient who had previously shown little interest in anything but the punctual reception of his daily laxatives and sedation suddenly "forgot" even to mention any medication and could be taken off this prescription. These two actually left the hospital and did not return during the "follow-up" period. Another patient showed less permanent changes. He had suffered from almost daily attacks of hyper-ventilation but remained free from attacks for almost two weeks after the start of the project. During the second month, however, the frequency of these attacks began to rise to such a degree that the patient was

prepared for transfer to another ward. Soon after the doctor had talked to him about this possibility, however, these attacks began to subside again and he was able to remain on the ward. This patient was sent out on trial visit at the end of treatment and remained outside for two months without symptoms. Then he was returned to the hospital and his symptoms flared up again.

Apart from such impressive changes, a number of less obvious but more widespread changes were observed. The psychiatric personnel of the Section and the ward were asked in the evaluating questionnaires (see appendix) whether they had noticed any changes. In spite of the unstructured character of this question there was a surprising agreement about the fact that ward living on B-15 had produced: Heightened tolerance for weakness in others, increased friendliness and group spirit. It was felt that life on the experimental ward had within the three months period resulted in the establishment of closer relations and better understanding among the patients than is the rule on other wards where chronic patients usually keep very much to themselves. Various psychiatric workers emphasized in team meetings, private conversations and questionnaires that it had been a rare event to encounter more than two patients sitting together in the beginning of the research, in spite of the fact that 70% of the patients had known five or more patients of the research group for periods of more than three months before coming to the ward. In contrast with this state of affairs, it was found that toward the end of the treatment period groups of five and more patients were frequently seen together in animated conversation over a cup of coffee in the kitchen.

An occupational therapist who worked closely with many of the patients in the O.T. shop, but was not directly connected with the research project, wrote on the questionnaire:

> There seemed to be a comradely feeling among B-15 patients which does not seem to exist on other wards which come to our clinic. For example, Mr. X. came in several times during B-15's period explaining that he wanted to see what the other patients were doing, even though he had no project in the clinic.

The answers given by other psychiatric workers concur with this statement. (See appendix)

The answers of the experimenter's co-workers have to be taken "cum grano salis" since they may be apt to report what they think the experimenter would like them to see. It is even more difficult to evaluate the answers of the patients to the questionnaires as well as their behavior in the evaluating interviews. Not that they had reported less positive examples of improvement resulting from the therapy project; on the contrary four patients grow actually enthusiastic in their replies. However, it is evident that patients may feel under even greater pressure to comply with the cultural demand of being polite and flattering than are the experimenter's co-workers. Not only are many patients over-compliant but some may wrongly assume that their answers may influence the final decision of their case.

Under these circumstances it seems feasible to use the answers of the patients only in order to determine roughly the presence or absence of resentment engendered by the therapeutic situation. The answers to the questionnaires failed to show such resentment. (See appendix) In order

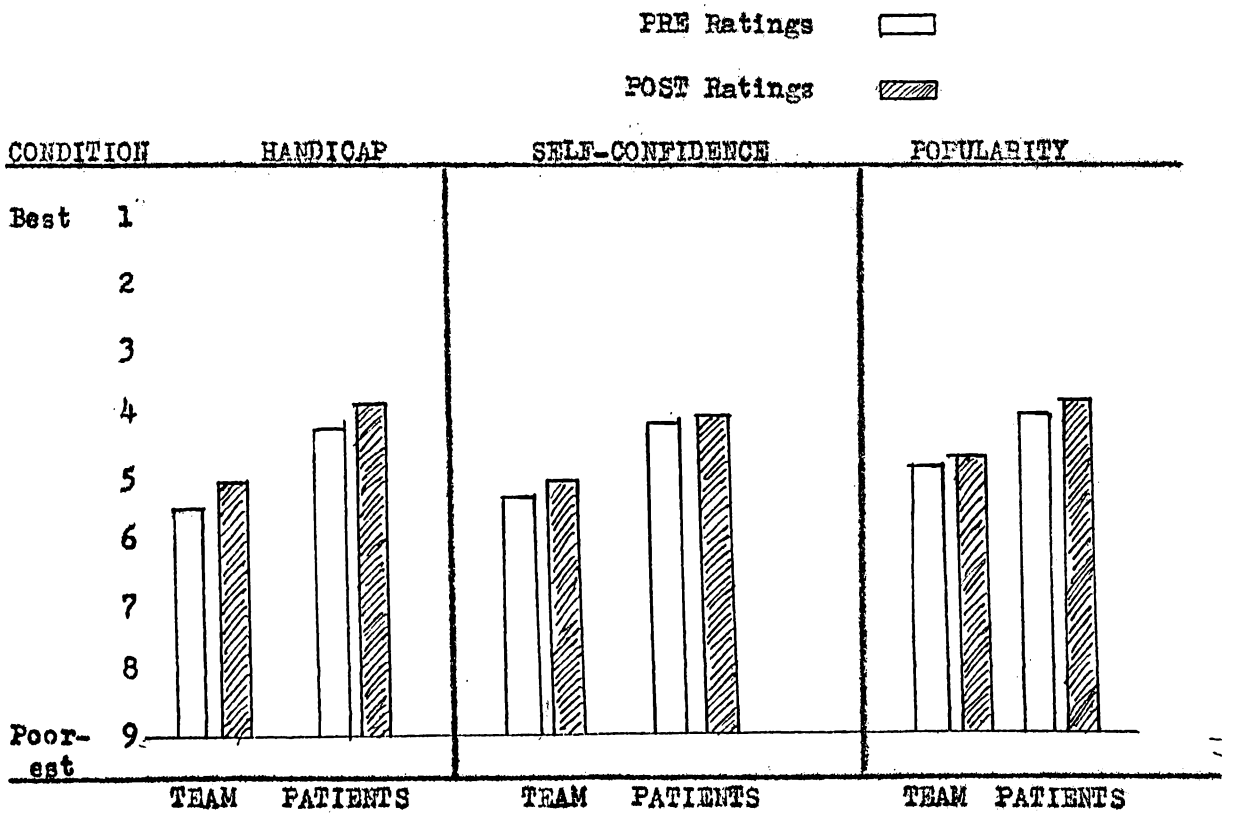
to have some measure of control a questionnaire similar to the one given to the research population was answered by the patients of an adjoining neuropsychiatric ward. A comparison of the two groups of replies does, however, not show any real differences. At least this would show that the patients on the experimental ward seemed to feel no more resentment than those on the neighboring ward. The experimenter as well as many members of the team felt strongly, however, that the experimental patients had developed a greater than usual degree of confidence in the various members of the psychiatric Team. Numerous spontaneous expressions of liking for team members, certain patterns of good natured kidding, and the eagerness of the patients to assist the personnel with small chores stood in marked contrast to their own behavior prior to the start of the project, as well as to the behavior of patients on other wards.

As further indication of absence of resentment against the members of the team and of eagerness for cooperation with them might possibly be mentioned the reaction of the patients to the "Follow-up" questionnaires. One the basis of experiences of other clinical psychologists with such studies, the experimenter had been advised that one had to expect a considerable "loss of correspondents" in any follow-up study by mail. In contrast with this prediction <u>all</u> 12 patients who had left the hospital had returned their questionnaires within three weeks. Among these 12 patients was one who had previously returned all questionnaires and rating-scales blank, another who had previously pasted newspaper clippings of advertisements suggesting "Strong Antiseptic" and "A

Complete Line of Shotguns" etc. into the spaces provided for the answers. Both these patients attempted to answer the questions of the Follow-up Questionnaire conscientiously. With exception of these two later "improved" patients, there was a close correspondence between the expressed feelings in the "End of Treatment" Questionnaire and those in the "Follow-up" study. There was one other notable exception: One of these discharged patients who had praised the "Research Project" in the earlier questionnaire in glowing terms attacked it in the "Follow-up" study most derisively.

Besides describing their impressions the team members and also the patients were asked to rate each patient with regard to handicap, self-confidence, and popularity on a nine point rating scale. A comparison of the July and October ratings reveals the following picture:

IMPROVEMENT SUGGESTED BY COMPARISON OF PRE - AND POST - RATINGS



In general patients appear to rate their fellow patients higher than the team members rate them. Patients' as well as team member ratings indicate an overall improvement in all three criteria. Statistical tests (Analysis of Variances, see appendix) show that none of these changes is statistically significant.

A survey of the various indications and comparisons of therapeutic changes for theward as a whole will suggest the following inferences:

1. The discharge data suggest that the experimental ward had a higher discharge rate and was more successful in achieving adjustment to trial visit and permanent discharge than the "average" ward on which patients with similar pathological conditions are treated. The presence of a therapeutic effect was also expressed in measures based upon the clinical expression of the psychiatric personnel, suchas pre- and post-treatment ratings and answers to questionnaires.

   All these measures show a consistent trend in the direction of at least equal but probably greater improvement on the research ward, even though the differences in the first three measures which permit quanitification are not statistically significant.

2. Caution in the acceptance of the preceeding statement is necessary. It is an inference which cannot be considered to be experimentally established until the assumptions concerning the impact of the

psychiatric team and the personality variables of the research population which formed the justification for the comparisons have been confirmed, which of course cannot now be done.

In spite of the impossibility to advance at the present time more conclusive evidence for a generalizable therapeutic efficacy of the "common" factors of the research project, the trend appears to be sufficiently strong to suggest a more detailed investigation.

The preceeding reflections have been concerned with those therapeutic factors which exerted their effect upon all patients to a more or less equal degree and which had therefore been called the common therapeutic factors. Besides these, the therapy had made use also of the three specific treatment methods previously described. As a matter of fact, the common therapeutic factors had been introduced mainly in the hope that they would boost the efficacy of the three specific treatment procedures to an equal degree, so to speak enlarge their effect as well as their differences, and thereby make possible a clearer understanding of these differences.

It remains then to investigate the differential effect of these specific treatment procedures.

2. The Specific Effect of the Different Treatment Methods

a) The Different Treatment Procedures in Practice

It has been mentioned that the total research population of 18 patients not only had been exposed to the "common" therapeutic structure which affected the ward as a whole, but had also been treated - divided into three groups of six patients each - according to three different treatment methods. The members of the first group were seen individually by their therapist, the second group met in group meetings which were focussed upon the problems of the individual, while the third group had the goal to produce and present a meaningful Marionette Show. Before attempting to analyze the influence which each of these treatment procedures exerted upon the patients, it may be well to become better acquainted with the concrete forms which these three therapeutic techniques assumed in the framework of the research project.

Unfortunately, it is not possible to present an even halfway complete account of the therapeutic processes. The transcribed recordings of the IC group therapy meetings alone would extend over more than 500 pages. Under these circumstances, it has been felt to be most appropriate to present here only summary process notes of the therapist and to include additional material in the appendix.

An understanding of the IC Individual Therapy process may be derived from the following summary process notes on the treatment of two of the six patients who received this form of therapy.

SUMMARY PROGRESS NOTES: This 28-year old, single male patient was accepted for the B-15 research program and was placed in the individual therapy group receiving two hours a week of therapy for a total of 22 hours. It was felt in the initial evaluation of the patient that therapy would be supportive in nature with an attempt focused on creating a feeling of acceptance in the patient and allowing him to express his feeling. His previous hospital course had been one of milieu therapy with very little individual attention from the doctors. He was not the type of person that one could easily become interested in because he was so withdrawn and seemed to be quite lacking any expression of emotional feeling. He would usually come to the doctor's attention by presenting some somatic complaint. It was evident that there was a severe problem with his parents since they did not seem to be able to accept him the way he was and they were on the one hand overly protective and on the other hand indirectly very aggressive and demanding of him. In the first few hours of therapy, he was extremely polite, but non-committal as to his feelings about treatment. I oriented the therapy around discussion of superficial reality problems which he faced every day in his hospital environment and expressed interest in his telling me how he felt about them. I found that I very quickly broke through a front of reserved polite disinterest when I made a comment about how lonely and isolated he must feel. At this point he broke down and cried during the greater part of one hour and after this seemed extremely dependent on me throughout the course of therapy, bringing in many minute problems and asking me to help him make a decision. During the second

month of interviews he opened up considerably in expressing his feelings about his parents. He talked quite freely about wanting to get away from them and bitterly resenting both the over-protectiveness and the passive aggression which his parents demonstrated toward him. We discussed for several hours the possibility of his moving away from his parents and working independently. He then began to recognize that in spite of all his resentment against his parents, he still had some need for them so actually he could not conceive of himself as being independent and, in the last month of therapy, we focussed more on how he could live with his parents and still resolve some of the resentment which he harbored.

In the last few hours of therapy (18 to 22) the patient began to see that there were some things that he could do to help himself while still living with his parents. He developed some capacity to act independently of them on some matters, for instance, to take a bus home on a weekend pass rather than insisting that they come and call for him and bring him back. He found that he could express some of his feelings toward his parents without being destroyed by them and he could improve further on this with help after he left the hospital. He accepted the idea of getting such help from the Mental Hygiene Clinic in Kansas City, even though his mother had some objection to this. In the last few hours the patient indicated some positive transference feelings in bringing me little gifts such as fruit or candy and was able to express also some resentment toward me over termination of treatment although he was quite timid in this. Because he had a great amount of money in

Finance (almost $5,000) it was administratively feasible to send him on trial visit to be discharged when the VA determined how his finances should be handled.

It is felt that with continued relationship in the Mental Hygiene Clinic, the patient has a fair prognosis for adjustment outside the hospital and has the possibility of further improvement. The great need of his parents to control his life and derive gratification from him is rather ominous and is discouraging since they may well resume the previous pattern they have had dealing with him when he does not conform with their demands; they withdraw the support he needs from them and try to get him into a hospital again. It is not at all unlikely that he will return to this or some other hospital in such a situation.

SUMMARY PROGRESS NOTES: This 30-year-old divorced, male patient had developed an acute paranoid schizophrenic break in July, 1950, and had six weeks of insulin coma therapy before admission on November 17, 1950. He had had about five months of individual psychotherapy with little progress. He was recommended for the three-month treatment program of the B-15 Research Project and was placed in the individual therapy group of treatment. At the onset of therapy, paranoid trends were still quite marked; the patient evidenced a great deal of hostility, yet seemed to be able to exert considerable control on himself so that among the other patients he stimulated the feeling that he was not sick and was in very good shape. His main resistance to treatment within the structure of this

program was that he did not feel he had benefitted any from treatment up to this time, in the course of nine months, and expressed the feeling that unless I could promise him that he would be well in these three months, there was not much use of our talking. I told him quite bluntly that I could make no promises as to what the treatment would accomplish, but could merely offer my interest and time to accomplish as much as possible. After bringing up this point in the first four hours repeatedly, he then expressed the feeling that he did not want to come to the therapy hours unless he had something specifically in mind to talk about. I made it clear that it was up to him whether he kept his appointments with me or not. During the three months of therapy, the patient participated in only nine of the 22 scheduled interviews completely. In four others he left the office before the hour was up. I continued to point out to him that I was interested in helping him and in trying to understand what his problems were and he continued to point out that if therapy had not helped him previously, he saw no point in getting involved with me. After the ninth scheduled hour he asked to leave the hospital AMA since he thought he was in as good a shape now as he would be at the end of three months. I refused to take any responsibility in advising him on this. He did hand in an AMA request, but it was not in proper form. I gave the request back to him and pointed out what was wrong with it and he did not give me another request.

At the 12th hour he came in and under a great deal of tension and somewhat tearfully expressed the feeling that he just didn't have the "guts" to go through with it. He felt he was still too sick. After this

the patient began to relax in the hospital situation with the idea of waiting out his time until they discharged him. One thing that seemed to help him considerably was a letter from a friend of his in which the friend told him that he would give him work at his previous place of employment. He thought his former employer was still disgusted with him for leaving his job the way he had. He said that he had avoided being very friendly with this employer when he worked with him and had declined several invitations for social outings with him because he felt a closer relationship with his employer would make him feel uneasy. He then asked me if I definitely planned to discharge him October 1; he recalled that I had said in the previous hour that he was still sick and it made him angry to have me say this. I replied by saying that it was still the plan to have him leave the hospital October 1. Then I commented on many occasions that he felt he was sick and yet when I made such a statement he usually denied this and became angry; that in this matter and several other things we had talked about since he had come on the ward, he seemed to take the opposite point of view from me--that when I pushed the black keys, he pushed the white and vice-versa. He smiled and remarked that he thought I understood what I was talking about. I pursued the point further by recounting several instances that occurred in which he tested me out to see if I had reacted the same way as previous doctors, whom he now seemed to consider a bunch of bastards who had never understood him and had mismanaged his case and that on several occasions he had made requests of me such as to go on a pass, to play

golf, to work at the radio station, to have a sedative order. With each of these requests he indicated it was most important that I grant them, but after I had granted them he made no use of them. I suggested that his primary purpose in making these requests was to prove that I was like the rest and that eventually he would make requests which I could not grant and that then he would have his proof but I wondered where that left him. I further said that my recognition of some of his problems could not be construed to mean that I did not feel he was potentially able to leave the hospital and make an adjustment that would be satisfactory to him. The patient opened up considerably, talking about himself, saying he was damned sure he wasn't licked yet, he wasn't ready to give up, and that he knew he could get along much better outside of the hospital than any of his friends though perhaps they would never be in a mental hospital, still they led a sad life from which they derived very little satisfaction. They fiddled away much of their time drinking, gambling as an escape or compensation for the better things in life that they were lacking. He described a tremendous feeling of loneliness that he had felt in the years preceeding hospitalization. He hadn't been able to mix with friends and had had a lot of time when he had drunk alcohol and frequented bars to satisfy his loneliness. He said that he felt now he was able to accept the friendliness of others at face value and not shy away from it and would be able to manage himself much better outside the hospital than he had previously. He thought

that now he would be able to save his money for constructive purposes instead of drinking it away and would be able to plan for the future. I had felt after this hour that the patient was perhaps going to seek some further help from me and work over additional problems and interviews. However, from the 15th to the 19th hours he produced virtually nothing and then for two hours did not come for the interviews at all. Two weeks before the time to leave, however, he came into the office and expressed a great deal of anxiety about going home, on leaving the hospital and for the first time in treatment, brought up many problems which he had with his family. He felt extremely insecure with his family, had a great deal of hostility unexpressed toward them, and was greatly concerned lest he lose control of his feelings when he returned to his family. He seemed to be caught between the desire to return to his family and be dependent upon them and the great hostility which he felt toward them. I could only reply that these seemed to be matters of quite some importance to him and that in bringing them up so late in therapy it was quite impossible to work through his feelings about these problems in such a short time. I reviewed all the ways in which he had been resisting therapy during these three months and how he brought up problems only at the time when he felt really threatened by them. I encouraged him to seek further treatment after leaving the hospital, preferably on an out-patient basis, but encouraged him to do this only if he felt moved to do so himself since he had learned from his experience and treatment with me that very little was accomplished

when he was unable to take the initiative in dealing with his problems. It was my feeling that the patient is able to exert sufficient control over himself to make an adjustment outside the hospital for a while, but that the underlying malignant thought disturbances very likely will break out again in the future and necessitate further hospitalization.

After these summary descriptions of IC Individual Therapies it is in order to summarize the IC Group Therapy process:

SUMMARY PROGRESS NOTES: During the meetings of the first few weeks the patients expressed in the main their doubts and disbelief in the possibility of being helped. They wanted to know why anybody would expect that they could be helped in a group when even the undivided attention of their therapists in previous treatments had failed. They wondered how this treatment was different from previous group therapy treatment which some of them had received on the Continued Treatment "D" Section. Doubts about the treatment frequently took the form of direct attacks against the experimenter. The patients left no doubt that they felt the treatment procedure served in the main to enrich the knowledge of the therapist and might possibly contribute to help future patients. Distrust against therapists in general, annoyance over their hierarchical status and their distance to the patients was repeatedly expressed during these first meetings. One patient asserted repeatedly that he had enough with his own troubles and he just couldn't see why he should have to listen to

other people's difficulties. One of the non-participating observers writes on July 24:

> What little group integration has developed is in terms of opposition to the leader and doubt about the therapy's value.

The therapist's acceptance of these feelings of doubt and fear appeared to permit the patients to recognize the pattern of their behavior. Instead of doubts and negativistic attacks against the therapeutic structure, the patients began to bring more and more personal, relevant problems to the group. At one point the therapist interpreted the remarks of a number of patients in which they attacked certain aides for their brutality and the hospital treatment in general for its tendency to treat patients as children, etc. He wondered if they did not have the feeling that they could get along all right except for the fact that others here were always doing the wrong thing and make things tough for them. The therapist wondered if the patients were not expressing their belief that they are really not sick. The patients in reply began to stress their illness; they pointed out in numerous ways that they were far from healthy mentally. One patient spoke about his feelings of inadequacy and ideas of reference which he had experienced so painfully on his recent weekend pass. Another patient mentioned how utterly inadequate he had felt when he had first moved from the country into the city. He went on to describe in detail a delusion which he had had at that time, expressing the hope that this disclosure would not interfere with his discharge. Another patient spoke about his alcoholic problem and

mentioned that he was only "one drink away from a drunk." This patient came to the next meeting drunk and hiding his eyes behind dark glasses. He monopolized the hour with hystrionic expressions of hostility, lamentations and vivid descriptions of his feelings of utter emptiness and purposelessness.

After the patients had in this manner left no doubt about the fact that they felt "ill," it seemed that during the next meetings the original feeling of doubt and disbelief in the therapy reappeared. Only now the patients were freer in the expression of their feelings. They showed up late for meetings, some brought newspapers and magazines along which they read during the therapy meeting; discussions were slow in getting started and dragged along interrupted by long pauses. One patient (3) who attempted to restore the former spirit of frank discussion of one's difficulties was rebuffed by one of the newspaper readers - "Why don't you mind your own goddamn business." During the ensuing heated argument it looked almost as if these two patients were coming to blows. The therapist intervened and promptly became the butt of the attack. He was accused of being a big hypocrite who pretended that he was interested in the patients but in reality was just trying to get a cheap education at government expense. This group was "just a waste of time" as far as the speaker was concerned. The therapist made it clear that the patient was correct in assuming that the therapist had other personal interests besides wanting to help them. This was reality, which one had to face.

Doubt about the therapy remained in the foreground during the following hours. However, it appeared that in distinction from the initial meetings in which doubt about the treatment had also been expressed, there was now always a number of patients who defended the treatment. It happened, however, that these same patients would in turn express their own doubts, at one of the next meetings. During the following meetings the patients began to speak about fear. They gave many personal examples of their fears and the meetings became very intense. Even patients who had previously remained passive were drawn into the discussion and one patient who while talking a lot had in the main avoided any sincere facing of his difficulties now began to speak about his difficulties. Fear of dealing with new situations (and job-hunting) were traced back by one patient to his lifelong dependency which made it impossible for him to develop his own initiative and which at the same time created in him impotent anger. He mentioned that his anger never showed. Other patients and the therapist mentioned numerous instances in which this patient had effectively "punished" those who kept him dependent (foster parents, teacher, therapist) by passively defeating their plans, or what he thought were their plans. In the following meetings the patients beganto direct their hostile remarks against "outsiders", in the main against the open ward patients of the Continued Treatment "D" Section. An "In-group" feeling seemed to be consolidated. One of the non participating observers wrote at this time:

> The leader has succeeded in removing the didactic quality that was always present. This has changed the group's feeling towards him. The aggression and resentment had gone...The group is no longer defending itself against him but sees him as someone interested in their welfare and their expressions about themselves.

The therapist wondered whether the resentment against these D-West patients might not be due to the fact that these patients are able to take it easy and remain in the hospital while the group members will have to leave at a definite deadline. The patients acknowledged this and spoke at length about the pampering of patients on Continued Treatment "D". One patient pointed out that the hospital could as r eadily become an escape as any of the means mentioned in previous meetings (alcohol, etc.) The problem of discharge began at this time to come more and more into focus. One patient returned from a pass and reported in the meeting he felt he had so many difficulties it had been difficult for him to control himself; for instance, when a young girl in his home village had asked him naively, "Say, is it true that you are nuts," that he felt maybe he should stay in the hospital. During the next meetings the therapist wondered what there was that could make anybody want to leave the hospital where everything appeared to be made to order. He maintained quite consistently the position of pointing out the advantages of hospital life leaving it up to the patients to argue for leaving the hospital. In doing so the therapist actually felt that he was helping some of the vacillating patients to express their real feelings which they might not have dared to do without his support. (A full transcription of one of these meetings is in the Appendix.)

Besides looking at the group process from the point of view of the total group, one might reasonably look at the group process from the point of view of the individual. In other words one might attempt to understand how the group affected each individual patient, how he changed in his relations to the group members, and the therapy, how the problems which he presented in the group changed. Such considerations are certainly pertinent but in order not to extend the paper unduly the preceeding account will suffice to foster an understanding of the concrete form of the IC Group Therapy.

PROGRESS NOTES - SUMMARY: SPC Group Therapy

In this group it was intended to focus the patients' interest and activity upon a meaningful common task rather than upon their individual difficulties. It was hoped that some of these individual problems would be eased in the process of constructive group activity, that others might come up spontaneously in discussions among the patients and the therapist during this group activity. The therapist spent two hours three times weekly with the group, during the other two weekdays the patients met with the therapist but he had to leave them shortly in order to attend the IC group meeting and they continued alone.

During the first meeting of the SPC group the therapist developed the idea of producing a marionette show presenting the difficulties a mental patient at his discharge from the hospital encountered. This included writing the play, making the marionettes, constructing

the stage and its eventual presentation to audiences in the hospital and in town. The patients were quite skeptical about the therapeutic effect of such an activity. One of them freely aired his disappointment over the fact that he had not been included in a "real" therapy group. He said that he would cooperate since he had signed up for the project but that he certainly was not going to be involved.

Others stressed the inadequacy of this old-fashioned medium in comparison with modern ways to propagate a message. One patient was of the opinion that playing with puppets was an activity for children and fools. Eventually the patients resigned and skeptically spoke about the fact that they had no choice since they had signed up for the project they might as well go through with it. Reluctantly they began to work on the construction of the puppets. Some parts and limbs were available and each patient selected some which seemed to fit together and then started out to carve the missing parts.
It was decided - that in line with the idea of the play - the marionettes were to represent present-day people in street clothes. This made it possible to begin work on the marionettes while the play had not yet been written. The patients soon began to become involved with their work. They became interested in their own marionettes as well as in those of the others. A competition developed between two of the less disturbed patients. They began to look for possible improvements. One of the patients had borrowed three books on puppetry from the library and soon became the "expert" on the various phases of the work. He became an authority who was consulted by the other

patients as well as by the therapist who himself had never worked with marionettes and had only a hazy notion about the work requirements. Although the discussions during the work period were still full of cynical kidding and derogatory remarks directed against the common undertaking half the patients became so involved that they began to use their own leisure time to advance the project. Three patients carved and molded puppet heads and limbs on the ward during many afternoons and evenings (according to the nurses' report.)

One patient who had chosen to work in the woodworking shop during his regular four hours of activity (It was previously mentioned that all patients on the ward had to choose four hours of daily activity) on his own initiative made a model which he had designed of a transportable stage. It was discussed in the group and some suggestions were made for its improvement. Then the patient who had built the model offered to build the stage in the woodworking shop. Another patient agreed to help him.

The writing of the play presented a major difficulty. Two patients had originally taken the responsibility to collect ideas of the other group members about relevant problems which were to be presented. One half hour of the daily two hour period was set aside for the discussion of suggestions for the plot - while the work went on. The patients reported a number of actual life experiences which vividly demonstrated the harm done by the prevalent prejudice against mental patients. The problem of how to join these scenes together

and present them dramatically was discussed for almost two weeks with considerable heat. A woman playwright from a local radio station was brought to the group as consultant and besides her helpful suggestions her presence and personality had a stimulating effect upon the patients. Eventually a complete outline of the play had been worked out in the group. Nobody in the group, however, felt capable of actually writing the play. It was then decided to ask a fellow patient from the IC Individual Therapy Group, who was taking a course in "Creative Writing" to write the play on the basis of the group's outline. He consented and the play was written by the end of the second month.

All this time the construction of the puppets had proceeded somewhat unevently. Some patients had shown greater imagination and skill than others. One patient had actually made three marionettes. It was quite evident that he worked faster and enjoyed offering his help to others. One patient became utterly disgusted with his own inadequacy and inability to equal the best. He began to be absent from the group and to neglect his work. The therapist talked to the patient about this difficulty and made it clear to him that he had other assets and that he could not expect to be tops in everything. This patient was able to overcome his disgust with himself and rejoined the group. Not so successful were the efforts of the therapist and the group to induce another patient to participate in the group activity. This patient showed up for about two weeks for the group meeting, but would sit with his head in his hands and not move.

The other patients asked him for small favors such as holding a wooden puppet-arm for the drilling of a hole, etc. This he would do willingly. He also began to work on definite assignments given to him by the therapist, but eventually he would throw them down and run out of the room. He finally refused to have anything to do with the puppets and could not be induced to even come to the group meeting.

Group meetings were in general very lively affairs. There was hardly a day without a quarrel between two or three of the group members. Yet despite these quarrels a feeling of friendship and familiarity among the group seemed to develop.

Besides the half hour for the discussion of the playwriting, fifteen minutes of every morning's meeting were reserved for the practice of the handling of the marionettes, which offered considerable difficulties. A senior Girl Scout troop was invited to the group meeting and gave a performance with marionettes which the girls had made. The girls made their puppets dance to records and the rhythm of the music made the movements appear more natural. This gave the patients the idea of including as much music as possible into the play and of putting the puppet play on records, so that the puppeteers did not have to bother about reading the script while they were manipulating the marionettes. Quite a few of the patients seemed to enjoy the visit of the Girl Scouts who, for some of them, were the first "outside" people they had seen for a long time. After the girls had given their demonstration, they stood around in groups and discussed informally with the patients various technical aspects of marionette handling.

At the beginning of September the script was ready, the stage built, and the marionettes strung. Numerous new problems arose. Curtains, props for the stage and backdrops had to be made, music had to be selected, the recording was to be arranged. Civic organizations had to be contacted in order to arrange for the scheduling of the play on their programs. In group discussions these tasks were distributed; smaller details such as the selection of the color of curtains and stage, etc. were also taken up. Two patients - who had never previously asked on their own to go into the city - were chosen to go downtown to buy the necessary curtain material, lighting fixtures, etc. They went more or less reluctantly, but reported after a successful shopping trip that they had really enjoyed it, and that their fears that they would feel lost had not materialized because they had had something definite to do. It was also decided to approach a number of women patients in order to ask them if they were willing to help with the sewing of the curtains.

In spite of the steady progress which was made it did not go without minor and major crisis. An an example the following might be mentioned: The patient who had volunteered to paint the backdrops had not yet produced a single backdrop, although he had had more than two weeks time for it. His attitude in the group became highly critical, he was dissatisfied with the quality of the materials, of the paints, of the work of the other patients, etc. In short, he criticized everything except his own capacity. When confronted with these facts he became very angry. After a discussion in which the

therapist attempted to show him that it was quite "normal" to expect too much of oneself and then to become disgusted, the patient changed considerably. He had finished one backdrop the next day. Unfortunately the proportions of the painted on furniture and windows were much too big so that he had to do it over. But even this mishap did not seem now to deter him. He finished all three backdrops in quick succession (and did an excellent job.)

For almost a week the group began to listen, while putting the finishing touches to their puppets, to records in order to select some appropriate ones as musical background. Then one of the patients suggested that an acquaintance of his, a patient from another section, be asked to compose and perform piano accompaniment instead of using recorded music as background. This suggestion was accepted. The patients spent a whole weekend, without the therapist, in working out and integrating an appropriate musical score with the script. They surprised the therapist with an almost accomplished performance on Monday morning and seemed to be greatly pleased by his amazement.

During the same week the recording of the play and the piano music was undertaken. This produced considerable tension with subsequent happy relaxation whenever one record was finished and the recorder called the group in to listen to it. It seemed to the therapist that this tense effort of doing a good job together more than the preceeding period began to produce a group feeling. The patients later mentioned how they had all, tired and excited from

the morning's work, gone to the mess-hall together and how they had enjoyed their group entry into the mess-hall.

The show was practiced during the next few days in front of small audiences which included observers from the Rotary Club, the American Legion, etc., as well as some members of the therapist's faculty. Excitement and tension during these performances was considerable and, by not hiding his own involvement and anxiety, the therapist seemed to establish a closer bond with the group. From now on the group began to appear as a unit with a common task and purpose, as an "in-group" distinct from the "others", the audience.

From the relatively informal rehearsals the group progressed during the last two weeks of September to performances in front of larger and more formal audiences. The play, which had been filmed,- and is available as a record of the work - was shown twice to audiences of patients and staff at Winter Hospital as well as to the Rotary Club, to patients of the State Hospital and to the American Legion. The sincere and well deserved applause and the many compliments which the patients received in all these performances not only gave them visibly more courage to face an audience but also increased the feeling of group cohesion. By this time, frictions and rivalries which had existed between the group members, had given way to an appreciation of the other person as a helper. The common experience and the approaching date of discharge increased also the feeling of together-ness between the patients and the therapist. After the first

performances the patients wanted the therapist to "have a glass of beer" with them. This he declined; he invited the group, however, after another performance to his home for a cup of coffee.

A small incident may illustrate the relation of the experimenter to the group. One day while the group was getting ready to go downtown for a presentation of the play, the experimenter noted an excited giggling among the group members which would and would not stop. When he attempted to find out what was so funny there were shouts of "don't tell, don't tell." Later on one of the patients came up to him and whispered, "I can't do it, it's too cruel, I have to let you know." He then revealed to the experimenter, after making sure that he would "not tell", that the patient who had written the musical score had gotten hold of two old records which he was going to break "accidentally" in front of the experimenter just before the show started, making believe that these were the master records on which the whole play was recorded. As it turned out the experimenter was able to put on a good show and feign utter desperation which the patients seemed to enjoy greatly.

The greatest difficulty arose during the last performance. This was the last day in which the whole group was together, the following weekday the discharges were scheduled to begin. The group was to perform in front of a large audience at the American Legion Headquarters. While they waited in the lobby of the Legion building, one of the patients sneaked out and got drunk. He returned in the middle of the play in which the other patients had taken his place and caused

considerable commotion by swearing and cursing the American Legion. The therapist took him downstairs and asked him to remain in an easy chair. The performance went on. But shortly before its end, the intoxicated patient again came upstairs and this time he climbed right unto the puppet stage. The curtain was dropped and the patient was taken down into the lobby a second time. There he explained to the therapist that he had never been as happy in his life as when he "wrecked that show." Asked if he felt that the show had done him any harm he replied, "On the contrary, it was the most wonderful thing that ever happened to me, but it's all over now."

After the end of their performance with which the other patients had gone ahead in the absence of the therapist, they were all invited by the Legion Commander to "free beer." For days they had spoken about this and enjoyed it in advance. Now they refused unanimously, because they felt that they should stick with the patient who was drunk, since they felt certain that he would get into trouble unless they took care of him by taking him back to the hospital together. This made it unnecessary to call the hospital police which might well have caused the patient's transfer to a locked ward.

The group had grown from isolated individuals who had initially resignedly submitted to the project into cooperating involved people who were bound together by the common task and had gained their accomplishments. Many personal problems had been casually discussed during the work or had been acted out and had then at appropriate

times been discussed by the therapist or by the patients themselves, but they had at no time become the focus of the group activity, as a matter of fact, they had usually been dealt with only to the degree to which they appeared to interfere with the group goal.

B. The Effect of the Three Treatment Procedures

After illustrating in the preceeding pages the differences between the three treatment methods, it is necessary to explore the effect of these differences. As previously mentioned, one may resort for this purpose to the qualitative and quantitative data discussed earlier.

The quantitative data consist of the discharge data as well as of the ratings for handicap, self-confidence, and popularity of each patient before and after the three months of therapy. These ratings had been obtained from members of the psychiatric team as well as from fellow patients. The rating scales used (see Appendix) had been constructed by the experimenter for this purpose.

The qualitative data consist of the opinions and judgments of members of the psychiatric team and of patients expressed as answers to questionnaires and in interviews.

It will be remembered that the main criterion of therapeutic success, as determined before the start of the research project, was the ability of the patient to leave the hospital at the end of the treatment and to remain outside during a three months "follow-up" period. One may therefore regard the differential therapeutic effect of the three treatment groups in terms of the number of their therapeutic "successes" and "failures." The distribution of the therapeutic "successes" and "failures" is as follows:

Therapeutic "Successes" and "Failures"

Determined after the "Follow-up" Study

	Total	Discharged	Hospitalized
IC Individual Therapy	6	4* (66%)	2 (33%)
IC Group Therapy	6	3 (50%)	3 (50%)
SPC Group Therapy	6	5 (83%)	1 (17%)

A proportional outcome with larger groups of patients might legitimately be regarded as an unambiguous indication of the superiority of the SPC Group Therapy. In view of the small number of patients in each group it can only be viewed as indicating a possible trend which might be formulated in the following manner:

There appears to be a tendency for the SPC Group Therapy to be equally or more effective in achieving the projected therapeutic goal of successful discharge from the hospital than either one of the two other therapeutic techniques used in the research.

Turning from the discharge data to the ratings, one finds similar results. Numerous statistical analyses of these quantitative data (see Appendix) leave no room for doubt about the fact that it is impossible to "prove" anything on the basis of these ratings. The

* One patient of the IC Individual Therapy Group listed above among the discharged has applied during the "follow-up" period for re-admission but was kept waiting for his "turn on the waiting list."

meaning of significant findings and consistent trends becomes questionable in the light of two outstanding weaknesses:

1. The rating criteria cannot be demonstrated to be exclusively relevant as matching and improvement characteristics.
2. Considerable lack of agreement exists between the raters, i.e., these ratings are relatively unreliable.

Two kinds of lack of agreement between raters are found in the ratings: those which express a basically different conception about the condition of the patient, pre- or post-treatment, and those which express a different evaluation of the change which the patient has undergone. Disagreement of the first kind is pronounced in the ratings of the patients' self-confidence which were turned in by the individual members of the psychiatric team. This disagreement exists also between the mean patients' ratings and the mean ratings of the psychiatric team, for all three criteria; marked differences in the appreciation of change, i.e. differences between pre- and post-treatment are found in the ratings given by the individual members of the psychiatric team with regard to handicap and popularity of the patients. Surprisingly enough there is, however, almost no difference between the change in each of the three rating criteria if one compares the mean ratings of the psychiatric team and of the patients. (For detailed information see Analyses of Variances of the Ratings of the Psychiatric Team and of the Mean Ratings in the Appendix.)

Of course the fact that no agreement exists among the individual psychiatrically trained observers about the amount of progress that has been made, does not decide whether or not actual progress has been made; it only serves to emphasize the fact that the use of these ratings as an adequate index of such progress has not been validated. Even areas of agreement therefore become somewhat suspect as possibly due to chance factors. It is nevertheless interesting to survey these ratings in order to find whatever common trends emerge. A comparison of the change in the average ratings of the members of each of the three treatment groups shows a consistent superiority i.e. maximal change in the direction of greater adjustment - in the SPC Group Therapy. According to the ratings of the psychiatric team, the SPC Group as a whole showed the greatest improvement in all three rating variables. According to the patients' ratings the SPC Therapy Group ranked equally highest in improvement of Handicap and Popularity ratings, while it held second rank in improvement of Self-Confidence ratings, behind the IC Group Therapy.

The Analyses of Variances (see Appendix) of the original data reveal that the differential effects of the therapy as they are reflected in the Handicap and Self-confidence ratings given by the Psychiatric Team actually reach statistical significance at the 5% level. (See interaction of Rating Groups) This means that

according to these ratings the therapeutic effect is not evenly distributed among the three groups. "Inspection" leaves no doubt that the more effective group is the SPC Therapy Group.

Although the unreliability of the individual ratings undermines the value of the above ratings as indices of differential effect, it is nevertheless remarkable that such agreement exists consistently about the greater therapeutic changes produced by the SPC Therapy Group.

TABLE

A Comparison of the Mean Ratings - Changes of the Three Therapeutic Groups

	PSYCHIATRIC PERSONNEL			PATIENTS		
	July	Oct.	Increment	July	Oct.	Increment
Handicap						
IC Ind. Therapy	5.45	5.19	-.26	3.96	4.17	+.21
IC Group	5.76	5.61	-.15	4.96	4.40	-.56
SPC Therapy	5.83	4.83	-1.00	4.30	3.46	-.84
Self-confidence						
IC Ind. Therapy	5.50	5.33	-.17	3.86	3.87	+.01
IC Group	5.81	6.21	+.40	5.18	4.68	-.50
SPC Therapy	5.42	4.67	-.75	4.19	3.92	-.27
Popularity						
IC Ind. Therapy	5.17	5.24	+.07	3.96	4.00	+.04
IC Group	5.02	4.90	-.12	4.62	4.28	-.34
SPC Group	5.05	4.43	-.62	4.42	3.80	-.62

The Rating Scales have been so constructed that a decrease in rating signifies improvement. The minus thus stands for improvement, the plus for decline.

By means of a preference questionnaire (see Appendix) an attempt was also made to obtain a measure of the popularity of each patient in the total research group. On the basis of preference questionnaires completed before and after the end of the treatment, a Sociogram was constructed in which any choice of one patient by another patient was recorded once. Analysis of these data show some interesting trends. While the members of all three groups were initially in approximately equal demand by the end of the treatment period the demand for relationships with members of the SPC Group had risen while that for members of both IC Groups had declined.

FREQUENCY OF SELECTION AS COMPANIONS

	July	October
IC Indiv.	16	15
IC Group	18	11
SPC Group	16	19

If one considers the number of choices made by a patient as an indication of his desire to associate, it appears that Groups 1 and 3 become more sociable while Group 2 declined in this respect.

TOTAL NUMBER OF CHOICES GIVEN

	July	October
IC Indiv.	15	17
IC Group	17	7
SPC Group	18	21

The number of "In-group" choices might well be considered as an indication of group cohesion. It is interesting to note that it increased slightly in Group 1, decreased greatly in Group 2 and increased to more than twice the original number in Group 3.

FREQUENCY OF INGROUP CHOICES

	July	October
Ic Indiv.	4	5
IC Group	4	1
SPC Group	4	9

It is, of course, obvious that such a small sample only offers a specualative basis for inferred trends. Yet, all indications point in the same direction and appear to support the hypothesis that the SPC Therapy is at least as effective as the other methods.

Turning from the analysis of the quantitative data to the evaluation of the opinion of the participants, it may be well to first consider the ideas expressed by members of the psychiatric team. A reading of their conclusions (see Appendix) regarding the different effect of the three treatment procedures makes it clear that they are far from unanimous. A nurse is of the opinion that "all three methods have their special benefits" while the ward psychiatrist holds that the SPC Group project helped the patients develop self reliance and confidence in interpersonal relationships more than individual therapy. A number of these psychiatric workers enumerate various advantageous aspects of the SPC Group Therapy.

No superiority of any of the other therapeutic methods is mentioned. On the basis of these answers, as well as from personal discussions with various staff members, one gains the impression that SPC Group Therapy is viewed by the members of the psychiatric team as a successful therapeutic technique which is more or less equivalent to the two other therapeutic methods.

The patients themselves show somewhat of a preference for the SPC Group Therapy. At the start of the program it was quite evident that IC Individual Therapy had the greatest prestige among the patients. A number of patients actually told the experimenter that they could only be helped in that group which was to have private interviews with their therapist. One patient in the SPC Group felt insulted because he had not been assigned to one of the IC groups. As the therapy proceeded, the attitude of a number of these patients changed noticeably. Many patients sought eagerly association with the SPC Group. They offered to help the patients in this group with their task. One patient who belonged to the IC Individual Therapy went to such lengths in his efforts to cooperate with the SPC Group that his therapist asked the experimenter to clarify with the patient his status as being in the IC Individual Therapy Group. A number of patients from other open wards also repeatedly asked the experimenter as well as various group members for permission to participate in the group activity. (A request which had to be denied with exception of

those volunteers which the group actually needed, i.e. the composer, the writer and the three girls who did the sewing.)

The answers of the patients to the questionnaires appear to corroborate the impression of the increasing appeal of the SPC Group Therapy. One question was formulated to elicit the feelings of the patients about the three treatment procedures; it read: "How does the therapy which you received on B-15 compare with the treatment that other patients on B-15 received?" Of the 14 questionnaires returned eight contain answers which fail to compare the three methods. Typical examples are the following answers: "All patients on B-15 received good treatment," "Don't know enough to judge", etc. Only six patients make a comparison; one of these is a patient who had expressed at the start of the program a strong preference for the IC Individual Therapy to which he had actually been assigned. He writes:

> If I were to take part in another activity I would ask for Group III. Projects such as the puppet show seemed to be most beneficial. Even Group II might have been better for me, but I don't know and certainly didn't know at the commencement of the program.

Another patient of the IC Individual Therapy Group writes:

> I believe the program is good. I do not think that the individual therapy treatment has any use in the program. Group 2 and 3 are good but I think that Group 3 should have a meeting a week like Group 2 had. Eliminate Group 1. The two hours a week that I spent with the doctor was not even therapy. If any treatment could have helped me it would have been Group 3. Regret not being in that group.

One patient of this group writes: "My therapy applied to my case; another type would not have been of any benefit."

A patient from the IC Group Therapy writes: "I think I got more out of my group than would out of the other groups."

Another patient from this group remarks:

> I think it may have some advantages over the other two. By talking about individual problems openly it seems to make you see them more clearly.

A patient from the SPC Therapy Group writes:

> I feel the third group to have been the best. The first group seems to have had the poorest results. I feel very enthusiastic about the group I was in and feel that it really helped me and some of the other fellows.

On the basis of these expressions, one might tentatively conclude that the IC Group Therapy as well as the SPC Group Therapy have produced a lesser amount of resentment or resistance among the patients than did the IC Individual Therapy.

It is, however, obvious that the statements of the patients cannot be used as index of the efficiency of either therapy just as little as one could use the statement that a dentist "hurts" or "does not hurt" as an indication of the quality of his work. All one can deduce from these statements is that there appears to be some difference in the personal feeling of discomfort created by these procedures. To what degree greater comfort goes together with greater achievement remains to be investigated.

Although the findings of this research fail to validate the superiority of any one of the three therapeutic methods under investigation, they suggest consistently that the therapeutic

effect of the SPC approach at least matches that of the other two therapies under the given conditions which of course include several uncontrolled variables. It is therefore necessary to subject this method as well as the other techniques to further experimental investigation. In the light of this fact it may be well to reflect on some of the additional problems which the use of thses methods of treatment entailed.

Some important aspects of these therapeutic techniques have thus far been somewhat neglected. Economy for instance is obviously a factor of prime importance which may well determine the acceptance or rejection of a successful therapeutic technique. In the present research study, the SPC therapist spent at least twice the amount of time with his group as did the IC Group therapist. Since the salary of the therapist constitutes in general the greatest single expenditure in psychotherapy, it is clear that the IC Group Therapy is doubtlessly more economical while both Group techniques have advantages in this respect over the IC Individual Therapy. It remains to be determined by a future study, if the time relationships maintained in the present research are actually the most adequate ones. It would be an important step forward if it could be established exactly where an extension of the meeting periods and an increase of the number of weekly sessions would reach a point of diminishing returns for either method.

Another economic factor besides the therapist's time is the cost of materials and supplies required for the SPC Group Therapy.

In order to produce the puppet show a considerable amount of art supplies and tools was required. The expenditure for these items brought no financial returns. Specific regulations of the Veterans Administration stipulate that patients may not engage in gainful labor. As a result, it was necessary to choose a therapeutic group project which did not bring any financial returns. This additional expenditure for materials and supplies is not required by the IC Group Therapy while, of course, IC Individual Therapy requires an even greater expenditure for the time of the therapist. On the other hand many of the materials and tools used for such a project are available in the average Occupational Therapy Shop and can be used over and over again by successive groups. Although not strictly speaking economically or financially lucrative, the potential of the SPC Group Therapy to act in the public interest of the community and to contribute to the betterment of public relations of the hospital is a factor not to be neglected. The puppet show and the film turned out by the experimental SP C Therapy group have been shown to a wide local audience and have met with a favorable response. They have brought the difficulties of the mental patient somewhat closer to the spectators and created an increased understanding of these problems in the community. Besides five live performances of the puppet show which were seen by approximately 1000 people, the film made of the puppet show was shown repeatedly; among others it was presented as a model by Dr. Karl Menninger to the psychiatric

residents of Winter VA Hospital and entertained the local Mental Hygiene Society. The experimenter has been informed that after the termination of the therapy project, two other groups of patients of Winter VA Hospital undertook the production of orthopedic toys and Christmas presents for a local school for crippled children. This group activity also had the character of SPC Group Therapy and left the psychiatric personnel who participated in these projects highly gratified with the effects upon the patients themselves as well as upon the crippled children who were the recipients of these toys.

In private and state institutions in which the aforementioned restrictions against gainful economic activity are not in force, it is of course possible to use the SPC therapy to actual economic advantage of patients and institutions. (Be it stressed again in this connection that the SPC approach is fundamentally distinguished from the employment of prison and institutional labor as it is practiced presently in various places, by its emphasis upon the necessity for the patient to be convinced that he is doing something which is <u>to his own advantage</u> as well as to the advantage of others.) Another problem which has not been mentioned is the problem of <u>potential universality of application</u>. A method, be it the most successful, which requires a constellation of conditions which can only rarely be created has less practical importance than a method which can function under all circumstances. The use of the IC Individual and IC Group Therapy approach is limited only by the

necessity to have a trained therapist available and the patient's ability to control himself sufficiently, so that he can participate in a group meeting or individual therapy session. SPC Group Therapy requires equally the presence of a psychologically trained therapist; it also necessitates a certain amount of control on the part of each patient. It appears possible, however, that even patients who are not sufficiently controlled to participate in one of the IC therapies may derive benefit from being included in an SPC activity. However, this statement is still speculative at this stage and will have to be subjected to scientific investigations.

Beyond the limiting conditions of the IC therapies, SPC Group Therapy requires in addition the availability of a task which is meaningful or potentially meaningful for the patients and also permits accomplishment in a context of cooperative group activity. These conditions certainly tax the ingenuity of the SPC therapist. However, the SPC therapist can find a wide field of creative potentialities even under the restrictions of the VA regulations, for instance, by helping to construct some of the necessities for private or public social agencies, public recreational facilities, making elaborate preparations for campaigns of public interest such as the "Mental Health Week," "Cancer Drive," etc. In private and state hospitals there appears to be hardly any boundary for the potentialities of an ingenious SPC Therapist.

CHAPTER IV

DISCUSSION

"The highest function of research is to help us ask better questions in our next study."
Edwards and Cronbach (89, 59)

The Relationship existing between "Common" and "Specific" Therapeutic Factors.

Thus far the present study has investigated:

1. The difference between the effect of the "common" therapeutic factors introduced on the research ward, and those found on the "average" continued treatment ward.
2. The differences among the effects of the three "specific" therapeutic methods used on the research wards.

In the first chapter hypotheses have been suggested which appeared suitable to account for the possible superiority of any one of the therapeutic factors under investigation. If a clear superiority of one of these therapeutic methods would actually have been found in this study, it would still have been necessary to subject such a finding to further scrutiny in order to ascertain if "hidden" factors might have influenced that outcome. Only after this possibility has been eliminated can the finding of a clear-cut superiority be accepted as scientifically valid; only then can confidence in the practical application of this method be justified and the outcome be considered as confirmation of the corresponding theoretical postulates.

A clear superiority of one therapy has, however, not been found. The absence of such a positive finding on the other hand cannot be accepted as any more final than evidence to the contrary. It is necessary first to examine whether these negative findings may not also be due to "hidden" variables which could have tended to veil actually existing differences.

Edwards and Cronbach (89, 57) remark:

> A genuine relationship may yield a non-significant difference for several reasons. One is that too few cases were used in testing it, so that sampling errors obscured a real difference. Second, errors of measurement have a similar effect. Thirdly, even when a new technique (say of therapy) is based on a superior concept, it is likely to be used inefficiently in its first trials, so that its advantage over other approaches will be obscured by technical faults in its application...'not statistically significant' - like the Scotch verdict 'not proven' - permits us to return the hypothesis on trial to the arms of those who live it, rather than at once chopping off its head.

It becomes clear that the very same factors which in the preceeding chapter were mentioned as possibly contributing to spurious differences could be equally suspected of masking those that may actually exist. One such factor has not yet been discussed. This is the possibility that the interaction between the "common" and the "specific" therapeutic measures might have also distorted the results of this study.

In the original design of the research project, it had been assumed that the existence of "common" therapeutic factors would step up the rate of improvement to the same extent under all three "specific" treatment conditions, and that this would at the same time increase the magnitude of differences between the effects of the

specific therapies. This assumption, however, has become questionable in the light of the experiences on the research ward. It appears possible that one or two "specific" methods have been so effective that they approached a therapeutic "limit" beyond which little progress could be made regardless of the presence or absence of the additional "common" therapeutic influences. A third method, remaining far below the potential therapeutic "limit" however, may have been boosted to the level of the other methods by the very presence of such "common" therapeutic factors. By virtue of such interaction, it would turn out that the presence of a "common" variable produces a levelling of the end results which would mask actual differences between the effects of the three therapies.

Analysis is further complicated by the possibility that "common" factors other than the ones discussed may have been present, though overlooked by the experimenter. These may have contributed to the masking effect. For example, the "novelty" in each of the "specific" therapeutic methods might have exerted a therapeutic influence. It seems that new methods are frequently more effective "in statu nascendi" when they are first introduced. The "novelty", the unexpected, may possibly have something like a catalytic effect. Each of the three "specific" treatment approaches creates to some extent continuously "novel" situations for the patients, which may - depending on the individual - contrast strongly with the empty drabness of a leaden existence. If this is the case, it would be necessary to

investigate by what means and to what extent each of the three treatment methods is able to maintain this "novelty" for any length of time.

If, and to what degree, any such "common" factor may have contributed to the masking effect cannot be determined on the basis of the present data. This investigation has shown, however, the need not only for more adequate control of factors which might tend to produce spurious differences, but also for an equally diligent effort to discover and control influences which might tend to level or mask potential differential effects.

Certain experimental safeguards for future investigations can be suggested on the basis of the experience gained in the present investigation.

Experimental Suggestions

A survey of the main difficulties encountered in the present study reveals two primary problem areas:

1. How to control the therapeutic situation. (How can one make sure that only those factors exert an influence which one wants to examine?)
    a) Reduction of "hidden" variables.
    b) Evaluation of interaction of simultaneously applied therapeutic measures.
2. How to determine the personality variables of the research population.
    a) Development of relevant criteria for selecting and matching patients and for comparing their progress.
    b) Achievement of a valid consensus of clinical judgment among members of the psychiatric team.

Therapeutic Control

This study has shown the necessity of extending the control of influences inherent in the therapeutic situation, i.e., of including as many as possible of those conditions which are not the subject of the investigation proper. "Hidden" influences, which might have played a part in the present study and which were not sufficiently controlled, were:

Personality of the therapist

Motivation (i.e., bias in favor of SPC or IC, etc.) of the therapist

Skill of the therapist

Personalities of the members of the psychiatric team

Another insufficiently explored and controlled area is the knowledge of those conditions under which each of the therapeutic techniques might achieve an optimum of therapeutic effect. The question of time structure, of optimal frequency of therapeutic sessions for each one of the treatment methods remains to be investigated. The impact of each of the three treatment procedures under different environmental conditions remains to be explored. With a little poetic license one might speak of at least three different atmospheres in Winter VA Hospital under which treatment was given to chronic patients at the time of the research project:

A "laissez faire" atmosphere in which the patient was left mainly to manage on his own, although he was of course able

to use the help of his doctor. This was practiced on some of the open wards of the Continued Treatment "D" Section.

A "dependency" atmosphere in which in return for passive submission under a fully structured ward regime the patient was assured of the satisfaction of all his physical needs. This atmosphere existed on some of the wards of the Continued Treatment "B" Section and on those of the Continued Treatment "C" Section.

A "democratic" atmosphere in which the initiative of the patient and his cooperation with the other patients was encouraged and remunerated. The research ward as well as possible other wards represented this climate.

A study of the effect of the three "specific" treatment methods in each of these atmospheres might throw simultaneously more light upon the problem of interaction of "common" and "specific" therapeutic measures.

Another exploration would clarify this interaction further, namely, a comparison of the impact of the three months time structure upon each one of the treatment methods and of its impact in the absence of any treatment method. Lewin mentions a similar situation (73, 149):

> A typical example from experiments Miss Dembo undertook for another purpose follows. The subject was forbidden to leave a certain place yet would like to; she does not dare to, that is cannot carry out her leaving in the form of a controlled action. Her way out is to form the intention: I will go as soon as the clock gets into this or that position. (Similar occurrences are frequent in everyday life.) Thus she creates valences for the future, which will then directly press her to leave and bring about or facilitate the intended action.

Here the impact of a time structure(self-imposed) upon a single individual is described. It is necessary to explore also its effect upon a group of people. When this is understood and when the interaction of each of the three "specific" treatment methods with such a time structure has been explored new and possibly important knowledge of therapeutic influences will have been gained.

Another important factor barely touched upon in this study is the problem of the patient's preparation for the "outside," particularly his vocational guidance counselling, his social service work-up, etc.

After more adequate information has been gained through successive series of experiments it will be possible to relate therapeutic effects more specifically to definite therapeutic components within a total therapeutic context. The present study has at least demonstrated that it may be well worthwhile to pursue this circuitous road of investigation.

Personality Variables of the Patient

The greatest difficulty in research on therapeutic efficiency lies in the initial evaluation of the personality of the patient and in the establishment of criteria of improvement.

By relying on clinical appraisals as a measure of the patients' personalities and therapeutic progress the study neglected to take into account data from the environment of the patient (case history) which were at least partially accessible to reliable investigation.

Thus, it would have been possible to obtain a verified account of the patient's physical health, his physical capacity, his energy reservoir, his intelligence, financial status, social position, occupational achievements, family cohesion, his own status in the family, etc. It might be possible to isolate eventually all these criteria for appraisal of a patient's personality and improvement by analyzing large numbers of patients' hospital histories with a factorial design based upon the above factors. Edwards and Cronbach (89, 54) say:

> There is some difference in the views of the writers here. Cronbach sees the number of relevant variables in the clinical study as likely to be so large that enough cases to account for them all will almost never be available. Edwards thinks a few well chosen organismic variables will clarify therapeutic conclusions and that in long range research the specified types to complete the cells of more complex factorial designs can be obtained.

Such a study, however, would require a great amount of time. In order to find and improve relevant criteria for selecting and matching patients, it may be sufficient to refine the clinical assessment of the patients and to use it in connection with selected biographical data and possibly clinical tests. One might thus match the patients on the basis of occupational and educational equivalence, cultural background, age, etc. as well as on the basis of clinical assessment.

Many clinical methods select judgment criteria for the pre- and post-evaluation of the patients which reflect therapeutic effects

as changes in the patient's behavior along a rating dimension. In this way the measure of change is not necessarily derived from a valid measure of the pre-experimental personality but rather from relative differences between certain aspects of the personality, pre- and post-experimental. Such an attempt was made in this study. The therapeutic process takes place in several interacting spheres, between patient and therapist: the phenomenal world of the patient, the corresponding phenomenal world of his therapist and the "geographic environment." How can one best obtain a measure of the changes which take place in these interconnected spheres? In the present study an attempt was made to obtain an index of these changes by means of recording changes as if they were occurring in a "geographical field," i.e., the patient's leaving the hospital. (How he experiences this leaving phenomenally cannot be determined.) This index was supplemented by the clinical appraisals obtained from the members of the psychiatric team.

Leaving the hospital is based upon a complex relationship of phenomenal and environmental factors. A clinical appraisal constitutes an effort to assess the totality of these relationships. It turned out that the clinical appraisals as expressed in the ratings and answers to questionnaires showed considerable differences. Such a lack of agreement makes it difficult to use these appraisals as reliable indices. Edwards and Cronbach (89, 56) write:

> When the outcomes are measured on a brief unreliable test, or when subjective judgments of personality introduce inaccuracy, errors of measurement tend to obscure true differences. In this event investigators are prone to accept the null hypothesis and not realize that a true difference may be concealed by their inadequate technique.

It is therefore necessary either to look for a difference in the approach to personality and improvement of the patient or to refine the appraisals. The latter can be done in a variety of ways:

1. The rating scales can be improved, in such a manner that they apply to the concrete observations of the rater, thereby reducing the necessity for the rater to make an arbitrary decision in an ambiguous situation.

2. The possible effect of unequal training and experience in a clinical setting on the part of the raters can be excluded. (This can be done statistically by determining the variation which is due to this factor and subtracting it from the error term, or better even experimentally by selecting as raters people with an approximately equal amount of training and experience.)

3. Possible differences in the appraiser's knowledge of the extramural environment of the patient can be equalized by acquainting all of them with the patients' case histories.

4. Variation in ratings, intra-individual as well as inter-individual can be further reduced by training the raters by statistical measures, i.e., by determining the amount of variation which occurs in an equal period prior to the start of treatment and deducting this from the error term.

The Problem of Objectivity

One of the difficulties which arose during an early phase of the experimental work was the necessity to present the findings of the research project with scientific "objectivity" rather than in the form of a testimonial or a statement of faith.

This task is hardly difficult for the physicist. He constructs a measuring instrument which can be tested repeatedly under known conditions until its reliability is established. It will then serve as a valuable tool to indicate differences in the contribution of various components of a total situation. It is frequently taken for granted that this approach is the only possible one for scientific research. R. S. Hartman (37, 240) writes:

> Theoretical research into human nature must proceed as objectively and competently as does research into physical nature, along lines dictated by logical necessity rather than practical consequences.

Other social scientists, however, seem to think differently. The conflict of methodology here involved may be illustrated by quoting Glazer and Mannheim (35, 489, 495):

> Physical science does indeed create sets of universal propositions (conceptual models) and from them deduces almost everything in the world with which it deals. Given the lawof gravitation and some historical conditions, practically nothing is left unexplained in the movement of the planets. Other sciences are not as strikingly successful in ordering their worlds...There are aspects of human behavior - like language and simple learning - that seem to be by nature of the facts about them that interest us, susceptible to organization into scientific systems. As we get further away from human behavior rooted in physiology, however, the application of scientific method becomes less and less fruitful and it becomes harder and harder to rise above the immediately given facts through organized scientific procedures.

Karl Mannheim (59, 147) writes:

> The modern mind has been permeated by measurement, formalization, and systematization on the basis of fixed axioms... In the cultural sciences in which we are not so much concerned with the human sphere which can be reduced to law as with

> the wealth of unique concrete phenomena and structures which are familiar to practical men of affairs but which are not attainable through the axioms of a positivistic science, this one-sidedness is particularly apparent. The upshot of this was that practical man dealing with concrete situations and applying his knowledge informally was more intelligent than the theorist who observed only a limited sphere because he was imprisoned by the presuppositions of his science.

The same author is even more outspoken when he remarks (59, 104):

> Today we almost take it for granted that science begins when it destroys our original approach and replaces it by one which is foreign to living experience. This is the most important reason why practice cannot profit by this kind of theory. This creates a tension between theory and practice which is increasingly aggravated by modern intellectualism...The scientist always approaches his subject matter with an ordering and schematizing tendency whereas the practical man...seeks orientation with reference to action...The desire for concrete orientation with reference to action leads us to view things only in the context of the life situations in which they occur. A schematically ordered summary tears apart the organic interconnection in order to arrive at an ordered system which, although artificially constructed, is nevertheless occasionally useful.

It seems then that people confronted with practical problems, a military strategist, for example, may develop a certain plan of action, an "action-hypothesis," e.g., (Karl von Clausewitz) "Offense is the best Defense." They will act on it and observe the effects under various conditions. In so doing, they will become aware of the limitations or of the correctness of the "Action-hypothesis." The scientist, however, would demand to know "facts" and the reasons for the success or failure of the "action" in terms of the underlying process. Turning experimenter, he is therefore forced to "objectify" his observation, to analyze the

global character of his impressions into "facts" which can be similarly observed by others.

It may appear as the ideal fulfillment of this task to record and transcribe every overt behavioral event. But even if one were to present only those events which have actually been recorded in the present research, extending over a treatment period of barely three months, one might easily cover more than 5,000 pages. Gordon Allport (2, 16) writing about a more extensive investigation of therapeutic changes, remarks:

> The total accumulation of single spaced recordings of visits, interviews, activities, centering about the lives of the T boys (the experimental group) amounts to approximately 22,000 pages. A social scientists beholds this bulk with consternation.

It is clear that if no selection is made reader and investigator will be so overwhelmed by an avalanche of material that the selection of relevant information will be interfered with by extraneous factors, such as the fatigue of the reader, the randomness of opening the book at a certain page, etc.

An example of the controversial and thus subjective nature of even this sort of factual reporting may be adduced. Writing about the social psychological mammoth work "The American Soldier" (2 volumes, 1250 pages), the authors (35, 408) note that their book contains

> a mine of data, perhaps unparalleled in the history of any single research enterprise in social psychology or sociology.

Another social scientist, Glazer (35, 496) in a critique of the same work remarks:

> Rarely was so little useful information about so large a question spread over so many pages. All because the aim was not science, not understanding; the mechanical and formal confining of knowledge, not the increase of it.

Another difficulty arises in connection with the complete recording of all overt behavioral events. To the participant an electrical recording frequently seems to lack likeness to the actual event. In Carl Rogers' work (74, 212) in which a number of recorded therapy sessions are transcribed, one finds the significant footnote:

> Just as it is impossible to convey on paper the venom and hatred in the client's voice, so it is utterly impossible to convey the depth of empathy in the counselor's responses. The counselor states, 'I tried to enter into and express in my voice the full degree of the soul consuming anger which she was pouring out. The words look incredibly pale, but in the situation they were full of the same feeling she was so coldly and deeply expressing.

It is possible that exactly those aspects of behavior which this scientist finds "impossible to convey on paper" may be very significant aspects of the situation. A lengthy verbatim report which excludes these nuances is apt to produce a distorted picture.

Left with the problem of selecting from the great accumulation of his data those facts which appear pertinent to him, the experimenter begins to realize that any selection might also be bearing the imprint of his personal values.

Allport (2, 117) remarks that:

> John Dewey has shown that psychological theories are profoundly affected by the political and social climate prevailing in a given time and place.

Alfred N. Whitehead (11, 520) holds that:

> Mankind have raised the edifice of science because they have judged it worthwhile. In other words, the motives involved innumerable judgments of value. Again there has been conscious selection of the parts of the scientific fields to be cultivated and this conscious selection involves judgments of value.

And Gustav Ichheiser (45, 25) makes it clear that not only ideas and conceptions of the scientist are greatly affected by cultural influences and values but that even perception and experience are influenced by the same frame of reference. He writes:

> We perceive, we "experience" often only those facts or only those aspects of social reality which fit into the scheme of our socially and culturally preformed or prepared dispositions of perceiving (or not perceiving), of having (or not having) certain experiences.

Numerous investigations have resorted to the use of formal characteristics which permit quantification. These are taken as pars pro toto of the patient's phenomenal field and behavior. Frequency of repetition of, or addition to, selected linguistic criteria, frequency of assumptions of specified roles in social contacts, etc., are recorded and presented as objective measures of behavior. The investigators who rely on these measures point to correlations which appear to connect these formal aspects of behavior with the total behavioral and phenomenal context. They fail, however, frequently to show how these correlations could be the expression of necessary and relevant connections rather than of mere incidental regularities. In the absence of such proof, it appears that the <u>substitution</u> of "formal" <u>part</u>-aspects for the

total behavioral context is in danger of being an arbitrary measure which is based upon the values and beliefs of the investigator rather than upon established facts.

It appears then that for the investigator of human relations there exist two possibilities for reporting his findings neither of which entirely eliminates the investigator's personal value system:

1. He may resort to various measures which appear to be objective because they are outside of the investigator. The selection of these measures itself, however, to some extent is an expression of the experimenter's value system and is based upon the assumption that by measuring part-aspects, one may gain an understanding of the whole of a person's phenomenal world and behavior.
2. He may attempt to describe the total contextual richness of the changes as he personally experiences them, without attempting to objectify his findings.

The dilemma of this choice has been powerfully expressed by J. W. v.Goethe:

"Wer will was Lebendiges erkennen und beschreiben
Sucht erst den Geist heraus zu treiben
Dann hat er die Teile in seiner Hand
Fehlt leider nur das Geistige Band." *

* He who desires to understand and describe a living thing
First attempts to drive out its soul
Then he has the parts in his hand
Unfortunately he lacks the spiritual connection.

An American social scientist, R. C. Cabot is quoted by Allport (2, 15) as saying:

> If truth to life is our intention we must, I think, realize that we are doomed to attempt literature. No modest confession of incompetence excuses us. The comedy, the tragedy, the poignant unexpectedness which emerge...almost every day...cannot truthfully be left out of record. But if we try to put them in, we are trying to write good literature and can escape neither its privileges nor its trials.

The experimenter has used in this presentation the first method, i.e., he has attempted to report only those data which could be communicated in objective terms, aiming at verifiability. He realizes regretfully that in so doing he was unable to portray the richness of the growth of emotional ties between the participants, the impact of the personalities of the patients and staff members on him, and the gradual changes of the patients' phenomenal field which he as a clinician believed he sensed.

The experimenter feels keenly that it is as important in clinical studies of human relationships to give a "literature-type" empathic presentation of the total "atmosphere" as it is to present genotypic and verifiable events. It may therefore be advisable that a future study of this type be reported in two distinct parts, possibly by a team of investigators: 1. A sensitive, subjective presentation of the total "atmosphere" in its development, and 2. Objectified verifiable "landmarks."

After emphasizing the impossibility of escaping from the influence of the experimenter's value system, which is not

necessarily distorting but frequently accentuating and mobilizing, it has been suggested that an attempt be made to recognize this state of affairs by permitting the investigator to present the full phenomenal impact of his investigation as well as to report overt behavioral indices.

APPENDIX A

INDIVIDUAL CENTERED GROUP THERAPY MEETING

September 25, 1951

Therapist: We have been speaking about staying in the hospital. Here is a place where we have to eat, to sleep, to blow off steam without being hit, etc., only you can't get in contact with the outside. You don't have to fight. That's another reason why the hospital sounds good to us. You can't have that on the outside.

C: The things that we are getting by with in here sure as the hell won't work on the outside.

Therapist: It seems that the more we look at the situation the better the hospital becomes. You have a place to stay.

H: I can't go along with that.

C: I can't either. Hell, it's just like...it's like taking a kid and pampering him along and spoiling the hell out of him then expecting him to go out when he's been pampered along and then Bingo! What I mean is maybe they can't handle it in a different way here but then...Well, I can cite an instance; it just happened the other day. This fellow had gotten away with a lot of stuff before and it just didn't work on the outside.

Therapist: Talking about a fellow on the ward?*

C: Well, yeah. It might not have been his fault entirely but maybe it could have been warranted. It might have been

Therapist: No, I don't think in that case that it was his fault.

C: Well, here's the only thing that you've got to figure. I've had the same thing happen to me a million times. Sometimes it could have been avoided and sometimes it couldn't have been avoided but the boss never knows whether it could have been avoided or not. You know yourself; but after all he is your boss and you're working for him and if a guy shows up late or something like that, then you've just got to expect him to tell you about it and if you pop off back at him, I know that if I were in his position I'd do the same thing. There's no other

* Vic, a patient on the ward, had gotten a job on which he was supposed to have started at 7:00. By 9:00 he was back on the ward telling that the bus had been ten minutes late and that his boss had fired him for being late. This patient later admitted that his whole story had been a hoax.

way out of it because that's...hell, that's just the way everything goes. I mean, like here in the hospital, you've got rules here and if a patient don't follow them, well, something's got to be said to them or pretty soon you wouldn't have any damn rules or regulations or discipline or anything so you've got rules like that on the outside. It ain't nothing against the fellow at all. Huh, uh! But it's just the fact that you can't handle things that way. Maybe if he stood there and took everything from him but he'd still been fired. But maybe...

H: I doubt that. I'll tell you that this labor market is too damn high in this part of the...

C: Yeah, I know that.

H: I'll tell you I don't believe a guy would can somebody just...

Co: You can't be sure about anything like that..

H: No, it does look like...

Co: You can't be sure of busses or anything like that.

C: No, the thought would be asinine that way. It ain't nothing against the boss. No, hu, uh. It's just the fact that you can't handle things that way. Huh, uh. Maybe he'd stood there and took everything and maybe he'd still fired you. It may be that he...

H: Oh, I doubt that.

C: I'll tell you this, this labor market isn't too damn sure right now.

Co: You can't be sure of nothing on anything like that.

C: No, no.

H: Hell, I've missed busses too and sometimes when I missed the damn bus and maybe I could have been on time and maybe it was my fault for not being on time. You put yourself into your boss' position, well, I mean, after all, boy! he's got a boss to look to, too, see.

C: Yes, that's right. What I was getting at, well, you can chew the nurses out here and the doctors and if you don't go too far, why they're not going to do too damn much about it...they're not

going to transfer you to a closed ward and stuff, where outside (snap fingers) you've just got to pop back a little bit and you'll get your walking papers and then you'll go walking down the street muttering to yourself.

H: You can talk. Hell, if a boss is a pretty fair-minded guy, you can talk to him without making him mad.

C: Oh yeah!

Co: It all depends on how you talk to him.

C: That's it. That's right. That's exactly it. You can't talk to him like we could Mr.Katzenstein or Dr. Hammersley or these nurses or aides. No, you can't do that.

Co: Yeah, I was going to say that if you did get late and sort of make it obvious that you are blaming him because you are late, why naturally he'll resent it. See? I'm not saying that Vic did that or anything but I just say that I know if I was the boss and then someone would be coming in late and then start chewing into my rear, well, heck, I'd probably get T'd off.

H: Well, now I kind of hate to talk about a guy when he's not here.

C: That's the same way with me. Hell, I thought about that after Vic told me about it. Somehow I kind of got the idea in a way that Vic was just a little afraid to begin with.

Therapist: Did you expect anything else? Do you think anybody wouldn't be afraid going to a new boss?

C: Well, no. Well, not to the point where I'd let it throw me. Well, I just kind of got the idea...I may be all wrong about it..but, I just kind of got the idea that Vic..that he was just a little afraid that day that he was going to get the job and keep it. Like I say I might be all wrong and hate like hell...it's awful to talk about anybody when they're not around to defend themselves because I know I wouldn't like it.

Therapist: The important point that you were making was that you don't have as much movement, as much freedom on the outside as you do in here.

C: A fellow has to be a little bit sharper and kind of control your emotions a little bit more than you do in here.

H: It all depends on how you look at it. In one sense of the word you don't have as much freedom on the outside as you do in here and in another sense you have more freedom on the outside. It's a different type. You've got a different type of freedom out there than you do here and you've got a different type of remunerations on the outside than you've got here so one balances the other out. The only thing about it is that it's two different types of environment and you've got to adjust to it and if you don't adjust to it, you're not going to get along.

Therapist: Why should one adjust to it on the outside if one can have it pretty much made up.

H: What...?

Therapist: Why should one leave?

H: Why should one want to leave the hospital? Well, why should one stay?

Therapist: Because, I think this is a part of what we all feel. I feel it and I think you all do that this is a nice place.

H: Not in my estimation.

Therapist: You get food, you get beds..beds are made for you even if you don't make them yourself. You get clean clothes and you don't have to pay a laundry bill. As a matter of fact, some of you even gets awards for being here, and you have some fellows who are always around who can play with you, who will talk with you plus whatever you want to do. Libraries, more recreation, more movies than any guy in town. Well, what the heck do you want?

H: Well, I can't see that. That's nothing. Well, I mean in comparison to being on the outside. My God! You can live your own life.

Therapist: What do you mean?

H: Well, you.. that's just what I mean, just living your own life.

Therapist: Are you living your own life or are you continuously being pushed? If you have a boss, you have to do what he tells you to do. Then you come home...

H: No, no...

Therapist: ...lots of things you have to do at home.

H: No, if you go to catch a bus, you're not letting the bus regulate you because you're choosing what bus you're going to catch.

Therapist: You don't have lots of choice.

H: Well, you do have a choice. You have a choice of which bus you want to catch and what time you want to catch it.

Therapist: No, I mean a boss.

H: I said bus. You have your choice which bus you want to catch and what time you want to catch it. The bus doesn't say you have to take a particular bus because you're choosing the bus you're going to catch.

Therapist: Are you talking about an employer or what?

H: Bus! B-u-s. Bus!

Therapist: No, I was talking about a boss.

H: Oh, boss (laughter)

Therapist: For eight hours a day, most of us have to work for a living, do what the boss says. When you come home there are lots of things, lots of chores. Little things or big things which take two or three hours. Then you have to eat and that's your day. Where's your freedom? What's good about it? You say you're a lot more free on the outside.

H: You're living your own life.

Therapist: In what way? It's all put down. Somebody tells you you have to do this from eight to nine, or nine to ten...

H: You made that choice yourself. There's no one telling you you have to work days...no one tells you you have to work nights.

Therapist: What choice do you have?

H: You can pick a day shift or a night shift. No one tells you you have to work for a certain company...you can pick your own company. You pick your shift. If you want to work days, you work days. If you want to work nights, you work nights. It's up to you. After you come home and done these little chores, as you say, well, you're doing that for yourself. You're not doing that for anyone else..you're doing it for yourself. You're helping yourself. You're living your own life..that's your freedom.

Therapist: Now, now let's take now..you have a family, but let's take Dick. He gets everything done. He doesn't have to worry about the little chores, he gets them all done here. Why go out and give the eight hours to some other guy who tells you what to do if you can have it all for yourself. You have much more time of your own.

C: Well, it's a question of getting it for yourself or having someone lay it in your lap. There's the thing.

H: If he goes out and gets himself a job and does everything like that, well, he's doing it for himself. He comes in and does these little chores that a single man might have to do and that's adding to his own comfort and benefit for it. He's not being told to do it. He doesn't have to do it. Here in the hospital you've got to see your doctor at a certain time and you've got to see, well, whoever your therapist is at a certain time. You've got meetingsyou've got to go to. You've got movies at a certain time. You've got only one movie you can go to. If there's a dance on Thursday night, there's only one place you can go to dance. On the outside, you've got a choice what movie you want to go to, what dance you want to go to, where you want to live. You don't have to see a doctor at a certain time. And you can go when you want to and come when you want to and do what you want to. There, there's your freedom.

Therapist: I don't know how the others feel about this..I think you're certainly right...certainly something to that. On the other hand, all these things that you add up don't come to eight hours a day in the hospital that you have to...

H: Eight hours a day! You've got 24 hours here that you live a regulated life.

Therapist: You mentioned that you have to see the doctor. You only have to see your doctor once or twice. There are lots of fellows on D-west who don't even do that.

H: Well, there's shops and everything else.

Therapist: Well, there's lots of guys who don't go or if you don't want to go, you don't.

H: Well, if you don't somebody gets on you. Just like you were late on the job, the boss gets on you.

Therapist: Well, they don't get on you.

H: Well, I mean they say something to you. The boss, too, does not necessarily get on you but he may say something to you.

Therapist: Well, of course, but...nobody on the outside has as much choice in the kind of job he wants to do and the speed with which he wants to work as we have in the hospital.

H: Oh, what choice does a patient have in here as to who his therapist is.

Therapist: Not there, but as far as job..if you want to go over to woodworking or to automechanic you can choose wherever you want to go and then on the place you can say, well, I want to work at this and this and you do it. And when you decide to take your own sweet time and do it in three months, you do it in three months or if you are a guy who wants to do it fast you do it in two days. That's all up to you. But if you come to a boss there is no question, you can't say I want to build an outboard motor.

H: Boy, you said that a boy in here has his choice of the shops, but if a guy comes to the outside, he starts looking around for a job. There are woodworking shops on the outside. They might not be called woodworking O.T. shops of course, but there is a..he can work in wood, he can work in automotive, he can work in electricity, he's got all the shops on the outside only they're industries.

Therapist: Yes..

H: They, yes..and he does not go to the boss to say I want to build a little motorboat because if he wants to do that, he is building motorboats eight hours a day or a night.

Therapist: Well, yes, there are such things, but...

H: No, I don't mean building motorboatd literally...

C: Well, it boils down to this, everything is done for us and we have a soft easy time here and all that. Say a fellow does figure he's got an easy time, he enjoys it here and everything, all right, so he goes on and maybe he stays here 15 years, and everything is done for him and if he does not want to make his bed, why, they make his bed and everything. All right, it's just like a kid that has been raised up at home and his folks have done every damn thing for him, he has no responsibility and all that. All right. That's the same damn trouble I run into. In some ways I was probably spoiled; I'm an only kid and in some ways I wasn't, but I know lots of time I never had to o damn much responsibility left. I don't know why I wasn't.

But God damn it, when I had to get out and do it myself why it was a hell of a job. I didn't know whether I was coming or going. But that's just like a fellow be here. It's worse here than in most homes in certain respects it is, because you don't have to pay for nothing and things like that, well, if a guy gets out from here after 15 years of that why he wouldn't know which way was up.

H: Well, I personally don't want things laid in my lap....I....

C: I don't either.

H: I suppose the satisfaction of getting ahead is making it myself. I mean regardless of what you pay in this place to me it would never be satisfying, I mean, I have only been here a short time this time, a little over three months and why...hell, I just don't see any point, that's all. If a guy is on a treadmill....he is not living when he's got it laid in his lap. He does not know how to. .he doesn't realize how to enjoy anything. He gets it without any effort and first thing you know he's taking this for granted andloses the enjoyment out of it, regardless what it is.

Co: What?

H: I've heard it said that a guy who worked like hell and saved his money and bought a new Ford, see, would enjoy that car a million times more than a son of a bitch that had a new Cadillac handed him every six months.

C: You're damn right. In everything I made when I was a kid, even now, I get more enjoyment of making the thing than what I get out after it's done. It's the same damn way if you are on the outside and making your own living, and you're going to have your knocks sure, but if you....you and your wife are planning, even a single guy why he can plan, maybe his....at least he has some outlook, maybe he is going to find some girlfriend, why here, Christ you can't even get a girlfriend unless you get some other....a....screwball. And maybe have a little couple of walnut kids. Well you can do that...Well....

Therapist: This is baloney, you know that.

C: Maybe it is and maybe it ain't. I don't know (laughter), there is no foresight here. Well, hell on the outside you can at least say, I am going to save my money, I am going to buy myself a damn car or something like that, why here, hell you go over there and you make a damn...a coffeetable or something.. well, here she is what are you going to do with it.

Co: Yes, I have felt the same thing a lot of times.

C: Sure.

Co: I got a big kick out of making it and so, but it wasn't useful to me, I didn't need it.

C: Sure

Co: I sent just damn near all my stuff away.

C: Everything I made.

H: If you are on the outside you don't make those things that don't amount to a damn. If you are on the outside, you can save your money and say you want to buy a car. And every time you go out and drive that car, by God you realize, that by God you worked and earned that car; or the idea, you go and buy yourself a lot of new clothes, you may save your money to buy those new clothes. Every time you wear those new clothes by God you get a jolt out of it...Yes, or anything, anything you do on the outside can be a pleasure...you ...even to carry out the trash or the garbage or doing things around the house. It doesn't have to be a job, it doesn't have to be...hell, that wouldn't be near as much of a job as me walking over here to eat dinner without giving a damn what I was going over there for.

C: What it looked to me if a fellow comes to the hospital he is just like a bear going into hibernation. He is dormant for the time that he lives here. If a fellow wants to do that for the rest of his life, why he <u>should</u> be in here. If that's what he wants, why he should be in here.

Therapist: Well you are really painting the neighbor's garden pretty green, you tend to forget that on the outside..It's not all green.

H: Well, hell haven't we experienced it, you are not telling us anything.

Therapist: Well, I mean from the way you describe it, if you are going to be plugging and plugging, you get somewhere. Well there are lots of people who have been working hard all their lives and haven't been getting anywhere.

C: Yes, but that is no reason to keep from going that way.

Therapist: Well, isn't it better than to just keep on working and not going anywhere. Isn't it better to just stay in here.

C: Well, I don't know, I guess the guy who got into that frame of mind, it probably would be better for him to come in here.

H: Yes, after a guy got into that frame of mind it might be a good place for him...As long as a guy is satisfied in this place, by God, it's the place for him.

C: Yes, he should be here.

H: If he is satisfied with this living like the guys live here, if that's all he wants out of life, why this is the place for him.

Co: Well, aren't you more satisfied on B-15 than on a closed ward?

H: Why yes, hell, yes, nobody likes to be locked up.

Co: Over there I didn't ever know what was coming up, but here on 15 when you get to feeling bad, why you can lay down. But if you are on the outside and you throw (laughter) the night before or something like that, had a rought time, you come in and you can hardly work, why you just have to keep on working. Why you couldn't lay down.

H: Well, that's part of the knocks that you got to figure on the outside. But I'd rather take...

Co: You can't get so used to this. If you feel bad, somebody here is going to say to you, well, just lay down for a while. I was out and couldn't stand it. On the other hand when I was on Acute I wanted to run away a couple of times, that was rought down there, I had to fight to keep from going down hill. Get some books and read some books, and do some work and stuff like that and get my mind out of the gutter. Those guys down there were so much further down the line, I could just feel it.

C: Why, hell, there is no future for a guy.

H: A guy who would want to stay here I just would like to know what his conception of future is.

C: Yes, there is no outlook, no future.

H: Hell, you just live from day to day.

C: We don't know and there may be a bunch of fellows from Korea come in, as I said before. The government got to put them somewhere.

Therapist: Well, there isn't much future in the life outside either, is there?

C: Why, hell there is.

H: What, you can kind of help determine it.

C: Out there.

Therapist: You don't know maybe next year you'll be in the army.

C: Well, that's true.

Therapist: Or you will be under the atom bomb.

C: No!

Co: Well, I often think about that.

C: This gate out here is not going to separate the guys from the atom bomb.

H: Damn right it isn't. You are going to be penned up here...

Therapist: So how about future on the outside. What else can you do on the outside.

H: Well, you can work for the future like I said. For next week, next year, planning. What you are going to do next week, what you are going to do next year. Ten years from now. You may be planning may be you want to buy a home, see. Well, maybe you, hell say I haven't got the damn payment now, but right away you start figuring see. Six months from now or a year or how long it's going you have got to plan when you are going to have that downpayment. Then you make your down payment. Then you have to plan maybe in ten years you want to have the house paid for. That's future. Then maybe you want to buy a new car, maybe you haven't got the money so three months from now I want to have the money, there you are planning again.

C: And if a guy ain't just living, just saying tomorrow I will get up just live that day. If he is physically all right and don't have some disease that may kill him off any imtance

why that guy is sick. In peace time. Of course during wartime it's a little bit different. If in peacetime he is just living from one day to the next I think that he is sick in the sense of the word.

Co: That's sort of what I do. I'm sick then. I just live to get up to go get my meals, play some tennis and swim and stuff like that. Well I get a big enjoyment out of that...I just live the life of Riley then. (laughter) Getting instructions in different strokes and diving and stuff like that, hell. I didn't ever get any of that when I was on the outside. Going to shops, my gosh...

C: Even if they are in a hell of a pinch and they know that their chances are damn slim to get out if a guy...if he is...has got some grip. He's thinking about what the hell he is going to do when he gets the hell out of there...Whether he'll be waiting for that gal back home or something else...Whereas some old guy is thinking (mimicks)"hell, I want to get my clothes, my rain clothes out today," why hell, he is going to go down with that attitude.

H: I mean it's question of everything laid in your lap security and everybody wiping your ass for you. If you enjoy that well that is one outlook. If you want to make it yourself on the outside and you can see where you enjoy it better for living that type of life that's another outlook. There's two outlooks there and the guy that wants it on the outside that's the place he'll go. The guy who wants it in here will stay.

Therapist: You mean you all have a choice.

H: Ah...well in some cases the individual may not have a choice... I mean he may be confused, he doesn't...he doesn't his perceptive (?) isn't quite clear. Well, I'm not going to go into theoretical cases here.

C: It kind of works in a way out here.

Co: Why don't you.

C: Let's take kings and stuff. They have everything laid in their lap well while they have everything laid in their laps they are getting soft. The people, their slaves are getting stronger not mentally but physically. Finally they are so strong that they overpower the king. And in a way it works here. If a fellow just laid around and gets everything laid in his lap he gets so god damn soft that if he does get out, then he can hardly do anything.

H: He gets screwed.

C: Eventually, lots of guys in one of these places...why, they can't do nothing else but stay in one of these. Then when he finally comes to the conclusion he has been on the wrong road and then when he finally gets out..then it is a rough thing out there.

H: Well in order to make anything work out in here as far as some plans...

Co: You say you get soft in here playing around. How about me, yesterday I played three hours of tennis with the aide.

H: Well, there is nothing about that...but your...attitude can get soft.

Co: Yeah, that's it, it's the mental outlook more than the physical. I built myself up pretty well physically but mental I'm dejected and..

C: Well, no, I wasn't referring to you. A lot of fellowsjust come here just to have a rest place, to take it easy.

Co: I didn't come on my own, I didn't even know I was coming here.

C: No, I know you didn't, I wasn't throwing it at you. But there are fellows that do come here maybe they are a very small percent...

Co: There are fellows, yes.

Therapist: You say you are getting soft mentally, what do you mean?

Co: Well, it's like H. has been talking here and C. here you have just everything thrown in your lap. Like when I was on B-9 it made me so terrifically mad I couldn't see straight. They brought that chow-cart right in on the ward right in front of my bed there. And dished it out to me and an aide carried it to me. Finally I started to get up and carry my own show and pretty soon I started dishing that stuff out and stuff like that. And the aides didn't like it too well. They saw that I was getting up and helping myself a little that made them sore because they weren't doing the job. Right there I was pretty sure I felt that way, maybe they don't even want you to do something. Finally I had to push my way in and start doing some things. I've got a lot better by taking the show off to different guys and stuff like that.

C: You know, sometimes in this mental sickness, it isn't at all cases, but sometimes, sometimes it's just a little bit damn orneryness. A fellow gets stubborn. A lot of guys won't eat and Christ you can't get them to eat. If you let that old boy go for about six days why he will eat damn near anything and be glad to get it because, well, it's not a way to do it, but just like there be some fellows lay there, they are probably out of their heads and they wouldn't know enough to eat, but a lots of fellows on many of these wards if they took it like Bill said, they would give them food, and they took it up to their beds and everything, and laying in their beds they knew they were going to get it. But if they knew that if they were not going to get up and get that they were not going to get anything why they probably just get up to that damn chow-cart so fast it wouldn't be funny.

H: That's one of the shortcomings of this whole hospital, right there. Not only of this program but I think it's a failing and shortcoming on the part of the hospital, that is the staff. I'm sure that the staff here, that is psychiatrists and psychologists and so forth are aware of patients mental status and capabilities and so forth, and when they see a patient not wanting to go out they can realize that. It seems to me that they should have some kind of a program here as a preparation for encouraging a guy to go out, but instead all these wards are practically run the same way - I mean fundamentally - we have a therapy program here - I'm not throwing this at this particular program but it's all over. So you go ahead and you see the doctor and everything and the day of your discharge comes along, it's the same thing right along, they will still want you to go to O.T. shops and everything keeps being the same right until up to the day you are discharged...see...now..in a lot of guys cases they take it on themselves to prepare themselves to go out. They begin to look forward to going out. It's sort of a preparation you might say, but...all the guys won't do that...many will, but a lot of them won't just like you was talking about a guy that don't eat say for instance. They try to push it on him. I think that the hospital or somebody ought to realize that...that...that are certain groups of patients that by God they could work out some kind of a program. Even make the damn thing attractive, if necessary. You might have to break it down into several different groups. I mean one group might take two or three more weeks of training program there before they get to thinking about going out, another group might take a few weeks less. But hell, so far I haven't even run across that and I haven't even though of it until now. So actually if they said then...hell, wouldn't you like to go on TV, "No I don't want to go, no." See, you got all

sorts of arguments against it. But hell there is more ways of killing a cat than throw it in water. After all if the psychologist can't figure out one way...

Therapist: You seem to think that we are trying to get you out of this place by ruse and all kinds of psychological tricks.

H: You can call it a trick if you want to...that's...I think it would work to advantage of some patients. You know of some patients...

Therapist: Do you think it would be of advantage to a patient if we were to get him out on the sly.

H: No, help him get confidence in himself through his own sort of approach. I don't know this is only an overall general statement. I'm not going to take the time, that's not my job to figure out how to set the thing up and what things we have to put into it and so forth. It's just a nucleus of an idea there.

Therapist: Hm, I think it's a good idea.

H: Because I...now some patients you can never do it that way. I don't mean just...you are looking at it from the wrong viewpoint. I'm not enticing the patient out of the hospital but give him a chance to make up his own mind that he would enjoy it better on the outside if you know that he has the capabilities to make it out there, why let him be in this damn doldrum and state of complacency, why hell.. Now if he couldn't do anything else, why that's a different proposition. I don't know whether he can do it or not. There'd be two stages to that type of approach.

Therapist: Hm...

H: I mean to diagram it out, I mean...If a guy is satisfied on this level the level of complacency, he is satisfied, doesn't want to go out, there is nothing out there for him, he doesn't have any idea, he might be afraid of the outside or whatever his reasons. So this program that I was just mentioning, if it could be worked around so, set up in such a manner that he could be raised off of this level and you could raise him through this program to a point of...where he had initiative and self-confidence so that he actually would want to get out. You would want to give him a try out, then when he gets out to 21st (street) he is on the next level, now when he gets out there he is either going to go all up by being out there or if the sufficient hard knock comes along like you said might make him back down again. But then I think it's worth taking a chance instead of letting his life here drag out. I know for some guys all the therapy in the world wouldn't do the trick. I believe some guys need encouragement.

Therapist: Hm, I think it's not encouragement that we can give a buy.

H: Well, I might be wrong, as I said.

Therapist: You know, if I said, I think you can make it...

H: That doesn't mean anything.

Therapist: That's right. There is no encouragement beyond a very honest exposition of the choice.

H: Well...

Therapist: This is what I'm trying to do, I'm trying to make you see that you have a choice, you can go out if you want to. This is a choice, you can take it or leave it. If you leave it you stay in. If you take it you go out, but this is only the beginning. You have a continuous process every day if you go out, this is where your choice begins. This is not an easy thing. This first choice isn't easy and all of you know this first choice isn't something you decide once, there is always the idea, maybe I should not go out. To make this choosing appear as if it was something easy is ridiculous. It is not easy...

H: I think you missed the point that I was trying to make it and I'm sorry if you did.

Therapist: Go ahead.

H: Well, I don't see much point in going over it again, because it's of no value to me, it would be only of value to someone else. Hey...that's a fallacy to just tell some guy you cane make it on the outside, that won't do the trick, that's why I got this idea of putting some kind of special program into effect. If I got the education that you got, I'm sure that I could figure out something like that, I mean, something to start on, an idea of what kind of a program.

C: Here is something I just thought of. I believe it would almost have been a physical impossibility for Vic to stay on that job for this reason: Vic is not too active; he hasn't been going to activities. He has been a lot better since he got on that ward, he's even been out there playing golf and that is for him quite a bit, I believe. I never had nothing to do with that golf course. I did not make it. W. and C. have worked on it.

Therapist: And H.

C: And H., yes, you made some of the work too.

Co: He started the whole thing.

C: Well, that may be so, I didn't know. Well, anyway, Vic said that he would have to work on that job 11 hours a day and I imagine it's pretty damn hard work, especially to begin with; now, there is your case I've been using for quite a while here. That fellow laid around here, takes it easy, don't have nothing to do. All right. Now Vic went out and boom, right like that he wants to start working 11 hours a day. Why hell, he couldn't do it. Hardly, if he did it he would have worn out. Well, there it is, the same old thing. If they had some way of, well, they got the gymnasium over there. Of course the fellows who don't want to don't have to go. It's hard to make them if they don't want to and it's hard to make them get up if they don't want to keep off their beds. But if there is some way of getting them interested in some thing, like playing golf, that would have helped a hell of a lot, that did help a hell of a lot.

H: Of course like I said it don't mean a god damn thing to me, I mean it is not going to make me anything, one way or another, but it seems to me that that is one thing that is lacking in this place, encouragement, incentive for a patient not only to get well, but to go out.

C: Yeah, you're right.

H: Since I have been out there three times and I have never seen it done. Well, I mean even try to encourage a guy to go out.

Therapist: The important thing is, and I believe it applies to you also, maybe not in this particular question of leaving the hospital. The important thing is: You will always be alone when it comes to the difficulties. When you have to make the step and nobody will be there and anybody who has told you before you can do it, it just seems like a parody to you at that moment, because you are up against it.

H: You know what, if a guy can tell himself that he can do it it means more than 10 million men telling him he can do it. It's up to the individual.

C: If he does not want to go out and you kick him out, well, he is not going to give a damn if he gets out there and all his plans are probably going to be to get back in if he liked it in here.

H: It seems to me that you guys should be able to figure out a program that could be a hell of a lot more efficient than this

telling a guy "I think you can make it on the outside." Now I have seen that happen a hell of a lot. I have seen lots of patients who are being told, you can make it, or take it easy. On D-West I run into that a lot. Well, Goddamn, that's the wrong approach. That's why I got this idea of setting up the program. Because it's necessary to instill the self-confidence in a man again and make him want to go out there. Until he wants to go out there and feels confident that he can go out there and be happy and make it and take the knocks by God he's going to be satisfied in here. Regardless of his mental condition. He may have as good a mind as anybody in the world.

C: Well, I see what you have been trying to get a. You know there are some fellows that don't know whether they want to go out or stay. You are trying to get out of them whether they have made up their mind or not that they <u>really</u> want to go out, huh...?

Therapist: No.

C: Well, it looks like that, if they don't know which they are going to do, then you got to find out where they want to go.

Therapist: What I want to do is to give them the idea of the dilemma they are in. If you see the choice that you have, you can do something about it. As long as you don't see it you can't do anything about it. And that's why I'm telling of those things. I think I would be lying if I were to tell you on the outside everything is rosy.

H: Oh yes.

C: Of course.

Therapist: That's why I try to give you both sides.

H: Well, I want to nail you. All through this program, you probably had a reason for doing it. I'm not questioning that, maybe it was a good one, but nevertheless you've done it, you have constantly painted the black side of every situation that comes up here. I mean including the outside. You never have shown us any part of the good side. Like I say you may have a reason and a good one. I don't know. (laughter) Just like this morning talking talking going on the outside you showed every reason in the

world why a guy shouldn't go outside. What effect is that going to have on the men that are already convinced that it's bad as hell out there. What good can come of that?

Therapist: Do you think it would have been better if I were to tell that I think it's pretty nice out there. They know I have made it pretty nice outside. I wouldn't be living on the outside if I would be convinced by the arguments that I gave, that this hospital is such a beautiful place and on the outside it's not, I would be in the hospital.

H: Well, we know that but why are you trying to convince a man that's already convinced. That's what you did here this morning.

Therapist: Well, I wanted to point out that I took my choice although I know that this is a nice place, but I have reasons to believe that I am happier on the outside.

H: You should have made this clear before.

Therapist: It's more important that you do this. I'm living on the outside. You fellows who live in here, if you begin to see that living on the outside has advantages that's more important. That's more convincing. You can always say, well you, you are a psychologist, you have a big income, you have a beautiful wife, you have this and that, all of which is a lot of baloney. (Laughter) You came in here because you needed this place for a while. But now you are saying "Well on the outside there is something to it." That's one way of getting both sides of the picture.

H: Well, there is all possible ways to look at the thing. Well, of course C and I we can say, boy we got it made and we are going out. See, we got confidence and everything well, but it's possible that some patients even though they may have formed the opinion even maybe some time ago. Old C., I know, he is pretty confident. I know he is going to make it outside. But maybe a guy has a little inferior feeling, see, and maybe he figures C. has a little more on the ball than he. Well, what you have been saying would only all the more prove that point.

Therapist: Can't do anything about it.

H: Not with me and C., no, that's where the program comes in. You got to have more than that.

Therapist: I am all in favor of this miraculous program.

H: No, no, it's not a miraculous program.

Therapist: Somebody told me this morning in the ward meeting that he had this terrible urge to kill. Well, we all have these urges sometimes. You can't do anything about it. You have to live with it. This is human.

H: I'm not talking about rooting out the...I'm talking about if a man has lost confidence in himself and he does not see anything on the outside for him, that's all. And I think that a program could be set up that could restore it.

Therapist: How about this program?

H: Well, you got a long ways to go. I mean not in this program. But I mean if that is your intention.

C: It looks like you are going to give a sales talk on both sides. There are things here that's nice, things like picture shows and this and that. But say if you figured that you liked to stay here for the next ten years why, these things might arrive, you might get crowded in, they might sent you to Norman, Oklahoma which is a son of a bitchen hospital and if you be held down there and a few things like that you might just be booted out of civilian life in the next five years.

Therapist: But these things are meaningless if you live for today and tomorrow. Like you and I remember it from during the war. We got up every morning with the thought if something might not be coming down on you during the day, or something like this where you lived from one morning to the next. These arguments don't mean a thing.

C: Well, it looks like you could tell a fellow that if they don't make up their mind now they aren't going to have too good security here over a rather long period, might be for a couple of years and, now show the advantages on the outside and then get that old boy to planning and start to figure out what he is going to do, what kind of work he is trying to get into. Then he get his mind shifted over on thinking that he is going to start working before he is trying to get out. So the fellows would have an urge to want to get out.

Therapist: Well, you all know you have to get out.

H: A program, such as I mentioned there would have to undoubtedly be defined to the point, where you could get this idea across to the patient without actually putting it into words. Because telling a man you can make it on the outside has failed so miserably so many times that something else would have to be done. If this was my job, if I was working here, if I had the advantage of a...of a...degree in psychology, I'd make goddamn sure that I could work on something like that.

C: Here is an example. It's going a hell of a lot to the extreme, but say that this hospital was set up so that as soon as the patients got well enough mentally and physically they would be put out and had to get hold of a hoe all day working. I'll bet 75% would be working as soon as that hoe gets in their hands, working to get out here. That would be physical work, and they wouldn't want it. Right there they'd start working for the day...

H: Well, like I said just a while ago you have to think this out into several different groups. Now one group would fit in that and another type of person wouldn't fit in that at all...see, but you have to have several different groups, with several different programs on the thing. Now just to show you how confused I mean, it's not exactly confused I mean..it is in a way it is confusion and I have heard them many times from time to time...They cuss certain things, certain moves, made by our government or made by other governments. I mean with socialization and things like that. And here they are living on socialized medicine. It is a socialized institution, it's run by the government, paid for by the taxpayers' money, it's a socialized institution, and there they are biting the goddamn hand that's feeding them. (C. laughs)

H: See, this is the best goddamn mental institution in the country and by God it's a socialized institution.

C: Is that supposed to be bad?

H: No, that just shows you how confused some people can get on issues. I mean it's not actually confusion. But they just don't stop and look at it.

Therapist: I was trying to say that we can try to lift that confusion by making up our mind. I personally can't say I believe life on the outside is better than life on the inside. I can't say this is so for anybody. All I can do is say these are the advantages of life on the inside, these are the advantages

of life on the outside, there are many difficulties, and sure as heck you come up against them, no sense fantasying about it; there are lots of disadvantages on the outside.

C: Oh, sure.

Therapist: Well, if you want to make a choice and go I think it's worthwhile.

H: Well, when we get down to this state of mind that I was talking about this complacency, that you rather stay here than get out. This program of mine that I was talking about it would have to be done in such a manner that you couldn't go on reasoning and say here are the advantages on the outside and here are the disadvantages, etc. Because the person like you say would already have made his mind up. It would have to be worked out in such a manner, psychologically so that you could get the point across to the patient. That he thinks the idea came from him, see.

Therapist: These are things that can't be done.

H: They can't be done?

Therapist: They can't be done. You said a guy has made up his mind to stay in the hospital, well nobody has, nobody likes it in the hospital. As soon, lets say I were to announce now, well we have changed our mind, we are not going to let anybody get out. Well, you should hear Bill bitching. He would be definitely decided that he wanted to go out. We have both desires, it's the same with you and me, we want both things and we don't always know which is best. And this is one thing we have to solve ourselves. Nobody can take this decision away from you. What we can do and what we are trying to do is to make you feel it. He wants to go out and he wants to stay in, he wants both things and it's up to himand only to him to make the decision. If he does not make this decision and we take it away from him, then the next decision comes up and he asks again I don't make any decision, you make it for me. This is here is the beginning of his making his own decision and we can't give him treats or sugar-coating or anything. This is the place for you to start making decisions.

H: Well, you certainly ought to encourage a guy though...I mean you should encourage him. If you see that he is starting to make a decision encourage him to continue to make those decisions. I bet you by God every man in this room will

verify the statement that there have been different people not just one or two but damn near every man in this room has maybe said something at one time or other that you came right back and pushed it right down his throat and painted the god-damn black side of it. Every damn time. Now I know how that would react on me if I was in the least bit in doubt, about going out, why, hell, it just would drive me back further.

Therapist: Let's talk about you. If you say and you actually say, "well, I'm going to lick my own problem, I'd come right back and say "Well, you aren't going to do that." Because I know this is just a statement, these are just words, you don't think that you can lick it. Because you can't start out with it.

H: Hm, yeah.

Therapist: This is not the way to lick it.

H: Hm, yeah.

Therapist: And this is the reason why I sometimes come back when somebody says something and say this is not so, there are lots of things of which you may not be thinking at the moment, but you come into the right state of mind and you are going right back to the same old thing. You have to start over differently, you have to feel that you have a choice. Your choice.

C: Some of the fellows who don't know if they want to go out or whether they are going to stay in, looks like they ought to make up their minds pretty soon or they won't at all; like myself, I thought well I won't try to get a room down there at the Y. If I had waited til the last day instead of going out yesterday well you find out you got to wait;they put your name on the list and it takes about a month, and maybe not then. Well, it so happened, I was interested in talking there and I found a room for seven dollars a week, which isn't too bad and isn't too good, but it's a room. But hell I would have been in a hell of a mess if I had waited til the last day and gon there, wouldn't have had enough money to pay for a hotel room and then could not have found another place. It would have been a hell of a mess.

H: As long a move as I'm going to make I have been planning a month on it.

C: Yeah, you see.

Therapist: Well, some people are, have to be under bigger pressure. The pressure certainly is on.

C: Here is what's going to make it bad. If a fellow does not have too much money and gets out of here and has to take some old dirt room at the spur of the moment, while he could get a nice room if he had time to look around, but instead has to take some old dismal room, boy that don't help you a damn bit.

Therapist: That's right.

H: Well, a guy should have been thinking about this some time back even if he had 1000 bucks in his wallet. Hell, I'd still been thinking about it at least a week in advance. I'd gone out to the bus station, find out the schedule, call...

Therapist: Well, you have to get used to that idea.

Co: I always wait until the last minute.

H: Hm?

Co: I always wait until the last minute. Well, before I get out of here I know I have to pack and send things away, so I don't carry ten packages in two arms. Well, I haven't done it yet.

Therapist: Well, it's time to break it off.

C: Are you going to send these things off?

Co: I suppose so...

Appendix B

JUNIOR, MY SON, MY SON

A Three Act Play

The Story

The tale of a former mental patient trying to readjust in a world of people who are afraid of him. His attempts and failures, disappointment in his home life, and the sudden solution which he finds, is representative of the way in which many other patients can take a given problem of readjustment, meet it calmly and carefully, and emerge from the battle--in every way--the winner.

The Characters

The Goblin:	The unseen instigator of fear, worry, doubt, disappointment, and general mental hazards.
Junior Crooks:	A former mental patient now living with his parents and trying to find a job.
Martha Crooks:	The mother who offers too much loving care and too little intelligent planning.
Calvin Crooks:	The father, afraid of his son's past illness and afraid of the youth's future.
Rocky Canyon:	Junior's best pal. Rocky, who fears nothing, keeps Junior's spirits up and offers his arm for support.
Mister Harris:	Prospective employer who refuses to hire Junior.
Mister Sidney:	Wants to take a chance on Junior if Junior will take a chance on him.
Margie Townsend:	Junior's girl friend.

PROLOGUE

I am known as The Goblin. I am the one who tempts wives to leave their husbands; who causes children to play with matches; who tricks the President into writing those nasty letters. Oh yes -- you know me.

Of course, I can't really be seen, but in order to show the part I play in everyday living, I have entered the body of a puppet.

Now my favorite role is played with mental patients.

Like Junior Crooks for example. Junior has recently left Winter General Hospital and is in good mental shape, but he is beginning to worry because he cannot find a job. Employers are afraid to hire him, since I have filled the air with doubt and prejudice. This is one of my very best talents.

Anyway, I'll let you come along with me and watch Junior try to land a job with Mr. Harris.

The scene: The office of Mr. Harris, with Junior explaining his qualifications for work.

Act I Scene I

Boss is sitting at his desk muttering to himself and searching through the drawers.

Harris: Dreaded where are those aspirins. Told that girl to .. girl, girl, where are those aspirins?

Voice of Stafe: I'll send out for some immediately and there is a Mr. Crooks to see you about getting his job back.

Harris: Crooks, Crooks? I thought I already had all the crooks in the country working for me. (Laughs) (He puts his hands on his belly in convulsions of laughter) He, I said I had all the crooks ....

Junior: Beg your pardon, sir.

Harris: Oh, hm, never mind.

Junior: Yes, sir.

Harris: Want your job back, he, boy?

Junior: Yes, Sir.

Harris: What did you quit for?

Junior: I was out at Winter Hospital.

Harris: Hospital, hm?

Junior: Yes.
(Demon comes down from the top, as boss begins looking for aspirins in the desk)

Harris: Where are those aspirins?

Junior: I don't know, sir.

Harris: Of course you don't know. (Goblin laughs)
Now who the devil was that.

Junior: Who.

Harris: I thought I heard somebody laugh.

Junior: I did not hear a thing.

Harris: In the hospital, hm?

Junior: Yes I had nervous trouble.

Harris: Nerves, hm, thought just women had nerves.

Junior: Sir I am all right now.

Harris: All right, of course you are all right.

Junior: And I'd like to get my job back.

Harris: You were a mental patient, he?

Junior: Yes, sir, but I'm all right now.

Harris: Yes, yes you are all right now I heard you before.

Junior: And I'd like to have my job back.

Harris: I don't know.

Junior: You don't know?

Harris: I don't know whether I can use you.

Junior: I did good work.

Harris: You did.

Junior: I surely did.

Harris: That was before.

Junior: I tell you I am all right now.

Harris: Hard worker he.

Goblin: Remember, he has been in an institution.

Junior: Yes sir, I am a good worker.

Harris: But you have been in an institution.

Junior: I'm O.K. now.

Harris: But you have been in an institution.

Junior: Yes.

(Silence)

Harris: Let me tell you, when I was your age.

Junior: Yes.

Harris: When I was your age I worked 14 hours a day sweeping the floors of these offices.

Junior: Sweeping the floors?

Harris: That's right I swept floors and went to nightschool besides.

Junior: You were ambitious.

Harris: I'll say I was ambitious.

Junior: What happened then?

Harris: What do you mean, what happened then?

Junior: How did you work and save and skrimp and slave to get to your present position.

Harris: Oh, that, well, my father died and left it all to me.

Junior: Oh.

Harris: But let me tell you.

Junior: Sir?

Harris: Yes.

Junior: May I have my job back?

Harris: Well, hm, I'll let you know in a week or so.

Junior: That is what they all say, who can't you try me out at least.

Harris: Now look Junior.

Junior: Just because I was a mental patient.

Goblin: Watch out now.

Harris: (Jumping up from his desk). What do you mean coming into my office and acting like that.

Junior: Sir, I was just asking for a job.

Goblin: That man is dangerous.

Harris: I am sorry I don't have a job for you.
(Calls to secretary) Miss Young are you ready to take dictation.
(Harris turns away from Junior who walks slowly off the stage)

Act 1 Scene 2

(Curtain opens with father lying on the sofa. Off stage is heard a woman singing)

Calvin: Martha can't you stop.

Martha: If I did not get the rugs vacuumed I don't know what would

Calvin: No, I mean the singing.

Martha: (Enters, when Calvin sees her coming in he sits up quickly) Calvin your feet are on the couch.

Calvin: What do you mean my feet are on the couch.

Martha: How many times must I ask you to keep your feet off the divan.

Calvin: Martha, I work hard all day.

Martha: I know dear.

Calvin: When I come home

Martha: All right dear...is Junior back yet?

Calvin: That boy of yours ruins me.

Martha: That boy of mine

Calvin: That boy of yours has been home two weeks and hasn't got a job yet.

Martha: Don't be impatient with him.

Calvin: Don't be impatient. Huh!

Martha: Calvin!

Calvin: O.K.

Martha: You should have a talk with that boy.

Calvin: A talk?

Martha: Yes, you should have a man to man talk.

Calvin: Now, Martha, he is twenty six years old and has

Martha: Oh, no, no I don't mean that kind of talk.

Calvin: What kind of talk.

Martha: You know he is trying hard to find a job.

Calvin: He is trying, but its hard going.

Martha: Yes, the employers say that if his old boss won't take him back why should they hire him.

Calvin: He is getting bitter.

Martha: And is disappointed.

Calvin: And he is giving up hope.

Martha: And he is worried.

Calvin: Oh Martha, I wish we could do somthing to help.

Martha: Can't you talk to him

Calvin: He needs a job to be independent. Just talking won't help.

Martha: You could try

Calvin: Yes, I'll try, but I don't know how much good it will do.

Martha: If we all try to help, you and me and Rocky and Marge.

Calvin: Rocky!

Martha: Yes Rocky.

Calvin: That's it,

Martha: Sure Rocky will try to help him.

Calvin: Will you call him.

Martha: Yes I'll call him right away. (She leaves the stage).

(The Goblin appears as Martha leaves, he dances over to Calvin and makes himself at home).

Goblin: Well Calvin, old boy, I see you are still doubtful about Junior. After the months he has spent in the hospital you have some doubts about his ability to hold a job.

(The Goblin's first words, cause Calvin to begin pacing the floor.)

Calvin: I don't know what to think. Junior is awfully disappointed.

Goblin: You know Calvin, you are a smart man. Mental trouble has never been in your family before and your wife's family was never troubled by it. I would be very, very careful, if I were you, and see that Junior does not do anything out of the way. You have read about such things happening to patients after they leave the hospital and it usually breaks the family up completely. Things like automobile wrecks, drunken parties and the like. I would be very watchful over Junior and see that he doesn't do these things to you or your wife.

Calvin: That's been in the back of my mind ever since I heard he was coming home. I can't help but worry about him. He always was an easygoing person and he never did get into trouble.

Goblin: That's the kind of guy to watch out for. When he becomes silent and doesn't want to do the things you want him to do, then you had better keep an eye on him.

Calvin: If he could only get a job...that would take his mind away from his other troubles, and make it easier for his Mother. She doesn't show that she is worrying but I know she is, just the same.
(Stops pacing and decides to sit down where Goblin is seated. Goblin hurriedly gets out of the way.)

Goblin: That's a laugh. Who is going to hire him? Thanks to me, these employers are plenty scared to hire mental patients. Excuse me, Former mental patients.
(Goblin gets up and does a short dance as Calvin gets feeling badly. Calvin gets up and holds stomach.)

Calvin: All this worrying makes my ulcers act up. I've got to get some bicarbonate of soda.
(Goes toward kitchen and calls out loudly: "Martha!" Hearing no answer, Calvin goes out into kitchen leaving Goblin alone.)

(Junior enters immediately after Father leaves and the Goblin dances over to him and dances along with him as Junior slowly and apparently very tired, finds a seat. The Goblin very happily jumps to a seat near Junior.)

Goblin: Well, if it isn't my favorite character, Junior Crooks. How goes it, Junior? You didn't happen to find a job, did you?

Junior: (Sadly) No, I didn't find any job. Nobody seems to want to even spend any time discussing my possibility of working. All I get, day after day, is "I am sorry but we just don't have any jobs today." I know they are hiring people because of the defense work.

Goblin: Yes, they are hiring people, Junior. But not just anyone. You have to be able to convince them that you can hold up when the pressure is on. You can't hold up and you know that yourself. You are always thinking what will happen if you should do something to get into trouble.

Junior: I know, but I still think I can do the work that I was doing before I was in the hospital. I've had experience and I am not stupid. Why can't I seem to find someone who will take a chance on me?

Goblin: Well, you have been trying for quite a few days now. Why don't you admit you are a failure and go back to the hospital.

Junior: I have been thinking about that. But I want to keep trying until I am sure I can't find a job. Besides, Margie Townsend thinks I can get a job, if I keep on looking for one.

Goblin: There you go, Junior. You shouldn't associate with people like Margie. She is a nice girl and doesn't want to be bothered by you. Didn't she refuse to go to the show with you tonight?

Junior: Yes, but that was because she had to stay with her Mother. I should have asked her to go earlier and she would have been glad to go.

Goblin: That's what they all say, Junior. When are you going to learn that you are getting the runaround from everyone? Your folks put up with you because you are their son, but what will they say if you are still out of work one month from now? Business men won't put up with you and now you get the cold shoulder from your girl. Wake up, boy.

Junior: (Gets up and begins to pace the floor while the Goblin paces in the rear.)

Yes, I guess I should give it up and go back to Winter General.

Junior: But darn it, I don't want to give up completely. I might just as well be dead as in the hospital.

Goblin: Well, speaking of being dead....Now I know a nice, quiet place, where no one ever comes, and where the water is cold and deep. If you want,.....

Junior: (Quickly and loudly interrupts Goblin.)
No!!! Anything but that. I'll go back to the hospital.

Goblin: Great. Now your brain is working, and you can see that you don't belong here at home.

(Junior's parents call from kitchen.)

"Is that you Junior? Come out into the kitchen and we'll get dinner on the table."

(Junior and Goblin walk slowly through door leading to kitchen.)

Curtain falls
ending Act One.

Margy sitting on sofa talking to Martha.

Martha: Margy, I'm so glad you could come.

Margy : You know I'm glad too.

Martha: Its for Junior.

Margy : You know I'd do anything for Junior.

Martha: You do love each other don't you?

Margy : Yes we do.

Martha: I'm going to call Rocky again.

Margy : Rocky will help.

Martha: Excuse me dear, I'll be right back.

Goes out, demon enters. Does his spellbinding dance.

Goblin: Sure you want to help your boy friend. But what can you do. He's got to get a job before he can be independent and happy.

Margie: (As if to herself) - Oh why can't he get a job.

Goblin: (laughs and dances - troika music from kije. At climax he says) I'll tell you why 'cause I have helpers. Up there is ignorance, (some lights go off) over here is prejudice (more lights go off) and finally over here is hate. All lights go off and sound effects of roaring wind and moaning come in.

Margie screams and Martha comes rushing into room turning all lights on.

Martha: Why what's the matter?

Margy : The lights went out.

Martha: What made the lights go out?

Margy : I don't know but it frightened me.

Act II Scene I

The curtain rises with Junior seated on the sofa. It is morning of the next day and Junior is feeling low for he has decided to return to the hospital.

Voice off stage: "Junior, where are you?"

The voice interrupts Junior's thoughts and he rises to greet Rocky Canyon who enters the room.
Both men shake hands and find seats on sofa.

Rocky: I talked with your father and he says you haven't had any luck finding a job. From the way he spoke, you are going to return to the hospital. I hope this isn't really true.

Junior: (sadly) It's true, Rocky. I'm tired of butting my head against a stone wall. I've been tagged a mental case and regardless of anything else, I just can't live it down. The "society" that I've heard so much about, refuses to accept me.

Rocky: That's a general statement, isn't it, Junior?

Junior: General statement? You should have been along with me when I tried to find a job. I didn't get one chance--not one, single, chance, to prove I am able to hold a job.

Rocky: Well, Junior, finding a job has become a difficulty, but that remark about "society refusing you." What about Margie Townsend?

Junior: Well, I suppose she thinks I am okay and her folks were pretty swell to me. But business people don't want me around. And my folks--Rocky, my folks are all mixed up.

Rocky: Time is the thing, Junior. It just takes time. You've got to convince people that the things you do and the way you act, are quite all right and entirely to your credit.

Junior: (Gets up from sofa and makes hand movement at Rocky.) It's easy for you to say these things. You are happily married; you have a good job; and you don't have any problems at all. But I can't sit around and wait for other people to become educated about mental illness. I'm only 24 years old and I'd like to be able to really enjoy the next 24. (Sits down again on sofa.)

Rocky: You know, Junior, I could start a long-winded discussion about my problems, because I have the same as you or anyone else. And mine are just as important to me. But I want to ask you one question. If you could have some person who would be willing to put aside his own troubles long enough to get you back on your feet, would you be willing to give him your complete co-operation?

Junior: Certainly. But where do I find this Dorothy Dix of the business world?

Rocky: (Laughing) I understand your doubt, Junior, but this is not some paid personal advisor. He is really a person who seems to know exactly what to do. He has a good business of his own, but what is really important--this man likes people. He takes an interest in others and is always around to help those people who need help. You won't regret the decision to meet him.

Junior: (Warmly) Gee Rocky. You really think he could help me? Do you really think I can make good?

Rocky : Of course. I never doubted it for one minute. You just need someone who has a little faith in his fellow men; someone who can give you reason for picking up faith in yourself.

Junior: When can I meet him, Rocky?

Rocky : This afternoon at 2:00. I've already told him about you and he seems very interested.

Margie Townsend has entered the room and at the last word of Rocky's conversation with Junior, she speaks, surprising Rocky and Junior.

Margie: Hello. Can I come in?

Junior and Rocky rise and meet Margie in center of room, and lead her to seat, while they are greeting her.

Junior: It's nice to see you again, Margie.

Rocky : Sure is.

Junior and Rocky find seats.

Margie: I'm awfully sorry to hear you are going back to the hospital Junior.

Junior: I'm not going back.

Margie: (Happily) Wonderful. I guess I made a silly mistake in coming over, but I did want to tell you I was sorry to see you leaving.

Junior: You have made me feel better, Margie, by just walking into this room. If things can only be worked out, I won't be such a bother to you and Rocky. And I think they might work out, now that I have talked with Rocky.

Rocky : Of course, things will work out. That's what friends are for. But let's go get some ice cream--what do you say?

The three people rise and start towards door.
Rocky continues to speak as they leave. "Have you seen--"

As they leave, the Goblin enters and gazes after them.
Then he finds a seat on the sofa. He speaks:

Goblin: (Mimicing Jimmy Durante) What a revoltin' development this is!!!

End of Scene I

Act II Scene II

The curtain rises on the office of Mr. Sidney. Junior is seated near the desk and Mr. Sidney is speaking from his chair behind the desk.

Sidney: So far as I can see Junior, I would be willing to hire you. Your past experience and training, certainly qualify you for the job. Do you think you will be able to get along with the other employees?

Junior: I am certain that I can, Mr. Sidney. I don't want to associate with them anymore than they do with me. I am embarrassed if people think of me as a former mental patient.

Sidney: You are probably justified for feeling this way. On the other hand, you might be able to reach a point where everyone will accept you and forget you were ever in the hospital.

Junior: But it is very hard to restrict myself to the few people who think I am okay. I want to have everyone I may meet, feel that I am just as normal as the next man.

Sidney: I can't say what should be and what should not be, and neither can anyone else. Certainly, courage and will power , will carry you over the rough spots, but don't forget that it will be a long time, before the world knows what good mental health really means. Until this happens, the public will be backward in dealing with problems like yours.

Junior: I've come to the conclusion that I've got to do most of the fighting by myself. And if this is so, I am certainly going to work hard at the job of letting others know I am in good shape. Beyond that, I can do nothing.

Sidney: Yes, I suppose you have the right idea. I would do the same as you, if I were in your position. But you can at least remember that you do have some people who will help you from time to time. I will always be around when you want to talk things out, and I know Rocky Canyon thinks of you as his best pal. So, you have a pretty good start, after all.

Junior: I don't like to think of what I might have done if I hadn't met someone like you. Someone who could see my side of the picture. Your willingness to help has certainly cleared the air of any doubts on my part.

Sidney: Well, Junior. Years ago, I was helped out of a bad spot, merely by a few words from a friend. I can't see any reason why I should not offer my help to others, who are willing to accept it. Not everyone does, you know, and you are moving along in the right direction, when you can see other people's viewpoints, and use them to help yourself.

(Sidney rises.)

Junior: Oh, no, Mr. Sidney. I'll be here on time and ready to do my best work. Thanks very much for what you have done.

(Both men start toward door and Sidney speaks again.)

Sidney: Don't bother to thank me, Junior. But remember, I'll be around if you should want to talk with me.

(Junior leaves and Sidney returns to the desk. As he sits down, Harris, an old friend, enters and sits down.)

Sidney: Hello, Harris. What brings you around?

Harris: I thought I'd stop by and ask you about your contribution for flood relief.

Sidney: I mailed in a check this morning. How much have you collected?

Harris: I'll have the official count tomorrow, but we'll make our goal. People are always willing to help the less fortunate. Say, didn't I see Junior Crooks leaving here?

Sidney: Yes, you did. He starts working for me tomorrow.

Harris: I think that's a mistake. He tried to get a job from me but I can't see hiring these people. Too many of them are liable to crack up again.

Sidney: When I hire a man to work for me, I must be sure that he can do the work. This applies to anyone who asks for a job. Junior can do the work, and he deserves a chance to try. Besides, you just said "people are always willing to help the less fortunate" and this should apply to former mental patients as well as to flood victims.

Harris: Well, it's your funeral, but I don't want any of them around me.

Sidney: You know, I don't understand you sometimes. People who become mentally sick, get that way without knowing it. Actual figures show that for once in their lifetime, 5 per cent, of all Americans, are hospitalized for mental illness. That is a lot of people. You could be one of them without knowing how you got that way.

Harris: (Laughing.) Not me. I'm not the type.

Sidney: There is no type, Harris. Remember that Chamber of Commerce luncheon, when the waitress spilled your soup? You flew into a rage and sent her into the kitchen bawling. Another night, you were drinking and started a terrible argument with Bill Kelly, over who was the best fighter: Joe Louis or Jack Dempsey? What caused you to do this?

Harris: Well, I was feeling upset when we had the luncheon and I suppose I shouldn't have been so mean to the waitress. But Bill Kelly insulted my intelligence when we discussed the Dempsey-Louis question. We haven't been friends since, but I don't think that means too much. Everybody gets into arguments.

Sidney: Certainly. And lots of people wind up in a mental institution. But I'm not trying to tell you that you are sick. I am only telling you that people crack-up, thinking they are completely well. Who knows that you or I, won't be sick tomorrow?

Harris: I have read a little about such things happening. I suppose you are right.

Sidney: Well, what I have been getting at is that you might have been pretty hard on Junior, not knowing that you could be in the same spot.

Harris: (Waves hand.)

Sidney: Well, I had to find out these things too. Why don't you see Junior and drop a few words of encouragement his way? You could help him a lot by this.

Harris: Why not? It wouldn't hurt me to try to help him a little. Say, Sidney, let's go out for a cup of coffee. I am beginning to get interested in this mental health business and I want to talk some more about it.

Sidney: Sure. Let's go over to the drugstore.

(Both men get up and leave room.)

CURTAIN

End of Scene II

Act III. Scene I

This Scene is the final scene of the play. It is a street scene near a bus stop. Few people are on the street and as the scene opens, Harris & Sidney, meet on the street. The time is six months later.

Harris: Hey, Sidney. Glad to see you again. How's everything?

Sidney: Pretty good. I am interested in hearing what you think of that repair job my company did on your house.

Harris: It was a beautiful piece of work, Sidney. My wife was very happy about it. Tell your men that I liked their work very much and you can be sure, that I will give you my future repair jobs, whenever I can.

Sidney: Well, that's nice to hear. Incidentally, do you know who did that work for us?

Harris: No. Who was it?

Sidney: One of our best workers.....Junior Crooks.

Harris: What? You mean he figured out the electrical wiring? That was too complicated for anyone I knew, but I never gave him credit for being able to do it.

Sidney: Well, he knows that kind of work. I always said he was okay and he has worked out very well.

Harris: I am glad to know this of course.

Sidney: So long, Harris. (Continues in same direction.)

(Not seen by either Harris or Sidney, Junior and his pal, Rocky enter the street and stop to talk.)

Rocky : How much of a raise did you get, Junior?

Junior: Well, I only got a $10.00 a month raise, but man, it is sure a good feeling to know I am doing the work as well as the next man.

Rocky : Yeah. I wish I could get a raise. My wife is always hollering about money.

Junior: You know Rocky, I thought I never would make the grade at times.

Rocky : I know about it, Junior. Your Mother told me that sometimes you were sent out on repair jobs and if the customer squawked, you were afraid you would get fired.

Junior: Yes, that's it. But with all the mistakes I made, Mr. Sidney seemed to think I would work out and I at last feel myself, that I am one of the best workers at the plant.

Rocky : Here comes the girl friend, Junior.

(Margie Townsend joins Junior and Rocky on the street.)

Margie: Hi fellas.

Rocky & Junior: (In unison) Hi Marge.

Margie: Are you two coming to my party tonight?

Rocky : I'll be there with bells on but let's not stand out here in the sun. Let's go into the drugstore and get a coke. What do you say?

Junior: Let's go....Come on Margie.

(The three walk down the street and a figure appears in back of them, gazing after them.)

Goblin: Well, my work's done here. I failed this time, but there will always be a next time. Starts off stage. (I wonder if I can find some gentleman in the audience).

THE END

APPENDIX C

SAMPLE OF ANSWERS TO THE QUESTIONNAIRES GIVEN BY MEMBERS OF THE PSYCHIATRIC TEAM

QUESTION: What is your personal feeling about the short term therapy project on B-15?

ANSWERS:

1) Section Chief: I am highly in favor of the program on two counts:
   a. It is accepting - accepts the patient for what he is.
   b. It is demanding - in that it gets quickly to the point to bring the patient to a realization of his responsibilities in his illness.

2) Social Worker: I feel that it's focusing on a well defined goal. (Leaving the hospital) Has been very helpful to the patients and to me in my work with them. Once a patient was referred we were able immediately to talk to a specific point and consider what we wanted to do about it.

3) Chief Nurse: Helped most of the patients in group relationships; working together motivated planning on their part to leave the hospital.

4) Nurse (Mrs. K.): It seems to be very good in that it gives the patient a definite goal to work toward and more of a homelike atmosphere in which to adjust to the idea of being on their own after a time which has been several years for some.

5) Nurse (Miss B): I feel that it was a good idea, as it has proved so far to benefit some patients whose prognosis has been guarded for years.

6) Nurse (Miss M): I think it has good points, but I think the selection of patients made it hard on those working with them and on some of the patients, as there were several who had so little to offer the project themselves.

7) Aide (Mr. C): From what I have noticed, I think it all ran pretty smoothly.

8) Aide (Mr. T): I believe it is a good type of therapy for the patients that have been in the hospital for years.

9) O.T.R. (Mrs. T): I think it was a very worthwhile project. Even though some patients may not be able to stay out of the hospital, I feel it gave each one a chance to better understand his own problems.

10) Aide (Mr. B.): Yes, more groups - no undertow.

11) Aide (Mr. C.): The patients seem to work together and seem friendlier.

12) Aide (Mr. T.): Most of them would sit together and all participate in the conversation.

QUESTION: Give your impression of the effect which each of the three therapeutic methods used in the project had on the patients.

ANSWERS: 1) Section Chief: I feel that the 90 day aspect was the prime organizer and that those aspects of the program which dealt with specific concrete problems about which talking and acting was possible afforded the most help.

2) Ward Doctor: Group project helped patients develop self reliance and confidence in interpersonal relationships more than individual therapy.

3) Social Worker: I am not at all aware of the difference in the end effect of any one therapeutic method as contrasted with the other two. I think, however, the activity therapy group had the most fun as well as the most acute awareness of being part of a project.

4) Nurse (Mrs. K.): I feel all three had their special benefit.

5) Director Educational Clinic (Miss G.): I think the Marionette Project did much for the patients who were struggling with personality problems. The creative endeavor, teamwork, assumption of responsibilities and social relationships observed were very good. The self-confidence and ability gained by working out a production that required several months of work was quite noticeable in several members of the group. I did not observe much change in the patients of the individual therapy group.

6) Nurse (Miss S.): Activity therapy group seemed to create more active interest in their group activities. Patients in this group are the only ones who made many comments about their treatment.

7) Psychiatric Aide (Mr. H.): I heard patients say that they would have liked to be in the puppet show group.

10) O.T.R. (Miss R.): It gave a group feeling.

11) O.T.R. (Miss N.): Good.

12) Director Educational Clinic (Miss G.): I feel that the therapy project on B-15, especially the group activity, was excellent for rehabilitation.

QUESTION: Have you noticed any changes in the behavior of the patients to each other and in the atmosphere on the ward since the beginning of the project?

ANSWERS: 1) Section Chief: Yes, I feel that the 90-day limit gave them a common bond and pulled them together -- I feel that chronic patients in a state of equilibrium all have the problem of hospital life versus life outside.

2) Ward Doctor: Yes, certain "in groups" developed. Minimum of friction.

3) Social Worker: Yes, indeed. There was much more interaction among patients even though some remained withdrawn. There seemed greater toleration of behavior of others, more attempts to understand and interpret behavior.

4) Chief Nurse: More friendly groupings, more enthusiasm on work.

5) Nurse (Miss B.): Yes, one of friendliness toward each other, group participation, and sharing of common interests.

6) Nurse (Miss G.): A closer harmony appeared to exist among the group during the program.

7) Nurse (Miss K.): Yes, at first there seemed to be a lot of doubts about the program, but soon they began to help one another, more friendly, discussing their problems more openly amid genuine interest.

8) Nurse (Miss M.): There were several friendships formed or groups that seemed to like to be together more than others.

9) Nurse (Miss S.): Developed an understanding of others' problems and illness. More friendly and seemed interested in ward being part of their treatment program.

10) Nurse (Miss M.): I felt the activity therapy helped those in that group more than the others. Those patients when doing something seemed much better and liked so very much to even talk of their work a lot.

11) Supervisor Woodworking: Activity therapy seemed to have developed self-confidence and social response.

APPENDIX D

SAMPLE OF ANSWERS GIVEN BY THE PATIENTS TO END OF TREATMENT QUESTIONNAIRES

QUESTION: Frankly describe your overall impression of the short term therapy project.

ANSWERS: IC INDIV.

Patient #19: In my opinion the project could of progressed much better had the selection of patients not been so differently in their personalities as well as illness. They all of should been men with clear thoughts of thinking or they should of been patients who are completely mixed and confused most of the time. The policy of mixing confused groups with those who are clear in their thoughts will never work out.

Patient #16: Very sensible and for good of patients.

Patient #17: I believe that it has been pretty much of a failure with this group. Most of the patients on the ward are ready to go home, but they were just as ready to go home three months ago. I don't believe the program hurt anyone, or did it help anyone very much.

Patient #2: I believe I benefited from the program as it was set up. I believe others (about eight) did not, because efforts to get them to enter into the group activities failed. Too little personal interest seems to have been taken by group activities such as ward meetings and only a limited few can feel the benefit. Puppet show project was a good thing from what the members of the group have told me. Group II and their activities are not known to me so the members seldom mentioned their activities. Group I, my group, could have been beneficial to me if the period had lasted longer than three months and had I not been discouraged by previous psychotherapy on ward C-9.

Patient #1: Well, I think that for a physical, energentical and mental recuperation, it is good.

IC GROUP

Patient #3: It's o.k. and got more out of it than figured on.

Patient #4: To my notion, I believe most, if honestly admitted would have gained. I see no reason why other groups couldn't benefit by similar therapy.

Patient #12: It impressed me as having had considerable preparation, with consideration of patients involved and so designed to aid the patient in his say toward his change from the hospital.

Patient #10: I think it has many advantages over any type of therapy I've ever seen. It is brief and to the point, and doesn't drag until complacency begins.

Patient #18:

SPC GROUP

Patient #9: Favorable.

Patient #15: My impression of the short term therapy project was, it's a test to see if we could work on a project together and work out the problems which we could encounter which in most cases the patients on the project did.

P atient #7: I feel the third group to have been the best. The first group seems to have had the poorest results. I feel very enthusiastic about the group I was in and feel that it really helped me and some of the other fellows. I think the ward could have been a bit more selected and also more supervision would have helped some of the other patients.

Patient #6: It was the opportunity of bringing together different problems of patients. Also a chance to disclose the ways which they might be able to receive help on the outside, considering what they were able to do on the project.

Patient #5: (Patient pasted an ad for Listerine in the space left for an answer to the above question.)

QUESTION: How does living on B-15 (during the project) compare with life on other wards that you previously experienced?

ANSWERS: IC INDIV.

Patient #19: Just about the same in an over-all evaluation; as long as there is a mixed group no great progress can ever be noticed.

Patient #16: As good as best - D-West, B-2, B-6.

Patient #17: The doors and windows weren't locked. That is the only difference.

Patient #2: I have only been on two other wards, C-9 and C-13. Both are closed and any open ward has better points in its favor.

Not being forced to go to the recreation hall and movies was the best thing in my opinion. Also, being able to take bookkeeping instead of O.T. made me feel like taking part in hospital activities.

Patient #1: Living closer to a mess hall is more.

IC GROUP

Patient #3: A lot better on B-15.

Patient #4: Much more freedom which allowed for more personal satisfaction, in the line of activity and recreation and personell problems.

Patient #12: Quite a bit more freedom and less surveilance. Less friction. Few or no arguments or disagreements. Yet, less feeling of group adhesiveness.

Patient #10: I liked it very much more. It seemed like everyone was working together for a common goal and through this the attitude of everyone was better.

Patient #18:

SPC GROUP

Patient #9: It is better.

Patient #15: It's kinda hard to compare this ward and other wards. I've been on because this is an open ward while the others I've been on were closed, but I think the patients here on this ward have tried to be more considerate of others than on closed wards I've been on.

Patient #7: B-15 was very much better than any other ward I've been on. I felt the atmosphere especially during the first month, among the patients to be the best I have ever encountered.

Patient #6: I experienced living with patients having more responsibility and was able to see my way clearer to what I must be able to do when I meet situations of difficulty on the outside.

Patient #5: (Patient pasted the following ad he had cut out of a newspaper in the space: "We carry a complete line of shotguns, rifles, revolvers and ammunition. Scrinopski Loan Office, 410 Kansas.")

APPENDIX E

SAMPLE OF ANSWERS GIVEN BY THE PATIENTS TO THE "FOLLOW-UP" QUESTIONNAIRE

QUESTION: What do you think NOW about the intensive treatment program?

ANSWERS: Group 1

Patient #19: I believe that as far as therapy is concerned it will work but that interference after completion will tend to undo all that has been accomplished.

Patient #17: I believe the program is good. I do not believe that the individual treatment has any use in the program. Groups 2 and 3 are good. I think that Group 3 should have a meeting a week like Group 2. Eliminate Group 1.

Patient #16: Good while it lasted.

Patient #2: Not intensive enough.

Patient #1: I think that it is too good.

Group 2

Patient #3: Still think its OK and helped me a lot.

Patient #4: I liked it and now when I get to thinking it over I'd like to go over it again and through more of it.

Patient #12: It was a very good program well carried out.

Patient #10: I feel that it was strictly an experiment with the main objective being research for the benefit of the staff.

Patient #18: OK.

Group 3

Patient #9: I believe that it is well worthwhile and should be employed for a greater number of patients.

Patient #15: I think it's a good thing. It helped me more than any other treatment, I believe.

Patient #7: I got more help out of these three months than from all the rest of my hospitalization.

Patient #6: I believe the first thing about it requires an active outlook of the present.

Patient #5: Satisfactory.

QUESTION: What was the worst thing about it?

ANSWERS: Group 1

Patient #19: Not being able to carry out an intelligent conversation with some members of the group. I believe that the groups should be classified accordingly.

Patient #16: Filling in the Questionnaires.

Patient #17: The two hours a week I spent with the doctor. They were wasted.

Patient #2: Films - all morning on Saturdays.

Patient #1: -----

Group 2

Patient #3: Should make patients keep active and have responsibilities so they will be better prepared when they get out.

Patient #4: I didn't find any of it intolerable.

Patient #12: There wasn't anything real bad about it, I believe.

Patient #10: Lack of proper treatment as evidenced by the treatment given me by my present doctor with the amazing results it is producing.

Patient #18: -----

Group 3

Patient #9: Nothing very serious. A better start might be a fully detailed exposition of the program by the staff and of the detailed group therapies to be tried. I believe that the weekly meeting should be scheduled for one hour only, with possibility of greater time when needed.

Patient #15: The worst thing about it was to walk three miles a day for chow.

Patient #7: I think if instead of being divided into three groups, the whole ward were engaged in some project, it would be more helpful.

Patient #6: The stubbornness of the schedule.

Patient #5: Leaving.

QUESTION: What was the best thing about it?

ANSWERS: Group 1

Patient #19: The cooperation and guidance received by personnel in charge of the program.

Patient #17: Having coffee whenever I wanted it.

Patient #16: Seeing the doctor.

Patient #2: Free movement of patients in various activities.

Patient #1: Learning to talk.

Group 2

Patient #3: Weekend passes and personal interest of doctors in patients.

Patient #4: I felt like at least someone out of this whole world cared a little about what happened to me.

Patient #12: It provided for discussion both somewhat formal, mostly informal, being good therapy.

Patient #10: Being shown what an inefficient, incompetent, and beaucracy ridden organization Winter VA is.

Patient #18: Promise of release.

Group 3

Patient #9: The willingness of the staff to adopt a positive attitude and answer questions, and to adjust conditions when reasonable complaints were offered.

Patient #15: I think was the way the doctors, nurses, and aides were always right there to help us in any way they could, but in a way that we learned to help ourselves.

Patient #7: Demonstrated concretely to me the real relationship between myself and others.

Patient #6: The choice of the interest of the patient.

Patient #5: Puppetshow.

QUESTION: How does the therapy which you received on B-15 compare with the treatment that other patients on B-15 received?

ANSWERS: Group 1

Patient #19: In my opinion my therapy applied to my case. Another type wouldn't have been of any benefit.

Patient #16: Can't guess.

Patient #17: The two hours a week I spent with the doctor was not even therapy.

Patient #2: About the same, except that some patients needed more of it.

Patient #1: I was picked for Dr. Hammersley.

Group 2

Patient #3: About the same.

Patient #4: We were occupied and had something to look forward to, whereas patients prior to that had to shift for themselves, without organization.

Patient #12: I imagine the treatment was best arranged for particular patient for their advantage.

Patient #10: No opinion.

Patient #18: Same

Group 3

Patient #9: It seemed to me that all patients on B-15 received good treatment.

Patient #15: In my opinion the treatment I received was not too much different, because all three types of treatment was designed to make us help each other and ourselves.

Patient #7: I feel that there was a great deal of interest and support given me. Maybe more than the rest.

Patient #6: I am still anxious to face my problems and see that others have their own.

Patient #5: ?

QUESTION: How does it compare with treatment you received prior to entering the project?

ANSWERS: Group 1

Patient #19: The treatment I received prior to that was mostly medical. A combination of both of them helped a great deal.

Patient #16: Improvement.

Patient #17: The only difference was that B-15 is an open ward.

Patient #2: No treatment other than therapy. Very good in comparison.

Patient #1: I had no specific treatment.

Group 2

Patient #3: It was considerably better than on other wards.

Patient #4: Far superior and more on equal basis with rest of civilization.

Patient #12: More intensive, arranged for closer relationship between therapist and patient.

Patient #10: About the same, except the sub-shock Insulin treatment I had, which helped me.

Patient #18: Surrounding seemed better.

Group 3

Patient #9: It was definitely superior. On closed wards the aides are used almost exclusively as guards; nurses have time only to administer cigarettes, PX books, and medicine, and doctors presumably use much time on paper work, being on the ward for half hour a day.

Patient #15: On other wards I depended too much on the doctors instead of getting a hold of myself and trying to help myself.

Patient #7: No comparison. By far the most helpful and most satisfying.

Patient #6: It caused me to work better.

Patient #5: -----

APPENDIX F

QUANTITATIVE DATA

MEAN RATINGS GIVEN BY THE PSYCHIATRIC TEAM

TO THERAPEUTIC "SUCCESSES" AND "FAILURES"

MATCHING VARIABLES AND DISCHARGE
(Mean Personnel Rating)

	July	October	
SELF-CONFIDENCE			
Group 1	5.9	5.9	Hospitalized
	6.0	7.0	Hospitalized
	5.1	5.6	Discharged
	4.6	3.4	Discharged
	4.6	3.7	Discharged
	6.9	6.3	Discharged
Group 2	6.1	6.9	Hospitalized
	6.4	6.1	Hospitalized
	5.3	7.7	Hospitalized
	6.0	5.4	Discharged
	5.3	5.7	Discharged
	5.7	5.4	Discharged
Group 3	7.3	7.3	Hospitalized
	2.6	2.0	Discharged
	5.6	3.3	Discharged
	4.4	2.7	Discharged
	6.0	5.6	Discharged
	6.7	7.1	Discharged
Mean Hospitalized	6.2	6.8	
Mean Discharged	5.3	4.7	

MATCHING VARIABLES AND DISCHARGE
(Mean Personnel Ratings)

	July	October	
POPULARITY			
Group 1	6.7	7.3	Hospitalized
	5.0	5.3	
	4.9	6.0	Discharged
	4.1	4.4	
	4.4	3.6	
	5.9	4.9	
Group 2	4.0	4.7	Hospitalized
	4.6	3.7	
	7.4	7.3	
	4.1	3.7	Discharged
	5.3	4.9	
	4.7	5.1	
Group 3	6.3	6.6	Hospitalized
	3.6	3.0	Discharged
	3.3	2.5	
	5.6	4.3	
	4.3	4.0	
	7.3	6.3	
Mean Hospitalized	5.7	5.8	
Mean Discharged	4.8	4.4	

MATCHING VARIABLES AND DISCHARGE
(Mean Personnel Ratings)

	July	October	
HANDICAP			
Group 1	5.4	7.4	Hospitalized
	6.1	7.0	
	3.1	5.7	Discharged
	4.0	3.1	
	6.3	3.0	
	7.7	4.8	
Group 2	4.6	5.3	Hospitalized
	6.6	5.7	
	8.3	8.7	
	3.6	3.0	Discharged
	5.6	5.9	
	6.0	5.1	
Group 3	7.4	8.4	Hospitalized
	3.4	2.3	Discharged
	4.1	2.5	
	5.4	3.7	
	6.4	4.7	
	8.1	7.3	
Mean Hospitalized	6.4	7.1	
Mean Discharged	5.3	4.3	

BISERIAL CORRELATIONS OF MATCHING CRITERIA

WITH THERAPEUTIC "SUCCESS" AND "FAILURE

Handicap Rating in July 1951 as related to "Success" and "Failure":

Biserial Correlation	r_{bis}	.37
Standard Error		1.7
5% Level of Significance		.34

<5%

Self-confidence Rating in July 1951 as related to "Success" and "Failure":

Biserial Correlation	r_{bis}	.30
Standard Error		1.7
5% Level of Significance		.34

Popularity Rating in July 1951 as related to "Success" and "Failure":

Biserial Correlation	r_{bis}	.31
Standard Error		1.7
5% Level of Significance		.34

Contingency Coefficient for identical data:

Handicap Ratings:	.17
Self-confidence Ratings:	.30
Popularity Ratings:	.30

ANALYSES OF VARIANCES OF MEAN RATINGS OF "SUCCESSES" AND "FAILURES", DETERMINATION OF RELEVANCY OF MATCHING CRITERIA.

ANALYSIS OF VARIANCES OF SELF-CONFIDENCE RATINGS

OF DISCHARGED AND CONTINUOUSLY HOSPITALIZED PATIENTS

Source of Variation	Sums of Squares	Degrees of Freedom	Means Squares
Total	3377	35	
Between Subjects	2895	17	170
Between Groups (Common Fate)	875	1	875.05
Between Subjects Within These Groups	105	5	21
	1915	11	174
	2020		195
Within Subjects	482	18	27
Between Ratings (Therapy)	13	1	13
Interaction Groups x Ratings	147	1	147.05
Pooled Interaction (Residual)	322	16	20

ANALYSIS OF VARIANCES OF HANDICAP RATINGS

OF DISCHARGED AND CONTINUOUSLY HOSPITALIZED PATIENTS

Source of Variation	Sums of Squares	Degrees of Freedom	Means Squares
Total	5622	35	
Between Subjects	4520	17	266
Between Common Fate Groups	1493	1	1493
Between Subjects Within These Groups	812	5	162
	2215	11	201
	3027		363
Within Subjects	1102	18	61
Between Ratings (Therapy)	96	1	96
Interaction Groups x Ratings	297	1	297
Residual	709	16	44

ANALYSIS OF VARIANCES OF POPULARITY RATINGS

OF DISCHARGED AND CONTINUOUSLY HOSPITALIZED PATIENTS

Source of Variation	Sums of Squares	Degrees of Freedom	Means Squares
Total	2890	35	
Between Subjects	2664	17	157
Between Groups (Common Fate)	522	1	522
Between Subjects Within These Groups	931	5	186
	1211	11	110
	2142	16	296
Within Subjects	226	18	12
Between Ratings (Therapy)	22	1	22
Interaction Ratings x Groups	29	1	29
Pooled Interactions (Residual)	175	16	11

SUMMARY OF RATINGS

GIVEN BY THE MEMBERS OF THE

PSYCHIATRIC TEAM

PERSONNEL HANDICAP RATING SUMMARY

	Dr.H.	A.K.	Miss B.	Mrs.K.	Mrs.M.	Mrs.S.	Mr.C.	July	Oct.	Total
Group 1										
13	4 4	3 3	2 4	3 9	4 9	3 7	3 4	22	40	62
19	6 3	5 4	2 4	4 2	3 6	5 1	3 2	28	22	50
16(H)	6 6	6 7	5 6	6 9	5 8	5 7	5 9	38	52	90
17(H)	7 8	7 6	7 7	6 7	6 7	6 7	4 7	43	49	92
2	6 7	7 3	7 1	5 2	7 5	6 1	6 2	44	21	65
1	8 4	6 6	9 5	8 4	7 5	8 4	8 6	54	34	88
	37 32	34 29	32 27	32 33	32 40	33 27	29 30	229	218	447
Group 2										
4	4 4	5 5	2 2	3 2	4 3	4 1	3 4	25	21	46
12(H)	5 5	8 5	3 4	5 6	5 7	3 5	3 5	32	37	69
10	5 7	7 7	4 5	6 8	6 6	5 5	6 3	39	41	80
18	6 5	6 5	5 6	7 3	6 8	6 3	6 6	42	36	78
14(H)	5 7	7 5	7 7	8 6	7 7	5 3	7 5	46	40	86
8(H)	6 9	9 9	9 8	8 9	8 9	9 9	9 8	58	61	119
	31 37	42 36	30 32	37 34	36 40	32 26	34 31	242	236	478
Group 3										
9	3 3	5 4	2 1	4 1	4 3	3 2	3 2	24	16	40
15	5 3	5 3	4 1	5 2	3 1	3 4	4 4	29	18	47
7	4 3	6 5	5 3	7 1	5 5	6 7	5 2	38	26	64
6	5 4	9 8	6 3	8 4	6 4	4 4	7 6	45	33	78
11(H)	6 8	8 9	8 8	8 9	7 8	7 8	8 9	52	59	111
5	8 5	9 8	8 8	8 9	8 9	8 6	8 6	57	51	108
	31 26	42 37	33 24	40 26	33 30	31 31	35 29	245	203	448
	99 95	118 102	95 83	109 93	101 110	96 84	98 90	716	657	1373

PERSONNEL SELF-CONFIDENCE RATING SUMMARY

	Dr.H.		Mr.K.		Miss B.		Mrs.K.		Mrs. M.		Mrs.S.		Mr.C.		July	Oct.	Total
Group 1																	
13	6	5	4	4	3	3	6	9	7	9	5	5	5	5	36	40	76
19	6	4	3	5	3	2	7	6	4	3	5	1	4	3	32	24	56
16(H)	4	5	8	6	5	4	7	9	8	9	3	1	6	7	41	41	82
17(H)	7	7	5	9	6	4	8	9	7	7	5	8	4	5	42	49	91
2	6	6	6	7	4	1	4	3	3	1	5	4	4	4	32	26	58
1	6	5	8	8	6	5	8	8	7	5	5	6	8	7	48	44	92
	35	32	34	39	27	19	40	44	36	34	28	25	31	31	231	224	455
Group 2																	
4	5	6	9	7	4	3	8	6	7	6	3	4	6	6	42	38	80
12(H)	5	7	7	8	6	5	8	9	7	7	7	6	3	6	43	48	91
10	7	6	5	6	4	6	5	7	7	7	4	5	5	3	37	40	77
18	5	4	8	6	5	4	8	8	6	8	4	4	4	4	40	38	78
14(H)	6	6	8	7	8	5	7	8	6	8	5	5	5	4	45	43	88
8(H)	7	8	5	8	5	6	4	9	6	9	5	8	5	6	37	54	93
	35	37	42	42	32	29	40	47	39	45	28	32	28	29	244	261	505
Group 3																	
9	2	2	4	4	1	1	3	1	4	2	1	2	3	2	18	14	32
15	6	4	7	3	5	1	5	2	6	4	4	4	6	5	39	23	61
7	4	2	6	4	2	2	7	5	4	1	6	3	2	2	31	19	50
6	6	5	9	8	6	6	6	4	5	3	4	6	6	7	42	39	81
11(H)	6	8	9	9	9	5	6	9	5	7	9	6	7	7	51	51	102
5	7	7	9	9	9	6	8	9	8	9	2	4	4	6	47	50	97
	31	28	44	37	32	21	35	30	32	26	25	25	28	29	228	196	424
	101	97	120	118	91	69	115	121	107	105	82	82	87	89	703	681	1384

PERSONNEL POPULARITY RATINGS SUMMARY

	Dr.H.		Mr.K.		Miss B.		Mrs.K.		Miss M.		Mrs.S.		Mr.C.		July	Oct.	Total
Group 1																	
13	5	5	4	7	6	5	6	7	5	9	4	4	4	5	34	42	76
19	5	4	4	4	3	2	6	7	4	5	5	5	2	4	29	31	60
16(H)	5	7	8	7	3	7	8	8	7	8	9	8	7	6	47	51	98
17(H)	6	6	6	3	6	6	3	4	3	6	6	7	5	5	35	37	72
2	5	5	3	3	4	2	5	5	5	4	3	1	6	5	31	25	56
1	8	5	7	7	5	1	3	3	5	6	6	6	7	6	41	34	75
	34	32	32	31	27	23	31	34	29	38	33	31	31	31	217	220	437
Group 2																	
4	4	5	5	5	6	3	2	2	3	4	5	2	4	5	29	26	55
12(H)	4	6	4	5	3	3	6	6	5	7	3	3	3	3	28	33	61
10	5	6	6	5	5	5	6	4	6	6	5	4	4	4	37	34	71
18	4	5	5	7	6	4	4	3	6	7	5	5	3	5	33	36	69
14(H)	4	4	4	4	3	3	6	3	8	7	2	2	5	3	32	26	58
8(H)	7	6	7	8	8	7	8	9	9	9	6	6	7	6	52	51	103
	28	32	31	34	31	25	32	27	37	40	26	22	26	26	211	206	417
Group 3																	
9	3	3	4	4	2	4	3	1	4	3	4	3	5	3	25	21	46
15	2	3	3	5	2	2	4	1	4	1	2	1	6	4	23	17	40
7	6	6	7	3	5	5	5	1	5	5	5	4	6	6	39	30	69
6	3	6	6	8	6	4	3	1	4	2	3	1	5	6	30	28	58
11(H)	6	7	5	6	4	3	8	8	8	9	7	7	6	6	44	46	90
5	8	5	8	5	7	6	8	8	9	8	6	6	5	6	51	44	95
	28	30	33	31	26	24	31	20	34	28	27	22	33	31	212	186	398
	90	94	96	96	84	72	94	81	100	106	86	75	90	88	640	612	1252

ANALYSES OF VARIANCES OF RATINGS OF THE PSYCHIATRIC TEAM WITH RESPECT TO THE TREATMENT GROUPS

PERSONNEL HANDICAP RATING

Source of Variation	Sums of Squares	Degrees of Freedom	Mean Square	
Total	1146	251		
Between Subjects	646	17	38	
Between Groups	8	2	4	
Between Subjects within Groups	638	15	42.5	
Within Subjects	500	234	2.1	
Between Ratings (Therapy)	14	1	14	
Between Raters	41	6	6.8	
Interaction Ratings x Raters	27	6	4.5	P .05
Interaction Groups x Ratings	8	2	4	P .05
Interaction Groups x Raters	25	12	2.1	
Interaction Groups x Raters x Ratings	22.5	12	1.87	
Pooled Interactions (Residual)	362.5	195	1.89	

Personnel Self-confidence Rating

Source of Variation	Sums of Squares	Degrees of Freedom	Mean Square	
Total	1087	251		
Between Subjects	413	17	24.5	
Between Groups	40	2	20.0	
Between Subjects within Groups	373	15	24.9	
Within Subjects	674	234	2.9	
Between Ratings (Therapy)	2	1	2	
Between Raters	176	6	29.3	
Interaction Ratings x Raters	13	6	2.1	
Interaction Groups x Ratings	14	2	7.0	P .05
Interaction Groups x Raters	20	12	1.7	
Interaction Groups x Ratings x Raters	64	12	5.3	P .05
Pooled Interactions (Residual)	385	195	1.9	

PERSONNEL POPULARITY RATING

Source of Variation	Sums of Squares	Degrees of Freedom	Mean Squares
Total	890	351	
Between Subjects	380	17	22.3
Between Groups	9	2	4.5
Between Subjects within Groups	371	15	24.7
Within Subjects	510	234	2.2
Between Ratings (Therapy)	3	1	3
Between Raters	50	6	8.3
Interaction Ratings x Raters	10	6	1.7
Interaction Groups x Ratings	6	2	3
Interaction Groups x Raters	34	12	2.8
Interaction Groups x Ratings x Raters	57	12	4.9
Interactions Pooled (Residual)	350	195	1.8

MEAN RATINGS FOR EACH PATIENT

AS GIVEN BY THE PSYCHIATRIC

TEAM AND HIS FELLOW PATIENTS

MEAN HANDICAP RATING

	Psychiatric Staff		Patients		
	July	October	July	October	TOTAL
Group 1					
13	3.1	5.7	3.8	4.0	16.6
19	4.0	3.1	1.5	3.2	11.8
16(H)	5.4	7.4	6.0	6.7	25.5
17(H)	6.1	7.0	5.0	4.0	22.1
2	6.3	3.0	2.8	2.0	14.1
1	7.7	4.8	4.2	6.0	22.7
	32.6	31.0	23.3	25.9	112.8
Group 2					
4	3.6	3.0	5.0	2.5	14.1
12(H)	4.6	5.3	4.1	4.6	18.6
10	5.6	5.9	3.2	4.0	18.7
18	6.0	5.1	5.0	5.2	21.3
14(H)	6.6	5.7	5.0	3.2	20.5
8(H)	8.3	8.7	7.2	7.0	31.2
	34.7	33.7	29.5	26.5	124.4
Group 3					
9	3.4	2.3	2.8	1.7	10.2
15	4.1	2.5	4.0	2.3	12.9
7	5.4	3.7	3.2	2.5	14.8
6	6.4	4.7	4.0	3.7	18.8
11(H)	7.4	8.4	5.5	6.1	27.4
5	8.1	7.3	6.0	3.4	24.8
	34.8	28.9	25.5	19.7	108.9
Sum	102.1	93.6	78.3	72.1	346.1

MEAN SELF-CONFIDENCE RATINGS

	Psychiatric Staff		Patients		
	July	October	July	October	TOTAL
Group 1					
13	5.1	5.6	4.4	4.7	19.8
19	4.6	3.4	2.8	2.5	13.3
16(H)	5.9	5.9	6.2	6.7	24.7
17(H)	6.0	7.0	2.0	4.0	19.0
2	4.6	3.7	3.0	2.2	13.5
1	6.9	6.3	4.8	4.7	22.7
	33.1	31.9	23.2	24.8	113.0
Group 2					
4	6.0	5.4	3.3	3.2	17.9
12(H)	6.1	6.9	5.5	4.6	23.1
10	5.3	5.7	4.0	4.7	19.7
18	5.7	5.4	5.8	4.8	21.7
14(H)	6.4	6.1	5.0	4.5	22.0
8(H)	5.3	7.7	7.0	7.1	27.1
	34.8	37.2	30.6	28.9	131.5
Group 3					
9	2.6	2.0	2.2	3.0	9.8
15	5.6	3.3	2.7	3.5	15.1
7	4.4	2.7	3.8	3.3	14.2
6	6.0	5.6	3.6	4.0	19.2
11(H)	7.3	7.3	6.5	3.7	24.8
5	6.7	7.1	6.0	5.8	25.6
	32.6	28.0	24.8	23.3	108.7
Sum	100.5	97.1	78.6	77.0	353.2

MEAN POPULARITY RATINGS

	Psychiatric Staff		Patients		
	July	October	July	Patients	TOTAL
Group 1					
13	4.9	6.0	3.4	3.3	17.6
19	4.1	4.4	2.0	2.5	13.0
16(H)	6.7	7.3	6.2	6.3	26.5
17(H)	5.0	5.3	4.8	3.0	18.1
2	4.4	3.6	3.0	3.2	14.2
1	5.9	4.9	4.0	6.3	21.1
	31.0	31.5	23.4	24.6	110.5
Group 2					
4	4.1	3.7	3.8	4.8	16.4
12(H)	4.0	4.7	3.7	3.7	16.1
10	5.3	4.9	4.0	4.0	18.2
18	4.7	5.1	5.3	4.8	19.9
14	4.6	3.7	2.3	2.3	12.9
8	7.4	7.3	7.8	7.0	29.5
	30.1	29.4	26.9	26.6	113.0
Group 3					
9	3.6	3.0	4.6	3.3	14.5
15	3.3	2.5	2.3	3.0	11.1
7	5.6	4.3	4.3	4.0	18.2
6	4.3	4.0	3.6	4.0	15.9
11(H)	6.3	6.6	5.8	4.3	23.0
5	7.3	6.3	5.0	3.8	22.4
	30.4	26.7	25.6	22.4	105.1
Sum	91.5	87.6	75.9	73.6	328.6

ANALYSES OF VARIANCES OF MEAN RATINGS

WITH RESPECT TO TREATMENT GROUPS

ANALYSIS OF VARIANCES OF MEAN HANDICAP RATINGS

Source of Variation	Sums of Squares	Degrees of Freedom	Mean Square	
Total	222.33	71		
Between Subjects	140.88	17	8.29	
Between Groups	5.44	2	2.72	
Between Subjects within Groups	135.44	15	9.02	
Within Subjects	81.45	54	1.51	
Between Ratings (Therapy)	3.18	1	3.18	
Between Judges (Patients : Staff)	28.52	1	28.52	P.05
Interaction Ratings x Judges	0.00	1	0.00	
Interaction Groups x Ratings	3.23	2	1.61	
Interaction Groups x Judges	.78	2	.39	
Interaction Groups x Judges x Ratings	4.90	2	2.45	
Pooled Interactions (Residual)	40.84	45	.91	

ANALYSIS OF VARIANCES OF MEAN SELF-CONFIDENCE RATINGS

Source of Variation	Sums of Squares	Degrees of Freedom	Mean Square	
Total	163.94	71		
Between Subjects	100.78	17	5.93	
Between Groups	12.23	2	6.11	
Between Subjects within Groups	88.55	15	5.90	
Within Subjects	63.16	54	1.17	
Between Ratings (Therapy)	3.47	1	3.47	
Between Judges (Patients : Personnel)	24.50	1	24.50	
Interactions Ratings x Judges	.45	1	.45	
Groups x Ratings	12.31	2	6.15	P.=.01
Groups x Judges	5.63	2	2.81	P.=.01
Groups x Ratings x Judges	.45	2	.22	
Pooled Interactions (Residual)	16.35	45	.36	

ANALYSIS OF VARIANCES OF MEAN POPULARITY RATINGS

Source of Variation	Sums of Squares	Degrees of Freedom	Mean Square	
Total	137.83	71		
Between Subjects	99.26	17	5.84	
Between Groups	1.36	2	.68	
Between Subjects within Groups	97.90	15	6.52	
Within Subjects	38.57	54	.71	
Between Ratings (Therapy)	.54	1	.54	
Between Judges (Patients: Personnel)	12.17	1	12.17	
Interactions Judges x Ratings	.04	1	.04	
Interactions Groups x Ratings	1.61	2	.81	
Interactions Groups x Judges	1.54	2	.77	
Interaction Groups x Judges x Ratings	3.14	2	1.57	P. = .05
Pooled Interactions (Residual)	19.53	45	.43	

APPENDIX G

Winter V.A. Hospital

Date: _____

I, , desire to participate in the intensive therapy program which is being instituted on B-15. I have been informed that my treatment will be part of a research study. I give my permission for the publication of information obtained from my treatment with the understanding that my name will be withheld in this connection. I agree also to have meetings and therapy sessions in which I participate recorded without prior additional notification. I understand, however, that all such information will be handled with the discretion due a patient.

I agree further to remain in the hospital for a period of three months until my treatment is completed, and I have been notified that I will be discharged from the hospital during the first week of October.

I will cooperate with the hospital personnel and abide with the ward rules as they will be announced for B-15.

I finally accept the responsibility to complete and return a questionnaire about my adjustment on the outside which will be mailed to me three months after my discharge from the hospital, i.e., in January 1952.

_____

Popularity Scale

1. _____ is liked by everybody. He is always willing to help others, is the kind of guy anybody would like to have as a lifetime buddy.

2. _____ is a dependable, substantial guy. He has a heart for his buddies. Most everybody would be happy to be associated with him.

3. _____ is a nice fellow, likeable, has very few enemies. He is an asset to any organization.

4. _____ gets along with everybody, is always nice to people, is respected but sometimes regarded as spineless, sort of a politician and apple-polisher.

5. _____ is an average guy, has his band of fellows who like him and others who don't care for him. He usually is honestly friendly to people, but wields a real punch when he is crossed up.

6. _____ is hard to figure out, can be real likeable and nice, and at other times is absolutely intolerable. Some people like him.

7. _____ is a selfish person who has little concern for others. Very few people like him.

8. _____ seems to aggravate and annoy people and to make many enemies.

9. _____ is a real obnoxious guy, nobody likes him, most people hate him.

Handicap Rating Scale

1. _____ appears to be capable of coping with most situations on the outside. He will be successful and make friends. He will not require readmission.

2. _____ is capable of handling situations of ordinary life. He will in all probability be successful. Only if he should be exposed to more than average stress might he be in for trouble again.

3. _____ is capable to face life on the outside, provided that he will be supported by an understanding person.

4. _____ is able to make it on the outside if his road is clearly outlined and free from major obstacles and if he is assured of continued guidance.

5. _____ will be able to adjust on the outside provided that he will be able to get initial support with finding and getting used to a job. He needs more help in dealing with personal problems, family matters, etc., than could be provided by guidance alone.

6. _____ needs special consideration on his job, continuous help and guidance in order to be able to live on the outside.

7. _____ will have hard going to keep from coming back into the hospital even with help and guidance on the outside.

8. _____ tends to get mixed up easily and to misjudge reality. It is unlikely that he can adjust on the outside.

9. _____ is very confused and so ill that he appears to be utterly unable to live outside of firm institutional boundaries.

Self-Confidence Scale

1. _____ is convinced that he is exceptionably capable, is confident that his actions turn out O.K., thinks that he is highly respected and liked by most people.

2. _____ has a high opinion of himself, feels he is respected, knows that some people like him well, believes that the things he does usually turn out right.

3. _____ thinks of himself as a go-getter, a sort of dynamo who, although he may not have as much abilities as others, gets even because he develops initiative and energy. He feels that his efforts to make friends are usually successful.

4. _____ thinks of himself as an average guy who does some things better, some poorer than others, occasionally pulls a real boner. He does not think that he is overly well-liked nor overly disliked, feels respected by some, overlooked by others.

5. _____ thinks that he is all right although he knows that he has too many mishaps in his life for which he feels partly responsible. Yet he thinks that people in general consider him a square dealer and kind of like him.

6. _____ feels that he is not a steady guy. At times he feels superior in most respects to all his acquaintances, at other times he feels that he is lacking in strength of character. He feels sometimes that he does not have a friend in the world.

7. _____ feels that he is below average in most anything that counts, believes that the things which he does frequently turn out to be flops, knows that people don't have a high opinion of him.

8. _____ knows that he is pretty much at the bottom of the scale. He hardly dares to express his point of view since he knows in advance that it is not worth anything. He knows that what he does is usually the wrong thing. He feels that people who seem to like him in reality just pity him.

9. _____ feels almost like a lower sort of human, worthless, unsuccessful, unliked and incapable.

Patient's Statement of Preference

Although we cannot make a definite commitment that the wishes which you may express in the questionnaire below will be respected, an effort will be made to take individual preferences into account as far as possible.

1. Name the fellows whom you would prefer to have as neighbors on the ward.

2. In case this could not be arranged who would be your second choice?

3. As you know, the fellows on the ward will be divided into three groups, whom would you like to see in the group to which you belong?

4. If it could be arranged that small groups of fellows could go to town or neighborhood recreation grounds and parks together, with whom would you like to go?

5. In the coming summer months there will be lots of opportunities to engage in recreational activities such as swimming, ballgames, etc., as well as ping-pong, chess, etc. Name the activity you prefer most and give the names of the fellows who you would like to see participate in it with you.

6. If it should be found advisable for a number of fellows to stay together for a while after they leave the hospital, with whom would you like to stay?

7. List the names of those patients on the ward whom you have known for more than three months.

All statements made here will be kept confidential and will not become part of the patient's hospital record. The exclusive purpose of these questions is to obtain an analysis of the therapy and the research procedures.

Frankly describe your overall impression of the Short term therapy project:

What do you think of the group of which you formed a part as compared with the two other therapy methods used in the project?

How does living on B-15 (during the project) compare with life on other wards that you previously experienced?

How does the personnal on B-15 (during the project) compare with the personnel previously encountered?

Name some specific shortcomings of the project as a whole.

Name some specific advantages of the project?

How could your therapy have been more effective?

How could the ward - living have been made more beneficial to you?

Describe some of the faults which you noticed in your ward personnel and therapists.

Name some specific advantages of the project.

Are you different now than when you entered the project?

In what way do you feel different?

What brought this change about?

What influence did the therapy have?

Which of the various therapeutic factors of the hospital helped you most during the last three months (Please number in order of importance to you) (give minus ratings to those which you think were detrimental (leave blank those with which you had no contact.)

Group Therapy

Activity Therapy

Individual Therapy

Gym

O.T.

Shop

Aides

Nurses

Therapists (as people)

Social Service

Vocational Rehabilitation

Wordmeeting

Special Services (organized Recreation, movies etc.)

Chaplain and Church

Educational Activities

What do you consider to be your main problems and difficulties now?

How could one have helped you better to deal with these problems?

Has life on B-15 in any way influenced you as far as your feelings about returning to the hospital are concerned, in case you should ever feel lousy and be wanting to find a safe heaven where you would have a roof over your head and three somewhat square meals? In other words do you feel the project has made it harder or easier for you ever to ask for hospitalization again?

Please feel free to make any additional criticism and suggestions.

In order to enable us to obtain a better analysis of the effects of the project please furnish the following information:

What is your personal feeling about the short term therapy project on B-15?

What if any changes have you noticed among the patients with whom you were in contact (Please be specific and name all patients who took part in the project) After each name describe the changes observed, or put "no change".)

Use the following list of names (following page) as reference

How much of these changes do you believe to be caused by the therapeutic set-up of the project?

What suggestions for the improvement of therapeutic efficiency do you have?

What do you consider to be the shortcomings of the project?

Have you noticed any changes in the behavior of the patients to each other and in the atmosphere on the ward since the beginning of the project?

Do you attribute these changes in the main to the normal process of getting acquainted, in other words have you noticed similar changes on other wards or do you consider them to be the specific results of the project?

Have you noticed any detrimental influence of the project on the atmosphere on the ward?

Give your impression of the effect which each of the three therapeutic methods used - the project had on the patients.

How did you get this impression?

Have you felt that there was any difference in the relations among the personnel on B-15 and on other wards? If so what?

If so do you think it affected the patients?

P O S T - T R E A T M E N T Q U E S T I O N N A I R E

Answers to this questionnaire are strictly confidentail and may not be identified by name.

1. What do you think NOW about the Intensive Treatment Program?

2. Was there anything that could have been done for you but wasn't done?

3. What was the most important part of the program?

4. What was the worst thing about it?

5. What was the best thing about it?

6. Did the program help you in any way? How?

7. What difference did it make?

8. How does the therapy which you received on B-15 compare with the treatment that other patients on B-15 received (in your opinion)?

9. How does it compare with treatment which you received prior to entering the project?

10. How are you getting along now?

11. What is your greatest difficulty now?

12. What do you expect in the future?

13. What suggestions do you have for the improvement of a program such as the one on B-15?

14. Please check the correct answer or answers to the following:

Are you living.....alone.....( )
.....with parents..( )
.....with wife.....( )
.....with children.( )
.....with friend...( )

Are you satisfied with your
present living arrangements? Yes ( ); No ( ); Undecided ( ).

Do you work.....Full time.....( )
Part time.....( )
Occasionally.....( )
Not Working.....( )
Looking for a job..( )

Are you satisfied with your working conditions?

Exceptionally good.....( )
As good as could be expected.( )
Better than expected.....( )
Below average.....( )
Bad.....( )
Intolerable.....( )

How is your health now?

Very good.....( )
Better than in the hospital.....( )
About the same as in the hospital...( )
Not so good.....( )
Going down.....( )
Worrying me.....( )

What is the trouble? — if any.

Do you have friends?..girl-friends.....( )
..boy-friends.....( )
..stick with my
family.....( )
..alone.....( )
..would like to..
make friends....( )

What do you do with your Spare-Time?

DO NOT SIGN YOUR NAME!!

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