PSYCHOLOGICAL RESEARCH AND SERVICES IN
AN ARMY AIR FORCES CONVALESCENT HOSPITAL

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DISSERTATION

Presented in Partial Fulfillment of the Requirements for
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By

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The Ohio State University

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Approved by:

[Signature]

Adviser
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The work which is here reported was done under the direction of the writer at the Army Air Forces Convalescent Hospital, Cochran Field, Georgia. A number of individuals participated in the various projects to be described. The writer's functions ranged from the general planning of the research program to assisting in the scoring of tests. The program was in essence cooperative. The writer is fully responsible for this presentation of the outcomes of the several investigations.

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CHAPTER I
INTRODUCTION

The Problem. In broadest terms, this is a study of the interrelated functions of service and research in applied psychology. Psychologists in government agencies, in business, in industry, in institutions may find that they can function at two levels to meet the stated requirements of the agency with which they work. They may give services in a restricted sense by administering and interpreting tests, interviewing, counseling, teaching, and similar functions. Or they may perform these functions and at the same time undertake research to discover ways of making their efforts more effective. Many of the specific skills which are the service tools of the applied psychologist can also be used by individuals trained in other fields, such as social workers, psychiatrists, industrial engineers, personnel managers, and the like. That which is, or should be, unique and an integral part of the services given by psychologists is an experimental viewpoint which will not rest content with the performance of routine service. Psychology as a science has a substantial experimental tradition. This tradition should be carried over to psychology as a service, if the full potentialities of the psychological approach to applied
problems is to be realized. Such is the viewpoint which gave direction to the work here to be reported.

The work which provides the material of this report was done in an Army Air Forces convalescent hospital. Psychologists assigned to the hospital made available to the patients, who were convalescing from various war-incurred difficulties, a variety of services, such as guidance in the planning of activity programs, testing, vocational counseling, and in individual and group psychotherapy. These services, which were routinely given, presented problems for a concurrent program of research directed towards improving the services and, at the same time, toward the accumulation of information that would have wider applications in the field of psychology. The problems were defined as twofold: how to identify with greater efficiency those patients who were in need of special psychological or psychiatric attention; and, once these men were identified, how to provide them with the best possible psychological treatment, within the limitations of the facilities of the hospital.

The Hospital and the Psychological Services Branch. The Army Air Forces operated a number of convalescent hospitals located in various part of the country. It will be helpful to know something about these hospitals and about the section of the hospital designated the Psychological Services Branch.
Frequently the convalescent hospitals were operated on Army Air Forces stations which had formerly been used as training installations. Some were converted hospitals. In all cases they had none of the atmosphere associated with the word hospital. The patients lived in barracks, wore regular uniforms, and were not confined to their beds. Most patients were encouraged to participate in various activities, on the theory that days filled with pleasant, purposeful endeavor would speed their return to health. The array of things to do was imposing. Facilities for various sports, such as golf, tennis, swimming, handball, were provided. Instruction in photography, auto repair, wood shop, machine shop, plastics, art, music, radio, electricity, weaving, modeling, and sundry other activities of a hobby nature was available. Also provided were courses in academic subjects which could be taken for pleasure or for credit in high school or college. For medical attention and for supervision of their activities, patients were assigned to a "personal physician," who was responsible for the general program of convalescence for his patients. A number of medical specialists, including competent psychiatrists, were available for consultation. Finally, psychological services were provided by the Psychological Services Branch.

The Psychological Services Branch was staffed by officers
with training in clinical psychology and by enlisted men with some experience in psychological work. The Branch was charged with a number of functions, which may perhaps best be described in the order in which each patient came to know them. The entering patient first met with a small group of other patients in a comfortably furnished room to be greeted by hospital officials and to be oriented to the hospital program by one of the officer psychologists. He then went to a testing room to take a battery of psychological tests. After a physical examination, he again reported to the Psychological Branch for an interview which was termed his "initial evaluation." On the basis of this interview, a brief biography, summarizing his family background, his early life, his educational and occupational adjustment, his Army training and experiences, his attitudes, his plans for the future, and similar factors, was prepared and made available to all professional personnel who would work with him. Following a tour of the facilities of the convalescent activities program, conducted by enlisted members of the Branch, the patient sat down with the interviewer whom he had met during his initial evaluation and planned a program of activities designed to meet his needs and interests. To this point, all patients had similar contacts with the Psychological Services Branch. After entering the convalescent program, they
were referred individually for special diagnostic testing or for individual psychotherapy. A number of men were routinely scheduled for group psychotherapy, as will be described subsequently. On their own initiative, many patients sought vocational counseling, which was also provided by the Psychological Branch. Finally, before discharge, each patient reported once again to the Branch for an interview known as the "terminal evaluation," in which an effort was made to assay his progress towards full convalescence. Thus from the day on which he entered the hospital to the day he left, the patient was likely to be in close contact with the work of the Psychological Services Branch.

Services and Research. Three of the directed services described above were the objects of continued study at the Cochran hospital. The work was concerned with development of an efficient battery of tests to identify men in need of psychiatric care, the improvement of techniques of individual psychotherapy, and the development of new insights into the process of group psychotherapy. In the pages which follow, these three focal points of research will be discussed in detail.

In this introduction, mention should perhaps be made
of the limitations and the aspirations of the investigations. The work done was not experimental in the laboratory sense of the word. It was in a very real sense opportunistic, a fact that is here presented as in its favor, in that it sought new ways of doing a prescribed job in a practical situation. It is indeed doubtful if investigations could be carried out, within the eminently purposeful and practical operations of a convalescent hospital, which would meet all of the canons of approved research procedure. All that is claimed for the work reported, and this is much, is that the application of research techniques during the ongoing course of services in the hospital added considerably to the effectiveness of the hospital program, and that, in addition, some contribution was made to the general body of psychological knowledge.

The Organization of the Report. Following this introductory chapter, there are three chapters which present the results of three separate investigations.

The first of these is concerned with the development of more efficient and more objective means of locating among entering patients men who were suffering from some psychological disturbance. Tests administered for this purpose will be described, and information on the validity of the single instruments will be presented. Finally, there
will be an evaluation of the tests arranged in various combinations to determine the composition of the most efficient available battery.

The second investigation is concerned with the problem of improving individual psychotherapy in the treatment of men with an anxiety state diagnosis. Only a single case is presented, but considerable time and thought have been put into an analysis of the process of therapy as evidenced in this series of treatment sessions. It is believed that such analyses of individual cases can contribute much to our understanding of psychotherapy.

The final, and most extensive, study is concerned with the problem of group psychotherapy. Specifically, work on this problem was directed toward the development of a technique for the quantitative analysis of group therapy sessions, the analysis of a series of group psychotherapy sessions through the application of this technique, the comparison of groups conducted by leaders who employed different approaches to therapy, and the statement of hypotheses for further study, based on the outcomes of this exploratory investigation.

The total problem has the unifying purpose of determining, first, how men in need of psychological help can be identified with most efficiency and, second, how the men so
identified can be given most efficiently the help they need.

In the appendixes will be found tabular data supporting the figures which are presented in the text, and test materials on the patient who was given individual therapy.
CHAPTER II

THE DEVELOPMENT AND EVALUATION OF A BATTERY OF TESTS FOR IDENTIFYING CONVALESCENT PATIENTS IN NEED OF PSYCHOTHERAPY

Introduction

Purpose. Patients were assigned to convalescent hospitals in the Army Air Forces with various preliminary diagnoses, ranging from "dermatitis, mild" to "anxiety state, severe." As has already been pointed out these diagnoses were not definitive, particularly in cases with some psychological involvement. Though a basic diagnosis of an orthopedic or nutritional difficulty might be quite accurate, there might often be an accompanying psychological disturbance which passed undetected. It, therefore, appeared highly desirable to develop a battery of tests which could be used to screen all incoming patients in order to identify those men who were in need of immediate psychiatric care or who would require a special program of therapy during their stay in the hospital. The objective was to get as complete a picture as possible of all entering patients to the end that individual programs of activity and treatment could be planned to meet the needs of each patient.

It was also felt that a battery of tests designed for the purpose of screening patients entering a convalescent
hospital might possibly be of value in other activities, such as screening large numbers of men on entrance into a particular type of training, or identifying in a large student body those individuals who might benefit from special psychological or psychiatric attention.

Procedure. With these two purposes in mind, economy of time and ease of administration were considered important in selecting the instruments to be used. Four tests and one rating scale were studied. These were the Incomplete Sentence Test, the Shipley-Hartford Scale for Intellectual Impairment, the Convalescent Personal Inventory, the C-H Adjustment Rating Scale, and the Bender-Gestalt Test. Each instrument will be described in detail in subsequent sections of this chapter.

These tests were administered to entering patients soon after their arrival at the hospital. The testing period followed an orientation period during which various officials greeted the patients and described to them the program and procedures of the hospital. Since the term hospital suggests wards and patients confined to beds, it should be mentioned again that in a convalescent hospital patients were ambulatory. They wore their regular uniforms and were given freedom of the post. Thus they were able to attend the orientation meeting and to remain for group testing and for an
interview. The Rating Scale and the Bender-Gestalt Test were accomplished individually. Other tests were given in groups of approximately 20 with adequate supervision and proctoring. Although conditions for testing remained fairly constant during the weeks in which the data to be reported were gathered, it was observed that the motivation of the patients fluctuated considerably from day to day, depending largely on the treatment they had received at prior stations which had processed them on the way to the convalescent hospital.

The tests were carefully scored, and the results were used as one of the bases for planning a program of convalescent activities for each patient. The test results were also made available to the personal physician of each patient and to the psychiatrist when a patient was receiving psychiatric treatment. Test scores were not available to the admitting physician who made the initial diagnosis on all patients. Until such time as the validity of the battery could be determined and incorporated as a routine step in initial diagnosis, it was desirable that the admitting diagnosis be made independently of testing. An estimate of the validity of the individual tests and of the total battery was sought by correlating test scores with the diagnosis made for each patient on entrance into the hospital.
The Criterion. Since all of the tests studied were validated against dichotomous groupings of "psychiatric" and "non-psychiatric" patients as indicated by the admitting diagnoses, it is pivotal to have a fairly clear picture of the nature of this criterion, of its adequacies and inadequacies, if the results of the studies are to be fully meaningful. It may be said at first that the admitting diagnoses provided a two-category criterion which was fairly dependable and generally sufficient to the needs of this study, although not as precise and reliable as might be desired. There were certain good features about the way in which the admitting diagnoses were made, and there were some features which were variably good, indeterminate, or undesirable.

Regardless of the adequacy of previous physical and psychiatric examinations, each patient entering the hospital was examined by an admitting physician. This examination was thorough, taking approximately two hours for routine admissions. For the patient with some difficulty requiring laboratory tests, a longer period was taken to define his condition. During admissions processing, patients with doubtful diagnoses were sometimes referred to a medical specialist for examination. In a few instances, mainly when a psychotic condition was suspected, a psychiatrist
was consulted in arriving at the initial diagnosis. In addition to local sources of information, the admitting physician in most instances had at his disposal records of previous examinations, made either in a combat theater or in another hospital in this country. There was wide range in the completeness of the medical records accompanying the patient. In some instances they were very complete, with X-ray plates and the results of previous laboratory tests. In some cases they were passable, consisting of a phrase describing the difficulty and a case history of approximately 200 words. And in some instances, there were no records except the special order sending the patient to the hospital, the medical records having been lost or delayed.

The physicians who accomplished the admitting examination varied in their competency to identify psychological difficulties. None was a psychiatrist, though some had had special short courses in psychiatric diagnosis and treatment. One of the admitting physicians was judged by the station psychiatrist to be quite skillful and alert to psychological problems. However, he did not examine all patients, and less adequate examinations were made by other doctors serving with him. The general picture, with reference to diagnosing psychological difficulties, is that fair competence was shown but improvement might readily have been achieved.
The greatest single source of weakness in the admitting diagnosis, and consequently in the criterion used in this study, arose from the tendency to neglect or overlook psychological disturbances in a patient who had a well defined "physical" injury or disease. Many patients with nutritional, orthopedic, or epidermic diagnoses had as well some psychological disturbance which was not noted. Thus a patient who had spent fourteen months in a prison camp was diagnosed as suffering from simple malnourishment. That his difficulty was more complex, involving a psychological problem as well, was suggested by the fact that after several months he still could not eat the adequate food that was provided for him. A few less than half of the patients were given diagnoses with no indication of psychological involvement. It is believed from an observation of this "non-psychiatric" group as a whole that they distinctly deviated from a norm for adequate adjustment which would be provided, say, by a comparable group of men assigned to regular Army duties. Consequently the criterion of "psychiatric" "non-psychiatric" was considered to have been made less rigorous by the presence in the latter group of patients who should also have been in the former group.

Finally, as the war drew to a close, policies with reference to the admission and disposition of patients
changed. An effort was made to return to their homes as soon as possible those men whose disabilities were mild and who might be expected to make rapid recovery without hospital care. As a result, the composition of the psychiatric and non-psychiatric criterion groups shifted slowly but perceptibly.

In summary, it may be stated reasonably that the diagnoses which served as the criterion used in the study were fairly good but that they might have been better. And to achieve a more adequate, more efficient diagnosis of psychological problems was precisely the purpose of the study.

The Incomplete Sentence Test

Description. In the psychological program of the convalescent hospitals there was a need for a personality test which would permit more freedom of response on the part of the patient than was allowed by most available personality inventories and which would at the same time be relatively easy to score and interpret. The opinion was advanced that such a test might have greater validity than questionnaires with fixed responses. It was believed that a test of this type might also provide rich materials for a counselor, who would be concerned with the unique ways in which a patient expressed his difficulties.
The Incomplete Sentence Test was developed to meet this need by Julian B. Rotter and Benjamin Willerman. The basic idea was drawn from work originally done by Cameron, (6)\textsuperscript{1} though considerable modification was made to fit the test to the military hospital situation. The patient was required to complete sentences, the first word or words of which were provided him in a list of "incomplete sentences." Typical beginnings for sentences were: "A mother....," "I need....," "I hate....," "My nerves....," and so on. The test is reproduced in full on page 17. The test was normally administered in groups. Approximately 20 minutes was allowed to complete the test, but no definite time limit was set.

There was more resistance to taking this test than to any of the other tests included in the battery. An interesting hypothesis which might be profitably examined is that the test requires productive effort and an organization of ideas which may make discomforting demands on already disturbed individuals. However, cooperation was achieved and all except a few patients completed the test satisfactorily. Incidence of treating the test lightly were rare, though the tedium of scoring was sometimes lightened by the presence of humor in one or two items. Having been subjected to testing

\textsuperscript{1}The numbers in parenthesis refer to numbered references in the bibliography at the end of the report.
Incomplete Sentence Test

Directions: Complete these sentences to express your real feeling. Try to do every one. Be sure to make a complete sentence.

1. I like .
2. The happiest time.
3. I want to know .
4. Back 
5. I regret .
6. At bedtime .
7. Overseas .
8. The best .
9. What annoys me 
10. People 
11. A mother 
12. I feel .
13. My greatest fear
15. I can't .
17. When I was a child
18. My nerves.
19. Other people
20. I suffer .
22. The most dangerous
23. My mind .
24. The future
25. I need .
26. A wife
27. I am best when
28. Sometimes .
29. What pains me.
30. This hospital.
31. I hate .
32. I am very.
33. The only trouble
34. I wish .
35. My father.
36. I secretly .
37. I .
38. The Army
39. My greatest worry is
40. Most girls .
on many occasions and having become aware of the importance of tests, most Air Forces personnel were inclined to take them seriously and to follow instructions conscientiously.

It may be instructive in this description of the test to indicate its usefulness in counseling, and in understanding group attitudes, before going on to a discussion of its validity. The types of responses made by individual patients were often very revealing as to their present conflicts. In some instances, the patient might be able to contrive for nearly every item a response which would indicate his current difficulties as he perceived them. Thus one patient indicated by the following responses a strong desire to get married:

3. I want to know "when I'll get married."
5. I regret "I'm not married."
13. My greatest fear "is that I won't get married."
25. I need "a wife."
26. A wife "is what I need."
36. I secretly "wish I had gotten married."

Hostility of a rather pervasive nature was a common pattern of responses. One patient wrote:

1. I like "nothing about this place."
2. The happiest time "is when I get out of here."
3. I want to know "when I'll get out of here."
8. What annoys me "are people and tests like this."
9. People "are crazy."
20. I suffer "nothing."
30. This hospital "stinks."
35. My father "doesn't understand me."
38. The Army "is a helluva place."
40. Most girls "are no good."

Not only were the materials of value to the counselor who was concerned with understanding the immediate sources of conflict within the individual patient but they were also of value to hospital authorities as indexes to the prevalent attitudes of the patient population.

**Method of Scoring.** Two methods of scoring were used. Method one was relatively objective and involved scoring each item separately and arriving at a total score by adding weighted item scores. Method two was less objective and involved scoring the total test on the basis of the clinical judgment of a trained psychologist, in an attempt to give adequate consideration to the pattern or interrelationship of responses.

The semi-objective scoring method was a modification of a system originally worked out empirically by Rotter and Willerman by drawing upon established principles of adjustment and on an analysis of the responses to the test given
by 45 patients of known diagnosis. Fifteen of the patients in the group originally studied gave evidence of maladjustment prior to military service, 15 seemed to be suffering temporary disturbances following unusually severe combat experiences, and 15 were considered to be normal and to have no debilitating psychological disturbances. Three types of responses were identified:

1. Conflict Responses (designated by the letter "C") indicated maladjustment and emotional disturbance.

2. Positive Responses (designated by the letter "P") indicated good adjustment and psychological health.

3. Neutral Responses (designated by the letter "N") indicated neither good nor poor adjustment and were generally of a matter-of-fact, descriptive nature.

Within categories "C" and "P," weights of plus three to minus three were assigned to sample responses, based upon clinical judgment and upon the frequency of the response in the three criterion groups described above. A weight of zero was assigned to the "N" category. This was done for each of the forty items. A scoring manual, showing the categories to which the sample responses belonged and the weights which were considered appropriate, was developed. Two types of scores were derived from this method of scoring. One was designated the "Quotient Score"
and represented the sum of the weighted Conflict Responses divided by the sum of the weighted Conflict Responses and Positive Responses. The second was designated the "Difference Score" and represented the algebraic sum of the total of the weighted Conflict Scores minus the total of the weighted Positive Scores.

Following is a sample of the guides used in scoring:

Item 19. Other people . . . . . . . . . .

C (+3) laugh at me; are no good.

C (+2) talk too much; should mind their own business; annoy me; irritate me; I envy; get on my nerves; just have worries; are happier.

C (+1) have their worries too; are in the same boat.

N (0) are different; some good and some bad.

P (-1) are entitled to their own opinions; get along with me; usually like me; amuse me.

P (-2) are O.K.; are friendly; are interesting.

P (-3) are swell.

The second method of scoring involved assigning an overall rating to the total test without the aid of the scoring manual. Papers were carefully read by trained psychologists and assigned ratings of (1) no disturbance, (2) mild disturbance, (3) moderate disturbance, and (4) severe disturbance. Two advantages were suggested for the second method. It should
consume less time than the objective scoring method, and it should permit appropriate allowances to be made for the pattern of the responses given.

Procedure. The test was administered to 148 patients on entrance to the hospital. Of this group, 80 were later diagnosed by the admitting physician as having some psychological disturbance and 68 as having no psychological disturbance. Four scorers, using the objective scoring method outlined above, independently scored the papers. Two raters, who were trained in clinical psychology, evaluated the same tests without the aid of the scoring manual, independently arranging the papers into four categories indicating no disturbance, mild disturbance, moderate disturbance, and severe disturbance.

To obtain an estimate of the validity of the test, biserial coefficients of correlation were computed using the admitting diagnosis as the criterion. Coefficients were computed for the scores of the four scorers and the ratings of the two raters, providing a total of six validity coefficients. An estimate of the reliability of the two methods of evaluating performance on the test was obtained by computing Pearson product-moment correlations between the scores assigned by the two scorers attaining highest validity
coefficients and between the ratings assigned by the two raters. Intercorrelations with other tests in the battery were also computed.

Results. The obtained validity coefficients are presented in Table I. Though other studies of this test have yielded higher validity coefficients, the validities found are believed to be fairly satisfactory, particularly in view of

TABLE I

VALIDITY OF THE INCOMPLETE SENTENCE TEST: BISERIAL COEFFICIENTS OF CORRELATION OF FOUR SETS OF SCORES AND TWO SETS OF RATINGS, WITH PSYCHIATRIC NON-PSYCHIATRIC DIAGNOSIS (N TOTAL = 148, N PSYCHIATRIC = 80, N NON-PSYCHIATRIC = 68)

<table>
<thead>
<tr>
<th>Scoring Method</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quotient Score (Q)</td>
<td>.41</td>
<td>.41</td>
<td>.40</td>
<td>.26</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Difference Score (D)</td>
<td>.45</td>
<td>.43</td>
<td>.42</td>
<td>.35</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Clinical Rating</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>.41</td>
<td>.39</td>
</tr>
</tbody>
</table>

the known deficiencies in the criterion. It should be noted that there is little difference between the validity coefficients of the scorers and the raters. This suggests that if trained psychologists are available for interpreting the test, they may do so with considerable saving of time. However, if trained psychologists are not available, personnel
who are not highly trained but who have some familiarity with the test may be employed to evaluate the test, using the scoring manual, with no great loss of validity. The validity of the Difference Score method is slightly but consistently higher than the Quotient Score method. Both of the objective scores appear to give slightly higher validities than the clinical ratings. Ancillary data for the correlations reported in Table I are given in Table II and Table III.

**TABLE II**

**MEANS AND STANDARD DEVIATIONS REQUIRED FOR COMPUTATION OF HISCERAL r'S GIVEN IN TABLE I**

<table>
<thead>
<tr>
<th>Groups</th>
<th>Scorer</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q Score</td>
<td>D Score</td>
<td>C Rating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M Psych.</td>
<td>.683</td>
<td>.649</td>
<td>.688</td>
<td>.692</td>
<td>17.44</td>
<td>14.21</td>
<td>15.94</td>
<td>20.06</td>
<td>2.74</td>
<td>2.68</td>
<td></td>
</tr>
<tr>
<td>M N-Psych.</td>
<td>.557</td>
<td>.519</td>
<td>.559</td>
<td>.604</td>
<td>5.35</td>
<td>2.34</td>
<td>5.06</td>
<td>9.37</td>
<td>2.10</td>
<td>2.13</td>
<td></td>
</tr>
<tr>
<td>M Total</td>
<td>.675</td>
<td>.590</td>
<td>.629</td>
<td>.652</td>
<td>11.89</td>
<td>8.76</td>
<td>10.94</td>
<td>15.15</td>
<td>2.45</td>
<td>2.43</td>
<td></td>
</tr>
<tr>
<td>SD Total</td>
<td>.19</td>
<td>.20</td>
<td>.20</td>
<td>.21</td>
<td>16.68</td>
<td>17.28</td>
<td>16.05</td>
<td>19.25</td>
<td>.98</td>
<td>.91</td>
<td></td>
</tr>
</tbody>
</table>

An estimate of the reliability of the test as scored objectively and as evaluated by the two best raters was obtained from

---

2Higher validity coefficients were reported by Rotter, using the original scoring system. (Unpublished manuscript)
TABLE III

STANDARD ERROR OF THE BISERIAL COEFFICIENTS OF CORRELATIONS REPORTED IN TABLE I

<table>
<thead>
<tr>
<th>Scoring Method</th>
<th>Scorer 1</th>
<th>Scorer 2</th>
<th>Scorer 3</th>
<th>Scorer 4</th>
<th>Rater 1</th>
<th>Rater 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quotient Score (Q)</td>
<td>.09</td>
<td>.09</td>
<td>.09</td>
<td>.10</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Difference Score (D)</td>
<td>.09</td>
<td>.09</td>
<td>.09</td>
<td>.09</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Clinical Rating</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>.09</td>
<td>.09</td>
</tr>
</tbody>
</table>

the intercorrelations among the two scorers having highest validity coefficients and the two raters. These intercorrelations are summarized in Table IV. Greater reliability is

TABLE IV

ESTIMATES OF THE RELIABILITY OF SCORING AND RATING OF INCOMPLETE SENTENCE TEST: INTERCORRELATIONS AMONG TWO SCORERS AND TWO RATERS (N=148)

<table>
<thead>
<tr>
<th>Scoring Method</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Q Score - Scorer #1</td>
<td>-</td>
<td>.97</td>
<td>.87</td>
<td>-</td>
<td>.62</td>
<td>.59</td>
</tr>
<tr>
<td>2. D Score - Scorer #1</td>
<td>.97</td>
<td>-</td>
<td>-</td>
<td>.91</td>
<td>.62</td>
<td>.61</td>
</tr>
<tr>
<td>3. Q Score - Scorer #2</td>
<td>.87</td>
<td>-</td>
<td>-</td>
<td>.91</td>
<td>.66</td>
<td>.59</td>
</tr>
<tr>
<td>4. D Score - Scorer #2</td>
<td>-</td>
<td>.91</td>
<td>.91</td>
<td>-</td>
<td>.62</td>
<td>.61</td>
</tr>
<tr>
<td>5. Rater #1</td>
<td>.62</td>
<td>.62</td>
<td>.66</td>
<td>.62</td>
<td>-</td>
<td>.68</td>
</tr>
<tr>
<td>6. Rater #2</td>
<td>.59</td>
<td>.61</td>
<td>.59</td>
<td>.61</td>
<td>.68</td>
<td>-</td>
</tr>
</tbody>
</table>
obtained using the objective scoring method, and these reliabilities in general appear satisfactory. The low correlations obtained between the two raters may be attributed in part to the restricted range of the ratings used, but there is doubtlessly some lack of agreement between the two clinical raters concerning the significance of responses.

**The Shipley-Hartford Retreat Scale**

**Description.** The Shipley-Hartford Retreat Scale is an instrument designed to measure the intellectual impairment which has been observed to accompany certain types of mental disturbances. The scale is based upon the assumption that some areas of intellectual activity will be adversely affected even in mild degrees of mental deterioration or dysfunctioning while other areas will remain unaffected. Specifically, it has been noted that under conditions of mental impairment, the capacity for abstract thinking declines rapidly whereas vocabulary remains fairly stable. The test is thus composed of two parts, one part measuring abstract or conceptual thinking and the other part measuring vocabulary. The assumption is that the individual who is functioning with well-rounded effectiveness and up to his normal level of ability will make comparable scores on the two parts of the scale. On the other hand, the individual who
is suffering from some psychological disturbance will achieve a score on the vocabulary section which is comparable to his normal functioning but will achieve a diminished score on the abstraction section due to the debilitating influence of his psychological difficulty on his ability to deal with abstract concepts. A ratio between the vocabulary test and the abstractions test should thus yield an indication of the extent of the impairment present. This ratio has been designated the "Conceptual Quotient." Three scores may be derived from the test, the Vocabulary Score, the Abstractions Score, and the Conceptual Quotient Score.

The test was originally validated by comparing the performance of approximately a thousand students from the fourth grade through college with the performance of about 375 mental patients in private or state hospitals. No validity coefficients were reported, but mean Conceptual Quotient Scores of the hospital groups were much lower than those of the norming group. The median C.Q. for the private hospital group was at the 14th percentile for the norm group, and the median C.Q. for the state hospital group was below the 1st percentile for the norm group. Greatest impairment was found in the functional and organic psychotics; it is not clear how much impairment was evidenced by psychoneurotics, though the indication is that little impairment was evident. (31, 46)
The Shipley-Hartford Scale was included in the experimental battery to investigate an area of adjustment that was not adequately covered by the other tests studied. The Incomplete Sentence Test and the Personal Inventory were expected to indicate directly the areas and extent of maladjustment. The Bender-Gestalt Test was expected to measure any perceptual and psychomotor impairment that might be present. The C-H Adjustment Rating Scale was expected to provide an over-all clinical judgment of the adjustment of the patients. The Shipley-Hartford was tried out as a measure of mental dysfunctioning which was deemed important and was not measured specifically by the remainder of the battery. A copy of the Shipley-Hartford Scale is given on pages 29 and 30.

Procedure. As with the Incomplete Sentence Test, the Shipley-Hartford Scale was validated against the criterion provided by the admitting diagnosis. The scale was administered to 351 enlisted patients and to 94 officer patients, and bivariate coefficients of correlation were computed, with the patients being divided into psychiatric and non-psychiatric groups. The data for enlisted men were treated separately from those of the total group in consideration of results of other investigations which had revealed that officers tended to be better adjusted after combat than did enlisted
Shipley-Hartford Retreat Scale for Measuring Intellectual Impairment

Part I. Vocabulary Test

In the test below, the first word of each line is printed in capital letters. Opposite it are four other words. Draw a line under the one word which means the same thing, or most nearly the same thing, as the first word. A sample has been worked out for you. If you don't know, guess. Be sure to underline the one word in each line that means the same thing as the first word.

Sample:

<table>
<thead>
<tr>
<th>LARGE</th>
<th>red</th>
<th>big</th>
<th>silent</th>
<th>wet</th>
</tr>
</thead>
</table>

Begin here:

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>TALK</td>
<td>draw</td>
<td>eat</td>
<td>speak</td>
</tr>
<tr>
<td>2</td>
<td>PERMIT</td>
<td>allow</td>
<td>sew</td>
<td>cut</td>
</tr>
<tr>
<td>3</td>
<td>PARDON</td>
<td>forgive</td>
<td>pound</td>
<td>divide</td>
</tr>
<tr>
<td>4</td>
<td>COUCH</td>
<td>pin</td>
<td>eraser</td>
<td>sofa</td>
</tr>
<tr>
<td>5</td>
<td>REMEMBER</td>
<td>swim</td>
<td>recall</td>
<td>number</td>
</tr>
<tr>
<td>6</td>
<td>TUMBLE</td>
<td>drink</td>
<td>dress</td>
<td>fall</td>
</tr>
<tr>
<td>7</td>
<td>HIDEOUS</td>
<td>silvery</td>
<td>tilted</td>
<td>young</td>
</tr>
<tr>
<td>8</td>
<td>CORDIAL</td>
<td>swift</td>
<td>muddy</td>
<td>leaf</td>
</tr>
<tr>
<td>9</td>
<td>EVIDENT</td>
<td>green</td>
<td>obvious</td>
<td>skeptical</td>
</tr>
<tr>
<td>10</td>
<td>IMPOSTER</td>
<td>conductor</td>
<td>officer</td>
<td>book</td>
</tr>
<tr>
<td>11</td>
<td>MERIT</td>
<td>deserve</td>
<td>distrust</td>
<td>fight</td>
</tr>
<tr>
<td>12</td>
<td>FASCINATE</td>
<td>welcome</td>
<td>fix</td>
<td>stir</td>
</tr>
<tr>
<td>13</td>
<td>INDUCE</td>
<td>defy</td>
<td>excite</td>
<td>signify</td>
</tr>
<tr>
<td>14</td>
<td>IGNORANT</td>
<td>red</td>
<td>sharp</td>
<td>uninformed</td>
</tr>
<tr>
<td>15</td>
<td>FORTIFY</td>
<td>submerge</td>
<td>strengthen</td>
<td>vent</td>
</tr>
<tr>
<td>16</td>
<td>REMAIN</td>
<td>length</td>
<td>head</td>
<td>fame</td>
</tr>
<tr>
<td>17</td>
<td>NARRATE</td>
<td>yield</td>
<td>buy</td>
<td>associate</td>
</tr>
<tr>
<td>18</td>
<td>MASSIVE</td>
<td>bright</td>
<td>large</td>
<td>speedy</td>
</tr>
<tr>
<td>19</td>
<td>HILARITY</td>
<td>laughter</td>
<td>speed</td>
<td>grace</td>
</tr>
<tr>
<td>20</td>
<td>SMIRCHED</td>
<td>stolen</td>
<td>pointed</td>
<td>remade</td>
</tr>
<tr>
<td>21</td>
<td>SQUANDER</td>
<td>tease</td>
<td>belittle</td>
<td>cut</td>
</tr>
<tr>
<td>22</td>
<td>CAPTION</td>
<td>drum</td>
<td>ballast</td>
<td>heading</td>
</tr>
<tr>
<td>23</td>
<td>FACILITATE</td>
<td>help</td>
<td>turn</td>
<td>strip</td>
</tr>
<tr>
<td>24</td>
<td>JOCOSE</td>
<td>humorous</td>
<td>paltry</td>
<td>fervid</td>
</tr>
<tr>
<td>25</td>
<td>APPRAISE</td>
<td>reduce</td>
<td>strew</td>
<td>inform</td>
</tr>
<tr>
<td>26</td>
<td>RUE</td>
<td>eat</td>
<td>lament</td>
<td>dominate</td>
</tr>
<tr>
<td>27</td>
<td>DENIZEN</td>
<td>senator</td>
<td>inhabitant</td>
<td>fish</td>
</tr>
<tr>
<td>28</td>
<td>DIVEST</td>
<td>dispossess</td>
<td>intrude</td>
<td>rally</td>
</tr>
<tr>
<td>29</td>
<td>AMULET</td>
<td>charm</td>
<td>orphan</td>
<td>dinge</td>
</tr>
<tr>
<td>30</td>
<td>INEXORABLE</td>
<td>untidy</td>
<td>inviolate</td>
<td>rigid</td>
</tr>
</tbody>
</table>
Shipley-Hartford Retreat Scale for Measuring Intellectual Impairment (Cont'd)

31. SERRATED dried notched armed blunt
32. LISSOM moldy loose supple convex
33. MOLLIFY mitigate direct certain abuse
34. PLAGIARIZE appropriate intend revoke maintain
35. ORIFICE brush hole building lute
36. QUEHULOUS manicul curious devout complaining
37. PARIAH outcast priest lentil locker
38. ABET weaken ensue incite placate
39. TEMERITY rashness timidity desire kindness
40. PRISTINE vain sound first level

Part II. Abstraction Test

Complete the following. Each dash (—) calls for either a number or a letter to be filled in. Every line is a separate item. Take the items in order but don't spend too much time on any one.

1. 1 2 3 4 5
2. white black short long down —
3. AB BC CD D —
4. Z Y X W V U —
5. 1 2 3 2 1 2 3 4 3 2 3 4 5 4 3 4 5 6 —
6. NE/SW SE/NW E/W N/S —
7. escape scape cape —
8. oh ho rat tar mood —
9. A Z B Y C X D —
10. tot tot bard farb 537 —
11. mist is wasp as pint in tone —
12. 57/26 73/26 52/67 26/57 3 —
13. knit in spud up both to stay —
14. Scotland landscape scapegoat —
15. surgeon 1234567 snore 17635 rogue —
16. tam tan rib rid rat raw hip —
17. tar pitch throw saloon bar rod free tip end plank meals —
18. 3124 82 73 — 154 46 13 —
19. lag leg pen pin big bog rob —
20. two w four r one o three —
men. The correlations between the three scores obtainable on the test and scores on the Army General Classification Test were determined in order to ascertain the extent to which the Shipley-Hartford Scale could be used as a measure of general intelligence of those patients for whom Army General Classification Test Scores were not available (a circumstance which often obtained for officers). The intercorrelation between the two part scores on the Scale was computed, as were appropriate correlations with other tests in the battery.

Results. In Table V and Table VI the validity coefficients for the Scale are presented. It is evident in the data for

<table>
<thead>
<tr>
<th>TABLE V</th>
</tr>
</thead>
<tbody>
<tr>
<td>VALIDITY OF THE SHIPLEY-HARTFORD SCALE FOR INTELLECTUAL IMPAIRMENT: HYSERIAL COEFFICIENT OF CORRELATION BETWEEN CONCEPTUAL QUOTIENT SCORES OF ENLISTED MEN AND ADMITTING DIAGNOSIS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>r_{b} r_{b}</th>
<th>s_{r_{b}} r_{b}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric</td>
<td>184</td>
<td>91.40</td>
<td>16.71</td>
<td>.07</td>
<td>.07</td>
</tr>
<tr>
<td>Non-Psychiatric</td>
<td>167</td>
<td>93.30</td>
<td>15.49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>351</td>
<td>92.31</td>
<td>16.09</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### TABLE VI

**Validity of the Shipley-Hartford Scale for Intellectual Impairment: Biserial Coefficient of Correlation Between Conceptual Quotient Scores of Enlisted and Officer Patients Combined and Admitting Diagnosis**

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>r_{bis}</th>
<th>SE_{r_{bis}}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric</td>
<td>217</td>
<td>92.79</td>
<td>16.37</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Psychiatric</td>
<td>228</td>
<td>96.21</td>
<td>15.37</td>
<td>.11</td>
<td>.06</td>
</tr>
<tr>
<td>Total</td>
<td>445</td>
<td>94.54</td>
<td>15.96</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Both the enlisted group and for the enlisted and officer groups combined that there is little relationship between performance on the Scale and the diagnosis given by the admitting physician. The Quotient Scores for patients in both the psychiatric and the non-psychiatric groups fell well above the point indicated as "normal" on the table of norms derived from the original validation of the test. Very few of the convalescent patients had either functional or organic psychoses, and they evidenced little of the impairment found for the groups included in the initial study. It was concluded that there was no appreciable evidence of mental dysfunctioning among the group of convalescent hospital patients in so far as such dysfunctioning could be measured by the Shipley-Hartford Scale.
Correlations obtained between the Scale and Army General Classification Test are given in Tables VII and VIII.

### TABLE VII

**CORRELATIONS BETWEEN SUBTEST SCORES ON THE SHIPLEY-HARTFORD SCALE FOR INTELLECTUAL IMPAIRMENT AND SCORES ON THE ARMY GENERAL CLASSIFICATION TEST**

<table>
<thead>
<tr>
<th>Test</th>
<th>M</th>
<th>SD</th>
<th>r_{13}</th>
<th>SE_{13}</th>
<th>r_{23}</th>
<th>SE_{23}</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vocabulary</td>
<td>28.22</td>
<td>5.94</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abstraction</td>
<td>25.00</td>
<td>8.23</td>
<td>.49</td>
<td>.05</td>
<td>.49</td>
<td>.05</td>
<td>204</td>
</tr>
<tr>
<td>AGCT</td>
<td>110.10</td>
<td>15.05</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### TABLE VIII

**CORRELATION BETWEEN THE CONCEPTUAL QUOTIENT SCORES ON THE SHIPLEY-HARTFORD SCALE FOR INTELLECTUAL IMPAIRMENT AND SCORES ON THE ARMY GENERAL CLASSIFICATION TEST**

<table>
<thead>
<tr>
<th>Test</th>
<th>M</th>
<th>SD</th>
<th>r</th>
<th>SE_r</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conceptual Quotient</td>
<td>91.75</td>
<td>15.46</td>
<td>.28</td>
<td>.07</td>
<td>193</td>
</tr>
<tr>
<td>AGCT</td>
<td>111.51</td>
<td>15.47</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As was expected in view of the materials in the Scale, the correlation with AGCT of the part scores, though not of the conceptual quotient scores, are substantial. It was concluded that the vocabulary and the abstraction sub-test scores could be used as a rough index of intelligence for patients for
whom more substantial test results could not be obtained. The correlation between these two parts of the Scale are given in Table IX.

**TABLE IX**

**CORRELATION BETWEEN THE VOCABULARY SUBTEST AND THE ABSTRACTIONS SUBTEST OF THE SHIPLEY-HARTFORD SCALE FOR INTELLECTUAL IMPAIRMENT**

<table>
<thead>
<tr>
<th>Subtest</th>
<th>M</th>
<th>SD</th>
<th>r</th>
<th>$SE_r$</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vocabulary</td>
<td>28.83</td>
<td>5.56</td>
<td>.49</td>
<td>.04</td>
<td>457</td>
</tr>
<tr>
<td>Abstraction</td>
<td>26.33</td>
<td>8.38</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The *Convalescent Personal Inventory*

**Description.** The Convalescent Personal Inventory attacked more directly the problem of identifying patients with psychological difficulties by getting their written response to questions that were quite similar to questions routinely asked by Army psychiatrists in performing a diagnostic examination, as on admittance to the hospital. The patient was required to give a "yes" or "no" answer to such questions as "Do you feel blue most of the time?" "Do you have a poor appetite?" "Do you frequently have dreams about combat?" and "Do you lose your temper more frequently than
you used to?" In the construction of the test, 90 items were phrased on the basis of symptoms noted in interviews with convalescent patients and in literature on "operational fatigue" and "anxiety state." These 90 items were administered to returned combat personnel, some of whom had a diagnosis of anxiety reaction and some of whom were diagnosed as normal or free from anxiety. An item analysis was performed, and the 50 most discriminating items were selected for the final form of the inventory. A copy of the inventory is given on pages 36 and 37. Though no time limit was prescribed, approximately 20 minutes was allowed to administer the test. The inventory was then administered to an independent group for purposes of validation, with results so favorable that the instrument was selected for use in the experimental battery here being described. The developmental work on the Convalescent Personal Inventory was done by Abraham S. Levine, Bert Morton, and Daniel D. Haylesberg, prior to the initiation of the research program at the Cochran Field convalescent hospital.

Procedure. The final form of the Convalescent Personal Inventory was administered to 441 patients at Cochran Field and the obtained scores were correlated with the psychiatric, non-psychiatric diagnosis given by the admitting physician.
The Convalescent Personal Inventory

Directions: Read each statement carefully. If the statement describes you or your condition, draw a circle around the "Yes" opposite the statement. If the statement does not describe you or your condition, draw a circle around the "No" opposite the statement. There are no right or wrong answers, only answers that describe you best.

Yes No  1. Do you find it difficult to sit still long enough to see a movie?
Yes No  2. Do you have trouble sleeping?
Yes No  3. Do you sometimes get touchy and irritable for no reason at all?
Yes No  4. Do you feel that your family doesn't understand you?
Yes No  5. Are you generally uninterested in what's going on around you?
Yes No  6. Do you find it difficult to concentrate?
Yes No  7. Do you dislike to ride in an elevator, bus, or streetcar?
Yes No  8. Do you have feelings of doubt and uncertainty about things in general?
Yes No  9. Do you get sore easily when someone tells you to do something?
Yes No 10. Do you often awaken in the morning feeling as tired as when you went to bed?
Yes No 11. Do you tend to drink (alcohol beverages) a lot more than you did before you went overseas?
Yes No 12. Do you become discouraged easily?
Yes No 13. Does your heart sometimes speed up or begin to pound for no reason at all?
Yes No 14. Do you bite your nails or pick at your hands?
Yes No 15. Do you feel blue most of the time?
Yes No 16. Can you take a good "ribbing" as well as you used to?
Yes No 17. Do you feel miserable almost all of the time?
Yes No 18. Do disturbing experiences frequently keep returning to you in your thoughts?
Yes No 19. Do you have a poor appetite?
Yes No 20. Does excitement make you unduly nervous?
Yes No 21. Do you often feel that you have "butterflies in your stomach?"
Yes No 22. Do your hands sometimes tremble so that you have difficulty in eating, tend to spill coffee, etc?
Yes No 23. Do you think more slowly now than before you went overseas?
Yes No 24. Do you tend to be nervous about little things?
Yes No 25. Do inspections and equipment checks make you feel as though you were being supervised too closely?
Yes No 26. Do you feel that you have a poorer memory than you did before you went overseas?
Yes No 27. Are you often short of breath for no apparent reason?
Yes No 28. When you have a lot of free time do you feel restless and out of sorts?
Yes No 29. Are you tired most of the time?
Yes No 30. Do you have difficulty in expressing yourself?
Yes No 31. Do you feel weak and shaky?
Yes No 32. Do you feel constantly under strain?
Yes No 33. Do you worry a lot more than you did before you went overseas?
Yes No 34. Are you as generally alert as you were before you entered the Army?
Yes No 35. Do you frequently have dreams about combat?
Yes No 36. Do you find it difficult to get back to sleep after being awakened during the night?
Yes No 37. Are you more jittery now than you were overseas?
Yes No 38. Do you feel as emotionally alive as you were before you entered the Army?
Yes No 39. Do you sweat a lot without much reason?
Yes No 40. Are you jumpy when talking about your combat experiences?
Yes No 41. Are you less self-confident now than when you entered the Army?
Yes No 42. Do you feel all tensed-up inside?
Yes No 43. Do you feel worse now than you felt overseas?
Yes No 44. Do you feel bewildered or confused by your own condition?
Yes No 45. Do you daydream a lot more than you did before you went overseas?
Yes No 46. Do you feel that you have to be on the move all the time?
Yes No 47. Do you often feel like vomiting?
Yes No 48. Do you lose your temper more easily than you used to?
Yes No 49. Have you had any boils or other skin irritations lately?
Yes No 50. Can you make decisions as quickly as you used to?
Data for enlisted patients were processed separately from the data for the total group, in view of previous findings that there was a significant difference in adjustment between officers and enlisted men after combat. Appropriate correlations with other tests in the battery were obtained. Finally, an item analysis was performed, using the chi-square test of significance, to determine which of the items effectively discriminated between normal and psychiatric groups.

Results. In Table X and Table XI are the biserial coefficients of correlation for the Inventory, computed first for enlisted men as a group and then for all patients combined. These coefficients were considered to be satisfactory, and the tentative decision was made to include the Convalescent Personal Inventory in the final battery. The results

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>$r_{bis}$</th>
<th>$\text{SER}_{bis}$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric</td>
<td>182</td>
<td>28.25</td>
<td>11.75</td>
<td>.34</td>
<td>.06</td>
</tr>
<tr>
<td>Non-Psychiatric</td>
<td>168</td>
<td>21.45</td>
<td>12.25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>350</td>
<td>25.00</td>
<td>12.50</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
TABLE XI

VALIDITY OF THE CONVALESCENT PERSONAL INVENTORY:
BISERIAL COEFFICIENT OF CORRELATION BETWEEN SCORES OF
OFFICERS AND ENLISTED MEN COMBINED AND ADMITTING DIAGNOSIS

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>r_{bis}</th>
<th>S.E.(r_{bis})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric</td>
<td>215</td>
<td>27.40</td>
<td>12.10</td>
<td>.38</td>
<td>.06</td>
</tr>
<tr>
<td>Non-Psychiatric</td>
<td>226</td>
<td>19.70</td>
<td>12.05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>441</td>
<td>23.40</td>
<td>12.70</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

of the item analysis are summarized in Table XII. It can
be seen that 41 of the 50 items, for the combined groups,

TABLE XII

VALIDITY OF INDIVIDUAL ITEMS OF THE CONVALESCENT
PERSONAL INVENTORY: CHI-SQUARE TESTS OF SIGNIFICANCE
OF ITEMS FOR OFFICERS AND EM PERSONNEL HAVING PSYCHIATRIC
OR NON-PSYCHIATRIC ADMITTING DIAGNOSIS (NON-PSYCHIATRIC
EM, N = 164; PSYCHIATRIC EM, N = 140; NON-PSYCHI-
ATRIC OFFICERS, N = 53; PSYCHIATRIC, N = 29.
TOTAL N = 386)

<table>
<thead>
<tr>
<th>Item</th>
<th>Enlisted Men</th>
<th>Officers</th>
<th>Total Off. &amp; EM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chi^2</td>
<td>P</td>
<td>Chi^2</td>
</tr>
<tr>
<td>1</td>
<td>9.04</td>
<td>.01</td>
<td>.23</td>
</tr>
<tr>
<td>2</td>
<td>21.07</td>
<td>.01</td>
<td>2.92</td>
</tr>
<tr>
<td>3</td>
<td>4.12</td>
<td>.05</td>
<td>4.53</td>
</tr>
<tr>
<td>4</td>
<td>85.11</td>
<td>.01</td>
<td>8.13</td>
</tr>
<tr>
<td>5</td>
<td>5.40</td>
<td>.02</td>
<td>12.84</td>
</tr>
<tr>
<td>6</td>
<td>3.54</td>
<td>.05</td>
<td>2.05</td>
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<tr>
<td>7</td>
<td>.00</td>
<td>.99*</td>
<td>.00</td>
</tr>
<tr>
<td>8</td>
<td>4.66</td>
<td>.02</td>
<td>5.34</td>
</tr>
<tr>
<td>9</td>
<td>.24</td>
<td>.70*</td>
<td>.32</td>
</tr>
<tr>
<td>10</td>
<td>9.77</td>
<td>.01</td>
<td>3.42</td>
</tr>
</tbody>
</table>

*Items having a probability of more than .05. These
items were considered to be not significant.
<table>
<thead>
<tr>
<th>Item</th>
<th>Enlisted Men</th>
<th>Officers</th>
<th>Total Off. &amp; EM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chi²</td>
<td>P</td>
<td>Chi²</td>
</tr>
<tr>
<td>11</td>
<td>2.71</td>
<td>.10*</td>
<td>4.57</td>
</tr>
<tr>
<td>12</td>
<td>4.33</td>
<td>.05</td>
<td>8.52</td>
</tr>
<tr>
<td>13</td>
<td>4.27</td>
<td>.02</td>
<td>.96</td>
</tr>
<tr>
<td>14</td>
<td>1.95</td>
<td>.15*</td>
<td>.94</td>
</tr>
<tr>
<td>15</td>
<td>13.63</td>
<td>.01</td>
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</tr>
<tr>
<td>18</td>
<td>15.58</td>
<td>.01</td>
<td>3.50</td>
</tr>
<tr>
<td>19</td>
<td>11.93</td>
<td>.01</td>
<td>7.40</td>
</tr>
<tr>
<td>20</td>
<td>22.10</td>
<td>.01</td>
<td>2.25</td>
</tr>
<tr>
<td>21</td>
<td>15.60</td>
<td>.01</td>
<td>2.36</td>
</tr>
<tr>
<td>22</td>
<td>4.40</td>
<td>.02</td>
<td>1.30</td>
</tr>
<tr>
<td>23</td>
<td>4.50</td>
<td>.02</td>
<td>1.92</td>
</tr>
<tr>
<td>24</td>
<td>7.78</td>
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<td>25</td>
<td>3.39</td>
<td>.05</td>
<td>.30</td>
</tr>
<tr>
<td>26</td>
<td>7.71</td>
<td>.01</td>
<td>3.45</td>
</tr>
<tr>
<td>27</td>
<td>8.09</td>
<td>.01</td>
<td>1.27</td>
</tr>
<tr>
<td>28</td>
<td>3.13</td>
<td>.05</td>
<td>.94</td>
</tr>
<tr>
<td>29</td>
<td>13.70</td>
<td>.01</td>
<td>2.05</td>
</tr>
<tr>
<td>30</td>
<td>.48</td>
<td>.50*</td>
<td>.89</td>
</tr>
<tr>
<td>31</td>
<td>15.39</td>
<td>.01</td>
<td>9.70</td>
</tr>
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<td>32</td>
<td>19.58</td>
<td>.01</td>
<td>8.13</td>
</tr>
<tr>
<td>33</td>
<td>3.23</td>
<td>.05</td>
<td>3.42</td>
</tr>
<tr>
<td>34</td>
<td>.20</td>
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<td>9.66</td>
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<td>36</td>
<td>15.40</td>
<td>.01</td>
<td>1.18</td>
</tr>
<tr>
<td>37</td>
<td>8.22</td>
<td>.01*</td>
<td>.22</td>
</tr>
<tr>
<td>38</td>
<td>.34</td>
<td>.75*</td>
<td>.21</td>
</tr>
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<td>39</td>
<td>.48</td>
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<td>3.60</td>
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<td>40</td>
<td>11.98</td>
<td>.01</td>
<td>.00</td>
</tr>
<tr>
<td>41</td>
<td>1.98</td>
<td>.15*</td>
<td>5.67</td>
</tr>
<tr>
<td>42</td>
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</tr>
<tr>
<td>43</td>
<td>11.94</td>
<td>.01</td>
<td>15.02</td>
</tr>
<tr>
<td>44</td>
<td>5.45</td>
<td>.02</td>
<td>4.19</td>
</tr>
<tr>
<td>45</td>
<td>.48</td>
<td>.50*</td>
<td>2.43</td>
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<tr>
<td>46</td>
<td>3.81</td>
<td>.05</td>
<td>.21</td>
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<td>47</td>
<td>6.67</td>
<td>.01</td>
<td>4.30</td>
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<td>5.30</td>
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<tr>
<td>49</td>
<td>.00</td>
<td>.99*</td>
<td>.00</td>
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<tr>
<td>50</td>
<td>8.63</td>
<td>.01</td>
<td>8.44</td>
</tr>
</tbody>
</table>

*Items having a probability of more than .05. These items were considered to be not significant.
discriminated between psychiatric and non-psychiatric patients at the 5 per cent level of confidence. In general, it was felt that the best way to predict the type of diagnosis used as a criterion was to ask the same types of questions that would be used in the psychiatric examination. Since these questions were not likely to be asked of all patients in the admitting examination but only of those who gave immediate evidence of psychological disturbance, it seemed desirable to administer the inventory to all incoming patients to identify those men who might be emotionally disturbed but who might have other difficulties which would claim the whole attention of the admitting physician.

The C-H Adjustment Rating Scale

Description. The C-H (Convalescent Hospital) Adjustment Rating Scale was developed to provide a quantitative, over-all estimate of the adjustment of each patient at the time of his entrance to the hospital. This estimate of adjustment was made independently of the admitting diagnosis, and it made full use of all available information on the new patient. Accomplished at the end of the initial evaluation interview, the rating was based on the interviewer's total impression of the patient. Since the
interviewers were encouraged to make full use of the results of the tests given on entrance to the hospital, as well as of impressions gained during the course of the interview, the Adjustment Rating Scale was not considered to be an independent measure of adjustment. Indeed, such was not desired.

The scale required the interviewer to make a rating of each patient on 12 items, pertaining to nervousness, sleep, dependence, depression, insight, sociability, and similar adjustment indexes, using a 7 point scale. Item 12 on the scale was a 7 point rating of general adjustment, as indicated below:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely Maladjusted</td>
<td>Very Maladjusted</td>
<td>Fairly Well Adjusted</td>
<td>Very Well Adjusted</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A copy of the entire scale is given on pages 43 and 44. The C-H Adjustment Rating Scale was developed by the writer.

Procedure. Previous experience with similar rating scales had indicated that the final general item would provide an adequate score for the entire scale, providing the other items on the scale were carefully completed prior to making the final rating. To check this assumption, the ratings
<table>
<thead>
<tr>
<th>Name</th>
<th>Grade</th>
<th>ASN</th>
<th>Date</th>
<th>Rating</th>
<th>Rater</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nervousness</td>
<td>Extremely tense, jittery, restless</td>
<td>Moderately tense, jittery, restless</td>
<td>No nervousness, calm, composed</td>
<td>Very cool, even under stress</td>
<td></td>
</tr>
<tr>
<td>2. Sleep</td>
<td>Insomnia, very disturbed sleep, nightmares</td>
<td>Disturbed sleep, occasional unpleasant dreams</td>
<td>Good, restful sleep, infrequent dreams</td>
<td>No insomnia, very sound, restful sleep</td>
<td></td>
</tr>
<tr>
<td>3. Worry and Fear</td>
<td>Extremely worried, fearful, anxious</td>
<td>Somewhat worried, fearful, anxious</td>
<td>Few worries, very little fear</td>
<td>Very sanguine, confident</td>
<td></td>
</tr>
<tr>
<td>4. Memory and Concentration</td>
<td>Very forgetful, unable to concentrate</td>
<td>Frequently absent-minded, inattentive</td>
<td>Occasionally absent-minded, inattentive</td>
<td>Concentrates and remembers readily</td>
<td></td>
</tr>
<tr>
<td>5. Sociability</td>
<td>Extremely asocial, withdrawn, concerned with self</td>
<td>Rather quiet, retiring, avoids groups</td>
<td>Has a few friends, participates in groups occasionally</td>
<td>Outgoing, very interested in people</td>
<td></td>
</tr>
<tr>
<td>6. Ailments</td>
<td>Many serious ailments reported</td>
<td>Many ailments reported</td>
<td>Few ailments reported</td>
<td>No ailments reported</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>7. Drinking</td>
<td>Excessive, compulsive drinking</td>
<td>Frequent, excessive drinking</td>
<td>Occasional excessive or frequent drinking</td>
<td>Moderate or no drinking</td>
<td></td>
</tr>
<tr>
<td>8. Hostility</td>
<td>Extremely hostile, anti-social</td>
<td>Very hostile, little acceptance</td>
<td>Somewhat hostile, some acceptance</td>
<td>No hostility, normal social values</td>
<td></td>
</tr>
<tr>
<td>9. Dependence</td>
<td>Extremely dependent, constantly seeks support</td>
<td>Very dependent, needs reassurance</td>
<td>Dependent, but shows areas of independence</td>
<td>Independent, seeks normal support</td>
<td></td>
</tr>
<tr>
<td>10. Depression</td>
<td>Exceedingly depressed, hopeless</td>
<td>Very or frequently depressed</td>
<td>Occasionally depressed, &quot;blue&quot;</td>
<td>Optimistic outlook on life</td>
<td></td>
</tr>
<tr>
<td>11. Insight</td>
<td>Lacking in insight, very unrealistic</td>
<td>Poor or spotty insight</td>
<td>Fairly good insight</td>
<td>Understands self well</td>
<td></td>
</tr>
<tr>
<td>12. General Adjustment</td>
<td>Extremely maladjusted</td>
<td>Very maladjusted</td>
<td>Fairly well adjusted</td>
<td>Very well adjusted</td>
<td></td>
</tr>
</tbody>
</table>

**REMARKS**
given on Item 12 were first correlated with the total of the ratings given on the other 11 items. This correlation proved to be satisfactory, and subsequent statistical work was done using the rating on Item 12 as one of the variables. As was the procedure in previously reported studies of validity, biserial coefficients of correlation were computed, using ratings on Item 12 and the criterion of "psychiatric" and "non-psychiatric." Finally pertinent correlations with other tests in the battery were computed.

Results. The correlation between the ratings given on Item 12 and the totals of the other ratings combined is presented in Table XIII. The assumption that Item 12 might

TABLE XIII

<table>
<thead>
<tr>
<th>Items</th>
<th>M</th>
<th>SD</th>
<th>r</th>
<th>SE_r</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 through 11</td>
<td>50.65</td>
<td>11.09</td>
<td>.83</td>
<td>.02</td>
<td>233</td>
</tr>
<tr>
<td>12</td>
<td>4.57</td>
<td>1.29</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

be used as representative of the total scale seemed adequately established. In Tables XIV and XV are validity coefficients for the scale computed first for enlisted personnel and then
### TABLE XIV

**Validity of the C-H Adjustment Rating Scale:**

**Biserial Coefficient of Correlation Between Rating on Item 12 For Enlisted Patients and Admitting Diagnosis**

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>( r_{bis} )</th>
<th>( \text{SE}<em>{r</em>{bis}} )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric</td>
<td>167</td>
<td>4.36</td>
<td>1.24</td>
<td>.34</td>
<td>.08</td>
</tr>
<tr>
<td>Non-Psychiatric</td>
<td>69</td>
<td>5.09</td>
<td>1.25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>236</td>
<td>4.57</td>
<td>1.29</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### TABLE XV

**Validity of the C-H Adjustment Rating Scale:**

**Biserial Coefficient of Correlation Between Rating on Item 12 of Officers and Enlisted Patients Combined and Admitting Diagnosis**

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>( r_{bis} )</th>
<th>( \text{SE}<em>{r</em>{bis}} )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric</td>
<td>197</td>
<td>4.38</td>
<td>1.24</td>
<td>.40</td>
<td>.06</td>
</tr>
<tr>
<td>Non-Psychiatric</td>
<td>102</td>
<td>5.21</td>
<td>1.16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>299</td>
<td>4.66</td>
<td>1.29</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For enlisted and officer personnel combined. On the basis of these coefficients it was concluded that the C-H Adjustment Rating Scale was a fairly satisfactory instrument for identifying those patients who would subsequently be classified as having or not having some psychological disturbance.
The correlations are lower than might have been expected had the criterion groups not been contaminated by the presence in the "non-psychiatric" group of patients who obviously were suffering not only from orthopedic, skin or nutritional difficulties but also from emotional difficulties as well.

**The Bender Visual Motor Gestalt Test**

**Description.** The Bender Visual Motor Gestalt Test consists of a series of simple geometric figures drawn on cards about 5 by 7 inches in size. Typical figures are an adjacent square and circle, two intersecting sinusoidal lines, three parallel rows of dots, and similar patterns. The designs are reproduced, in full scale, but grouped on one page, in Figure 1. The subject is supplied with a set of cards, an unruled sheet of bond paper approximately 8½ x 11 inches in size, and a pencil. He is required to reproduce the figures with the materials at hand, with no time limit prescribed but with the expectation that the task will require from 10 to 20 minutes. By the theoretical conception on which the test is based, one would expect to find in the reproductions of the figures evidence of perceptual and motor dysfunctioning accompanying psychological disturbance. Preliminary investigations have
Figure 1. The Bender-Gestalt Figures.
indicated that the test may have distinct value as a diagnostic instrument. (2) A most cursory exploration of the test was made in connection with efforts to develop a battery of tests for screening convalescent patients.

Procedure. Following the directions prescribed in a manual prepared by M. L. Hutt, (24) the Bender Gestalt Test was administered to 33 psychiatric patients who had been referred for psychotherapy or for special psychological evaluation, and to 23 enlisted men, not patients, who were assigned to the Psychological Services Branch. The "normal" group was composed of enlisted men of above average intelligence who had some acquaintance with clinical psychology, though they were not trained psychologists. The test was administered to the "normal" group with the same instructions as were given to the psychiatric group. The men were not familiar with the test or with its theoretical assumptions before they took the test.

The 56 Bender Gestalt records were scored by 10 men who were selected from the 23 enlisted men comprising the "normal" group. These 10 scorers were given a one hour lecture on the interpretation of the test; they were each supplied with a set of Bender cards and a mimeographed copy of instructions for interpreting the test; and they were
asked to place the 56 records in rank order, assigning a rank of 1 to the patient who seemed to be least disturbed. The judges did not know to which individual or group any record belonged, except that each judge might be expected to recognize his own reproduction. An estimate of the reliability of judgments was obtained by computing inter-correlations among pairs of judges, and between one half of the judges and the other half of the judges.

Results. Fairly satisfactory evidence of reliability was obtained. The rankings of 17 pairs of judges were correlated, using the rank-order method. The 17 rhos were combined (by converting rho to z), and an estimated uncorrected reliability of .73 was obtained. By correlating the mean ranks assigned by one half of the judges with mean ranks assigned by the other half of the judges, a rho of .93 was obtained. It was decided that the reliability of the scoring method used was adequate.

Since the number of cases was quite small, no attempt was made to obtain a single statistic that would indicate the degree of relationship between the performance of the subjects and the groups to which they belonged. The mean ranks assigned by all of the judges combined to each record was computed, and a final ranking for all subjects was
determined by reranking on the basis of these mean scores. The records of the two groups were separated, and the distribution of ranks compared. These data are summarized in Table XVI. The mean rank of the psychiatric group was 35.9 and of the normal group 17.3. With perfect discrimination by the test, mean ranks of 39 and 11, respectively, would have been expected.

**TABLE XVI**

VALIDITY OF THE BENDER GESTALT TEST:
RANKING OF PSYCHIATRIC PATIENTS AND NORMAL SUBJECTS
ACCORDING TO DEGREE OF EMOTIONAL DISTURBANCE

<table>
<thead>
<tr>
<th>Rank</th>
<th>Description</th>
<th>Psychiatric (N = 33)</th>
<th>Normal (N = 23)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 14</td>
<td>No Disturbance</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>15 - 28</td>
<td>Mildly Disturbed</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>29 - 42</td>
<td>Moderately Disturbed</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>43 - 56</td>
<td>Very Disturbed</td>
<td>13</td>
<td>1</td>
</tr>
</tbody>
</table>

Mean Rank 35.9 17.3

These results were interpreted with extreme caution, in view primarily of the fact that the normal group was composed of men who were superior in ability and highly motivated to do a good job. It was decided not to use the Bender Gestalt Test in the final screening battery until
additional data could be obtained that would substantiate these tentative findings. However, the results of this little study are reported here to suggest that further work on the Bender Gestalt Test might be very fruitful.

The Total Battery

To complete the analyses that have been done so far and to meet the demands of a practical situation in which decisions had to be made, there was need to determine which combination of the tests studied would be most efficient in identifying those patients who should be included in groups to receive special psychiatric attention. Information was also required relative to the weights that should be assigned to each of the tests when combined with other tests. Finally, there was desired an estimate of the over-all effectiveness of the final prediction made on the basis of test results.

A desirable goal in a convalescent hospital was to reduce routine testing to a minimum. To be subjected once again to a formidable battery of tests, many of which probed directly and impersonally at sore spots, was to many returnees a vexing experience. Efforts to assure the returnees of the purposefulness of the tests lessened but did not wholly dispell the irritation. Though the results of testing were quite valuable, the strain of taking a number of difficult
tests would not fit in with the general therapeutic climate of the hospital. Thus a first goal was to ascertain what would be the optimum efficiency to be obtained by grouping the tests in various combinations.

The primary consideration was whether one test would suffice. From the validity coefficients reported in previous sections of this chapter, it will be remembered that the single tests with the highest validities were the Incomplete Sentence Test and the C-H Rating Scale. Either of these instruments used alone would yield validity coefficients in the neighborhood of .40. Though this coefficient is high enough to make either of these tests useful, there seemed to be a good possibility that more efficiency in prediction could be achieved by combining tests. For this purpose, an indication of the interrelationships among the tests studied was required. In Table XVII are given the intercorrelations among all tests considered. For convenience, the correlations have been summarized in Table XVIII, along with the biserial coefficients of correlation indicating the degree to which performance on each test was associated with psychiatric and non-psychiatric diagnosis.

The validity coefficients in Table VIII are based on combined data for officer and enlisted patients. Examination of the tables reporting validity data separately for
<table>
<thead>
<tr>
<th>Test</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>r</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incomplete Sentence</td>
<td>139</td>
<td>11.47</td>
<td>16.73</td>
<td>.30</td>
</tr>
<tr>
<td>Shipley-Hartford (Q)</td>
<td>139</td>
<td>95.38</td>
<td>15.05</td>
<td></td>
</tr>
<tr>
<td>Incomplete Sentence</td>
<td>138</td>
<td>12.34</td>
<td>16.90</td>
<td>.46</td>
</tr>
<tr>
<td>Personal Inventory</td>
<td>138</td>
<td>23.30</td>
<td>12.82</td>
<td></td>
</tr>
<tr>
<td>Incomplete Sentence</td>
<td>105</td>
<td>14.06</td>
<td>16.72</td>
<td>.41</td>
</tr>
<tr>
<td>C-H Rating, Scale</td>
<td>105</td>
<td>4.70</td>
<td>1.16</td>
<td></td>
</tr>
<tr>
<td>Personal Inventory</td>
<td>419</td>
<td>23.15</td>
<td>12.57</td>
<td>.17</td>
</tr>
<tr>
<td>Shipley-Hartford (Q)</td>
<td>419</td>
<td>95.12</td>
<td>15.76</td>
<td></td>
</tr>
<tr>
<td>Personal Inventory</td>
<td>260</td>
<td>25.00</td>
<td>12.94</td>
<td>.49</td>
</tr>
<tr>
<td>C-H Rating, Scale</td>
<td>260</td>
<td>4.67</td>
<td>1.27</td>
<td></td>
</tr>
<tr>
<td>Shipley-Hartford (Q)</td>
<td>257</td>
<td>93.80</td>
<td>15.89</td>
<td>.25</td>
</tr>
<tr>
<td>C-H Rating, Scale</td>
<td>257</td>
<td>4.69</td>
<td>1.26</td>
<td></td>
</tr>
</tbody>
</table>

enlisted men and for total groups indicate that higher coefficients are obtained by combining scores. The mean scores for officers are higher (or are in the direction of better adjustment) than are the scores of enlisted men. Combining
**TABLE XVIII**

**Matrix of Intercorrelations for Tests Considered for Use in Battery and Biserial Coefficient of Correlation for Each Test Using Psychiatric and Non-Psychiatric Groups as Criterion**

<table>
<thead>
<tr>
<th>Test</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Rbis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Incomplete Sentence</td>
<td>--</td>
<td>.30</td>
<td>.46</td>
<td>.41</td>
<td>.40</td>
</tr>
<tr>
<td>2. Shipley-Hartford (Q)</td>
<td>.30</td>
<td>--</td>
<td>.17</td>
<td>.25</td>
<td>.13</td>
</tr>
<tr>
<td>3. Personal Inventory</td>
<td>.46</td>
<td>.17</td>
<td>--</td>
<td>.49</td>
<td>.38</td>
</tr>
<tr>
<td>4. C-H Rating Scale</td>
<td>.41</td>
<td>.25</td>
<td>.49</td>
<td>--</td>
<td>.40</td>
</tr>
</tbody>
</table>

Scores tend to extend the range of scores and thus increase the correlation.

Table XIX reports multiple correlations obtained by all possible combinations of the tests in pairs. With the exception of the combination "Shipley-Hartford and Personal Inventory," each of the other five combinations is superior, by at least a slight amount, to the best single test. The three combinations involving the Incomplete Sentence Test, the Personal Inventory, and the C-H Rating Scale are definitely superior. If it is considered administratively desirable to use only two tests, without an interview, it would seem best to use the combination of the Personal Inventory and the Incomplete Sentence Test. If an interview is planned, the combination of Incomplete Sentence Test and the C-H Rating
TABLE XIX

THE PREDICTIVE EFFICIENCY OF ANY TWO TESTS IN THE BATTERY: MULTIPLE CORRELATIONS BETWEEN PAIRS OF TESTS WITH PSYCHIATRIC AND NON-PSYCHIATRIC GROUPS

<table>
<thead>
<tr>
<th>Tests</th>
<th>R</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incomplete Sentence and C-H Rating Scale</td>
<td>.48</td>
</tr>
<tr>
<td>Incomplete Sentence and Personal Inventory</td>
<td>.46</td>
</tr>
<tr>
<td>Personal Inventory and C-H Rating Scale</td>
<td>.45</td>
</tr>
<tr>
<td>Shipley-Hartford and C-H Rating Scale</td>
<td>.43</td>
</tr>
<tr>
<td>Shipley-Hartford and Incomplete Sentence</td>
<td>.41</td>
</tr>
<tr>
<td>Shipley-Hartford and Personal Inventory</td>
<td>.39</td>
</tr>
</tbody>
</table>

Scale would appear to be promising, although the validity of the Rating Scale may be reduced if the rater does not have available the results of the other tests. The predictive efficiency of these two instruments is doubtlessly due to their apparent similarity to the type of cursory examination on the basis of which the criterion groups were established. With more precise diagnosis, it would not be unlikely that others of the tests studied would be more useful in a screening battery.

Now, using the total resources of the battery, what is the most efficient prediction that could be obtained? Table XX gives the multiple correlations obtained between
### TABLE XX

**The Predictive Efficiency of Two Test Batteries: Multiple Correlations Between the Indicated Tests Combined and Psychiatric and Non-Psychiatric Diagnosis, with Beta Weights**

<table>
<thead>
<tr>
<th>Battery</th>
<th>Beta Weights</th>
<th>R</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Battery No. 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incomplete Sentence</td>
<td>.2330</td>
<td></td>
</tr>
<tr>
<td>Personal Inventory</td>
<td>.1627</td>
<td></td>
</tr>
<tr>
<td>C-H Rating Scale</td>
<td>.2248</td>
<td></td>
</tr>
<tr>
<td><strong>Battery No. 2</strong></td>
<td></td>
<td>.504</td>
</tr>
<tr>
<td>Incomplete Sentence</td>
<td>.2336</td>
<td></td>
</tr>
<tr>
<td>Personal Inventory</td>
<td>.1632</td>
<td></td>
</tr>
<tr>
<td>C-H Rating Scale</td>
<td>.2234</td>
<td></td>
</tr>
<tr>
<td>Shipley-Hartford</td>
<td>-.0010</td>
<td></td>
</tr>
</tbody>
</table>

two test batteries, using the psychiatric, non-psychiatric diagnosis as the criterion for computing the zero-order coefficients. Beta weights are also given. Battery No. 1 is composed of the Incomplete Sentence Test, the Personal Inventory, and the C-H Rating Scale. This battery yields a multiple coefficient of correlation of .495. Battery No. 2 is composed of the same tests plus the Shipley-Hartford Scale. The addition of this test raises the correlation by a negligible amount to .504. However, both of these batteries are considered sufficiently superior to the two-test combinations to warrant the addition of the extra tests. In the interest
of economy of time and minimum demands upon the patients, the decision should be to use Battery No. 1. However, if, for reasons other than predicting admitting diagnosis, some estimate of the general intelligence of the patients is desired, Battery No. 2 might be used in order that the results of the Shipley-Hartford could be abstracted for special purposes.

Summary. The over-all problem of this study was to develop more efficient techniques for identifying and giving treatment to convalescent hospital patients who needed special psychological attention. In this chapter, efforts to improve procedures for singling out patients with psychological disturbances have been described. These efforts centered around the development of a battery of screening tests to be administered to all patients on entrance to the hospital. The tests studied were the Incomplete Sentence Test, the Convalescent Personal Inventory, the C-H Adjustment Rating Scale, the Shipley-Hartford Scale for Intellectual Impairment, and the Bender Motor Gestalt Test. The Incomplete Sentence Test, the Convalescent Personal Inventory, and the C-H Adjustment Rating Scale were found to be individually adequate as predictors of the psychiatric non-psychiatric diagnoses made by the admitting physician, and to be
considerably more efficient when combined into a battery. The Shipley-Hartford Scale was found to be of little value for this purpose, either alone or in a battery of tests. However, it was recognized that this test might be useful as an index of general intelligence or possibly as an aid in completing the C-H Adjustment Scale. Results of a preliminary study of the Bender Motor Gestalt Test were favorable and have been included as encouragement to further research on the instrument.

The conclusion was drawn that it was possible to use a battery of tests to improve procedures for identifying men in need of psychological or psychiatric treatment. A second aspect of the over-all problem was how the men so identified could be treated to their greatest benefit and with greatest efficiency. Individual treatment is one answer that must be given. An exploration into the process of providing effective individual therapy is the topic of the next chapter.
CHAPTER III

TREATMENT OF PATIENTS WITH ANXIETY REACTIONS THROUGH INDIVIDUAL PSYCHOTHERAPY

The Problem. Giving individual psychotherapy is a very difficult job. How one becomes adept in helping others with their psychological problems is something that we know too little about. We know, or we postulate at least, that one desiring to attain skill in counseling or individual therapy should begin his study equipped with some understanding of himself, of his own needs, his strengths, his weaknesses. We are fairly confident that he should learn a good bit about human behavior, about the needs of others and how these needs are satisfied and how they are thwarted, about normal and neurotic modes of adjusting. We feel that he is likely to be more successful as a counselor if he has integrated the observations that have been made about human behavior into some plausible theory of personality. We are quite confident that he must understand the dynamics of therapy, and that he must have at hand techniques for accomplishing therapy.

Sources of instruction in the above requirements are too limited, too meager, even though there has been an encouraging growth in recent years of a body of psychological
and psychiatric literature on the subject. Surveying this literature, one wishes for more accounts of how therapy was carried out in individual cases, with fairly complete notes from each session, verbatim, if possible, and with critical and explanatory observations about the counseling process as illustrated in the specific case. There are a few such records of counseling, the most notable being that of Rogers,(38) published several years ago. But there should be hundreds of such accounts available, illustrating all types of therapy, with failures as well as successes represented. These hundreds of cases could be studied, reflectively, to enrich one's understanding of the intricacies of counseling, to obtain a feeling for the dynamics of therapy.

The case here presented is believed to have some value as such a source of understanding of individual psychotherapy. It might be said to be a particularly good case for study, because ineptness on the part of the counselor, in one of the latter sessions, came perilously close to shattering all that had been painstakingly built up in weeks of work with the patient. That counseling was done in an Air Forces convalescent hospital, and that the patient was an enlisted man and the therapist an officer, should be kept in mind, although it is believed that these circumstances impose no serious limitations upon generalizations
relative to theory or technique. Finally, the case is believed to be valuable as illustrative of one technique of individual therapy which has a fairly well developed theoretical background.

The Technique. For the most part, the principles of non-directive therapy were followed in the treatment of this case. No attempt will be made to discuss these principles, as they will become evident in the comments given at the end of each session. For the sake of clarity, however, it seems desirable to define two of the terms that are frequently used in the protocols of the meetings, and in the appended comments.

A frequently used term is "reflect" or "reflection." An effort has been made to use it only in the technical sense of a response of the counselor to a statement of the patient, in which the counselor restates the ideas or feelings expressed by the patient. The term "interpret" or "interpretation" is also frequently used. This refers to statements by the counselor which explain to the patient the significance of his behavior.

Presentation. The covering letters, describing in brief the case to the Chief Psychiatrist before and after treatment,
and the summaries of the counseling sessions have been left in their original forms to preserve some feeling for the significance of these materials in the services given in the hospital. The comments which follow each session were prepared separately. They provide generalizations which may find application in larger areas, and as such they constitute whatever research significance that may be claimed for this chapter.

The summaries of each meeting are based on notes made by the counselor during the meeting, using a system of abbreviated writing.
SUBJECT: Individual Counseling for Corporal West, Frank G., 35521691.

TO: Officer-in-Charge, Psychiatric Services Branch
AAF Convalescent Hospital
Cochran Field, Macon, Georgia

1. Corporal West was referred to the Psychological Services Branch by Chaplain Pollard, who felt that he was in need of immediate counseling. Major Hobbs phoned this information to Major Mattis, the Chief Personal Physician, who requested that Major Hobbs take the case in your absence.

2. Initial Evaluation: Corporal West is profoundly disturbed emotionally and is believed to be in need of extended aid. He recounts a long history of adjustment problems, starting in the 2nd grade of school and recurring periodically to the present (age 32), centering around any difficult situation involving new problems, uncertain situations, or large numbers of people. For two years in the Army he achieved fair adjustment as an instructor at a radio school. However, he was sent overseas and after four days assignment to a Replacement Depot (in England) reported to the hospital, complaining of severe headaches, uncontrollable trembling, loss of appetite, inability to sleep, and faintness. He reports that he was seen by a psychiatrist and that papers were initiated for his return to the States. When interviewed here, he cried frequently, evidenced little emotional control, seemed anxious for someone to help him. He said that he was afraid that he would "go to pieces entirely." In view of the long history of persistent maladjustment and absence of extended experience in an operational theater, he is not typical of operational fatigue cases, but presents the picture of a poorly adjusted individual who reacted violently to the minimum threats of war. However, it is believed that Corporal West is capable of improvement at least to the point where he could be returned to duty.

3. Recommendation: It is recommended that Corporal West be entered into the convalescent program and that counseling be continued. No diagnostic testing is indicated as the patient seems primarily to need supportive therapy.

NICHOLAS HOBBS
Major, Air Corps
Officer-in-Charge
Psychological Services Branch

---

This name is fictitious and is used for convenience in writing a summary report. All other identifying information has been removed or changed.
HEADQUARTERS
AAF CONVALESCENT HOSPITAL
COCHRAN FIELD, MACON, GEORGIA

10 September 1945

SUBJECT: Final Report and Recommendations with Reference to Corporal West, Frank G., 35521691.

TO: Officer-in-Charge, Psychiatric Services Branch
AAF Convalescent Hospital
Cochran Field, Macon, Georgia

1. Individual counseling for Corporal Frank G. West has been terminated after eleven sessions extending over a period of about 10 weeks. It is believed that West has obtained as much benefit as he can assimilate now, and that he is ready to leave the hospital.

2. Final Evaluation: Any evaluation of West's condition at this time must bear witness to very real achievement on his part in effecting a more adequate adjustment to life. At the same time, there must be a clear recognition of the fact that West is still far from being capable of deriving, with calm assurance, the satisfactions that his life might give to him. He is basically neurotic, and little has been done to help rework his fundamental modes of adjustment, or to resolve deeply-rooted conflicts. Diagnostic testing, given near the end of treatment, indicates problem areas, chiefly centering around sexual conflicts, that have been touched upon only indirectly in counseling. In these areas, he remains at a very immature level of development. But many positive aspects of his present condition should be mentioned. Though there is a residual anxiety, he has gained considerably in his ability to meet situations that were formerly entirely too much for him. He has achieved appreciable insight into his emotional needs and is aware of likely barriers to the satisfying of these needs. Perhaps most important of all, he appears to have new courage and a new confidence that he can make an adequate adjustment. It is believed that West has grown considerably during the course of counseling and that he is now better able than at any previous period to meet the demands that will be made upon him.

3. Recommendation: To avoid taxing too heavily the relatively good adjustment that West has achieved, it is recommended that he be considered for a discharge for medical reasons, in order that he may return to his former civilian job, where it is believed that he can find the security that he still needs, and in which he can be a useful member of a community.

NICHOLAS HOBBS
Major, Air Corps
Officer-in-Charge,
Psychological Services Branch
Patient: Corporal West, Frank G., 35521691
Counselor: Major Hobbs
Referred by: Chief, Personal Physicians Branch
Referred for: Personal Counseling
Date: 28 June 1945
Meeting: First

1. Corporal West saw Chaplain Pollard in accordance with routine schedule. He exhibited great emotional disturbance and the Chaplain felt that he needed help immediately. Chaplain Pollard phoned Major Hobbs, who, in turn, phoned Major Matthias, Chief Personal Physician. Major Matthias requested that Major Hobbs see Corporal West. Corporal West reported immediately to the Psychological Services Branch. The first meeting lasted for approximately one hour.

2. For the first few minutes of the interview, West cried uncontrollably and was unable to talk. After a few minutes he began to recount in a systematic, chronological order, life experiences which he felt were the cause of his present condition. He talked throughout the hour rapidly and without prompting or questioning, though his story was interrupted by periods of crying.

3. West said that he had been nervous "all his life." He reported that the first instance of nervousness and feeling of insecurity grew out of an experience in the 2nd grade with a teacher who did not understand him and frequently threatened punishment. He refused to go to school, was out for about a month, and was able to return only when his mother would walk one-half the way to school with him one day, two-thirds of the way the next day, etc. He had to repeat the 2nd grade with the same teacher, who became very sympathetic. However, he said that he became afraid of any new situation and lacked confidence in himself thereafter. He seemed to have made fairly adequate adjustment for the remainder of elementary school. During this period he was given glasses which helped him overcome some of his school difficulties.

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4 This heading was used to identify the report of each meeting. In this summary report, the complete heading is replaced by briefer identifying information for subsequent meetings.
4. When West was one year old, his father died. His mother remarried (time not ascertained) and West remarked that his step-father was always good to him. This was the only statement made about his step-father.

5. During the sophomore year in high school, he had a second experience which again severely undermined his confidence in himself. All students were routinely required to participate in the school assembly program, appearing before approximately 500 pupils and teachers. When his turn came, West developed severe stage fright and "went all to pieces." He said that he felt very much ashamed of himself but that he could not make himself appear before so many people.

6. A similar experience was reported on graduation from high school. Although he lived in a small town and was a member of a graduating class of only 16 boys, the prospect of appearing before a group of people to get his diploma made him a "complete wreck." He thus did not appear at graduation exercises to get his diploma. He said that he feels now that he should have seen a psychiatrist at that time. Instead he went to work on a farm where he would not have to meet many people.

7. The same difficulty was repeated on a subsequent job in a rubber factory. He felt that he was getting along well with individual workers. However, he had to join the local union, which entailed appearance before about five hundred men to take an oath. Again the prospect of such an act disturbed him greatly and he quit his job. He said that he went to see a psychiatrist and a psychologist but got little help from either. He returned to gardening and odd jobs where he would have little contact with people and could work alone. He reported that he could not even "go to a show with a girl" because of the nervousness he would develop in a group. On his next job he made fairly satisfactory adjustment. It was a small gas plant which employed about 20 men. One of the older men was sympathetic and helped him adjust to the demands of the job. In time he was entrusted with the collection of bills and similar jobs involving the meeting of people. He reported that he thought he was well when he was inducted in the Army.
8. Rejected first for defective vision, he was subsequently inducted and sent to radio school at Sioux Falls, South Dakota. Radio had been a hobby and he got along very well during the four months course. He was grounded because of his vision and was selected to be an instructor in the radio school, teaching groups of about 20 men. He reported some nervousness with each new class, but he was able to overcome this in a few days. He felt that this experience helped him a lot, and he was successfully occupied there for two years. An interesting evidence of his motivation to help himself solve his own adjustment problems is apparent in the fact that he took dancing lessons and went out with small groups. He reported that "once again I was on my feet."

9. After two years as an instructor in radio school, he was classified for overseas duty. He crossed on a troop ship in convoy and reported no emotional disturbances. Docking briefly in France he witnessed for the first time the ravages of war and began to reflect on the significance of what he was about to enter. His transport moved to England and he was sent to a Replacement Depot, arriving there on Thursday. On the following Sunday morning he began to tremble. His friends called his attention to the trembling, but he "could not shake it off." During these days he was kept busy policing and on KP. He reported that headaches started and that he became dizzy and felt faint, weak and panicky. He also reported loss of appetite. He went to see a medical officer and recounted the experiences told to this interviewer. He reported that he was referred to a psychiatrist who told him, according to West, that "if it were not for your age everything would be over." This statement worried West a great deal. He repeated it several times during the interview. It seemed possible that he had misquoted someone, and it was evident that he had worried a great deal over this confused and confusing sentence.

10. West said that he did not want to leave the States again, that life in this country was difficult enough for him. However, he said that he did not particularly desire to go home, except that to do so might give him an opportunity "to reassure my mother that I am all right."

11. He reported that someone told him that he was "tied to his mother's apron strings." He somewhat emotionally
rejected this statement. He indicated that his relationship with his one brother had never been as close as he would have liked it to be. For instance, he never discussed his difficulties with his brother, though he sought help from other people. He said that his brother simply would not understand. He said also that his brother did not offer to set up a small business partnership with him, which was disappointing.

12. West talked of his concern over getting married, asking first whether the counselor felt that his difficulty was hereditary or was a result of the experiences which he had described. His main concern over getting married was fear that he would "crack-up" if confronted with any very difficult problem and that he would be unable to fulfill the responsibilities of married life.

13. He reported that he drank beer occasionally but did not go to "cheap bars with all their silly talk." He said that he was not deeply religious but that he had some religious inclinations.

14. Much of the meeting was interrupted by periods of crying and loss of ability to talk. However, West had well organized a story of experiences which served to help him explain his present situation. It was apparent that he was badly in need of help, and the counselor suggested that he would be glad to assist him in getting his problems under control. However, the initiative for seeking help was left with the patient. He was told that the counselor would be available at 10:00 A.M. on the following Saturday morning but that no definite appointment would be made, that he was to come at that time if he felt like it, and that the counselor would be perfectly free to see him.

Comments: West, First Meeting

1. During this first meeting, the patient seemed to need primarily someone to lean on, someone to tie to after weeks of agonizing insecurity in a world which appeared very hostile to him. His life-long needs for affection and security had increased to unbearable intensity. The fact that his entire
experience with war was contained in a few hours during which he viewed a war-ravaged city, from the security of his transport, serves to emphasize how fragile was his adjustment to life, how profoundly he was in need of emotional support. It was decided that he could best be helped by an extended series of meetings in which he was given such support and in which he could search out the causes of his anxiety.

2. The hour went rapidly, with the patient doing almost all of the talking. The counselor did little more than show genuine interest in his problem, saying only enough to aid the patient in the outpouring of his pent-up feelings. Almost straight catharsis occurred, accompanied by intense abreaction.

3. In this situation, a detailed diagnosis seemed relatively unimportant, for it would have aided little in giving the patient the kind of help he most needed. Therefore no intensive testing was done. Indeed, it is believed that the taking of the Rorschach or of the Thematic Appreception Test at this time would have been a cruelly disturbing experience for him, attesting once again the hostile nature of his world.

4. Care was taken in defining for the patient the nature of the counseling situation, stressing his responsibilities,
setting up time limits for meetings, and leaving to him the initiative for coming to each meeting. At first, this procedure was a matter of adherence to a technique, but later in the counseling process these simple issues proved, as they often may, to provide a well structured situation against which the patient could test his needs to be dependent and his needs to be responsible for his own behavior. He could try out the therapist, to see if the therapist would be consistent in his demands. Then, knowing the boundaries set up by the counselor, and wanting to live within these boundaries, the patient could gain the satisfaction of living up to demands made upon him, as an expression of normal desires rather than of neurotic compulsions.

5. The most promising aspects of this case are that the patient recognizes his need for help and is willing to seek help. He wants help; he is ready to be helped. He has also evidenced some ability to try to find solutions for his problems in the past. The most discouraging feature for complete recovery is that fact that his difficulty is one of very long standing.

West, Second Meeting, 30 June 1945

1. West arrived promptly at 10:00 A.M. for the second meeting. He appeared much less tense than he was when last seen on Thursday. He was calm and able to talk and smile freely.
2. He reported that he no longer felt panicky and nervous, that he felt somewhat secure at this station, but that he still had headaches. He had been on a tour of the station and was particularly interested in the shops. He said that he would have no trouble in putting in five hours a day and would like to even put in extra time. He stated that he thought he would be able to get on his feet again and expressed with feeling the hope that he "would not have a recurrence" of the experience he had had in England.

3. He took up his story rather systematically at the point where he left off at the close of Thursday's meeting. While waiting to return from England, he felt that he would "collapse." The waiting was very hard to stand. In contrast to his trip over, the trip by boat home was a very trying experience. The boat was crowded and his berth was deep in the hold of the ship. On the way there was a false alarm of fire. All of the men were very frightened and the experience jolted him a good bit. For two nights he tried to sleep on deck but got little rest. He said that he though he had a "natural fear of fire." He was very glad to get off the ship and was very tired when he arrived at Camp Shanks.

4. In four days at Camp Shanks he relaxed somewhat and felt a little better. The trip to Cochran on a hospital train was pleasant. However, when he got here he said that he was still nervous and felt like "hesitating all of the time." "Every little thing bothers me."

5. He returned to a description of the experience of attempting to take a girl to a place where there were many people, how going to a movie was quite a struggle, and how he feared that he might have a "complete nervous collapse." Several similar experiences were recounted—going to a water-show at the Cleveland Exposition; going with a girl to an amusement park and riding a water bicycle; riding in a speed boat. Each of these experiences was preceded by a great fright and nervousness. However, he said that after each experience he felt better, and that the experience had helped him become prepared to meet such situations. He described his symptoms as feeling as though he were in a trance and knowing that in this condition he did not act natural.
6. West said that he "split up" with his first girl over his nervousness. He went with another girl subsequently who helped him a lot. However, there were many recurrences of situations which he felt he could not meet. She asked him to drive her home one night and he was very afraid to do so because it meant driving in Cleveland, a large and unfamiliar city. He reported that it was a struggle to take her to restaurants where there would be many people. On one occasion she wanted to go to a movie and he was very nervous and afraid but did manage to go. These experiences helped build up confidence though they were accepted with much pain. He felt that he could enter into a difficult situation best if he did not have time to think about it.

7. At this point West became rather disturbed again, and started to cry but not nearly so violently as on the previous Thursday. He said that he was very worried about himself, worried that he might never be able to readjust.

8. After a period of silence, he said that he often wondered if he "lacked emotional stability." He said he worried "like an old woman" about things that "do not bother other men," such as wars, strikes, and any kind of violence. He said that his brother was the same way and would frequently break down in tears when West was leaving home after a furlough. He wondered if there were something weak in his family which could account for his present condition.

9. He explored further possible causes of his maladjustment, describing an experience at the age of five when he was severely burned. He remained in bed for a very long time (exact time not ascertained) and had to learn to walk all over again. He feared that this might have "injured his nervous system."

10. He revealed other information which was presented as an explanation of his emotional difficulties. He reported that his mother had a speech impediment, the cause of which was unknown, though his father did choke her once in anger. He hurried on to say that he had an aunt who was very nervous and that he wondered about the possibility of there being some hereditary factor causing his difficulties.

11. After this, he referred to his own experiences again. After the death of his father, his mother was very poor and
had to work as a scrub woman. Things were very difficult, financially, and he was teased a lot by his classmates, mostly for having to "wear cheap clothes." He accepted a statement reflecting some resentment for his inadequate early home life. He said that his "whole childhood was insecure" and wondered if his present condition went back to those early difficulties. He cried a bit and then became quiet and looked at his watch.

12. The counselor said "perhaps you have talked all you want to today." He did not seem to want to leave and said that he wanted somebody to help him. Then he said that the psychiatrist and psychologist whom he had seen as a civilian had not tried to do anything for him. The counselor reflected this feeling as a desire for reassurance and tried to redefine his responsibility in helping the patient. He pointed out that the counselor would assume the responsibility for helping him recognize his feelings about himself and about his problems but that West himself would have to accept the responsibility for working out his adjustment. West then stated that he wanted someone to help him and that he also wanted to help himself. The counselor pointed out the mixed feeling that he had about wanting someone else to solve his problems and still wanting to solve his problems himself. West accepted this and seemed somewhat relieved actually to recognize how he felt. It is believed that this is the first evidence of insight gained so far in the two meetings.

Comments: West, Second Meeting

1. The emotional release achieved in the first meeting had had its salutary effect, and the patient returned feeling much better than he had felt before seeking help. It is to be noted, however, that very little real help had been given to him, that he was not essentially stronger or better able to handle his problems. But the atmosphere had been cleared of immediate tensions, and the patient seemed to feel that he had found someone on whom he could depend for help. More constructive work could start.
2. The counselor had more frequent occasion to reflect the feelings expressed by the patient. The first of several statements showing desire for someone else to solve his problems and the contrary desire (not too strong at this point) to solve them himself appeared in this meeting, and was clearly restated for him. It is believed that this was the patient's first hesitating step towards working out his difficulties.

3. The temptation was strong throughout this meeting for the counselor to give reassurance. But the very number of problems on which the patient desired reassurance suggests the futility of giving it specifically. His basic need was for support, which could more convincingly be demonstrated by the counselor's willingness to accept him as he was, rather than by superficial reassurance or by an intellectual discussion of the validity of his fears.

West, Third Meeting, 3 July 1945

1. In the beginning of the interview, West said that he had been to see Major Wright and that he had another appointment with him Wednesday. He asked whether he might be permitted to continue to come to see the counselor in addition to filling the scheduled appointment with Major Wright. The counselor said that tentative arrangements could be made for another meeting and that the desire of Major Wright in this matter would be ascertained.

2. West asked for information about furlough policy and said that he would like for the counselor to decide

5Major David Wright, Officer-in-Charge of the Psychiatric Services Branch, had just been assigned to the station. West was routinely scheduled to see him.
whether it would be best for him to go home or not. The counselor said that this was a matter which would have to be handled by West's Personal Physician but he interpreted for West his desire that the counselor assume responsibility for making the decision about the furlough. The use to which West could put the available time in these meetings was re-defined. The meetings could be used best to help him clarify his own feelings and arrive at decisions about his problems. West then stated that he would like to go home but was really afraid that it would not do him any good. The ambivalent feelings expressed were reflected, West stated that a visit home "might make it even harder to return to Cochran."

3. As in previous interviews, the patient spent some time in talking about symptoms and attempting to define the source of his difficulties. With reference to an offer to provide priority on Air Transport Command planes for patients going on furlough, West said that he "could never do that." He reported that he was able at his last station before going overseas to take a ride in a Piper Cub and that he enjoyed the experience. However, he contrasted his present state of anxiety with his relatively composed and confident condition while serving as a radio instructor. He said that he was afraid that he would not be able to maintain control of himself. He believed that he would have to work back gradually to the condition he was in prior to going overseas.

4. West stated that he still had slight headaches but that he felt much better now. Still concerned about being different from other people, he said that he thought there was "something embedded which causes these crack-ups, may be an inferiority complex or something." He thought once that he would take up boxing and try to develop himself physically, but realized that he could not "go around with a hammer beating on people." This somewhat indirect aggression was interpreted for him by the counselor, but West said that he felt that physical strength was not a solution to the problem since a "slip of a girl does not have such problems." He said with apparent self-concern that he was still groping for a cause of his difficulty. The counselor reflected the feelings of inadequacy and concern.

5. West recounted how he was tagged for his trip back from England with a label marked "Inadequate Personality, Severe." He wondered if this was an explanation of his difficulty and asked the counselor if he thought so.
The counselor, responding to the feeling rather than to the content of this statement, reflected the desire for reassurance. West recognized this desire on his part, and asked if there were some people who just had weak nerves. He could not accept the idea of some physical impairment because he had always been able to pull out of his previous episodes. However, his concern now was that, even though he achieved complete convalescence, he might break down again in the face of some difficult problem.

6. West stated that he had recounted his experiences so that the counselor could diagnose his difficulty and do something about it. He had read articles and books, seeking help from someone. The counselor reflected the desire for someone else to solve his problems for him.

7. West returned to a recounting of symptoms and a comparison of himself with other people. There was evidence of mounting tension. He said that he realized that normal people were jittery at times and told of physical training exercises in net climbing which made him nervous for a little while but did not seriously upset him as things now do. He said that such nervousness was not so severe nor so long lasting. He stated again that he was afraid even though he might get well, that there might be a recurrence of the "breakdown." West said that he wanted some professional man to get at the bottom of his difficulty. He told a story of a relative who went to a psychiatrist because he would frequently faint at his job. West obviously identified himself with this relative and said with some feeling how horrible such experiences were. His desire for someone else to assist him was interpreted, and the interpretation accepted.

8. After a few minutes of quiet, West looked at his watch. There were 25 minutes left of the hour. He explained that he did not want to stay overtime but that he had wanted so much to come that he had stayed away from a pay formation to keep the appointment, but he said that "if you have work to do I would go." The counselor redefined the situation and told West that he might leave if he so desired but that the decision to leave would have to be made by him. There was evidence of growing tension at this time and West stated not too confidently "that's fine." There was a period of quiet and tension mounted to the highest point in this interview, with some crying and wringing of the hands.
9. At this point West’s talk evidenced strong emotional attachment to the counselor with evidence of identification. He described the counselor as being calm and self-assured and having “no problems at all to bother you.” The counselor recognized this feeling by saying “you would like very much to be like me, would you not?” and this recognition of feeling was fully accepted. West then mentioned a Lt. Colonel, age 30, in the Armored Force who was a strong leader of men, and he wondered why he could not be like that Colonel. The feeling of personal inadequacy was reflected by the counselor. West said that his confidence in himself had been shattered in early life and that it had dogged him all his life. He feared that he would have a terrible time to overthrow it. He said that he had made progress after past episodes but that he had never made enough progress.

10. West became a little disturbed again and looked at his watch. He did not speak for several minutes. Finally, with some effort and with real warmth, he asked “Why is it that I always feel better after talking with you?” Here the counselor probably missed the significance of the statement and reflected its content rather than its feeling by saying “it does help you then to talk over your problems.”

11. West said that when he went to see the psychologist in Akron after his experience on the factory job that he felt better but did not get any help that would solve his problems. The counselor reflected the fear that he might feel better after talking but that it might not help him fundamentally at all. West said in effect that he would like very much for science or for a psychologist to find out what was the matter with him but that he felt after all it was perhaps up to him. This ambivalent feeling of desire to refuse responsibility and to accept responsibility at the same time was pointed out, and the clarification of his feelings was accepted. West said “yes, I guess it is all pretty much up to me.” This was believed to constitute a decided step forward for the patient.

12. After a recounting of additional differences between himself and other people, West saw that his hour was up. He asked if he might ask a question before leaving and said “Can you make anything out of all this that would help me?” The interviewer reflected his desire for reassurance and West did not press the issue. There seemed now to be developing some very real appreciation for his own role in overcoming his inadequacies.
Comments: West, Third Meeting

1. This case was taken by the psychologist before a psychiatrist had been assigned to the station. Soon after the arrival of Major Wright (mentioned in the footnote on page 75), the counselor talked over the case with him, as he was properly responsible for psychotherapy done in the hospital. It was decided that Major Hobbs would continue to carry the case and that Major Wright would occasionally see the patient. This would afford a basis for consultation on progress and technique, and for a decision on final disposition. Such sharing of a case is believed to be highly desirable, particularly in an institutional situation. Administrative decisions affecting the patient need not then be made by the counselor, thus avoiding a confusion of his role. Therapy may be speeded. For instance, in one brief meeting, Major Wright helped West consolidate his advances in achieving insight by assuming that West had already firmly established a degree of insight which he had been able only tenuously to express in meetings with the counselor. And not the least of the value to be gained from such an arrangement is the guidance of the counselor by a technically competent person who knows the case well but who is not himself emotionally involved.
2. It is evident that a strong emotional relationship has now been built up between the patient and the counselor. For an individual suffering from acute anxiety, touched off by a traumatic experience, but having its roots deep in his past, it is believed that such emotional support is more significant in the dynamics of recovery than would be the development of insight. Real insight into the conflicts with which West has lived for so many years could probably be achieved by him only through long and intensive treatment. The goal of therapy in this case was to give the patient enough strength to return to a relatively secure life and make a fairly adequate adjustment. Some insight and much security, even though obtained from a few hours of treatment, are sources of strength which may be expected to carry over to all areas of adjustment after therapy is concluded.

West, Fourth Meeting, 7 July 1945

1. When West arrived, he was depressed and more disturbed than he had been since the first meeting. He talked little and it appeared that he didn't use the hour too profitably. It is possible that his inability to talk resulted from disappointment in the necessary postponement of the meeting from Friday to Saturday. However, it seemed unlikely that West would be capable at the time of much overt aggression. He remained profoundly worried about himself and greatly in need of emotional support.

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6This change in appointment time was necessitated by an administrative order requiring the presence of the counselor at a meeting.
2. At the beginning of the hour, the counselor explained why it had been necessary to change the appointment from Friday to Saturday, indicating clearly that it was not his choice but a matter of official business. West accepted this with his usual polite deference.

3. The counselor asked, "How have you been getting along?" and West said, "About the same." He became quiet and began to show signs of more emotional disturbance than at any meeting since the first. He cried and remained quiet. The counselor took some initiative and asked "What would you like to talk about today?" West replied that he had already "covered about everything." He said that he did go on the tour of Macon, planned by the Special Services Officer, but that he was nervous at the thought of going with so many people and "dreaded it at first." At this point he cried without much control and lapsed into a long silence.

4. The counselor attempted to follow-up the insight which West seemed to have gained in the last meeting when he verbalized his ambivalent feelings towards wanting help and rejecting help, simultaneously. The counselor asked "Why do you cry when you are with me?" West replied, "I am just worried about this nervousness."

5. After a long silence, the counselor said, kindly, "You don't feel much like talking this morning, do you?" West replied, "I don't know, there isn't much to talk about." Pause. "I have told you everything." West then said that he got temporary relief from talking with the counselor but that he was "still in a rut." He then recounted again some of his symptoms and some of his experiences. The counselor attempted to indicate the significance of his statement by saying, "you want very much for me to do something about your problems." West replied, "Yes, but there is nothing that can be done...I sense it." The counselor asked "Nothing that can be done about it or nothing that I could do about it?" It was hoped that this question would lead to a further clarification of the feelings expressed in the last meeting, but West replied, "I don't know which it is," and lapsed into a long silence.

6. West said that he had been looking for the "secret" or the "key" to his problems but that the first psychologist he went to see could not help him. His desire for someone else to be responsible was reflected by the counselor. West said they would probably keep him here for a
few weeks, that he would get along all right, and they would send him out, perhaps back to duty, perhaps back overseas. He expressed also concern about his adjustment after discharge from the Army. Seeking again to reinforce the previously gained insight, the counselor said, "You doubt very much if I can be of help to you." West then very clearly expressed his dependence and lack of confidence in himself—"Even though you want to help, your hands are tied... Science and you can't help me."

7. West then said that he was sent home because "they knew it was hopeless." The counselor said "And you are very much afraid that it would be hopeless here," a statement which was accepted. There was much tension and West cried profusely. There followed a long period of silence. The counselor attempted to let West talk very freely about this fear, to live with it openly, and asked "Would you like to talk about that, West?" West replied, "I just don't know," and lapsed again into silence.

8. West said, "I don't know how to get started" putting the statement almost as a question. He went on to say that if he stayed here for six months, he would be well temporarily. His basic fear of having always to live with his difficulty was reflected and West responded with a warm smile. The following notes are an almost verbatim record of an important part of the conversation:

W: I have searched and searched.

C: You search for answers from somebody else?

W: Is that it?

C: What do you think?

W: I have searched in articles by psychologists and psychiatrists and I observe people a lot.

But at this point West diverted the conversation and continued.

W: You can't tell why you're different by observing another person.

C: You can't tell why you are different?

W: That's right, sir.
There was a long period of quiet.

9. West continued to explain that being in a foreign country was "like being trapped." He also said that his fear of groups was related to his fear of being in a foreign country. They are part of the same thing and he stated with full recognition of his inadequacy, "if I were normal over here, I'd have been normal over there. There's something lacking, a missing link somewhere. It's either hereditary or some other reason. If it is not hereditary, it is because of my past experiences, because of experiences in childhood which kept me in a state of anxiety that is not good for anyone." Again the rejection of responsibility was reflected.

C: You can blame it on heredity or on experience?

W: (Passively) Yes, sir.

There followed a long period of silence.

W: (Looking at his watch) Time goes by fast.

C: You like to come to these meetings, don't you? (again trying to help him recognize his dependence on others).

W: Yes, sir (warmly and with a smile).

C: And you hate to see the end of the hour come?

W: Oh, I don't know.

This was followed by a long period of silence. The counselor felt that disturbed feelings were evident, that the statement "time goes by fast" might have been a way of saying "time goes very slowly." West accepted the statement that he like to come but rejected the statement that he hated to see the end of the hour come.

C: You want to stay and yet you don't want to stay.

There was no verbal response at all but evidence of about as much aggression as West seemed capable of. There was a long silence, about five minutes, with West appearing determined to sit it out.

10. West then asked if the counselor had had a case like this before, whether it was unusual. The counselor recognized in this question West's need for reassurance and interpreted it to him.
C: You want me very much to reassure you that everything is all right.

West seemed to accept this but significantly added...

W: But it's not all right.

C: And you would not accept any reassurance from me.

There again ensued a long period of silence.

W: (With much feeling) I feel confused today.

C: It's hard to talk, hard to work at your problems, isn't it, Frank?

W: Yes. (A long pause) It's all a jumbled mess to me.

C: You can't see any picture at all.

W: Yes.

C: And that discourages you.

W: Yes. (Pause, and then with deep emotion) I wish I were five and could start all over again.

C: Sometimes you feel that you would like to be a little boy again?

W: Yes, if I knew then what I know now, it would be different.

C: You feel that you could make it different?

W: I don't know.

C: You think you can, but you are not sure.

There was no reply to this but some crying and a long silence. Here the counselor went somewhat beyond the actual feelings expressed and said "You would really like a chance to do something about it yourself." This seemed too great a threat and West explained immediately....
W: I don't know what I can do.
C: And that's what worries you, isn't it?
W: Yes, sir, (and a long period of quiet).
C: I see that our time is about up.
W: Yes, sir.
C: This has been a pretty rough session, hasn't it?
W: Yes, sir, (with feeling).

11. The counselor said that on Tuesday morning at 10:00 o'clock there would be an hour set aside for West if he cared to come, and that he might use the hour in any way he desired. It was pointed out that if he merely wanted to come and sit and say nothing that he could do so if it were his decision, that he could leave at any time or stay, but that these decisions would have to be made by him.

W: I will be here Tuesday.

C: (Feeling that West badly needed reassurance and support) I will be looking forward to seeing you.

Comments: West, Fourth Meeting

1. As counseling proceeds, the patient may, as is evident in West's case, oscillate between progress and regression. Knowledge of this tendency may save the counselor many moments of despair. After taking a hesitating step forward toward achieving insight, he may withdraw from the vantage point gained, and take comfort in his old defenses. A fruitful session may be followed by one much less productive, as though the patient unconsciously desired to balance off the business. Fortunately, sessions that yield meager
results are often followed by sessions rich in value for the patient. This is most likely if the patient has been led to conceptualize clearly his responsibility in the therapeutic process. Resistance is kept at a minimum and treatment speeded. Responsibility will not grow from occasional hortative statements to the effect that he must be responsible; his responsibility must be evident and implicit in every statement and act of the counselor.

2. In this meeting dependence and helplessness are again and again expressed, either aloud or in miserable silence. They are eloquent in the statement, "I wish I were five and could start all over again." He seems to be testing the limits of dependence. The full acceptance of him by the counselor, the reflection of his expressed feelings, the counselor's quiet confidence that he can get well should serve to give the patient strength and understanding so that he may make much progress in the next session.

3. It is interesting to reflect on the extent to which the counseling situation serves as a surrogate life-situation for the patient. There seems to be evidence, even at this relatively superficial level of therapy, of two processes:

   First, the counseling situation may provide for the neurotic patient an opportunity to relive certain parts
of his life with normal emotional support, which had been denied him in the course of his actual life. There may be symbolic regression to the status of a child, followed by rapid growth to maturity, with years telescoped into hours, because the counseling hours are highly significant periods of time for him.

Second, the counseling situation may provide the patient with a well-structured and predictable environment in which he has the opportunity to live for a few precious occasions, limited in number and each limited in time. In his day-by-day world, which is fractions and capricious, unpredictably kind and hostile, almost whimsically disregardful of his needs, the timorous neurotic dares not try to grow. His normal efforts have been so frequently frustrated that he declines the challenge and seeks refuge in his painful but familiar modes of adjustment. However, in strong contrast to life as he has known it, the patient in the counseling situation finds, for the first time, a life-situation which is predictable, stable, kind, and accepting, and which is also demanding, but demanding in a consistent fashion. Here he can find the courage to make a few hesitating attempts to try his strength to give normal expression to his feelings. Against the predictable boundaries of the counseling situation, he tests his needs to be dependent,
to be hostile, to be punished; and he also asserts his
independence and demonstrates his ability to make decisions
and give mature affection to someone else. He grows in the
ability to pattern his life after his own wishes, shaking
free from compulsive urges of his day-by-day existence,
which he can not understand and cannot control, but which
he can tentatively satisfy only by neurotic behavior.
Having expressed his neurotic demands in the counseling
situation, he finds less need to express them in daily
life. Having learned to make mature decisions in the
counseling situation, having learned to be responsible
for his own behavior, having learned to express his emo-
tions freely, he finds it easier to be more mature in all
of his life relationships.

West, Fifth Meeting, 10 July 1945

1. When West arrived for the fifth meeting, he appeared
much more confident and secure than he did at the last meet-
ing. After a brief discussion of his program of activities
(which is being scheduled by another officer, rather than
by the counselor, in order to avoid confusion of the coun-
selor's role), West began immediately to talk of his condi-
tion. He began by saying that he realized now why he was
sent to a convalescent hospital. He said that it was much
better for him than a general hospital would be, that the
rest would help him get better. He reported that he felt
a good bit better and that the headaches were not severe
any longer. He reflected on the severity of his emotional
experiences overseas, saying "This thing really rocked me.
It is like burning your hand; after the fire is removed,
your hand still burns."
2. West then talked of going on the Special Services tour of Mecon. He said it was very rough for him to plan to go and that even after he was on the bus he was tempted to get up and leave. However, after the trip he felt much better. He said the experience gave him a boost. The counselor attempted to help West see how he felt better after accomplishing something on his own responsibility by saying "You felt a sense of achievement." West replied "Yes," and the counselor continued "For which you are responsible." Somewhat embarrassed, West replied, "For which Special Services was responsible."

3. West then returned to a recounting of his symptoms, saying that "It really bothers me when I reach this state of collapse." His concern was that the panicky feeling and nervousness accompanied by dizziness and headaches occurred entirely too often. He recalled the incident of having to join a union and of "breaking down" overseas. The counselor reflected his feelings of inadequacy, which West now mildly rejected by stating that he had not been panicky before the Special Services trip, only a little nervous. The counselor began to feel the presence of new strength in the patient.

4. West paused for awhile and then said that he had figured out "logically" what the psychiatrist in the ETO meant when he said "If it were not for my age, everything would be over." West now interpreted this to mean that "at 32 there is hope that I will keep on fighting." This statement is in strong contrast to his depressed and negative reaction evident in the interpretation of this statement made in the first meeting.

5. The counselor said, "It is fine to hear you say that," and after a pause, "You are really ready to accept responsibility for your own recovery." West replied confidently, "Yes, sir."

6. After this first really strong expression of confidence, West relapsed a bit into the relative security which he achieves by dwelling on his difficulties and differences. There was also once again an expression of dependence. West said that he feared that his nervousness would stick in spite of all that he could do. The counselor said, "You would like to have someone else to cut off that feeling." West frankly admitted his desire for support, saying, "Yes, that's it."
7. West continued to consider his differences from other men. He said, "I know now what they meant when they wrote, 'Inadequate Personality,' on my card (the identification and diagnosis tag used on his return from Europe), they knew I was not the type to get along. I don't mingle with other men and my interests are different. Cards and bridge and poker are a waste of time to me." He mentioned his interest in sports and said that he could read a book anytime and be satisfied. He talked of the fact that he spent much time thinking, and said "the average soldier does things and thinks afterward; I think first and then do things. I take things seriously; they say 'What the hell.'" The counselor reflected his feelings of being different from other people. West replied that he was different, "in that respect." But here again the counselor felt a protest, a resurging strength not apparent in former meetings.

Then followed a series of statements showing a gradual growth of insight, and evidencing a new strength to meet his own problems.

W: I should have participated in everything, doing the things that other boys did. That would have helped me a lot.

C: You want very much to be with people.

W: Yes....in a way....and then, I don't.

The counselor reflected his ambivalent feelings and asked, "Do you have any idea why that might be?"

W: I guess it's the feeling of stage fright. It puzzles me and I have never been able to figure it out.

He then went back to recount disturbing experiences, most of them occurring in early childhood, including going to a circus at the age of fourteen and "bordering on collapse." He mentioned experiences which were unpleasant but which he had stuck out, gaining therefrom a sense of confidence.

W: If there had been more such experiences in childhood, it would have given me the boost I needed.
C: You feel that much of your difficulty can be attributed to your childhood experiences.

W: Yes.

And he hurried on to say that even at the age of twenty, when he attended a ball game he had very much the same feelings. However, they were not so intense because his brother was present with him.

W: It was a comfort for him to be there.

C: You felt more secure when you were with your brother?

W: Yes.

C: You feel very close to your brother?

W: No, not particularly. I write about once a week but I don't call them (his family) all the time. Even on coming back from overseas, I didn't want to rush home. I don't have any sisters and I do think an awful lot of him.

C: Your brother has been one of the closest men you have ever known.

W: Yes, I had a small family, my mother and brother, and later on, my step-father. My brother did not spend much time at home. We were very poor and he got hard knocks but he has the emotional stability that I don't have. His hard knocks were all good. Mine were all bad. Mine tore down my confidence.

C: You feel your childhood was pretty rough, unfortunate.

W: Yes, I do. That's the thing I must rebuild. I have tried. It has never been lasting.

C: You are ready today to be responsible.

W: Yes, but I fear it all coming back.
There was a reflection of his mixed feelings of dependence and independence, and West said that if he had kept working at the same company before the war and if he had remained at radio school, he would have gotten along all right, but going overseas was like a "bombshell." When asked why he felt that he got along all right, West said that it was through varied work, meeting the public, developing new friendships, going to small parties and meetings—"sorta hanging around the edge of things." He said "it definitely was helping me." He talked then about Army travel and being away from home and added significantly,

W: My folks expected me to have trouble in the Army; they didn't think I could get along.

C: The folks at home did not have too much confidence in you?

W: Yes—they didn't express it but I believed it.

C: And how did you feel about this, Frank?

W: I never thought about it until now.

(There was silence, but vastly different silence from the resistant silences of the last meeting. West was obviously thinking.)

West thought that he partly overcame his fear of crowds by being with men in Army camps. But he said that noise worried him and described a hypothetical "hammer test," (some test by which men would be subjected to the noise of a hammer beating on a board) which would make him break down sooner than other men.

He talked then about the poverty and starvation overseas and said:

W: That really got on my nerves. I had no sense of security over there.

C: And you need that badly—all of us do.

W: Yes, sir.
He proceeded to enumerate differences between himself and other people. He said that he worried about revolutions in South America and he knew that "the fellows would laugh at me if they knew that." The counselor reflected his feelings of being different from other men and West continued:

W: When I have a collapse, it tears down everything that was built up before. I find it difficult to do now what I used to do with ease. Overseas was awfully rough. Regardless of what they say, I would have lost my mind, and that is about the worst thing that can happen to anyone. What worries me in this respect is that something will come up here in the States. I have got to build up again.

C: You are thinking of it as more and more your problem.

W: Yes, in a way I must do what I want to and still work ahead.

C: I don't believe I understand what you mean.

W: I must do those little things one by one until I get rid of this nervousness and get a hold on myself. In fact, it would not be good for me to go into a large crowd now. I must go to a movie on the post and then to a movie in town in a larger theater and gradually build back that way.

There was a period of silence and evidence of tension mounting again. Tears came to West's eyes and his jaws trembled. He said, "If they told me I had to go overseas tomorrow, I think I'd take my life. I'd rather be dead than be insane." The counselor attempted to tie this in with the strong evidence of independence given before by reflecting his mixed feelings.

C: You have rather mixed feelings, don't you. You want very much to get well, but you are afraid that if you get well you will be sent overseas, and you don't want to do that.
W: (Strongly) I have no mixed feelings about going overseas. If I did, it would happen again. I know it. I don't have the constitution to take that sort of thing. I could never be a doctor and see people in pain. I could not stand that. I could not stand to be jobless in a depression. I need security.

G: You need security.

W: Yes, and I'll never get it overseas. I don't care if the flag is there or three million men or fifty men. (With evidence of real belligerence) It's like another world and I can't stand it.

G: Overseas symbolizes insecurity for you?

W: Yes. There have been men who could not adjust in the United States and the Army would not take them in. I just could not stand up overseas. Some men can take 200 missions. Some crack up after ten. I guess God is responsible for people being different.

G. West looked at his watch and said, "Time is surely going fast this morning, guess I've been doing a lot of talking. These meetings get me excited, a little nervous. My head aches and my neck aches. I really feel worse than when I came in. I cry because I worry about it." And he continued, "I'll be thankful if I can simply adjust here in the United States, meet family problems without ever cracking up again." West talked briefly about getting married and said that he had asked the psychiatrist in the European Theater if he should get married. The psychiatrist answered, he reported, "It's a good question. It may give you a lift." But West indicated that he was very much afraid of breaking down in the face of some difficult problems, which marriage would bring.

G. At this point, West returned to his early home life and talked so rapidly and intently that direct quotations of what he said were lost. He began by saying that his mother was not aware of his problems, that if she had known how to handle them she could have given him the help he needed in the second grade when his teacher did not understand him and punished him. The counselor reflected this first expression of his feelings that his mother had not
given him all of the support that he needed in growing up. West accepted this fully and then said, most significantly, "If you had been there to help me, I would never have had all that trouble." With confidence in West's growing insight into his needs, the counselor said, "You needed very much to have a father then, too, did you not?" West fully accepted this also. The counselor pointed out that West had never had the understanding and help that he needed to grow up and that he was now finding some of that support in his dependence on the counselor. This West also accepted. It was felt that this part of the fifth meeting constituted a high point, so far, in his own responsibility and also his need for strong emotional support.

Comments: West, Fifth Meeting

1. It is apparent that the counselor is attempting to follow non-directive techniques. One characteristic which makes this patient particularly amenable to this type of treatment is that he is quite thoughtful and articulate. Such a statement as "It is like burning your hand; after the fire is removed, your hand still burns" is indicative of an ability to verbalize which facilitates counseling. A few patients who were referred for counseling were so restricted in their ability to comprehend and to work through their problems on a verbal level that non-directive techniques were felt to be inapplicable.

2. In this meeting, the fifth, the patient rebounded with impressive strength from the depressed and dependent state in which he was during the last meeting. He is really beginning now to get himself in hand. He has
become aware of his ability to handle his problem on his own. It is theoretically important to notice that there is no real problem of the counselor taking the initiative in breaking off "transference." There is obviously a strong emotional tie between the patient and the counselor, but since the patient has been left largely responsible for his recovery throughout all of the meetings, the counselor does not have to take the initiative in breaking off the relationship. Full and final independence from the counselor is but an extension of the independence demanded of the patient in all of his relationships with the counselor.

3. It is important to note that without probing by the counselor, the patient goes to the heart of his problem—his feelings with reference to his mother, his brother, and to the father he has always wanted. Having explored the counseling situation, having felt out the counselor, having gained some confidence in himself in previous meetings, he now feels free to get out into the open some of the feelings which have heretofore been effectively repressed.

West, Sixth Meeting, 13 July 1945

1. West arrived ten minutes late for the meeting this morning. He explained that he had been at pay call, which he had missed once before because of an appointment with the counselor. He went on to state that he had started
his activity program and that he was enjoying it. However, there was no evidence of enthusiasm. West seemed depressed and was very quiet. Finally, the counselor said, after several periods of quiet, "Perhaps you'd rather not talk today, Frank?" West remained quiet and seemed very depressed. Tension mounted. He did not answer. After a period of quiet, he spoke again.

W: It is very difficult to undo what has been done before (referring to his experience in the European Theater).

C: It is plenty rough, eh?

W: Yes—(pause)—I saw in the paper where they are going to send all men overseas who have not already had six months service overseas. I tried once; that was a failure.

C: And you feel you could not stand that again?

W: No, sir. Things simply went out of my control.

C: You could not be responsible.

W: No, sir (pause) I am not a combat man. I have been grounded and rejected twice for overseas duty. But I was selected the third time. I know I won't be asked to fight but I still can't take it overseas.

C: You are awfully worried about going back overseas, aren't you?

W: Yes, sir. The events of my life are so deeply embedded that I just can't shake them off. I cannot make the adjustment for overseas duty.

C: Your life hasn't given you all you need.

W: No, sir, it hasn't, sir.

C: You've needed things that you did not get.

W: Yes, sir. (Quiet and growing tension) I feel it would be an injustice for them to send me overseas. They have everything over there but United States soil. If they could have done anything for me over there they would have done it, but they couldn't.
C: You were tremendously insecure over there, weren't you?

W: Yes, sir. I'd relax temporarily and would seem, on the surface, to be all right, but I could not take it over there. It was like being trapped in a submarine, for many days, and feeling panicky and insecure. That is the same feeling I had overseas. I cracked up. I did not know how to break it; the medics did not know how to break it. When they said "Inadequate Personality," that described it very well. If I could be changed into a two-fisted man, I could fit overseas. But I never had the chance to be that. I never had a chance at home and my early experiences were all bad. I have been knocked down from the start.

C: From the earliest days you have been knocked down?

W: Yes, sir. It has all left me in a state of anxiety and it was multiplied a million times over there.

The counselor reflected this feeling, but he lapsed into a long period of silence.

W: I have read some psychiatrist who suggested training; but I don't know what that is.

C: You're still seeking these answers.

W: My chance is gone now. The training should have come in childhood.

C: People did not give you the help they should have?

W: No, sir.

2. At this point West began to talk rapidly and verbatim notes were not possible. The counselor reflected his feeling that his early life had been inadequate and West said that he did not like to blame his mother for it. Mixed feelings towards his mother were reflected by the counselor. After listening for several minutes, the counselor said:
C: Although you don't want to blame your mother for not helping you, yet you still do blame her a bit.

W: Yes, that's right.

C: You felt your mother was a little inadequate.

W: Very much so. She did not have the education that she needed. She was not capable of rearing children.

C: She is responsible in part for your condition now?

W: Yes, sir. (Pause and much tension) It would have been easier for you to have worked with me then.

C: You wanted a father then very much, too?

W: Yes....the right kind of a father....a father who could understand.

At this point West broke down and cried similar to the seizures he had had during his first meeting.

C: You needed very much a father who understood you.

W: That's right. (Crying)

C: And you never had that?

W: No.

C: And the father that you did have did not give you what you needed.

W: No, sir, and neither did my mother. I used to wake up in the morning and my mother would not be there. She would be at the neighbors or down at the village, leaving me alone. I would wonder where she was, and I would cry, not exactly hysterically, but nervous and panicky. That was wrong (with deep feeling). That was no way to bring up children.

C: She did not treat you right?
W: No, the house would be cold and there would be no breakfast, and I was left alone.

C: And you resent it now?

W: I do. I resented it at the time. I would even become resentful then. I would be afraid for a while and cry, but I would also be resentful.

C: You even resented it then?

W: Yes, sir.

C: You feel that your mother sort of walked out on you?

This was perhaps too strong a statement on the part of the counselor and West accepted only part of it.

W: She did the best she could. She gave me clothes and food. She could have put me in an orphanage, but she didn't. It was on the spiritual and mental side that she was lacking.

C: She did not give you the love you needed?

W: In her sort of way I had love. The one time she helped me out was in the second grade when she would walk one-half of the way to school with me, then three-fourths of the way, then all of the way, and she talked to the teacher. But there were other times when I had stage fright, when I had to graduate from high school, when I had to join the union, when she did not help. I struggled through these by myself.

C: She did not help?

W: No.

C: And you resented it?

W: No, I didn't know what she could do, what anyone could do.

C: The damage was done then.
W: To a very large extent. It was after I had quit my job to keep from joining the union that I consulted the psychiatrist and the psychologist, but I made no progress. They said very little.

C: No one has helped you, your mother, your father, no one to whom you have turned.

W: No.

C: And you very much need help.

W: Right. Even overseas they seemed to recognize the trouble. But they could not just snap their fingers and change me.

C: And they did not try to help you.

W: They could not help me. If they could have, they would have forced me to stay. I get so tense and wrought up that I lose control. That's the way I was overseas. I have read of similar cases but they are not like me. I don't know how they pull out of it. (Here he told the story of Navy pilots who had traumatic combat experiences but managed to recover after some rest.) When I've had trouble before, I've had to work out inch by inch by myself.

C: You have had to do it yourself.

West nodded "yes."

W: In paratroop training many men refuse to jump on the seventh jump. I don't know why they break there. I lose control in a similar way.

C: And that worries you very much.

W: Yes, sir. Another thing, when a man goes up for drafting, if they determine that he is a psycho-neurotic, he is rejected. There is no attempt made to try to change that man. The Army does not have time to do that for a man.

C: You feel that the Army doesn't have time to help you?
W: Yes.

3. West repeated some of his symptoms again and the hour ended. He left the meeting very depressed.

Comments: West, Sixth Meeting

1. What is doubtlessly the basic source of West's neurotic condition is evident in the account during this meeting of his early relationships with his mother, and of his reaction to the void that should have been filled by a father. Anxiety and hostility are inextricably interwoven. It is believed that West has considerable hostility which he has effectively repressed. He makes several statements indirectly indicative of this hostility, such as, "If I could be changed into a two-fisted man," and "(I could not) go around with a hammer beating on people."

In this meeting he is able to come out with a direct statement of this hostility. One could hardly make a stronger indictment of his mother than to say "She was not capable of rearing children," and to accept with only excusing comments the interpretive statement that his mother was responsible for his present condition. Having gained confidence in the permissiveness of the counseling situation, and having gained confidence in his own ability to be responsible for such a statement, West succinctly phrases his feelings of resentment towards his mother. This clear
recognition of how he feels about his mother, and the emotional relief obtained in the expression, are believed to be dynamically critical in his readjustment. They should make possible a somewhat more normal relationship with his mother and free him from some of the general anxiety that is an outgrowth of his repressed hostility toward her.

2. The verbatim notes obtained in this meeting illustrate what is meant by the counselor reflecting the feeling of the patient's statements. As conceived in this approach to psychotherapy, the restatement of expressed feelings should lead to a fuller understanding of the significance of those feelings, and it should facilitate the efforts of the patient to go to the core of his problem. The distinction between reflecting feeling and reflecting content is important, for the latter is likely to contribute little to the progress of counseling. To illustrate the difference between reflection of feeling and reflection of content, let us consider the statement made by West (on page 100), "No, the house would be cold and there would be no breakfast, and I was left alone." A rigid (and almost absurd) reflection of content would have been to say, "You were left alone in a cold house, with no breakfast." This would have helped little. A better statement would have
been, "You were neglected when you were little." This would probably have lead to a deeper exploration of feeling. But it is believed that West had expressed more intense feeling, and of a different sort, than the above statement would have reflected. He seemed definitely to be expressing resentment, and this feeling was recognized by the counselor with the statement, "And you resent it now." This helped West to proceed immediately to a focal point in his difficulties, with full recognition of his hostile feelings toward his mother.

3. This reflecting of expressed feelings has produced some levity among counselors considering the technique, and also one misconception. The levity is evident in the designation "The Uh-huh Technique." The misconception is evident in the opinion that the procedure is lifeless, cold, mechanical, artificial, a formula applicable by a technician and requiring no real skill or understanding of people. Nothing could be further from the truth. Adequately to reflect expressed feelings imposes the most exacting demands upon the counselor's clinical resources. A reflection of feeling will have a convincing rightness only when the counselor appreciates intimately the significance of what the patient is saying, only when he is keenly aware of every nuance of changing feelings. Sensitivity to expressed feelings, to
the meaning of what a patient is saying, comes from an understanding of the patient, from insight into psychological processes, and from hard work.

West, Seventh Meeting, 18 July 1945

1. West came in and the counselor asked him how things were going. He replied that they were about the same and that he did not know what he would talk about today. There was a period of quiet and the counselor invited West to think over what he had learned in the previous meetings in order to formulate more clearly his feelings about his problem. West replied that he did not know what good he was getting from the meetings other than temporary emotional release following each session. West then repeated rapidly an account of the various situations which have caused his anxiety. He recounted also his feeling of differences from other people. The counselor reflected his constant feelings of insecurity where other people were concerned and where he was likely to be rejected. West accepted this interpretation and replied that he had often been able to become established in very small groups and that he could "go forward but not far enough" in becoming accustomed to large groups. The counselor reflected his need for being with people existing at the same time that he felt free to make normal social advances.

2. West then returned quickly to a discussion of his feeling of going overseas and said that if he did not have to go overseas again, he might be able to adjust fairly well in this country, although he expressed some doubt as to whether he would ever "be normal again." He expressed his feelings of insecurity and inferiority when with other people and stated that it was only in radio school that he had been able to adjust in the Army. The positive value of his relationship with people as an instructor in a radio school was pointed out and West accepted this constructive statement. He then added an example of his own, when, working for the gas company, he had formed relationships with people which were quite satisfying to him. But he returned immediately to his current major fear, and said: "This overseas experience is like a terrible nightmare. I cannot stand the idea of being sent overseas again. They won't do it. I walked up that gangplank once but I could never do it again."
3. The basic nature of this insecurity was reflected and West said, "Yes, sir, it has been a struggle from childhood all the way up. I have had to struggle. This emotional instability has been like a shadow. I just can't seem to get complete mastery of myself." The counselor reflected at this time some slight feeling of independence and responsibility that West assumed for his behavior. West reverted to recounting ways in which he is different from other men. The material was mainly anecdotal and has been summarized previously in the reports of the meetings.

4. In the last minutes of the hour, West expressed a desire for help and, interestingly enough, used the same phraseology he had used in describing how his mother had, when he was in the second grade, encouraged him to go back to school after an illness by walking a little way with him each day, and increasing the distance. The counselor reflected this as one of the clearest expressions of West's desire for support which he has never had, not even in childhood. West, with some emotion, accepted this clarification of his feelings.

5. He left at the end of the hour, rather depressed, possibly because the meetings were demanding that he be responsible for his behavior and not providing him with the solace which he was seeking.

Comments: West, Seventh Meeting

1. A fascinating problem in counseling is suggested by the seemingly casual and fortuitous recurrence of certain phrases, metaphors, similes, or other figures of speech. That these statements are not casual and fortuitous becomes more and more certain when they are repeatedly used to a purpose. For instance, this patient has referred on two occasions to being helped "half the way," "three quarters of the way," etc., in the solution of a problem, referring
first to his mother and then to the counselor. He also has used the expression of "six or seven times" as referring to the limits of tolerance of some recurrent noxious or threatening situation. Is he suggesting that he has pulled through four or five traumatic experiences, and fears he cannot get through the sixth or seventh without a complete disintegration of his personality? It appears as though the patient is trying to tell the counselor something important which he is not quite able to bring out openly on a conscious level. There should be further systematic study of this intriguing problem.

2. The question may be asked why the counselor did not attempt to reassure the patient about the possibility of being sent back overseas, or why arrangements were not made to have him declared medically unfit for overseas service. It was simply felt that his violent reaction to the prospect of being overseas was symptomatic of basic conflicts, and that an administrative arrangement blocking off the possibility of returning overseas would merely have allayed temporarily his anxiety. "Overseas" is simply the most powerful symbol of insecurity that he has yet encompassed in his experience. It should be remembered that he worries about revolutions in South America, about strikes, about possible earthquakes. He absorbs this anxiety in
part through the rationalization that he is a more thoughtful, sensitive (and thus superior) person, as compared, for instance, with other soldiers. But his differences are both a source of comfort and a source of concern for him, with the scales tipped toward the latter. There is still a tremendous weight of anxiety. It is plausible that this anxiety, which is focused on various situations and events ranging from going to a movie to hearing of a revolution in South America, arises through an exteriorization or a projection of his repressed hostility towards people in his immediate life orbit. The goal of therapy appeared to be to give the patient an opportunity to work through his feelings about people who are important in his life, with attendant reduction of the diffuse but intense anxiety which seems to attach itself to most any likely situation.

West, Eighth Meeting, 24 July 1945

1. Prior to this meeting, it was decided, in conference with the psychiatrist, that the counselor should take a more active role and attempt to assist West in understanding the basic patterns of his behavior. Through this process it was hoped that West could gain enough insight and confidence in himself to be relieved sufficiently of his current fears and anxiety to make at least a temporary adjustment before being returned possibly to civilian life. The specific plan entailed the questioning of the patient on pertinent areas where he has expressed strong feeling in previous interviews,
such as the experiences in early childhood when his mother would leave him alone for several hours while she visited with the neighbors, his early school experiences which were so traumatic for him, the experience in grammar school when he was unable to get up before the class to receive his diploma, the experience when the demand was made of him that he appear before a large group of union members to take an oath, and his experiences overseas, in order that West could realize the similarities of his behavior in each of these situations.

2. When West came in, he was quiet and somewhat depressed. The counselor asked him first what he would like to talk about today and West replied that he had covered everything. The counselor asked West if he would attempt to piece together the bits of information which he had developed for himself in previous meetings into some kind of pattern. West replied that he could not make heads or tails out of it. After a few moments of silence, the counselor began directing the interview along predetermined lines.

3. West was first asked to talk once again about his experiences in the second grade when he was punished unjustly by his teacher, following which he was absent from school for about six weeks. West recounted again how unjust his teacher was and also how the children teased him because of his shabby clothes. By questioning, the counselor led the patient to see that school represented for him a crowd of hostile and cruel people, including both the teacher and the children. West accepted this. The counselor then asked, what he had done about it, and West said that he had left school. It was difficult at first for West to say that he became sick in order to avoid going to school but after some discussion, he came around to admitting that this was a mechanism for escaping a very unpleasant situation, the chief characteristic of which was the presence of a number of people who were hostile to him. Two methods of escape were recognized. One was escape by simply withdrawing from the situation, which he did by going home. However, West realized that he could not stay at home without a good reason and was finally able to admit that his sickness at that time was a second means of withdrawal from the very unpleasant situation. West admitted freely his resentment of the teacher and of the other children in the classroom who were cruel to him, and openly expressed his hatred of them.
4. His situation at home was next discussed. The counselor asked that he talk a little bit about how his mother used to leave him to visit with the neighbors. West quite willingly described, in terms similar to those used before, how he would wake up alone in the morning with his mother gone, how he would play quietly for awhile, then attempt to get breakfast for himself, and finally become panicky, nervous, and very fearful. West readily admitted that he resented very much his mother leaving him like that. He said, "that is no way to treat a child." The counselor asked West if he had ever before been able to admit to himself that he resented and hated, perhaps a little bit, his mother. West said that he had admitted it to himself. The counselor then inquired as to whether he had ever told anyone else that he resented his mother. West replied that he had told one person, the girl with whom he went when he was an instructor in radio school. The counselor asked West to talk to him a bit about his girl, to tell him something about her. West said that they had planned to get married, but that he could not marry her because he could not afford it, since he sent home his allotment to his mother. He said that his step-father had no trade and was in bad health and thus unable to support the people at home. This statement caused some emotion and West cried just a bit. An attempt was first made to find out whether West resented having to give up marriage because of the need for supplying funds to his family at home, but West denied any resentment at all. He then went on to say with considerable show of emotion that he wanted very much to have a home of his own since he had never found security in a home. The counselor reflected this statement of a need for emotional security which he had never before had. An attempt was then made to find out more about the girl whom West had planned to marry, but he became very resistant and refused to talk, saying "there is no use dragging her into this. I don't want to be a burden or a bother to her." The counselor felt that this should not be pushed very hard and returned to questions about his early home life.

5. After West had recounted again his school experiences and made a few observations about his home, the counselor asked if he saw any similarity between the two situations. The counselor interpreted for him roughly in this fashion: that the teacher in punishing him had been cruel to him and had rejected him,
that the students in the school had teased him and had been cruel to him and had rejected him, that his mother, too, in leaving him alone with his fears and need for comfort, had also rejected him. West accepted all of this readily. The counselor then asked West what he had done in each of these situations. West was able to say that he had usually withdrawn, either by going off by himself alone, or by becoming nervous, panicky, and upset.

6. The counselor then asked West to talk about some of his experiences overseas. West recounted landing in France and staying outside of one of the harbors there for several days. This gave him an opportunity to see the terrible destruction of war and the poverty which followed in its train. The counselor pointed out that West could identify himself very well with these impoverished, underfed, and poorly clothed people. West then said with feeling that he could, that he knew what they were suffering. He then said that they departed for England and, after landing at Southampton, took a train to the central part of England. While riding on the train, he noticed that the people were very different, that they were dressed strangely, and that they did not act like the people here at home. The counselor said that they seemed to him to be hostile people, people who might hate him. And then West said, "Yes." The counselor said, "And they were perhaps like the little children in your second grade class, who hated you, and whom you hated." West accepted this statement readily. The counselor then asked West what happened, and he recounted once again how he had gotten sick, with the attendant nervousness, shaking, headache, and other symptoms. The counselor asked him what this meant, but West was at first unable to do more than to say that he had gotten sick. After several minutes of discussion, West came around to a repetition of the explanation of his own withdrawal from the situation which he had given with reference to the schoolroom situation. He said that he could not actually withdraw himself in England and that he had therefore become ill.

7. West then pointed out with considerable insight that he understood how his sickness, his nervousness, and his other symptoms were for him a very real withdrawal from an unpleasant situation, but he pointed out that after a while he began to fear the fear itself. He
feared the possibility of never being able to recover from his symptoms even though there was nothing in the situation to cause him concern.

8. At the point, West symbolically stated the core of his problem by bringing up an allegory which was so bizarre in its content that the counselor felt immediately that it was more significant than one might normally expect, even in a person as articulate as West. The illustration used was as follows: West said that, suppose someone was slashing up his wife. He said that he might be able to live through it once and even a second time, but that if it happened again and again, that after the sixth or seventh time he could no longer stand it and he would break down completely. This was presumably an analogy to the six or seven instances which he had reported in previous interviews as causing him his major breakdowns prior to the last. Since West was not married and since so many of his problems seem to center around his mother, the counselor tried to get further expression and clarification. West continued by swapping the roles of the people involved, saying, suppose I should cut up your wife. You might be able to live through it, stand it, once or twice or maybe more often, but sooner or later, after six or seven times you could stand it no longer and would break down. The counselor then asked, "Why did you say my wife and not my brother?" West hastily replied that it did not make any difference. The counselor thought this topic should be dropped and started to terminate the meeting by checking on the time. When West got up to leave, he broke down into a paroxysm of crying and grief, wringing his hands, and writhing through his whole body. He cried without control for three or four minutes. The counselor felt immediately that the question which clearly differentiated between man and woman in the symbolic illustration used by West was entirely too much for him to accept and that he was terrifically jolted by this unexpected and severe attack upon him. West said in the midst of his sobbing, "There is one way out of it all," and then a moment later, "They will never get me back on board a ship again." The counselor was very worried about the profound depression into which West had sunk and attempted to give him some reassurance, particularly with reference to returning overseas. This reassurance, as might be
expected, had little apparent value. After about ten minutes of talking, mostly by the counselor, West gained some control over himself and stopped crying. An appointment was made for the following Monday at the same time. West left in great depression. The counselor, feeling that he might do himself some harm, phoned his personal physician and requested that someone be appointed to watch him for the next few days.

Comments: West, Eighth Meeting

1. This meeting is an object lesson in the need for patience in counseling, and for sticking to a plotted course. The counselor had felt that the patient was not making as much progress as he should and an attempt was made to speed up therapy. That the session rushed to a traumatic close for the patient (and for the counselor!) suggests that new and uncontrolled factors had been interjected into counseling. There are several points of interest in this meeting.

a. The most obvious is that the framework within which counseling had been taking place was violently disrupted. Instead of the well-structured situation which the patient had come to expect and which he had learned to use to solve his problems, he was confronted with an unpredictable, authoritative, and very demanding situation. His violent reaction at the close of the meeting resulted from an awkward and untimely thrust that could never have occurred in using non-directive techniques. Further, the
patient was caught unawares. Having become accustomed to one attitude on the part of the counselor, the patient's defenses were down when that attitude was suddenly changed. For the counselor to shift tactics is to take unfair advantage of the patient, and possible to retard his progress toward recovery.

b. One of the most significant aspects of non-directive counseling is that the pace of therapy is set by the patient. He is allowed to go as fast as he feels that he can go, and he is not goaded to a reckless speed that threatens disaster. This does not put a brake on therapy, for, with skillful handling, the patient can go very rapidly to the center of his difficulties, under his own motivation and under his own guidance.

c. A danger in directive therapy is evident in the episode at the end of the meeting when the patient allegorically phrased what seemed to be the heart of his problem. Without the least bit of apprehension, without the least awareness of the sensitiveness of the spot he was touching, the counselor blandly made one remark that set off an explosive response, so violent as to result in a threat of suicide. This may conceivably have had therapeutic value, but it was certainly probing at a level far below that on which it had been intended that counseling be done.
2. These comments are not meant to be an indictment of directive therapy. They condemn the shifting of techniques midway in the counseling process, and they set up warning signs for what can happen when directive techniques are used by anyone but the most adept clinician.

3. Recognizing all that was bad, it is still possible that some good came from this meeting. At first it was thought that the counselor's attack on the patient's inner defenses had been so severe that further work with him would have been impossible. The surprising thing was that he came back for his next meeting. The meeting following was, as might be expected, meager in content. The patient was wary, careful, resentful. Little seemed to be accomplished. However, on the second meeting following, the patient showed that he had made much progress in the interim. The wisdom of hindsight suggests that one source of this progress is that the patient, during the course of the meeting now being discussed, did work several seemingly discrete occasions of non-adaptive behavior into a related and meaningful pattern. He wove the rejection, the hostility, the anxiety of his early home life and his characteristic withdrawal by sickness into a pattern with later behavior—in school, in his job, in his Army life. From this recognition of his characteristic modes of response to any threatening
situation, the patient may have gained insight that bore fruit in later disappearance of symptoms and in growth of confidence in his ability to get well.

West, Ninth Meeting, 6 August 1945

1. The ninth meeting with West occurred almost two weeks after the eighth. The counselor was unexpectedly ordered away from the station on temporary duty. A scheduled appointment with West had to be broken, which was unfortunate at this time, in view of the great disturbance which occurred in the last few minutes of the preceding meeting. In order to give him assurance of the concern of the counselor, a note was written, explaining why the appointment had to be broken, and telling West of an appointment with the psychiatrist that the counselor had made for him. The note read as follows:

"I have been ordered out of town for about a week and regret that I will be unable to keep our appointment this morning. However, I have made an appointment for you to see Major Wright on Friday at 1:30. He will be expecting you. I will return next week and will get in touch with you at that time."

2. When West arrived, the counselor explained in more detail the reason for his absence and said that he was sorry that he had to be away when West was feeling as bad as he was at the end of the previous meeting. With his usual deference, West said that he understood and that he really could not expect too much attention. This was interpreted by the counselor (but not to West) as an expression of a desire for pity. The interpretation of his attitude was not pressed openly because the counselor felt that the last session had been rough enough on him, and that a slow pace would be best for a while.

3. The counselor returned to a strictly non-directive technique, perhaps unconsciously showing more concern over West's condition than usual, but consciously trying to demonstrate confidence in his ability to handle his own problems. Responsibility for carrying the meeting was left with West.
4. It was soon apparent that West did not feel like working on his problem. He said that he was still nervous and upset and doubted if he would ever get well. He spoke of his meeting with Major Wright and said that he thought he had a pretty good understanding of his difficulties now, but he was still worried as to what could be done about them. His posture and his speech, as well as his words, pleaded for someone to sympathize with him. He was sorry for himself and wanted the counselor to be sorry for him, too. He was very much like a child wanting someone to love him.

5. The conversation was sporadic, with long periods of silence between patches of speech. The counselor suggested that perhaps West would prefer not to talk today, but would rather come back later to continue to work through his problems. But the decision was left with West, and he did not accept the invitation, preferring to remain with the counselor even if he did not talk. The invitation was repeated later in the hour, and West still could not decide to leave. The counselor pointed out in different ways how dependent West was on him. These interpretations were accepted readily but with a dejected hopelessness.

6. During the hour there were periods of emotional disturbance manifested by quiet crying and a mild wringing of the hands. Little was accomplished on a verbal level, but it is believed that some good accrued from the counselor's acceptance of West in all his misery and self-pity, without blame or admonition to stand on his own feet, and, most importantly, without commiseration.

7. Feeling more strongly than ever the need for West to practice being responsible for his own behavior, the counselor left the next appointment rather indefinite, saying that an hour would be available at 10:00 a.m. on Monday, Tuesday, and Wednesday of the next week, and that West was to come in if he wanted to.

Comments: West, Ninth Meeting

1. From the standpoint of therapeutic theory, this meeting is replete with instruction. First, and perhaps
most significant, is the illustration of the counselor's involvement in the therapeutic process. Not to recognize that the counselor, in any real therapy, becomes intensely concerned on a deep emotional level with the growth of the patient is to remain blind to important dynamic forces acting in the process. It is apparent that the counselor in the beginning of this meeting had very real feelings of guilt, first over having awkwardly gone too far in the preceding meeting, and second, over having left town when the patient needed him badly. The fact that he left on official orders does not fully assuage the conflict. There was a very strong tendency to overdo reassurance, to offer commiseration, to join the patient in his woeful feelings about life. To have done this would have meant to abandon the position that has been the mainspring of the patient's progress to date. To grow in ability to handle his own life, the patient needs to use the solidity of the counselor. The meetings with the counselor must give him, perhaps for the first time in his life, a well-structured, predictable, accepting environment in which he can live and grow normally to a solution of his problems. It is believed that West's pathetic appeals to be treated as a child, to have no
demands made upon him, were a testing of the boundaries of this environment, to try their security. To the extent that he gained reassurance of the strength of the counselor and of the counselor's genuine concern over him, he gained confidence in what he might finally obtain from the meetings.

2. The fact that little progress was made in this meeting attests the difficulty, if not impossibility, of shifting techniques in the middle of therapy, as was done in the last meeting. It is easy to make the transition from non-directive to directive procedures; it is almost, if not wholly impossible to shift back from directive to non-directive procedures. This is another facet of the problem of providing a well-structured counseling situation, discussed above.

3. Interesting observations on the significance of appointments are suggested. An appointment is an obligation willingly assumed by both patient and counselor. It is imperative that the counselor scrupulously live up to his obligation by being ready to see the patient at the appointed time, to the minute. This is one of the non-verbal assurances of the counselor's stake in helping the patient get well, and it adds appreciably to the patient's
security. And the patient's concern over keeping of appointments often reflects the course of therapy. He may even forego another important meeting in order to see the counselor, as West once did, when he missed pay call. Or he may miss or be late for an appointment as a result of hostile feelings toward the counselor, perhaps engendered by unskillful treatment. On the other hand, appointments may sometimes have to be broken, and the breaking of the appointment may have therapeutic value if the incident can be shown to be a legitimate demand on the counselor's time that should properly take precedence over the demands of the patient. The patient should be helped to use the situation as one of the realities which he must be mature enough to accept.

West, Tenth Meeting, 15 August 1945

1. West came in on the last day of the three suggested days, at the appointed time. He was calm and smiled freely, without tension. He said that he felt much better than he had been feeling, and that he thought he was really considerably better than he had been in a long time. The counselor got the impression of one who had had a bad experience from which he had rebounded with strength and vigor. West said that he had been sleeping well and that he had been enjoying participation in the convalescent activity program. He said with very real concern that he hoped that he might never have to go back overseas, that he simply could not stand it. But this expression of concern over a possible overseas assignment was not fraught with the terrific anxiety that had always accompanied it before. West seemed to handle his feelings with some assurance that he was master of them and not they of him.
2. He told the counselor that he had gone to one of the dances for enlisted men and their guests which had been held a few evenings before and that he had gotten a "boost" out of it. He said that it was hard for him to make himself dance for he was "not much of a hand at it," but that he did dance several times and enjoyed it. The counselor congratulated him on seeking social contacts.

3. West then for the third time asked the counselor what he thought about the possibility of getting a furlough. The counselor replied that he was sure that his Personal Physician would grant him one if asked for it. Then the counselor said, feeling almost wholly confident that the suggestion would be rejected, "You would like me to make the decision as to whether you should go or not?" West smiled and said, "Oh, I see what you mean. No, I would like to go, and it is one of those decisions that I have got to make." The counselor then asked how he felt about going back home to see his family, particularly his mother. Though he had been content, even desirous of remaining in the hospital without going home for over two months, West now said that he would like very much to see them and that he thought a furlough would do him a lot of good. The counselor agreed to talk with his Personal Physician and make the recommendation that the furlough be granted.

4. West was then asked if he realized the significance of his request to go home, and he replied that he guessed he did. The suggestion that the meetings were coming to an end caused some mild anxiety and West asked what would be done with him when he returned. The counselor asked "Well, what do you think should be done?" West replied that he would like to come back and stay around a few weeks to see if he really felt all right and then go back to duty, somewhere, but not overseas. The counselor reflected the presence of both the fear of another overseas assignment and the confidence with which he looked forward to his furlough and to another assignment in this country. West accepted this reflection of his feelings.

5. A good bit of thinking had been done by the counselor as to what would be the best disposition to make of West when he had gotten all the god that he could out of these meetings, and the problem had been discussed with Major Wright. It was felt that West should be returned
to duty if possible, but that this should be done only if he could be given a job in which he could find some security, and which would not stir up all of the feelings of inadequacy that have dogged him all of his life, and which he now had begun to get under control. Tentative arrangements had therefore been made for West to be assigned, on dismissal from the hospital, as an instructor in the radio shop in the convalescent program. There he could do the type of work in which he had found security before going overseas and he could maintain casual contact for a somewhat longer period with the counselor. This prospect was then presented to West and he responded enthusiastically, even with some incredulity that the Army could take such personal interest in him after he had left the hospital. West was told that every effort would be made to get such an assignment for him, but that he must not count on it too heavily, as things sometimes could not be worked out the way we might want them.

6. Before leaving at the end of the hour, West made an embarrassed attempt to thank the counselor for his help. The most significant aspect of this seemed to be, not the expression of appreciation, which was obviously very sincere, but the recognition on West's part that he had come to a critical point in his relationship with the counselor and that he was ready to break off the relationship, on his own initiative.

Comments: West, Tenth Meeting

1. The patient's condition in this meeting stands out in bold contrast to his condition in the last meeting, a week previously. Then he was depressed, dependent, miserable, inadequate and aware of being inadequate. At this meeting, he was relatively calm, poised, independent, purposeful. What has happened to cause this sudden change? Following are speculative suggestions:
a. The transformation may be explained as evidence of the cyclical nature of growth through therapy, which has been commented upon previously. Following an unproductive session, there is often a richly productive session.

b. It may be, and this seems to be a more satisfactory explanation, that the effect of therapy is cumulative, that sudden progress may occur as a result of an integration of materials developed in many previous sessions, with accompanying deepening of insight and reinforcement of assurance.

c. It suggests also the important concept that therapy occurs outside of the counseling sessions, as well as during these few scattered hours of work with the therapist. To each new session, the patient may bring the yield of previous sessions, plus new content that has grown from his day-by-day reflections and from his experiments in making more mature responses in daily life.

d. Or, again, there may have been some current but unrecorded incident in the patient's life that gave him a substantial boost, that strengthened his confidence in himself. If this is true in the present instance, then it may be said of therapy that it at least had made the patient capable of reacting to such support.
e. The patient was also routinely participating in the convalescent activity program which was doubtlessly having a beneficial influence.

2. If non-directive techniques of therapy have been followed fairly well (which cannot be said of the entire handling of this case), the problem of terminating therapy is seldom a difficult one. The patient gradually loses his need for the counselor, and begins to want to be independent of him. He wants to be on his own, and because counseling has helped him free himself from his neurotic need to be dependent, he feels free to break off the relationship. Throughout counseling this prerogative has been honestly left to him, so that he may withdraw from his dependence on the counselor with no attendant feelings of guilt, at a time of his own choosing. Naturally, the first steps at withdrawal are hesitating ones. In this instance, the patient indicated his desire to be on his own by suggesting a furlough and by thanking the counselor for his help, the obvious implication being that the help had already been given and was needed no more.
West, Eleventh Meeting, 10 September 1945

1. About three weeks later, after his return from furlough, West came in on his own initiative to see the counselor. His appearance was strikingly different from what it had been when he first reported for help almost three months before. He carried himself better, he wore his clothes with more care, and his walk showed no signs of the utter despondency that was reflected in his every movement when he first came to this hospital. He smiled warmly as though he was very glad to see the counselor.

2. The counselor said, "Well, West, what kind of a time did you have at home?" West replied, "I had a real good time, about the best time, I guess, that I ever had. I believe I am on my feet again, now." West seemed to be just about as happy as is able to express, not exuberant, which would be very unlike him, but timidly happy and much more confident of his regained strength than he had ever been before. He said "I would like to know what is going to happen to me next so that I can plan." The counselor diverted this question for a moment by asking West to tell him something about his experiences at home. This West started to do immediately with very apparent satisfaction to himself.

3. West first said that he had spent more time at his home than he had ever done before when he was on leave or on a vacation when he was still in civilian life. It seemed good for him to be there. On specific inquiry about how he got along with his mother, West said that he enjoyed being with her very much. He evidenced normal affection for his mother with no apparent feelings of guilt about the hostility which he had expressed in previous meetings with the counselor, and also with no evidence of undue dependence upon her. It seemed to the counselor that he had made quite significant strides forward in achieving a more mature relationship with his mother.

4. This same evidence of growth was reflected in his discussion of his brother. He said that he spent a great deal of time with his brother and that he enjoyed it very much. In contrast to a previous statement of disappointment arising over the fact that his brother had failed to
ask him to go into business with him at one time in the past. West now reported that he had turned down a similar offer made by his brother. Although he spoke in glowing terms of admiration and respect for his brother, telling an anecdote about how his brother had handled a particularly difficult problem with a customer in his business, West still felt that he did not want to lean on his brother but that he wanted to be more on his own. The counselor interpreted this new feeling of independence and West warmly accepted the re-statement of his feelings.

5. On his own, West brought up the subject of his girl friend. Without prompting, he told with considerable pleasure of how much he had enjoyed being with her. He said that they had been together for over a week, and that it had meant a lot to him. He said that they had gone to several movies together, that he had taken her to dinner a couple of times, and that he had rented a car and gone driving with her in the city. The counselor cajoled West a bit about driving in a city and West accepted this recognition of his achievement with satisfaction. He said, with some embarrassment, but also with very real pride, that he planned to marry her if he could talk her into it. The counselor said, "Do you think you can do it?" and West replied, "I am pretty sure that I can, with a little time."

6. The counselor asked if West thought he could support a wife, and West, of his own accord, brought up the problem of his step-father, who is ill and unable to support a family. West thought that he would have to continue to contribute to the support of his mother but that he hoped to be able to work it out so that he could get married also. It was impossible for the counselor to determine whether he accepted this responsibility as an unjust burden, as a realistic responsibility which he must meet as a mature person, or as a means of escape from the actual undertaking of responsibilities entailed in getting married. This point was simply not settled. However, he evidenced no particular feeling toward his step-father, which has been characteristic of his attitude toward him as expressed in all of these meetings.

7. West then said that he had visited the company with which he was employed just prior to going into the Army. He said that he found his old boss there and enjoyed talking to him very much. The company told him that his job was waiting for him and that he could take it at
any time. This evidence of their confidence in him apparently gave him great satisfaction. The counselor tried clearly to identify the boss of whom West spoke and learned that he was the one older man in West’s life who had given him the support that he needed, acting somewhat in the role of a father. West said that he could never really be a father to him because he was too slow and not ambitious enough, but that he was the only man who had ever understood him. Apparently this relationship is a very solid one and one which may be depended upon to give West a considerable amount of security when he returns to civilian life.

8. Having elicited a great deal of very satisfying information about West’s furlough, the counselor turned to the problem of disposition to be made upon his discharge from the hospital. While West was on furlough, the radio shop in which it had been hoped that he could be employed, had been closed, making it impossible to obtain a suitable assignment for him on this station. Recognizing the possibility of mal-assignment or of long periods of waiting in replacement pools if West were reassigned to duty, it had been agreed with Major Wright that West should be given a discharge on medical grounds. In the interest of the Army, of the country, and of the patient, it seemed desirable to get him back into civilian life just as soon as possible. The information gained in this conference about the status of his job and the possibility of obtaining real support from his former boss made this decision appear most sound. West accepted the proposal that he be discharged for medical reasons with very real understanding of his condition. Although he recognizes that he has made great progress during the course of treatment at the hospital, he is also fully aware of the limitations under which he still must labor. He accepted the suggestion of a discharge as an opportunity for him to return to civilian life to continue the process of adjustment which has been started here.

9. At the end of the meeting, just before leaving, West asked the counselor if he lived in Ohio, and said, "I would like to know how I could get in touch with you again if I ever wanted to." The counselor recognized the feeling expressed and tried to interpret its significance by saying, "I think I understand how you feel. We have had a pretty close relationship, and you would naturally
like to see me again, as I would like to see you. But think about it. Do you think it would be best for you to depend on seeing me in the future?" West replied, reflectively, "Well, I know what you mean. I would like to be able to see you, but I guess that's not best for me. I've got to stand on my own feet. It's the thing we have talked about all along. I must be on my own, from now on."

Comments: West, Eleventh Meeting

1. Few cases so objectively validate the efficacy of psychotherapy as does the case under discussion. There is no need to depend solely on the judgment of the clinician that the patient has improved. There is abundant behavioral evidence of his improvement in the account of this meeting as compared with accounts of earlier meetings. The patient reports that while on furlough he did, almost casually, a number of things that he has never been able to do before in his life without a trying struggle. He took his girl to dinner, he took her to a movie, he drove an automobile in a big city, he turned down an offer of a business relationship with his brother, he readily made contacts with people at the company for which he formerly worked. He is not well, but he is patently a healthier man.

2. Of importance for theoretical considerations is the fact that there was no need for a prolonged de-conditioning process with reference to each of the specific situations which had formerly set off an intense anxiety
reaction. The most economical explanation of the altered response to situations which were formerly anxiety-producing is that the patient himself has changed and that he, consequently, no longer perceives these situations as hostile to him.

3. Psychotherapy has often been called a dull, slow-plodding, and vexing endeavor, productive of meager results. Many capable psychologists and physicians have avoided it as an unrewarding undertaking. By comparison the cures effected by surgery or chemotherapy are often dramatic, appealing. But such comparisons give undue emphasis to the difference between living and dying, or between vigorous health and impaired health. They undervalue the distinction between living in happiness and living in misery, or living with a longing for death. To aid a person to free himself for full enjoyment of life is surely not a meager accomplishment, is surely worthy of the efforts of many more psychologists, doctors, social workers—particularly in view of the widespread need for such assistance.

4. The progress which this patient made cogently attests man's abundant capacity for growth to a more satisfying way of life. Confidence in the ability of individuals to master their problems can be, to both the patient and the counselor, a source of great encouragement.
West, Twelfth Meeting, 20 September 1945

1. Arrangements were made for West to be given a medical discharge. About ten days after the last meeting, West came in to tell the counselor that he would soon come before the dispositions board. He appeared calm, not as happy as he had been during the meeting just following his furlough, but still composed and relatively confident of himself. He talked freely and easily with the counselor, with no evidence of the tension that marked earlier conferences. He seemed genuinely to anticipate his return to civilian life.

2. After a brief discussion of his plans for clearing the station, he said that he intended to go right to work when he returned home, taking only enough time off to buy clothes, to get his insurance straightened out, to see what his income tax situation was, and to get his car out of storage. These evidences of planning were particularly satisfying to the counselor as indicative of an ability to assume responsibility that West could not possibly have achieved when he arrived, distracted and despondent, at the hospital.

3. The counselor asked West to think back over his recent past, to think of the days just before coming into the Army, to think of the time when he was assigned in the Army as a radio instructor, of the weeks following his return from overseas, and of the present, and to describe the condition he was in during each of these periods. West grasped the significance of the request and, with evident pleasure, tried to summarize how he felt during each of these periods. He said, after listening attentively, "Oh, yes, I see what you mean. Well, that job (referring to his last job prior to entering the Army) did me a lot of good. It gave me a chance to meet the public, and I was getting along very well, when I was drafted. I was given tests and sent to radio school, but I was grounded because of my eyes, and they made me an instructor. At first that worried me, but I soon began to like it, and after a while I felt really good. That lasted a long time. I was on top of the world and I could lick anything. Then I was put on shipping orders and got to England. That was awful. I could not stand that. I could not stand that again, ever. I have got to stay in this country. I'll never leave it again. When I got back
from overseas, I still felt awful. I could not get hold of myself. But now, after staying here, and this furlough and all, I feel pretty good. I've got to go out and go to work, and I've got to meet people. I know what my problems are, I understand them, and I've got to work on them. The counselor asked, "Well, how do you feel about them, do you think you can lick your problems?" And West replied, "Yes, sir, I can do it. I am pretty confident that I can."

Comments: West, Twelfth Meeting

1. A limitation to non-directive counseling became apparent as the case was brought to a close. Part of the economy of this approach to therapy is its limitation to currently felt problems. It may be called the therapy of "Now." The past experiences of the patient are considered significant only as they impinge upon the problems which he currently feels to be of importance to him. That a patient is capable of putting his finger on present, tension-producing conflicts that will be evident time and time again in using this technique. But, unfortunately, the patient may not be able to go to the heart of the problems that are nicely sealed off in his present life situation. Sometimes these problems may be expected, with much confidence, to be a source of difficulty, if not of disaster, in the future. For instance, in the case here under discussion, there has been no real exploration of problems of sexual adjustment. The problem has
been but indirectly touched upon by the patient. It is evident, however, that he has deep-seated sexual conflicts, of which he is hardly aware on a conscious level.

The presence of underlying sexual conflicts was strikingly evident in the patient’s Rorschach and Thematic Apperception Test records. Of four responses on a meager Rorschach, three had sexual content. All of the T.A.T. pictures which could in any way be associated with sex were designated by him as being either "wrong or sinful" or "unpleasant."

The issue for counseling seems to be this: The patient shows evidence of sexual conflicts, the significance of which he is unaware, but which may be expected to cause trouble in the future. Marriage to him is a haven of refuge, a hope for security; sexual relations are bad, immoral, and unpleasant, and probably sinful; he plans to try to get married. He is unaware of a problem at the present time, because his moral code is stringent, it conforms to the moral code expected of him, and he is living by it now. How he will adjust to sexual demands in the future is patently conjectural, but on the basis of all clinical evidence, the prognosis is not good. All that counseling has given to him is an increased ability to meet new problems. One can only hope that there will be sufficient transference.

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See Appendix A.
to the specific problem of sexual adjustment to tide him over difficult times, or that counseling will be available to him when these problems become current, when they are problems of "Now."

**Summary.** There has been presented in this chapter a detailed study of the process of individual psychotherapy, given to a patient who was profoundly disturbed by his war experiences. An essentially non-directive technique was used, with perhaps more interpretation and directing throughout the series of meetings than would be approved by therapists who follow closely the precepts of non-directive counseling. In one meeting, the non-directive technique was abandoned in favor of a carefully planned (though perhaps ineptly executed) attack on some of the core problems of the patient, with an attempt to direct the patient to an understanding of the patterns of inadequate responses to certain types of situations reappearing throughout his life history. The rather violent reaction of the patient to the probing of the therapist indicated some of the difficulties involved in shifting techniques in the middle of the course of treatment. The treatment of the patient proved to be fairly successful, as evidenced by his ability to do, casually, during a visit to his home,
a number of things that he had formerly not been able to do without a struggle and much attendant pain. But a possible limitation to non-directive techniques is indicated in the failure of the therapist and the patient to get at an obviously important determinant of the patient's difficulty. No exploring of his sexual conflicts grew from the technique used, though the presence of such conflicts was not only evident to the therapist but was also revealed by Rorschach and Thematic Apperception Test results.

Individual treatment for this patient seemed necessary, as indeed it was necessary for many patients in the hospital. But individual therapy is expensive of time and talent, and other techniques were sought to give maximum help to patients who needed help. Group treatment offered a means of extending fairly intensive therapy to a greater number of patients, and, at the same time, of utilizing some of the therapeutically positive factors in group situations which are absent in individual therapy. In the following chapter, efforts to make psychological treatment more effective through group techniques will be discussed.
CHAPTER IV
TREATMENT OF PATIENTS WITH ANXIETY REACTIONS THROUGH GROUP PSYCHOTHERAPY

Introduction

The Problem. Psychiatric casualties in modern warfare are great in number. The citizen soldier, torn from his accustomed pattern of life, is subjected to an increasingly strange, irrational, and demanding new existence, in which he is expected to learn rapidly not only new ways of doing things but new ways of evaluating the consequences of his behavior. To sit and wait for endless, purposeless days; to forget sleep and creature comforts for weeks of unrelieved exertion; to destroy; to kill; to endure the sight of death, starvation, and ravaged earth; to know aloneness; to feel rejected by his own group; to lose a close friend and be haunted by a festering sense of responsibility for his death; to live in constant fear of death and of that fear being found out--these and myriad other demands are almost casually made of men in war. Apparently many men go through the experience with little overtly evident hurt to their personality. Others disintegrate to a point almost beyond hope of recovery. But a large group suffer greatly yet preserve enough strength to augur well their return to fairly
adequate adjustment. It is with this last group that the work here to be described was done.

These men wore the somewhat vague diagnosis of "anxiety state," a description that was tempered by the euphemisms "operational fatigue" or "combat fatigue." Their symptoms were legion, but they fell into a recognizable pattern—loss of appetite, upset stomach, inability to sleep, dreams of combat, nightmares, feelings of intense and irrational hostility, irritability, tenseness, jumpiness, heart palpitations, excessive sweating, desire for whiskey, sexual excesses, sexual impotency, tics, feelings of futility, despair, and bitterness, and many others. The prognosis for most of the men was good. It was believed that their condition was temporary, that many would, on their own, work back to a scarred but fairly normal way of life. It was believed that their recovery could be speeded by psychological help.

However, the facilities for giving such help were limited. Psychiatrists were overburdened with cases and were needed primarily to care for men with more deeply seated difficulties. Group psychotherapy offered a means of reaching more patients, of spreading further the psychiatric and psychological talent that was available. The problem is expressed well in an official War Department publication:
Individual treatment of large numbers of psychiatric patients in the Army is not possible, however, because of the need for rapid disposition and the limitations of time and personnel. Valuable as recreational and occupational therapy activities are, they are in themselves insufficient to meet fully the problem of rehabilitating the psychiatric casualty. The need for treatment can be met in part by a method which permits the handling of more than one patient at a time. . . . Experience with group psychotherapy has been sufficiently successful to warrant its recommendation for use in the Army as a partial solution to the problem of rendering more adequate treatment to the psychiatric casualty. (38)

In the directives which guided the work of the Psychological Services Branches, provisions were made for meetings designated "Personal Adjustment Group Conferences." These conferences were defined as "a series of talks and discussions conducted to assist the patient to understand and revise unwholesome attitudes which generally accompany the mental or physical illness causing hospitalization." Patently this was a vague and general statement, and much could be done, or not done, within its boundaries. The plans for the conferences were made more specific at the Cochran hospital with two goals in mind. The first was to strive for maximum therapeutic effectiveness in the meetings, even though the numbers of patients treated had to be limited. The second was to study systematically the
process of group therapy in order to arrive at some dependable generalizations about the dynamics of this type of treatment.

Group psychotherapy was a fairly widespread method of treatment in the Army, Navy, and Marine Corps. There are a number of reports on group therapy which grew out of experiences in the services, as well as a few accounts of group treatment in civilian practice. Most of these reports are characterized by enthusiasm and vagueness. The use of various techniques is advised, and there are sundry explanations of the psychological processes involved in group therapy. But nothing could be found by way of a systematic analysis of group psychotherapy sessions. The literature is rich in valuable suggestions but these remain in the nature of hypotheses, albeit customarily stated with more assurance than is implied by the term. Two directions of attack seemed indicated to provide a research basis for generalizations about group psychotherapy. The first of these was to develop a method of analyzing individual sessions in order to identify and obtain a quantitative expression of the various processes operating in this type of treatment. The second was to determine, by at least a rough experimental procedure, what therapeutic techniques would be most effective in
group work. The quantitative method of analysis would provide a tool for a more accurate description of the experimental sessions.

There seemed to be available two techniques for conducting the meetings. In one of these techniques, which may be called a "directive" technique, the group leader presents prepared lecture materials during the first part of the hour and then encourages discussion of these materials and related topics for the remainder of the hour. The lecture materials should be germane to the needs of the group and should be usable by members of the group in developing insight into their problems. In the other technique, which may be referred to as a "non-directive" technique, the group leader attempts to stimulate discussion of problems which are of immediate concern to the group and seeks to assist the members of the group in developing from the discussion some insight into their problems. Other descriptive terms which might be applied to the two techniques are "deductive" and "inductive." In the former, the group leader presents general principles of human behavior and encourages and assists the group members in drawing specific application of these principles to their problems. In the latter, the group leader encourages first a discussion of the specific problems of
the members of the group and assists them in developing for themselves somewhat more general principles of value in understanding themselves. But none of the above terms has proven to be wholly satisfactory. Certain rigidities of thought encumber these words because of their previous use in individual therapy and mental hygiene. It was thought undesirable to impose these words or similar restricting terms upon the two techniques to be employed in this exploratory investigation of group psychotherapy, at least until much more experience has given richer understanding of each technique. Perhaps later it will be possible, and unhampering, to find appropriate descriptive terms.

It was, therefore, decided to refer to the techniques, respectively, as the "X Technique" and the "Y Technique." An attempt to define these techniques rather precisely is made, with the full knowledge, however, that additional experience is actually conducting groups will doubtlessly alter and add to the concepts employed in the definitions, demanding redefinitions.

Using the X Technique, the group leader plans sessions, presents materials, and leads the discussion. The content of the sessions is largely factual, intellectual, and systematic. Content is given order and sequence by the
logical arrangement of subject materials. The method operates by teaching modes of adjustment by giving intellectual insight. It involves encouragement, reassurance by authority, and reinforcement of constructive activity by group approval. It stresses the need for transfer to day-to-day practice the principles recognized as healthy in the conferences. It stresses the individual responsibility of each patient for his own behavior, for his choices, and for his recovery, but the nature of the technique limits this to instruction on a verbal level, and to admonition and precept. It recommends the manipulation of his environment by the patient, as by planning a program of activities requiring social participation, by better vocational or educational planning, by avoiding situations which experience has shown to lead to conflict, and by similar techniques. It attempts to remove symptoms by an explanation of the nature of conflicts of which symptoms are the somatic or behavioral manifestations. It removes debilitating guilt feelings by the recognition that other patients are suffering from similar difficulties and by reassurance that such symptoms are the normal results of continued strain. Finally the technique ensures positive motivation to get well by setting up and stressing the importance of new goals that are healthy and socially acceptable.
Using the Y Technique, the group leader structures the sessions, defines the areas of permitted discussion, encourages participation, accepts without blame or censure the feelings expressed by the group, and reflects and interprets for the group the feelings expressed. The content is largely personal, emotional, and nonsystematic. It is given order and sequence by the personality structure and the emotional needs of the group members, including the group leader. It has a spontaneity not likely to be found in more formal meetings. The technique hopes to achieve insight through interpretation of freely expressed feelings arising from basic conflicts, and stresses the reorganization of emotional life in order to free the patients for normal affective satisfactions. It demands that the patient gain reassurance and confidence in himself through conviction carrying experiences for which the patient himself is responsible. It stresses the group conference itself as a social situation so structured as to make possible the immediate expression of constructive feelings. It stresses the individual responsibility of each patient for his own behavior, for his choices, and for his recovery, but an awareness of this responsibility is engendered by the manner in which the meetings are conducted rather than by admonition. The technique is not concerned with
symptomatology directly but seeks to remove symptoms by a basic reorganization of patterns of feeling. It removes debilitating guilt feelings by the recognition that other patients are suffering from similar difficulties and by acceptance by authority without blame. Finally, the technique ensures positive motivation to get well by reliance on the great capacity for healthy emotional development present in most if not all people when basic sources of conflict are resolved. The two techniques may be compared, point by point, in the following summary:

**Technique "X"**  
("Directive," "Deductive")

1. Group leader plans sessions in detail, presents materials, and leads discussion.

2. Content is largely factual, intellectual, and systematic. It is given order and sequence by the logical arrangement of subject materials.

3. The level of therapy is likely to be superficial, tuitional, normative, and rational.

4. The technique hopes to achieve insight through intellectualization.

**Technique "Y"**  
("Non-Directive," "Inductive")

1. Group leader structures sessions, defines areas of profitable discussion, encourages participation, and verbally interprets feelings expressed by group members.

2. Content is largely personal, emotional, and non-systematic. It is given order and sequence by the needs of the group members.

3. The level of therapy is likely to be deeper, personal, and non-rational.

4. The technique hopes to achieve insight through free expression of feelings arising from basic conflicts.
5. The technique may encourage sublimation as a means of resolving conflict.

6. The technique may involve reassurance by authority, encouragement, reinforcement of healthy activity and feeling by group approval.

7. The technique would stress the need for transfer to day-to-day practice of the principles recognized as healthy in group conferences.

8. The technique would systematically explore the etiology of behavior disorders in general.

9. The technique would stress the individual responsibility of each patient for his own behavior, for his choices, and for his recovery, but the nature of the technique would limit this to instruction on a verbal level, and to admonition and precept.

10. The technique would recommend the manipulation of his environment by the patient, as by planning a program of activities requiring social participation, by better vocational or educational planning, by avoiding situations which experience has shown to lead to conflict, and by similar techniques.

5. The technique would stress the reorganization of emotional life to free the patient for normal satisfactions.

6. The technique would demand that the patient gain reassurance and confidence in himself through conviction carrying experiences for which he himself is responsible.

7. The technique would stress the group conference itself as a social situation so structured as to encourage the immediate expression of constructive feelings.

8. The technique would give emphasis to the currently felt problems of the group.

9. The technique would stress the individual responsibility of each patient for his own behavior, for his choices, and for his recovery, but an awareness of this responsibility would be engendered by the manner in which the meetings are conducted rather than by admonition and precept.

10. The technique would consider the immediate reorganization of the patients' basic feelings as more important and as prerequisite to the successful use of intellectually conceived activity programs.
11. The technique would remove debilitating guilt feelings by the recognition that other patients are suffering from similar difficulties and by reassurance by authority that symptoms are the normal results of conflict.

12. The technique would ensure positive motivation to get well by setting up and stressing the importance of new goals that are healthy and socially acceptable.

11. The technique would remove debilitating guilt feelings by the recognition that other patients are suffering from similar difficulties, and by acceptance by authority without blame.

12. The technique would ensure positive motivation to get well by reliance on the great capacity for healthy emotional development evident when basic sources of conflict are resolved.

As here outlined, the antecedents of the two techniques are fairly clear. Army practice has traditionally favored the X technique, and most of the publications describing group psychotherapy in the Army refer to a talk prepared by the group leader and to the discussions which are expected to follow the talk. Recommended topics, such as "The Role of the Unconscious," "The Role of Fatigue," and "Explanations of Symptoms in Terms of Conditioned Reflexes," suggest the flavor of the traditional approach. The Y Technique finds precedent in the work of Allen and Rogers (1, 38, 47) in individual therapy and of Slavson in group therapy, although there may well be areas of strong disagreement. The opposing directions of the two techniques, however, are unmistakable.

The procedures of conducting sessions of these two types, the method developed for analyzing the records of the conferences,
and the tentative conclusions drawn with reference to the processes involved in group psychotherapy will be summarized below.

**Procedure**

**Selecting the Groups.** Following the suggestions of previous workers in group psychotherapy, it was decided to limit the size of the groups to a maximum of ten patients, with seven or eight being sought as an optimum number. To have made the groups much larger or smaller would probably have been to extract from the situation some of the most important elements of therapy in groups, among which is the factor of establishing strong feelings of group identification among several individuals of approximately similar difficulties.

Using all available information on patients, which included scores on various tests, a fairly complete case history, and the admitting diagnosis, a number of men were selected for possible participation in the conferences. Participation was limited to patients with a psychiatric diagnosis of anxiety state. Severely disturbed individuals and individuals with a life history of maladjustment, who were in most instances undergoing intensive individual therapy, were excluded. Also excluded were patients who
were so negative to the entire hospital program that their
treatment by group methods might profit little. Patients
with low Army General Classification Test Scores were ex-
cluded on the grounds that the progress of the groups
would suffer from their verbal deficiencies. Finally a
few men over 35 years of age were excluded in order to
make the groups relatively homogeneous as to age. Fol-
lowing a preliminary sifting on the basis of records,
patients were called in for individual interviews with
the psychologist who was to be the leader in the group
being formed. Further eliminations were made to meet
the criteria suggested above and to omit the names of
men who were to be transferred from the hospital. In
total, every effort was made to ensure that the men
selected would be responsive to group therapy.

The individual interviews prior to the first meeting
were also used to establish a preliminary relationship of
cordiality between the patient and the group leader. This
was considered important to counteract the tendency in an
Army situation for members of groups rather readily to
identify with one another against whatever symbol of
authority is most available for opposition. It is impor-
tant for the men to have some identification with the
group leader as well.
When selected, patients were scheduled for meetings of one hour's length twice a week. Patients were assigned at random to "X type" and "Y type" groups.

The Meetings. The meetings were held in a small room which was comfortably furnished with easy chairs, a rug, a couple of small tables, lamps, draperies, and water colors of pleasant character. Though far from sumptuous, the room was nevertheless in favorable contrast to the barracks, the day rooms, and the recreation halls available to the patients. It was a pleasant place. A not too formidable blackboard was available for the leaders of type X sessions.

The meetings in which the X Technique was used were not unlike some college classes. The leader talked informally, either standing or sitting with the group, but he followed a prepared outline. Topics believed to be close to the interest of patients were selected, such as "Symptoms of Operational Fatigue and Their Causes," "The Nature of Emotion," "Guilt Feelings," and so on. The talks were made as interesting as possible, with frequent use of case records from other hospitals. The language used was simple and non-technical. The aim was to relate general psychological principles as closely as
possible to the experiences which the men in the groups had had, and to do so in words that they could understand and accept. Interruptions of the talk were permitted, and they occasionally occurred. However, the general pattern was to take up a little more than half of the hour with the prepared talk and to use the latter part of the hour for discussion.

Group leaders employing the Y Technique, on the other hand, kept their remarks to a minimum. At the beginning of the initial session, several minutes were taken by the group leader to explain the purpose of the meetings and to indicate that the members of the group would be free to talk about anything they desired. The suggestion was given that this talk should be to a purpose, that greater understanding of their difficulties should emerge from the discussions. Freedom to participate or to refrain from participation was explained again, though regular attendance was expected. Occasionally leading statements were made, such as "Well, what's on your mind today, Williams?"

In most instances, patients responded readily to the invitation to talk about themselves, and the talk ranged from the traditional Army pastime of griping about the "chow" to a serious reflection on the causes of their difficulties.
Although the ebullient G.I. humor was fairly frequent in these sessions, seldom did the group stray from the purpose of the meetings. In some instances, the group leaders introduced case histories or interpretations of the topic under discussion, and these went to the length of several minutes of talk. However, the materials introduced always grew out of the immediate discussion.

It should be pointed out that neither of the above techniques was "pure" in its application. The personalities of the leaders involved mitigated against the employment of the authoritarian methods suggested by Technique X, and against the passive role that might be implied by Technique Y. For instance, in the former groups, there were digressions for the spontaneous discussion of ideas advanced by the patients, and in the latter groups, the leaders often encouraged the less aggressive members of the group to express themselves. In general, however, it is believed that the actual conduct of the two types of sessions followed with due faithfulness the predetermined plans of action.

The meetings were attended by an "observer," an enlisted man who was assigned to the Psychological Services
Branch and who had had some training in psychology. The observer sat quietly and did not participate in the discussions. He listened carefully and attempted to arrive at an estimate of the effectiveness of each meeting, with particular attention being paid to the participation of each individual patient. His presence did not seem to inhibit the members of the group, who accepted him casually.

Records of Meetings. Provisions were made for obtaining a verbatim transcript of the conferences. A microphone was concealed in the conference room, and plastic-disc recording machines were installed in an adjacent private booth. Typed transcripts were made from the records, the manuscripts being checked for accuracy by the group observer. Having been present during the meetings, the observer was able in most instances to identify with no difficulty the voices of the patients. A system for noting the sequence of statements made by patients during the conference was worked out in order to facilitate the identification of the voices on the recordings, but this proved to have been an unnecessary precaution. Parts of sentences were lost during the changing of the records, and voices were sometimes drowned out by the noise of a passing truck or airplane. However, the procedures for recording were considered to give quite satisfactory results.
In addition to the phonographic record of each of the meetings, it was standard operating procedure for the leader and the observer to prepare, independently, a resume of the events of each meeting. This resume included a brief sketch of the behavior of each patient during the meeting and an evaluation of his progress from meeting to meeting.

The Scoring Technique

The scoring procedures employed were built on an empirically established framework. It would conceivably have been possible to translate the constructs of some particular school or system of psychotherapy into a series of descriptive categories which could then be used to label each of the statements occurring in group conferences. It was felt, however, that such an approach would too much prejudice the scoring. It might possibly require that the meaning or feeling of a statement be warped to fit a prefabricated mold, with the result that the systematic summary of the events in the conferences would be distorted, in total. The decision was made to start from the type-scripts and to build a scoring procedure that would best reflect the conferences studied.
The typescripts of several preliminary conferences, which are not summarized in the data reported in this chapter, were examined. An attempt was made to find some descriptive word or phrase that would rather precisely define the process that was implicit in each of the statements made by the group leader and by each of the patients. Since the goal of the analysis was to achieve a better understanding of therapy, the emphasis was on process rather than on content. The critical question applied to each statement was "What is its function, its purpose, its significance in the situation?" No attempt was made at first to couch these descriptions in psychological terminology; the effort was to get clear meaning in simple language.

This procedure resulted in a long list of terms, totaling to some 70 items. Since a system of classification so discrete would have served not much better purpose than the transcripts themselves, a series of more inclusive categories was sought. This series was arrived at by combining like-terms into larger units and by setting up categories descriptive of the psychological processes implicit in many superficially dissimilar items. Thus the category "hostile-aggressive" was found to embrace many seemingly diverse statements made by the patients. At this point,
guidance from established viewpoints in psychotherapy was followed to obtain the most meaningful terms for some of the categories. These terms were drawn for the most part from the work of Rogers, though many other clinical concepts were employed. The point which should be stressed is that the categories finally agreed upon were solidly anchored to the materials which were to be described and that they were not pre-established categories into which the materials were to be forced.

The method of arriving at the categories which are used in the following analyses is here described in some detail by way of caution to those who might desire to employ a similar technique for analyzing other records of group psychotherapy. The members of the groups studied were patients in an Army convalescent hospital, and the group leaders were Army officers. These circumstances may limit the applicability of the specific categories employed, and other categories may be required, in other similar studies. But the basic technique and the categories finally used are believed to have ample validity for the group studied, and basically for other groups as well.
Describing the Statements of the Group Leader. The statements made by the group leader were relatively easy to describe, and appropriate categories were readily established. These categories are given below, along with a brief definition and an illustration drawn from recorded conferences. In each instance the abbreviation used in the scoring is given.

1. **Directing Statements** (DIR) are defined as statements which serve to steer the discussion in the direction desired by the therapist. Statements are scored as directing even when they do not introduce new topics, but simply direct further discussion concerning a topic already under discussion. All probing statements are scored as directing. Illustrations of directing statements are:

   Leader: Can you see any reason for this, White, any reason for the way the hospital is operated?
   
   . . . . . . . . . . . . . . . . . . .

   Leader: Well, how many different kinds of resentment have you expressed today? Let's total up. What are your complaints, Patrick?

2. **Accepting Statements** (ACC) are defined as responses reflecting an attitude of permissiveness. They demonstrate the non-authoritarian attitude of the group leader and assure
freedom of discussion. This attitude should be implicit in all of the statements of the group leader, but more explicit expression sometime occurs. An illustration of an accepting statement is:

Patient: The convalescent hospital has, well, the attitude of too much Army.

Leader: Too much Army?

3. Rejecting Statements (REJ) are responses of the group leader which express a position contrary to that taken by some member of the group. Such statements are not believed to have much therapeutic value, if any, but an examination of typescripts revealed occasions when the leader expressed or implied disapproval of something that had been said. These statements seemed to spring at times from exasperation, and were accompanied by at least mildly aggressive feeling.

Leader: I don't get this fellows, now, I really don't. You all, a couple of weeks ago, felt that this was a pretty sorry place.

Leader: Well, I think we'll all agree that this sort of thing happens. But I think you're still trying to put me in the position of trying to apologize for it.
4. Reflecting Statements (REF) are responses which serve to recognize or restate the content or feeling of a statement made by a member of the group, or, in some instances, to recognize in a summary statement the general trend of opinion or feeling of the group with reference to a particular matter upon which several members of the group have commented. Example:

Patient: The tension is more nerve-wracking this way. Just give us much more of this and the guys will go completely nuts.

Leader: You feel that the hospital really isn't offering what you need to help you get well?

5. Interpreting Statements (INT) are responses in which the therapist attempts to explain the psychological principles exemplified in some topic under discussion. They tend to be an extension of the materials brought up by members of the group, with the purpose of fostering the development of insight.

Leader: Of course you can take sleeping pills, but that is temporary at best.

Leader: Well, you're probably aware that one of the things that goes along with an emotional disturbance is an upset stomach. One of the first things that hits you is an upset stomach. It's one of those things that's part of the results of combat fatigue....
6. **Explaining Statements (EXP)** are responses which define the structure of the sessions, the course of therapy, or which answer questions about administrative matters, or which define the nature of the group conferences at a level below that of interpretation. Examples of this type of statement are:

**Leader:** You realize, fellows, that I don't want to ask you any questions, but just give you an opportunity to talk about any problem that you still might have. Feel free to talk about anything, or not, as you like. Considerable experience has shown that if you have an opportunity to discuss your main problems, when you sort of get them out in the open, you feel better about them afterwards.

.................

**Leader:** One thing you could do here is take an examination for possible college credit, so that you can start out in your sophomore year, possibly. . . . They are called the General Educational Development Tests. . . .

7. **Continuing Statements (CON)** are responses which are brief, which indicate the interest of the leader, and which serve to keep the discussion going without adding much to the process. Examples of this kind of response are:

**Leader:** Uh-huh, I see.

.................

**Leader:** In what way?
8. **Reassuring Statements (REA)** are defined as responses in support of the patient which serve to decrease psychological stress. Example:

Leader: Well, this (upset stomach) is one of the fairly common effects of combat. One thing happens to it, it subsides.

9. **Minor Rapport Building Statements (MRB)** are bits of conversation which serve to identify the leader with the group. An example of this category is:

Patient: They said you were to get the benefit of a convalescent camp closes to your home.

Leader: Are you very close to home?

Patient: No, I'm from New York.

Leader: I hear they closed down Camp Davis. They might have sent you there.

**Describing the Statements of the Group Members.** Adequately to categorize the statements of the members of the group presented a much more difficult job than defining the statements of the leader. There were more different statements by patients, their content was varied, and the freight of feeling which they bore was often subtle, often ponderable. The categories finally determined will probably need revision if the technique described here is to be used for analysis of conferences with other groups. But the following
would probably supply at least a fairly inclusive system of classification.

Reflection on the nature of the responses given by the patients led to an hypothesis that two types of expressions were evident—statements which seemed on the whole to be healthy and in the direction of psychological strength, and statements which seemed to be but further expression of neurotic tendencies. An independent examination of transcripts by several psychologists tended to confirm this conjecture, and the decision was made to try to break specific categories into two large groupings, designated as positive and negative. In general, it is considered that the positive factors represent conditions under which reorganization of personality could be effected; whereas negative factors represented conditions which tend to maintain the present personality structure.

The positive factors are identified as belonging to the following categories:

1. **Insight (INS)** is considered to be evidenced in statements which reflect greater understanding of the reasons for a particular type of behavior or of the significance of some experience or symptom. The term is used as in individual psychotherapy to indicate achievement of greater understanding of the dynamics of one's
behavior. Expressions of insight tend to be less frequent than might be expected, or hoped for. Examples of this type of statement are:

Patient A: I've been on missions when I was actually shaking. They stayed out of range and kept right after me. They wouldn't shoot at us, and we wouldn't shoot at them. But they were just out of range to shoot at. It was more of a nuisance raid. You'd just keep your eyes riveted on that one plane that you had. All of a sudden we'd go through a cloud or something, and you'd search the sky—be right on edge all the time.

Leader: You mean, you'd start trembling?

Patient A: We'd come down all right, but everybody was just shaking. It's one of those things that built up all that tension. You just can't let it go anymore.

Leader: You just can't turn it off like that.

Patient B: If you could have had a shot at them or something like that you probably could have relaxed a bit.

2. Abreaction (ABR). Statements which are descriptions of personal experiences accompanied by apparent emotional tone are designated by the term abreaction. Such statements are fairly frequent during the sessions which appeared to be most effective. They represent characteristically a reliving of war experiences, some
of which had been traumatic and some of which seemed to have exacted their toll by prolonged exposure to tension-producing situations. An example of this type of statement is:

Patient: Well, in northern Italy you're supposed to have a milk run where you go along just as smooth, no fighters, no flak or nothing. I guess the first burst of flak caught the ship right behind us. I was sitting in the tail and it caught the ship right behind us. I didn't know it was flak until I saw the wheels fall off, then the wings fold up and it went down, and then all at once it just come to me that we were in flak, and weren't supposed to be in flak, and it just seems like you forget everything but the fellow that's leaving, and you wonder if he's killed or what's wrong with him. I don't know, you sit there and you see something, every thing going so smooth and then some things go wrong all at once. I don't know. It's tough. You're surprised. You wonder what's going on. The right wheel was the first one that comes off, and I can see it just peeling off, just like something had ripped it off, you know. I don't know who was in the plane. I don't know what the plane was.

3. Rapport (S-C). Statements are scored as contributing to rapport when they represent the establishment of friendly relationships between the patient and the therapist, or between members of the group. Conversational statements and remarks indicating support, acceptance,
and approval are considered to belong to this category. Examples are:

Patient A: How is your eye sight?
Patient B: Huh?
Patient A: How were your eyes on your last exam?
Patient B: This one over here on this side was 20-50.

Leader: Do all of you stay in the same barracks?
Patient A: Yeah, in 206.
Leader: You know each other a little bit, then?
Patient B: Yeah. I know one thing. It's gonna pay us to come down here and get these things off our mind.

4. Acceptance of Interpretation (A-I). Statements are scored as acceptance of interpretation when they involve a response indicating that the patient understands an explanation made by the leader and seems ready to incorporate the explanation into his own beliefs and feelings about matters. The term is limited to acceptance of interpretations of a psychological nature. Acceptance is differentiated from insight in that the latter was considered to involve a positive and relatively spontaneous understanding of dynamics. Example:
Leader: You know, the process of psychotherapy in a way is just like learning something new. It's relearning previous experiences and readjusting to them in the light of later knowledge. In this sort of process, we go back to that experience and study it again, and relearn how to adjust to it. Does that make sense?

Patient: Yes, it does.

Leader: You sort of feel sometimes that there's a pattern in your life that brought grief on people that you're responsible for.

Patient: Yeah. Especially this kid. Every time something happened to him, I was the ___ guy that was doing it.

5. Understanding (UND). The category of understanding is included in order to provide a means of classifying a response similar to "acceptance of interpretation," but which applies to some other individual. The additional category is included on the premise that this type of acceptance would not be as significant from a therapeutic standpoint as accepted interpretations applying to oneself. Example:

Leader: That's true. In many cases where a patient goes out of the present world, and goes off into an eerie world, it's because the conscious life he's led has been too terrible, that he has to escape from it. Maybe, his memories
were so horrible that he just couldn't live with them. So nature helps him out. Shuts him off some place where he doesn't have to pay any attention to them. He lives in a world of his own. . . .

Patient: Maybe. . . . he's retreated to the same life he led before the war.

6. Reorientation (RO). Statements are scored as reorientation when they indicate that the patient is tending toward a changed perception of a situation. The example given below will illustrate how a reorientation of attitudes occurs, for the sentiments expressed contrast strongly to the generally negativistic and hostile statements made in earlier meetings:

Patient: I feel that if they had established this group when I first came here, I feel I'd been right in with them. I was kinda bitter and nervous myself when I first came down here.

Leader: Did it help you get over some of the bitter feeling?

Patient: It did me. Seemed like I could talk and ease this feeling or emotion that you've got all tangled up in you.

Categories for negative statements included appropriate descriptions for various types of apparently unadjustive responses found in the typescripts. However, the system was extended to include categories which have become traditional in describing inadequate modes of meeting demanding
situations, although appearance in the typescripts of statements fitting into these extra categories was not frequent. The negative categories are:

1. Rationalization (RAT) is defined as the substitution of a different motive for an existing and less acceptable motive. The usage is identical with that found in current texts describing types of defense mechanisms. Among the convalescent hospital patients, rationalization was seldom used, primarily because the men were forthright in giving expression to their feelings and because the atmosphere of acceptance created by the group leader made apologies for feelings unnecessary. But here is one example, growing out of an instance in which some pressure for compliance was operating, in that all hospital patients were expected to participate in the convalescent activity program:

   Patient: What's going to happen to them (patients who are participating)? They may get half way through the course and the next thing you know they ship them some place else. It's all screwed up then. Well, I figured the time down there was just wasting time.

2. Projection (PRO) is defined as the assignment of one's own unacceptable motives and reactions to an external person or object. An example of this mechanism is:
Patient: (Talking of his pilot) He had good sense, was cool, calm, and could fly a ship; and he said he wouldn't leave the crew, but you could see that he was bucking for the position, and when the position was offered to him he didn't consult the crew at all. As if it would have made any difference. I mean, we didn't have the say so, whether he could get the boost or not. But it's just the idea he didn't come and say anything until after his orders came out.

3. **Displacement** (DIS) is defined as a shift in emphasis to a relatively innocuous person, thing, or reaction for the purpose of avoiding unacceptable motivation or reaction or concommitant psychological stress. An example:

Patient: It's true that while waiting and waiting, just waiting for them to come in, you have a feeling that if it would come on and get it over with you'd be better off. It gives you more time to think about it. I think that anybody who doesn't try to see ahead, well, there isn't much in them.

**Symptom Formation** is a general grouping into which were placed a number of negative responses, which were more specifically described as follows:

4. **Passive-Dependent Reactions** (p-d) are defined as expressions of self pity, usually made to elicit sympathy from the group leader or the group. They show an attachment to someone else with at least the hope that a supporting response will be obtained. Such feelings are evident in the following statement:
Patient: As I said before, sir, I'm completely lost.

5. Hostile-Aggressive Reactions (h-a) were frequently evident in all of the conferences studied. The hospital patients were generally a thwarted group with much bitterness stored up against the Army and all symbols and processes of authority, a feeling that is summed up eloquently in the off-heard expression "too much Army." Here are a couple of brief examples of this type of reaction:

Patient: If a man was deathly sick and went through the routine they got around here, before he got any attention he'd be dead.

Patient A: (talking of people at home) Then they keep after you about prison life, and how it was.

Patient B: They elaborate on it, on everything!

Leader: And what you wanted to do was forget it.

Patient B: Christ, they won't let you forget it.

6. Obsessive-Compulsive Reactions (o-c) are revealed in statements describing tendencies to behave in a fashion that the individual recognizes to be wrong or undesirable, yet which he cannot control. Patients frequently reported that they drank to excess but that they "did not want to." One patient got into serious trouble because he could not
resist picking fights with the military police. The compulsive nature of his behavior was further indicated by the fact that after inciting an M.P. to aggressive measures, he would not defend himself. One example of this type of reaction is:

Patient: Well, my main trouble is, I'll get a couple of beers in me, and I just want to hit somebody, I mean I really do--specially civilians.

7. Depressive Reactions (dep) are similar to expressions of dependence but they are characteristically more extreme, with evidence of despair and hopelessness. An example:

Patient: Just like I said before, I'm a hopeless case. I give up.

8. Guilt Reactions (gu) are evidenced in expressions of feelings of responsibility for having caused injury or death to someone, or having neglected some duty with unfortunate consequences. Such expressions were relatively rare, through the feelings involved are believed to be at the root of much of the anxiety that men develop in wartime. Few men are able to bring these feelings to the point of full awareness of their meaning, or to express them verbally. The best example of expressed guilt reactions is quoted in some detail on pages 197 to 201.
9. Anxiety Reactions (anx) are defined as behavior indicative of emotional stress which finds expression as a diffuse disturbance such as inability to sleep, to eat, to remain still, and so on. For example:

Patient: Having trouble eating. Have a false appetite. I mean, I'll be hungry as a son of a gun, and then when you load your plate in the mess hall, you lose your appetite.

10. Somatic Reactions (som) are anxiety reactions that take the form of bodily complaints. The example given below is quoted at some length because it illustrates the appearance of a somatic symptom immediately following a traumatic experience.

Patient: The thing that made me pretty nervous was that they put me in a cell, when it was Friday afternoon. Come Saturday morning, I was in just a cell by myself, had a little hole in the door. This guy (a German guard) came in and laughed his head off. Just looked in and laughed at me. I'd sit there for a while, then I'd hear another door open, and I'd hear people walk around. About 10 or 15 minutes later, I'd hear guns going off. This guy would come back in, open the door, and laugh some more. I was waiting for my turn. . . . I started to have headaches about Saturday night or Sunday morning. I had them all the time then.

Leader: Do you still have them?

Patient: All the time.
The reader may find a summary of the categories useful. The categories, divided into Group Leader Techniques and Patients' Responses, with the latter being sub-divided into Positive and Negative Factors, are given below, along with the abbreviations used in the charts to designate each category.

**GROUP LEADER TECHNIQUES**

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<thead>
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**PATIENTS' RESPONSES**

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The Results

In presenting the results of this exploratory study of group psychotherapy, the following plan will be used to organize the materials. First, the full course of one series of sessions in which the Y Technique was used will be examined in detail. At this stage in the development of systematic knowledge of therapy given in groups, most profit is likely to be gained simply from the study of the content and processes of carefully recorded sessions. In such lies the chief value of this study. Second, what data there are available on the two techniques used will be presented, in order that tentative comparisons may be made between the Y method and the X method. For such a comparison, one would like to possess evidence of the relative effectiveness of the two methods as reflected quantitatively by some independent criterion, such as the degree to which the patients in the two groups recovered their psychological adequacy as a result of treatment. Such data are not available, as indeed, they are seldom available for the validation of long established and much used methods of individual therapy. Whatever objective evidence of validity that may be adduced must be drawn from internal analysis of the two types of
sessions and from comparisons which may be made between them. Finally, an attempt will be made to state certain tentative conclusions concerning the nature of group psychotherapy. These conclusions will be made seemingly with more confidence that may be warranted by the data here presented. But it seems desirable to make fairly definite statements in order to suggest procedures for others who will work with group therapy as a service and in order to suggest hypotheses for those who will do further research on this important problem.

Analysis of a Series of Group Psychology Sessions, Using the Y Technique. The series of group psychotherapy sessions which will be studied in detail was conducted by Gerald R. Pascal. The group consisted of only five men, all having a diagnosis of anxiety state. All of these men were obviously very disturbed, and they were chosen for participation in the group because it was believed that they would be most amenable to this type of treatment. These men were examined by the chief psychiatrist of the hospital prior to the first meeting, and they were interviewed individually by the group leader to get them prepared for participation in the meetings. The men were not aware that the meetings were being recorded or that they were members of an experimental group.
First Session. The group leader's notes on the first session are given below:

The session began by general gripes about the field. These gripes were directed against the lack of interest of the personal physician, the confusion of the program of the field, the fact that they were required to sign in and out of the barracks, even to go to the PX, and the fact that roll call was held twice daily. Many complained of not having anything to do. "Just sitting around the barracks all day, stewing and waiting for roll call." They said that because no one was interested in their illness then they, in turn, could not be interested in taking part in the reconditioning program. Some stated that they would rather do more work and know just exactly what they had to do than do little and never be sure when they would be required to do something. They complained of the fact that their records had been lost. One complained of the food, and was joined by the others. This discussion led to questions concerning upset stomach. Could it still be a hangover due to poor food as a POW, or was it due to an emotional condition; and how could that be?

This sessions was quite typical of all of the first sessions of the different series studied, regardless of the technique used. The patients arrived chock full of hostility. The war was over for them and the hospital and the Army stood as a barrier between them and the realization of their strongest desire—to go home. Surrounding this main block in their lives were a number of minor sources of frustration arising mainly from the
inconsequentiality of Army tradition and from the routine of Army administration. Made less resistant by their general emotional condition and being further frustrated by a denial of their desire to be done with the Army, the men were exacerbated by these petty inconveniences, which they had once taken in stride. All of the first sessions were marked by strong expressions of hostility.

The percentage of lines showing various reactions of the patients and the percentage of lines indicating the techniques used by the group leader are shown in Figure 2 for this first session. The most striking feature of the graph for patients' responses is the preponderance of negative factors. On the positive side, only the rapport building responses (S-C) are much in evidence. The size of the rapport building factor and an examination of the typescripts of the session reveals that the hostility expressed by the patients was not directed toward the group leader but was general and diffuse. Their feelings found expression by attachment to most any circumstance in their environment that was in the least vulnerable to criticism. Thus the mess, the heat, the geographic location, the adjacent city, the transportation system, the regulations on wearing the uniform, the physicians, the activity program, and innumerable
FIGURE 2

DISTRIBUTION OF PATIENTS' RESPONSES AND GROUP LEADER'S TECHNIQUES FOR SESSION 1

PATIENTS' RESPONSES
(64.8% OF ALL LINES)

GROUP LEADER'S TECHNIQUES
(35.2% OF ALL LINES)

PERCENTAGE OF PATIENTS' LINES

NEGATIVE FACTORS

POSITIVE FACTORS

PERCENTAGE OF GL'S LINES

TECHNIQUE FACTORS
other matters were made purveyors of their hostility.

The patients did most of the talking during this session (65 per cent of the lines). The group leader spent more time in explaining (EXP) during this session than during later sessions, primarily to make clear the nature of the meetings. His other statements were directing (DIR), which consisted mainly of asking questions to stimulate discussion, and reflecting (REF) which involved a recognition of the feelings being expressed by the patients. Other techniques were less used, though there was an appreciable usage of reassurance (REA) and interpretation (INT).

Second Session. The group leader's notes on the second session are given below:

The session began with a report by the group leader on some information that had been requested by the members of the group at the previous session. From then on the group's conversation was spontaneous. There were occasional pauses, but, for the most part, the patients carried the conversation. Talk was about battle experiences which had given rise to fear reactions, as for instance, how it felt to pull the rip-cord in bailing out, the frightfulness of flak, etc. It was chiefly a "bull" session, but also something more, in that talk was largely confined to harrowing experiences.

This second meeting contrasts in striking fashion to the first. In the first few minutes there was some talk about the regulations of the hospital and the inefficiency
of record keeping, but the group seemed to have no desire to pursue further this type of talk. They seemed to have spent most of their hostility during the first meeting. In this meeting, they began to explore cautiously their memories of combat and of months spent in German war prisons. But there was no deep probing. The discussion was serious and yet on a relatively superficial level.

The incidents selected for discussion were good conversational material but not too closely related to those experiences that bothered them most. Occasionally there was some evidence of affective overtones to the accounts, but the talk generally was not emotionally trying.

During this session the patients talked most of the time (79 per cent of the lines), and the group leader merely kept the discussion going, allowing it to take what paths the patients desired. The nature of the statements of the patients and of the leader can be seen in Figure 3. Two of the bars on the graph of patients' responses are reversed from Figure 2. The hostility factor (h-a) which was so large in the first session, has now shrunk to inconsiderable size, whereas the rapport building responses (S-C) have grown to the single most important factor in this session. Note too the shift from a preponderance of negative factors to a preponderance
FIGURE 3
DISTRIBUTION OF PATIENTS' RESPONSES AND GROUP LEADER'S TECHNIQUES FOR SESSION 2

PATIENTS' RESPONSES
(78.7% OF ALL LINES)

GROUP LEADER'S TECHNIQUES
(21.3% OF ALL LINES)

PERCENTAGE OF PATIENTS' LINES

PERCENTAGE OF GL'S LINES

NEGATIVE FACTORS

POSITIVE FACTORS

TECHNIQUE FACTORS
of positive factors. If the assumptions on which this analysis is based are sound, it may be said that here is first evidence of the effectiveness of the therapeutic process. It should be noted, too, that there is an increase in abreactive statements (A-B), as compared with the first session. As one might expect from experience in individual therapy, statements carrying a heavy emotional burden should be found as the patients gain confidence in the group leader and a sense of security in the group.

The amount of explaining done by the group leader is seen to decrease slightly. Actually the length of this bar (EXP) is accounted for mostly by a few minutes talk in the beginning of the session when the leader gave answers to some questions concerning hospital administration raised at the previous meeting. His directing statements (DIR) again sought to keep the conversation in profitable channels. The size of the rapport factors (MRB) indicates that the leader entered into the conversation freely.

The group leader reported: "This session, therefore, built rapport, achieved some abreaction, and, in general, set the stage for a more decisive role for the leader."

**Third Session.** The group leader's notes on the third session are given below:
The first part of the session was occupied by the presentation of two case histories to illustrate the difference between an essential neurosis and operational fatigue. From that the discussion proceeded to questions of symptom formation. One patient then led off with a description of his own intimate combat experiences and resulting symptoms. The group considered this case, offering possible explanations of symptom formation. This was followed with an explanation by the group leader of the mechanisms of conversion and anxiety symptoms. Following this, another patient presented his case, describing, with great emotional tone, his combat experiences. Explanations and interpretations by the group leader followed.

Figure 4 shows the types of expressions of the patients and of the group leader. Feeling that he had established a very good relationship with the members of the group, the group leader in this session began to take a much more active role. His purpose was to encourage the patients to discuss and think constructively about the experiences which were at the root of their disturbance. The group leader gave case histories of two men, one who had a long history of maladjustment and one who suffered the relatively temporary disturbance characteristic of operational fatigue. The men were ready to follow through after the presentation of these cases with a discussion of their own experiences. Note the marked increase in the per cent of lines in the abreaction (AB) category. This factor is now most prominent in the statements of the patients. There
FIGURE 4
DISTRIBUTION OF PATIENTS' RESPONSES AND GROUP LEADER'S TECHNIQUES FOR SESSION 3

PATIENTS' RESPONSES
(38.4% OF ALL LINES)

GROUP LEADER'S TECHNIQUES
(61.6% OF ALL LINES)

PERCENTAGE OF PATIENTS' LINES

PERCENTAGE OF GL'S LINES

NEGATIVE FACTORS

POSITIVE FACTORS

TECHNIQUE FACTORS
is a slight resurgence of hostility (h-a), growing mainly from expressions of hostility against some of the officers who figured in the recalled experiences in battle and in prison. The hostility expressed was no longer diffuse and irrational but was an integral part of the experiences which the patients were reliving verbally. There is a slight increase in number of statements of dependence (p-d), which seems to occur as confidence in the group leader is built up and as the emotionally toned experiences are recalled.

The most notable difference in the techniques used by the group leader is found in the increase in amount of interpretation (INT) offered. This is accompanied, in the response of the patients, by an increase in the positive factors of acceptance of interpretation (A-I), of understanding (UND), and of insight (INS). The directing statements of the group leader took on more of the character of probing as he attempted to get each patient to examine the war experiences which he found to be most unpleasant to him. It should be noted all along that the leader of this group took a more active role than is recommended in non-directive individual therapy. Other leaders relied more on the technique of reflecting and interpreting the responses of the patients, in greater conformity to non-directive principles.
However, the point to stress is that in all of the Y type sessions, the patients were allowed spontaneous expression, and that the group leader, regardless of his personal inclinations in therapy, followed the pattern set by the patients. Such differences indicate the need for the terms "X" and "Y" techniques, as opposed to the use of established terminology in individual therapy.

**Fourth Session.** The group leader's notes on the fourth session are given below:

Group leader began by questioning the patient about his symptoms. This opening led to further discussion of symptom formation, and a discussion of one patient of his own personal problems, which were then discussed by the group. In response to a request made in the previous session the group leader then discussed the topic of dreams, using case material. Some time, then, was devoted to the interpretation of dreams brought by the patients. There was some tendency towards a "bull" session, but this was checked by the group leader in a restatement of what might be obtained from these sessions. The session ended by a further discussion of symptom formation by the patient and the group leader.

Disturbed sleep and dreams in which they relive combat experiences are characteristic symptoms of men suffering from operational fatigue. The experience is so common that most patients feel a need for discussing dreams, as was done in this session. Two patients dominated this meeting,
discussing their combat experiences and their dreams about combat. Most of these lines were put into the S-C category because of their conversational nature and the absence of much personal involvement. As can be seen in Figure 5, the positive factors again outweighed the negative factors. Among the negative factors, the passive dependent responses (p-d) were still in evidence.

Turning to the group leader's techniques, the explaining and interpreting factors remain large and were concerned with dream materials. The directing statements were again used to encourage participation. This brings up a feature of group therapy which deserves study. Ordinarily, the leader might do little to assist all patients to participate actively in the meetings, other than to establish an atmosphere of permissiveness. Yet some patients are quite content to listen only, drawing what help they may from the remarks of the other members of the group. It is more difficult to build up a feeling of responsibility for actively working on a problem in the group situation than is true in individual therapy. Thus the question is whether the group leader should place responsibility on each individual in the group by showing through his directing statements that each individual is expected to get to work on his
FIGURE 5
DISTRIBUTION OF PATIENTS' RESPONSES AND GROUP LEADER'S TECHNIQUES FOR SESSION 4

PATIENTS' RESPONSES
(53.5% OF ALL LINES)

GROUP LEADER'S TECHNIQUES
(46.5% OF ALL LINES)

PERCENTAGE OF PATIENTS' LINES

PERCENTAGE OF GL'S LINES

NEGATIVE FACTORS

POSITIVE FACTORS

TECHNIQUE FACTORS
difficulties. No answer to this question is available in these data, but the leader of this group felt that such an attitude should be developed. Thus he reported that in this meeting two of the patients carried most of the burden of the conversation and that "the others were waiting, and it seemed that they were wondering which of them should be next for discussion by the group."

A comparison of this meeting with the preceding meetings is interesting. In the first session, most of the lines were hostile; in the second, rapport-building; in the third, abrasive; and in the fourth, rapport building again. This alternation of rapport-building and abreaction occurred again in this series before the sessions were concluded, and the pattern was evident in other series, though the data are not extensive enough to permit the drawing of a definite conclusion. The hypothesis may be stated, however, that the sessions which are predominately rapport-building set the stage for more productive sessions in which abreaction occurs, and that after an emotionally trying session there may be a relapse into more comfortable conversation. Similar oscillations are often noted in individual therapy.

Fifth Session. The group leader's notes on the fifth session are given below:
Introductory remarks consisted of straightening out a matter over which there had been general concern—when they would see the psychiatrist for final disposition. The group leader assured them that they would see the psychiatrist as soon as the sessions were completed. The group leader then asked each patient about his symptoms. Each patient talked about how he was feeling and what was bothering him. From the remarks upon sleeplessness the group leader led the patients to discuss matters which might prevent them from sleeping. This led to talk of recurring, anxiety producing memories. Each of the patients who had not previously brought up his problems for discussion by the group was led, in turn, to speak of himself. In each case, the other patients were invited to discuss the case of the patient. The group leader followed with explanation and interpretation.

The distribution of patients' responses and of group leader's techniques for this session are shown in Figure 6. Seeking causes in their combat experiences for their present sleepless nights, their restlessness, their dreams, the patients recounted some of their combat experiences which had been most harrowing to them. The patients told their stories with evident feeling. To illustrate, here is a typical example of a patient's account of his experiences. The patient has been talking about his headaches and his constant reflection on his life as a prisoner of war. The account serves also to indicate the tenor of the group meetings:

Leader: What particular aspect of the fighters coming over bothers you? What do you see?
FIGURE 6

DISTRIBUTION OF PATIENTS' RESPONSES AND GROUP LEADER'S
TECHNIQUES FOR SESSION 5

PATIENTS' RESPONSES
(55.3% OF ALL LINES)

GROUP LEADER'S
TECHNIQUES
(44.7% OF ALL LINES)

PERCENTAGE OF
PATIENTS' LINES

PERCENTAGE OF
GL'S LINES

NEGATIVE FACTORS

POSITIVE FACTORS

TECHNIQUE FACTORS
Patient: Well, when they first come over, you know, we thought they were American planes. There was a layer of clouds, and below the clouds there were six ME 109's, and these P-47's came out above the clouds and they were going in the opposite direction to the ME 109's. Then they turned around and came back in the same direction that the ME 109's were. Everybody started to cheer, because they thought they were going to take them. Next thing we knew, they were coming at us. A P-47 is mighty dangerous, coming down about 400 with 6 to 8 guns blazing away, and two bombs falling off the wings.

Leader: What happened? The P-47's were shooting at you?

Patient: Yes, one minute, we were across the field, you know, cause we thought they were going to chase the Germans, the ME 109's that went by, and we started to cheer, cause they were going in the opposite direction and then they turned around and started in the same direction the Germans were. We thought they were going to chase them. Everybody cheered, you know, and thought they were going to see a fight. The next thing you know, they turned right over in a dive. They went down in formation.

Leader: They started shooting your formation?

Patient: Yeah, there was a bridge, and I was just about 20 yards this side of the bridge. A company was just passing below the bridge, and the whole ten ranks was wiped out. I mean, four P-47's coming down and each one dropping two 500 pounders and coming back twice to shoot us up with .50's.
Leader: I can imagine that's pretty rough. Were a lot of the fellows who got killed your friends?

Patient: Most of them were English. There were three or four American officers.

Leader: Well, what happened to you?

Patient: I just ran out into the woods.

Leader: Did you go hide behind a tree or something?

Patient: No. I just ran into the woods and jumped onto the ground, that's all. I looked up once and about twenty feet away from me, I could see the ground kick up from the bullets hitting the ground. The branches of the trees started to come down. I got up and ran farther.

The group leader spent much of his time in showing how the symptoms of the patients could be associated with their recounted experiences, and his interpreting statements (INT) were matched by an increase in the percentage of responses indicating acceptance of interpretation (A-I). The group leader reported: "This session was considered to be rather a successful conference, for the patients spent most of their time discussing their problems and the interpretations offered by the group leader."

Sixth Session. The notes of the group leader for the sixth session are given below:
First part of the session was devoted to a discussion of administrative problems, patients being interested in knowing exactly what would happen to them at the conclusion of group conferences. Patients talked of their combat experiences. There were more pauses in this session than in previous ones, as if each man had already talked himself out of the principal things that were bothering him. There was some discussion by the patients of symptoms and some discussion of a particular patient's experience in terms of its effect upon that patient.

This was the next to the last session in the series, and the members of the group were aware of the fact that the meetings would soon stop. An increase in the number of negative factors is evident in the analysis of the responses of patients, as can be seen in Figure 7, and it is believed that this increase is a reflection of the patients' anticipation of the ending of the sessions. The prospect of leaving the hospital stirs up the general hostility (h-a responses) against the administration, which was so freely expressed in the first meeting, and which now centers around their probable disposition on discharge. The number of passive-dependent responses (p-d) is also seen to be greater than in previous sessions, possibly reflecting the strong group identification which had been built up in the course of therapy but which now had to be terminated. This dependent factor was found to continue
FIGURE 7
DISTRIBUTION OF PATIENTS' RESPONSES AND GROUP LEADER'S TECHNIQUES FOR SESSION 6

PATIENTS' RESPONSES
(52.2% OF ALL LINES)

GROUP LEADER'S TECHNIQUES
(47.8% OF ALL LINES)

PERCENTAGE OF PATIENTS' LINES

PERCENTAGE OF GL'S LINES

NEGATIVE FACTORS

POSITIVE FACTORS

TECHNIQUE FACTORS
to increase into the final session. However, though there is an increase in negative factors, the positive factors still outweigh the negative. Rapport-building statements have taken the lead from abrasive statements, and the other positive factors have dwindled in size.

The group leader's techniques are more evenly divided among several factors in this session. Examination of the typescript reveals that the directing statements (DIR) consisted for the most part of inquiries concerning the problems of individual patients. These inquiries were followed up with interpretations and explanations. The patients, having previously recounted in some detail their combat experiences, now were interested in discussing the relation of these experiences to their symptoms. The group leader's efforts, however, did not seem to yield immediate results at least, for the acceptance of interpretation (A-I) and the insight (INS) factors for the patients remain small. However, several patients indicated in statements that they felt they had made considerable improvement. The group leader wrote: "It seemed to the group leader that a general feeling of 'closure' prevailed."

Seventh Session. The notes of the group leader for session seven are given below:
The meeting was opened by asking each patient, in turn, about his symptoms. Each patient was asked to evaluate his progress and adjustment. The group was asked to comment upon this. Some time was spent in discussing the matter of points and how each man could get out of the Army. There was also discussion of the role of personal physician and psychiatrist in the final disposition of their cases. The series of conferences ended with the understanding that each patient was to see the group leader individually for a short interview.

In Figure 8 the factors in the statements of the patients and of the leader are presented. The group leader's technique, it can be noted by comparing this figure with the figures for the preceding sessions, has gradually changed. In this session, most emphasis is placed on interpretation (INT), with directing statements (DIR) taking second place. The responses of the patients are interesting. Insight (INS) is more in evidence in this final session than in any previous meeting, and there is some evidence of re-orientation (R-O), indicative of progress in therapy. The abreaction category has diminished and there is much conversational material in the session, which is shown by the large S-C category. On the negative side of the ledger one notes an increase again in hostile-aggressive and passive-dependent responses. The leader
FIGURE 8

DISTRIBUTION OF PATIENTS' RESPONSES AND GROUP LEADER'S TECHNIQUES FOR SESSION 7

PATIENTS' RESPONSES
(49.5% OF ALL LINES)

GROUP LEADER'S TECHNIQUES
(50.5% OF ALL LINES)

PERCENTAGE OF PATIENTS' LINES

PERCENTAGE OF GL'S LINES

TECHNIQUE FACTORS

NEGATIVE FACTORS

POSITIVE FACTORS

DIS, PRO, h-d, p-d, anx

S-C, AB, A-I, UND, INS, R-G

REF, EXP, LPR, DIR, REL, RLE, CON, ACC, INT
reported that "the former reflected the discussion of anticipated poor treatment in the process of disposition, and the latter the anticipation of leaving the group conferences."

The nature of the conferences is illustrated well in the following particularly fruitful exploration made by one patient during this session into events which might possibly be the main springs of his present disturbance.

Leader: How about you, Owens? How are your headaches?

Owens: Still have them. I've been awake the last two nights, practically all night long.

Leader: What's been keeping you awake?

Owens: I don't know.

Leader: You've been tossing and turning and thinking about things? What kind of thoughts have you been having?

Owens: About everything, nothing in particular. Everything and anything.

Leader: All little worries that you've been having?

Owens: That's right.

Leader: About your future?

Owens: Oh nothing special. Just anything that comes along. I just think about it. Wake up in the middle of the night, toss and turn, take a walk to the latrine, sit down, take a drink, come back, still toss and turn all night.
Leader: Combat experiences on your mind?

Owens: No, not too much. Just once in a while. Just anything comes to mind. The things I did the other day. Nothing in particular.

Leader: Not sleeping the last two nights?

Owens: Yes, the last two nights.

Leader: Have you been exercising much lately?

Owens: I played golf yesterday.

Leader: Well, what's your own opinion of what causes it?

Owens: I don't know. I can't seem to relax. I'm uneasy.

Leader: You seem to have a constant tension that doesn't relax.

Owens: I can't seem to get any rest. I don't know what it is.

Leader: Well, what would you think the tension might come from?

Owens: Well, that's what keeps me puzzled. I don't know where it comes from. I mean, if you were thinking of one thing all the time, that would probably get your nerves. But I just think of anything.

Leader: Do you see yourself in any particular situation?

Owens: Well, I think about going back to school and things like that, but I don't think about--I can't get my mind fixed on one thing. Everything just rushes in, and I just can't seem to get settled on one thing.
Leader: What would you like to do over again in your past? Last night when you were staying awake--remember yesterday when you told us about being on the road and the P-47's came back to strafe? Do you think about that?

Owens: No, not much.

Leader: What about being out of the Army? Do you think about that?

Owens: It could be almost anything to do with combat--just don't feel sure of myself, that's all.

Leader: Your future seems sort of uncertain?

Owens: Yes, I see myself going home and going to work. I'm afraid to do my work because I'm afraid I'll blank up. Just don't feel sure of the things I'm doing.

Leader: Isn't there anything back in your combat or pre-combat experience that you feel you wish you could have done over and done it better? Remember yesterday when we were talking about those guilt feelings like K had the time he didn't check those wheels? Something like that in your experience?

Owens: Only one time I ever remember of. We were on a flight and I was the lead radio operator and I sent in a wrong position report on a ship that went down, and it took two ____ weeks to find it. I mean, I was the one that was supposed to send in a position. The ship went down, and everybody just stood there looking at the ship go down. The navigator never told me the position and I never thought to ask him.

Leader: Did you send in the report?
Owens: I got my ass chewed off for not sending in the right position report. I thought it was a little bit my fault, but I thought it was his fault more than mine, because he was the navigator. But no one even took any stock of it.

Leader: But what happened to that crew?

Owens: There were two crews. 25 men got killed. It was December 27, 1943. It happened at Wendover. We were on a cross country flight from Wendover to Pocatello, Idaho, and there were 13 ships in formation. We were supposed to finish basic training up there. We had some hours to put in and the weather was bad down where we were, so they took us up there.

Leader: You do feel a certain amount of responsibility for that?

Owens: I do. I should have know enough to ask him. I wouldn't take the full responsibility, but he was the navigator. He should have given me a position. I should have asked him for one, too.

Leader: You feel that that's one thing that preys on your mind?

Owens: Yes. Another thing, I used to know a kid in school. Him and I didn't get along any too well. We played on the same football team in high school. He was running with the ball one time and I happened to tackle him and he broke his arm. Got around school and they knew we didn't like each other, and all the kids used to remind me of it. And then we played basketball. I was captain of the basketball team—we're just practicing one day, and I took him. We wasn't suppose to do it, but I threw a block at him and I broke his other arm. After that I never played
basketball again. I mean, the kid's still home. I see him when I go home and talk to him, but the kids back home will remind me of it sometimes. I never played basketball anymore.

Leader: You sort of feel sometimes that there's a pattern in your life that brought grief on people that you're responsible for.

Owens: Yeah, specially this kid. Every time something happened to him, I was the ____ guy that was doing it.

Leader: And you feel maybe that if you attempt something, it might bring somebody grief?

Owens: Yeah, I mean I didn't really do it on purpose. Lot of the kids knew I didn't like him. They just thought that I did it to hurt him.

Leader: Well, it may be that the reason you feel guilty is because you didn't like the fellow. If you had liked the fellow it probably wouldn't have bothered you too much. But the very fact that you disliked him to begin with, you sort of feel that, well, maybe you did do it purposely.

Owens: Yes.

Leader: And that's probably one reason why you feel so guilty about it.

At the end of the session, the group leader summarized and reformulated for each patient materials developed in the conferences which seemed to throw light on his condition, with particular emphasis being placed on the understanding
and insight achieved. This seemed to the group leader to be a good way to close the series, for the summaries would provide a starting point for the patients as they continued to seek more effective adjustments after leaving the hospital.

**All Sessions.** The group leader's notes on the series of sessions are as follows:

Considering the entire series of counseling sessions, it was evident that the patients' first need was to discuss problems of immediate concern. Their second need was that of establishing interpersonal relationships among themselves and between themselves and the group leader. These needs were fulfilled in the first and second sessions, and the group was ready and waiting for further developments. The third session was considered crucial. The patients had "talked themselves out" of superficial topics and now needed direction. At this point, the group leader assumed greater responsibility and a more active role. As a result of his efforts, he succeeded in getting one patient to lead off with a discussion of his problems, and from then on the leader's job consisted of getting each patient to participate. The more aggressive patients were the first to discuss their problems. The discussion of problems by some members of the group encouraged the more inhibited patients to air their own problems. This process continued until each patient's problems had been presented to the group for discussion. The course of therapy appeared to be similar to that of individual counseling. First there was the need to establish rapport; next to stimulate the patients to talk about themselves; then to have them understand their problems; and
finally, to help them re-orient themselves to more acceptable modes of adjustment.\footnote{This is a brief but good statement of the conception of therapy of this group leader, a viewpoint which is reflected in his handling of the group conference.}

The analysis by categories for all seven sessions, giving the group leader's techniques and the patients' responses, is presented graphically in Figure 9. The first item of importance is that the patients talked somewhat more than the group leader (57 per cent of the lines). It is believed that this is desirable. Indeed, the group leader may be criticized by therapists inclined to a more non-directive approach for talking too much. However, techniques for the most part were well within the boundaries for the Y method as they were delineated prior to the first conference. The important fact here is that the patients did participate fully and freely, an element believed to be essential to progress toward better ways of adjusting.

It can be seen that the group leader relied mainly on explaining, directing, and interpreting in conducting the meetings, and that these techniques were used, in total, with roughly equivalent frequency. This is a reflection of the leader's concept of the role of the therapist,
either in individual or group treatment. In commenting on his handling of the group, the leader wrote:

He was, first of all, the explainer. He explained the nature of the sessions. He explained symptom formation, how the patients would get well, etc. Secondly, he directed. He steered the course of discussions. He carried through, with dominating consistency a preconceived notion of the course of therapy; and, although, he did, on occasion, use the technique of reflecting patients' feelings this was only when he relinquished, temporarily, the direction of the discussion, for purposes of establishing rapport. It would be safe to say that the group leader's approach to the problems of the patients was a direct one. Interpreting is the third technique of importance used by the group leader. And this follows what one might expect from an active explaining, directing group leader. He loaded each patient with all the interpretation, all the insight he could bear, and it was an active and deliberate process. With a group leader disposed towards a less direct approach to therapy, one might conceive that the size of the bar graph for directing might well have been very small and that those for reflecting, continuing, and accepting would have been larger.

The responses of the patients showed more positive than negative factors for all of the sessions, 75 per cent of the lines falling into the positive categories. Rapport-building (S-C) responses comprised the largest single type of expression. To appreciate the therapeutic
significance of this type of response, it should be remembered that the category covered statements of a conversational nature and that these statements usually were about war experiences, although less charged with feeling than the statements placed in the abreaction category. Abreaction was the next most important type of response. The leader of this group was particularly successful in encouraging patients to relive their more harrowing experiences. The men scrutinized traumatic events with a seriousness of purpose that was beyond doubt beneficial. The two factors in the negative categories which were most frequent were the hostile-aggressive and the passive-dependent responses.

Totals on patients' responses given above for all sessions combined are given for each session in sequence in Figures 10 and 11. Figure 10 pictures well the trend of positive and negative responses throughout the series. Only in the first session do the negative responses outweigh the positive responses. In the middle sessions, the number of positive responses remains high and fairly constant. In the final sessions, as there is evidence of continuing hostility and of passive-dependent feelings, the curve for positive factors drops slightly.
Figure 10
DISTRIBUTION OF TOTAL POSITIVE AND NEGATIVE FACTORS

PERCENTAGE OF PATIENTS' LINES

100

60

40

20

0

SESSIONS

1 2 3 4 5 6 7

POSTIVE FACTORS
NEGATIVE FACTORS
FIGURE 11

DISTRIBUTION OF PATIENTS' POSITIVE (75%) AND NEGATIVE (25%) FACTORS FOR ALL SEVEN SESSIONS

(X AXIS = SESSION NUMBER; Y AXIS = PERCENTAGE OF ALL PATIENTS' Lines BY SESSION)

NEGATIVE

POSITIVE

NEGATIVE

POSITIVE

NEGATIVE

POSITIVE

NEGATIVE

POSITIVE

NEGATIVE

POSITIVE

NEGATIVE

POSITIVE

NEGATIVE

POSITIVE

NEGATIVE

POSITIVE

NEGATIVE

POSITIVE
The cumulative curve is broken down by specific categories in Figure 11. This is believed to be a particularly instructive graph, not only for understanding the sessions described, but as a suggestion of the value of the analytical process employed. A series of 20 or 30 such charts, each depicting the course of therapy in various groups led by psychologists with various viewpoints in therapy, would doubtlessly be richly revealing of the dynamics of this type of treatment. In this one series of meetings, hostility was great in the first session and dropped swiftly thereafter until near the end of the series when there was a slight upsurge. The group leader reported that "most of the expressions of hostility were concentrated in the first session. The patients were extremely anxious to give vent to their resentment and until this was done little therapeutic progress could be expected." In explanation of the increase in responses in the passive-dependent category, the leader suggests that such statements reflect an increasing security in the group with an accompanying willingness to reveal feelings normally kept well cloaked.

Following the decrease in hostile-aggressive responses, the therapeutically positive factors of rapport and abreaction become dominant. It is interesting to note that the
peaks of the rapport graph fit into the valleys of the abreaction graph, an occurrence that has been commented on in analysis of individual sessions. Among other positive factors, there was a peak in acceptance of interpretation (A-I) occurring during the fifth session, an increase in frequency of insight (INS) during the final two sessions particularly, and some evidence of re-orientation (R-O) during these same final sessions.

No strenuous effort would be made to defend this patterning of the course of therapy in groups. However, the results are imminently reasonable. In other groups observed, much the same process was evident, though there is not available a detailed analysis of the data. One might only hope for more evidence of insight and of reorientation, an outcome which may well be possible with other groups.

Comparison of Sessions by Types

There are sufficient data available to justify limited observations concerning the nature of group psychotherapy as administered by the two techniques which have been studied. It should be recognized at the outset that the comparisons made are based on limited data and that they
thus may not be applicable in full to other groups. By some standards, such as the requirements of the Aviation Psychology Program for the validation of various selection procedures, the data are inconsiderable in quantity and precision. However, when compared with other available data on group psychotherapy, the materials on which this report is based loom large and impressive. Thus, in making the following comparisons between the techniques, the orientation will be to present every bit of suggestive data, to draw what conclusions seem warranted, and to do so with full cognizance of the need for corroborative investigations. Perhaps one of the chief values of this study may lie in its suggestions for the quantitative study of group psychotherapy and in the stimulation it may provide for the initiation of further research.

The most obvious difference between sessions conducted by the X Technique and by the Y Technique is the difference in amount of patient participation. The percentage of participation which may be expected of patients when the two techniques are used is graphically shown in Figure 12. The single bar representing participation in the X type sessions shows that the members of the group spoke about 15 per cent of the total number of lines.
Figure 12. Patient Participation in Three Different Series of Group Conferences, in Per Cent of Total Lines of Participation.
This is to be expected, as the leader's responsibility is defined in such a way that he is obliged to preempt most of the available time. The two remaining bars in the graph represent patient participation in Y type sessions conducted by two different leaders. These leaders differed considerably in their concept of how group therapy should be conducted, but they agreed that the patients should have full opportunity for expression, and the Y Technique makes such expression possible. In the light of the accumulation of evidence in psychology that learning is an active process, and in consideration of the well established principle in psychotherapy that the individual must actively participate in seeking solutions to his problems, one may tentatively accept these comparisons as evidence in favor of the Y Technique. This is not to say that participation will ensure psychological growth but to maintain that there is no great likelihood of much growth occurring if participation is too sharply limited. Validation of the two techniques against an outside criterion remains the critical process by which this question may be answered; in the meantime, by running group psychotherapy sessions, best judgment would indicate the
desirability of adopting the technique that provides most opportunity for relevant participation of the members of the groups.

The types of techniques used by leaders of the different groups are shown in Figure 13. Represented here are one X type series and two Y type series, the latter being conducted by two different leaders. For clarity, only the four most used categories are shown in this graph: directing, reflecting, interpreting, and explaining. The chief difference between the two techniques is immediately apparent in the large number of lines devoted to explaining. In the X type sessions eighty-one per cent of the total leader lines were devoted to this factor. There is some interpretation in the X sessions, and almost no reflecting or directing. Essentially this means that there is little effort to encourage patients to participate. Directing, reflecting, interpreting, and explaining are all used by the leaders of the Y groups. But a difference in conception of treatment between the two leaders is evident. The leader of the Y-2 group took a much less active role than did the leader of the Y-1 group, preferring to encourage participation through directing statements and to promote insight by reflecting the expressed feelings.
Figure 13. Per Cent of Total Leader Lines Devoted to Four Techniques for One Type X Series and Two Type Y Series of Group Psychotherapy.
of the patients. The explaining statements of the leader of this group are confined almost entirely to discussions of administrative matters. The leader of the Y-2 group, on the other hand, did much explaining, interpreting, and directing. When this figure is read with reference to Figure 12 from which it can be seen that the leaders ranked in participation in the order X, Y-1, Y-2, the differences in the sessions is even more pronounced. Within the framework of the Y Technique, marked differences in specific procedures are evident, though the salient features of this approach to therapy are retained.

Observations of limited significance can be made with reference to the responses of patients in groups conducted by the two techniques. These differences are shown graphically in Figure 14, based on an analysis of seven type Y sessions and three type X sessions. The small number of X sessions and the fact that the absolute number of lines on which the percentages for X sessions are based make it necessary to interpret these data with much caution. For the two groups studied, a considerably larger proportion of positive factors appeared for the Y group. This is accounted for largely by the heavy S-C factor. The most conspicuous negative factor for the X group is the hostile-
Figure 14. Comparison of Patient Responses in Y Type and in X Type Sessions, Per Cent of Total Lines Falling in Each of the Indicated Categories (from data on 7 Y Type Sessions and 3 X Type Sessions).
aggressive response. It will be remembered from the analysis of the series of type Y sessions that the first session was given over almost entirely to responses of this nature. But the men seemed to get their ill feelings worked out in short time. Perhaps in groups so frustrated as these, there is a certain amount of hostility that must find expression before more constructive elements become evident. If so, there would be little time in the type X sessions for such release. Indeed, it is conceivable that the lectures of the leader may add to the feelings of frustration and the need to express aggression. But this is conjecture. In interpreting Figure 14 perhaps more stress should be placed on the similarities which appear than on the differences. Although the leader of the X type group used the explaining technique almost exclusively, the patients in this group responded with the same kinds of expressions as those in the Y group. Although the percentages in each category cannot be relied on with great confidence, it is apparent that the two techniques produced no gross differences in the quality of responses. It is possible that these varieties of expression will appear regardless of what the leader does, providing minimum encouragement for
their expression is present. Again, this must be stated as an hypothesis requiring substantiation.

**A Note of Patient's Attitudes**

In the absence of validity data obtained by an independent criterion, it has been necessary to adduce validity from the internal evidence found in typed transcripts of the conferences. Such a procedure omits consideration of the reactions of the patients to their experience in participating in the group psychotherapy sessions. Although the expressed opinions of those who have worked as members of a group are not weighty in establishing the validity of group psychotherapy techniques, such information is believed to be of value. It at least indicates the type of activity that patients think is effective in speeding their convalescence.

The following statements were obtained from the five men who were members of the group which was led by Pascal and analyzed in detail in a previous section of this chapter. The statements were written after the group leader had urged the men to make a frank and critical evaluation. The papers were turned in unsigned. With due discount for what kindness and courtesy there may be present, the following
statements do reflect a very favorable attitude toward this type of treatment:

1. These conferences told me a whole lot about my case and also brought to light the reasons for my condition. I learned a great deal from them and think they are O.K. They gave me a chance to blow off steam.

2. Personally I think these group conferences are very good if the person attending will take an interest in them and try to understand what it is for. I know it is one of the best to relax that I've found in the entire program. To make the story brief I think this is the best class of the program.

3. The Group Sessions are a very great help. They bring out information that is kept secret. Most fellows are tired of telling their combat experiences, and so tend to hide them. These Group Sessions bring all that out. After each session I left with the feeling that I accomplished something. Each person should write down different thoughts after each meeting so that they can bring them up at the next meeting.

4. I think it has been very good. It has helped me to understand quite a bit more about myself. It would be good to keep on having other boys to have group meetings. As a whole it will do very much for each man.

5. I think the group conference is very good, and it has helped me a lot. And I think there should be many more of them. It makes a man feel that there is someone trying to help him.

In other groups a few more hostile patients thought the sessions useless, but it is the opinion of all of the
group leaders that the patients generally felt the sessions to be beneficial.

Conclusions

No claim of experimental precision is made for the studies of group therapy which have been summarized. Two points seem apparent, however. One is that the work reported is more extensive and more precise quantitatively than other work which has been described in publications to date. The other is that in the work reported is rich in suggestions for further research, both as to techniques that may be profitable to use and avenues of investigation that may be profitable to explore. In view of the limitations of the present study, it seems required that no "conclusions" be drawn concerning the nature of group psychotherapy. Rather it would seem more sound to state as hypotheses some of the major concepts which have emerged from experience in conducting group psychotherapy sessions and from the analysis of verbatim accounts of recorded sessions. These hypotheses may be stated at two levels of confidence. On the first level there are included hypotheses which are of the nature of "tentative conclusions" based directly on the work reported. These hypotheses are submitted with some confidence that they will be verified
by further experimentation. On the second level there may be included hypotheses which are drawn from experience in group therapy, which pertain to factors of apparent importance, but which are not tied directly to the quantitative analyses accomplished. These hypotheses are submitted as important problems in group therapy with no suggestion as to their likelihood of being substantiated by further investigation.

1. Hypotheses which on the basis on present evidence seem very likely to be confirmed by further research:
   a. That patient participation will be greater when the Y Technique is used than when the X Technique is used.
   b. That a series of meetings conducted by the Y Technique will be therapeutically more effective than a series of equivalent length conducted by the X Technique.
   c. That positive factors in the responses of patients will gradually increased throughout the course of the series, when the Y Technique is used.
   d. That there will be a slight increase in negative factors as the patients become
aware of the approaching termination of the meetings, when the Y Technique is used.

e. That the positive factors will outweigh the negative factors for the entire series, when the Y Technique is used.

f. That during the course of therapy in which the Y Technique is used there will be strong expressions of hostility in the early sessions.

g. That expressions of hostility will decrease rapidly if the group leader evidences a permissive, accepting attitude.

h. That expressions involving a reliving of disturbing or traumatic experiences will increase as expressions of hostility decrease.

i. That passive-dependent tendencies will become more evident during the course of the meetings as the members of the group gain a sense of increasing security in the group.

j. That the types of patient responses, though not the number of statements within each category, will be similar regardless of the technique the group leader uses.
k. That there will be an evident fluctuation in the level of therapy during a series, with an alternation of relatively profitable with relatively unproductive sessions.

2. Hypotheses which on the basis of present experience seem important for a fuller understanding of the dynamics of group therapy and which should be tested experimentally:

a. That groups homogeneous with reference to type of difficulty, age, sex, level of verbal facility, and similar factors can be more effectively treated than groups made up without reference to these factors.

b. That group therapy is more effective than individual therapy in developing wholesome relationships with other people.

c. That the recognition of neurotic tendencies in other members of a group acts to speed progress in therapy rather than to retard it, as has sometimes been maintained.

d. That there is no difference in effectiveness within the general framework of the
Y Technique of leaders who tend strongly to direct, explain, and interpret and of leaders who tend strongly to reflect, accept, and interpret. (This is stated as a null hypothesis with no present suggestion that one tendency is better than the other. Ultimately experimental work should identify with some accuracy those specific techniques which are therapeutically most effective.)

e. That a given number of patients represents the optimum number for treatment by the group method.

f. That groups conducted with occasional individual conferences between the leader and the members of the group are more effective than those in which the leader has contact with the patients only when they are in a group.

g. That the amount of participation of initially depressed and withdrawn individuals will increase until their participation is about average for the group.
h. That the amount of participation of initially elated, compulsive, and aggressive individuals will decrease until their participation is about average for the group.

i. That the effectiveness of group therapy will be reflected in the performance of the members of the group on various relatively objective measures of adjustment.

j. That some patients will find it easier to approach their problems in a group situation than in the individual therapy situation.

k. That for certain types of patients group therapy is considerably more efficient in terms of progress toward adjustment per therapist hour than individual therapy.

Summary. In order to extend psychological treatment to as large a number of patients as possible, group psychotherapy was used in the Air Forces convalescent hospitals. The technique was relatively new, and little was known about best usages and procedures. Available literature on the subject gave valuable suggestions for conducting meetings and advanced various hypotheses concerning the
dynamics of group treatment. Hospital directives prescribed its use, and group therapy was initiated as a service. However, in line with the thesis that the applied psychologist should extend his activities beyond routine services, research was also undertaken to discover; first, a means of obtaining a quantitative analysis of recorded sessions in group therapy; second, of arriving at more than conjectural statements relative to the course of such therapy; and, finally, of ascertaining the nature of group therapy when two different methods are used. The two methods studied were designated the Y Technique and the X Technique, the former being relatively non-directive and the latter conforming to the traditional pattern of mental hygiene lectures and discussions as recommended by the Army. It was concluded, in general, that the Y Technique was the more promising, and a number of tentative hypotheses were advanced which may profitably be used in further research on this important technique for providing effective therapy to larger numbers of individuals who have been identified as needing psychological help.
CHAPTER V  
SUMMARY AND EVALUATIVE COMMENTS

In this paper are reported three studies which had as their common immediate goal the improvement of the services given at an Army Air Forces convalescent hospital. The long range value of these studies resides in their worth as contributions to general psychological knowledge and in their pertinence as illustrations of the basic thesis that psychologists working in applied fields should constantly seek to make their services more effective by a concurrent program of research. To be persistently effective the applied psychologist must keep his service tools sharp by the honing that research can provide. The interrelated service and research functions which are here described had two central problems: (1) how to identify most efficiently incoming patients who would need psychological treatment; and, (2) how to provide the patients so identified with the most efficient treatment possible within the personnel limitations of the hospital.

In connection with the first problem, that of increasing the objectivity and precision of initial diagnoses of psychological difficulties, a balanced battery
of psychological tests seemed to provide the most promising possibilities. Several tests which complemented each other in the areas which they purported to measure were therefore tried out experimentally. These tests were administered to incoming patients soon after their arrival at the hospital and prior to the routine accomplishment of an initial diagnosis by the admitting physician. This initial diagnosis was made independently of the test results, and served as a criterion for the validation of the tests. The diagnosis provided a dichotomous grouping of "psychiatric" and "non-psychiatric" cases, and it was hoped that the battery of tests would predict with fair adequacy into which of these two groups patients would be assigned. With reasonably satisfactory prediction, the test battery could then be used to increase the reliability of the diagnosis. Crucial to the success of this investigation was the adequacy of the criterion against which the tests were to be validated. In general, the admitting diagnoses were satisfactory for the purposes of this study, a fact attested not only by an examination of the procedures used in making the diagnoses but also by the fact that reasonably high correlations were obtained between the battery and the criterion. However, it was
believed that there was considerable room for improvement in admitting diagnoses, particularly with reference to patients who were precisely diagnosed as having some "physical" difficulty, but who also were suffering from some psychological disturbance which frequently passed undetected.

Five tests were studied: the Incomplete Sentence Test, the Convalescent Personal Inventory, the C-H Adjustment Rating Scale, the Shipley-Hartford Scale for Intellectual Impairment, and the Bender Motor Gestalt Test. The first three of these (the Incomplete Sentence Test, the Personal Inventory, and the Rating Scale) individually yielded biserial correlations of around .40 with the psychiatric non-psychiatric diagnosis. The Shipley-Hartford Scale appeared to be little related differentially to the types of psychological difficulties found in the convalescent hospital population. Inadequate data were available for the Bender Gestalt Test to warrant more than the statement that further investigations appeared desirable on the basis of the promising results obtained. When any two of the first three tests were combined, multiple correlations as high as .48 were obtained, and when the three tests were grouped into a battery, the correlation rose to .50. The
addition of the Shipley-Hartford added little to the predictive efficiency of the battery, but its possible use as a substitute for missing Army General Classification Test scores was suggested. These results indicated that the battery of tests studied might be used to supplement and improve the procedures for determining which patients should be referred for psychotherapy.

The second phase of the work reported was concerned with individual psychotherapy. Individual treatment will probably remain as the most effective basic type of therapy for men suffering from psychological disturbances. But the process of individual therapy is too little understood even after its years of use. To add to this understanding, and to stimulate a reflective evaluation of their work by the psychologists who were locally concerned with giving individual therapy, the course of therapy with a single patient was carefully recorded and comments prepared to highlight significant developments in treatment.

The technique used in the treatment of this patient was for the most part non-directive. It was carried on consciously at a relatively superficial level, without an attempt to explore systematically the basic source of difficulty which had manifested itself in periodic episodes
of severe disturbance, the most recent of which was the cause of his assignment to the hospital for treatment. The therapist met with the patient for twelve sessions, the last two following a furlough during which the patient went home. While at home he evidenced the beneficial effects of his work with the therapist by doing without effort a number of things which he had formerly done only with great strain and discomfort. Two instructive generalizations were suggested by the analysis of the treatment given to this man. First, the difficulty of shifting therapeutic techniques during the course of treatment was indicated by the violent reaction of the patient to a shift from a relatively non-directive to an aggressive (and perhaps awkward) attempt of the therapist to reveal to the patient the consistent pattern and perhaps the cause of his difficulties. Second, the inability of the therapist, using non-directive techniques, to elicit from the patient a consideration of his deeply rooted sexual conflicts suggests a limitation to the technique, at least as it was used by the writer. Rorschach and Thematic Apperception Test materials are adduced as evidence of the sexual conflict which was touched upon only indirectly during the course of therapy.
Individual therapy is costly of time and talent. Circumstances often make it desirable to economize and extend to as many patients as possible the services of those qualified to give psychotherapy. During the war, the Army and Navy turned to group treatment as a means of resolving the difficulties of hospitals with a few psychiatrists and psychologists but with many patients who needed psychological help. Though expediency was the stimulus to the emphasis of group therapy, the general feeling was that certain types of patients might possibly profit more by group treatment than they would by individual treatment. But the concepts of group therapy were only hazily formulated. The traditional mental hygiene lecture-discussion method was suggested in so far as technique was concerned, and only random observations were made concerning the dynamics of group therapy. At the Cochran hospital, group psychotherapy was initiated as a service to patients with anxiety state diagnoses. At the same time, there was started a program of research, the goal of which was to develop means of attaining a quantitative analysis of recorded group therapy sessions and to formulate on the basis of such analyses some tentative suggestions as to the nature of this type of treatment.
A series of group psychotherapy sessions were recorded phonographically, and verbatim typescripts were obtained. On the basis of these typescripts, there was devised, empirically, a series of categories descriptive of the techniques used by the group leader and of the responses made by the patients. The response categories for the patients were further identified as positive or negative, being either in the direction of better adjustment or in the direction of continued maladjustment. This scheme for analyzing recorded sessions made possible a quantitative study of the course of therapy and of the nature of different therapeutic techniques. Two techniques were studied, one designated Technique Y which was relative non-directive, and one designated Technique X, which followed the traditional lecture-discussion method.

The complexity of the problem and the tentative nature of the findings of the study suggested that no conclusions should be drawn but rather that a number of hypotheses should be stated, and that these hypotheses should be grouped according to a judgment as to the probability of their being confirmed by further research. These hypotheses are given in detail on pages 222 to 226. Experience in the use of group techniques, however, corroborated the
expressed opinion of others that this type of treatment is most promising and deserving of further study.

So much by way of summary. It may be profitable now to turn to an over-all evaluation of the work done, to indicate points of weakness, and to describe some of the features of the work which were ancillary to its main purposes but which may have usable suggestions for other applied psychology programs, particularly those in the clinical area. Apart from specific procedures and results, what, in total, are the significant aspects of these studies which call for evaluative comment?

First of all, there are flaws in procedures which may be said to be gross, from the standpoint of exacting experimental requirements. In the development of the screening battery, only a limited number of tests were tried out, and these were not the most promising of tests that might have been chosen. The number of subjects in the study of the Bender-Gestalt Test was insufficient, and men with some familiarity with clinical psychology had to be used as the normal group. All of the tests were validated against an impure criterion, whereas it might have been possible to have boosted the validity coefficients appreciably by seeking a "normal" group outside of the hospital population.
A more efficient scoring procedure might have been used in the study of the Incomplete Sentence Test. Reliability indexes should have been obtained for all of the tests, and particularly for the C-H Adjustment Rating Scale, which, being newly developed, lacked previously reported estimates of reliability. A more sensitive measure of mental dysfunctioning might have been used in place of the unproductive Shipley-Hartford Scale. In the studies of individual and of group therapy, more cases are sorely needed. With an extension of therapy to groups of different composition from the ones studied, a refinement of the categories for scoring might have been achieved. These weaknesses are rather immediately apparent, and there are perhaps others that could be found. If one were designing a strictly research program to solve the problems that have here been studied, he would doubtlessly have done many things differently. But the work done was not only an experimental program; it was first a service program, and research techniques were introduced to make the services more effective. The battery of tests, though not the most desirable, had the compelling worth of being reasonably adequate, immediately available, and suitable for administration within the time and space limitations extent at the hospital.
More analyses of individual therapy cases would have added value to the work reported, but only so much effort could be invested in analysis of the course of therapy, since the chief purpose of therapy was to help as many patients as possible. In regard to the adequacy of the explorations in group therapy, there was simply not enough time to do all that might well have been done. These comments are not by way of apology for the work reported; if the work did not have a substantial adequacy it would not bear reporting, regardless of the circumstances under which it was done. But these comments do point up the imminently practical necessity of maintaining, in an applied psychology program, an effective balance between service and research functions. Taken in context, the weaknesses in the research done are tokens of the strength of the program, for they reveal compromises imposed by the service objectives of the work done.

The service and research program described was rich in suggestions for the effectiveness of cooperative research. The efforts of a number of individuals were shaped by the requirements of a well defined problem, and though the problem was divided among several groups, their work had a unity which is requisite to maximum productivity in
applied research. In the beginnings of the work reported, there was a centrifugal tendency which seems to be fairly characteristic in such activities. The tendency is to formulate a research program around the interests of the individuals participating without adequate regard for the requirements of the problems at hand. It is amazing into what byways research can wander, in an applied program, if it follows the tradition of laboratory science, in which such wanderings are essentially sound. There is a sort of perseveration of interests which will determine what work is done unless there is full acceptance by the group of the principle that all will cooperate to work on the defined problems.

The work in the convalescent hospital also had suggestions for defining the relationship between the work of psychologists and psychiatrists. A most cordial relationship existed between these two groups at the Cochran hospital, and the basis for this cordiality seemed to rest on two principles—a recognition of areas of competency and a willingness to pool resources to find answers to the hospital's problems. Instances of this close cooperation were many. Psychiatrists contributed substantially to the planning of group therapy, though this function was
delegated by directives to psychologists. Individual therapy cases were often carried together by a psychologist and a psychiatrist, as was done in the case of West. Such cooperation proves particularly effective in an institution for it allows the person responsible for therapy to keep his role well defined, without having to take responsibility for administrative decisions. It is believed that oft-discussed problems of defining the areas of work of psychologists and psychiatrists is more a matter of both groups being genuinely competent in certain skills (which are actually already well designated in the two disciplines) and then establishing in individual instances responsibilities for sharing work on a well defined problem.

The shortage of psychologists, now being felt in civilian pursuits, was also a matter of concern in military programs. The program at Cochran (and at other installations as well) suggests steps which may be taken in meeting the civilian needs for psychological services. It is quite possible to use, for many essentially psychological jobs, men who have less than the Ph.D. degree. The enlisted personnel of the Psychological Branch, with a few exceptions, had had little or no formal training in psychology. They were simply smart people who were eager to do a good job.
That such people are able to master specific tasks is evidenced by the reliability of judgments attained in the scoring of the Bender Gestalt records, and in the validity coefficients obtained for the C-H Adjustment Rating Scale. With careful instruction and under supervision of psychologists, men of intelligence and good judgment can often perform many tasks commonly delegated only to professionally trained personnel. This is not to argue against adequate training for people in psychology but to suggest that the need for psychological services and research so far exceeds the ability of psychologists to satisfy the need that all available talents (irrespective of labels) should be fully marshalled, guided always of course by people of professional competence. This suggests that there are levels of skills among people trained in psychology as well, and that such resources should be used fully, as, for instance, the Russian government has done in training large numbers of medical men at a level below that of the M.D. The objective is to meet an urgent need by providing competent research and services, not to sanctify a degree.

The careful study of individual and group therapy at the Cochran hospital indicated a problem that has been too much neglected in recent thinking about psychotherapy and
that is the significance of the personality of the therapist in the process of treatment. There has been something of a tendency to define rather strictly the techniques to be used in therapy to the unfortunate end that these techniques are mechanically used. This is an abnegation of the accepted principle that psychotherapy is essentially an important life-relationship between two individuals or among individuals in a group. That the relationship is human should be given more consideration in studies of the nature of therapy. And this fact must be more than a formulated phrase added, by way of admonition, after an overwhelming consideration of techniques.

Finally, there should be some note taken of what might be called the heuristic value of research. In an applied psychology program, the research done may often stimulate people to discover unsuspected value in the work of psychologists, a discovery and a consequent stimulation of interest which may spell the difference between the success or failure of the project. The scrupulous validation of his work is mighty armor for the psychologist. To be experimentally critical of work in progress, to make known the results of research in a straightforward manner,
to revise operations on the basis of research results
these procedures not only improve the work done but also
gain a respect for psychologists that is not enjoyed by
service groups that do not subject their efforts to con-
tinued rigorous evaluation.


52. Stevens, P. "The Station Hospital Psychologist," *Journal of Cons. Psychology*, 1944. 8:318-322.


APPENDIX A
The Rorschach Test and the Thematic Apperception Test were given to the patient at the close of counseling to obtain an independent evaluation of his condition at the time. The results of the Rorschach have already been mentioned briefly. As a matter of interest, the results of the T.A.T. are here presented in full, with an interpretation. The interpretation was made by a clinician who was not familiar with the details of the case, on the basis of the T.A.T. stories.

Interpretation of Thematic Apperception Test, West, Frank C.

"The predominant features of this patient's personality are his strong tendencies to withdraw from interpersonal relationships and his strong need for emotional support. His extreme passivity prevents him from taking a normally aggressive attitude toward solving his problems and makes him most dependent on others for help. His schizoid trends seem to result from his fear of involvement with others and from feelings of insecurity in regard to obtaining consistent support from others--in other words, from a fear of rejection.

"He is a moralistic person, especially sexually, in which regard he is immature, rigid, and has guilt feelings. It may be conjectured that his 'principles' are being used as defenses to prevent him from healthy sexual expression.

"Some evidence of repressed hostility is present. He seems to be able to express hostility but not in the presence of its source.

"He identifies himself with the lower economic class and has insecurity in that area as he does in most every aspect of living.

"He recognizes some of these aspects of his personality but it seems doubtful that he will make a good adjustment without consistent and strong emotional support from a figure whom he can trust."
Notes on Thematic Apperception Test, West, Frank G.

The test was given in accordance with instructions in the T.A.T. Manual. Rapport had already been established through several months counseling. The test was administered in an effort to uncover further the dynamics of the patient's difficulties, prior to dismissal, as a theoretical exercise pertinent to reflections on the adequacy of counseling techniques used. After a few preliminary remarks, the directions were read as given in the manual.

Picture No. 1 (Boy and Violin) "I would like to say that the boy is interested in that violin. (Pause) He would like to know what makes it operate, how to use it. He has a longing to play that violin himself. Still, the expression on that face might lead you to believe that he had to practice on that violin and that he wasn't very enthusiastic about it. He might be expressing desires but he might also just be whiling away the time so that he doesn't have to practice. He has a lazy, dreamy attitude."

Picture No. 3 FM (Boy Leaning Against Couch) "This looks like a very young boy. He goes to school. He is very distressed about something, perhaps about friends in school or something at home. He feels bad about something. He would be a person who would be easy to hurt. He finds it difficult to throw things off. He is probably a boy who doesn't associate with other boys much. He has a high degree of intelligence. He is too sensitive for his own good." (At that point, the clinician said, "What happens?") "Instead of getting those feelings expressed, he goes into himself instead of outward. It is a very bad thing. He needs a lot of social activities to get him out of himself. It depends on how big the problem is, whether it is the death of a relative or some minor thing. He is a type of boy that needs a lot of friends, someone to give him a tremendous boost." (Clinician asked, "How does it turn out?") "It depends on the boy, whether there is someone to help him or not, whether he is willing to do things himself."

Picture No. 3 GF (Girl Coming In Door) "This is very similar to the other one. The girl has been hurt about something. Perhaps she has a friend who meant a lot to her and he has walked out on her. He has hurt her in some way and she feels very bad about it. She is past school age. She has probably been in the outside world. Apparently she is
somewhat ashamed also. You would think she was going to open that door without someone seeing her. Then again, it would be difficult to know whether there is a sense of shame or whether her feelings have been hurt."

Picture No. 4 (Man and Woman in Room) "Well, apparently these two people have been very good friends. There is a disagreement between them. Probably he has suffered financial loss and he is desperate about something. She is pleading with him, trying to get him back on his feet. She wants him to listen to her. He shows grief or anxiety on his face. He is worried about something. Her encouragement does not seem to have much effect on him. He is in a very bad spot for the time being, but he will probably pull out of it. Probably she has brought him out of it. It is a well-known fact that the right girl can do wonders for a man, either make him or break him."

Picture No. 5 (Older Woman Coming Through Door) "This woman has evidently answered a call. She is conversing with someone. She is telling him goodnight. It must be in the evening because the lamp is lit and there are shadows. I have seen that same thing. I have been with a young lady the evening. They retired much earlier than we did and came in to say goodnight and to turn off the stove. That is about all I can tell you."

Picture No. 6 PM (Mother and Son) "Apparently there has been an argument between a man and a woman, possibly a mother and her son. From his face, I would say that he is perplexed. She has tried to reason with him, but he still doesn't have the correct answer to the problem. The problem could be an argument over most anything, over money matters, it could be an argument over a girl. He wants to marry the girl but there is dissension in the family. She might want him to do something like going to school or trying to better his position. He is satisfied to stay as he is. I would not say that she is angry. She has been talking to him, and she has one point of view and he has another, and he is perplexed. What the problem is is hard to say. He might be going to leave college or school and she is trying to get him to stay. Could be that he is already married, and she is unhappy. Some fellows will talk over with their mother things they will talk over with no one else."
Picture No. 7 EM (Father and Son) "I would say that the young boy is expressing bitterness. He has a feeling of hatred, as if he had been double-crossed. He is disillusioned by some sort of disappointment he has experienced. To the younger boy, it seems to be very, very important. He takes it seriously. The older man is interested, but he takes it more lightly. He is trying to give him advice, trying to help him. Could be many things, he lost a job, it may be money matters, his girl walked out on him, he may be married and unhappy or he may be in college and failed, his college career is about to be ended. The older man is trying to help him out, get him on his feet. He is giving him good sound advice. Another person can often see a problem better. The older man has experienced the same thing and is well qualified to help the younger man."

Picture No. 8 EM (Young Boy and Operating Room) "This is a complicated one. Apparently, there is to be an operation on the man who is prone. Doesn't look like a modern surgical ward, though. There are no white caps or capes and then there is the presence of that gun. I don't see where the well-dressed boy comes into the picture at all. Perhaps the pictures on the side are in the boy's mind. He is thinking about something that has happened. He may have had an operation and it took on those gruesome details that are in this picture. He may have had the operation or may be he is still going to have it and is thinking about it. The presence of the gun there may mean that rather than have the operation, he had as soon end his own life. He apparently did not have the same attitude that I had. I was in so much pain that I was glad to have the operation. He may have had an anesthetic and dreads having it again. That is a terrible feeling just before you go under. That boy needs help and should be helped. They could drugg him before giving him the anesthetic and do away with that fear. This is a case in which ignorance would not be bliss. If things were explained to him, he would not feel as he does. He would not have those pictures in the back of his mind."

Picture No. 9 EM (Men Lying on Ground) (Before taking this card, West said, "Psychology is really coming into its own, isn't it?"") "Well, this looks like a labor gang to me, during the noon hour, relaxing and trying to get a little rest. The hot weather makes them sleepy. These men
are fairly well dressed, so you would not call it a poor group. They are men who work with their hands, their bodies, physical work."

**Picture No. 10 (Man and Woman)** "Two people are very fond of each other. This is probably a parting. The woman doesn't look too happy about the situation. There is a little grief on her face. If it was a greeting they would be looking directly at each other. He is about to go away, leave. Men are usually able to stand those things better than women. He has no particular grief in his face."

**Picture No. 12 EG (Country Side)** "This is a very nice place to be." (said with emphasis) "A nice quiet spot in the country, lot of trees around, shady, flowers, a little stream and a boat, a place I would always like to go. When you get fed up with the city, all the noise and bustle, it sure would be nice to go to a place like that. If it were possible for more people to go to a place like that, there would not be so much trouble in the world. Just be a good place to relax, if you like to fish, swim, to be out-of-doors. This is especially true if you were raised in the country. If you lived in a city all your life, you probably would be bored and think it was a God-forsaken place."

**Picture No. 13 MF (Man and Woman in Bedroom)** (there was evidence of emotional blocking.) "That looks like a sad story too. Both people seem to be very young. It is hard to figure a plot out on that. I don't know whether she is dead or not. It might have a plot like this. In a weak moment, they both went to the room. The sex factor entered into their lives and now they are both ashamed of it. He seems to be especially. In other words, he has a sense of guilt whereas she is either sleepy or is not showing any emotion whatsoever. This sort of story has taken place around these Army camps. It is very unfortunate."

**Picture No. 13 B (Little Boy in Doorway)** "This looks very familiar in this particular section. He comes from a home that is not very modern. There is poverty, but he seems to be content. The family is in the lower class. This boy could be one of a large family which makes poverty all the more present. His father and mother
have a limited income. His father is not a skilled worker and is not ambitious. He is not caring for that family the way it should be taken care of, but maybe they are depression years and the father is perhaps not to blame." (The clinician asked, "How does the little boy feel about it?") "He seems to have a look of wonder on his face. He may resent the intrusion of some well-dressed people in a shiny car in the driveway."

Picture No. 14 (Boy at Window) "This is a boy that is in a darkened room. Apparently he is looking out into the right. He is wondering about something. Perhaps about a job or some girl friend who was very young--childish love affair. He is thinking of a problem."

Picture No. 18 BM (Drunk) "This boy has been out on an evening. He has a desire for drink. He is just one of those happy-go-lucky fellows with no sense of shame that someone might see him in that condition. He doesn't have pride. This is shown by his coat being open, his tie being out, and by his hair. Someone is trying to help him."

Picture No. 18 GF (Woman and Girl) "This would be a mother or a sister showing anxiety over a daughter or sister. Still, the woman's arms are not about her, it's more like a clutch. The woman does show anxiety rather than anger. She wants the younger woman to listen to her, but the other girl has been staying out late nights, doing things that made people talk about her. The older woman seems to be pleading with her, trying to explain things to her. The younger woman is not willing to listen to her, as shown by the grasp of the older woman. There is anxiety or sorrow in the older woman's face."

Picture No. 20 (Man on Street) "This looks like a man who is not very energetic, perhaps a playboy. You see this type of person in cities, leaning up against buildings, watching the girls go by. This is the type of person who strikes me as being shiftless and worthless. When he has a dollar, he is wealthy; when the dollar is gone, he will take off the clothes and go back to work."
**TABLE II. Distribution of Patient’s Responses and Group Leader’s Techniques for Session I (Type Y)**

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**Total Lines for Session 383**
TABLE III. Distribution of Patient's Responses and Group Leader's Techniques for Session 2 (Type Y)

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<tr>
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<td>157</td>
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<tr>
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</table>

TABLE IV. Distribution of Patient's Responses and Group Leader's Techniques for Session 3 (Type Y)

<table>
<thead>
<tr>
<th>Patient's Responses (38.4% of all lines)</th>
<th>Group Leader Techniques (61.6% of all lines)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative Factors</td>
<td>Number Lines</td>
</tr>
<tr>
<td>Dis</td>
<td>7</td>
</tr>
<tr>
<td>p-d</td>
<td>10</td>
</tr>
<tr>
<td>h-a</td>
<td>20</td>
</tr>
<tr>
<td>Total Neg.</td>
<td>37</td>
</tr>
<tr>
<td>Positive</td>
<td></td>
</tr>
<tr>
<td>ABR</td>
<td>81</td>
</tr>
<tr>
<td>S-C</td>
<td>73</td>
</tr>
<tr>
<td>AI</td>
<td>3</td>
</tr>
<tr>
<td>Und</td>
<td>6</td>
</tr>
<tr>
<td>Ins</td>
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</tr>
<tr>
<td>Total Pos.</td>
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</tr>
<tr>
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### TABLE V. Distribution of Patient's Responses and Group Leader's Techniques for Session 4 (Type Y)

<table>
<thead>
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<th>Negative Factors</th>
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<th>Per Cent Lines</th>
</tr>
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<tbody>
<tr>
<td>Dis</td>
<td>4</td>
<td>1</td>
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<tr>
<td>p-d</td>
<td>22</td>
<td>8</td>
</tr>
<tr>
<td>h-a</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Anx</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total Neg.</strong></td>
<td><strong>34</strong></td>
<td><strong>12</strong></td>
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</table>

**Positive**

<table>
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<tr>
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<th>Per Cent Lines</th>
</tr>
</thead>
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<tr>
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<td>7</td>
<td>3</td>
</tr>
<tr>
<td>ABR</td>
<td>33</td>
<td>12</td>
</tr>
<tr>
<td>S-C</td>
<td>196</td>
<td>71</td>
</tr>
<tr>
<td>Und</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total Pos.</strong></td>
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<td><strong>86</strong></td>
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<td><strong>Total Lines</strong></td>
<td><strong>276</strong></td>
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### TABLE VI. Distribution of Patient's Responses and Group Leader's Techniques for Session 5 (Type Y)

<table>
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<th>Per Cent Lines</th>
<th>Techniques</th>
<th>Number Lines</th>
<th>Per Cent Lines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pro</td>
<td>3</td>
<td>1</td>
<td>Ref</td>
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<td>8</td>
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<tr>
<td>Dis</td>
<td>4</td>
<td>2</td>
<td>Exp</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>p-d</td>
<td>9</td>
<td>5</td>
<td>MRB</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>h-a</td>
<td>4</td>
<td>2</td>
<td>Dir</td>
<td>53</td>
<td>31</td>
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<tr>
<td><strong>Total Neg.</strong></td>
<td><strong>20</strong></td>
<td><strong>10</strong></td>
<td>Rej</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Rea</td>
<td>6</td>
<td>3</td>
<td>Con</td>
<td>10</td>
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<td>1</td>
<td>1</td>
<td>Int</td>
<td>76</td>
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</tr>
<tr>
<td><strong>Total Lines</strong></td>
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### TABLE VII. Distribution of Patient's Responses and Group Leader's Techniques for Session 6 (Type Y)

<table>
<thead>
<tr>
<th>Patient Responses</th>
<th>Group Leader Techniques</th>
</tr>
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<td><strong>Negative Factors</strong></td>
<td><strong>Number</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Lines</strong></td>
</tr>
<tr>
<td>Pro</td>
<td>3</td>
</tr>
<tr>
<td>Dis</td>
<td>2</td>
</tr>
<tr>
<td>p-d</td>
<td>26</td>
</tr>
<tr>
<td>h-a</td>
<td>38</td>
</tr>
<tr>
<td>Ou</td>
<td>1</td>
</tr>
<tr>
<td>Anx</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total Neg.</strong></td>
<td><strong>71</strong></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Positive</th>
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</tr>
</thead>
<tbody>
<tr>
<td>ABR</td>
<td>69</td>
</tr>
<tr>
<td>S-C</td>
<td>122</td>
</tr>
<tr>
<td>A-I</td>
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<tr>
<td>Und</td>
<td>12</td>
</tr>
<tr>
<td>RO</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total Pos.</strong></td>
<td><strong>211</strong></td>
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<tr>
<td><strong>Total Lines</strong></td>
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</tr>
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### TABLE VIII. Distribution of Patient's Responses and Group Leader's Techniques for Session 7 (Type Y)

<table>
<thead>
<tr>
<th>Patient Responses</th>
<th>Group Leader Techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Negative Factors</strong></td>
<td><strong>Number</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Lines</strong></td>
</tr>
<tr>
<td>Pro</td>
<td>1</td>
</tr>
<tr>
<td>Dis</td>
<td>2</td>
</tr>
<tr>
<td>p-d</td>
<td>23</td>
</tr>
<tr>
<td>h-a</td>
<td>26</td>
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<tr>
<td><strong>Total Neg.</strong></td>
<td><strong>52</strong></td>
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</table>

<table>
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</thead>
<tbody>
<tr>
<td>Ins</td>
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</tr>
<tr>
<td>ABR</td>
<td>15</td>
</tr>
<tr>
<td>S-C</td>
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<tr>
<td>A-I</td>
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</tr>
<tr>
<td>RO</td>
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</tr>
<tr>
<td><strong>Total Pos.</strong></td>
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<td><strong>Total Lines</strong></td>
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### TABLE IX. Distribution of Patient's Responses and Group Leader's Techniques for all Sessions (Type Y)

<table>
<thead>
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<th>Patient Responses</th>
<th>Group Leader Techniques</th>
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<tr>
<td></td>
<td>Number Lines</td>
<td>Per Cent Lines</td>
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<tr>
<td>Dis</td>
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<td>p-d</td>
<td>114</td>
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</tr>
<tr>
<td>h-a</td>
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<td>16</td>
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<tr>
<td>Pro</td>
<td>7</td>
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</tr>
<tr>
<td>Anx</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Total Neg.</td>
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</tr>
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<td></td>
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</tr>
<tr>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Total Lines</td>
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TABLE X. Distribution of Total Positive and Negative Factors (Type Y Sessions)

<table>
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<th>Session 3</th>
<th>Session 4</th>
<th>Session 5</th>
<th>Session 6</th>
<th>Session 7</th>
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<tr>
<td>Neg.</td>
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<td>42</td>
<td>37</td>
<td>34</td>
<td>20</td>
<td>71</td>
<td>52</td>
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<tr>
<td>Pos.</td>
<td>111</td>
<td>28</td>
<td>164</td>
<td>242</td>
<td>174</td>
<td>211</td>
<td>131</td>
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</table>

TABLE XI. Distribution of Factors in Type Y Sessions

<table>
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<th>Session 3</th>
<th>Session 4</th>
<th>Session 5</th>
<th>Session 6</th>
<th>Session 7</th>
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<tbody>
<tr>
<td>Dis</td>
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<td>5</td>
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<td>2</td>
</tr>
<tr>
<td>p-d</td>
<td>23</td>
<td>6</td>
<td>10</td>
<td>22</td>
<td>9</td>
<td>26</td>
<td>23</td>
</tr>
<tr>
<td>h-a</td>
<td>232</td>
<td>60</td>
<td>33</td>
<td>20</td>
<td>4</td>
<td>28</td>
<td>26</td>
</tr>
<tr>
<td>Pro</td>
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<td>2</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>ANX</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>T. Neg.</td>
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<td>42</td>
<td>37</td>
<td>34</td>
<td>20</td>
<td>71</td>
<td>52</td>
</tr>
<tr>
<td>Ins.</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>ABR</td>
<td>18</td>
<td>5</td>
<td>97</td>
<td>81</td>
<td>35</td>
<td>82</td>
<td>69</td>
</tr>
<tr>
<td>S-C</td>
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<td>73</td>
<td>196</td>
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<td>122</td>
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<tr>
<td>A-I</td>
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<td>3</td>
<td>2</td>
<td>31</td>
<td>16</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Und</td>
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<td>1</td>
<td>6</td>
<td>6</td>
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<td>12</td>
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<tr>
<td>RO</td>
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<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>T. Pos.</td>
<td>111</td>
<td>28</td>
<td>164</td>
<td>242</td>
<td>174</td>
<td>211</td>
<td>131</td>
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TABLE XII. Comparison between Type "X" and Type "Y" of Patient's and Group Leader's Participation

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<th>Type &quot;X&quot;</th>
<th></th>
<th>Type &quot;Y&quot;</th>
<th></th>
</tr>
</thead>
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<td>Per Cent Participation</td>
<td>No. of Lines Participation</td>
<td>Per Cent Participation</td>
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<tr>
<td>Patient</td>
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<td>2135</td>
<td>57.4</td>
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<td>Group Leader</td>
<td>1805</td>
<td>85.2</td>
<td>1587</td>
<td>42.6</td>
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<td>Total Lines</td>
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<td>3622</td>
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TABLE XIII. Techniques of Group Leaders in Type "Y" and Type "X" Group Conferences Compared
(From data on seven type "Y" sessions and three type "X" sessions)

<table>
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<th>Per Cent Lines</th>
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</thead>
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<tr>
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<tr>
<td>Type X</td>
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</tr>
<tr>
<td>Type Y</td>
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<td>Accepting</td>
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<td>Type X</td>
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<td>X</td>
</tr>
<tr>
<td>Type Y</td>
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</tr>
<tr>
<td>Rejecting</td>
<td></td>
<td></td>
</tr>
<tr>
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<td>X</td>
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<tr>
<td>Type Y</td>
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<tr>
<td></td>
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</tr>
<tr>
<td>Reflecting</td>
<td></td>
<td></td>
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<tr>
<td>Type X</td>
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</tr>
<tr>
<td>Type Y</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>16</td>
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<tr>
<td>Interpreting</td>
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<td></td>
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<tr>
<td>Type X</td>
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<tr>
<td>Type Y</td>
<td>347</td>
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</tr>
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<td></td>
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<td>Explaining</td>
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<tr>
<td>Type Y</td>
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<td>Type X</td>
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<tr>
<td>Rapport Building Type Y</td>
<td>94</td>
<td>6</td>
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</tbody>
</table>
TABLE XII
PER CENT OF TOTAL LEADER LINES DEVOTED TO FOUR TECHNIQUES FOR ONE TYPE X SERIES AND TWO TYPE X SERIES OF GROUP PSYCHOTHERAPY

<table>
<thead>
<tr>
<th>Type of Statement</th>
<th>Type X</th>
<th>Type Y</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Leader 1</td>
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</tr>
<tr>
<td>Directing</td>
<td>4</td>
<td>26</td>
</tr>
<tr>
<td>Reflecting</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Interpreting</td>
<td>9</td>
<td>21</td>
</tr>
<tr>
<td>Explaining</td>
<td>83</td>
<td>35</td>
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</table>

TABLE XIII
PATIENT PARTICIPATION IN THREE DIFFERENT SERIES OF GROUP CONFERENCES, IN PER CENT OF TOTAL LINES OF PARTICIPATION

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<th>Type Session</th>
<th>Patient Participation Per Cent of Lines</th>
</tr>
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<tbody>
<tr>
<td>Type X</td>
<td>16</td>
</tr>
<tr>
<td>Type Y, Leader 1</td>
<td>58</td>
</tr>
<tr>
<td>Type Y, Leader 2</td>
<td>67</td>
</tr>
<tr>
<td>Type of Responses</td>
<td>Per Cent of Lines</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td></td>
<td>Type Y</td>
</tr>
<tr>
<td>Insight</td>
<td>3</td>
</tr>
<tr>
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</tr>
<tr>
<td>Rapport Building</td>
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</tr>
<tr>
<td>Understanding</td>
<td>2</td>
</tr>
<tr>
<td>Projection</td>
<td>1</td>
</tr>
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<td>Passive Dependent Reactions</td>
<td>6</td>
</tr>
<tr>
<td>Hostile-Aggressive Reactions</td>
<td>16</td>
</tr>
<tr>
<td>Displacement</td>
<td>2</td>
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<tr>
<td>Rationalization</td>
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</tr>
<tr>
<td>Depressive Reactions</td>
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</tbody>
</table>
AUTOBIOGRAPHY

I, Nicholas Hobbs, was born in Greenville, South Carolina, March 13, 1915. I received my secondary education in the public schools of Spartanburg, South Carolina. I attended The Citadel on a scholarship and received the degree of Bachelor of Arts in 1936 from that institution. After teaching two years in secondary schools, I enrolled in the Graduate School of the Ohio State University, with an appointment as an assistant in the Department of Psychology. I obtained the degree of Master of Arts in 1938 and continued graduate study until 1941, at which time I went into the Army. My Army service was devoted almost entirely to work of a psychological nature pertaining to the selection and training of aircrewmen, and the care of convalescent patients in an Air Force hospital. Upon discharge from the service I returned to the Ohio State University to complete requirements for the degree of Doctor of Philosophy. All of my graduate study has been done under the guidance of Dr. Sidney L. Pressey.