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HARSHMAN, Gordon Adair, 1921-
GROUP COUNSELING IN A NEUROPSYCHIATRIC
HOSPITAL IN CONTINUED-TREATMENT AND
EXTENDED-PRIVILEGE SETTINGS.

The Ohio State University, Ph.D., 1963
Psychology, clinical

University Microfilms, Inc., Ann Arbor, Michigan

often tended to become dull, apathetic, and increasingly dependent upon the institution. The same situation often occurs in today's hospitals, and is a source of concern for everyone involved. Current emphasis trends toward a stepped-up out-patient care program, with the aim of cutting down the incidence of hospital admissions, as well as returning to the community as large a percentage of patients as possible.

The present study centers primarily upon the latter of these two objectives, the major interest being, "What can be done, from a counseling viewpoint, to facilitate the rehabilitation of Np hospital patients, including those who have become to some degree 'institutionalized'?"

Characteristics

The "institutionalized" patient is believed by the writer to possess at least some of the following characteristics. (1) He is anomic, evidencing a lack of purpose, feelings of meaninglessness, hopelessness, and often, of despair. (2) He has withdrawn from active life--physically, socially, and mentally. (3) He seldom carries on a normal conversation, usually speaks only in answer to questions, then reluctantly. Often his responses, both words and emotional expression, seem inappropriate. (4) No zest for living is apparent, since the future holds no promise. (5) A characteristic lack of self-respect often generalizes to a total disregard for the rights of others. Thus he is apt to be uncooperative or hostile in interpersonal relationships.

possible the study of one person or the comparison of an individual's concept of himself with his concept of others by correlation techniques. In their recent critique of the literature on the measurement of self-concept, Strong and Feder (1961, 171) comment on the wide-spread usage of the Q-sort as a tool to measure self-concept:

The Q-sort is very adaptable and has been used as a research technique in the exploration of self-concept with various groups. These have included juvenile delinquents (Balester, 1956); hospital patients (Chase, 1957); Junior High School boys in group counseling (Caplan, 1957); university student leaders (Snoxell, 1953); and students from broken homes (Miller, 1958). It has perhaps been most widely used by Rogers and his associates in studying the self-concept in its relationship to psychotherapy (Rogers and Dymond, 1954).

Elsewhere, Strong and Feder (1961, 170) trace the development of self-concept as a criterion measure:

Raimy (1948) was the first to develop a methodology for measuring self-reference changes during psychotherapy. Because he observed that positive changes took place in self-reference during successful counseling, the self-concept emerged as an important variable in counseling evaluation.

In the present investigation the intent was to note the discrepancy between the subject's concept of self and his concept of "the typical, well-adjusted person out in the community, who is getting along well in every way," and to analyze increases or decreases in such discrepancies concomitant with treatment.

The SAQS, or Chicago Q Sort, developed by Corsini (1956), was chosen for several reasons, including simplicity, ease

of administration to groups, time requirements, ease of quantification of self-concept for statistical analysis, and adaptability to the sample in the present study. Corsini (1956) describes the instrument in terms of characteristics such as:

Distribution--The 50 adjectives are to be laid out in a rectangular distribution of ten columns or piles of five words each. The words when laid out are in a checkerboard pattern so that they can all be seen, and they may be placed on a surface that is 10 by 20 inches in size.

Time--The SAQS can be sorted in one-third the time that is needed to sort sentences. The first sort ordinarily takes a subject about 15 minutes; subsequent sorts take from 10 to 15 minutes.

Flexibility--Since the items are words, they can be sorted readily in terms of a variety of directions.

Recording--After the words are sorted, it is a matter of about 2 minutes to record the column-pile number of each word on a record sheet.

Correlating--By use of the special Table I in this manual, it is possible to correlate any two sorts of the SAQS within three to five minutes.

Difficulty--These 50 adjectives originally were taken from a considerably longer list obtained from diverse sources, and purified for difficulty, so that the list contains items familiar to adults of average intelligence.

Ambiguity--By a variety of procedures, steps were taken to eliminate words that were equivocal, ambiguous, or likely to be misinterpreted.

Stereotypy--Stereotyped words, which is to say words that may be applied to almost everybody or to very few, have been eliminated.

Representation--Steps were taken to insure that there was representation of seven major areas or "factors" of personality (Life style, dominance, mood, intelligence, activity, emotional stability, social sensitivity).

Reliability--The SAQS was given to two college groups for "self" a week apart. The 27 women had an average test-retest correlation of .81, and the 31 men had a reliability correlation of .79.

The subjects, in almost all cases, readily understood how to sort the SAQS. Each subject was given a pack of the 50 (1 1/2 X 3") cards containing the adjectives, and directed as indicated in Appendix VI. A chalkboard diagram was used to supplement these instructions, and individual assistance given as required. When a subject completed the sort, the cards were immediately scored and identified as to subject and sort. The second set of cards was then handed the subject, with a repetition of basic directions, with the exception that he was told to "sort this set . . . the way a typical, well-adjusted person out in the community, getting along well in every way, would do." As in all the testing done, the tester circulated continuously among the subjects to provide direction or assistance as needed.

Scoring was done according to the manual, with column weights of from "0" to "9" being assigned from left to right respectively, so that each card in the column "least like me" received a score of "0," those "most like me" a score of "9," etc. Since the major use of the Q technique was to ascertain changes in discrepancy between "concept of self" and "concept of other," the scores were tabulated to facilitate this analysis. The steps involved putting the two sorts of a subject into juxtaposition, to enable seeing the

column values of each word for the two sorts at a glance. Next, the smaller value was subtracted from the larger, the differences squared, then the sum of the squared differences (D^2) determined. This score, D^2 , was used in the analysis of group differences. Note that the larger D^2 scores are indicative of greater discrepancy between self-other sorts.

Two additional analyses of the data were conducted in a similar manner, in order to provide (a) a comparison of the subject's concept of "self" before and after treatment, and (b) a comparison of his concept of "other" before and after treatment.

(3) Dogmatism Scale (Appendix VII).--The third test of "attitude toward self in relation to others and the future" was Rokeach's Dogmatism Scale, Form E. Rokeach (1960, 71) states that "The primary purpose of this scale is to measure individual differences in openness or closedness of belief systems." It is also purported to measure general authoritarianism and general intolerance. Two of the dimensions of the scale seem especially appropriate: (1) items involving the "central-peripheral" dimension, including beliefs regarding the aloneness, isolation, and helplessness of man; uncertainty of the future; and self-adequacy and inadequacy; and (2) items involving the "time-perspective" dimension, including attitudes toward the past, present, and future, and knowing the future.

A modified version of the scale used by Swearingen (1963) in a study of a VA Domiciliary population seemed most appropriate for the present study, because of simplicity of directions and format. A six-point scale was inserted below each of 60 items taken from Rokeach's D-scale (1960), including all forty Form E items, to permit easy marking of degree of agreement or disagreement with the statement. For example, item (1): "A person who thinks primarily of his own happiness is beneath contempt."

X	X	X	X	X	X
I Agree Very Much	I Agree on the Whole	I Agree a Little	I Disagree a Little	I Disagree on the Whole	I Disagree Very Much

Test instructions are included in Appendix VII. The tester read the instructions orally as the subject read silently.

Agreement with the item was scored as "closed-minded," disagreement as "open-minded." The forty items of Form E were scored, eliminating "fill-in" items #'s 3, 6, 9, 12, etc. Weights of 1-2-3-5-6-7, corresponding to choices ranging from "I agree very much" to "I disagree very much," respectively, were assigned. Therefore, a person receiving a high score on the test would be termed "open-minded."

Rokeach (1960, 90) reports reliability of Form E on two VA Domiciliary studies of .93 and .84 (test-retest after one month), indicating that the scale went through five editions to increase reliability to that point. He observes that:

These reliabilities are considered to be quite satisfactory, especially when we remember that the Dogmatism Scale contains quite a strange collection of items that cover a lot of territory and appear on the surface to be unrelated to each other.

For statistical treatment, the assigned scores of the (forty) items were totaled and tabulated for later comparison of groups on the basis of pre-post treatment change.

To sum up, the subjects were evaluated before and after treatment in terms of three major criteria, utilizing five criterion measures: (1) "general observed behavior"--the Hospital Adjustment and Placement Scale (HAPS); (2) "verbal behavior"--the Judges Rating Scale for Verbal Behavior; and (3) "attitude toward self in relation to others and the future"--by three instruments, (a) Elmore's Scale of Psychological Anomie, (b) Corsini's Standard Adjective Q Sort (SAQS), and (c) Rokeach's Dogmatism Scale.

Analysis of the group counseling process

Rather than just assume that each group would be counseled according to pre-arranged standards, procedures, and instructions, two means of obtaining more specific descriptive information about the actual "group process" were employed. These involved evaluations by (1) the subjects who served as members of the counseled groups and (2) judges who evaluated the groups on the basis of recorded protocols.

(1) The (Patients') Group Evaluation Worksheet (Appendix VIII).--This instrument was administered to counseled

subjects as part of the post-treatment evaluation. It contains fourteen scaled items in four parts, including: (A) "Focus of Group Discussion," with emphasis on amount of talk about the future and the degree to which that talk was centered around the strong points or abilities of group members, as compared with their weak points or problems; (B) "Control of Discussion," which contrasts the leader (counselor) and members as to amount of talk and introduction of new topics; (C) "Atmosphere and Freedom of Expression," which probed the subjects' opinions about the freedom they felt to discuss any topic or to express any feeling they wished to, regardless of what they may be; and their feelings about the atmosphere of the group meetings in terms of warmth, friendliness, acceptance, anticipation; and (D) "Outcomes," designed to elicit expressions of opinion regarding the helpfulness of the group meetings in providing the following: sharing of information and experience (Item 9), increased self-confidence and ability to accept self "as-is" (Item 10), improved self-expression and ability to get along with others (Item 11), improved participation in available activities and increased use of privileges (Item 12), realistic plans and actual steps toward life outside the hospital (Item 13), and a general feeling about the value of the group meetings (Item 14).

The use of clients' reports of counselor variables have been used by several previous investigators. Grigg

(1961) cites Arbuckle (1956), Forgy and Black (1954), Snyder (1957), and Grigg and Goodstein (1957) as examples. Others, such as Snyder's (1961) Penn State studies could be added.

Grigg (1961, 218) concludes:

. . . since studies find that one cannot predict counselor responses by the theoretical orientation subscribed by the counselor (Fiedler, 1950; Strupp, 1955, 1957; Wrenn, 1960), it is imperative to obtain some report of observations of counselors during the interview hour. The use of client observations is one method of studying counselor behaviors.

The specific dimensions used in the patient ratings of the present study were selected because of assumed relation to the general orientation and focus of the study, as previously described, to allow comparison of patient and judge opinions, as well as correlational comparisons with other measures.

Instructions were quite simple, and orally given:

For several months you have been a member of a group in which you have had a chance to discuss many things. At this time we would like your frank opinions about certain aspects of such group participation. We believe that knowing how you really feel will help us to better meet your needs. Your name will not be written on these forms, so please indicate your honest opinions.

The subjects were then shown how to mark the items, which consisted of placing an "X" on the line in front of the one statement (of the four given) which best expressed their opinion (Parts A-C); or placing an "X" at "any point" on the scale that best expresses your opinion" (Part D).

Items selected and scored for statistical analysis and the dimension represented were: Item 3.a.--Focus of Group Discussion (on future); Item 4.a.--Focus of Group Discussion (strengths vs. weaknesses); Average of items 5.a. and 6.a.--Control of Discussion; Average of items 7.a. and 8.--Atmosphere and Freedom of Expression; Items 9-14--Outcomes (helpfulness of group meetings). All items except #8 were weighted 4-3-2-1, with largest weights given responses indicative of more positive attitudes (Item #8 was weighted 1-2-3-4).

Two sub-total scores were obtained and tabulated for analysis: (1) Parts A-C, (2) Part D.

(2) The Judges' Analysis of Group Counseling Process (Appendix IX).--This scale, devised by the experimenter, is composed of four dimensions: I.--"Focus of Discussion: Time Orientation"; II.--"Focus of Discussion: Weaknesses vs. Strengths, Liabilities vs. Assets"; III.--"Control of Discussion: Division of Responsibility" (talk ratio and introduction of topics); and IV.--"Degree of Acceptance, Warmth and Permissiveness." It will be noted that these are comparable to the dimensions used for the patients' Group Evaluation Worksheet, and fit into the general theoretical approach of the experimenter in the present study. The dimensions of both instruments are in part a modification of Robinson's (1955) dimensions of counselor response, which he developed as a means of studying the dyadic counseling process. His dimensions are (1) "acceptance attitude,"

(2) "responding to the core of the client's remark," (3) "division of responsibility," and (4) "degree of lead"--each of which he supports by reference to pertinent research findings.

Two judges--the experimenter and another graduate student in Counseling Psychology--analyzed eight taped group sessions, the second and eleventh of each counseled group. The instructions for rating were to:

Listen to the first 5-minute segment of the tape, stop the recorder, and rate the segment just audited on each of the four dimensions. Repeat the operation for the next segment, etc., until the entire tape is rated. Rate each dimension by placing an X on the scale at that point which best expresses your judgment.

A pilot run was taken during the training period, and consideration given to the framework of each dimension, the mechanics of the rating process, etc.

Scoring was done on a basis of one to five points, with the larger weights corresponding to more emphasis on (1) future events, (2) strengths and assets of group members, (3) group members taking more responsibility for selection of topics and discussion, and (4) warm, friendly, comfortable atmosphere. Each of the five-minute segments was weighted, and the average score for each dimension, as well as a total score, was recorded. Appendix IX shows the Format For Dimension I, as well as the general instructions. The same format was used for each of the four dimensions. However, to conserve space, only the scale descriptions and first five-minute segment scale for dimensions II-IV are included.

(6) He adapts slowly to the demands of the present situation, is rigid and closed-minded, as contrasted with a person who is flexible, adaptive, and open-minded. He is unwilling to change, to try new ideas. (7) With extended hospitalization, the patient often appears to lose his sense of identity, becoming less autonomous, less independent, showing little initiative or competence. (8) Often this state is accompanied by a loss of pride in personal appearance, and a general apathy toward assignments and social activities, which are engaged in carelessly and often under duress, if at all. (9) Hostility toward others and self may be controlled by medication, but is often apparent in attitude as well as action. (10) Since he has become "resigned to fate," with little or no hope for the future, progress is nil, and a gradual withdrawal, as well as increasing development of such negative characteristics as the above, is noted. (11) Plans for leaving the hospital are often either entirely lacking or are based on fantasy, with little resemblance between aspiration and present actuality. Long-range goals fit a similar pattern, and nowhere to be discovered are such desirable attributes as realistic short-term goals, plans, or actual steps being taken in the direction of improvement of either self or situation.

Analysis of the situation

It was the writer's opinion that a view of some of the facets of the total milieu based on the perceptions of the subjects themselves would prove useful. An instrument, the Patient Activities Checklist and Opinionnaire (PACO, Appendix X) was devised to assist in obtaining such information. An attempt was made to include items dealing with: a wide range of patient activities; use of privileges; assignments and their selection; participation in operation and maintenance of the unit; opinions regarding adequacy of facilities; and freedom and responsibility in handling own choices, property, funds, and time.

After constructing the PACO, item weights were determined as explained in Appendix X. The CT Unit was used as the standard of comparisons, since the total sample originated there, and it was used as the standard for the HAPS.

Three combinations of scores were recorded and coded as the basis for analysis of groups and units: (1) a combination of Parts A-D, composed of a checklist for indicating the individual subject's present level of activity (defined as the (a) average time spent per twenty-four hour day in the following activities: sleeping or napping; sitting--thinking, watching TV, etc., but not reading or in conversation or recreation; reading or writing letters; recreation or conversation; work assignment; educational therapy; (b) number of passes and LOA's taken within the

past eight weeks; and (d) level of medication and whether medicine was self-administered); (2) a combination of Parts E-G, eliciting expression of opinions (regarding: (e) selection of assignments; (f) patient freedom and responsibility in establishing rules and procedures for running the unit; (g) the physical facilities and policies regarding their use, degree of freedom and responsibility in regard to extra-hospital communication, use of pass and leave privileges, use of funds, safety of and access to personal property--including clothing, restrictions on shaving and TV viewing); and (3) a total PACO score, obtained by adding all item scores, Parts A-G.

The PACO was administered to all (forty-six) subjects during the post-treatment evaluation period, with instructions to:

Place an X on the line in front of the answer which best describes your own actual situation at this time (not what you feel you should or would like to be doing).

Patients were assured, as with all tests, of confidentiality, and were told to use a code number (assigned at the first of the pre-treatment evaluation sessions) instead of their name if they wished.

The major use of the data obtained from this instrument will be to compare patients' level of activity and opinions regarding their unit in the two experimental settings (CT Unit and EP Unit). This will be done in Chapter IV.

Background variables

Since the six experimental groups were selected at random from the screened population, no effort was made to match groups on the basis of experience of various kinds, age, etc. However, data was readily available in hospital records, with additional information obtained during post-treatment evaluation by means of a personal data form (Appendix XI). A general description of the subjects was included in an earlier section ("Design"). The specific procedure used to assess each of several background variables in order to facilitate comparison of groups is included in Appendix XI. The background variables studied were: age, education, verbal comprehension, marital status, length of hospitalization, length of military service, diagnosis, vocational background, financial situation, number of group sessions attended, and number of days on pass or leave during treatment period. Scoring was done in a way to permit use of analysis of variance as the statistical technique in comparison of groups, as well as correlation with other measures.

Testing order and evaluation time, pre and post-treatment

Figure 2 indicates the order of testing, which was the same for each (testing) group, and the patient testing-time required.

Figure 2

Testing Order and Time per Patient in Evaluation,
Pre- and Post-treatment

Order	Test or Activity	Time (Range) in Minutes
1 ^a	Wesman, verbal scale	15-30
2	Standard Adjective Q Sort (SAQS)	30-60
3	Psychological Anomie Scale	40-80
4	Dogmatism Scale	20-50
5 ^b	Personal Data form	15-30
6 ^b	Patient Activity Checklist & Opinionnaire	20-40
7 ^c	Patient Scale for Group Evaluation	10-20
8	Individual Interview	10-15

^aPre-treatment evaluation only

^bPost-treatment evaluation only

^cPost-treatment, counseled subjects only

Additional data

Two other instruments were utilized to obtain information of interest, but not to directly test any of the hypotheses. (1) The Hospital Adjustment Scale (HAS, Appendix XII) was previously discussed in relation to the HAPS, and was scored according to the Manual. (2) The Counselor Rating Worksheet (Appendix XIII) was devised as a means of assessing counselor ratings of the subjects in their counseling groups. Ratings were made after the third and twelfth sessions. Items focus on (a) degree of insight regarding own condition, relations with other patients and staff members, and aims of the hospital; (b) adequacy and realism of plans for the future; (c) apparent attitude toward the group; and (d) two items

dealing with degree of participation in the group, including social interaction and verbal expression.

Scores were based on a five-point scale, and both individual item and total scores were recorded for each counseled subject. Results will enable comparison with data from other measures, including the patient and judge analyses of the group process.

In this section the instruments used were described and discussed in five groups: (1) those used as criteria measures, (2) those developed for the purpose of analyzing the actual group counseling process, (3) one to provide an analysis of the situation in CT Unit and EP Unit from the viewpoint of the subjects, (4) the form used to gather personal data and the rationale adopted to investigate several background variables, and (5) those used to add validating data or information of interest but not designed to test any specific hypotheses.

Explanation of the instruments covered includes: reasons for choice of the instrument; limitations; a general description, including attention to reliability and validity; instructions and procedures; system of scoring and statistical treatment to be employed. All scores and other pertinent data were carefully recorded on individual tabulation forms, and later coded on data-processing sheets, to allow for more efficient punching of IBM cards. The services of the Numer-

ical Computation Laboratory of The Ohio State University were made available, and the statistical computations done on the 7090 computer.

CHAPTER IV

FINDINGS AND DISCUSSION

Findings

The major findings and their implications are presented in this order: (1) conclusions regarding the two major experimental hypotheses; (2) tests of the comparability of the six groups and two units in terms of pre-treatment criteria measures; (3) tests of the specific hypotheses, in terms of the major and sub-criteria; (4) examination of differences on criteria measures in terms of background variables; (5) analysis of the treatment settings and the group process; and (6) additional findings.

Choice of the statistics

The statistic decided upon for comparison of groups in relation to the criteria was analysis of variance. In addition, it was decided that inter-judge reliability and relationships among background variables and the major and sub-criteria could best be assessed by correlation techniques. It is believed that the nature of the design, the assumption of continuous scores on each measure, and the assumption of a normal distribution of stabilized Np patients (as limited by the sampling procedure explained above) in each group all point toward the use of the analysis of variance method. The number and type of instruments used, some of which were untried, thus lacking information regarding

reliability and validity, indicated the desirability of the correlational process.

Tables 1, 2, and 3 present the major findings. Before referring specifically to them, conclusions regarding the two major hypotheses will be discussed.

Conclusions regarding the two major experimental hypotheses

The two major experimental hypotheses were: H I-- "Regular Hospital activities plus group counseling is a treatment milieu more conducive to positive behavioral change than is regular hospital activities without group counseling," and H II-- "An extended-privilege building provides a treatment milieu more conducive to positive behavioral change than does a continued-treatment building." Findings are negative to both hypotheses. In general, trends were in the direction opposite to the hypotheses, with the exception of those showing no change (SAQS, H II) or very slight positive support for the hypotheses (JRSVB, H II; Dogmatism, H I). Definitely negative trends (not statistically significant) are noted on Psychological Anomie (H I) and SAQS (H I), two measures of "attitude toward self in relation to others and to the future."

Theoretical implications of these and other findings will be considered in detail later in this chapter. It would seem that the most important single finding is that the results and trends are so consistently negative to the hypotheses.

Previous studies found similar difficulty in realizing positive results in terms of "immediate" criteria. Wright (1956, 89), in explaining negative results concluded that measures comparable to some used in the present study (Curtis Sentence Completion Form, Bills Index of Adjustment and Values) were not valid measures of progress, on grounds that ". . . the Candidate Employee Program was so successful according to environmental criteria." He found (72) that his "success" group (in terms of "ultimate criteria" as defined in present study) "slipped slightly," while the "non-success" group improved significantly. In all comparisons on his "self-other concept" measures more improvement was registered for the non-success group. He concludes (73)

Thus we have evidence that the Index Adjustment and Values is sensitive to change occurring during nine months of C.E.P. participation--but only for a non-successful group. It is also capable of differentiating successful and non-successful groups--but in the unexpected direction. These results are difficult to rationalize.

Wright hypothesized that the stress of a new job, etc., or plans for leaving the hospital, on the part of the "success" group, plus "less than a warm reception" from society, might have flattened the progress scores; while the non-success group were not thus disturbed. The present results tend to confirm this hypothesis. He also noted a trend similar to that mentioned above, that since his "non-success" group scored lower on initial measures, they had more room

for improvement. This trend in both the Wright study and the present study could plausibly be due to artifact.

Luborsky (1962), in his criticism of Eysenck's (1952) findings regarding the effects of psychotherapy, disqualified the findings because subjects in Eysenck's sample were not equal at the beginning (no baseline). He believes that since the number of points of improvement depended upon the initial level, only slight increase could be shown on those having high pre-treatment scores, with greater increases possible for those beginning with low scores.

Wright used the Hospital Adjustment Scale (Appendix XII), finding no significant differences between groups, although some predictive value was claimed. Stotsky (1955) also failed to predict success on the Member Employee Program by means of psychological tests. His study had features similar to those tested by H II of the present study.

Comparability of groups and units in terms of pre-treatment criteria measures

The meaning and significance of experimental findings are relative to many factors, some of which can be determined and controlled, at least partially. The intent throughout the study was to maintain as rigorous controls as feasible within the limitations of the design and practical factors of the setting. Pre-treatment measures provide an indication of the comparability of the randomly selected groups. Later

Contributing factors

Nearly every discipline dealing with human behavior attempts to explain the roots and development of these characteristics. From such divergent areas as the animal laboratory and existentialism are coming claims, with increasing evidence to support them, that the thriving animal or human depends on the interaction of others of his species. The human is indeed a social being, demanding love and trust in a reciprocal relationship.

Situational factors such as broken homes, extended periods of isolation or stress as in wartime, extremes of over- or under-protectiveness of parents--are only a few of the possible reasons for growth of distrust and subsequent warped or inadequate development. Erikson (1959) points out that without the development of such trust, a child can never adequately achieve rich relationships with others.

In many instances patients have apparently never developed a warm, trusting relationship in their entire lives. This results in withdrawal or anti-social behavior, and becomes a major concern in treatment.

Various means of improving social relationships are employed, including group activities and therapies. It is believed by many (Kepinski, et al., 1960; Jones, 1956; Wright, 1956, 1959) that provision of a permissive atmosphere in which the patient can assume responsibility for his actions according to his ability to do so is extremely

analysis of pre-post treatment difference scores and conclusions drawn from them may at times be modified by information thus obtained.

Tables 1 and 2 provide a comparison of groups and units on pre-treatment measures. Means and standard deviations are shown in Table 1 for each of the (5) major and (24) sub-criterion measures.

An analysis of variance of each criterion measure is presented in Table 2, and makes possible a check of the significance of any of the differences noted in Table 1. No significant differences on either total or sub-criteria pre-treatment measures are indicated by the F ratios. Thus it can be assumed with some confidence that the subjects of all six groups were comparable insofar as pre-treatment criteria measures were concerned. Also, no significant differences between the subjects of the two units are noted on pre-treatment measures.

There are, however, some trends that should be pointed out. This will be done by summarizing trends relating to the three major criteria--general observed behavior, verbal behavior, and attitude toward self in relation to others and the future. General observed behavior was measured by the HAPS. CT Unit subjects were given a higher (not statistically significant) rating by nurses and assistants than those of EP Unit as to their chances for rehabilitation (HAPS, items 1-5). The subjects assigned to EP Trainee were on

TABLE 1
MEANS AND STANDARD DEVIATIONS ON PRE-TREATMENT
AND PRE-POST TREATMENT DIFFERENCE MEASURES

Criterion Measure	Unit	Pre-Treatment Measures				SD	Difference Measures				SD
		Mean					Mean				
		Staff	Trainee	Non-C.	Total ^a		Staff	Trainee	Non-C.	Total	
HAPS ^b (Total)	EP	46.00	45.40	47.40	46.50		-4.74	-1.83	-1.13	-2.41	
	CT	49.20	46.97	48.30	48.20		-1.54	-0.23	-0.34	-0.68	
	Tot.	47.60	46.19	47.90	47.30	5.630	-3.14	-1.03	-0.74	-1.55	6.880
HAPS- (I-VIII)	EP	32.53	32.18	32.97	32.60		-3.59	-0.70	-0.14	-1.33	
	CT	34.71	32.60	35.05	33.90		-1.29	0.40	0.09	-0.25	
	Tot.	33.62	32.39	33.51	33.25	4.060	-2.44	-0.15	-0.03	-0.79	4.881
HAPS (1-5)	EP	13.49	13.25	14.45	13.80		-1.20	-1.18	-0.99	-1.10	
	CT	14.51	14.40	14.26	14.40		-0.27	-0.67	-0.63	-0.53	
	Tot.	14.00	13.83	14.36	14.10	1.900	-0.74	-0.93	-0.81	-0.82	2.478
HAPS I	EP	3.49	3.40	3.19	3.33		-0.51	-0.28	0.05	-0.10	
	CT	3.24	3.27	3.22	3.24		0.37	0.58	0.35	0.42	
	Tot.	3.36	3.33	3.21	3.29	0.653	-0.07	0.15	0.20	0.10	0.819
HAPS II	EP	4.29	4.67	4.52	4.49		-0.39	-0.33	0.38	-0.04	
	CT	4.63	4.35	4.25	4.39		-0.14	0.10	0.15	0.05	
	Tot.	4.46	4.51	4.39	4.44	0.685	-0.26	-0.12	0.27	0.00	0.867

TABLE 1--Continued

Criterion Measure	Unit	Pre-Treatment Measures				SD	Difference Measures				SD
		Mean					Mean				
		Staff	Trainee	Non-C.	Total		Staff	Trainee	Non-C.	Total	
HAPS III	EP	3.80	4.40	4.51	4.27		-0.34	-0.02	0.20	-0.02	
	CT	4.74	4.28	4.60	4.56		-0.29	0.13	0.10	-0.01	
	Tot.	4.27	4.34	4.56	4.41	0.782	-0.31	0.06	0.15	-0.02	0.992
HAPS IV	EP	4.60	4.00	4.84	4.55		-0.14	0.52	0.00	0.09	
	CT	5.16	4.77	4.66	4.84		-1.03	-0.70	-0.20	-0.58	
	Tot.	4.88	4.38	4.75	4.69	0.699	-0.59	-0.09	-0.10	-0.25	0.689
HAPS V	EP	3.94	3.70	3.80	3.82		-1.24	-0.75	-0.46	-0.77	
	CT	4.06	3.70	4.20	4.03		-0.03	0.23	-0.03	0.04	
	Tot.	4.00	3.70	4.00	3.92	0.652	-0.64	-0.26	-0.25	-0.37	0.966
HAPS VI	EP	4.07	4.25	4.23	4.19		-0.03	0.37	0.17	0.16	
	CT	4.41	4.07	4.49	4.36		-0.03	0.22	-0.04	0.03	
	Tot.	4.24	4.16	4.36	4.27	0.758	-0.03	0.29	0.07	0.10	0.921
HAPS VII	EP	4.41	4.12	4.28	4.28		-0.47	-0.23	-0.21	-0.30	
	CT	4.63	4.32	4.40	4.45		-0.34	-0.18	-0.33	-0.30	
	Tot.	4.52	4.22	4.34	4.36	0.663	-0.41	-0.21	-0.27	-0.30	0.721
HAPS VIII	EP	4.13	3.98	3.83	3.96		-0.64	-0.08	-0.47	-0.42	
	CT	4.09	4.03	4.35	4.19		-0.04	-0.08	-0.05	-0.06	
	Tot.	4.11	4.01	4.09	4.07	0.845	-0.34	-0.08	-0.26	-0.24	0.933

TABLE 1--Continued

Criterion Measure	Unit	Pre-Treatment Measures				SD	Difference Measures				SD
		Mean					Mean				
		Staff	Trainee	Non-C.	Total		Staff	Trainee	Non-C.	Total	
HAPS 1	EP	2.47	2.67	2.83	2.68		0.50	0.28	0.18	0.30	
	CT	3.01	2.73	2.73	2.82		-0.01	0.00	-0.10	-0.05	
	Tot.	2.74	2.70	2.78	2.75	0.409	0.24	0.14	0.04	0.13	0.575
HAPS 2	EP	2.44	2.18	2.82	2.54		-0.56	-0.18	-0.68	-0.51	
	CT	2.77	2.63	2.59	2.66		0.04	0.20	0.12	0.12	
	Tot.	2.61	2.41	2.71	2.60	0.541	-0.26	0.01	-0.28	-0.20	0.701
HAPS 3	EP	3.11	2.98	3.33	3.17		-0.46	-0.10	-0.14	-0.23	
	CT	3.04	3.23	2.39	3.20		-0.29	-0.68	-0.53	-0.50	
	Tot.	3.08	3.11	3.31	3.19	0.435	-0.37	-0.39	-0.34	-0.36	0.671
HAPS 4	EP	3.20	3.15	3.36	3.26		-0.36	-0.77	-0.19	-0.39	
	CT	3.39	3.61	3.32	3.42		-0.09	-0.40	-0.08	-0.17	
	Tot.	3.29	3.38	3.34	3.34	0.513	-0.22	-0.58	-0.14	-0.28	0.707
HAPS 5	EP	2.27	2.45	2.11	2.25		-0.30	-0.60	-0.13	-0.30	
	CT	2.37	2.37	2.37	2.37		0.00	0.03	-0.11	-0.04	
	Tot.	2.32	2.41	2.24	2.31	0.502	-0.15	-0.28	-0.12	-0.17	0.645
JRSVB ^b (Total)	EP	32.84	30.00	26.10	29.17		4.97	-3.48	4.51	2.57	
	CT	34.61	23.28	32.69	30.82		-0.13	0.30	1.68	0.77	
	Tot.	33.73	26.63	29.40	29.99	8.700	2.42	-1.59	3.10	1.67	6.837

TABLE 1--Continued

Criterion Measure	Unit	Pre-Treatment Measures				SD	Difference Measures				SD
		Mean					Mean				
		Staff	Trainee	Non-C.	Total		Staff	Trainee	Non-C.	Total	
JRSVB a	EP	5.43	5.05	3.67	4.57	1.644	0.30	-0.73	0.67	0.19	1.320
	CT	5.39	3.35	4.76	4.58		-0.47	-0.23	0.48	0.00	
	Tot.	5.41	4.20	4.22	4.57		-0.09	-0.48	0.58	0.10	
JRSVB b	EP	4.39	4.00	3.80	4.03	1.619	0.13	-0.60	0.40	0.06	1.153
	CT	4.16	3.67	4.48	4.17		0.64	-0.56	0.55	0.29	
	Tot.	4.27	3.83	4.14	4.10		0.39	-0.58	0.48	0.17	
JRSVB c	EP	3.91	2.67	3.09	3.23	1.700	0.71	-0.47	0.88	0.48	1.407
	CT	4.53	2.88	4.34	4.02		0.33	0.07	-0.41	-0.06	
	Tot.	4.22	2.78	3.71	3.62		0.52	-0.20	0.24	0.21	
JRSVB d	EP	3.47	2.78	2.87	3.03	1.278	0.57	-0.22	0.83	0.48	1.400
	CT	4.37	2.60	3.91	3.71		0.04	0.52	0.01	0.15	
	Tot.	3.92	2.69	3.39	3.37		0.31	0.15	0.42	0.32	
JRSVB e	EP	4.91	4.72	3.57	4.28	1.352	0.07	-0.32	0.96	0.36	1.352
	CT	4.41	3.22	4.36	4.08		-0.10	-0.03	0.69	0.26	
	Tot.	4.66	3.97	3.97	4.18		-0.01	-0.18	0.83	0.31	
JRSVB f	EP	3.57	3.23	3.11	3.28	1.346	0.70	-0.47	-0.01	0.09	1.140
	CT	3.76	2.03	3.50	3.20		-0.50	0.50	0.07	0.09	
	Tot.	3.66	2.63	3.31	3.24		0.10	0.02	0.03	0.05	

TABLE 1--Continued

Criterion Measure	Unit	Pre-Treatment Measures				SD	Difference Measures				SD
		Mean					Mean				
		Staff	Trainee	Non-C.	Total		Staff	Trainee	Non-C.	Total	
JRSVB g	EP	4.20	4.95	3.50	4.09		0.64	-0.52	0.36	0.22	
	CT	3.96	2.88	4.36	3.85		0.04	0.27	-0.16	0.13	
	Tot.	4.08	3.92	3.93	3.97	1.407	0.34	-0.13	0.10	0.12	1.179
JRSVB h	EP	3.00	2.38	2.66	2.82		1.76	-0.60	0.37	0.54	
	CT	3.66	3.18	2.99	3.11		-0.54	-0.30	0.44	-0.05	
	Tot.	3.33	2.78	2.83	2.97	1.403	0.61	-0.45	0.41	0.24	1.354
Anomie ^{bc} (Total)	EP	886.57	770.83	814.10	824.90		-100.14	-23.83	-26.90	-48.40	
	CT	926.57	851.00	957.60	920.30		-10.29	-4.67	-10.20	-6.30	
	Tot.	906.57	810.92	885.85	872.60	132.320	-55.21	-9.58	-18.55	-27.35	73.657
Anomie ^c (Scales 1, 6)	EP	126.00	111.17	119.20	119.20		-14.29	-1.67	-7.30	-7.96	
	CT	133.29	125.83	144.20	136.10		2.29	-6.83	-3.30	-2.52	
	Tot.	129.65	118.50	131.70	127.65	23.835	-6.00	-4.25	-5.30	-5.24	15.362
Q Sort ^b	EP	609.86	787.50	749.60	716.95		-3.14	67.17	285.60	140.70	
	CT	521.71	793.67	571.70	615.26		28.00	236.50	198.80	156.70	
	Tot.	566.50	791.41	660.65	666.10	225.830	12.43	151.84	242.20	148.70	257.840

TABLE 1--Continued

Criterion Measure	Unit	Pre-Treatment Measures				SD	Difference Measures				SD
		Mean					Mean				
		Staff	Trainee	Non-C.	Total		Staff	Trainee	Non-C.	Total	
Dogma ^{bc}	EP	154.00	126.00	133.00	137.60		-2.00	8.50	-5.00	-0.57	
Scale	CT	138.71	140.83	145.90	142.40		-1.86	8.50	8.20	5.21	
	Tot.	146.36	133.42	139.45	140.00	31.585	-1.93	8.50	1.60	2.32	35.622

^aN for each building = 23, staff = 7, trainee = 6, control (Non-counseled) = 10; Sample N = 46

^bMajor criterion measure

^cHigher scores positive

TABLE 2

COMPARISON OF GROUPS AND UNITS ON PRE-TREATMENT AND
PRE-POST TREATMENT DIFFERENCE MEASURES
BY ANALYSIS OF VARIANCE

Criterion Measure	Source of Variance	Pre-Treatment			Difference			F.95	F.99
		SS	df	F	SS	df	F		
HAPS (Total)	B/G	71.563	2	0.113	60.260	2	0.064	3.38	5.57 ^a
	B/U	178.67	1	0.564	1.0805	1	0.002	4.24	7.77 ^b
	GXU	<u>400.50</u>	3	0.421	<u>448.75</u>	3	0.316	2.99	4.68 ^c
	Total	7925.1	25		11834.0	25			
HAPS (I-VIII)	B/G	92.123	2	0.279	96.848	2	0.203	3.38	5.57
	B/U	33.050	1	0.200	6.7632	1	0.028	4.24	7.77
	GXU	<u>176.02</u>	3	0.356	<u>236.82</u>	3	0.331	2.99	4.68
	Total	4125.6	25		5955.6	25			
HAPS (1-5)	B/G	.98118	2	0.014	8.9882	2	0.073	3.38	5.57
	B/U	58.364	1	1.615	6.4735	1	0.105	4.24	7.77
	GXU	<u>69.882</u>	3	0.645	<u>61.327</u>	3	0.333	2.99	4.68
	Total	903.27	25		1535.6	25			
HAPS I	B/G	.22702	2	0.027	2.7771	2	0.207	3.38	5.57
	B/U	.00455	1	0.001	17.974	1	2.682	4.24	7.77
	GXU	<u>.50530</u>	3	0.040	<u>33.593</u>	3	1.671	2.99	4.68
	Total	106.46	25		167.58	25			

TABLE 2--Continued

Criterion Measure	Source of Variance	Pre-Treatment			Difference			F.95	F.99
		SS	df	F	SS	df	F		
HAPS II	B/G	3.0175	2	0.321	4.2511	2	0.283	3.38	5.57
	B/U	.33825	1	0.082	7.6365	1	1.017	4.24	7.77
	GXU	<u>3.5617</u>	3	0.253	<u>29.382</u>	3	1.304	2.99	4.68
	Total	117.43	25		187.81	25			
HAPS III	B/G	2.3208	2	0.190	3.5730	2	0.181	3.38	5.57
	B/U	.00564	1	0.001	.07369	1	0.007	4.24	7.77
	GXU	<u>19.882</u>	3	1.084	<u>1.9940</u>	3	0.068	2.99	4.68
	Total	152.86	25		246.13	25			
HAPS IV	B/G	8.5166	2	0.872	8.8103	2	0.927	3.38	5.57
	B/U	7.9891	1	1.636	46.054	1	9.696**	4.24	7.77
	GXU	<u>19.967</u>	3	1.363	<u>60.390</u>	3	4.238*	2.99	4.68
	Total	122.10	25		118.75	25			
HAPS V	B/G	7.0491	2	0.830	9.8660	2	0.529	3.38	5.57
	B/U	.51554	1	0.123	21.212	1	2.275	4.24	7.77
	GXU	<u>17.027</u>	3	1.336	<u>44.165</u>	3	1.579	2.99	4.68
	Total	106.22	25		233.08	25			
HAPS VI	B/G	2.7720	2	0.241	3.1158	2	0.183	3.38	5.57
	B/U	.42402	1	0.074	.15281	1	0.018	4.24	7.77
	GXU	<u>4.8937</u>	3	0.284	<u>3.5183</u>	3	0.138	2.99	4.68
	Total	143.77	25		212.27	25			

TABLE 2--Continued

Criterion Measure	Source of Variance	Pre-Treatment			Difference			F.95	F.99
		SS	df	F	SS	df	F		
HAPS VII	B/G	5.8568	2	0.666	6.5560	2	0.640	3.38	5.57
	B/U	1.1055	1	0.251	.32246	1	0.060	4.24	7.77
	GKU	<u>5.1163</u>	3	0.388	<u>.84452</u>	3	0.054	2.99	4.68
	Total	110.00	25		129.96	25			
HAPS VIII	B/G	1.1170	2	0.078	2.7390	2	0.157	3.38	5.57
	B/U	2.0634	1	0.289	3.9267	1	0.451	4.24	7.77
	GKU	<u>15.837</u>	3	0.738	<u>19.048</u>	3	0.729	2.99	4.68
	Total	178.72	25		217.64	25			
HAPS 1	B/G	2.8752	2	0.859	1.4102	2	0.213	3.38	5.57
	B/U	.00457	1	0.003	.75564	1	0.229	4.24	7.77
	GKU	<u>9.6340</u>	3	1.919	<u>15.816</u>	3	1.598	2.99	4.68
	Total	41.837	25		82.605	25			
HAPS 2	B/G	.68447	2	0.117	.77935	2	0.079	3.38	5.57
	B/U	8.1389	1	2.779	.00156	1	0.000	4.24	7.77
	GKU	<u>12.069</u>	3	1.373	<u>14.506</u>	3	0.984	2.99	4.68
	Total	73.229	25		122.85	25			
HAPS 3	B/G	7.6221	2	2.021	5.9803	2	0.665	3.38	5.57
	B/U	3.8262	1	2.019	19.002	1	4.224	4.24	7.77
	GKU	<u>5.8773</u>	3	1.034	<u>32.877</u>	3	2.436	2.99	4.68
	Total	47.388	25		112.46	25			

desirable. Such a situation indicates to the patient that he is trusted, yet makes no demands beyond his ability and readiness to achieve.

While it is true that the locked doors and barred windows (with attendant restrictions of activities) appear necessary in extreme cases, it is becoming more evident that they are neither necessary nor desirable in the majority of cases. This has become increasingly true with the advent of improved drugs, as well as a (too slowly) developing understanding of mental health and mental distress on the part of the public.

Nevertheless, and regardless of the reasons, our mental hospitals in too many ways still reflect more primitive attitudes. Uses of closed wards for such reasons as punishment or as an expedient due to lack of trained personnel still persist only too frequently.

It is from such thoughts as these that the present study was conceived. Can it be shown that a patient's progress will be more satisfactory if provided a situation including more freedom and responsibility, while at the same time being encouraged to develop improved interpersonal relationships? What role, if any, should group counseling play in the process of rehabilitation of long-term Np hospital patients?

TABLE 2--Continued

Criterion Measure	Source of Variance	Pre-Treatment			Difference			F.95	F.99
		SS	df	F	SS	df	F		
HAPS 4	B/G	2.1220	2	0.404	3.3471	2	0.335	3.38	5.57
	B/U	6.6112	1	2.517	.03980	1	0.008	4.24	7.77
	GXU	<u>7.4123</u>	3	0.941	<u>6.1733</u>	3	0.412	2.99	4.68
	Total	65.663	25		124.82	25			
HAPS 5	B/G	.00829	2	0.002	.06040	2	0.007	3.38	5.57
	B/U	.00784	1	0.003	9.3140	1	2.241	4.24	7.77
	GXU	<u>.98095</u>	3	0.130	<u>20.068</u>	3	1.609	2.99	4.68
	Total	63.111	25		103.91	25			
JRSVB (Total)	B/G	31043	2	2.050	9288.9	2	0.993	3.38	5.57
	B/U	264.68	1	0.035	6.0322	1	0.001	4.24	7.77
	GXU	<u>14551</u>	3	0.641	<u>2976.4</u>	3	0.212	2.99	4.68
	Total	189200	25		116850	25			
JRSVB a	B/G	140.64	2	2.602	66.330	2	1.904	3.38	5.57
	B/U	20.305	1	0.751	.02667	1	0.002	4.24	7.77
	GXU	<u>88.149</u>	3	1.087	<u>10.416</u>	3	0.199	2.99	4.68
	Total	675.63	25		435.46	25			
JRSVB b	B/G	23.512	2	0.448	38.951	2	1.460	3.38	5.57
	B/U	7.2438	1	0.276	.12131	1	0.001	4.24	7.77
	GXU	<u>60.163</u>	3	0.765	<u>31.349</u>	3	0.786	2.99	4.68
	Total	655.40	25		332.51	25			

TABLE 2--Continued

Criterion Measure	Source of Variance	Pre-Treatment			Difference			F.95	F.99
		SS	df	F	SS	df	F		
JRSVB c	B/G	37.399	2	0.647	2.6444	2	0.067	3.38	5.57
	B/U	44.538	1	1.541	.35586	1	0.018	4.24	7.77
	GXU	65.774	3	0.759	31.440	3	0.529	2.99	4.68
	Total	722.46	25		495.18	25			
JRSVB d	B/G	72.825	2	2.230	13.221	2	0.337	3.38	5.57
	B/U	3.7529	1	0.230	2.8675	1	0.146	4.24	7.77
	GXU	39.234	3	0.801	33.845	3	0.575	2.99	4.68
	Total	408.20	25		490.22	25			
JRSVB e	B/G	54.313	2	1.485	33.944	2	1.485	3.38	5.57
	B/U	8.3632	1	0.457	2.8784	1	0.457	4.24	7.77
	GXU	84.583	3	1.541	9.0501	3	0.225	2.99	4.68
	Total	457.28	25		334.90	25			
JRSVB f	B/G	113.54	2	3.134	50.598	2	1.948	3.38	5.57
	B/U	5.9132	1	0.326	4.2109	1	0.324	4.24	7.77
	GXU	18.783	3	0.346	55.172	3	1.416	2.99	4.68
	Total	452.86	25		324.67	25			
JRSVB g	B/G	50.009	2	1.263	3.6668	2	0.132	3.38	5.57
	B/U	15.385	1	0.777	8.0053	1	0.576	4.24	7.77
	GXU	60.135	3	1.012	10.996	3	0.264	2.99	4.68
	Total	495.02	25		347.44	25			

TABLE 2--Continued

Criterion Measure	Source of Variance	Pre-Treatment			Difference			F.95	F.99
		SS	df	F	SS	df	F		
JRSVB h	B/G	25.007	2	0.635	182.47	2	4.978*	3.38	5.57
	B/U	41.100	1	2.088	20.267	1	1.106	4.24	7.77
	GXU	<u>47.883</u>	3	0.811	<u>186.98</u>	3	3.401*	2.99	4.68
	Total	492.04	25		458.17	25			
Psychol Anomie (Total)	B/G	33722	2	0.963	5402.1	2	0.498	3.38	5.57
	B/U	12999	1	0.742	2055.5	1	0.379	4.24	7.77
	GXU	<u>102230</u>	3	1.946	<u>27630</u>	3	1.698	2.99	4.68
	Total	437720	25		135630	25			
Psychol Anomie (Scales 1,6)	B/G	1503.8	2	1.324	357.89	2	0.758	3.38	5.57
	B/U	317.44	1	0.559	17.950	1	0.076	4.24	7.77
	GXU	<u>4301.8</u>	3	2.524	<u>861.64</u>	3	1.217	2.99	4.68
	Total	14203	25		5899.9	25			
Q Sort (Self-Other)	B/G	166260	2	1.630	248790	2	1.871	3.38	5.57
	B/U	26420	1	0.518	10291	1	0.155	4.24	7.77
	GXU	<u>175510</u>	3	1.147	<u>25260</u>	3	0.127	2.99	4.68
	Total	127500	25		166210	25			

TABLE 2--Continued

Criterion Measure	Source of Variance	Pre-Treatment			Difference			F.95	F.99
		SS	df	F	SS	df	F		
Dogmatism	B/G	871.70	2	0.437	1118.0	2	0.441	3.38	5.57
	B/U	522.05	1	0.523	29.842	1	0.024	4.24	7.77
	GXU	<u>3353.0</u>	3	1.120	<u>151.67</u>	3	0.040	2.99	4.68
	Total	<u>24940</u>	25		<u>317.23</u>	25			

^aTest of hypothesis that means of counseled and non-counseled groups were equal [d.f. = 2/25, F.95 = 3.38, F.99 = 5.57 (Walker and Lev, 1953)]

^bTest of hypothesis that unit means were equal (d.f. = 1/25, F.95 = 4.24, F.99 = 7.77)

^cTest for significance of interaction between groups and units. For d.f. of 3/25, F.95 = 2.99, F.99 = 4.68

*Significant at .05 level of confidence

**Significant at .01 level of confidence

the whole rated lower than those of other groups, while those of the CT Staff rated generally higher than those of other groups.

Verbal behavior, analyzed by means of the Judges' Rating Scale of Verbal Behavior (JRSVB) again gives subjects of CT Unit a higher rating than those of EP Unit on two of the eight dimensions (c and h--"anticipation of outcomes or optimism toward the future," "realism of plans for the future"). The CT Non-counseled group stands above EP Non-counseled, which in general is rated lowest of all groups. Subjects of CT Trainee, although rated higher on total score than those of CT Staff or CT Non-counseled, on individual items (a, d, f, g) fell below all other groups except EP Non-counseled. This was especially true on dimension "f" (openness to experience, willingness to change, to try new ideas), where CT Trainee group members rated lower than other groups almost at the .05 level of significance.

On measures of attitude toward self in relation to others and the future (Anomie, Q sort, and Dogmatism), staff and non-counseled groups had consistently higher measurements than did the subjects of the trainee groups. Although not statistically significant, these trends indicate that members of staff groups, as compared with trainee groups, were (at start of treatment) at least slightly less anomic (higher scores are indicative of less anomie). They also showed less discrepancy on Q sorts of personal adjectives referring to

"self" and "well adjusted person out in the community" (higher scores indicate greater discrepancy), and were somewhat less dogmatic or closed-minded.

In brief, analysis of variance showed no significant differences between groups or units before treatment. Trends indicate that on three sub-criteria (HAPS/1-5 and JRSVB/c, h)--CT Unit had somewhat higher average scores. EP Unit Non-counseled subjects averaged lowest of all groups on verbal behavior. Members of CT Trainee group were rated nearly significantly lower on openness to experience. Members of staff and non-counseled groups measured somewhat above those of both trainee groups on attitude toward self in relation to others and the future.

Tests of the specific hypotheses

The core findings of the entire study are summarized in Table 1 (means and standard deviations on pre-post treatment criteria measures) and Table 2 (Analysis of variance of pre-post treatment differences on major and sub-criteria measures). Findings are presented in three categories, according to the three major criteria, with discussion of statistically significant differences and relevant trends.

A. General observed behavior.--As rated by nursing staff and assistants, using the HAPS, this criterion shows no significant differences between groups or units on the basis of the total test or either of the two sub-totals (I-VIII, 1-5). One sub-criterion, IV--"aggressiveness toward

others," shows significant group-unit interaction as well as very significant between-unit differences. One difference between groups (EP Trainee-CT Staff) of over two standard deviations is noted, with others (EP Staff-CT Staff, EP Trainee-CT Trainee) differing over one S.D. This difference is in the direction of affirming H II--"Patients living in an extended-privilege unit, as compared with those living in a continued-treatment unit will modify aggressiveness toward others more in line with social expectations." (Note that the opposite is the trend on HAPS, Total score.) Although no significant differences were observed on pre-treatment measures, members of EP Trainee group, who contribute considerably to pre-post differences, were rated lower on the average (pre-treatment) on "aggressiveness . . ." than other groups. In reverse, members of CT Staff group, who made a quite significant negative change, were rated highest of all on the pre-treatment measure.

Another between-unit difference of significance at just below the .05 level is found on the sub-criterion related to the "Patient's chance of making it in a family care or nursing home." This appears due to the less negative changes in EP Trainee and EP Non-counseled groups than in CT Trainee and CT Non-counseled groups, as all six groups indicate a negative trend.

Other between-units trends on HAPS sub-criteria measures are negative in terms of H II, which affirms that patients

living in an extended-privilege unit, as compared with those living in a continued-treatment unit will be more highly motivated to leave the hospital (HAPS-I), develop higher and more realistic regard for self and others (HAPS-V), develop clearer and more realistic plans for the future (HAPS-5). Perhaps of greater real significance are the over-all trends noted in Table 1. These indicate (1) EP Unit subjects regressed (change negatively) more than did CT Unit subjects, (2) non-counseled groups regressed less than counseled groups, with the exception of CT Trainee group, and (3) all groups showed at least slight regression.

B. Verbal behavior.--Total score, as judged by means of the JRSVB, shows no significant differences between groups or units according to Table 2, in pre-post treatment changes. One group (EP Trainee) averaged over one S.D. lower than either the EP Staff or EP Non-counseled groups. No explanation for this is apparent in terms of pre-treatment judgments, where the three EP Unit groups were fairly comparable.

Turning to the sub-criteria measures, significant between-group differences and group-unit interaction are seen on JRSVB--h ("Realism of plans for the future"). Most notable is the difference between EP Staff and EP Trainee group means. It is also noteworthy that with the exception of the EP Staff group all counseled groups changed in the negative direction, while both non-counseled groups changed in the positive direction, as regarding the development of

clearer and more realistic plans for the future. The significant difference, then, is between EP Staff and the other counseled groups, rather than between counseled and non-counseled. However, the trend is negative to the hypothesis (H I) that "Patients receiving group counseling as compared with those receiving no group counseling will develop clearer and more realistic plans for the future."

Other negative between-group trends are seen (sub-criteria measures a, b, e). Criterion measure "a" ("fluency, rate of talk") again shows EP Staff group as the only counseled group changing positively, with greatest differences noted between EP Trainee-EP Non-counseled and EP Trainee-EP Staff groups. Here a definite trend negative to H I is indicated. Criterion measure "b" (Appropriateness of remarks and affect") shows both trainee groups considerably lower than either staff or non-counseled, although not significantly so. On "e" ("Interpersonal relations--cooperation and ability to relate to the interviewer") a trend definitely negative to H I is seen, as both non-counseled groups changed positively while only EP Staff of the counseled groups showed a slight positive change.

Considerable inter-group difference is seen on measure "f," although this apparently balances out relative to statistical significance. EP Staff and CT Trainee groups changed positively (on "f") while CT Staff and EP Trainee

groups moved negatively. Thus total staff-trainee differences and counseled vs. non-counseled group differences are negligible.

Over-all trends on the JRSVB (total score) show (1) more positive changes for non-counseled than for counseled groups; (2) EP Unit-CT Unit over-all differences were statistically insignificant, but EP Staff and EP Non-counseled were both higher than CT Staff and CT Non-counseled (EP Trainee group regressed or this would be much greater); and (3) more positive (or less negative) changes for staff than for trainee groups.

There seems to be an inverse relationship between trends on pre-treatment and pre-post treatment sub-criteria measures, which possibly will help account for these results. This was true with the exception of criterion measure "b," on which the staff pre-treatment measure was slightly greater than that of trainee groups, while on pre-post measures staff groups were considerably higher. On other measures staff groups were considerably higher. On measures a, e, f, and h the groups which produced the lower pre-treatment scores showed greater positive change. Such a relationship might indicate that if pre-treatment scores were lower, the S's had more chance to make a positive change and less chance of a negative change, etc. However, the fact that on the total score as well as on a large majority of the sub-measures the non-counseled groups showed more positive

A Review of the Literature

Several facets of interest in the present study can perhaps best be highlighted by reference to the literature. Consideration will be given to the meaning and historical development of group counseling, the distinction between counseling and psychotherapy, situational factors in the treatment program, and the selection of outcome criteria.

Group Counseling: Its Meaning, Function, and Historical Development

Why groups?

The aim of present-day mental institutions is to provide the situation and treatment most conducive to improvement of the patient and leading to his ultimate rehabilitation as a member of the community. Historically, as a practical means of extending at least some treatment of a personal nature, group methods of treatment were instituted. Although techniques, size, and stated purposes of these groups have and do vary considerably, generally speaking they have served well by providing a more intimate interpersonal relationship with others, both patients and staff.

Slavson (1956, xi), speaking of the future of group psychotherapy, holds this optimistic view:

The growth of group psychotherapy has had few parallels in the development of the healing arts. The ready acceptance it has received is testimony to its inherent value and its even

modification in verbal behavior than did the counseled groups (although not statistically significant), needs further explanation. Discussion of these trends is found in the section on theoretical implications.

C. Expressed attitude toward self in relation to others and the future.--This criterion was measured by the Scale of Psychological Anomie, Standard Adjective Q Sort, and the Dogmatism Scale. On none of these scales were statistically significant pre-post treatment changes noted.

Over-all trends regarding differences between units (on all three pre-post treatment measures of expressed attitude toward self in relation to others and the future), although statistically not significant, are opposite to the direction hypothesized--that is, CT Unit averages are greater than those of EP Unit. A check of between-groups differences shows a fairly strong trend ($F = 1.871$) on pre-post treatment difference scores on the Q sort. This trend is opposite to H I, which posits that "Patients receiving group counseling as compared with those receiving no group counseling will develop a higher degree of congruence between concept of self and concept of the typical, well-adjusted person out in the community." This trend supports those noted on criteria A and B ("general observed behavior" and "verbal behavior"). Had the scores of subjects in CT Trainee group fallen closer to those of the other three counseled groups the difference between non-counseled and counseled

groups would no doubt have been significant statistically. On Anomie (Total), interaction between groups and units is due to the regression (over one S.D.) of EP Staff group as compared with those of other groups.

In summarizing all tests of the specific hypotheses, two major results stand out. (1) No statistically significant differences between either groups or units on any of the measures of the three major criteria were found. (2) Over-all trends are in the direction opposite to both major experimental hypotheses. Results on only one of the twenty-four sub-criteria measures (HAPS-IV) supported a hypothesis (H I) at above the .05 level of significance. On two major criteria measures changes were negative for all six groups (HAPS Total, Anomie Total).

An apparently inverse relationship of pre- to pre-post treatment difference scores was noted in connection with sub-criteria on the JRSVB. Closer inspection, however, reveals that such a trend is not true of other measures, including all five major criteria (total score) measures. Therefore, further explanation of these findings is needed, and is included in the next major section, "Theoretical Implications."

Examination of effect of background variables

As indicated in Chapter III, even though assignment to groups was done on a random basis, provision was made to

ascertain the effects of certain background variables and to take them into consideration in the comparison of units and groups. This was done by means of a two-factor analysis of variance with the background variables in covariance, using the 7090 computer. All F's reported in Table 2 are thus modified by such effects. A statistical summary of this process is shown in Table 3.

The Multiple R, or coefficient of multiple correlation, indicates the strength of relationship between each criterion measure and the background variables taken together (Guilford, 1956). Once computed, a multiple R is subject to the same kinds of interpretation as is the simple r . Two main principles are (1) a multiple correlation increases as the size of correlations between dependent and independent variables increases and (2) a multiple correlation increases as the size of intercorrelations of independent variables decreases. Intercorrelations of background variables are found in Appendix XIV, and correlations between background variables and criteria measures (pre-treatment and pre-post treatment difference measures) are in Appendixes XV and XVI, respectively.

Results shown in Table 3 can be analyzed as follows: (1) check F's for level of significance; (2) where statistical significance or strong trends are noted, corresponding t's can be observed to determine which variable(s) exert the strongest effect on the criterion measure (or are most responsible for the R).

TABLE 3

TESTS OF PARTIAL AND MULTIPLE CORRELATIONS OF BACKGROUND
VARIABLES WITH CRITERIA MEASURES, PRE-TREATMENT AND
PRE-POST TREATMENT DIFFERENCE MEASURES

Criterion Measure	Age	Educ	Married	Hosp Yrs	Mil Yrs	Diag Schiz	Voc Bkgr	Fin Sit	Verb Abil	Pass LOA	Activ Level	Opin Bldg	R	F
<u>Pre-</u>														
HAPS-T	--- ^a	--	--	--	--	--	1.07 ^b	--	--	--	1.38	--	0.55	0.53 ^c
"I-VIII	--	--	--	--	--	--	--	--	--	--	1.57	--	0.57	0.60
" 1-5	--	--	--	--	--	--	1.11	--	--	--	--	--	0.52	0.46
" I	-1.03	--	--	--	--	-1.41	--	--	1.31	--	2.08	--	0.70	1.20
" II	--	--	--	--	--	--	--	--	--	-2.36	1.36	--	0.62	0.76
" III	--	--	--	--	--	--	1.04	--	--	--	--	1.03	0.55	0.54
" IV	--	1.20	--	--	-1.28	2.95	--	--	-1.97	--	-1.09	--	0.78	1.98
" V	--	--	--	--	--	--	--	--	1.97	--	2.06	1.30	0.67	1.00
" VI	--	--	--	--	--	--	--	--	--	--	1.52	1.76	0.61	0.74
" VII	--	--	--	1.37	-1.58	--	1.29	--	--	-1.05	1.26	1.17	0.68	1.09
" VIII	--	--	--	--	--	--	--	1.27	--	--	1.17	--	0.58	0.62
" 1	--	--	--	--	--	--	--	--	1.67	--	--	1.04	0.57	0.59
" 2	--	--	--	-1.02	--	--	--	--	--	--	2.23	1.48	0.70	1.23
" 3	-1.27	-1.25	-1.88	1.60	--	--	1.87	--	--	-1.09	-1.05	--	0.66	0.94
" 4	--	--	--	--	--	--	--	--	--	--	--	--	0.50	0.42
" 5	--	--	--	--	--	--	1.08	--	--	--	1.13	--	0.54	0.53
<u>Diff.</u>														
HAPS-T	--	--	--	--	--	--	--	--	--	--	--	--	0.52	0.46
"I-VIII	--	--	--	--	--	--	--	--	--	--	--	--	0.54	0.53
" 1-5	--	--	--	--	-1.04	--	--	1.04	--	--	--	--	0.51	0.44
" I	--	--	-1.74	--	--	--	--	--	-1.67	--	--	-1.14	0.64	0.87

TABLE 3--Continued

Criterion Measure	Age	Educ	Married	Hosp Yrs	Mil Yrs	Diag Schiz	Voc Bkgr	Fin Sit	Verb Abil	Pass LOA	Activ Level	Opin Bldg	R	F
HAPS II	--	--	1.39	--	--	--	--	--	--	1.22	--	--	0.64	0.88
" III	--	--	--	-1.22	-1.00	--	--	--	--	--	--	--	0.53	0.48
" IV	--	--	--	--	--	--	--	1.69	1.19	--	--	--	0.79	2.09
" V	--	--	-1.23	--	--	--	--	--	-1.13	--	--	--	0.64	0.85
" VI	--	--	--	--	--	-1.27	--	--	--	--	--	--	0.52	0.47
" VII	-1.43	-1.03	--	--	--	--	--	--	--	--	-1.02	--	0.57	0.61
" VIII	--	--	--	--	--	-1.21	--	-1.23	--	--	--	--	0.63	0.82
" 1	--	--	--	--	--	--	1.04	--	--	--	--	--	0.58	0.64
" 2	--	--	--	--	-1.61	--	--	1.41	-1.01	2.09	-2.84	-1.09	0.74	1.49
" 3	--	1.16	--	--	--	1.31	--	--	--	--	--	--	0.63	0.81
" 4	--	--	--	--	-1.13	--	--	--	--	--	--	--	0.65	0.93
" 5	--	--	--	-1.07	--	--	-1.46	--	--	--	--	--	0.60	0.72
<u>Pre-</u>														
JRSVB-T	2.28	--	--	-2.36	1.92	--	--	--	--	--	3.35	--	0.83	2.69
" a	2.30	--	--	-1.34	1.35	--	--	--	1.29	--	3.64	--	0.79	2.04
" b	1.35	--	--	-1.65	1.50	--	--	-1.22	--	--	1.25	--	0.66	0.99
" c	1.21	--	--	-2.57	--	--	--	--	--	--	2.99	--	0.77	1.86
" d	1.14	--	--	-1.66	--	--	--	--	--	1.34	2.21	--	0.77	1.81
" e	1.97	--	--	-1.48	2.02	--	--	-1.17	1.04	--	2.54	--	0.78	1.91
" f	--	--	--	-1.83	--	--	--	--	--	1.42	1.31	1.04	0.76	1.71
" g	2.91	--	--	-2.09	2.11	--	--	--	2.41	--	2.68	--	0.81	2.40
" h	1.49	--	--	-1.81	1.76	--	1.20	--	--	1.29	2.76	--	0.82	2.61
<u>Diff.</u>														
JRSVB-T	-1.38	-1.66	--	1.04	-1.95	--	--	--	--	--	--	-1.08	0.68	1.07
" a	--	-1.16	--	--	--	--	--	--	--	--	--	--	0.58	0.64

TABLE 3--Continued

Criterion Measure	Age	Educ	Married	Hosp Yrs	Mil Yrs	Diag Schiz	Voc Bkgr	Fin Sit	Verb Abil	Pass LOA	Activ Level	Opin Bldg	R	F
JRSVB b	--	--	--	1.17	-1.27	--	--	2.31	1.43	--	--	--	0.67	1.04
" c	--	-1.41	--	1.30	--	--	--	--	--	--	-1.32	--	0.66	0.95
" d	--	--	--	--	--	--	--	--	-1.85	--	--	-1.93	0.62	0.78
" e	--	-1.03	--	--	-2.25	--	--	--	--	--	--	--	0.64	0.88
" f	-1.38	-1.07	--	1.49	--	--	1.01	--	--	--	1.01	-1.41	0.67	1.02
" g	-2.03	-1.34	--	1.08	-1.59	--	--	--	--	--	1.11	--	0.68	1.05
" h	--	-2.46	--	--	-2.23	--	--	-1.13	--	--	--	--	0.78	1.93
<u>Pre-</u> Anomied	--	--	--	-1.97	--	--	--	--	--	--	--	1.11	0.68	1.07
" (1,6)	--	--	--	-2.63	--	1.16	-1.40	--	--	--	1.04	1.33	0.68	1.08
" Diff	--	1.76	--	--	--	--	1.07	-1.04	--	--	--	1.81	0.69	1.13
" (1,6)	--	--	--	1.05	--	--	1.46	--	--	--	--	--	0.62	0.77
<u>Pre-</u> Q (S-O) ^e	--	--	--	--	--	--	--	2.02	1.66	--	--	1.83	-0.73	1.39
" Diff	--	--	--	-1.12	--	1.28	--	-1.45	-1.69	1.15	--	-1.52	0.69	1.14
<u>Pre-</u> Dogmad	-1.62	--	-1.38	--	--	--	--	--	--	--	-2.28	--	0.61	0.74
" Diff	--	--	1.50	--	1.53	1.11	--	--	--	--	1.07	--	0.61	0.74
HAS-T	-1.02	--	--	1.30	--	-1.65	1.98	-1.09	--	--	2.33	--	0.64	0.85
" I	--	--	--	--	--	--	1.09	--	--	--	2.50	--	0.59	0.68
" II	1.45	--	--	--	--	--	1.68	-1.14	--	--	1.66	--	0.66	0.66
" III	--	--	--	1.42	--	--	2.37	-1.31	-1.06	-1.02	1.55	--	0.61	0.75

TABLE 3--Continued

Criterion Measure	Age	Educ	Mar-ried	Hosp Yrs	Mil Yrs	Diag Schiz	Voc Bkgr	Fin Sit	Verb Abil	Pass LOA	Activ Level	Opin Bldg	R	F
Q (S-S) ^d	--	-2.90	-2.14	1.82	--	-1.25	--	--	--	-1.19	--	--	0.73	1.43
Q (O-O) ^d	1.06	--	--	--	--	3.07	-1.37	3.19	--	--	--	-2.73	0.83	2.84

^aAll t's of 1.00 or above are shown. N = 46, d.f. = 25, t._{.95} = 2.06, t._{.99} = 2.79

^bAll t's for voc. background presented with signs corresponding to those of other variables, i.e., higher scores more positive

^cF ratio used as test of Multiple R, to show combined effect of the background variables on each criterion measure. D.f. = 20/25, F._{.95} = 2.00, F._{.99} = 2.70

^dHigher scores positive

^eHigher scores negative

The HAPS was used to rate major criterion "general observed behavior." Background variables being considered had little over-all relationship to ratings on the HAPS (Total). A significant F is found only on one sub-criterion measure of the HAPS (IV--"Aggressiveness toward others"). It indicates that both positive financial situation and verbal ability are related to more positive ratings, but with financial situation having the most effect. Comparing this finding on the pre-post difference measure to the pre-treatment findings, it is seen that there, too, the F was nearly significant at the .05 level, but in this case the two major factors contributing to the R are diagnosis and verbal ability. The diagnostic category weighted least was "schizophrenic." Since "aggressiveness toward others" was weighted 0-6 from most to least aggressive, the positive correlation occurs, and might perhaps indicate that aggressive patients are often schizophrenics, or at least are labeled so. Also, the higher the verbal ability of the subject (as measured on the Wesman Scale), the less aggressive he was judged to be.

Each of the trends could be analyzed in a similar fashion, by referring to scoring codes for each background variable (Appendix XI). From another perspective, looking down the columns of Table 3 gives an idea of the over-all relationship of any one background variable to the criteria measures. For example, on the pre-treatment ratings "activity level"

(from the PACO, patients' ratings of activities they engage in) appeared to have the strongest over-all relationship to HAPS ratings. Significant t's are seen in relation to three categories (I, V, 2), which rate "motivation to leave the hospital," "attitude toward self and other," and "chance of returning to independent life in the community." Interestingly, the higher the patient judged his activity level to be, the less he "improved" over the treatment period (pre-post differences) according to judges ratings. This could be due to starting the treatment period at such a (relatively) high level as to have no way to go on subsequent ratings except "down."

Turning to the JRSVB, the measure of "verbal behavior," a very significant F on (Total) pre-treatment measures appears. This seems due to especially consistent scores on three background variables: age, length of time in the hospital, and activity level--especially activity level. Number of years in military service affected this F to a lesser degree, as did verbal ability. All of these except length of hospitalization were positively correlated with JRSVB dimensions, while length of hospitalization is negatively correlated with all dimensions. Large F's are noted on each dimension.

On JRSVB pre-post differences, the total score shows only a trend, with the coefficient of determination (R^2) being about .46, whereas the pre-treatment R^2 was .69. In

other words, a larger per cent of the pre-treatment JRSVB judgments are explicable in terms of the background variables being considered than is true of the difference measures. Only JRSVB-h ("Realism of plans for the future") approaches the .95 level of confidence. Here it appears that the higher the level of education, the less the comparative progress in making plans of a realistic nature. A significant negative relationship also occurs between years of military service and "h."

The Scale of Psychological Anomie, Standard Adjective Q Sort and Dogmatism Scale were used as measures of "Expressed attitude toward self in relation to others and to the future." On these measures of the third major criterion no significant R's are found (Table 3), either on pre- or pre-post treatment measures. This would indicate that factors other than the background variables observed played important roles on these measures. It should be noted that all F's except those for Anomie (scales 1, 6--Difference) and Dogmatism (Difference), while not significant statistically, are over 1.00. F's of this size, together with the R's of between .61 and .73, do suggest some degree of relationship between the background variable and the criteria measures.

By checking individual background variables for each measure, those contributing most to the R's are easily seen. For Anomie (both Total and sub-scales 1, 6 on pre-treatment

greater promise for the future. As some of the proponents of group psychotherapy will replace extravagant claims and overconfidence by scientific objectivity, its service will be even further enhanced.

He points out the lack of active opposition to the use of group therapy by both the public and professional personnel, but feels there is a "healthy skepticism--an attitude of watchful waiting until this new clinical fledgling will grow its wings and demonstrate its potency" (1956, xii).

Some advantages of the group approach to therapy are indicated by Beckenstein (1959, 148). He cites the obvious economy of group therapy in terms of reaching more patients, but more importantly emphasizes, "We must understand that the patient breaks down in society, that he can be studied effectively for diagnosis in a group setting, and that he can be treated successfully in a group setting." Thus it is believed there may be other and perhaps even more significant reasons for group therapy (or group counseling) than for the sake of economy.

What is a group?

Perhaps before going further, some of the properties people have in mind when they talk about groups should be discussed. Speaking of groups in general, Thelen (1954, 229) gives some of these properties as follows:

1. The membership can be defined.
2. The members think of themselves as constituting a group.
3. There is a sense of shared purpose among the members.

measures), length of hospitalization bears a nearly significant ($-.197$) negative relationship. Another factor, vocational background, also correlates negatively with Anomie (1, 6). Changes (pre-post treatment) on Anomie (Total) are seen to be positively related to level of education and opinion of the building.

Smaller discrepancies between Q sort measures (pre-treatment) of "self" and "other" concepts are correlated with financial situation, opinion of the building and verbal ability. On difference measures, change in discrepancy between the two sorts was negatively correlated with verbal ability, opinion of the building, and financial situation. Those variables having greatest negative relationship to the pre-treatment Dogmatism scores were activity level, age, and being married. However, being married and activity level relate positively to positive change.

The Settings and the Group Process

In order to better understand the findings resulting from tests of the hypotheses, an analysis of the major factors bearing upon these findings (the treatment situation and the group process) is made at this point. This includes discussions of the expressions of opinion from the subjects themselves in regard to both the "situation" and the "group process," and the judges' analysis of the processes involved in the four group situations.

The picture of the two settings as seen through the eyes of the hospital personnel, and especially as interpreted by the experimenter, was presented earlier in Chapter III. At this time the findings of the Patient Activities Checklist and Opinionnaire (PACO, Appendix X) will be presented. Contrasting the average responses of the members of the two units, it is seen that only in "time spent in recreation, conversation, and work assignments," was there an appreciable difference. EP Unit subjects spent less time than did CT Unit subjects in recreation and conversation, but more time in work or training assignments and in educational therapy. No appreciable difference between units was noted in amount of time reported as spent sleeping or napping, sitting, reading and writing letters; or in the number of passes and LOA's taken (although EP Unit reported a slightly larger number). Most subjects on both units received medicine from nurse or assistant, and both groups felt they had considerable freedom in selection of assignments.

In regard to opinions about freedom and responsibility in establishing rules and running the unit, EP Unit subjects reported higher ratings than those of CT Unit, as was also true of their freedom to shower, shave, or watch TV. EP Unit subjects also perceived greater freedom in obtaining passes or LOA's, access to clothing and other personal property, as well as feeling more secure about the safety of

their personal property, and reported correctly that their building was locked at a later hour. CT Unit subjects rated adequacy of space and personal privacy higher than did EP Unit subjects. There was little or no difference of opinion regarding availability of recreational facilities and refreshments, or exercise of personal responsibility in getting to assignments and activities. Both expressed the opinion that most members of the staff were available to talk to and interested in the men in the unit. Both felt they could write anything within reason, with staff approval.

To sum up, emphasis in EP Unit, from the patient viewpoint, was on work or training assignments to a greater degree than was true in CT Unit, with the opposite being true of recreation, where CT Unit patients reported a greater emphasis than did those of EP Unit. EP Unit subjects reported more freedom and responsibility in establishing rules and in running the unit than did CT Unit subjects, as well as more liberal scheduling of shower, shaving, TV viewing, passes and leaves. Safety of and access to clothing and other personal property was greater in EP Unit, and the building was unlocked longer in the evenings. In general, it would seem that EP Unit subjects appeared to regard their unit, with the responsibilities and privileges it afforded, somewhat more highly than did CT Unit subjects, although there were some exceptions and some of the differences were slight.

The process

The following analysis of the group counseling process will be divided into three sections: (1) a description of the physical setting; (2) discussion of the counselors and their instructions; and (3) the analysis of the process, including findings from the patients and judge evaluations.

A. The group setting.--In both units the counseling setting was the staff conference room. In EP Unit this was a large room with windows on three sides. Comfortable upholstered chairs were drawn into a small circle surrounding a low coffee table which held ash trays and the recording microphone. The CT Unit conference room was about half the size of that of EP Unit, although adequate. Comfortable, upholstered chairs were drawn into a partial circle, incomplete due to a table at the side of the room which held the recording microphone.

In both settings the subjects gathered at the set time, smoked, talked, or relaxed. The recorder was turned on at the time the counselor entered the room. In each case the recorder was placed unobtrusively (not hidden) on the floor outside the circle.

The times of meetings, as scheduled independently according to the desires of individual group members and counselor, were: EP Staff--Wednesday, 1:45 P.M.; EP Trainee--Wednesday, 8:45 A.M.; CT Staff--Friday, 1:45 P.M.; CT Trainee--Friday, 11:30 A.M. Members of all groups were

personally notified by a nursing assistant on the day of each meeting. Sessions were approximately one hour in length. Individual attendance ranged from eight to twelve of the total of twelve scheduled, with an over-all average of 10.5. Average number of sessions attended were: EP Staff--9.9, EP Trainee--10.3, CT Staff--11.0, and CT Trainee--10.8. EP Unit subjects averaged 10.1 sessions, while CT Unit subjects averaged 10.9 sessions.

B. The counselors.--Counselors were staff and trainee counseling psychologists. Those for EP Staff and CT Staff groups were regular staff personnel, and counselors for EP Trainee and CT Trainee groups were trainees at the fourth year graduate student level of experience. In order to balance the personal variable as well as possible between units, one staff psychologist and one trainee were assigned to each unit.

Training consisted of discussion of the general frame of reference as developed in Chapter I, and a set of "Instructions for Counselors," which follows:

1. Sessions
 - a. Minimum of 12, weekly, 1 hr. sessions
 - b. Record of absences, individual interviews
2. Focus of the group
 - a. Common problem and goal of group--"Planning life away from the hospital environment"
 - b. "Future" orientation, accent on positive attributes of participant
3. Type Leadership (majority of sessions)
 - a. Mixed: non-directive, moderator-participant, teacher, etc.

- b. Counselor will attempt to achieve a permissive, friendly, intimate group climate
- c. Participants urged to act and say what they feel, whether angry and irritated or gay and loquacious, etc.
- d. Participants not to be forced into self-revelation
- e. Emphasis where possible on the positive assets of the participant
- f. Attempt to build enjoyment of sessions as social experience
- g. Topics for discussion to be initiated by participants (usually) or by counselor (at times)
- 4. Type Discussions
 - a. Free discussion chiefly; role-playing when appropriate
 - b. Range from "leaderless" to seminar-type sessions
- 5. Hoped-for experiences and outcomes
 - a. Support, reassurance
 - b. Shared information, insight
 - c. Enhanced self-esteem
 - d. Social interactions and improved verbal expression
 - e. Fuller participation in available activities and more responsible use of hospital privileges (visitors, passes, loa's, etc.)
 - f. Formulation of realistic plans and initiation of steps toward life away from the hospital environment

C. Analysis of the group counseling process.--Such analysis was considered essential (although not a major objective of this study), as previously pointed out, due to the wide variance in theoretical frames of reference, techniques employed, and group dynamics involved. It is hoped that the description presented in this section will provide a clearer picture of what actually occurred in terms of group process. It is one thing to theorize and give instructions to counselors. At least as important, however, in order to

interpret the results of this study more adequately, is gaining as accurate a picture as possible of the counseling process in action. To do this, in addition to the instructions and general framework already presented, two steps were taken: (1) patients' opinions and (2) judges' opinions--in regard to certain counselor-patient variables--were obtained. The instruments used for collection of data have already been described, and findings will now be presented. Both patients' and judges' ratings of the group process will be discussed in terms of comparisons between units as well as presenting an over-all picture of the "group counseling process" on which this study is based.

(1) The patients' evaluation of dimensions and outcomes of the group process.--This evaluation is summarized in Table 4. To make possible the comparison of groups and units in terms of subject ratings of the group process, ratings were called "favorable" or "unfavorable," according to the part of the scale that was checked. Weights of four and three were termed favorable, while those of two or one were called unfavorable. Percentages of favorable ratings given to the various items are shown.

In general, subjects of CT Unit rated the group "process" and "outcomes" higher than did those of EP Unit, although the differences are not great (compare units in terms of total--Parts A-C and D--scores). In terms of the hypothesis that subjects in EP Unit would respond more favorably

TABLE 4

PERCENTAGES OF FAVORABLE RATINGS GIVEN TO
CERTAIN DIMENSIONS AND OUTCOMES OF THE
GROUP PROCESS BY GROUP MEMBERS ON
THE GROUP EVALUATION WORKSHEET

	GROUP								
	1a	2	3	4	1+2	3+4	1+3	2+4	1+2+3+4
<u>DIMENSION^b</u>									
3a	71	33	71	100	52	86	71	67	69
4a	57	83	71	83	70	77	64	83	74
5a+6a	57	67	29	45	62	37	43	56	50
7a+8	86	50	71	80	68	76	65	65	72
<u>A-C</u> (3a-8)	68	58	61	77	63	69	65	68	66
<u>OUTCOME</u>									
9	71	50	71	50	61	61	71	50	61
10	86	50	100	33	68	67	93	42	68
11	86	50	100	67	68	84	93	59	76
12	71	33	86	33	52	60	79	33	56
13	100	50	57	40	75	49	79	45	62
14	43	50	100	33	47	67	72	42	57
<u>D</u> (9-14)	76	47	86	46	62	66	81	47	64

^aGroups: 1--EP Staff
2--EP Trainee
3--CT Staff
4--CT Staff

^bDimension: 3a--Focus on the future
4a--Focus on strengths, abilities
5a+6a--Control of the discussion
7a+8--Atmosphere and freedom of expression

on the post-treatment criteria measures, these ratings seem to provide additional insurance that any such verification of the hypotheses would be attributable to the situation itself, not to the counseling process per se. That is, since the subjects of CT Unit appeared to respond more favorably to the group process than did those of EP Unit, if post-treatment evaluation should still indicate a more positive trend for EP Unit subjects, the "situation," apart from group counseling, must be responsible.

It is to be noted that only on items 5a + 6a (average) and 13 were EP Unit ratings higher. These items relate to control of the discussion (5a + 6a) and opinions regarding the helpfulness of the group in promoting realistic plans and steps toward life outside the hospital. On the other hand, CT Unit patients rated dimensions A ("focus of the discussion on the future and on the assets of group members") and C ("atmosphere and freedom of expression") higher than did members of groups in EP Unit. Also, items 11, 12, and 14 were rated considerably higher by CT Unit groups. Those items deal with the helpfulness of the group in promoting (11) self-expression and ability to get along with others, (12) participation in available activities and increased use of privileges, and (14) a general feeling about the value of the group meetings. No, or very slight, differences were shown between units on items 9 and 10 ("helpfulness of group through sharing information and experience,"

and "increasing self-confidence and ability to accept self 'as-is,'" respectively).

Looking at total sample ratings (average of all four counseled groups) of dimensions gives an over-all picture of the group counseling process from the patient viewpoint. Nearly three-fourths of the subjects rated the groups favorably on dimensions dealing with "focus of the discussion on strengths or assets" (Item 4a) and "atmosphere and freedom of expression" (C. 7a + 8, average). Sixty-nine per cent felt that emphasis in the discussion was generally oriented toward the future. Subjects were about equally divided in rating the dimension "control of discussion," with 50% feeling that the group members took more responsibility than the counselor in introduction of topics and amount of talk. (Raw data indicate that counselors were seen as taking most responsibility in introduction of new topics, but that members did most of the talking.) Observation of total sample (Groups 1 + 2 + 3 + 4) percentages dealing with opinions regarding the helpfulness of the group process (Part D, items 9-14) reveals that on each of these six items a majority of the subjects rated the groups as helpful. Highest over-all rating was for item 11 which indicates the feeling (on the part of 76% of the subjects) that the group had been helpful in promoting self-expression and ability to get along with others. It is interesting that Item 14, "feeling in general about the value of the

4. There is a feeling of greater ease of communication among members than between members and nonmembers.
5. One has a sense of approval or disapproval for himself and his actions, receiving feedback from others in the group.
6. One feels an obligation to respond to the behavior of others in the group.
7. Behavioral norms or expectancies for groups of people exist.

Slavson (1959, 453) describes the characteristics of a therapy group in terms of size, functions of the therapist, selection of members, structure of the group, and atmosphere of the group. He believes the group should not exceed eight persons in order to achieve the best interpersonal reactions and interactions, but that if fewer than five, the members tend to reinforce each other's problems and neuroses. He holds that the therapist should permit group mobility, not assuming the central position or sole "focus of cathexis" at all times. Members should be selected on the basis of diagnostic criteria. Freedom and spontaneity of action and conversation must be maintained.

Of course there are many views on these characteristics. Most writers agree that group size should be small, with minimums stated as low as three and maximums as high as twelve. As to function of the counselor or therapist, considerable divergence of opinion is noted. Some advocate considerable interpretation and leading on the part of the therapist. Others see him as a resource person but

group meetings" rates near the lower end, with 57% of the subjects responding favorably. This would seem to indicate the need to look at specific opinions (such as items 9-13) when gathering client data, rather than asking more global questions, such as Item 14.

(2) The judges' analysis of the group counseling process (Appendix IX).--The judges' analysis is presented in Table 5. To make possible a comparison of patient and judge

TABLE 5
AVERAGE JUDGES' RATING OF GROUPS IN TERMS
OF PERCENTAGE OF POINTS POSSIBLE FOR
EACH OF FOUR PROCESS DIMENSIONS

		GROUP								
		1 ^a	2	3	4	1+2	3+4	1+3	2+4	1+2+3+4
D I M E N S I O N	I	66	56	60	52	61	56	63	54	59
	II	58	52	52	50	55	51	55	51	53
	III	52	70	48	66	61	57	50	68	59
	IV	70	70	64	64	70	64	67	67	67
	N (Ave.)	61.5	62.0	56.0	58.0	61.8	57.0	58.8	60.0	59.5

^aGroups: 1--EP Staff
2--EP Trainee
3--CT Staff
4--CT Trainee

^bDimension: I--Focus of discussion: time orientation
II--Focus of discussion: weakness vs. strengths, etc.
III--Control of discussion: Division of responsibility regarding talk ratio and introduction of topics
IV--Degree of acceptance; warmth and permissiveness

ratings on the four common dimensions (time-orientation--future vs. past; assets vs. liabilities; control of discussion; acceptance, warmth and permissiveness) the judges' ratings are also presented as percentages based on the number of points possible (averages of judges' ratings divided by possible points--five, except for total score, where twenty points were possible). Notice that the four dimensions are comparable in intent (although not in exact wording) to the four dimensions of table 4.

An immediately noted contrast between patient and judge ratings of process dimensions stands out. Whereas on three of the four dimensions subjects from CT Unit rated their groups higher than did those from EP Unit, judge ratings without exception are higher for EP Unit groups. One possible answer to this contradiction might be in terms of "subject bias." That is, subjects from CT Unit were more used to being assigned to activities in an authoritarian manner; whereas, by the time of post-treatment evaluation (at which time the subjects evaluated their group) the subject from EP Unit might well have absorbed the "atmosphere of freedom" of their unit to the extent they tended to rate down the group as an example of the "forced activity" they were beginning to dislike. Also, in the discussion of subject ratings it was noted that the subjects of CT Unit rated "control of discussion" lowest of all items, particularly in regard to introduction of topics. Apparently, however,

this fact failed to bother them to the extent of generalizing to other dimensions. These arguments would tend to support the hypothesis that the "atmosphere" of EP Unit, including its "extended privileges," favors the development of autonomy and self-direction, with concomitant assumption of greater responsibility (as in "control of discussion").

It is to be noted that the judges' ratings favor all EP Unit dimensions by rather small margins of from four to six percentage points. However, the trend seems definite.

A check of Table 5 for over-all judge ratings (average ratings of Groups 1 + 2 + 3 + 4) again finds that in general the groups were conducted favorably in relation to the dimensions assessed. This statement is based on the fact that any rating of 50 per cent or higher would fall on the "positive" end of the scale. Average ratings ranged from 53 per cent ("focus on discussion: weaknesses vs. strengths") to 67 per cent ("degree of acceptance; warmth and permissiveness"). It should be pointed out that considerable inter-group variation occurred, especially on dimensions I and III, with ranges of 14 percentage points on dimension I and 22 percentage points on dimension III.

Additional findings

Appendix XVII has been compiled to show intercorrelations of all major and sub-criteria measures. Inter-observer reliability on ratings of "general observed behavior" was stated in Chapter III. Appendix XVIII furnishes a more

complete breakdown on this, as does Appendix XIX for the inter-judge reliability on ratings of "verbal behavior." Although reaching statistically significant levels, the r 's of .29 (pre-treatment) and .48 (post-treatment) obtained indicate that not too great confidence should be placed in HAPS ratings, especially individual ratings. Since a minimum of three ratings were averaged to obtain the scores used in the present study, the results are considered useful as descriptive indexes of general observed behavior. However, need for refinement of the instrument is indicated. Consideration should be given to methods of training observers, development of a more adequate base of comparison, and to terminology used.

Theoretical Implications

As clearly indicated, both the group counseling process and situational influences tended to produce negative results in terms of the criteria used. In general, the subjects' observed behavior was rated less appropriate; verbal behavior seemed to regress somewhat; and expressions of attitude toward self in relation to others and to the future took an "anomic turn for the worse," with accompanying increases of discrepancy between perceptions of "self" and "other." Only one exception is noted: counseled subjects held their own or even progressed slightly in the direction of becoming less dogmatic or closed-minded as compared with non-counseled subjects.

Experimental findings such as these challenge us for an explanation. Had results proved negative on only one or a part of the criteria measures, the conclusion may well have been that "the criteria or the measures, or both, were inappropriate." Had the measures of "general observed behavior," with the relatively low inter-observer reliability obtained been the sole source of information, negative findings could have more easily been dismissed. However, negative trends are very consistent, applying to all three major criteria measures and nearly all sub-criteria measures. Such consistent trends, the writer concludes, suggest that the foregoing explanation, in terms of adequacy of criteria or criteria measures, may be insufficient.

Partial explanation seems plausible in terms of previous research findings, while more complete theoretical foundations await further clarification. The following discussion is presented as a possible framework for dealing with such findings as those of the present study, as well as results observed by Wright (1956). Integration of these findings in relation to the descriptions of the group counseling process and the situation seems to form a pattern not inconsistent with previous findings in the fields of group dynamics, experimental psychology, personality theory, psychotherapy, and personality assessment. These will be discussed in an effort to clarify the findings of the present study, to increase our understanding of them, and to formulate a tentative frame of reference for dealing with such trends.

It has been well established that group pressures are toward conformity, which seems to help the group accomplish its purposes and helps the group maintain itself (Cartwright and Zander, 1953). The applicability of this principle to the present study seems very pertinent. The need for acceptance by peer groups--whether childhood, gang, club, political party, or religious sect--may well not extend in the same degree to the mental hospital, where quite often motivation seems to be toward disassociation from all that is reminiscent of hospital experience.

Esprit de corps seems to be a basic ingredient in the production of internal group pressure. Schacter (1953) discusses what he terms the "attractiveness" that the group holds for the member, claiming that the group can exert pressures toward conformity only as great, but no greater, than the strength of the attractiveness the group holds for a given member. With voluntary membership, solidarity of purpose or goals and functions of the group is maintained by internal pressures. The alternative is the withdrawal or expulsion of the disinterested or rebellious member.

The threat of non-conformity is different where members are involuntary, or "assigned" to a group. Here it may become a matter of restraints, rather than the attractiveness of the group, that causes even surface conformity. Cartwright and Zander (1953, 143) conclude that:

It should be expected, then, that the group with restraining forces will obtain overt conformity

of behavior, but that only the attractive group will develop genuine changes of attitude and motivation.

This appears to apply to the present study in some degree, since the groups were organized and assignments made arbitrarily. Later personal involvement may or may not have developed to the extent necessary to produce internal pressures toward conformity, with concomitant changes of attitude, motivation, etc. Since the general opinion of group members toward their membership and the effects of the group were favorable, it would seem that such involvement and cohesiveness did develop to a certain degree, although probably not so much as if membership had been voluntary.

A trend toward the breaking down of defenses to an extent enabling the enlarging of the perceptual field to at least some degree was evidenced by the results obtained on the Rokeach Dogmatism Scale. This happened despite increasing fears regarding the future and internal tensions and doubts regarding ability to meet demands on the self that seemingly occurred as movement toward the "outside world" began to appear more and more inevitable.

That the significant realities of the immediate task presented by the group or the situation (clarification of personal plans regarding vocational training or experience, or living arrangements; assumption of greater personal responsibility for plans and actions, etc.) were not adequately perceived or acted upon is not too difficult to understand.

The accumulated defenses of many years were being at least partially crumpled, and often without being replaced by equally comforting but more rehabilitative structure, or only partially so. Such structure, the writer maintains, is at least potentially available within the present Np hospital program, at least within the Veterans Administration program. Insufficient personnel, inadequate budgets, and over-emphasis upon "turnover" may mitigate against full implementation of such resources. However, increasing emphasis is being placed upon a "gradualist" approach to community adjustment of Np hospital patients. This is seen in programs (Night Resident, Halfway House, Day Care, Out-Patient Care, Sheltered Workshop) that enable the patient in effect to "keep one foot in the hospital and put the other out into the community," gradually developing skill and self-confidence by concentration on only a part of the various sources of pressure at one time. These measures, in addition to rehabilitation-oriented assignments and activities within the hospital, should give the patient assurance that something tangible is available to trust in, once the old defenses are gone. In this way tension can be controlled while moving toward ultimate goals.

Such an ideal condition is, in actual practice, approached neither quickly nor completely, as witnessed by the present study. Although oriented toward the future, undergirding supports in terms of clear and achievable

step-by-step plans and actual evidences of progress were not consistently available, or the length of time of treatment was insufficient to realize such progress, or perhaps both. This pattern could hardly have been divorced from a rising sense of confusion, self-doubt, distrust of the institution which was about to eject the patient into a "cold and unreceptive external world." Rokeach (1960, 57) comments upon pressures of this kind and their effects:

Examples of irrelevant internal pressures that interfere with the realistic reception of information are . . . the need to allay anxiety, and so forth. By irrelevant external pressures we have in mind most particularly the pressures of reward and punishment arising from external authority: for example, as exerted by parents, peers, other authority figures, reference groups, social and institutional norms, and cultural norms.

The approach-avoidance schema of Dollard and Miller (1950, 359-363) and their discussion of the "negative therapeutic effect" appear to fit into the present context. As long as the subjects of the present study could sit back becoming progressively more encapsulated in their defenses against life "on the outside," their distance from the "goal" (as perceived by the counselor) was so great as to be essentially non-fear producing. With the injection of the counseling group into the life pattern the accommodation to hospital routine was shattered. This was true also in the case of those patients transferred to EP Unit, where the general atmosphere is one of orientation toward the future, assumption of greater personal responsibility, etc. Both

of these variables forced the subjects into the very situation they had by one means or another been avoiding, in most cases for years.

Motivation, whether internal or external, was toward the "goal," with accompanying heightened anxiety or fear. As the goal came closer with passage of the treatment period, intra-personal conflict mounted, and was reflected to at least some degree on all instruments except the Dogmatism Scale, as previously noted. This forced "looking at alternatives," as contrasted with the constricted patterns of the past, apparently broke the "set" (as reflected by Dogmatism Scale), but at the same time increased fear. As Dollard and Miller (363) state it:

According to our hypotheses, symptoms are produced by the strong drives involved in conflict. Thus we shall expect this increase in conflict to produce an increase in symptoms.

They cite Freud (1925) as reporting that symptoms are especially likely to occur when strong repressions and inhibitions are on the verge of breaking down.

Dollard and Miller maintain that the answer to this problem lies in reduction of fear and avoidance before trying to increase motivation to "approach" the goal. Perhaps with institutionalized patients a more appropriate attack would be to integrate the two. It appears to the writer that some degree of motivation must be induced (if not maintained from the beginning of hospitalization) by some method such as group counseling or situational manipulation before

essentially inactive other than helping to provide the situation. A teaching role is anathema to some but indicated as useful by others. Whether the group members should be selected according to diagnosis, sex, or other characteristic also is a matter of differing opinion. While some urge that a group must center on a specific theme or goal, others see this as unnecessary or unwise. Such divergent views seem to indicate the need for much research. Certainly, at the very least, any report of group work should carefully describe the characteristics of that particular group. The present study attempts to observe this admonition as carefully as possible.

Fields covered by group methods

Group methods are seen by advocates as applicable to all countries and cultures (Moreno, 1957). In addition to mental hospitals, many other fields, such as the following, have utilized this method of treatment: psychosomatic disorders, addiction, alcoholism, stuttering, allergies, geriatrics, expectant mothers, unmarried mothers, delinquency, child guidance, family services (sex and marriage) problems, private practice, community mental health, industry, training, research (Slavson, 1956, xi). "Group Guidance" has become a byword in modern schools, and "Gamblers Anonymous" adds color to a growing list.

working to reduce fear and avoidance. This should be done, however, with full awareness of the anxiety that is being aroused, and with every effort being made to work through these fears and conflicts as they arise. Movement toward the "goal," then, would be accompanied by a controlled level of anxiety, permitting the realistic mobilization of personal resources to meet the demands of the forthcoming situation.

Supporting evidences for the above theoretical framework are also found in the writings of Mowrer and Snyder. Mowrer (1953), in his discussion of tension during the course of therapy, using three separate measures: GSR measurements of palmar sweating, the discomfort-relief quotient--DRQ, and the patient's self-rating, found that the peak of tension was often reached somewhere around the twelfth session. He also shows graphic evidence that patients remaining in therapy enjoyed a gradual lessening of tension with concurrently increasing "happiness." The report of Snyder's (1961) studies of the psychotherapy relationship in part emphasize a parallel situation in respect to the transference phenomenon, with the curve representing the (negative) transference following the same general pattern of the tension curve Mowrer charts: that is, starting at a moderately stable level, such feelings increase until a peak is reached after several therapy sessions, after

which a gradual lessening of negative feelings terminate at a lower level than experienced at the start of therapy.

Such evidence suggests that the length of treatment-time of the present study was just about optimum for achieving the peak of tension in both intra- and inter-personal conflict. Follow-up study is indicated to ascertain whether this conclusion is warranted. According to the Dollard and Miller schema, a lessening of motivating pressure--by discontinuance of group counseling or removal from EP Unit, or reduction of fear and avoidance within the counseling or EP Unit setting by appropriate techniques and activities--should be measurable in terms of reduced fear or anxiety.

Subsequent research is needed to confirm or repudiate such theoretical implications of the above discussion as: (1) a certain degree of tension or anxiety will accompany progress of long-term Np patients toward rehabilitation, (2) the level of tension or anxiety can be predicted by means of assessment procedures, (3) the level of tension or anxiety can be controlled sufficiently to effect progress toward rehabilitation goals, (4) group counseling and/or situational therapy (environmental manipulation) are means of achieving progress within the limits of optimal tension or anxiety levels.

The finding of trends negative to the major experimental hypotheses of this study, rather than being interpreted as conclusive evidence against either hypothesis, is believed

by the investigator to have added substantially to the development of a theoretical framework within which counseling may be carried out more effectively, especially in a neuropsychiatric hospital setting.

Suggestions for Further Research

In reviewing the purposes and outcomes of the present study, several areas in need of future clarification through research are apparent:

1. A longer treatment period, of from six months to one year, or some other means of increasing the total number of sessions, such as holding two sessions per week, should be explored while holding other variables as similar to the present study as possible. Bi-monthly checks, using appropriate criteria measures, could be used to plot a "tension-curve" for group counseling.
2. A follow-up of the present study is indicated. This could provide information regarding behavioral changes occurring after six months or more separation from group counseling and/or unit stresses. Such a study would also permit the checking of predictive validity of the criteria measures used in the present study.
3. Since wide individual differences on all measures occurred, analysis of data in terms of intra-personal changes relative to the criteria measures and background variables could prove valuable.
4. A similar study, using different specific criteria and/or measures should prove beneficial. Measures designed more specifically to evaluate anxiety or tension could be employed to test hypotheses arising from the theoretical implications stated above. Such measures could also be used in conjunction with those used in the present study, which would provide desirable information regarding concurrent validity for the latter.

5. Research is needed to better define the general areas of concern to patients facing the task of transplanting themselves back into "normal" community living. In this connection, general principles should be determined, rather than attempting a definition of one or several specific "situations."
6. As in the area of individual counseling, additional insight within the group counseling context is needed in relation to the effects of various counselor roles or techniques on patient behavior. Improved, practical means of assessing group counseling process should enhance the meaningfulness of reported studies.
7. Continued attention to and study of both ultimate goals of counseling in an institutional setting and specific criteria by which to measure progress toward those objectives should be forthcoming.

CHAPTER V

SUMMARY AND CONCLUSIONS

The need persists to develop increasingly effective means of assisting in the rehabilitation of hospitalized neuropsychiatric patients. A special interest of the investigator, group counseling, coupled with a deepening conviction that a high level of freedom, activity, and personal responsibility on the part of the patient are ingredients of such rehabilitation, led to the present study.

A large proportion of the patients in our mental hospitals become increasingly "institutionalized" or encapsulated within a system of defenses. Often they are characterized by loss of hope and purpose, withdrawal from active life, loss of self-esteem or personal pride, increased rigidity and closed-mindedness, growing dependence on others, and loss of initiative and personal autonomy.

The general objectives of the present study were to evaluate the effectiveness of two treatment methods in dealing with such patients. The first method in this two-fold approach was designed to evaluate the comparative effects of (a) regular hospital activities with no group counseling and (b) regular hospital activities plus group counseling, on specified behavioral variables. The second objective was to evaluate the comparative effects of (a) an extended-privilege unit and (b) a continued-treatment unit, on the modification of specified behavioral variables. An attempt

was made to distinguish between the effects of the counseling itself and the setting in which it occurs.

Secondary considerations were: the selection of appropriate criteria, additional clarification of the role of counseling psychology in an institutional setting, increased understanding of the group counseling process, and the investigation of the relationship of several background variables (age, marriage, length of hospitalization, length of military service, diagnosis of schizophrenia, vocational background, financial situation, verbal ability, activity level, opinion of the unit) to changes of behavior as determined by the criteria measures.

A sample of fifty-two subjects was selected from a unit (termed CT Unit) in the Veterans Administration Neuropsychiatric Hospital at Chillicothe, Ohio which was composed primarily of "continued-treatment" patients--those who had achieved at least some degree of stabilization. Selection was made on the recommendation of staff personnel in such a manner as to exclude from the sample any patient who was: over 55 years of age, known to be leaving the hospital within the four-month evaluation and treatment period, an alcoholic, extremely aggressive or suicidal, too far "out of contact with reality" or not sufficiently stabilized, exhibiting extremely deviant behavior, illiterate, or already engaged in a type of group activity similar to that proposed in the present study.

Subjects were randomly assigned to six groups in two settings: two counseled and one non-counseled group were left in CT Unit, from which the total sample was drawn; while three comparable groups were transferred to an extended-privilege unit (termed EP Unit). Of the original sample, forty-six subjects completed the treatment program, these being equally divided between the units (twenty-three in each), with seven subjects in each unit counseled by a regular staff counseling psychologist, six subjects in each unit counseled by a counseling psychology trainee, and ten in each unit receiving no group counseling.

The behavioral variables or criteria selected for the purpose of measuring the treatment outcomes were (1) "general observed behavior," (2) "verbal behavior," and (3) "expressed attitude toward self in relation to others and the future." The first two of these criteria were measured by the Hospital Adjustment and Placement Scale (HAPS) and the Judges' Rating Scale for Verbal Behavior (JRSVB), respectively. Both instruments were devised by the experimenter in an effort to operationally define the criteria by means of quantifiable measures. The third criterion was evaluated by three instruments: Elmore's Scale of Psychological Anomie, Corsini's Standard Adjective Q Sort, and Rokeach's Dogmatism Scale.

Sub-criteria evaluated by these measures provided indexes of observable behavioral change related to the three

major criteria, as follows. Criterion #1, "general observed behavior," provided measures (HAPS, ratings by staff personnel) of motivation to leave the hospital, observed actions and habits, aggressiveness toward others, level and realism of regard for self and others, ability to function independently and competently, cooperation and socialization, appropriateness of emotional expression, and clarity and realism of plans for the future.

Criterion #2, "verbal behavior," was measured (JRSVB, psychologists trained as judges to analyze taped protocols of individual interviews) in terms of dimensions relating to fluency and appropriateness of speech, appropriateness of expression of emotion, degree of anticipation of outcomes or optimism toward the future, level and realism of regard for self and others, interpersonal relations with interviewer, openness to experience, autonomy or independence, and clarity and realism of plans for the future.

Criterion #3, "expressed attitude toward self in relation to others and the future," assessed the degree of psychological anomie (feelings of meaninglessness, hopelessness, powerlessness, valuelessness, aloneness, and closed-mindedness), congruence of concepts of "self" and "the typical, well-adjusted person out in the community," and open-mindedness.

Pre- and post-treatment evaluation provided (1) assurance, statistically speaking, of pre-treatment compara-

bility of both the six groups and the two units, and (2) indexes of change in terms of the criteria used. Application of a two-factor analysis of variance with the background variables in covariance was made. This statistical procedure assured that effects of background variables had been taken into account, and made available an appropriate means of comparing groups and units in relation to the effects of treatment.

No statistically significant differences were found either between groups or between units, in relation to the modification of behavior as indicated by the total scores on the five criteria measures. Over-all trends were in the direction opposite to both major experimental hypotheses, which were: H I--"Regular hospital activities plus group counseling is a treatment milieu more conducive to positive behavioral change than is regular hospital activities without group counseling"; and H II--"An extended-privilege setting provides a treatment milieu more conducive to positive behavioral change than does a continued-treatment setting." Only one sub-criterion measure supported a hypothesis at above the five per cent level of significance. On two major criteria measures (HAPS, Anomie) changes were negative for all six groups, although not statistically significant.

The findings therefore indicated that, in general, in relation to both major hypotheses, the subjects' "observed

behavior" grew less appropriate, as did his "verbal behavior"; and "expressions of attitude toward self in relation to others and the future" also regressed, as seen on two of the three measures of this criterion. One noteworthy exception to this trend occurred: counseled subjects progressed slightly in the direction of becoming less dogmatic or closed-minded.

An apparently inverse relationship of pre- and post-treatment scores was noted in connection with certain sub-criteria. However, closer inspection revealed that such was not true of other sub-criteria measures, and did not apply to total scores of any of the five major measures.

Examination of the relationship of background variables to the criteria measures showed that age, length of hospitalization, and activity level were especially important factors, while all variables investigated showed a significant relationship to one or more of the sub-criteria measures.

No great differences were noted in regard to patients' opinions of the two treatment settings, although subjects of EP Unit rated their unit somewhat higher than did those of CT Unit. These ratings confirmed the experimenter's evaluation of the settings, and would seem to indicate that "progress" in EP Unit should be at least as good as in CT Unit.

In regard to the group experiences, members of the counseled groups in CT Unit rated the four dimensions studied

Historical development of group counseling

As an explanation of the group methods used in the present study, a brief review of their historical development seems in order. More detailed accounts are readily available (Corsini, 1957; Meiers, 1946; Moreno, 1932, 1957, 1960; Ryan, 1951; Slavson, 1956, 1959; Thomas, 1943). It has been seen that group treatment has been extended into a wide range of problems. Application of the method to a new field may develop spontaneously, but more likely will involve some modification of already existing methods in other fields.

The use of group counseling in a hospital setting is not a new discovery. However, since the term "group counseling" has not been extensively used in the literature, some effort will be made to define its usage, especially in relation to the more common term, "group psychotherapy." Furthermore, there are specific implications in relation to the use of group counseling in such a setting as an Np hospital, and some of the thinking of leaders in the field will be presented.

Several streams of influence have led to the development of group counseling in a hospital setting. Those bearing especially upon this study are group psychotherapy, group work in education, and the specialized work of the group dynamics movement.

slightly higher than did the members of counseled groups in EP Unit. Judges, on the other hand, gave slightly higher ratings to EP Unit groups. This factor, then, also appears not to have influenced the major findings to any great extent.

At most, only partial explanation of the consistently negative findings seems to be found in relation to the above factors. Had these findings been less consistent, reference to "invalid criteria" or "inappropriate measures" (Wright, 1956) would be a logical answer. Such a conclusion seems partially warranted, due to the questioned reliability of the ratings of "general observed behavior," using the HAPS. The writer, however, although strongly recommending further refinement of criteria and measures of outcomes of counseling in institutional settings, concludes that the general evidence rather strongly indicates the need for additional explanation. The effort to provide such an explanation is summarized in the following paragraphs.

It appears to the writer that an integration of previous research findings from the fields of group dynamics, experimental psychology, personality theory, psychotherapy, and personality assessment provides at least partial explanation of the over-all findings. Internal and external group pressures toward achievement of "group goals," causing the crumpling of encapsulated defenses, seemingly resulted in increased intra-personal conflict and tension. These, in

turn, resulted in apparently "regressive" behavior, as related to the experimental hypotheses of the present study.

The "approach-avoidance" schema of Dollard and Miller (1950), with supporting evidence from studies of tension during the course of therapy (Mowrer, 1953) and negative transference trends during therapy (Snyder, 1961) appears to be an appropriate explanatory framework. The latter two studies suggest that had the treatment period of the present study been extended, intra-personal tension and negative inter-group feelings might well have abated.

Future research is needed to test the theoretical implications found in the present study. In addition to the use of an extended or more intensive treatment period, other indicated research includes: analysis of intra-personal changes in relation to treatment and background variables, follow-up of the subjects of the present study, comparison of the criteria and measures used in the present study with others--especially those capable of obtaining indexes of tension or anxiety more directly, clarification of the general areas of concern to Np hospital patients facing return to the community, study of the group counseling process--especially the counselor role--in the institutional setting, and better definition of both ultimate and immediate counseling criteria.

Such research, interpreted within the framework suggested above, could conceivably improve our understanding

of the treatment needs of institutionalized patients. It is the investigator's conclusion that the results of the present study may bear implications beyond those originally conceived. The negative findings reported may ultimately bear fruit by providing a basis for increased understanding of hospitalized Np patients, as well as the clarification of counselor-expectations regarding behavioral and attitudinal changes of patients during the course of treatment.

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Kotkov (In Slavson, 1956, 319) defines group psychotherapy as

. . . The development of verbal and emotional interactions and part identifications in an initial collection of unrelated malfunctioning individuals, led by a qualified psychotherapist, purposely motivated toward the common goal of the alleviation of reality problems on a conscious level.

Moreno was among the first to view group therapy as offering more than a means of saving time. Writing as early as 1934, he asserts that "Group therapy treats not only the individual who is the focus of attention because of maladjustment, but the whole group of individuals who are interrelated" (1934, 301). Concerning the origin of the terms "group therapy" and "group psychotherapy," Moreno (1960, 58-59) presses his own claim as a founder of the movement:

Group psychotherapy owed its emergence to sociometry and small group dynamics which was expounded by the author between 1931 and 1934; he formulated group therapy as a scientific methodology with the help of Drs. White, Whiten, Branham and Jennings. There have been fore-runners of pre-scientific group methods in the U.S.A. and Europe before 1931. The most important influence came from Vienna since 1909. Many of these methods (psychodrama, 1911; interaction methods, 1913; psychodrama combined with group therapy, 1923) have been launched by this author and described in his German books. . . . the moment of emergence of the scientific group psychotherapy movement into scientific history, . . . was the year 1932.

In 1932 Moreno (1932, 131) envisaged the development of an exact science of group organization, a "sociometry,"

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A P P E N D I X E S

APPENDIX I

SCALE A

WESMAN, VERBAL SCALE

Scale A

NAME _____

DATE _____ AGE LAST BIRTHDAY _____ SECTION NO. _____

EDUCATION: Circle the last school grade you completed

(Grade School)								(High School)				(College)			
1	2	3	4	5	6	7	8	9	10	11	12	Fr	So	Jr	Sr

DIRECTIONS: Below each question are given four choices for the answer. Read the question and select the one choice (A, B, C, or D) which is the best answer. Then, at the right of the question, make an X on the letter of the word you have chosen.

EXAMPLES:

A. Which is an animal?

(A) orchid, (B) squirrel, (C) tulip, (D) crystal A X C D

The only animal among the four choices is SQUIRREL--choice B. Therefore, the B has been marked with an X as shown at the right of the question.

B. Which does not belong?

(A) red, (B) green, (C) purple, (D) sweet A B C X

Red, green and purple are colors but SWEET (choice D) is not a color and does not belong with the other words. Therefore, the D has been marked as shown at the right of the question.

WORK AS RAPIDLY AS YOU CAN

DO NOT TURN THE PAGE UNTIL YOU ARE TOLD TO

1. Which means furious?
(A) hairy, (B) angry, (C) distant, (D) rarely 1. A B C D
2. Which does not belong?
(A) cheat, (B) chisel, (C) plane, (D) hammer 2. A B C D
3. Which does not belong?
(A) pint, (B) gallon, (C) pound, (D) quart 3. A B C D
4. Which are shears?
(A) sickles, (B) cliffs, (C) stockings,
(D) scissors 4. A B C D
5. Which is a seaport?
(A) New Orleans, (B) Reno, (C) Des Moines,
(D) Omaha 5. A B C D
6. What is a scaffold?
(A) clothing, (B) platform, (C) building,
(D) noose 6. A B C D
7. Which is a lubricant?
(A) glue, (B) eraser, (C) grease, (D) comedian 7. A B C D
8. Which means annual?
(A) celebration, (B) always, (C) flower,
(D) yearly 8. A B C D
9. Which does not belong?
(A) diamond, (B) ruby, (C) gold, (D) emerald 9. A B C D
10. Which does not belong?
(A) map, (B) cartoon, (C) chart, (D) graph 10. A B C D
11. Which does not belong?
(A) brush, (B) towel, (C) broom, (D) mop 11. A B C D
12. Which does not belong?
(A) rabbi, (B) minister, (C) priest,
(D) doctor 12. A B C D
13. Which does not belong?
(A) ash, (B) birch, (C) vine, (D) oak 13. A B C D
14. Which is a filter?
(A) sieve, (B) smoke, (C) plane, (D) tailor 14. A B C D
15. Which means to detach?
(A) draw, (B) fight, (C) join, (D) separate 15. A B C D
16. Which is a marsh?
(A) forest, (B) candy, (C) parade, (D) bog 16. A B C D

17. Which does not belong?
(A) hearts, (B) aces, (C) diamonds,
(D) spades 17. A B C D
18. A team always has
(A) equipment, (B) uniforms, (C) schedule,
(D) members 18. A B C D
19. Which is corrosion?
(A) gulley, (B) sewage, (C) rust,
(D) depravity 19. A B C D
20. Which does not belong?
(A) shoes, (B) socks, (C) stockings, (D) hose 20. A B C D
21. Which means precision?
(A) surgery, (B) accuracy, (C) value,
(D) seeing 21. A B C D
22. Which is an emblem?
(A) charcoal, (B) flag, (C) scar, (D) honor 22. A B C D
23. Which does not belong?
(A) silo, (B) barn, (C) granary, (D) cattle 23. A B C D
24. Which does not belong?
(A) hotel, (B) inn, (C) motel, (D) house 24. A B C D
25. Which does not belong?
(A) barometer, (B) clock, (C) speedometer,
(D) generator 25. A B C D
26. Which is brittle?
(A) cotton, (B) water, (C) glass, (D) sand 26. A B C D
27. Which is a disease?
(A) antitoxin, (B) influenza, (C) bacteria,
(D) fracture 27. A B C D
28. Which is a windlass?
(A) winch, (B) woman, (C) shelter,
(D) boaster 28. A B C D
29. Which is an architect?
(A) builder, (B) planner, (C) inventor,
(D) supervisor 29. A B C D
30. Which does not belong?
(A) key, (B) latch, (C) lock, (D) bolt 30. A B C D
31. Which means banish?
(A) exile, (B) forbidden, (C) angry,
(D) horrid 31. A B C D

32. Which are forceps?
(A) decrees, (B) armies, (C) predictions,
(D) tongs 32. A B C D
33. Which is acceleration?
(A) stressing, (B) agreeing, (C) quickening,
(D) nearing 33. A B C D
34. Which is zeal?
(A) enthusiasm, (B) fur, (C) reluctance,
(D) closing 34. A B C D
35. Which is prestige?
(A) agility, (B) leveling, (C) equality,
(D) distinction 35. A B C D
36. Which means wary?
(A) cautious, (B) hardy, (C) hostile,
(D) bent 36. A B C D
37. Which is disorder?
(A) command, (B) cancellation, (C) refusal,
(D) confusion 37. A B C D
38. Which does not belong?
(A) nail, (B) brad, (C) spike, (D) screw 38. A B C D
39. A horse always has
(A) withers, (B) reins, (C) bridle, (D) rider 39. A B C D
40. Which does not belong?
(A) infantry, (B) artillery, (C) military,
(D) cavalry 40. A B C D
41. Which does not belong?
(A) Texas, (B) Denver, (C) Arkansas,
(D) Maine 41. A B C D
42. Which is a dory?
(A) window, (B) boat, (C) gateway,
(D) column 42. A B C D
43. Which means intricate?
(A) involved, (B) brave, (C) decorate,
(D) accuse 43. A B C D
44. Which does not belong?
(A) nozzle, (B) spigot, (C) hose, (D) spout 44. A B C D
45. What does @ mean?
(A) at, (B) about, (C) always, (D) articles 45. A B C D

46. A guarantee always has a
(A) penalty, (B) guard, (C) pledge,
(D) signature 46. A B C D
47. Which does not belong?
(A) cup, (B) dish, (C) saucer, (D) plate 47. A B C D
48. Which does not belong?
(A) tax, (B) assessment, (C) income, (D) fine 48. A B C D
49. Which does not belong?
(A) pound, (B) acre, (C) weight, (D) yard 49. A B C D
50. Which means grovel?
(A) stone, (B) dismal, (C) crawl, (D) snarl 50. A B C D

GROUP COUNSELING IN A NEUROPSYCHIATRIC HOSPITAL
IN CONTINUED-TREATMENT AND EXTENDED-
PRIVILEGE SETTINGS

DISSERTATION

Presented in Partial Fulfillment of the Requirements for
the Degree Doctor of Philosophy in the Graduate
School of The Ohio State University

By

Gordon Adair Harshman, B.A., M.Ed.

The Ohio State University
1963

Approved by

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to be based on a quantitative analysis of groups. He foresaw farreaching results:

Through techniques of reorganization, assignment, retraining, and other methods of group manipulation which assist each member of the community in finding for himself the most desirable place, the abodes of the unfortunates, correctional institutions and training schools, may bring about for our time what the monastery accomplished for its age, a renaissance of society.

Slavson (1959, 456) sees the development of the group movement prior to the 1930's as essentially only a forerunner to the present group psychotherapy. He asserts that lecturing was the exclusive means employed by all workers in the field in the first two decades of this century ("Class method" of J.H. Pratt, A.A. Low, etc.), the groups were too large, etc.

Meiers (1946, 3ff.), in his discussion of the origins and development of group psychotherapy, goes back to an "enormous number of almost untraceable roots" far in antiquity:

The history of cults and religion, of folklore, folk tales and poetry, of Egyptian, Greek, Oriental, East Indian, Chinese, Polynesian and, last but not least, our own American Indian medicine provide ample fields of the "past" where these roots can be found.

In speaking of the use of specific terms, Meiers sticks to the first recorded evidences, stating that the term "psychotherapy" was first used by Johannes Christian Reil in 1803. He, too, believes the term "group psychotherapy" to have been first recorded in 1931 by Jacob L. Moreno.

APPENDIX II

**SUPPLEMENTARY INSTRUCTIONS FOR OBSERVER RATINGS
AND COPY OF THE HOSPITAL ADJUSTMENT
AND PLACEMENT SCALE (HAPS)**

Supplementary Instructions for Observer Ratings:

1. Rate each individual on the list below in relation to the "typical Unit I patient."
2. Think of the patient's behavior during the past 2-4 weeks, and rate accordingly.
3. Try to avoid being influenced by how the patient was before January 1st.
4. Allow for unusual events or situations which may have recently placed undue stress on the patients, unless he is reacting inappropriately.

HOSPITAL ADJUSTMENT AND PLACEMENT SCALE

Patient _____ Date of birth: mo. ____ day ____ yr. ____

Marital status: Married() Single() Widowed() Divorced()
Separated()

Military service: (total) ____ yrs. ____ mo.

Total time in NP hospitals to date: Yrs. ____ mo. ____

Present diagnosis _____

Rating Instructions: Please check (✓) most appropriate overall description of the patient for each of the following categories. **Note:** check only one blank for each category, then cross out the phrase(s) which do not apply to the patient. Add other pertinent information about each category in the space provided for comments.

I. MOTIVATION TO LEAVE THE HOSPITAL

- a.() Very strongly motivated to leave; actions and statements indicate strong desire to leave; agitates to leave; constantly talks to staff about leaving
- b.() Strongly motivated to leave; talks frequently of leaving, but doesn't "push" or agitate to get out; often speaks to staff member about leaving
- c.() Fairly motivated to leave; shows interest in leaving; sometimes initiates a request to leave; sometimes talks to staff about leaving
- d.() Slightly motivated to leave; appears neutral-no concern one way or the other; seldom talks about leaving; would probably go anywhere without question
- e.() No apparent motivation to leave; rather passive about leaving; no talk about leaving; would possibly be slightly upset if moved out of the hospital
- f.() No apparent motivation to leave; generally quite passive about leaving; might resist leaving; resigned to hospital life
- g.() No motivation to leave; would probably resist leaving; very much resigned to spending rest of life in hospital

Comments:

II. LEVEL OF MEDICAL AND NURSING CARE REQUIRED

- a.() Very little or no special care needed; well above average physically; very seldom ill, then never seriously; no regular medical or nursing care needed; no medication on regular basis; regular diet
- b.() Special care seldom needed; average or above physically; seldom ill; no regular nursing or medical care needed; on self-medication or no medication on regular basis; regular diet
- c.() Special care occasionally needed; above average physically; occasional illness requiring nursing care; on self-medication or medication required only on short-term basis; limited on some foods, but generally on regular diet
- d.() Special care frequently needed; probably below average physically; no chronic physical condition; frequent illness requiring medication and/or nursing care; generally takes care of own medication; needs only periodic checkup; some dietary needs
- e.() Special care regularly needed; chronic condition requiring regular medication and/or nursing care; sometimes takes care of own medication; below average physically; non-acute; confined to bed at times; special diet required
- f.() Regular nursing care and frequent medical visits required; poor physical condition; regular medication; unable to take care of own medication; non-acute; bed-care; non-ambulatory; incontinent; special dietary needs
- g.() Intensive medical and nursing care required; very poor physical condition requiring frequent or constant hospitalization; bed-care; incontinent; special equipment needed; special dietary problems.

Comments:

III. OBSERVED BEHAVIOR

- a.() Outward behavior normal; no unusual habits or quirks; actions don't bother others; always acts about the same from day to day; careful about personal appearance and habits
- b.() Appears to be nearly normal in behavior; has his little quirks, but not too unusual or noticeable; actions seldom bother others; always acts about the same from day to day; usually careful about personal appearance and habits
- c.() Has some noticeable quirks or habits; actions seldom bother others; usually acts about the same from day to day; unconcerned about personal appearance but usually clean and neat
- d.() Quite different from others but harmless or amusing; doesn't bother others; usually acts about the same from day to day; sometimes careless about personal appearance or habits
- e.() Odd habit(s); very unusual behavior, but doesn't seem to bother others; usually acts about the same from day to day; a little careless about personal appearance; not repulsive to others; others usually ignore him
- f.() Very odd, bizarre behavior which bothers others at times; not especially repulsive to others; hard to tell what he'll do next; careless about personal habits and appearance
- g.() Extremely odd, deviant behavior; bizarre; bothers others; repulsive to others; erratic--can't tell what he'll do next; very careless, sloppy about personal care.

Comments:

IV. AGGRESSIVENESS TOWARD OTHERS

- a.() Very non-aggressive; never fights or hits back; very passive toward others; avoids trouble at all costs; careful of own and others' property
- b.() Non-aggressive; seldom fights back, even when provoked; tries to avoid trouble; careful of own and others' property
- c.() Slightly aggressive; fights or strikes back but only in self-defense; not easily provoked; usually gets along with others; careful of own and others' property
- d.() Moderately aggressive; will fight or hit back but never starts trouble; sticks up for own rights, respects rights of others; takes care of own and others' property
- e.() Aggressive; doesn't pick fights; fights when provoked; bossy or quarrelsome at times; careless about others' property, but not destructive
- f.() Strongly aggressive; picks fights; quarrelsome; never known to threaten to kill; chip on shoulder, picks on others; breaks things unnecessarily and otherwise destructive of property
- g.() Extremely aggressive--assaultive; homicidal; threatens to kill others; uses abusive, foul language; dangerous if not controlled; must be restrained at times; destroys property

Comments:

V. ATTITUDE TOWARD SELF AND OTHERS (Self-esteem)

- a.() Apparently high and realistic opinion of self; regularly does things for others; self-confident; seems about as interested in problems of others as in his own; seems quite interested in local and world events; quite optimistic about the future; plans and goals well defined and realistic
- b.() Fairly high and realistic opinion of self; helps others frequently; seems self-confident; sees own problems realistically; never acts too depressed; interested in local and world events; optimistic about the future; plans and goals fairly well defined and realistic
- c.() Usually has good and realistic opinion of self; helps others at times; not very self-confident; seems to worry about own problems but seldom acts very depressed; some interest in local or world events; expresses some hope for the future; plans and goals OK but not well defined
- d.() Usually has fairly low or unrealistic opinion of self; seldom helps others; little self-confidence; worries a lot; sees self as having failed in many ways; expresses some hope for the future; little interest in local or world events; plans and goals rather vague, not well defined
- e.() Low or unrealistic opinion of self; rarely helps anyone else; very little self-confidence; worries about past failures, inadequacies; very little interest in local or world events; has some hope for improvement; would like to "live life over"; plans and goals vague or confused
- f.() Very low or unrealistic opinion of self; sees self as of no worth to anyone; no apparent self-confidence; believes he "has made a mess of life"; no interest in problems of others; no interest in local or world events; expresses little or no hope for the future; plans or goals apparently lacking or unrealistic
- g.() No apparent self-respect; sees self as unwanted; not needed, unloved, "just a burden on society"; no self-confidence; no interest in problems of others; no interest in local or world events; appears absolutely hopeless; plans or goals completely lacking or very unrealistic; speaks of or has attempted suicide.

Comments:

VI. ABILITY TO FUNCTION INDEPENDENTLY AND COMPETENTLY

- a.() Quite independent in most ways; performs assigned duties very well; is punctual; shows initiative; assumes responsibility; very dependable in use of special privileges; takes care of all personal needs; communicates well; in good contact with reality--well oriented to time, place, person
- b.() Usually independent in most ways; handles assigned duties adequately; shows some initiative, sense of responsibility; dependable in use of special privileges; needs some supervision on more complex tasks; cares for own personal needs; communicates well; in good contact with reality--well-oriented to time, place, person
- c.() Fairly independent in most ways; handles assigned duties adequately; shows some initiative and/or sense of responsibility; fairly dependable in use of special privileges; needs supervision on many tasks; relies somewhat on others in caring for personal needs; communicates adequately; in contact with reality--adequate orientation to time, place, person
- d.() Dependent on others in some ways; unable to hold regular assignment even under supervision, but some ability and interest in less demanding activities, hobbies, very little initiative or responsibility; usually dependable in use of special privileges; needs help with certain personal needs such as shaving, dressing; otherwise can take care of self; communicates fairly well; in rather poor contact with reality--but usually aware of time, place, person
- e.() Dependent on others in many ways; slight interest and ability in certain hobbies or simple tasks; very little initiative or sense of responsibility; not dependable in use of special privileges; must have help with certain personal needs; communicates poorly; in rather poor contact--sometimes confused as to time, place, person
- f.() Dependent on others for most needs; does even simplest tasks only with much help; no initiative or sense of responsibility; cares for personal needs only with help; communicates very poorly; in poor contact--usually confused as to time, or place, or person

g.() Very dependent on others for most needs; can't do even simplest tasks; no initiative or sense of responsibility; requires careful supervision and help for personal needs; has trouble communicating his needs; out of contact with reality--very confused as to time, place, person.

Comments:

VII. COOPERATION--SOCIALIZATION

- a.() Actively cooperative; follows rules willingly; often does more than his part; gets along well in group activities; well liked and accepted by others
- b.() Cooperates well but not so enthusiastically; follows rules without question; does what is expected of him; gets along well in group activities; liked and accepted by others
- c.() Usually cooperative; follows rules in passive manner; does what is expected of him but no more; gets along fairly well in group activities; others seem to like and accept him
- d.() Passively cooperative; obeys rules passively; does what is told to do; has to be told "why" at times before he will do his part; causes no trouble in group activity; others accept him passively
- e.() Uncooperative at times; breaks rules at times, but generally conforms to expected standards; must be urged to do his part at times, but will respond to urging; avoids group activities; others usually ignore or avoid him
- f.() Usually uncooperative; breaks rules frequently; will not conform to expected standards of conduct; seldom does his part; disturbs group activities; ignored or disliked by others
- g.() Very uncooperative; refuses to observe rules; makes no attempt to conform or cooperate; refuses to do his part; will not take part in group activities without causing trouble; disliked by others, not accepted.

Comments:

Meiers (1946, 8) poetically describes more recent events:

From 1935 on, especially in America, the activities and various beginnings of group psychotherapy become too numerous to be pointed out here by the simple names of authors: founders or followers. The springs have become rivulets, and these have merged into streams.

G.W. Thomas, in 1943, wrote the first comprehensive survey, Group Psychotherapy, a Review of the Recent Literature. He attempted, along Freudian lines, to categorize group therapy by contrasting "analytic" principles and the "repressive-inspirational" approach. Meiers believes Thomas neglected such principles as: structure of the groups, forms of activities; role of the "one" (leader-therapist) vs. the "many" (the group); and the difference between "lecture-explanation and group-member interaction in free discussion and dramatic, spontaneous self-presentation."

Moreno became chief exponent of psychodrama and sociometry, with emphasis on the group-centered method, as well as chief mover in the development of a scientifically based group psychotherapy. He recognized (1) the need for knowing the dynamic structure of groups as prerequisite to therapy and (2) the need for systematizing such knowledge.

World War II brought a tremendous upsurge in the various schools of group psychotherapy, and many converts,

VIII. EXPRESSION OF EMOTION

- a.() Quite appropriate expression of emotion--spontaneous, easy laughter; jokes and can take a joke; shows interest and enthusiasm toward many activities; shows enjoyment in talking and association with others; never seems upset or angry without good reason; expresses pleasure or displeasure appropriately
- b.() Appropriate expression of emotion--laughs and jokes freely; can take a joke; shows interest and enthusiasm toward some activities; appears to enjoy talking and association with others; seldom upset or angry without good reason; sometimes hides or fails to express feelings of pleasure or displeasure
- c.() Usually appropriate expression of emotion--at times appears to hide or keep self from freely expressing emotion; sometimes jokes but not always good at taking a joke; shows some interest but not enthusiasm toward others and toward activities; sometimes gets upset too easily; seldom shows displeasure
- d.() Fairly appropriate expression of emotion--never shows much emotion; doesn't laugh much; seldom appears angry or displeased; rather flat and passive toward others and toward activities, but emotions when expressed are usually appropriate at the time
- e.() Often inappropriate expression of emotion--can't take a joke; angers easily or ignores others; seems to hide real feelings or appears not to notice what is going on; shows little interest in others or in activities; sometimes angry or laughs without apparent reason
- f.() Usually inappropriate expression of emotion--seems very inhibited; no appropriate laughing or joking; little or no expressed interest in others or in activities; seems insensitive to surroundings; laughs, cries, or shows anger without apparent reason; seldom shows pleasure or displeasure as you would expect
- g.() Quite inappropriate expression of emotion--either severely inhibited, speaking in monotone and hiding feelings or becomes angry, gay, or excited without apparent reason; shows no interest in others or in activities; rarely shows pleasure or displeasure as you would expect.

Comments:

IX. On the following items place an X on the scale at any point which best indicates your opinion. For example:

Item A. The patient follows instructions

Never Always

X

Comments:

1. Within the past two or three months the general condition of the patient has

Regressed	Greatly Improved
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9
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84	84
85	85
86	86
87	87
88	88
89	89
90	90
91	91
92	92
93	93
94	94
95	95
96	96
97	97
98	98
99	99
100	100

Comments:

2. The chance of this patient returning to independent life in the community is

Excellent Chance	No Chance
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9
10	10
11	11
12	12
13	13
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93	93
94	94
95	95
96	96
97	97
98	98
99	99
100	100

Comments:

3. This patient's chance of making it in a (family care; nursing home) is

No Chance	Excellent Chance

Comments:

4. If you (rater) were in the family care or nursing home (See item #3) "business" how readily would you accept this patient?

Gladly Accept	Turn Down as Unacceptable

Comments:

IX. (Cont.)

5. At this time the patient's plans are: (Consider vocation, living arrangements, social contacts, funds, time-span of plans, present behavior and abilities.)

Very Unrealistic	Quite Realistic:
or	Clearly Defined:
Has No Plans	In Line with Abilities

Rater: _____ Date of Rating _____

Present location of the patient: Bldg. _____ Ward _____.

APPENDIX III**JUDGES' RATING SCALE FOR VERBAL BEHAVIOR**

Judge _____

Tape or disc # _____

Patient # _____

JUDGES' RATING SCALE FOR VERBAL BEHAVIOR

Instructions: (1) After listening to the entire interview, rate the subject on each of the following eight criteria. (2) Use "the average continued-treatment patient," such as in Buildings 1 or 35, as the standard. (3) Think, "Is this patient above or below the average continued-treatment patient on this criterion?" Then ask yourself, "How much?" (4) Place an X at that point on the scale which best expresses your judgment.

For example: a. Fluency. Rate of Talk

Very fluent; Talks quite easily, smoothly; Volunteers information

Talks very little, or hesitantly and with difficulty; Short Responses to questions; Volunteers little or no information

b. Appropriateness of Remarks and Affect

Remarks quite appropriate to the situation; Display of emotion related to topic and situation; Appropriate, spontaneous expression of emotion

Remarks or display of emotion quite inappropriate, irrelevant or not related to the situation; Monotone or severely inhibited expression

c. Anticipation of Outcomes: Optimism toward the Future

Remarks indicate eager and optimistic outlook; future appears rosy, full of promise; Communicates easily, jokes or laughs warmly

Remarks re. future quite pessimistic, or avoids the topic; Future holds nothing of worth, is empty, hopeless; Communication blocked or strained; Despair or self-condemnation quite apparent

d. Attitude toward Self, Others

Quite high and realistic regard for self and others; Accepts self "as is"; Expresses concern re. welfare and rights of others; Predominantly non-self communication

Very low or unrealistically high opinion of self; Little or no apparent concern re. rights and welfare of others; Extremes of egoism or self-derogation

e. Interpersonal Relations--Cooperation and Ability to Relate to Interviewer

Quickly and easily adapts to interview situation; Warm and Comfortable in the interview relationship; Cooperative, accepts responsibility for carrying on interview

Little or no effective adaptation to interview situation; Cold, withdrawn; Uncooperative or hostile; Flattened or inappropriate emotional expression

f. Openness to Experience: Willingness to Change, to Try New Ideas

Attitude quite flexible, willing to consider alternatives; Reserves judgment until all evidence is in; Considerable insight into own condition, relations with others, and in aims of hospital

Attitude quite rigid, unwilling to consider alternatives; Defensive and/or authoritarian; Narrow, constricted by habit or tradition; Very little or no insight into own condition, relations with others, or aims of hospital

g. Autonomy--Independence, Initiative, Competence

Quite independent, self-sufficient; Shows initiative, stability, strength; Freely expresses opinions; Retains uniqueness

Very dependent on others; "Institutionalized," no initiative or self-reliance; Contributes no personal viewpoints; Responses limited to acceptance remarks

h. Realism of Plans for Future

Realistically motivated to leave the hospital; Has adequate and clear-cut plans for both immediate and long-range future; Present activities and assignments are coordinated and fit into plans for future

No apparent plans or very unrealistic plans for the future; No motivation or unrealistic motivation to leave the hospital or into relation of present activities and future plans; May talk big but no realistic action on his part

APPENDIX IV
PATIENT OPINIONNAIRE

PATIENT OPINIONNAIRE

Preliminary remarks: "The hospital staff is interested in knowing how you feel about certain things. Your answers to the questions I am about to ask will be helpful in planning activities and treatment that we hope will help you.

Please give your honest opinions. Tell how you really feel about each question. We can only help you as we understand how you feel about certain things. To better remember your answers, I would like to record them, if that is OK with you.

General leads:

1. How do you feel about the way things are going for you?
2. How do you feel about the future? What does it hold?
3. Is there a place for you outside the hospital?
4. Are you ready to leave? Do you feel well enough to leave?
5. Do you want to leave? Why?

6. Is there anything a patient can do on his own to get out?
7. What steps are you taking toward getting out?
8. Where would you go?
9. What would you do? How about a job?
10. How and where would you live? Are there relatives, friends?

11. Do you feel that the staff members understand you?
12. Are they trying to help you?
13. How do you feel about the other patients?
14. Do you have some good friends here?
15. On the whole, how do you feel about your treatment here?

16. Are you pretty much able to do the things you want to?
17. How about your assignment and other activities?
18. How would you change things if you could?
19. Which building or ward do you think would be best for you?
20. What do you like most about the building you are in?

21. What do you think should be changed about it?
22. What do you like most about the whole hospital? Dislike?
23. What would be the best thing that could happen to you at this time?
24. One more question--If you could do anything, or have anything you wanted, what would it be?

Concluding remarks: "I guess that's about all at this time. Do you have any questions? Thank you very much for coming in."

APPENDIX V

**DIRECTIONS FOR SCALE OF PSYCHOLOGICAL ANOMIE
AND ITEMS IDENTIFIED (PARENTHETICALLY) AS
TO ORIGINAL SUBSCALE AND NUMBER**

such as R.R. Grinker and L.A. Spiegel, who wrote Men Under Stress (1944). Meiers (1946, 11) quotes these men as saying:

Dealing with groups has a positive value in that the group more nearly approximates the state of the human being in his natural surroundings, as a gregarious animal seeking a satisfactory niche in his social setting. His inhibitions and repressions are motivated by the mores of the group. By working out his problems in a small way, he should be theoretically able to face the larger group that is his world in an easier manner.

At the time of Meiers' writing, 1945, the introduction of group psychotherapy into state hospitals was in its initial stages. Almost prophetically he speaks of "this rather deficient situation where group psychotherapy would truly come fully into its own" (Emphasis his).

Some specific developments of the past three decades are of interest. Slavson, by 1934, working with various sizes and types of groups in and out of classrooms, had established the use of eight as the maximum number of group members, though stating that five or six yield better results. He has maintained that group psychotherapy had its beginnings with the introduction of the small group (1959, 457). His contention is that only in a small group can "free-associative catharsis" occur, valid interpretation be given, and telling insight acquired.

In England Bion and Foulkes, during World War II, followed the American practice of working with groups of "battle-fatigued" soldiers. Foulkes (Slavson, 1959, 458)

WORKSHEET E

Name..... Date.....
 Last First

In order to better understand how patients here at the hospital feel about certain things, a study is being made involving the present test. On the following pages are listed a number of statements which express certain personal attitudes or feelings. Following each item is a scale such as this:

X	X	X	X	X
Definitely	Slightly	Very	Slightly	Definitely
Agree	Agree	Undecided	Disagree	Disagree

You are to indicate the extent of your agreement or disagreement with what the statement says by circling the X above one of the five possible answers.

The following examples are given to give you an idea of how you are to mark your answers. For instance if you definitely agree or are sure you agree with a statement you should circle the X as follows:

ⓧ	X	X	X	X
Definitely	Slightly	Very	Slightly	Definitely
Agree	Agree	Undecided	Disagree	Disagree

If you only slightly agree with a statement but not very much, you would circle as this way:

X	ⓧ	X	X	X
Definitely	Slightly	Very	Slightly	Definitely
Agree	Agree	Undecided	Disagree	Disagree

If you have an extremely hard time trying to decide whether you agree or disagree and are undecided you should circle the X as follows:

X	X	ⓧ	X	X
Definitely	Slightly	Very	Slightly	Definitely
Agree	Agree	Undecided	Disagree	Disagree

To show that you slightly disagree with a statement you may circle an X in this manner:

X	X	X	ⓧ	X
Definitely	Slightly	Very	Slightly	Definitely
Agree	Agree	Undecided	Disagree	Disagree

If you are rather sure of your disagreement or definitely disagree with a statement circle the X as shown here:

X	X	X	X	(X)
Definitely	Slightly	Very	Slightly	Definitely
Agree	Agree	Undecided	Disagree	Disagree

For each statement circle only one X. Don't skip any statements. There are no right or wrong answers. You are simply to carefully read each statement and then indicate your reaction by circling one of the X's above the five possible answers. If you run into any word or statement you don't understand raise your hand and someone will come by to help you.

.....

For practice, give your response to this statement:

Eighteen-year-old men should be allowed to vote.

X	X	X	X	X
Definitely	Slightly	Very	Slightly	Definitely
Agree	Agree	Undecided	Disagree	Disagree

1. There is so much to be done and no way to do it. (1, 1)
2. Today our nation's leaders don't know what they stand for as much as did the patriots in early American history. (2, 1)
3. I often find myself wavering between two different opinions. (3, 1)
4. It seems to me that people are acting more and more like animals. (4, 1)
5. The skills and talents that I used to have seem to be fading. (5, 1)
6. The future is so uncertain that it's almost impossible to make serious plans. (6, 1)
7. Man is like a leaf tossed around on the stormy sea. (7, 1)
8. Frequently I feel that my destiny is determined by fate. (8, 1)
9. The way people are now you just don't know who you can depend on. (9, 1)
10. Persons in authority lack an understanding of the common man. (10, 1)
11. The world we live in is a pretty lonesome place. (11, 1)
12. My parents felt that children were to be seen and not to be heard. (12, 1)
13. Considering the shape that our country and the world is in right now, it's not right to bring children into the world. (13, 1)
14. Since I don't know what else to do, I have to do what others do. (14, 1)
15. In order to be a success today a man has to fight for what he wants, even if he has to do things that sometimes hurt his conscience. (15, 1)
16. I often feel as if it would be good to get away from it all. (16, 1)
17. Life is a rat race where more is expected of a man than he is able to accomplish. (1, 2)

18. In these times people are so different in what they believe that talk about a world brotherhood is pretty useless. (2, 2)
19. I frequently find that two of my thoughts are at war with each other. (3, 2)
20. Our country looks like it is going to the dogs. (4, 2)
21. I seem to be losing the love of my family and the respect of other people. (5, 2)
22. I don't see much hopes of amounting to anything in the future. (6, 2)
23. My opinion just doesn't count. (7, 2)
24. It seems that whatever will be will be and there's little that any of us can do about it. (8, 2)
25. Most people have so much trouble of their own that they aren't concerned about mine. (9, 2)
26. Those in power are unconcerned about the individual man. (10, 2)
27. I often feel lonely even when with other people. (11, 2)
28. I was never allowed to express my opinions when I was a child. (12, 2)
29. I can see no purpose in getting up and facing the world each day. (13, 2)
30. In order for us to do good work, our bosses should outline carefully what is to be done and exactly how to go about it. (14, 2)
31. It's hard to remain honest and get ahead in the world today. (15, 2)
32. I would like to get away from the maddening competition of the world. (16, 2)
33. The road to success is filled with insurmountable obstacles. (1, 3)
34. People are so mixed up today that they don't know which way to go. (2, 3)
35. It bothers me because I am often torn between love and hate for members of my family. (3, 3)

36. There has been such a breakdown in the morals of the American people that we are headed for destruction if we don't change. (4, 3)
37. No matter how hard you try you just end up back where you started. (5, 3)
38. The young people today have good reason to be confused about the future. (6, 3)
39. People are always pushing me around. (7, 3)
40. Getting a good job depends mainly on being lucky enough to be in the right place at the right time. (8, 3)
41. People are too busy to help each other today. (9, 3)
42. Leaders are more concerned with serving themselves than with serving others. (10, 3)
43. You really can't get close to people any more. (11, 3)
44. My parents never really understood me. (12, 3)
45. Life has no meaning for me any more. (13, 3)
46. In order to get along in the world it's best to always follow orders and do exactly what people expect of you. (14, 3)
47. It's hard to make an honest living nowadays. (15, 3)
48. I prefer to be foot-loose and fancy-free. (16, 3)
49. I can't achieve the standard of living that society expects of me because society won't allow me to do what is necessary to get ahead. (1, 4)
50. Nowadays there are so many conflicting philosophies that a person hardly knows what to believe. (2, 4)
51. I used to know what was what, but now I don't know which way to turn. (3, 4)
52. The American Society is disorganized and unstable. (4, 4)
53. I seem to be getting nowhere fast. (5, 4)
54. There's nothing ahead for me so why try. (6, 4)
55. No matter what I try something outside me always holds me back. (7, 4)

56. Sometimes I feel that I have little influence over the direction my life is taking. (8, 4)
57. Most people love themselves rather than their neighbor. (9, 4)
58. Nobody cares about the little man any more. (10, 4)
59. Some sort of wall seems to separate people today. (11, 4)
60. My parents never seemed to have time for me. (12, 4)
61. Little satisfaction can be derived from family life today. (13, 4)
62. Strict obedience and respect for authority are the most important virtues children should learn. (14, 4)
63. In getting ahead today you sometimes must use foul means as well as fair ones. (15, 4)
64. A person has to shy away from making too many new friends because they expect too much of you. (16, 4)
65. The good things in life seem impossible to get. (1, 5)
66. It seems that every time I turn around someone is telling me one thing but doing another. (2, 5)
67. I don't know what to believe about religion any more. (3, 5)
68. Things are so stirred up in the business world that it's not safe to start a business today. (4, 5)
69. It seems that with every step I take forward that I slip two steps backward. (5, 5)
70. As uncertain as the future appears, it doesn't pay to get married. (6, 5)
71. If you're born with the odds against you, there's nothing you can do about it. (7, 5)
72. I have usually found that what is going to happen will happen no matter what I do. (8, 5)
73. Nobody will help you out of the ditch today. (9, 5)
74. All that employers care about you is what they can get out of you. (10, 5)

75. I simply don't feel as if I really belong anywhere. (11, 5)
76. There was little love and companionship in my family as compared to other homes. (12, 5)
77. The way things are today a person can get no satisfaction from his work. (13, 5)
78. A good way to live is not to aim high and you won't be disappointed. (14, 5)
79. You have to be a schemer in business in order to make a profit. (15, 5)
80. Doing things by oneself is better than doing them with others. (16, 5)
81. There are too many little things to keep a guy back today. (1, 6)
82. Society has so many different rules for different people, that it's hard to know what rules apply to me. (2, 6)
83. In trying to decide what is the right thing to do, I feel like I'm caught between the devil and the deep blue sea. (3, 6)
84. It seems that today rules are made to be broken. (4, 6)
85. I feel that the skids have been knocked out from under me. (5, 6)
86. The outlook in the world of work is so uncertain that it's almost impossible to know what job to prepare for. (6, 6)
87. Most people are victims of things which they cannot help. (7, 6)
88. Most of the unhappy things in my life have been due to bad luck. (8, 6)
89. In the business world, "It's dog eat dog," and "It's every man for himself." (9, 6)
90. Employers don't keep in mind the welfare of their workers. (10, 6)
91. I feel like an outcast in the family of mankind. (11, 6)

92. I never really felt that I was a part of the family when I was growing up. (12, 6)
93. Life has nothing to offer me today. (13, 6)
94. I always felt that it was best never to question the judgment of my parents. (14, 6)
95. Sometimes it's all right to get around the law if you don't actually break it. (15, 6)
96. I usually pass by people and don't speak unless they speak to me first. (16, 6)
97. Society makes unimportant rules that keep me from getting anywhere. (1, 7)
98. It looks as if everybody I run into nowadays is uncertain about the best way he can live his life. (2, 7)
99. The findings of science make me confused concerning many of the religious beliefs I have held. (3, 7)
100. The large number of divorces today is an indication that family life in America is falling apart at the seams. (4, 7)
101. It's getting more difficult all the time to have a happy family. (5, 7)
102. As I see it now, the future looks pretty empty for me. (6, 7)
103. Sometimes I feel that I don't have enough control over what happens to me. (7, 7)
104. Most people don't realize the extent to which their lives are controlled by accidental happenings. (8, 7)
105. Most people just don't give a damn about others. (9, 7)
106. More employers criticize you than praise you. (10, 7)
107. People ignore my feelings and don't pay any attention to me. (11, 7)
108. My family just hasn't tried to understand my condition. (12, 7)
109. Nothing seems to turn out right any more so why even try? (13, 7)

110. If you want to be liked, the best thing to do is to go along with the crowd. (14, 7)
111. To be a success, who you know is more important than what you do. (15, 7)
112. There have been many times when I would have been glad to get sick just so I could get away from the rush of the everyday world. (16, 7)
113. Everybody is expected to be a success today but the rules for achieving success are not made clear. (1, 8)
114. Nowadays it's hard to know what is right and what is wrong. (2, 8)
115. I often find that I think one thing but do another. (3, 8)
116. With the great increase in crime and juvenile delinquency, it looks like the present generation of young people is getting completely out of control. (4, 8)
117. I feel that I'm losing everything I've gained in life. (5, 8)
118. The confusion and disorder that exist today are probably signs that the end of the world is not far away. (6, 8)
119. This world is run by a few people in power and there is not much that the little guy can do about it. (7, 8)
120. Getting promoted is really a matter of being a little luckier than the next guy. (8, 8)
121. Today, most people appear to love their neighbors. (9, 8)
122. Although many politicians make good sounding campaign promises to help relieve the problems of the common man, they are seldom carried out. (10, 8)
123. Nobody is on my side. (11, 8)
124. My family has neglected me. (12, 8)
125. There appears to be no rhyme nor reason to living today. (13, 8)
126. A good way to live is to do what is expected of you and not complain. (14, 8)

127. In order to get ahead in today's world, a person can't worry too much about fair play. (15, 8)
128. When I work or play I usually like to do it by myself. (16, 8)
129. I've always wanted to work to provide my family with the better things of life, but it seems that somebody has always beat me out of the good jobs. (1, 9)
130. I wish I were living in the old days when the world didn't change so fast. (2, 9)
131. Even when I let my conscience be my guide, I often feel guilt. (3, 9)
132. The world is becoming more and more civilized. (4, 9)
133. Everything worthwhile is slipping away. (5, 9)
134. There is so much corruption in our government today that the time is not far away when law and justice will not exist. (6, 9)
135. I feel insecure and inadequate to meet the demands of everyday living. (7, 9)
136. A person's future is largely a matter of what fate has in store for him. (8, 9)
137. If we'd only let other people know our troubles they would be willing to help us out. (9, 9)
138. Our government is so large today that the needs of the average man are ignored. (10, 9)
139. Much of the time I have the feeling that no one really cares about me. (11, 9)
140. As I see it now I don't owe my family anything. (12, 9)
141. It's hard to see that anything is worthwhile nowadays. (13, 9)
142. When you're caught in a bind trying to satisfy different people, it's best to try to please both of them rather than risk disappointing either of them. (14, 9)
143. Although it may be unfortunate, if a person is going to be successful in business or politics, it is sometimes necessary to take advantage of people. (15, 9)

is now psychoanalytically inclined, but maintains the belief that the group is an agent of treatment. Ezriel is now the foremost exponent in England of "here and now" group therapy, the central idea being the analysis of group tensions.

According to Slavson, major points in the development of group psychotherapy are: (1) a permanent swing from large to small groups; (2) with some form of analytic psychotherapy the predominant direction, but with wide variations, with most group leaders encouraging free communication and attempting to uncover significant feelings; (3) the development has not been a continuum, as many workers have developed their ideas independently, with much overlap and imitation, as well as parallelisms; (4) educational-didactic methods are increasingly less used, although still appropriate in special situations.

Slavson (1959, 451) points out that the publication sequences employed by writers such as Klopman, Hadden Hulse, Bach, Illing and himself assume a true reflection of the historical growth of the movement, but that:

There are few areas of historic recording known to the present writer in which notions of developmental events have been accepted with so little scientific evaluation as in group psychotherapy.

He continues by indicating that while many streams of influence historically are related to the development of group psychotherapy (Psychology, Psychiatry, Psychotherapy,

144. Some people laugh at the old hermit, but his way of living might not be bad after all. (16, 9)
145. No matter how hard I try, I still can't seem to accomplish what is expected of me. (1, 10)
146. Nowadays, parents are so mixed up that they don't know how to tell their children what is right and what is wrong. (2, 10)
147. I can usually make an important decision on the spur of the moment without much previous thought. (3, 10)
148. Our country is on an even keel. (4, 10)
149. You just can't win for losing. (5, 10)
150. The future has great things in store for me. (6, 10)
151. Now that machines have taken over so many jobs, most men are just like cogs in a wheel. (7, 10)
152. I don't do some things because I feel that luck is against me. (8, 10)
153. Most people seem to have enough time to help their fellowman. (9, 10)
154. It doesn't do any good to complain to government officials because they won't listen to you anyhow. (10, 10)
155. No matter where I go, I can find people who are concerned over my welfare. (11, 10)
156. My family life has been empty. (12, 10)
157. My life has been barren and meaningless. (13, 10)
158. In order to keep peace in the home, it's a good idea to try your best to do what the family expects you to do. (14, 10)
159. The Golden Rule is all right, but if you always try to follow it in real life people will take advantage of you. (15, 10)
160. When the going gets too rough on the job, the best thing to do is to quit and get away from it all. (16, 10)

161. If I try, I can usually do what people want me to do.
(1, 11)
162. As time has gone by, so many old ideas have fallen by the wayside that finding the right way to live is easier today. (2, 11)
163. There's no question about it, I know the way that I should live. (3, 11)
164. With the group of young men coming along today our country will be in safe hands. (4, 11)
165. I feel that I am winning the battle of life. (5, 11)
166. Our government and courts are being so strengthened today that in the years ahead people will have a better chance to be heard and to receive a square deal. (6, 11)
167. The average citizen can have an influence on the way the government is run. (7, 11)
168. What will happen to me in the future will be largely a matter of my own choice. (8, 11)
169. In times of trouble most people will help you out.
(9, 11)
170. Those men who are in power are concerned with assisting the individual man. (10, 11)
171. I feel that some people are really pulling for me.
(11, 11)
172. My family has stuck by me through thick and thin. (12, 11)
173. The good things of life have filled my life and given it purpose. (13, 11)
174. A person's life is largely determined by what people expect him to do, so he might as well try not to disappoint them. (14, 11)
175. It may not be nice, but the fact is you will never get anywhere if you try to tell the truth all the time.
(15, 11)
176. When you can't satisfy people, it's best to get as far away from them as possible. (16, 11)

177. I usually find that I can keep up on the things that are expected of me. (1, 12)
178. When people tell you they will do something nowadays you can usually depend on it. (2, 12)
179. I feel that most of the things I do would make my family feel proud of me. (3, 12)
180. In recent years more people have come to respect the rights of others. (4, 12)
181. More and more worthwhile things are coming my way every day. (5, 12)
182. If a man will work hard and study today, he can be pretty assured that a job will be open for him later. (6, 12)
183. Although man is afloat on a stormy sea, he is able to chart his own course. (7, 12)
184. Our lives are controlled more by conscious decisions that we make than by chance happenings. (8, 12)
185. Many people are ready to give us guidance and support when we need it. (9, 12)
186. People who are in charge seem to be aware of the feelings of persons under them. (10, 12)
187. When I hurt inside, most people are concerned about how I feel. (11, 12)
188. My family has given me sympathy and understanding when I needed them the most. (12, 12)
189. If a person looks around him he will find tasks to do which will give him satisfaction. (13, 12)
190. The good citizen is one who obeys his government and doesn't complain about how it is run. (14, 12)
191. If you're going to get ahead these days, you have to realize that rules are made to be broken. (15, 12)
192. I would like a job that would take me away from the go-go-go of the business world. (16, 12)
193. Although many little things are always coming up to bother a fellow today, I can usually manage to handle them. (1, 13)

194. Most people tell you they will do something nowadays you can usually depend on it. (2, 13)
195. You can trust most people to live clean upright lives. (4, 13)
196. I have more to gain from living now. (5, 13)
197. In the future a man will probably have a much better opportunity to provide for his family. (6, 13)
198. Hard work, not luck, is what helps a man get a good job. (8, 13)
199. Most bosses will pat you on the back when you do a good job. (10, 13)
200. In one sense, I feel that all men are my brothers. (11, 13)
201. My parents felt that I was an important member of the family. (12, 13)
202. Most men have a good reason for living. (13, 13)
203. If you want to rise to the top today, you have to be willing to push people around. (15, 13)
204. I can sympathize with men who like to escape from the world of reality by drinking. (16, 13)
205. Luckily, most people are able to get most of the good things in life today. (1, 14)
206. One advantage to living today is that most people are able to live by the same rules. (2, 14)
207. Nowadays a person is better able to have a satisfactory home life. (5, 14)
208. There is every reason to believe my efforts can result in a brighter tomorrow for me. (6, 14)
209. From the actions of most employers, it is obvious that they want to give their workers a square deal. (10, 14)
210. I feel that people understand each other more. (11, 14)
211. Our family was drawn together by love. (12, 14)
212. I feel that I'm getting something valuable out of living. (13, 14)

213. When your family is expecting a good living, you can't let them down no matter what you have to do to make a dollar. (15, 14)
214. It would be good to be a child again, free from worry and fret. (16, 14)
215. Although there is much to be done, some way will be found to do it. (1, 15)
216. Now that there are better means of transportation, it appears very probable that almost all men will come to agree with each other over important matters. (2, 15)
217. I feel that I'm on a more solid footing now than in the past. (5, 15)
218. A child today has a lot to look forward to. (6, 15)
219. Most of our public officials are willing to help the common man if they are only notified of his problems. (10, 15)
220. With the increase in population, the world is getting more friendly. (11, 15)
221. My parents devoted much time to me. (12, 15)
222. Working on most jobs has given me a feeling of amounting to something. (13, 15)
223. There are many foolish laws today to prevent a man from making a good living. (15, 15)
224. It would be enjoyable to live on a faraway island, away from the hurry and scurry of modern civilization. (16, 15)
225. With the freedom we have in our country, I can maintain the standard of living that society demands. (1, 16)
226. The men who lead our government today are firm and unwavering in their convictions concerning what is good for the country. (2, 16)
227. Step by step, bit by bit, I'm making progress every day. (5, 16)
228. I feel that I will be able to amount to something in the years ahead. (6, 16)

229. The Federal and State governments do a good job dealing with the problems of the average citizen. (10, 16)
230. My parents always listened to me. (12, 16)
231. In most respects, life seems worthwhile. (13, 16)
232. I'd like to live in a world where I didn't have to compete with other people for a living. (16, 16)
233. Although the road to success is difficult, where there's a will there's a way to the top. (1, 17)
234. The way for a person to act seems clearer today. (2, 17)
235. As time goes by I feel that my family and friends have become more concerned about me. (5, 17)
236. Since the future is predictable it is possible to plan ahead. (6, 17)
237. Our representatives in Congress are vitally concerned with passing laws that will help the common working man. (10, 17)
238. My parents always listened to me. (12, 17)
239. Children born today have many worthwhile things awaiting them. (13, 17)
240. As hard as it is to get ahead in the world today, it's a wonder that there aren't more tramps and hobos. (16, 17)
241. Nowadays, parents are more sure of their beliefs so that the present generation finds it easier to know what to believe. (2, 18)
242. Although I'm getting older I still feel that I have retained most of the skills and abilities that I have had. (5, 18)
243. My parents welcomed my participation in family discussions. (12, 18)
244. In many ways a bum's life is better than the life of a man who is striving to make a success in the world. (16, 18)

APPENDIX VI**DIRECTIONS FOR ADMINISTRATION OF THE
STANDARD ADJECTIVE Q SORT (SAQS)
AND ITEMS (ADJECTIVES)**

Directions for Administration

Here are 50 cards, each with a word that can be used to describe people. You are to lay these cards out on the table in such manner that you can see all of them in ten piles or columns, five words in each column-pile. Those words that will be in the last column to the left are those that you think describe you least, and the five words in pile to the extreme right will be those that you think describe you best. The other words will distribute in the same manner in terms of how well they describe you. Before you finish, look over all of the words to make sure that as they go to the right they describe you better and better.

Items

1. Daring	26. Independent
2. Cautious	27. Stubborn
3. Aloof	28. Dominant
4. Adventurous	29. Outspoken
5. Secretive	30. Submissive
6. Foresighted	31. Dependent
7. Witty	32. Quick
8. Shrewd	33. Hasty
9. Imaginative	34. Hurried
10. Original	35. Talkative
11. Resourceful	36. Active
12. Clever	37. Warm-hearted
13. Clear-thinking	38. Soft-hearted
14. Responsible	39. Gentle
15. Dependable	40. Appreciative
16. Self-controlled	41. Discreet
17. Moderate	42. Unselfish
18. Persevering	43. Insensitive
19. Jealous	44. Sensitive
20. High-strung	45. Sarcastic
21. Nervous	46. Easy-going
22. Suspicious	47. Calm
23. Immature	48. Worrying
24. Aggressive	49. Emotional
25. Forceful	50. Excitable

APPENDIX VII

DIRECTIONS FOR DOGMATISM SCALE (FORM E) AND ITEMS
(*Starred items not scored)

SCALE H

Name _____ Date _____ Section No. _____

On the following pages are statements which express the opinions of people about a number of social and personal questions. As the opinions of people are not always the same, they give many different answers. The thing we are interested in now is your opinion.

You are to indicate the extent of your agreement or disagreement with what each statement says by circling the X above one of the six possible answers. Here are some examples for you to try so that you may have some practice in marking answers before you begin indicating your opinion about the actual statements.

Example No. 1: If you agree very much with a statement, how would you mark your answer on the scale?

X	X	X	X	X	X
I Agree	I Agree	I Agree	I Disagree	I Disagree	I Disagree
Very	on the	a Little	a Little	on the	Very
Much	Whole			Whole	Much

Example No. 2: If you agree on the whole with a statement, how would you mark your answer on the scale?

X	X	X	X	X	X
I Agree	I Agree	I Agree	I Disagree	I Disagree	I Disagree
Very	on the	a Little	a Little	on the	Very
Much	Whole			Whole	Much

Example No. 3: If you agree a little with a statement, how would you mark your answer on the scale?

X	X	X	X	X	X
I Agree	I Agree	I Agree	I Disagree	I Disagree	I Disagree
Very	on the	a Little	a Little	on the	Very
Much	Whole			Whole	Much

Example No. 4: If you disagree a little with a statement, how would you mark your answer on the scale?

X	X	X	X	X	X
I Agree	I Agree	I Agree	I Disagree	I Disagree	I Disagree
Very	on the	a Little	a Little	on the	Very
Much	Whole			Whole	Much

Sociology), there is no chronological sequence in the sense of one building on the previous ones.

Kotkov (In Slavson, 1956, 319) also warns of accepting too quickly the more obvious inducements of group psychotherapy, stating:

About 2 percent of published papers in group psychotherapy can be designated as experimental research. . . . Only a trickle of experimental research has been applied to such gross problems as selection, the role of the therapist, comparison of therapies, and the goals of group psychotherapy.

Specific reference will be made to some of these experimental studies later in this chapter.

Slavson (1959, 461) credits Alfred Adler as among the foremost in the use of the group in mental health education, although not so recognized by most historians. He encouraged group discussions in the area of personal and psychological problems, under the guidance of an adult with a mental health orientation, as early as the second decade of the 1900's. Working with groups of students, he didn't think of this as psychotherapy, but recognized the values of ventilating feelings with the peer group, the sharing of similar preoccupations, and the giving of mutual support and guidance.

Other influences in the development of group counseling in an institutional setting have come from the comparatively recent group guidance movement in education. Although dramatically pinpointing public as well as professional

Example No. 5: If you disagree on the whole with a statement, how would you mark your answer on the scale?

X	X	X	X	X	X
I Agree Very Much	I Agree on the Whole	I Agree a Little	I Disagree a Little	I Disagree on the Whole	I Disagree Very Much

Example No. 6: If you disagree very much with a statement, how would you mark your answer on the scale?

X	X	X	X	X	X
I Agree Very Much	I Agree on the Whole	I Agree a Little	I Disagree a Little	I Disagree on the Whole	I Disagree Very Much

Raise your hand when you have completed the six examples above.

Remember that you are to circle only one X for each statement. Remember, also, that there are no right or wrong answers. You are simply to carefully read each statement and then indicate your answer by circling one of the X's above the six possible answers. Don't skip any statements. If you come to any word or statement you don't understand, raise your hand and someone will come to help you.

NOW TURN TO THE NEXT PAGE AND CONTINUE MARKING YOUR ANSWERS UNTIL YOU HAVE INDICATED YOUR OPINION ABOUT EACH STATEMENT.

1. A person who thinks primarily of his own happiness is beneath contempt.
2. The main thing in life is for a person to want to do something important.
- *3. I wish people would be more definite about things.
4. In a discussion I often find it necessary to repeat myself several times to make sure I am being understood.
5. Most people just don't know what's good for them.
- *6. A person who has bad manners, habits and breeding can hardly expect to get along with decent people.
7. In times like these, a person must be pretty selfish if he considers his own happiness primarily.
8. A man who does not believe in some great cause has not really lived.
- *9. I work under a great deal of tension at times.
10. I'd like it if I should find someone who would tell me how to solve my personal problems.
11. Of all the different philosophies which have existed in this world, there is probably only one which is correct.
- *12. Whether it's all right to manipulate people or not, it is certainly all right when it's for their own good.
13. It is when a person devotes himself to an ideal or cause that his life becomes meaningful.
14. In this complicated world of ours the only way we can know what is going on is to rely upon leaders or experts who can be trusted.
- *15. If people would talk less and work more, everybody would be better off.
16. There are a number of persons I have come to hate because of the things they stand for.
17. There is so much to be done and so little time to do it in.
- *18. It is when a person devotes himself to an ideal or cause that he becomes important.

19. It is better to be a dead hero than a live coward.
20. A group which tolerates too much difference of opinion among its own members cannot exist for long.
- *21. The business man and the manufacturer are much more important to society than the artist and the professor.
22. It is only natural that a person should have a much better acquaintance with ideas he believes in than with ideas he opposes.
23. While I don't like to admit this even to myself, I sometimes have the ambition to become a great man, like Einstein, or Beethoven, or Shakespeare.
- *24. Plain common sense tells you that prejudice can be removed by education, not legislation.
25. Even though freedom of speech for all groups is a worthwhile goal, it is unfortunately necessary at times to restrict the freedom of certain political groups.
26. If a man is to accomplish his mission in life it is sometimes necessary to gamble "all or nothing at all."
- *27. A person must be pretty stupid if he still believes in differences between the races.
28. Most people just don't give a "damn" about others.
29. A person who gets enthusiastic about a number of causes is likely to be a pretty "wishy-washy" sort of person.
- *30. Do unto others as they do unto you.
31. To compromise with our political opponents is dangerous because it usually leads to the betrayal of our own side.
32. If given the chance I would do something that would be of great benefit to the world.
- *33. The trouble with many people is that they don't take things seriously enough.
34. In times like these it is often necessary to be more on guard against ideas put out by certain people or groups in one's own camp than by those in the opposite camp.

35. In a heated discussion I generally become so absorbed in what I am going to say that I forget to listen to what the others are saying.
- *36. It bothers me when something unexpected interrupts my daily routine.
37. Once I get wound up in a heated discussion, I just can't stop.
38. There are two kinds of people in this world; those who are on the side of truth and those who are against it.
- *39. What the youth needs is strict discipline, rugged determination, and the will to work and fight for family and country.
40. Man on his own is a helpless and miserable creature.
41. The United States and Russia have just about nothing in common.
- *42. I set a high standard for myself and I feel others should do the same.
43. In the history of mankind there have probably been just a handful of really great thinkers.
44. The highest form of government is a democracy and the highest form of democracy is a government run by those who are most intelligent.
- *45. Appreciation of others is a healthy attitude, since it is the only way to have them appreciate you.
46. The present is all too often full of unhappiness. It is the future that counts.
47. Unfortunately, a good many people with whom I have discussed important social and moral problems don't really understand what is going on.
- *48. People who seem unsure and uncertain about things make me feel uncomfortable.
49. Fundamentally, the world we live in is a pretty lonely place.
50. It is often desirable to reserve judgment about what's going on until one has a chance to hear the opinions of those one respects.

- *51. In general, full economic security is bad; most men wouldn't work if they didn't need the money for eating and living.
- 52. The worst crime a person can commit is to attack publicly the people who believe in the same thing he does.
- 53. In the long run the best way to live is to pick friends and associates whose tastes and beliefs are the same as one's own.
- *54. The American re-armament program is clear and positive proof that we are willing to sacrifice to preserve our freedom.
- 55. Most of the ideas which get published nowadays aren't worth the paper they are printed on.
- 56. It is only natural for a person to be rather fearful of the future.
- *57. Most of the arguments or quarrels I get into are over matters of principle.
- 58. My blood boils whenever a person stubbornly refuses to admit he's wrong.
- 59. When it comes to differences of opinion in religion we must be careful not to compromise with those who believe differently from the way we do.
- *60. America may not be perfect, but the American way has brought us about as close as human beings can get to a perfect society.

APPENDIX VIII**GROUP EVALUATION WORKSHEET
(*Starred items used in scoring)**

GROUP EVALUATION WORKSHEET

Instructions for Parts A, B, and C: Place an X in front of the statement which best expresses your opinion.

Part A. Focus of Group Discussion

1a. The group talks about past experiences and problems

- ☐ 1) Most of the time
- ☐ 2) Quite a bit (over half) the time
- ☐ 3) Fairly often (but less than half the time)
- ☐ 4) Seldom

1b. This seems to me to be

- ☐ 1) About right
- ☐ 2) Too much
- ☐ 3) Too little

2a. The group talks about present activities and problems

- ☐ 1) Most of the time
- ☐ 2) Quite a bit (over half) the time
- ☐ 3) Fairly often (but less than half the time)
- ☐ 4) Seldom

2b. This seems to me to be

- ☐ 1) About right
- ☐ 2) Too much
- ☐ 3) Too little

*3a. The group talks about plans for the future

- ☐ 1) Most of the time
- ☐ 2) Quite a bit (over half) the time
- ☐ 3) Fairly often (but less than half the time)
- ☐ 4) Seldom

3b. This seems to me to be

- ☐ 1) About right
- ☐ 2) Too much
- ☐ 3) Too little

*4a. Most generally, emphasis seems to be on

- ☐ 1) The strong points or abilities of the members of the group
- ☐ 2) Both strong and weak points of the members, but more often on the strong points or abilities
- ☐ 3) Both strong and weak points of the members, but more often on the weak points or problems
- ☐ 4) The weak points or problems of the members

4b. This seems to me to be

- ☐ 1) About right
- ☐ 2) Too much emphasis on strong points, not enough on weaknesses
- ☐ 3) Too much emphasis on weak points, not enough on strong points

Part B. Control of Discussion

*5a. The members of the group

- ☐ 1) Do most of the talking, while the leader observes
- ☐ 2) And the leader share the time about equally
- ☐ 3) Added together, talk less than the leader
- ☐ 4) Talk very little, usually listen to the leader

5b. This seems to me to be

- ☐ 1) About right
- ☐ 2) Too much group member talk, not enough leader talk
- ☐ 3) Too much leader talk, not enough group member talk

*6a. The topics discussed

- ☐ 1) Are usually or always introduced by a group member
- ☐ 2) Are more often introduced by a group member than by the leader
- ☐ 3) Are more often introduced by the leader than by group members
- ☐ 4) Are usually or always introduced by the leader

6b. This seems to me to be

- ☐ 1) About right
- ☐ 2) Too much group member control, not enough leader direction
- ☐ 3) Too much leader control, not enough group member direction

Part C. Atmosphere and freedom of expression***7a. Members of the group**

- ☐ 1) Feel perfectly free to talk about anything they wish and to express their feelings no matter what they may be
- ☐ 2) With certain limitations have freedom to say what they wish and to show how they really feel
- ☐ 3) Soon learn what kinds of things to say and also to be fairly careful in showing how they feel
- ☐ 4) Need to be very careful about what they say and how they express their feelings

7b. This seems to me to be

- ☐ 1) About right
- ☐ 2) Too much freedom of expression; members should talk about some subjects only in private, not in a group
- ☐ 3) Too little freedom of expression; members of the group would benefit from discussion of other topics

***8. Generally speaking, the atmosphere during the group meetings is**

- ☐ 1) Very cold and uncomfortable; the members come only because they are assigned to the group
- ☐ 2) Fairly comfortable, but not really warm and friendly
- ☐ 3) Comfortable, warm and friendly
- ☐ 4) Quite warm, friendly, and comfortable; members look forward to the meetings

Part D. Outcomes: How helpful are the group meetings in providing the following: (Place an X at any point on the scale that best expresses your opinion.)

*9. Sharing of information and experience:

Help Very Much	Help Quite A Bit	Help A Little	No Help

*10. Increased self-confidence and ability to accept self "as is":

Help Very Much	Help Quite A Bit	Help A Little	No Help

*11. Improved self-expression and ability to get along with others:

Help Very Much	Help Quite A Bit	Help A Little	No Help

*12. Improved participation in available activities and increased use of privileges (parties and other social activities, visitors, passes, LOA's Patient Assembly, etc.)

Help Very Much	Help Quite A Bit	Help A Little	No Help

*13. Realistic plans and actual steps toward life outside the hospital:

Help Very Much	Help Quite A Bit	Help A Little	No Help

*14. In general, my feeling about the group meetings is that they are:

Time Wasted	Of Some (Little) Value	Quite A Lot of Help	Very Helpful

interest following Sputnik I, the guidance movement in our public schools has been steadily developing for at least two decades, with roots going back to Frank Parsons, Boston, 1907, and vocational guidance. With the school assuming increased responsibility for assisting each student in the development of both educational and vocational plans, group techniques were utilized. This not only saved time but served as a vehicle for developing social interaction and interpersonal skills. It was in the schools, too, that Lewin and his followers did pioneer work in group dynamics in the early 1930's. Generalizations from their studies regarding the effects of various types of leadership--democratic, laissez faire, autocratic--have been received and utilized not only in school settings, but in a wide variety of group situations, including group therapy and group counseling.

A recent application of group counseling methods in the school setting is that of Broedel, Ohlsen, Proff, and Southard (1960). Using group counseling techniques with ninth graders, they found that experimental subjects improved more than controls in acceptance of self and others and in rated behavior, although there was no improvement in grades.

The therapeutic group dynamics of Lewin and his followers, based on his field theory, is seen by Slavson (1959, 458) as yet in the beginning stages as far as application

APPENDIX IX

**INSTRUCTIONS FOR JUDGES' ANALYSIS OF GROUP COUNSELING
PROCESS, SAMPLE SCALE FOR DIMENSION I,
DIMENSIONS AND SCALE DESCRIPTIONS
FOR DIMENSIONS II-IV**

ANALYSIS OF GROUP COUNSELING PROCESS

Instructions: Using timer, listen to the first 5 minute segment of the tape, stop recorder, rate the segment just audited on each of the four criteria. Repeat the operation for the next segment, etc., until entire tape is rated. Rate each criterion by placing an X on the scale at that point which best expresses your judgment.

I. Focus of Discussion: Time Orientation

Tape Segment #	<u>Most</u> emphasis on past events or problems	<u>More</u> emphasis on past than on present or future	<u>More</u> emphasis on future than on present or past	<u>Most</u> emphasis on future events, plans, etc.
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

Total Tape

II. Focus of Discussion: Weaknesses vs. Strengths: Liabilities vs. Assets

Tape Segment #	Most emphasis on weak points, problems, liabilities of group members	More emphasis on weaknesses and liabilities than on strengths or assets	More emphasis on strengths and assets than on weaknesses and liabilities	Most emphasis on strengths and assets of group members
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III. Control of Discussion: Division of Responsibility (Talk ratio and introduction of topics)

Tape Segment #	Group members take <u>most</u> of the responsibility for both selection of topics and discussion; Leader usually in background--resource person, etc.	Group members take <u>more</u> responsibility for topic selection and discussion than does Leader, although he participates freely	Leader takes <u>more</u> responsibility for both topic selection and discussion than do group members, although they participate fairly freely	Leader takes <u>most</u> of the responsibility for both topic selection and discussion; Members seldom participate except in answer to questions
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IV. Degree of Acceptance; Warmth and Permissiveness

Tape Segment #	Atmosphere <u>quite</u> warm, friendly, comfortable; Members seem perfectly free to express any thoughts or feelings	Atmosphere <u>fairly</u> warm, friendly, comfortable; Members seem free to express <u>most</u> of their thoughts and feelings, but within definite limits	Atmosphere rather cool, formal; Members seem somewhat uncomfortable and uncertain about their freedom to express real thoughts or feelings	Atmosphere cold and uncomfortable; Members seem entirely unable to express their real thoughts and feelings
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APPENDIX X

**METHOD FOR DETERMINING ITEM WEIGHTS, ITEM WEIGHTS,
INSTRUCTIONS, AND ITEMS FOR THE PATIENT
ACTIVITIES CHECKLIST AND
OPINIONNAIRE (PACO)**

Determination of Item Weights

1) Copies of the PACO were given to five psychologists (3 regular staff Ph.D.'s, 2 fourth-year trainees), who were asked, a) "To what extent do you feel that the typical Building I patient should engage in each of the following activities?" They were told b) to use ratings of 4-3-2-1, from most to least desirable, in rating each of the 4 choices for the item, and c) to be sure to rate the items according to their own feelings as to which answer was best for the patients' welfare.

2) Final weights for each choice were determined by totaling the number of points assigned each choice by all respondents. For example, if choice (a) received two 4's, two 3's, and one 2, the total points add up to 16, which would be compared with the total points received by each of the other 3 choices, with final weights of 4-3-2-1 being assigned--"4" to the choice receiving the highest total number of points, "3" to the next highest, etc.

Item Weights (KEY)

Part	Item	Weight	Choice	Part	Item	Weight	Choice
A.	1.--	2-4-3-1	(a-b-c-d)	G.	4.--	4-3-2-1	(a-b-c-d)
"	2.--	2-4-3-2	"	"	5.--	4-3-2-1	"
"	3.--	1-4-3-2	"	"	6.--	4-3-2-1	"
"	4.--	1-2-4-3	"	"	7.--	1-2-3-4	"
"	5.--	1-2-4-3	"	"	8.--	4-3-2-1	"
"	6.--	2-4-3-1	"	"	9.--	3-4-2-1	"
B.--		1-2-3-4	"	"	10.--	4-3-2-1	"
C.--		1-2-3-4	"	"	11.--	1-2-3-4	"
D.--		1-4-3-2	"	"	12.--	1-2-3-4	"
E.--		4-3-2-1	"	"	13.--	1-3-4-2	"
F.--		3-4-2-1	"	"	14.--	4-3-2-1	"
G.	1.--	4-3-2-1	"	"	15.--	2-3-4	(a-b-c)
"	2.--	4-3-2-1	"	"	16.--	4-3-2-1	(a-b-c-d)
"	3.--	4-3-2	(a-b-c)	"	17.--	1-4-3-2	"

PATIENT ACTIVITIES CHECKLIST AND OPINIONNAIRE

INSTRUCTIONS: Place an X on the line in front of the answer which best describes your own actual situation at this time (not what you feel you should or would like to be doing).

- A. The average time spent (per 24-hour day) in the following activities is:
1. Sleeping or napping
 - ☐ a) 6 hrs. or less
 - ☐ b) 7 to 8 hrs.
 - ☐ c) 9 to 10 hrs.
 - ☐ d) 11 hrs. or more
 2. Sitting (thinking, watching TV, etc., but don't include time spent on 3 and 4 below)
 - ☐ a) Less than 1 hr. per day
 - ☐ b) Between 1 and 2 hrs. per day
 - ☐ c) Between 2 and 3 hrs. per day
 - ☐ d) Over 3 hrs. per day
 3. Reading, writing letters
 - ☐ a) Less than $\frac{1}{2}$ hr. per day
 - ☐ b) $\frac{1}{2}$ to 1 hr. per day
 - ☐ c) Between 1 and 2 hrs. per day
 - ☐ d) Over 2 hrs. per day
 4. Recreation, conversation (include group activities)
 - ☐ a) Less than $\frac{1}{2}$ hr. per day
 - ☐ b) $\frac{1}{2}$ hr. to 1 hr.
 - ☐ c) 1 to 2 hrs.
 - ☐ d) Over 2 hrs.
 5. Work assignment, PMR&S, OT, Incentive Therapy, etc.
 - ☐ a) Less than 2 hrs.
 - ☐ b) 2 to 4 hrs.
 - ☐ c) 4 to 6 hrs.
 - ☐ d) 6 to 8 hrs. or more
 6. E.T. (Educational Therapy)
 - ☐ a) Less than 1 hr.
 - ☐ b) 1 to 2 hrs.
 - ☐ c) 2 to 4 hrs.
 - ☐ d) Over 4 hrs.

B. Number passes and LOA's taken during the past 8 weeks:

- ☐ 1) None
- ☐ 2) 1 to 3
- ☐ 3) 4 to 6
- ☐ 4) Over 6

C. Time distribution of passes, LOA's during the past 8 weeks:

- ☐ 1) None taken
- ☐ 2) Occasional passes (at least 1 or 2) but no LOA's
- ☐ 3) Several passes (at least 3 or 4) or at least 1 week of LOA
- ☐ 4) Several passes (at least 3 or 4) and at least 1 week of LOA

D. Medication

- ☐ 1) None
- ☐ 2) Self-medication when needed
- ☐ 3) Medication usually given by Nurse or Assistant
- ☐ 4) Medication always given by Nurse or Assistant

E. Selection of Assignments

- ☐ 1) Selected present assignment(s) on my own, with Staff approval
- ☐ 2) Selected present assignment(s) with Staff advice
- ☐ 3) Placed in present assignment(s) by Staff with some consideration of my own desires
- ☐ 4) Placed in present assignment(s) by Staff with very little or no consideration of my own desires

F. Building Operation (government, maintenance, etc.)

1. It is my opinion that:

- ☐ a) The men establish their own rules and procedures and carry them out with very little Staff supervision
- ☐ b) The men have considerable freedom and responsibility for rules and procedures and also considerable advice and supervision from Staff
- ☐ c) The Staff makes an effort to meet the needs of the men, but usually run things pretty much their own way
- ☐ d) The patients really have very little or nothing to do with the way the building is run

G. Opinionnaire regarding Building and Policies

1. The space in my building is

- ☐ a) Quite adequate
- ☐ b) Adequate
- ☐ c) Fairly adequate
- ☐ d) Not at all adequate for our needs

2. Personal privacy (sleeping, bathing, reading, etc.) is
☐ a) Quite adequate
☐ b) Adequate
☐ c) Fairly adequate
☐ d) Not at all adequate for our needs
3. I can shower
☐ a) Whenever I am free from assignments
☐ b) Often enough, but only at certain times
☐ c) Too seldom, and only at certain times
4. Recreational facilities (pool, cards, reading materials, etc.) are
☐ a) Quite adequate
☐ b) Adequate
☐ c) Fairly adequate
☐ d) Not at all adequate for our needs
5. Refreshments (coffee, pop, ice cream, candy, etc.) are available
☐ a) Always
☐ b) Usually
☐ c) Sometimes
☐ d) Seldom or never
6. Travel to and from assignments and activities:
☐ a) I am solely responsible for being places on time
☐ b) I am reminded at times, but generally am responsible for keeping appointments on my own
☐ c) A Staff member usually reminds me of assignments and may go with me
☐ d) I am always reminded of appointments and often taken by a Staff member
7. My building is locked
☐ a) Almost always
☐ b) After 9 or 9:30 at night
☐ c) After 11 or 11:30 at night
☐ d) Never
8. Most members of the Staff
☐ a) Are easy to talk to and interested in the men on the building
☐ b) Are usually available when needed but sometimes not too interested in the men
☐ c) Often too busy to talk or not interested in problems that arise
☐ d) Indifferent to the needs of the patients on the building, seem to hate being bothered

9. I am able to write (or phone)
- ☐ a) Whenever and whatever I wish
 - ☐ b) Anything within reason, with Staff approval
 - ☐ c) Only certain things because of hospital regulations
 - ☐ d) Very little of what I'd like to if I had the chance
10. The Pass and Leave policies of my building are
- ☐ a) Very liberal
 - ☐ b) Satisfactory
 - ☐ c) Too strict
 - ☐ d) Very strict and unfair
11. I can get an LOA
- ☐ a) Never
 - ☐ b) Only when really necessary, for emergencies, etc.
 - ☐ c) Whenever my family or guardian sign for it and the Staff agrees
 - ☐ d) Whenever I wish, with Staff approval
12. I can get a town pass
- ☐ a) Only with the approval of my family or guardian and the Staff
 - ☐ b) Every other week
 - ☐ c) Once a week
 - ☐ d) Any evening or weekend
13. Assuming that I have funds in my account, for a day pass to town I can draw:
- ☐ a) Money only for authorized purchases
 - ☐ b) Up to \$5 plus money for authorized purchases
 - ☐ c) Up to \$10 plus money for authorized purchases
 - ☐ d) Any amount I ask for
14. My personal property, clothes, etc. are
- ☐ a) Quite safe, never stolen or lost
 - ☐ b) Usually OK, seldom stolen or lost
 - ☐ c) Often not safe on the building
 - ☐ d) Not at all safe from being lost or stolen--you can't turn your back
15. Access to my clothing and other personal property is
- ☐ a) Difficult, since it is locked up except at certain hours of the day
 - ☐ b) Fairly easy--attendants will help me store or pick up what I need at about any time of day
 - ☐ c) Easy--I have my own locker and can get into it and the clothing room whenever necessary

16. I can shave

- ☐ a) Whenever needed with any equipment I wish to use
- ☐ b) Whenever needed, but I must use an electric shaver or be issued blades as I use them
- ☐ c) Only at certain times, with my own electric shaver or supplies issued as I use them
- ☐ d) Only under the supervision of a member of the Staff

17. I can watch TV

- ☐ a) At any time, night or day
- ☐ b) Until after 11:00 any night, longer on weekends if I want to
- ☐ c) Until 9:00 or 9:30 any night
- ☐ d) Only at certain times during day and early evening

to group therapy is concerned, making its primary gains in the fields of sociology and social psychology. This view is in direct contrast to that of Bach (1954, 347ff.), who in a work dedicated to his teacher, Kurt Lewin, includes a chapter (Chapter 19) on the application of group dynamic principles in the management of therapy groups. He cites such authorities in the field as Bion, Lewin, Lippitt, Redl, Newcomb, Thelen, Bales, Cartwright, and Festinger.

Bach bases his application of group dynamics to group therapy on the eight factors of group dynamics listed by Cartwright (1951), which may be summarized as follows:

- (1) to be effective as a medium of change, there must be a strong sense of belonging to the same group;
- (2) the more attractive the group is to its members the greater its influence;
- (3) the more relevant to the basis of attraction to the group an attitude, value, or behavior is, the greater will be the influence the group can exert on them;
- (4) the greater the prestige of a group member the greater his influence on other members;
- (5) strong resistance will occur if efforts are made to change members in a direction contrary to group norms;
- (6) pressure for a change can be established by creating within the group a perception of the need for change, thus making the source of pressure for change lie within the group;
- (7) information relating to the need for such change must be shared by all relevant members;
- (8) changes in one part of a group produce strain

APPENDIX XI**PROCEDURE USED IN ANALYSIS OF BACKGROUND
VARIABLES AND PERSONAL DATA FORM**

Procedure Used in Analysis of Background Variables

Information regarding background variables was coded as follows:

- a) Age--(1) under 32, (2) 33-41, (3) 42-50, (4) 51-55
- b) Education--(1) literate but not over 8 yrs. school, (2) 9-11 yrs. school, (3) 12-15 yrs., (4) B.A. or above
- c) Marital Status--(1) married, (2) single, (3) widowed, (4) divorced, (5) separated
- d) Length of Hospitalization--(1) 18 mo. or less, (2) 19-47 mo., (3) 4-10 yrs., (4) 11 yrs. or over
- e) Length of Military Service--(1) 18 mo. or less, (2) 19-47 mo., (3) 4-10 yrs., (4) 11 yrs. or over
- f) Diagnosis--(1) schizophrenia, (2) chronic brain syndrome, (3) mental deficiency, (4) personality disorder, (5) psychiatric observation
- g) Vocational Background--(1) excellent, (2) good, (3) fair, (4) poor, (5) very poor
(Four aspects were combined: level of past experience vs. aspiration for future, using Roe's (1956) categories to arrive at a discrepancy score; time lapse since last paid job; total length of work experience, including armed services; and average time on the job. Each of the four was weighted and the average of these used as the score)
- h) Financial Situation--(1) indigent, (2) limited, (3) average, (4) ample
- i) Number of Sessions Attended--actual number used
- j) Number Days on Pass or LOA--actual number used
- k) Verbal Comprehension--total number right out of 50, Wesman, Verbal scale

(Personal Data Form)

C O N F I D E N T I A L

Name _____ Year of Birth _____

Last year of school completed _____ Marital status _____

Date first Np hospitalization _____ Total time in Np

Hospitals _____ yrs. _____ mo.

Number times hospitalized for Np disorder _____

Date of first serious difficulty leading to hospitalization

Total time in military service _____ yrs. _____ mo.

Total monthly income--\$ _____ Total financial worth (sav-
ings, real estate) \$ _____I consider my financial situation to be (underline one):
excellent; good; average; poor.I consider the financial situation of my family to be (under-
line one): excellent; good; average; poor.

My present hospital assignment is (describe): _____

LIST ALL JOBS AND LENGTH TIME HELD, STARTING WITH LAST JOB
AND WORKING BACK:

<u>Job Title or description</u>	<u>Date of job</u>
	from _____ to _____
_____	" "
_____	" "

(If more room is needed, use back)

When I leave the hospital I will (underline one): retire;
work part time; work full time.

When (If) I go to work, I will apply for _____

APPENDIX XII
HOSPITAL ADJUSTMENT SCALE
INSTRUCTIONS AND ITEMS

HOSPITAL ADJUSTMENT SCALE

For Evaluating Patients' Behavior in a Psychiatric Hospital

James T. Ferguson, M.D.

Paul McReynolds, Ph.D.

Egerton L. Ballachey, Ph.D.

INSTRUCTIONS TO OBSERVER: The purpose of this Scale is to help you to report on the behavior of the patient named below. The Scale consists of a number of statements which describe some of the ways patients act in different places in a psychiatric hospital. These statements were taken from descriptions of patients made by psychiatric aids in a large psychiatric hospital.

You are to mark each statement as True (T), Not True (NT), or in some cases as Doesn't Apply (DA), for the patient named below. Marking a statement T, NT, or DA should be based on actual observation by yourself or others of the patient for the past two weeks to three months. The behavior described in a statement is true if present most or all of the time during the past two weeks to three months.

Think of the patient named below as you have seen him act in the last two weeks to three months. Look at statement No. 1 on the next page. If No. 1 is generally True--that is, True most or all of the time--for the patient, put a circle around T. If No. 1 is generally Not True for the patient, put a circle around NT. You must put a circle around either T or NT for all statements which have only T and NT in front of them.

A few of the statements, for example No. 2, have DA in front of them, as well as T and NT. DA is to be circled when the statement Doesn't Apply to the patient. Look at No. 2. If, during the past three months, the patient has not had any visitors, No. 2 obviously Doesn't Apply to him and you would circle DA. If the patient did have visitors and No. 2 was generally True for the patient, put a circle around T. If the patient had visitors and No. 2 was generally Not True for the patient, put a circle around NT. Also, if the statement concerns Occupational Therapy and the patient did not have O.T. during the past three months either on or away from the ward, then DA should again be circled.

Note that if a statement does apply to the patient but you don't know the answer (T or NT,) you should make an attempt to find out the answer and mark it the best you can. Do not circle DA just because you don't know offhand whether T or NT is correct. Circle DA as sparingly as possible; use it only when a statement clearly Doesn't Apply to the patient.

Be sure you have circled the right letters. It is necessary to mark all statements, but you may have to observe the patient more, or secure information from other personnel, before marking some of them.

Be sure to mark every item. Don't leave any out.

Patient's last name	First name	Middle name
---------------------	------------	-------------

Name of hospital	Ward	Name and title of observer
------------------	------	----------------------------

1. T NT The patient ignores the activities around him.
2. T NT DA The patient gets dressed up for visitors.
3. T NT DA The patient follows events in the daily paper.
4. T NT DA The patient laughs if he's kidded.
5. T NT DA The patient writes sensible and understandable letters.
6. T NT The patient stays by himself.
7. T NT The patient spends a lot of time talking to himself.
8. T NT The patient doesn't mix with other patients.
9. T NT The patient's talk is mostly not sensible.
10. T NT The patient doesn't make distinctions between new and old personnel.
11. T NT The patient chooses to talk either to the personnel or to patients who talk sensibly.
12. T NT DA The patient doesn't want social group contacts with other patients.
13. T NT The patient never says more than 3 or 4 words at a time.
14. T NT DA The patient doesn't open letters unless someone tells him to.
15. T NT The patient talks about sports with the aide.
16. T NT The patient can tease another patient back into good humor.
17. T NT The patient answers sensibly if talked to.
18. T NT DA The patient sometimes remarks when it's time for a family visit.
19. T NT The patient doesn't have close friends on the ward.

20. T NT The patient isn't backward about talking to you after he gets acquainted.
21. T NT The patient can talk sensibly if you ask him to.
22. T NT The patient won't discuss many subjects.
23. T NT DA The patient never asks for a pass (short stay away from hospital).
24. T NT The patient talks about his family with the aide.
25. T NT DA The patient never writes a letter.
26. T NT The patient seems to enjoy being talked to.
27. T NT The patient doesn't take part in back and forth conversation.
28. T NT DA The patient plays ball with other patients.
29. T NT DA The patient is either silent or talks foolishly during visits.
30. T NT The patient sometimes approaches the aide with dry humor about his situation in the hospital.
31. T NT The patient is always chatting with someone.
32. T NT The patient's words aren't understandable.
33. T NT DA The patient asks to leave the hospital to visit his family.
34. T NT The patient resents it if he's asked a question.
35. T NT The patient will always reply if you make some remark to him.
36. T NT The patient talks over happenings on the ward with the aide.
37. T NT The patient's talk is mostly straight, sensible talk.
38. T NT The patient starts conversations with aides to become better acquainted.

39. T NT The patient can take teasing.
40. T NT The patient never volunteers any information about himself.
41. T NT The patient knows the names of all the doctors, nurses, and aides.
42. T NT DA The patient maintains a correspondence.
43. T NT The patient has to be pushed to follow routine.
44. T NT The patient wants to do the right thing on the ward.
45. T NT DA The patient seldom dresses up.
46. T NT The patient doesn't like to change his clothes.
47. T NT The patient takes no pride in his personal appearance.
48. T NT DA The patient is very interested in his clothes.
49. T NT The patient is making realistic plans for when he leaves the hospital.
50. T NT The patient occasionally needs supervision with dressing.
51. T NT The patient's clothes are unbuttoned.
52. T NT The patient has to be reminded to attend to routine.
53. T NT DA The patient never combs his hair.
54. T NT The patient yells at attendant when he's dissatisfied.
55. T NT The patient stays neat and clean.
56. T NT The patient never asks for anything; he waits for things to be given to him.
57. T NT The patient has to be dressed.
58. T NT DA The patient behaves exceptionally well when taken off grounds.

59. T NT The patient occasionally has to be reminded to change his clothes.
60. T NT DA The patient takes pleasure in fixing his hair.
61. T NT The patient easily becomes upset if something doesn't suit him.
62. T NT The patient is usually sloppy.
63. T NT DA The patient keeps his clothes cleaned and pressed.
64. T NT The patient likes to do the opposite of what he's asked to do.
65. T NT DA The patient is so well dressed that he can't be distinguished from a "normal" person.
66. T NT DA The patient seems to manage his money.
67. T NT DA The patient is interested in looking well when he leaves the hospital on trips.
68. T NT DA The patient plays cards occasionally.
69. T NT DA The patient is a good worker in shop.
70. T NT The patient asks if there's work for him to do.
71. T NT DA The patient doesn't take part in ward games.
72. T NT DA The patient always attends ward parties.
73. T NT DA The patient will do anything for recreation that comes up.
74. T NT The patient reads newspapers and magazines.
75. T NT DA The patient won't do any assigned duties.
76. T NT DA The patient is willing to do any extra chore.
77. T NT The patient is interested in nothing.
78. T NT DA The patient doesn't take part in recreation.
79. T NT DA The patient doesn't need supervision on a job.

in other related parts which can be reduced only by eliminating the change or by bringing about readjustments in the related parts.

In this section a brief discussion of some of the influences bearing upon group counseling in a hospital setting has been presented. Major attention centered on the development of group psychotherapy, as well as an effort to point out the roles of group work in education and the group dynamics movement in helping to set the framework for group counseling. Of course, individual psychotherapy and counseling have been and continue as major influences on the development of group counseling. Since much of the basis of the present study does stem from dyadic (counselor-client) counseling, an expanded discussion of this influence on group counseling, particularly as it relates to individual psychotherapy, is undertaken in the following pages.

A Distinction: Counseling vs. Psychotherapy

Although much of the history of group counseling, as presented above, stems from the same sources as that of group psychotherapy, some differences in emphasis and application are noteworthy. These two methods can perhaps best be compared by discussion of over-all similarities and differences, including those pertaining to the dyadic relationship. Such an approach seems especially

80. T NT DA The patient has to be helped along to stick to any activity.
81. T NT DA The patient doesn't take part in athletics.
82. T NT DA The patient helps out when needed.
83. T NT DA The patient isn't capable of doing a good job at anything.
84. T NT The patient shows no reaction to entertainment.
85. T NT DA The patient doesn't like to go out for exercise.
86. T NT DA The patient helps take care of the laundry.
87. T NT The patient would sit all day if not directed to an activity.
88. T NT DA The patient does a good job, once someone get him started.
89. T NT DA The patient is very interested in O.T.
90. T NT DA The patient works well on the ward.

APPENDIX XIII
COUNSELOR RATING WORKSHEET

COUNSELOR RATING WORKSHEET

Patient _____ Date of rating _____

- I. Insight (re. own condition, relations with other patients and staff, aims of hospital, etc.)

Excellent					None
-----------	--	--	--	--	------

- II. Adequacy and Realism of Plans for Future

Quite Adequate and Realistic					Very Inadequate or Unrealistic
---------------------------------	--	--	--	--	-----------------------------------

- III. Apparent attitude toward group (individuals and as a whole)

Quite Positive					Very Negative
-------------------	--	--	--	--	------------------

- IV. Degree of participation in group (Social interaction, verbal expression) at beginning of treatment.

Very Active					Very Passive
----------------	--	--	--	--	-----------------

- V. Degree of participation of group at present time (Social interaction, verbal expression)

Very Active					Very Passive
----------------	--	--	--	--	-----------------

APPENDIX XIV

TABLE 6

INTERCORRELATIONS OF BACKGROUND VARIABLES

TABLE 6
INTERCORRELATIONS OF BACKGROUND VARIABLES

	Age	Educ	Mar- ried	Hosp Yrs	Mil Yrs	Diag Schiz	Voc Bkgr	Fin Sit	Verb Abil	Pass LOA	Activ Level	Opin Bldg
Age	--	-.17	.34 ^a	.09	-.15	-.18	.15	-.22	.00	-.12	.16	.32
Educ.	-.17	--	-.08	-.30	-.03	-.12	.33	-.13	.44	.00	.02	-.20
Married Length	.34	-.08	--	-.20	-.11	-.28	.31	-.27	.19	.04	.19	.12
Hosp. Military Years	.09	-.30	-.20	--	-.04	.41	-.62	.11	-.14	-.09	.06	-.08
Diag. Schiz.	-.15	-.03	-.11	-.04	--	-.06	-.04	.23	-.32	.08	-.13	-.08
Voc. Bkgr.	-.18	-.12	-.28	.41	-.06	--	-.17	.10	.03	-.23	.04	-.29
Finan. Situation	.15	.33	.31	-.62	-.04	-.17	--	-.22	-.27	-.01	-.00	-.04
Verbal Ability	-.22	-.13	-.27	.11	.23	.10	-.22	--	-.43	.11	.07	.07
Pass LOA	.00	.44	-.19	-.14	-.32	.03	.27	-.43	--	-.03	-.01	-.21
Activity Level	-.12	.00	.04	-.09	.08	-.23	-.01	.11	-.03	--	.09	.23
Opinion of Bldg.	.16	.02	.19	.06	-.13	.04	-.00	-.07	-.01	.09	--	.11
	.32	-.20	.12	-.08	-.08	-.29	-.04	.07	-.21	.23	.11	--

^aN = 46, r.95 = .29, r.99 = .37

APPENDIX XV**TABLE 7****CORRELATION OF BACKGROUND VARIABLES WITH
PRE-TREATMENT CRITERIA MEASURES**

TABLE 7
CORRELATION OF BACKGROUND VARIABLES WITH
PRE-TREATMENT CRITERIA MEASURES

Criterion Measure	Age	Educ	Married	Hosp Yrs	Mil Yrs	Diag Schiz	Voc Bkgr	Fin Sit	Verb Abil	Pass LOA	Activ Level	Opin Bldg
HAPS	.03	.05 ^a	.13 ^b	.05	-.10	.13 ^c	.20 ^d	-.07	.12	-.09	.28	.02
" I-VIII	.02	.04	.13	.10	-.12	.18	.19	-.02	.09	-.09	.31	.01
" (1-5)	.04	.05	.10	-.06	-.02	.01	.17	-.19	.15	-.05	.15	.04
" I	.06	.06	.33	-.21	-.21	-.33	.26	-.25	.24	.23	.41	.10
" II	-.18	-.01	-.13	-.13	.02	.17	.05	.09	-.02	-.20	.05	-.23
" III	.01	.16	-.03	.01	.16	.03	.21	-.07	.13	.01	.08	.00
" IV	-.15	-.10	-.16	.26	-.04	.59	.07	.25	-.25	-.09	-.14	-.13
" V	.09	.06	.17	.07	-.14	-.02	.10	.01	.21	.07	.41	.09
" VI	.11	.12	.14	.08	-.03	.13	.23	-.09	.14	-.06	.32	.14
" VII	.09	-.06	.19	.24	-.26	.19	.14	-.05	-.04	-.11	.23	.07
" VIII	.08	.02	.14	.07	-.18	.06	.11	.05	.11	-.06	.37	-.02
" 1	-.11	-.02	-.13	.08	.09	.18	-.05	.02	.16	-.07	.09	-.04
" 2	.11	.08	.17	-.25	.01	-.12	.15	-.20	.19	.01	.28	.21
" 3	.01	-.10	-.10	.24	-.05	-.10	-.02	.04	-.04	-.20	-.16	-.01
" 4	.04	.11	.08	-.05	-.09	.07	.15	-.23	.07	-.03	-.05	-.03
" 5	.08	.10	.22	-.11	-.12	-.13	.33	-.27	.22	.04	.22	-.04
JRSVB	.24	.10	.19	-.37	.21	-.25	.33	-.10	.11	.30	.42	.16
" a	.25	-.03	.15	-.11	.12	-.11	.16	-.09	.09	.19	.50	.07
" b	.21	.05	.16	-.33	.23	-.31	.22	-.13	.01	.27	.18	.23
" c	-.01	.15	.10	-.38	.15	-.01	.27	.12	-.04	.26	.38	.00
" d	.09	.12	.18	-.39	.15	-.20	.34	-.01	.13	.33	.28	.08
" e	.30	.00	.17	-.21	.18	-.25	.21	-.20	.11	.17	.38	.21
" f	.22	.08	.20	-.32	.11	-.24	.30	-.11	.11	.31	.34	.29
" g	.33	.13	.02	-.32	.14	-.25	.31	-.16	.32	.13	.33	.17
" h	.22	.11	.32	-.52	.19	-.35	.43	-.06	.00	.32	.37	.18

TABLE 7--Continued

Criterion Measure	Age	Educ	Married	Hosp Yrs	Mil Yrs	Diag Schiz	Voc Bkgr	Fin Sit	Verb Abil	Pass LOA	Activ Level	Opin Bldg
Anomie ^e	-.16	.13	.19	-.30	.03	.03	.20	.14	.03	.15	.08	.04
" (1,6)	-.12	.17	.09	-.27	-.06	.12	.13	.08	.11	.05	.15	.02
Q (S-O)	.06	.06	.20	-.13	-.09	.06	.29	.16	.13	.08	.22	.19
Dogmatism ^a	-.32	-.03	-.23	.14	.11	-.08	-.30	.10	-.01	.20	-.39	-.02

^a.05 significance level = .29, .01 = .37

^b"Married," not "marital status"

^cDiagnosis "Schizophrenia" (any type), not Diagnostic categories

^dHigher scores on "vocational background" are negative (This table has been changed accordingly, so that a positive r between vocational background and the criterion measure is obtained if the higher scores on the criterion measure are also positive.)

^eHigher scores on "Anomie" and "Dogmatism" are positive (less anomic and less dogmatic)

APPENDIX XVI

TABLE 8

CORRELATION OF BACKGROUND VARIABLES
WITH PRE-POST DIFFERENCES
ON CRITERIA MEASURES

TABLE 8

**CORRELATION OF BACKGROUND VARIABLES WITH PRE-POST
DIFFERENCES ON CRITERIA MEASURES**

Criterion Measure	Age	Educ	Mar-ried	Hosp Yrs	Mil Yrs	Diag Schiz	Voc Bkgr	Fin Sit	Verb Abil	Pass LOA	Activ Level	Opin Bldg
HAPS	-.12	.19 ^a	.02 ^b	-.25	.01	.12 ^c	.05 ^d	.15	-.08	.07	-.11	-.08
" I-VIII	-.05	.21	.04	-.30	.01	-.21	.09	.06	-.03	.09	-.07	-.05
" (1-5)	-.25	.09	.00	-.07	-.03	.07	-.06	.26	-.15	.04	-.16	-.10
" I	.11	.09	-.03	-.11	.02	.02	.08	-.06	.01	-.13	-.10	-.23
" II	-.03	.16	.05	-.19	.03	-.07	.07	.07	.04	.20	.20	-.02
" III	.02	.15	.01	-.22	-.06	-.10	.01	.15	-.12	.03	-.08	.10
" IV	.14	.22	.20	-.20	-.17	-.44	.06	.07	.10	-.03	.15	.12
" V	-.08	.14	.00	-.13	.19	.00	.12	-.01	-.05	.08	-.11	-.22
" VI	-.10	.07	-.17	-.21	.05	-.24	-.05	.02	-.04	.14	-.12	-.05
" VII	-.28	.01	-.09	-.25	.01	.02	-.00	.12	-.09	.00	-.17	-.03
" VIII	-.10	.19	.20	-.24	.03	-.28	.19	-.16	.03	.05	-.16	-.04
" 1	-.01	-.14	.16	-.19	-.10	-.17	.11	.17	-.18	-.12	-.13	.16
" 2	-.19	.17	-.07	-.02	-.05	.15	.11	.16	-.01	.14	-.33	-.27
" 3	-.24	.10	-.03	-.11	.12	.05	-.09	.21	-.18	.05	.09	.01
" 4	-.26	.07	.07	.08	-.02	.08	-.15	.29	-.21	-.08	-.16	-.10
" 5	-.01	.03	-.01	-.09	-.01	.04	-.16	.01	.03	.05	.15	.00
JRSVB	-.10	-.13	.09	.20	-.32	.03	-.25	.08	-.01	-.10	.06	-.02
" a	-.06	.00	.08	.00	-.12	-.05	-.16	.11	-.03	-.13	-.06	-.02
" b	.06	.09	.14	.17	-.19	.09	.03	.21	.14	-.09	.17	-.02
" c	-.06	-.20	-.04	.15	-.15	-.16	-.27	.00	.05	.02	-.20	.06
" d	-.10	-.15	-.07	.15	-.08	.15	-.29	-.01	-.18	-.17	-.06	-.22
" e	-.02	.01	-.01	.14	-.32	.11	-.10	.21	.06	-.04	.17	.00
" f	-.13	-.03	.22	.10	-.20	-.02	-.13	-.11	.00	-.10	.10	-.17
" g	-.11	-.22	.32	.09	-.25	-.16	-.12	.02	-.20	.08	.24	-.01

appropriate since group counseling in an institutional setting is yet in its infancy.

Regarding the early group work of Adler, Slavson (1959, 461) indicates a distinction important to this study:

This work can properly be classified among those efforts which we now designate as group guidance or group counseling . . . but it should be rigidly differentiated from psychotherapy (with individuals) who have already internalized noxious or pathological psychic elements as a result of a traumatic life or specific traumata.

Slavson (456) emphasises the point that true psychotherapy must deal with noxious unconscious memories and release anxiety, thus leading to reconditioned feelings and responses. This is done by working through transference relations with both leader and fellow patients. Another distinction inferred by Slavson (457) is that an aim of psychotherapy is to induce a "basic change in personality." This is made possible, he believes, in the small group, by (1) providing a narrower field for emotional operation, (2) prevention of loss of self-identity, as the individual is pitted against other individuals more directly than in larger groups, and (3) reactivating the hostilities and discomforts the patient had experienced in his family to a degree not obtainable in large groups.

The above views serve to point up a distinction important to the present study. Several other writers (Caplan, 1957; Perry, 1955; Fletcher, 1954; Vance and

TABLE 8--Continued

Criterion Measure	Age	Educ	Married	Hosp Yrs	Mil Yrs	Diag Schiz	Voc Bkgr	Fin Sit	Verb Abil	Pass LOA	Activ Level	Opin Bldg
JRSVB h.	-.07	-.16	-.06	.29	-.37	.11	-.31	-.03	.12	-.06	.04	-.01
Anomie	.12	.35	.07	-.08	-.02	.08	.33	-.30	.21	-.04	.08	.06
" (1,6)	.08	.23	.18	-.16	.05	-.15	.42	-.24	.14	.08	.01	.02
Q (S-O)	-.04	-.01	-.11	.10	.16	.17	-.25	.04	-.21	-.02	-.11	-.23
Dogmatism	-.06	.19	.30	-.31	.14	.01	.24	-.09	.06	.04	.26	-.01

^aSignificance levels are-- $r_{.95} = .29$, $r_{.99} = .37$

^b"Married," not "marital status".

^cDiagnosis "Schizophrenia" (any type), not diagnostic categories

^dHigh scores on vocational background are negative. Signs have been changed in this table to compensate (thus the positive correlation of .05 between vocational background and HAPS (Total) indicates that the stronger the vocational background, the higher the score on the HAPS).

APPENDIX XVII

TABLE 9

INTERCORRELATION OF CRITERIA MEASURES

TABLE 9

INTERCORRELATION OF CRITERIA MEASURES

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1 Anomie	--	91	33	-58	-31	-12	17	25	05	11	22	18	27	18	00	05	05	38	10	00
2 " (1,6)	91	--	23	-56	-35	-16	14	19	07	07	31	28	31	20	10	16	09	43	18	07
3 Dogmatism	33	23	--	-06	06	19	-03	04	-16	-03	-11	-17	04	-16	-08	-16	-05	-05	-18	-26
4 Q (S-O) ^a	-58	-56	-06	--	44	34	05	03	04	05	-22	-23	-16	-30	05	-05	-02	-37	-23	-21
5 Q (S-S) ^a	-31	-35	06	44	--	52	-15	-10	-22	-05	-20	-19	-19	-21	13	-26	-26	-19	-08	-15
6 Q (O-O) ^a	-12	-16	19	34	52	--	-20	-05	-39	-10	-29	-27	-27	-29	15	-35	-03	-21	-26	-36
7 HAS	17	14	-03	05	-15	-20	--	85	80	84	57	51	58	37	24	47	-13	54	48	32
8 " I	25	19	04	03	-10	-05	85	--	44	59	51	45	54	43	15	27	-17	53	37	24
9 " II	05	07	-16	04	-22	-30	80	44	--	62	49	43	51	25	14	62	01	41	41	30
10 " III	11	07	-03	05	-05	-10	84	59	62	--	43	42	39	19	40	31	-10	38	46	29
11 HAPS	22	31	-11	-22	-20	-29	57	51	49	43	--	97	86	43	39	71	28	79	80	76
12 " (I-VIII)	18	28	-17	-23	-19	-27	51	45	43	42	97	--	71	39	47	69	30	78	85	83
13 " (1-5)	27	31	04	-16	-19	-27	58	54	51	39	86	71	--	45	14	62	16	67	55	44
14 " I	18	20	-16	-30	-21	-29	37	43	25	19	43	39	45	--	02	24	-36	48	44	30
15 " II	00	10	-08	05	13	15	24	15	14	40	39	47	14	02	--	33	10	17	41	26
16 " III	05	16	-16	-05	-26	-35	47	27	62	31	71	69	62	24	33	--	29	47	52	46
17 " IV	05	09	-05	-02	-26	-03	-13	-17	01	-10	28	30	16	-36	10	29	--	-09	01	34
18 " V	38	43	-05	-37	-19	-21	54	53	41	38	79	78	67	48	17	47	-09	--	73	54
19 " VI	10	18	-18	-23	-08	-26	48	37	41	46	80	85	55	44	41	52	01	73	--	73
20 " VII	00	07	-26	-21	-15	-36	32	24	30	29	76	83	44	30	26	46	34	54	73	--

TABLE 9--Continued

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
21 HAPS VIII	27	37	03	-25	-08	-02	33	51	09	14	75	77	56	31	26	37	08	72	58	54
22 " 1	29	34	14	-31	-09	-11	34	36	26	16	57	48	66	29	15	48	06	53	40	28
23 " 2	20	21	-15	-12	-27	-37	46	39	50	25	64	52	78	33	13	46	09	56	43	24
24 " 3	09	10	24	07	21	16	29	29	14	32	51	41	63	10	10	35	25	30	26	21
25 " 4	16	24	06	-03	-27	-12	52	41	48	42	69	57	81	21	15	55	37	40	34	29
26 " 5	20	18	00	-18	-15	-34	45	44	38	25	64	57	66	60	-02	36	-17	59	54	54
27 JRSVB	46	46	-03	-34	-31	-29	30	33	21	20	32	30	29	27	09	27	-27	48	32	07
28 " a	23	28	-13	-27	-15	-20	21	31	05	15	33	34	24	37	10	16	-36	55	40	23
29 " b	43	40	22	-15	-27	-22	32	24	27	32	24	22	26	09	17	29	-20	35	24	-05
30 " c	60	60	-03	-39	-38	-13	19	19	20	07	27	25	27	18	06	19	09	37	18	01
31 " d	51	49	12	-42	-37	-22	27	23	20	24	28	28	25	13	16	20	-03	29	30	03
32 " e	30	35	20	-33	-21	-20	10	27	-12	03	23	25	14	17	17	00	-36	41	39	-01
33 " f	40	42	11	-30	-52	-40	36	34	33	25	48	49	40	-04	21	44	06	40	42	11
34 " g	28	33	14	-28	-19	-21	32	37	13	29	18	18	15	11	32	16	-44	42	36	-12
35 " h	49	49	05	-36	-51	-29	32	22	32	30	25	24	22	18	08	36	00	17	29	-04
36 Co. Rating	10	17	29	-17	03	25	16	42	-15	03	21	26	06	12	-03	-15	-27	48	29	12
37 Jud. Grp. Anal.	-30	-26	-02	26	16	12	-13	02	-27	-11	-35	-32	-37	-01	-05	-35	-43	-15	-14	-26
38 " I	20	09	21	-38	-07	-12	-25	-07	-38	-21	-01	06	-13	-15	-09	-25	07	21	00	15
39 " II	10	02	22	-23	01	-03	-26	-04	-42	-22	-13	-08	-21	-15	-16	-40	-05	13	-09	05
40 " III	-38	-25	-19	51	19	19	13	07	14	11	-24	-27	-14	12	04	-02	-35	-28	-10	-31

TABLE 9--Continued

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
41 JudGrpAnal IV	-20	-21	02	10	10	05	-20	-01	-35	-16	-30	-25	-37	-05	-04	-34	-37	-06	-10	-19
42 Pa.Rating A-C	24	34	08	-26	17	14	03	-02	08	04	10	08	11	27	-04	-03	-14	29	17	09
43 " A1	31	38	05	-39	09	-03	02	03	06	-05	35	35	30	-11	-18	08	04	45	34	33
44 " A2	-08	00	-12	-07	04	11	-03	-22	12	08	-25	22	-26	23	24	06	-11	-08	-13	-14
45 " B	-12	10	07	45	16	17	17	25	02	15	19	17	19	-22	00	-10	-02	26	05	-01
46 " C	26	22	38	-17	08	05	06	04	07	05	01	-04	11	17	-20	-26	-02	-01	07	07
47 " D	43	41	-04	-44	-07	06	-10	-02	-07	-21	33	34	26	-04	-22	10	43	19	14	40
48 " D9	33	34	-04	-33	-11	15	00	07	-01	-14	32	35	22	-22	-07	15	44	11	14	32
49 " D10	37	30	22	-34	00	15	-01	13	-13	-09	34	35	25	-05	-20	-07	26	30	24	38
50 " D11	43	39	-03	-44	-11	14	-13	04	-21	-21	20	20	16	26	-24	07	31	13	03	23
51 " D12	37	33	-16	-37	01	20	-09	03	-08	-23	33	34	26	-17	-14	18	47	21	08	33
52 " D13	31	35	05	-36	07	-10	-07	-05	00	-15	26	25	23	-08	-16	-04	26	14	12	37
53 " D14	27	30	-21	-30	-23	-25	-18	-27	04	-17	16	17	12	11	-28	17	36	02	10	29
54 Co.Rating I	-10	-08	14	-03	13	17	09	27	-08	-01	-02	02	-11	10	-07	-12	-35	19	14	03
55 " II	16	17	18	-13	-10	-03	21	35	04	06	35	37	26	04	-15	-01	-02	35	33	32
56 " III	02	09	12	-17	11	29	-02	30	-34	-14	14	23	-06	10	06	-19	-23	33	23	11
57 " IV	24	36	46	-27	-08	31	21	43	-10	13	26	29	16	17	08	-10	-23	65	31	02
58 " V	20	31	-06	-25	-20	-23	36	22	41	30	36	37	28	01	14	32	-07	36	41	17

TABLE 9--Continued

	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
1 Anomie	27	29	20	09	16	20	46	23	43	60	51	30	40	28	49	10	-30	20	10	-38
2 " (1,6)	37	34	21	10	24	18	46	28	40	60	49	35	42	33	49	17	-26	09	02	-25
3 Dogmatism	03	14	-15	24	06	00	-03	-13	22	-03	12	20	11	14	05	29	-02	21	22	-19
4 Q (S-O) ^a	-25	-31	-12	07	-03	-18	-34	-27	-15	-39	-42	-33	-30	-28	-36	-17	26	-38	-23	51
5 Q (S-S) ^a	-08	-09	-27	21	-27	-15	-31	-15	-27	-38	-37	-21	-52	-19	-51	03	16	-07	01	19
6 Q (O-O) ^a	-02	-11	-37	16	-12	-34	-29	-20	-22	-13	-22	-20	-40	-21	-29	25	14	-12	-03	19
7 HAPS	33	34	46	29	52	45	30	21	32	19	27	10	36	32	32	16	-13	-25	-26	13
8 " I	51	36	39	29	41	44	33	31	24	19	23	27	34	37	22	42	02	-07	-04	07
9 " II	09	26	50	14	48	38	21	05	27	20	20	-12	33	13	32	-15	-27	-38	-42	14
10 " III	14	16	25	32	42	25	20	15	32	07	24	03	25	29	30	03	-11	-21	-22	11
11 HAPS	75	57	64	51	69	64	32	33	24	27	28	23	48	18	25	21	-35	-01	-13	-24
12 " (I-VIII)	77	48	52	41	57	57	30	34	22	25	28	25	49	18	24	26	-32	06	-08	-27
13 " (1-5)	56	66	78	63	81	66	29	24	26	27	25	14	40	15	22	06	-37	-13	-21	-14
14 " I	31	29	33	10	21	60	27	37	09	18	13	17	-04	11	18	12	-01	-15	-15	12
15 " II	26	15	13	10	15	-02	09	10	17	06	16	17	21	32	08	-03	-05	-09	-16	04
16 " III	37	48	46	35	55	36	27	16	29	19	20	00	44	16	36	-15	-35	-25	-40	-02
17 " IV	08	06	09	25	37	-17	-27	-36	-20	09	-03	-36	06	-44	00	-27	-43	07	-05	-35
18 " V	72	53	56	30	40	59	48	55	35	37	29	41	40	42	17	48	-15	21	13	-28
19 " VI	58	40	43	26	34	54	32	40	24	18	30	39	42	36	29	29	-14	00	-09	-10
20 " VII	54	28	24	21	29	54	07	23	-05	01	03	-01	11	-12	-04	12	-26	15	05	-31

TABLE 9--Continued

	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
21 HAPS VIII	--	43	34	40	43	45	31	31	18	24	17	37	29	15	09	56	-02	06	05	-06
22 " 1	43	--	42	30	39	40	20	25	05	17	18	16	10	30	-06	-14	-47	-20	-37	-15
23 " 2	34	42	--	28	56	39	38	23	33	40	35	20	49	19	33	-05	-41	-01	-11	-27
24 " 3	40	30	28	--	61	20	-12	-19	04	-08	-11	-28	-06	-27	-04	20	-06	-06	-02	02
25 " 4	43	39	56	61	--	35	12	-02	20	20	09	-06	34	-05	21	01	-28	-24	-25	02
26 " 5	45	40	39	20	35	--	31	47	19	12	08	26	19	23	02	09	00	-12	-13	11
27 JRSVB	31	20	38	-12	12	31	--	79	84	77	88	85	91	80	83	37	-03	28	19	-27
28 " a	31	25	23	-19	-02	47	79	--	54	45	55	88	62	81	38	42	08	34	27	-25
29 " b	18	05	33	04	20	19	84	54	--	60	72	67	82	62	81	37	03	14	13	-10
30 " c	24	17	40	-08	20	12	77	45	60	--	85	43	68	38	79	21	-22	25	14	-36
31 " d	17	18	35	-11	09	08	88	55	72	85	--	62	76	54	84	21	-25	25	11	-39
32 " e	37	16	20	-28	-06	26	85	88	67	43	62	--	75	83	52	48	19	31	29	-14
33 " f	29	10	49	-06	34	19	91	62	82	68	76	75	--	69	77	33	01	31	22	-26
34 " g	15	30	19	-27	-05	23	80	81	62	38	54	83	69	--	46	32	24	16	15	02
35 " h	09	-06	33	-04	21	02	83	38	81	79	84	52	77	46	--	24	-12	08	01	-15
36 Co.Rating	56	-14	-05	20	01	09	37	42	37	21	21	48	33	32	24	--	49	38	55	01
37 Jud.Grp.Anal.	-02	-47	-41	-06	-28	00	-03	08	03	-22	-25	19	01	24	-12	49	--	20	47	51
38 " I	06	-20	-01	-06	-24	-12	28	34	14	25	25	31	31	16	08	38	20	--	93	-74
39 " II	05	-37	-11	-02	-25	-13	19	27	13	14	11	29	22	15	01	55	47	93	--	-49
40 " III	-06	-15	-27	02	02	11	-27	-25	-10	-36	-39	-14	-26	02	-15	01	51	-74	-49	--

TABLE 9--Continued

	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
41 JudGrpAnal IV	00	-44	-38	-10	-35	-02	09	20	08	-11	-12	29	13	30	-07	52	94	49	68	22
42 Pa.Rating A-C	05	18	-09	11	10	01	06	27	00	11	-10	11	-09	06	-05	20	-12	-06	-02	-02
43 " A1	36	37	10	15	16	20	22	30	06	16	11	26	19	23	05	19	-23	11	09	-25
44 " A2	-45	14	-27	-33	-15	-25	-13	10	-16	-04	-24	-15	-30	-02	-21	-19	-10	-19	-22	09
45 " B	32	-17	15	40	32	03	-08	01	05	-17	-31	10	10	06	-21	36	53	06	25	31
46 " C	-07	-25	14	19	06	07	16	03	23	33	28	03	06	-17	28	32	-17	14	16	-23
47 " D	25	19	-03	30	18	10	22	23	-01	46	32	09	23	-11	21	16	-27	36	25	-50
48 " D9	34	14	-08	25	24	06	21	12	08	42	28	08	28	-14	26	27	-17	21	15	-29
49 " D10	36	26	-04	24	12	21	27	32	10	36	37	24	23	-03	16	23	-29	36	24	-52
50 " D11	23	20	-21	32	11	05	13	17	-09	35	30	02	04	-18	19	04	-36	24	11	-46
51 " D12	27	21	04	27	18	06	17	18	-09	41	27	02	23	-10	16	11	-28	38	26	-53
52 " D13	17	03	07	29	18	05	09	17	-01	25	03	08	17	-11	03	33	01	34	36	-29
53 " D14	-11	14	00	09	03	05	24	20	01	47	36	03	16	00	28	-23	-28	20	05	-38
54 Co.Rating I	20	-37	-09	05	-09	07	07	14	15	-15	-16	21	11	19	03	78	64	28	51	19
55 " II	43	-28	19	27	28	19	37	30	39	25	26	40	45	20	31	81	32	45	60	-17
56 " III	65	-04	-18	07	-17	07	39	46	29	23	35	54	30	30	28	81	35	24	33	03
57 " IV	54	19	-02	28	05	05	39	45	38	33	26	43	27	35	19	85	29	28	36	-04
58 " V	32	10	36	08	21	05	59	27	57	54	56	38	56	47	64	40	07	-11	-06	14

TABLE 9--Continued

	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58
1 Anomie	-20	24	31	-08	-12	26	43	33	37	43	37	31	27	-10	16	02	24	20
2 " (1,6)	-21	34	38	00	10	22	41	34	30	39	33	35	30	-08	17	09	36	31
3 Dogmatism	02	08	05	-12	07	38	-04	-04	22	-03	-16	05	-21	14	18	12	46	-06
4 Q (S-O) ^a	10	-26	-39	-07	45	-17	-44	-33	-34	-44	-37	-36	-30	-03	-13	-17	-27	-25
5 Q (S-S) ^a	10	17	09	04	16	08	-07	-11	00	-11	01	07	-23	13	-10	11	-08	-20
6 Q (O-O) ^a	05	14	-03	11	17	05	06	15	15	14	20	-10	-25	17	-03	29	31	-23
7 HAS	-20	03	02	-03	17	06	-10	00	-01	-13	-09	-07	-18	09	21	-02	21	36
8 " I	-01	-02	03	-22	25	04	-02	07	13	04	03	-05	-27	27	35	30	43	22
9 " II	-35	08	06	12	02	07	-07	-01	-13	-21	-08	00	04	-08	04	-34	-10	41
10 " III	-16	04	-05	08	15	05	-21	-14	-09	-21	-23	-15	-17	-01	06	-14	13	30
11 HAPS	-30	10	35	-25	19	01	33	32	34	20	33	26	16	-02	35	14	26	36
12 " (I-VIII)	-25	08	35	22	17	-04	34	35	35	20	34	25	17	02	37	23	29	37
13 " (1-5)	-37	11	30	-26	19	11	26	22	25	16	26	23	12	-11	26	-06	16	28
14 " I	-05	27	-11	23	-22	17	-04	-22	-05	26	-17	-08	11	10	04	10	17	01
15 " II	-04	-04	-18	24	00	-20	-22	-07	-20	-24	-14	-16	-28	-07	-15	06	08	14
16 " III	-34	-03	08	06	-10	-26	10	15	-07	07	18	-04	17	-12	-01	-19	-10	32
17 " IV	-37	-14	04	-11	-02	-02	43	44	26	31	47	26	36	-35	-02	-23	-23	-07
18 " V	-06	29	45	-08	26	-01	19	11	30	13	21	14	02	19	35	33	65	36
19 " VI	-10	17	34	-13	05	07	14	14	24	03	08	12	10	14	33	23	31	41
20 " VII	-19	09	33	-14	-01	07	40	32	38	23	33	37	29	03	32	11	02	17

TABLE 9--Continued

	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58
21 HAPS VIII	00	05	36	-45	32	-07	25	34	36	23	27	17	-11	20	43	65	54	32
22 " 1	-44	18	37	14	-17	-25	19	14	26	20	21	03	14	-37	-28	-04	19	10
23 " 2	-38	-09	10	-27	15	14	-03	-08	-04	-21	04	07	00	-09	19	-18	-02	36
24 " 3	-10	11	15	-33	40	19	30	25	24	32	27	29	09	05	27	07	28	08
25 " 4	-35	10	16	-15	32	06	18	24	12	11	18	18	03	-09	28	-17	05	21
26 " 5	-02	01	20	-25	03	07	10	06	21	05	06	05	05	07	19	07	05	05
27 JRSVB	09	06	22	-13	-08	16	22	21	27	13	17	09	24	07	37	39	39	59
28 " a	20	27	30	10	01	03	23	12	32	17	18	17	20	14	30	46	45	27
29 " b	08	00	06	-16	05	23	-01	08	10	-09	-09	-01	01	15	39	29	38	57
30 " c	-11	11	16	-04	-17	33	46	42	36	35	41	25	47	-15	25	23	33	54
31 " d	-12	-10	11	-24	-31	28	32	28	37	30	27	03	36	-16	26	35	26	56
32 " e	29	11	26	-15	10	03	09	08	24	02	02	08	03	21	40	54	43	38
33 " f	13	-09	19	-30	10	06	23	28	23	04	23	17	16	11	45	30	27	56
34 " g	30	06	23	-02	06	-17	-11	-14	-03	-18	-10	-11	00	19	20	30	35	47
35 " h	-07	-05	05	-21	-21	28	21	26	16	19	16	03	28	03	31	28	19	64
36 Co.Rating	52	20	19	-19	36	32	16	27	23	04	11	33	-23	78	81	81	85	40
37 Jud.Grp.Anal.	94	-12	-23	-10	53	-17	-27	-17	-29	-36	-28	01	-28	64	32	35	29	07
38 " I	49	-06	11	-19	06	14	36	21	36	24	38	34	20	28	45	24	28	-11
39 " II	68	-02	09	-22	25	16	25	15	24	11	26	36	05	51	60	33	36	-06
40 " III	22	-02	-25	09	31	-23	-50	-29	-52	-46	-53	-29	-38	19	-17	03	-04	14

Vosky, 1962; Patterson, 1959; Super, 1955; Brigante, 1962; Tyler, 1961) have elaborated on the characteristics of counseling as compared with psychotherapy. There appears to be general agreement that much overlapping occurs. Differences of opinion are seen to be primarily in terminology and specific emphasis. Caplan (1957, 124) characterizes group counseling as emphasizing,

. . . a permissive relationship in which an individual can evaluate himself and his opportunities, can choose courses of action, and can accept responsibility for those choices. It overlaps with group guidance (emphasis on imparting facts) and with group psychotherapy (emphasis on treatment).

Perry (1955, 396) reminds us that "counseling" is a process performed in many settings by widely different kinds of people, such as internists, social workers, psychologists, ministers, and educators. He sees the counselor as more interested in helping clients establish role patterns, with the major goal that of developing competence in a given problem area, and where dynamics are considered with emphasis on projection on "the problem." In contrast, the psychotherapist's concern is with intense intrapersonal conflicts, and where dynamics are considered with emphasis on projection on the therapist.

Perry conceptualizes a patient "continuum" according to degree of disturbance, and distinguishes the roles of counselors and psychotherapists according to where they

TABLE 9--Continued

	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58
41 JudGrpAnal IV	--	-16	-21	-14	46	-16	-14	-10	-15	-25	-13	08	-16	61	36	38	32	01
42 Pa.Rating A-C	-16	--	62	58	07	34	38	22	25	37	18	55	26	06	21	04	31	01
43 " A1	-21	62	--	-08	.03	04	47	34	39	36	43	45	31	00	33	08	19	24
44 " A2	-14	58	-08	--	-22	06	-01	-07	-09	05	-12	10	09	-11	-33	-28	02	-29
45 " B	46	07	.03	-22	--	-17	-09	-04	-07	-30	-09	24	-28	33	39	19	25	11
46 " C	-16	34	04	06	-17	--	48	37	43	27	13	49	18	12	41	23	30	05
47 " D	-14	38	47	-01	-09	48	--	89	87	84	87	73	70	-16	38	19	15	-04
48 " D9	-10	22	34	-07	-04	37	89	--	80	66	81	65	42	-03	44	33	20	04
49 " D10	-15	25	39	-09	-07	43	87	80	--	71	69	55	55	-17	38	32	25	-13
50 " D11	-25	37	36	05	-30	27	84	66	71	--	74	42	65	-30	17	16	10	-17
51 " D12	-13	18	43	-12	-09	13	87	81	69	74	--	51	51	-09	32	12	04	-04
52 " D13	08	55	45	10	24	49	73	65	55	42	51	--	36	19	53	15	25	08
53 " D14	-16	26	31	09	-28	18	70	42	55	65	51	36	--	-45	-03	-15	-12	01
54 Co.Rating I	61	06	00	-11	33	12	-16	-03	-17	-30	-09	19	-45	--	66	41	48	21
55 " II	36	21	33	-33	39	41	38	44	38	17	32	53	-03	66	--	55	51	36
56 " III	38	04	08	-28	19	23	19	33	32	16	12	15	-15	41	55	--	69	39
57 " IV	32	31	19	02	25	30	15	20	25	10	04	25	-12	48	51	69	--	36
58 " V	01	01	24	-29	11	05	-04	04	-13	-17	-04	08	01	21	36	39	36	--

^aHigher scores are negative (discrepancy scores); therefore, reverse sign to read r

APPENDIX XVIII

TABLE 10

INTER-OBSERVER RELIABILITY ON RATINGS
OF GENERAL OBSERVED BEHAVIOR
USING THE HAPS

TABLE 10
INTER-OBSERVER RELIABILITY ON RATINGS
OF GENERAL OBSERVED BEHAVIOR
USING THE HAPS

Measure	Observers			Ave. r
	A-B	A-C	B-C	
<hr/>				
	Pre-Treatment			
HAPS (TOTAL)	.26 ^a	.28	.34	.29
" (I-VIII)	.32	.30	.30	.31
" (1-5)	.04	.22	.35	.20
<hr/>				
	Post-Treatment			
" (TOTAL)	.54	.53	.38	.48
" (I-VIII)	.49	.43	.36	.43
" (1-5)	.23	.27	.37	.29
<hr/>				
	Average			
" (TOTAL)	.40	.41	.36	.39
" (I-VIII)	.40	.36	.33	.37
" (1-5)	.14	.25	.36	.25

^aN = 46, $r_{.95} = .29$, $r_{.99} = .38$

APPENDIX XIX

TABLE 11

INTER-JUDGE RELIABILITY (r) ON RATINGS OF
VERBAL BEHAVIOR, USING THE JRSVB

TABLE 11
INTER-JUDGE RELIABILITY (r) ON RATINGS OF
VERBAL BEHAVIOR, USING THE JRSVB

Measure	Judges			Ave. r
	1-2	1-3	2-3	
Total (Pre)	.75 ^a	.70	.63	.69
" (Post)	.63	.67	.52	.61
" Average	.69	.69	.58	.65
Ia (Pre)	.80	.77	.72	.76
Ib "	.50	.46	.59	.52
Ic "	.65	.71	.66	.67
Id "	.60	.40	.45	.48
Ie "	.65	.56	.52	.58
If "	.58	.48	.46	.51
Ig "	.58	.55	.45	.53
Ih "	.62	.58	.42	.54

^aMinimum r for .05 level of significance,
N = 26, is .39; for .01 level is .50

AUTOBIOGRAPHY

I, Gordon Adair Harshman, was born in Cory, Colorado, September 29, 1921. I received my secondary-school education in the Delta, Colorado public schools. My undergraduate training was completed at the University of Colorado, as was the work on the Master of Education degree. The Bachelor of Arts degree, with major in Psychology, was granted in 1950 and the Master of Education degree, with major in Counseling and Guidance, in 1953.

In 1960, following ten years' teaching and administrative experience in the public schools of Chadron, Nebraska and Pueblo, Colorado, I received a Teaching Assistantship in the Department of Psychology at The Ohio State University. This position was held for two years. From June through August of 1961 and July, 1962 to the present date, I have worked as a Psychology Trainee with the Veterans Administration Hospital in Chillicothe, Ohio, and at the Veterans Administration Mental Hygiene Clinic in Columbus, Ohio.

I have accepted a position as Assistant Professor in the College of Education of the University of Arizona, to begin in September, 1963.

ACKNOWLEDGMENTS

The active support of many individuals and groups made this research possible. Although it is impracticable to mention all who contributed, special appreciation is due those who especially influenced the final outcome. First, my sincere gratitude goes to the consultants from the Ohio State University who assisted at various stages of development, especially Drs. F.P. Robinson, J.R. Kinzer, and my Adviser, Dr. F.M. Fletcher, as well as to Dr. D.R. Whitney for his assistance in the statistical analysis.

The cooperation of the administration and staff of the Veterans Administration Neuropsychiatric Hospital at Chillicothe, Ohio was essential to carrying out the project, once it was conceived. Drs. K.F. McCormick, Helen B. Barshay, and A.R. Howard, members of the psychology staff, and Dr. H.R. Albrecht, Chief of Psychology Service, played especially important roles, as did several members of the Nursing and Social Work Services. Time, facilities, and assistance were also made available at the VA Mental Hygiene Clinic of Columbus, Ohio, especially by Dr. Jean W. Branson, Chief Psychologist.

Continued stimulation and assistance were received from many fellow graduate students, with special thanks due Milton E. Foreman, who helped in so many ways.

The faith and constant support shown by my wife, Tru, and daughter, Lylann, have meant more than they can ever know.

fit along this dimension. In his words (1955, 401):

. . . The less internally handicapped a person may be by pathological anxiety, depression, or other disturbance, the more he will be able to respond with his full capacities to the briefer and more direct forms of guidance in regard to the skills of choice and management among life's roles. . . . At the other end of the dimension, however, persons with a strong internal disturbance tend not to be able to make use of direct guidance in its own terms, no matter how kindly or skillful it may be. Instead, they more frequently require a very extended relationship with a single person, or small group of people, whom they test out over a period of time, before they can trust enough, or love enough to learn effectively the emotional and social skills required for successful handling of the roles expected of them and desired by themselves.

He concludes (401) that the psychotherapist spends the predominance of his time in areas of moderate to intense intra-personal disturbance. The counselor, by contrast, spends most of his time in areas of minimal to moderate personal disturbance and in relation to some particular problem area in which he claims a competence, such as vocations, education, marriage, or the like. Perry (1955, 404) states:

We can express the difference in emphasis, then, by saying that counseling looks more often toward the interpretation and development of the personality in the relations characteristic of specific role-problems while psychotherapy looks more often toward the re-interpretation and reorganization of malignant conflictual elements within the personality through the relation with the therapist. It is, we believe, from this difference in emphasis that other differences follow that have sometimes been mentioned in distinguishing the two

processes--such differences as attention to "ego integration" as against the "analysis of infantile conflict or impulse," attention to "conscious and pre-conscious material" as against "unconscious" or "repressed," attention to the present as against the past, and so on.

Fletcher (1954, 240), in an earlier paper, attempted to view the total rehabilitation process, seeing it as a continuum extending from the onset of disability to the time of integration back into society with at least minimal social, personal, and occupational adjustment. He believes that in the middle of the continuum or process there is a crucial, but often not clear-cut transition period, which he calls "the stage of stabilization." In general, this stage, for the mentally handicapped, is the point in time when progress by therapy becomes minimal, the individual again has "his feet on the ground," and is in reasonable contact with reality. His behavior becomes more predictable on a moderately long-range basis during this stabilization stage, which divides the rehabilitation process into "therapy" and "adjustment" phases.

It is primarily in the "therapy" stage that Fletcher places those services, including psychotherapy, that involve the "remaking or remodeling of the patient physically or mentally, insofar as science will enable." Counseling psychology's primary responsibility falls in the "adjustment phase" along with social case work and occupational therapy. He recognized that at the time (1954), this latter

phase of rehabilitation was still in an early stage of development, with little theoretical groundwork and limited research to provide definition of potential functions of the counseling psychologist in rehabilitation work.

Realizing that this adjustment process is complex, Fletcher includes the more traditional "interview-test-interview-decision" method as only a part of the total function. He stresses the importance of the interaction between the individual and his constellation of environments, calling for careful observation and manipulation of the environment as a potentially useful aid. He believes (1954, 242) that proper and regular use of this technique

. . . can serve the rehabilitation process in three ways: (1) in obtaining a better estimate of skills and potentiality of acquiring new skills; (2) in aiding the client to adjust to new physical and social environments so crucial in gaining employment; (3) in reducing the chances that an individual will get into a psychological rut and become dependent upon a single physical and social setting.

Fletcher calls upon those (therapists and counselors) working with individuals in this adjustment phase to be alert to the many variables and limiting factors of each case, such as the home, means of livelihood, social setting, attitude of employer, practical possibilities of employment, and training facilities. This means that much counseling will be done before, during, and following the placement of the individual back in the community. Thus a

step-by-step procedure of counseling, evaluation of progress, and environmental manipulation is suggested as the most promising approach.

A new approach to defining the role of the counseling psychologist has just recently been presented. Vance and Vosky (1962) attempt to disentangle "process" and "practitioner." They are aware that being trained as and called a "clinical psychologist" or a "counseling psychologist" is far from conclusive evidence as to whether "psychotherapy" or "counseling" will be the term most descriptive of later practice. They describe psychotherapy as a process of relearning or reeducation, with emphasis on the old behavior as pathological and the new behavior as healthy. Thus (566) ". . . psychotherapy deals with the pathological and seeks to cure."

In order to describe the complex work of the counseling psychologist, they believe it necessary to replace (rather than redefine) the term, "counseling," when used in reference to goal-related process, with "unambiguous, theoretically useful concepts" (566). They "attempt to describe a kind of nonpathological emotional distress that is clearly the special province of the counseling psychologist, using terms growing out of the situations with which he works and the techniques he employs."

Drawing upon Festinger's (1957) concept of "cognitive dissonance," which is seen as basically a discrepancy

between belief and behavior, Vance and Vosky speak of psychological discord in terms of inconsistencies between interests and abilities, abilities and performance, goals and external pressures, etc. These areas are seen to be of concern in "counseling."

In an early article setting forth the role of counseling psychology, as formally begun in 1951 by American Psychological Association action, Super (1955, 5) affirms that the counseling psychologist is interested in the handicapped, abnormal, or maladjusted person as well as in the "normal," but in a way which is different from the concern of the clinical psychologist. His distinction is based primarily on the dimension of "abnormality vs. normality." He indicates that traditionally (as of 1954) the clinician has focused on the abnormal, with a concern for diagnosis of the nature and extent of psychopathology, even of "normal" persons, with uncovering adjustment difficulties, and with the acceptance and understanding of these tendencies so that they may be modified.

Super characterizes counseling psychology, on the other hand, as concerned with the normalities even of abnormal persons, with locating and developing personal and social resources and adaptive tendencies so that the individual can be assisted in making more use of them. Robinson (1950) has also urged that an important role of the counselor is that of assisting the client with the job

of "bettering the best." Rudikoff and Kirk (1961, 243) maintain that the primary goal of counseling is that of "mobilizing a person toward the fulfillment of a crucial need," such as a job. This theme, too, is supported strongly by Tyler (1961, 12):

Let us use "counseling" to refer to a helping process the aim of which is not to change the person but to enable him to utilize the resources he now has for coping with life.

After citing several studies conducted with long-term Np patients, Tyler (280) concludes:

What these studies are suggesting to those who work with the disabled is that counseling and training designed to enable individuals to make use of their assets can be effective even in cases where serious personality difficulties persist uncorrected.

Super believed that in due time the two fields might merge, in a more broadly trained and oriented field. He (1955, 8) also anticipated that in the evolving field of counseling psychology important future developments would occur, especially in connection with rehabilitation work. This line of reasoning is upheld by Block. In an effort to present some operational principles for counseling the disabled, Block concludes that until the early 1950's, the setting for the counseling psychologist was industry, the school, the university counseling center, and other community agencies. Counseling was conducted with "those whose anxieties are interfering and disruptive but not disabling" (Quoting Hahn, 1955). Block (1955, 262) ties

counseling in these more traditional settings to the work of the counselor in the clinic or institution:

In effect, these principles require the counseling psychologist to counsel the whole person, for psychological problems accompanying disability are often inextricably interwoven with manifest vocational problems.

One exception to current writers on this subject is Patterson. He (1959, 11) uses the terms counseling and psychotherapy interchangeably, although he devotes several pages to definitions and distinctions between the two as seen by various writers (APA Committee on Definition of Counseling Psychology, 1956; Bordin, 1955; Mowrer, 1951; Super, 1955; Sanderson, 1954; Patterson, 1958; Porter, 1950). He (1959, 8) justifies this by claiming that "The process of helping individuals may be conceived as varying on a continuum." At one end is simple information-giving, at the other extreme falls intensive psychotherapy or psychoanalysis, and in between lies a graduated continuum according to focus and severity of the problem. Patterson (1959, 7) further claims that ". . . techniques of therapeutic counseling are no different from those of psychotherapy." There is a careful distinction, however, in use of the term "therapeutic counseling" as compared with the more traditional usage. Brammer and Shostrom (1960) follow a similar line of reasoning in their text.

Other current writers, such as Hadley (1958), Brigante, Haefner, and Woodson (1962), and Vance and Vosky

(1962) are also tending to de-emphasize the distinction between counseling and clinical psychology. Hadley (1958, 49) suggests that the distinction between clinicians and counselors has become less apparent, but that counseling psychologists are more often employed in schools, industry, and various community activities, whereas clinical psychologists are more often found in clinics and hospitals.

Although agreeing that there is some apparent blurring of distinctions between the two specialties, Brigante, et al. (1962, 225), conclude that the very fact two specialties exist indicates that areas of differentiation are present. The findings of Brigante, et al., are consistent with several of Hahn's (1955) hypotheses regarding differences between clinicians and counselors, such as that counselors (a) are less concerned than clinicians with reorganizing basic personality structure, (b) tend to focus more upon personality assets, and (c) are more similar to industrial psychologists than to psychotherapists.

It would seem that four rather clear-cut dimensions can be utilized in comparing counseling and psychotherapy: the setting, major goals, stage of disturbance, and focus and severity of the problem. (1) The setting in counseling varies widely: school, industry, institution, clinic, private practice, community (including home, social setting, agencies, etc.); whereas the setting of most psychotherapy is the clinic or institution, or private practice. (2) Major

goals in counseling are the locating and developing of resources, adaptive tendencies or assets; the mobilization of these resources, etc., to meet specific, crucial needs, such as social, vocational, educational, marital; adjustment and integration back into the community; while in psychotherapy the major goals are to produce basic personality change through reorganization of malignant conflictual elements, relearning or re-education--exchange of old, pathological behavior for new, healthy behavior, and reconditioned feelings and responses; transference relationship is usually seen as basic. (3) The stage of the disturbance in psychotherapy is from onset to at least minimal stabilization; in counseling from at least minimal stabilization to time of return to the community and attainment of some degree of acceptable adjustment there. (4) The focus and severity of the problem also varies considerably. In psychotherapy one deals with more severely disturbed, disoriented individuals with intense anxiety, intra-personal conflict, noxious memories, crippling depression; stress is on the abnormal, even in the "normal" individual; in counseling one works with individuals presenting minimal to moderate disturbances, who are in reasonably good contact with reality, and whose long-range behavior has become more predictable; the focus in counseling is on areas of psychological discord, such as inconsistencies between interests and abilities, abilities and performance, personal goals

and external pressures, self and ideal self-concepts; stress is on aspects of normality, even in the "abnormal" individual.

Although there appear to be many distinctions, there is general agreement that much overlapping occurs, and the need arises to be aware of the distinction between "process" and "practitioner," as labels applied during training and later practice may not coincide or be meaningful in relation to actual function. The specific setting, type of patient or client, etc., may well indicate similar approaches by both "counselor" or "therapist," regardless of background. Some, such as Patterson and Brammer and Shostrom, hold that the techniques of "therapeutic" counseling are essentially no different from those of psychotherapy.

There has been some speculation that the two fields might eventually merge, but in spite of many similarities in both training and function, many differences persist. This is evidenced not only by such an analysis as presented above, but more practically by the two as training specialties in several universities, each with APA approved programs. In 1962 an effort was initiated by the Veterans Administration to combine the two specialties into one "Psychology Service." This appears to enable either specialist to function according to the needs of the situation and those of the patient or client, as well as providing the basis for a more cooperative pooling of psychological resources.

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For the counseling psychologist, any attempt to work with "the whole person" seems to indicate the necessity of doing so where he is, including the institutional setting, and continuing to do so until the individual is again operating on at least a minimal level in the community.

Situational Factors

Environmental manipulation, or "situational therapy" involves the entire treatment milieu, as Fletcher and others (Jones, 1953; Beckenstein, 1959; Kepinski, et al., 1960) have suggested. In a rather glowing foreword to Dr. Maxwell Jones' The Therapeutic Community, Watson (1953, vii) comments on the trends in rehabilitation of mental patients. Casting individual therapy aside as "too expensive for most people and of dubious value in rehabilitating severe social misfits," he recounts the more recent developments in the area of group therapy, such as Moreno's psychodrama, Slavson's relatively non-verbal "activity group therapy," Axline's play therapy with groups of children, and Hobbs' experimental work with "group-centered psychotherapy." Watson challenges the reader with the statement that the experiments of Dr. Jones, though lacking scientific rigor at times, go a substantial step beyond what we know as group therapy.

In Jones' experimental community "therapy" covers the entire working day of the patient and includes all his

contacts with other persons. Although the doctor has a vital role, so also do nurses, job supervisors and the other patients. Work experience transcends the usual time-killing "occupational therapy" by assuming the proportion of a genuine job, created by governmental edict. Working with some of the most institutionalized, hence most "de-socialized" of all the patients, the situation developed by Jones and his staff has apparently made employable the "unemployable" and lovable the "unloved." Emphasis was toward casualness on part of staff and mutual support among patients. Traditional doctor-nurse-patient relationships came in for considerable revision, as did the various group techniques attempted. Watson (1953, x) concludes,

It is impressive to read of isolated, depressed, bitter, resentful, suspicious, uncooperative, unproductive personalities responding to a fairly healthy social situation by accepting responsibility and learning active, cooperative participation . . . within three or four months.

The great contribution of Dr. Maxwell Jones and his co-workers is not in the results they have already achieved, but in the vista they have opened. When they discuss the "therapeutic community," they are referring only to carefully managed relationships within a closed institution.

Jones (1953, 156) believes, on the basis of follow-up studies, that his work justifies the conclusion that "It is possible to change social attitudes in relatively de-socialized patients with severe character disorders, provided they are treated together in a therapeutic community." More recently, in an effort to evaluate developments in

this area, Beckenstein visited several "open" hospitals in Europe. He concludes that the concept of the "therapeutic community" is more effective now with the use of better defined therapeutic methods. Describing Dingleton Hospital in Melrose, Scotland, he (1959, 148) states:

All doors were unlocked and patients were able to move freely through the doors to their various activities. One of the most important elements necessary for the success of this program is the formation of small groups of patients, and the establishment of a variety of group activities . . .

Beckenstein (149) also calls for further research in an effort to define the role of group psychotherapy, asserting that "After the facts are collected there will come the period of classification, followed by the formulation of principles which will enable us to predict what will happen when a given set of factors are brought together."

Kepinski and Gatarski (1960, 182-187), of the Psychiatric Clinic of Cracow Academy of Medicine in Poland, give a detailed report of their work with "group psychotherapy as an approach to a psychotherapeutic community." Starting by converting a corridor into a pleasant, colorful corner for visiting purposes, their work gradually evolved into more formal, voluntary group therapy, with emphasis on relating the group to the entire situation, or community, within the hospital.

Utilizing group meetings as the core of their program, they encouraged the patients who were further along

in their treatment to assume responsibility for other members of the group, to the point where the patients themselves made up their own psychotherapeutic group, conducting the sessions often in the same way the physician would have, "and sometimes even better." Their professed aim was to "make a psychotherapist out of every patient." Apparently the element of trust and confidence in one of "their own" was involved, as well as the belief that by developing an interest in and understanding of his neighbor, the patient himself would be helped.

These examples, hopefully, point up an interest in a re-definition of treatment of psychiatric patients that involves all aspects of the treatment situation. Such a concern, regrettably, has thus far made only slight inroads on the more traditional custodial-type treatment evident in the mental hospitals of this country. Efforts such as the Exit Service program, the Member Employee program (now being replaced by a different "incentive therapy" plan), and sheltered-workshop programs, although not widespread, are encouraging trends. Each of these, in some way, is an effort to utilize existing opportunities, including treatment funds, to provide a situation more like the environment to which the patient will ultimately return. Treatment, including counseling, can be done within a meaningful context, including more "normal" social, recreational, and vocational aspects of life.

Hoped-for Outcomes: Selection of Criteria

In such a study as the present one, an obvious concern is the measurement of outcomes of the treatment program. Two major independent variables are the basis of the present study: (1) group counseling and (2) the treatment situation. A frame of reference for use of the term "group counseling" and the importance of the treatment situation have been considered. In order to determine the effect of these variables on the behavior of patients, criteria and means of evaluating change in relation to the criteria must be selected. A review of the literature on outcomes of counseling and psychotherapy reveals such a diversity of ideas that a need to delimit the present study becomes quite apparent. The approach to selection of criteria was to consider many of those used previously in similar settings, and to choose from these the ones deemed most appropriate.

Ford (1959, 57) takes the stand that

It is now quite clear that it is fruitless to deal with global and extremely heterogeneous variables such as "Improvement" or "Personality change." . . . The client variables selected for study should reflect those behavior patterns the therapy is intended to change and related variables which have a bearing upon the way in which the change may be brought about.

Ford believes that variables involved in the interpersonal relationship between client and therapist are (1) affect--the extent of positive or negative feelings directed toward

the other person, (2) control--the extent to which each individual attempts to direct or control the behavior of the other or allows himself to be controlled, and (3) confidentiality--the extent to which experiences and behavior previously inaccessible to the observation of others are brought into the open and dealt with. He states that Snyder, Ford, Urban, and Ray have been developing such dimensions.

Wright (1956, 1959), in a study especially pertinent to the present investigation, was instrumental in establishing the first Exit Unit program in a veterans' administration Np hospital setting. He attempted to (1) provide a testing situation in which a patient's ability to cope with increased freedom and responsibility could be more adequately appraised by staff and (2) provide laboratory-type learning experiences in the areas of financial management, recreational activities, basic social and psychological adjustment skills, occupations, and community living accommodations. His criteria were environmental: ability to live and work in the community; ability to live at home satisfactorily but without being employed; employment on the Member Employee program; living in the hospital as a night resident while working in the community; or approved for discharge, awaiting employment. He (1959, 119) concluded:

These results indicate that, in terms of its objectives, the Unit was more effective than the regular hospital routine. Furthermore, it was shown that there was a fair degree of stability in these results.

There is, however, a significant point not clearly focused in the Wright study. Was it the "situation," the "special attention" received by the experimental group, the "individual counseling," the "group counseling," or a combination of these that made the "Unit more effective"? It would seem desirable to attempt, by means of additional controls, such a discrimination. Such an effort has been made in the present study.

Similar criteria--release from hospital and length of time remaining in the community--were used by Vernalis and Reinert (1961, 12). They agree that treatment cases had significantly more time in the community than controls, but carefully pointed out several possible weaknesses both in methodology and selection of criteria, including: (1) change of 12 matched pairs after the experiment was well under way; (2) moving to new buildings during the treatment period; (3) resistance to the tests used; (4) the decision to use the criterion "time in the community" over a year after the study was begun (although they had accurate data); (5) the number of sessions varied from 12 to 217, with no indication as to whether these varied equally for experimental and control groups. They emphasize a major weakness in using the criterion "time in the community" as being doubt as to the validity of "adjustment," there being too many variables determining whether a patient stays out of the hospital (understanding relatives, employers, etc.). Also, the patient

may place varying degrees of strain on the community or family by his behavior.

Several studies (Straight, 1960; Wright, 1959; Luborsky, 1962; Peters and Jones, 1951; Gersten, 1951) have been interested in improvement of some phase of social adjustment, social maturity, or quality of interpersonal relations. Straight, doing a follow-up of the Vernallis and Reinert study, was not satisfied with their criterion of "social adjustment," and although finding positive trends, could report no significant results in favor of group psychotherapy. Peters and Jones (1951), testing Negro male schizophrenics before and after a four-month treatment period, found significant differences in favor of the treated group. In addition to improved social adjustment, they report improvement in understanding, performance facility, and motor reactions.

Closely related to "social adjustment" as a criterion are "responsible behavior" and "effect of patient on his environment," which are seen as important by Patterson (1963), Robinson (1955), and Luborsky (1962). Improvement in "usage of abilities," "work performance," and "academic performance" (Luborsky, 1962; Wright, 1959; Stotsky, et al., 1955; Peters and Jones, 1951; Spielberger, 1962; Gersten, 1951; Sheldon, 1950) are other criteria which have been used successfully in showing the efficacy of group treatment procedures.

Another group of criteria is based on the ability of the individual to adjust to his problems, discomfort, or distress (Gersten, 1951; Luborsky, 1962), with reduction of anxiety or fear (Mowrer, 1951, 1953, 1960; Shoben, 1954) and emotional release (Gersten, 1951). This type of criterion is in many ways comparable to "counselee satisfaction," which continues to come in for its share of both negative and positive criticisms. Cundick (1962), after reviewing the limitations set forth by Hathaway (1948) and Patterson (1959), took this as the criterion for comparison of student and counselor expectations in counseling. He concluded that the arguments of Forgy and Black (1954) and Grigg and Goodstein (1957) outweighed those against the use of "counselee satisfaction" as an outcome criterion.

Robinson (1955) states that "The ultimate criterion of effectiveness is the client's behavior outside of the interview," but that the counselor has to use immediate symptoms, such as willingness to talk, take responsibility, statements of insight, etc., as his criteria within the counseling situation. However, he points out that these immediate symptoms have no significance unless related to later expected outcomes, such as fuller use of skills or growth in maturity. Patterson (1962) also stresses the fundamental need of communication, or oral expression on the part of the patient, as does Chenven (1953), in order to arrive at self-understanding and insight, which are more

ultimate goals of counseling (Patterson, 1963; Peters and Jones, 1951; Robinson, 1955; Gersten, 1951). On the basis of such observations as these, the use of some measure of verbal behavior as a means of assessing the effect of counseling seems logical.

Paving the road toward "autonomy," "self-direction," and "self-actualization" (Allport, 1955, 1963; Luborsky, 1962; Rogers, 1961; Patterson, 1963; Shoben, 1954, 1963; Jahoda, 1958; Maslow, 1955, 1963) are to be found criteria such as "breadth and depth of interests" (Luborsky, 1962), "openness" and "flexibility" (Rogers, 1961; Shoben, 1954, 1963; Rokeach, 1960; Kemp, 1960), "integration," "organization," and "self-ideal self congruence" (Rogers, 1961), as well as "adaptiveness" (Rogers, 1961) and a "time-binding capacity," or as Shoben (1954, 48) phrases it, "a foresighted evaluation of the various situations with which he must deal." Some adaptation of these criteria would seem to be appropriate for the present study.

Selection of the criteria

From such a sampling of outcome criteria, and the list could be extended, it is indeed obvious that the experimenter must arbitrarily choose those criteria which, because of the specific situation, personal interests, operational definability, and pertinence to the proposed study, seem most appropriate. Jensen, Coles, and Nestor (1955, 59) set forth some desirable characteristics of a criterion variable

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as being (1) definable, (2) stable, (3) relevant, (4) applicable to the general population as well as to the sample, and (5) knowledge of the "ultimate-immediate" nature of the variable.

Of special interest in selecting the criteria is the population being studied. A very practical goal in treatment of mental patients is that of successful rehabilitation in the community. It is certain that the "observed characteristics" of the patient are a determining factor in his acceptance or rejection by family or community. Thus an attempt was made to limit the selection of criteria to those which are either directly observable or are expressions of attitudes, themselves observable in the act of expression.

The three major criteria finally selected, with their specific definitions (in terms of sub-criteria) as used in this study are: (1) "general observed behavior"--including attitude toward self and others, motivation to leave the hospital, aggressiveness toward others, independence, competence, cooperation, socialization, participation in available activities, realism of plans for the future, expression of emotion; (2) "verbal behavior"--defined in terms of fluency and rate of talk, appropriateness of remarks and affect, anticipation of outcomes and optimism toward the future, attitude toward self and others, interpersonal relations, cooperation and ability to relate to the interviewer, openness to experience or change, autonomy, realism of plans for

the future (including motivation to leave the hospital and time-span of plans); and (3) "attitude toward self in relation to others and the future"--defined as degree of optimism, self-other concepts, and openness or willingness to change.

Review of literature pertinent to specific criteria

The review of literature regarding outcome criteria reveals some references that are especially pertinent to the specific criteria selected for this study. Jahoda (1958), Caplan (1957), Kelman and Parloff (1957), Balester (1956), Ewing (1954), Friedman (1955), Chodorkoff (1954), Chase (1957), Rogers (1951), Rogers and Dymond (1954), Corsini (1957), Stephenson (1953, 1935), and many others have examined, at great length, the self-concept as a criterion in counseling and psychotherapy. Jahoda (1958, 23ff.) comes up with six major categories or criteria for positive mental health: (1) attitudes of an individual toward his own self; (2) growth, development, or self-actualization; (3) integration; (4) autonomy; (5) perception of reality; and (6) environmental mastery. She (1948, 25) sees the aspects of the self-concept that stand out most clearly as being accessibility to consciousness, correctness, feeling about the self, and sense of identity. The term "self-actualization," as used by Jahoda, Rogers, Maslow, etc., implies a movement forward, thus in many ways is similar to the intent of the present experimenter

to stress the "attitude of the self in relation to others and the future," which criterion is operationally defined in Chapter III.

Allport (1955) and Maslow (1955) are in agreement that the individual experiences pleasure in maintenance of tensions in relation to self-actualization of potential capabilities, in devotion to a mission in life or a vocation, etc. Allport (1955) says that growth motives "maintain tension in the interest of distant and often unattainable goals." Maslow (1955) found that self-actualizing people "in general focused on problems outside themselves," . . . and are capable of deeper and more profound interpersonal relations than any other adults.

Balester (1956, 1169) gives the following operational definition of self-concept, ". . . the manner in which an individual reflectively ascribes a number of statements to himself." In his study with juvenile delinquents, among other findings he lists "The magnitude of the positive Q-sort self-concept score is related to the quality of adjustment. Good adjustment is associated with more positive Q-sort scores." Chase (1957, 497) found that psychiatrically maladjusted groups may be distinguished from adjusted groups on the basis of self-concept. He concludes:

The maladjusted subjects . . . tended to perceive themselves as quite different from their ideals and from their concepts of the average other person. It is suggested that this dissimilar perception of self reflects a realistic

appraisal of the self in relationship to other selves in contrast to the beliefs of many who hold that severely disturbed patients are incapable of such appraisal. . . . The data in the present study may also be seen as confirmatory evidence for the hypothesis that lower self-esteem is closely associated with maladjustment.

Caution is urged, however, in accepting individual sorts with too high confidence. "Maladjusted subjects may sort items so as to yield spuriously high correlations." Chase feels that due to possible spurious individual sorts, only the group results are valid, and that any individual deviation could have occurred by chance.

Ewing (1954) correlated changes in client ratings of self, ideal self, father, mother, and counselor's estimate of improvement in personal adjustment during counseling. He noted that clients who were estimated to be most improved tended to be those who (1) change their rating of "self" toward that of "ideal," "counselor," and "culturally approved"; (2) change rating of "ideal" toward second rating of "self" and "counselor"; (3) change rating of "counselor" toward second rating of "self" and second rating of parent of same sex as the "counselor"; (4) change ratings of parents as they relate to the other figures; and (5) change each figure somewhat toward all of the other figures.

In a recently reported study Bass and associates (1963, 110) found a significant correlation (beyond the .01 level of confidence) between self-orientation and

(1) dogmatism, (2) disagreeable, and (3) aggressive-competitive. Another of their findings of interest here was that "task-orientation" was found to correlate significantly with lack of dogmatism, as well as with "self-sufficient-resourceful." Such findings would seem to have implications regarding plans for the future.

Even more to the point are some of the findings in Lippitt's (1940, 118) classic research, in which he attempted to answer Lewin's question, "What changes in the perceived structure of the psychological present lead to a change in the structure of the psychological future, and what are the laws governing the interdependence of these two parts of the psychological field?" In his studies of democratic and authoritarian group atmosphere, Lippitt noted:

The future, in terms of the general steps from the present to the group goal, existed quite clearly in the cognitive structure of each democratic group member. . . . For the authoritarian member the future perspective ended almost entirely with the immediate activity of that particular club meeting. . . . The future remained unknown, in the possession of the leader, and even the structure of the immediate situation was rigid, for the leader directed each member toward a particular activity goal which he structured for the member.

This seems relevant both to the counselor and to an understanding of the process of goal-structuring. In Lewinian field theory there is a dual point of view: on the one hand the present influences the view of the future; on the other hand the view of the future and the past conditions one's feelings regarding the present.

Lewin (1951, 75) expresses the importance of future-orientation on shaping the life pattern:

The behavior of an individual does not depend entirely on his present situation. His mood is deeply affected by his hopes and wishes and by his views of his own past. The morale and happiness of an individual seem to depend more on what he expects of the future than on the pleasantness or unpleasantness of the present situation.

Another attempt to pinpoint the influence of goal-structure and future-orientation was undertaken by Fink (1953), who studied the relationship of time-perspective to age, institutionalization and activity. A very pertinent finding indicated that institutionalization is a more potent factor than age in influencing time-perspective. Institutionalization was associated with a channelizing of the time perspective into the past.

That certain aspects of an individual's orientation to the future can be utilized as a criterion for differentiating "degree of progress" of a mental patient is indicated by Wallace (1956, 240). He defined future time perspective as "the timing and ordering of personalized future events," and examined two dimensions: extension--the length of future time conceptualized, and coherence--the degree of organization of the events in the future time span. He hypothesized that if future time perspective were significantly affected by mental disturbance, then schizophrenics would differ from normals on these two dimensions. His data supported his prediction on both counts. Extension scores were higher

for normals, and although there were some inconsistencies as far as coherence scores were concerned, Wallace concluded that normals were superior to schizophrenics as to ability to order the contents of the future time span logically and meaningfully.

Bonier (1957) studied time perspective in relation to belief systems, using Rokeach's (1960) dogmatism scale to designate groups of "open-minded" and "closed-minded" college students. He had them tell stories to five TAT cards, and as his criterion of concern for the future, he used the proportion of future tense verbs each subject used in his stories. His results suggested that closed-minded S's were more concerned regarding the future than were open-minded S's. He also found that on the basis of TAT stories and Taylor Manifest Anxiety Scale scores, closed-minded S's were more anxious than the open-minded S's. This was interpreted by Bonier as by Rokeach. The closed-minded group, in greater need of cognitive structure, reduces the ambiguity of the future by imparting to it a structure that it does not have. Both the concern of the closed-minded S's for the future and the high level of dogmatism are related to their anxiety and can be interpreted as means of defending themselves against threat.

Writing on "Time Perspective, Dogmatism, and Anxiety," Bonier (1960, 366) later states:

A person may be said to have a broad time perspective if what he does is influenced not only by his conception of the present situation, but

also by his appreciation of past events leading up to the present, and by his anticipation of future outcomes. On the other hand, a person may be said to have a narrow time perspective if he is too greatly oriented in the past, or the present, or the future.

A recent study by Pavey (1961, 32-35) distinguishes between different types of concern regarding the future.

He affirms that

Different kinds of concern, arising out of distinct sources, can and must be distinguished in the interest of conceptual clarity. On the one hand, there is concern for the future that is relatively free from anxiety, which occurs as a normal and necessary anticipatory function. While it still may be generated by anxiety, it is accepted, culturally-prescribed anxiety, motivating but not incapacitating. The middle-class values of making plans for one's education and vocation, for financing one's children's education and one's old age--even making plans for one's own death--are within this normal realm.

The present study is interested in this type of orientation to the future, rather than the concern for the future that is not so constructive, but rather born of the threat of ambiguity and attempts to make the future more definite than it is, to provide it with a structure it does not possess.

Considerable effort has been directed in recent years toward an understanding of the "belief-systems" of a person. An individual's belief system includes both beliefs and disbeliefs, and may be located somewhere along a continuum that stretches from open to closed. Rokeach (1960, 57) defines a belief system as being open or closed on the basis of "the

extent to which the person can receive, evaluate, and act on relevant information received from the outside on its own intrinsic merits, unencumbered by irrelevant factors in the situation arising from within the person or from the outside."

The descriptions of psychological anomie and closed-mindedness appear to have much in common. Rokeach (75), looking at the background of closed-minded individuals, sees feelings of aloneness, isolation, helplessness, and, hence, anxiety about what the future holds for them.

Pavey (1961, 35) affirms, "Indeed, concern for the future, anxious concern, is one of the dimensions along which belief systems may be analyzed." An intensive evaluation of this dimension serves as the basis for his doctoral dissertation. Following Rokeach's analysis, he asserts that the closed-minded individual defends against his anxiety regarding the "not knowable future" by declaring a rigid knowledge about it that remains unshaken even in the face of "facts" in the present. Open-minded persons are assumed to have a cognitive system which is more truly cognitive and less a defense against anxiety. According to this view the open-minded person should conceivably respond more favorably to stimulation designed to promote interest in making specific plans for the future, both immediate and remote, even though this might prove anxiety-laden. The closed-minded individual would be expected to resist the making of such plans, as a defense against anxiety.

Pavey did find a significant difference, as predicted, in pre-test concern regarding the future, with his closed-minded group evidencing the greater concern, as Bonier (1957) had declared. In discussing implications for further research, Pavey (32) maintains that:

Eventually, what we find in the laboratory about modifications in future time perspective should be applicable to "real life" situations. In psychotherapy, for example, we should expect to find changes in future time perspective associated with various phases of the treatment, including the outcome. Indeed, modification of future time perspective may well be a vital criterion measure for success in psychotherapy.

A comprehensive description of the functions of belief-disbelief systems is given by Rokeach (1960, 67-69). He asserts that two powerful and conflicting sets of motives are simultaneously served: (1) the need for a cognitive framework to know and to understand and (2) the need to ward off threatening aspects of reality. The first is related to the open belief system, the second to the closed system. He (68) proposes:

. . . that for most persons in most situations, both sets of needs operate together to one degree or another. A person will be open to information insofar as possible, and will reject it, screen it out, or alter it insofar as necessary.

The more closed the belief-disbelief system, Rokeach believes, the more it represents a tightly woven network of cognitive defenses against anxiety. Thus, conceivably, by means of such treatment as group counseling, the individual

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might be able to restructure his cognitions, with a concurrent opening of the belief-disbelief system.

It appears evident that much of the suffering endured by the institutionalized mental patient is related in some way to a feeling of hopelessness and lack of power to do anything about their status. Goals, either short or long-term, are in many cases entirely lacking. Life seems to be something to simply be endured from one day to the next, often by regression into reverie concerning the past or by escaping into some delusional or hallucinatory system.

This situation is not, of course, confined to institutionalized mental patients, as much recent evidence indicates. In his review of a recent book by a group of sociologists (Srole, et al., 1962), Murphy (1963, 36) cites some staggering evidence. On the basis of psychiatric judgments of interview protocols of a randomly selected group of 1660 persons in Midtown Manhattan, only 18.5 per cent were considered "well," with 36.3 per cent showing "mild symptom formation." The remainder, nearly half the total group, showed more severe evidence of suffering, according to the psychiatrists' evaluations. Murphy (36) believes:

If one looks more closely at the specific form taken by this unhappiness, it may, as Dr. Srole had pointed out in earlier writing, represent what French sociologists have called anomie. The Greek term *nomos* means norm or code. . . . Insofar as a society loses *nomos*, its members have less adequately defined standards, codes and values. . . . Pathology might take the form of too little *nomos* or too

much. It would appear from the material gathered by Srole and his associates that there is too little in Midtown. The society in fact seems to be sick partly as an expression of the fact that nomos is weak; in other words, there is much anomie.

Findings of the above study indicate strongly that both increasing age and lower socio-economic class correlate highly with anomie.

This type of evidence points to the possibility that degree of anomie, or its opposite--nomie, might well be used as a measuring rod to indicate the effect of hospital treatment, such as group counseling. Elmore (1962) has aided greatly in clarifying the concept of anomie in psychological terms. The roots of the term, as indicated by Murphy, can be traced back to the Greek, but "anomie" was given prominence in the social sciences by Durkheim in the 1890's. Only quite recently has it been adapted to describe the psychological reaction of individuals to (for them) ". . . a disrupted society, wherein the lack of dependable or consistent standards for action and the absence of structure and support cause the individual to become confused, frustrated, and defeated by a seemingly chaotic, meaningless, and uncaring world" (Elmore, 160).

In developing his scale for measuring psychological anomie, Elmore's intent was to pinpoint anomic characteristics of the individual, whereas most previous references to this concept had been related to society as a whole.

Noteworthy exceptions such as the writings of May (1961) and Davol and Reimanis (1959) are mentioned by Elmore. May believes that feelings of loneliness, emptiness, vacuity, and hollowness are characteristic of a large part of present society, and lead to neurotic anxiety, and that this occurs as a consequence of society giving no clear picture of "what we are and what we ought to be." This, of course, sounds almost identical to the findings of the Srole study, as reported by Murphy (1963).

Maslow (1963), in a recent lecture, has expressed the view that meaning in life, or in his terminology, "values" are more difficult to attain and maintain in such a society as ours. This, he believes, is due to a feeling of "Once the basic, primary needs of safety, food, shelter, etc., are met, why strive beyond?" He maintains that neurosis is a product of a high level of cultural development in an affluent society, and that zestfulness, purposefulness, etc., are more prevalent in that society where the focus is on the meeting of primary needs. This seems to be a further elaboration of his earlier contention that valuelessness is the predominant "disease" of our day (1959). His explanation of this term refers to such states as amorality, rootlessness, emptiness, alienation, and hopelessness. It is the "lack of something to believe in and to be devoted to."

Frankl (1959, 1962, 1963) has gone to great effort, both in his books and by means of personal speaking tours,

to emphasize the desperate need of the individual to find meaning in his life. In speaking of the "existential vacuum" he is presenting a picture of the truly anomic person. His criterion of adjustment is the extent to which a person feels there is some meaning in his life. Meaning is to be found primarily in the achieving of certain tasks and in personal relationships with others, but in an anomic society the means of such achievement are not easy to find.

Maslow (1963) seems to carry this theme to its ultimate conclusion, "If there is nothing we're willing to die for, we suffer from valuelessness." Contrasting the anomic person and his opposite, he characterizes the nomic person (or opposite) as being zestful and serene, dedicated, committed to something outside himself. Speaking of such ultimate values, long-term goals, or causes, Maslow asks, "What do you live for when you have plenty of money?" His answer is in terms of self-actualization. This seems to the writer to involve a never-ending cycle of striving to achieve short-term, personal goals within a continuously evolving frame of reference, total-goal-structure, or philosophy of life.

Prevalent in this type of philosophy is the idea that one of the major goals of counseling is that of assisting the individual to become more self-directing and autonomous. This includes the achievement of greater insight and self-acceptance as well as the development of values and a future-orientation that is uniquely one's own, yet congruent with the demands of social living.

Shoben (1963) calls for a genuineness in the counseling relationship that will meet the affiliative needs of the client in such a way as to enhance his positive self-regard and self-discovery. He calls for a viable culture which will increase the range of individual differences, and challenges the counselor to aid the client in such self-determination. Allport (1955, 1963) calls this process "functional autonomy," which he has aptly termed "moving the backbone from the outside to the inside of the body." He believes that counselors may be too protective at times, and that we should let the "coping-process" of individuals alone insofar as possible. However, the findings regarding anomie would seem to indicate that too loose or ambiguous an environmental structure, including the counseling relationship, while perhaps the antithesis of over-protectiveness, may be just as damaging to the individual. This idea seems particularly worth considering in the case of the institutionalized patient who has grown so dependent that his "coping-process" has "ceased to cope." In many cases it would seem appropriate to provide a setting where the patient can gradually regain (or learn) characteristics of independence and a flexible autonomy in his approach to both daily life and future orientation.

Berdie's (1959, 176) declaration that "The purpose of counseling is to assist persons to select goals and objectives and to discover means for obtaining these goals" emphasizes

this point. As he goes on to point out, it is important to recognize our own dogmas or set of values, and to examine them critically. Essentially the purpose of this chapter has been to do just that, in an effort to clarify some of the important outcomes of treatment. The criteria chosen for the present study undoubtedly reflect the experimenter's present value structure. It is believed that the present study will be of worth in indicating what, if any, modifications of behavior can be effected by the proposed treatment, as measured by these criteria.

To sum up, such a sampling of the literature makes obvious both a great diversity of opinion and many common views as to desirable outcome criteria to be used in a study of the effects of counseling. The field from which the criteria for the present study were chosen was seen to include: length of time out of the hospital; social adjustment, interpersonal relations, social maturity, responsible behavior; self-understanding or insight; adequacy of oral expression or talk ratio; reduction of anxiety or emotional release; seriousness of symptoms or discomfort; academic or work performance, ability to use abilities; effect of the patient on the environment; autonomy or self-direction; openness or flexibility, breadth and depth of interests; time-binding capacity or future orientation; integration and organization; self-concept; anomie and its opposites--zestfulness, adaptiveness, and self-actualization.

The final selection of criteria was based on such considerations as the population under study, the specific situation, personal interests of the experimenter, operational definability, relevance to the study, and applicability to the general population as well as to the sample used for the study. A special effort has been made to provide a background for the specific criteria finally chosen, particularly those which are less commonly used as outcome measures. Such emphasis centered on the self-concept, dogmatism or closed-mindedness, future time-perspective in relation to belief-systems, and anomie--including feelings of meaninglessness, valuelessness, and hopelessness.

On the basis of the evidence presented, the writer expressed the value-judgment that a major goal of counseling should be that of assisting the individual to become more self-directing and autonomous. Such a goal was seen to include helping the patient work toward increased insight, self-acceptance, and the development of values, a life-philosophy, and a future orientation uniquely his own, yet congruent with the demands of social living.

CHAPTER II

STATEMENT OF THE PROBLEM

Purposes of the Study

Having selected the criteria believed to be appropriate as measures of the effect of group counseling, a more specific statement of the purposes of the present study can be made. Both group counseling and the setting within which it is done are major considerations. The first of these involves the development of a clearer definition of the role of group counseling in an institutional setting. This means determination of the effects of group counseling as a treatment method. The second major objective is to examine the effects of a treatment setting designed to foster the development of individual freedom and initiative, as well as personal responsibility in regard to present activities and planning for the future. Thus, an attempt will be made to distinguish between the effects of the counseling itself and the situation in which it occurs, a distinction, it is believed, that has not been clearly made in previous studies of this nature (Wright, 1956; Stotsky, et al., 1955).

Another, although less explicit purpose of the study is to contribute to the understanding of the role of counseling psychology in the institutional setting, and of the group counseling process in particular.

The Hypotheses

Arising out of the purposes just stated are the two major experimental hypotheses of the study:

H I: Regular hospital activities plus group counseling is a treatment milieu more conducive to positive behavioral change than is regular hospital activities without group counseling;

H II: An extended-privilege setting provides a treatment milieu more conducive to positive behavioral change than does a continued-treatment setting.

"Positive behavioral change" is defined, for the purposes of this study, in terms of the three major criteria and twenty-one sub-criteria. The two settings are described in Chapters III and IV. Specific hypotheses relating the major and sub-criteria to the above two major experimental hypotheses will now be stated, together with the instruments for evaluating each criterion.

A. "General Observed Behavior"

1. The general observed behavior of those patients receiving group counseling in addition to regular hospital activities will show greater positive modification than will that of patients engaged in regular hospital activities but receiving no group counseling.

2. The general observed behavior of patients living in an extended-privilege setting will show greater positive modification than will that of patients living in a continued-treatment setting.

- a) Modification of general observed behavior will be measured in terms of motivation to leave the hospital, observable actions and habits, aggressiveness toward others, ability to function independently and competently, cooperation and socialization, appropriateness of expression of emotion, and realism of plans for the future.

b) General observed behavior will be measured by means of observer (Staff) ratings, using the Hospital Adjustment and Placement Scale (HAPS).

B. "Verbal Behavior"

1. The verbal behavior of those patients receiving group counseling in addition to regular hospital activities will show greater positive modification than will that of patients engaged in regular hospital activities but receiving no group counseling.

2. The verbal behavior of patients living in an extended-privilege setting will show greater positive modification than will that of patients living in a continued-treatment setting.

a) Modification of verbal behavior will be measured in terms of appropriateness of fluency and rate of speech, appropriateness of remarks and expression of emotion, anticipation of outcomes or optimism toward the future, realism of regard for self and others, interpersonal relations as evidenced by cooperation with and ability to relate to interviewer, openness to experience, independence and competence, and realism of plans for the future.

b) Verbal behavior will be assessed by qualified judges using the Judges' Rating Scale for Verbal Behavior. Judgments will be based on taped protocols of individual interviews.

C. "Expressed Attitude toward Self in Relation to Others and to the Future"

1. The expressed attitude toward self in relation to others and to the future of those patients receiving group counseling in addition to regular hospital activities will show greater positive modification than will that of patients engaged in regular hospital activities but receiving no group counseling.

2. The expressed attitude toward self in relation to others and to the future of patients living in an extended-privilege setting will show greater positive modification than will that of patients living in a continued-treatment setting.

CHAPTER I

BACKGROUND OF THE PROBLEM

Introduction

A growing interest in counseling, especially group counseling in a neuropsychiatric (Np) hospital setting, developed into the present study. Preliminary investigation revealed little formal research aimed toward a clarification of the outcomes of such counseling. The general role and function of the counseling psychologist in such a setting, as distinguished from those of the clinical psychologist, while partially established during the past decade, seemed in need of further definition. These interests were coupled with a deepening conviction that maintenance or development (on the part of the patient) of a high level of activity and personal responsibility would result in earlier rehabilitation in community living.

Those acquainted with life in an Np hospital are aware that in most cases the patient sooner or later reaches a point where his "illness" becomes less acute, or to some degree reaches a state of remission. In many cases this point is achieved with little or no overt recognition on the part of members of the hospital staff or administration.

Some patients remain in such a state of "remission" or "partial remission" for years, often in a situation providing only very limited privileges or chance to develop or

a) Modification of this criterion will be determined by changes of attitude expressive of psychological anomie, degree of congruence between concept of self and concept of other ("the typical, well-adjusted person out in the community"), and open-mindedness.

b) The three sub-criteria relating to "expressed attitude toward self in relation to others and the future" will be measured as follows: degree of anomie, by the Elmore (1962) Scale of Psychological Anomie; congruence of self-other concepts, by Corsini's (1956) Standard Adjective Q Sort; and open-mindedness, by means of Rokeach's (1960) Dogmatism Scale, as adapted by Swearingen (1963).

CHAPTER III

PROCEDURE

This chapter will present the procedure used in testing the hypotheses, including descriptions of the design, the evaluation process, and the instruments.

The Design

The general setting

Since the setting is of central importance in the present study, a rather complete description will be provided. The setting was the Veterans Administration Neuropsychiatric Hospital located approximately four miles north of Chillicothe, Ohio. This is one of the larger of many such installations throughout the country, providing treatment facilities for 2100 male veterans. The spacious grounds are beautifully located in a green, wooded, gently rolling area in the valley of the Scioto River, in south-central Ohio. An atmosphere of semi-isolation from community and world events appears to be a major drawback of the location, adding to the problems of extra-hospital recreation, employment, and placement, and making it difficult in general for the long-term patient to remain (or become) oriented to life outside the hospital.

The facilities of the hospital compare favorably with those of other such institutions in the provision of such opportunities as recreation, education, development of hobbies and occupational skills, and personal adjustment on

work assignments. A recent welcomed addition was a new inter-faith chapel. Bus lines provide fairly easy access to surrounding areas.

In addition to regular hospital services, such as nursing, medical, social service, psychology, psychiatry, and occupational, educational and physical therapy, many service organizations regularly lend support with volunteer services and activities.

A comparison of the two settings involved in the present study yields further understanding of the total treatment situation. The foregoing description applies to all the various hospital units, but the degree of utilization of such services and activities varies considerably from unit to unit. This is seen to be partly a function of physical aspects of the buildings, but more often seems due to administrative and staff decisions and procedures.

To enable the evaluation of such a setting as that described in Chapter II, two units were selected. One, Unit I, was composed largely of continued-treatment patients (those past the acute stages of illness, and stabilized to at least some degree). The second, Unit II, seemed to match the description of the setting described in Chapter II in regard to provision of extended privileges and an atmosphere of "movement" toward life in the community outside the hospital. (Unit II houses the "Exit Service" program, which was developed largely as the result of the Wright study.)

Unit I, the continued-treatment unit, will be referred to from here on as CT Unit, while Unit II, the extended-privilege unit, will be known as EP Unit. These units were conveniently located, adjacent to one another.

CT Unit is a large, two-story, H-shaped brick structure containing central offices for medical, nursing, and other personnel, both dormitory and semi-private sleeping quarters for the 240 patient population, and day-rooms--providing opportunity for TV, pool, cards, reading, writing, and visiting--in each of the four wards. At the time of the study all wards were unlocked, as was the building, from 8:00 A.M. to 9:00 P.M.

Both group and individual activities were engaged in throughout the day, with each patient going to a regular job assignment, therapy, special appointments, etc., at scheduled hours. Most daytime activity was carried on in other units. Setting up of assignments, and unit regulations were primarily administrative responsibilities, although soon after the treatment period was started an effort was made to institute a type of patient-government. This seemed to be well received by a majority of the patients.

In contrast, EP Unit is a much smaller, two-story, U-shaped brick structure. It provides sleeping accommodations for only 74 men, in dormitory-type facilities on the 2nd floor. The main floor contains offices for staff, two large day-rooms with facilities similar to but more extensive than

those of Unit I for recreational purposes. Candy, soft-drink, and ice-cream vending machines are available at all times.

During the treatment period the building was open from 8:00 A.M. to 11:00 P.M., two hours later in the evening than for CT Unit. A much broader range of activities, especially work assignments, was available. Whereas in CT Unit many activities involved all members of a particular ward, more allowance for individual choice of program was available on EP Unit, especially after the first few weeks a patient spends there.

The nature of some of the special programs of EP Unit was indicative of an atmosphere of optimistic expectancy regarding rehabilitation plans and movement toward the community. That is, a new member of the unit came into a "Portal Group," where orientation to the general "Exit Service" program was carried out. In from three to six weeks most patients would become full members of "Exit Service," with increased privileges such as leave and pass privileges, more funds available, etc. A group of "Night Residents" lived in the building, going into town to work during the day. Another group to which many aspired was the "Member Employee" group, which, although living in a separate building, were chosen from Exit Service rolls, and while living on "Trial Visit" status, were paid substantially for their work.

A considerable amount of self-government (with administrative support and guidance) existed. The "Patient Assembly" met once each week to discuss plans for improvement of the general program, recreational events, trips to industrial plants, etc. A "Rehabilitation Educational and Advisory Committee" met weekly, serving not only therapeutic ends for committee members, but meeting service needs for the entire unit by suggesting modifications or innovations in regard to the existing program.

Expectancy of "movement" was also inherent in the one-year maximum time limit for residence in the unit. This time limit, together with the features of the program outlined above, resulted in a rapid turnover rate as compared with other units. Exit Service members were "expected" to be more self-sufficient and responsible, not only in regard to work assignments, but in taking fuller advantage of pass and leave privileges, helping plan and carry out maintenance functions around the building, and in making realistic plans for the future.

Administrative arrangements

The study was made possible not only because the experimenter was interning at the hospital, but also because of a research-oriented administration and staff. Without the extensive cooperation and support of the many personnel and services involved the study would never have been started. Clearance for the project, including use of hospital facili-

ties, materials, and personnel, was prerequisite to the study itself, and involved many consultations.

Selection of the sample

The entire sample for the study was drawn from CT Unit, then a randomly selected half of the subjects were transferred to EP Unit for the treatment phase of the study. It was desirable to obtain a sample of at least minimally stabilized patients with some potential for vocational rehabilitation. The screening criteria used to choose such a sample were: (1) not over 55 years of age; (2) not known to be leaving the hospital within the four months required for the study; (3) not carrying "alcoholic" as a major diagnosis; (4) not extremely aggressive or suicidal; (5) at least fairly good "contact with reality"; (6) no extremes of "deviant behavior"; and (7) literate enough to satisfactorily undergo the testing program. It is to be noted that the provision about alcoholism was based on previous experience in EP Unit, as well as studies such as that of Stotsky (1955, 274), in which he found that either present difficulty with alcohol or difficulty prior to the past two years were major reasons for failure of patients on the VA Member-Employee program. Parenthetically, two such patients slipped by the screening process in spite of precautions, and later became two of the dropouts.

The screening process itself was composed of several steps. First, a roster of the 232 patients in CT Unit was checked for the age limit of 55. This eliminated 49, leaving

183 who were 55 years of age or younger. This list was then presented, along with the 6 criteria for selection, to the staff personnel of CT Unit, including one nurse and five nursing assistants (aides). They were instructed to (1) circle the names of those patients who were leaving the hospital within 4 or five months, carried "alcoholism" as a major diagnosis, were extremely aggressive or suicidal, extremely low in reality-contact, exhibited extremes of culturally taboo or deviant behavior, or were illiterate; (2) star those they felt strongly about; (3) double-star those there was just no doubt about; (4) identify those starred with the number (1-6) of the criterion that fit the patient.

Any patient was eliminated from further consideration who was designated (a) by at least four staff members or (b) by at least three staff members where all three checked the same screening criterion. Where two or three staff members circled the same patient's name but gave different reasons, he was then discussed with each of the staff members before inclusion in or exclusion from the sample.

Two other steps were carried out prior to pre-treatment evaluation. The roster (after nursing-staff screening) was studied by the CT Unit Psychiatrist and by the Supervisor of EP Unit, each of whom contributed to narrowing the population pool to a total of 71.

Since confounding of results would undoubtedly occur in case any subjects were involved in other group projects

of a nature similar to group counseling, all therapists known to be conducting group work were contacted, and no such subject was included in the final sample.

The last phase of the screening process was the pre-treatment evaluation. Of the 71 subjects who started, 61 were adjudged to have satisfactorily completed: (1) the verbal scale of the Wesman (Appendix I), with a score of 23 or above; (2) all other tests; and (3) a 10 to 12 minute individual interview with the experimenter.

The final sample of 61 included the 52 subjects and 9 alternates. The "typical" subject was a single, male, 42 year old patient, who had received 10 years of schooling, carried a psychiatric diagnosis of schizophrenia, and had been hospitalized for 8 years. To be more exact, the age range of those 46 subjects who completed the treatment was 25-55, $M = 42.4$; education range was 3 to 18 years of school, $M = 9.8$; length of hospitalization was from 6 months to 22 years, $M = 7.9$; diagnosis of 30 S's was schizophrenia of some type, 2 had a brain syndrome, and 14 were variously designated as "psychiatric observation," "psychoneurotic," and "psychotic."

Assignment to groups and buildings

Fifty-two of the sample were randomly selected from the 61 screened subjects and assigned to the six groups and two units as indicated in the following chart (Figure 1),

designated as "original N." The "final N" shows the number remaining at the end of treatment. The size of the original

Figure 1

Assignment of Sample to
Groups and Units

Group Designation	Description	N	
		Original	Final
EP Staff	EP Unit, Counseled, Staff	7	7
EP Trainee	EP Unit, " , Trainee	7	6
EP Non-Couns.	EP Unit, Non-counseled	12	10
CT Staff	CT Unit, Counseled, Staff	7	7
CT Trainee	CT Unit, " , Trainee	7	6
CT Non-Couns.	CT Unit, Non-counseled	12	10
Total N =		52	46

groups, aside from the discussion in Chapter I relative to optimum size, was determined in part by the practical limitations of the number of patients who could be moved into EP Unit without producing undesirable changes in "atmosphere" or routine. Twenty-six was set as the maximum for each unit. Determination to conduct two counseling groups in each unit was made essentially to provide greater reliability of results, as well as to utilize available staff and trainee counseling psychologists. It would also be of some interest to compare results of groups counseled by psychologists at different levels of experience (Grigg, 1961).

Essentially, the subjects were involuntary, their assignment to groups and units being handled as a routine administrative matter. They were never informed of their role in

regain independence, competence, and eventual restoration to community life. Only too often the "individual" has become a "number," somehow misplaced or so fused into the mass of the hospital population that little or no realistic planning for restoration to the community is done, either by patient or staff.

It is believed that many such patients could greatly profit from provision of certain opportunities and experiences in a more permissive atmosphere, including extension of privileges and personal responsibility. If, at the same time, a more intimate relationship could be established with other patients and staff personnel, the prognosis would indeed be brighter.

Thus, it is hypothesized that provision of a meaningful group counseling experience, coupled with life in an atmosphere of greater freedom and personal responsibility, will facilitate a more effective orientation toward the future, including realistic plans and actual steps toward their implementation. The present study has been undertaken to test some of the effects of such group counseling, and at the same time to analyze the effects of situational factors on patient behavior.

Such counseling should be done with fullest possible awareness of the positive attributes and assets of each group participant, as well as knowledge of his limitations and history. Accent toward the future, once the illness is

the research, and none of the 61 comprising the sample and alternates objected openly to the evaluation itself or to being placed in a group or in a different unit, with one exception. One subject was transferred to EP Unit and after two or three days (prior to start of "treatment") was returned to CT Unit at his request, being replaced by an alternate. The transfer of patients to EP Unit was effected in two groups, so as to maintain routine procedures as nearly as possible. All EP Unit subjects were assimilated into the regular program of the unit and received no special consideration or attention, other than the assignment to counseling groups. Since other such groups were currently operating in the unit, this was not believed to be a biasing factor in terms of being "singled out."

Holding the sample

Knowing that loss of subjects over extended treatment periods can become a major pitfall in such a study as the present one, several precautions were taken. The major one was communication throughout with administrative personnel of the hospital, including the Assistant Hospital Director, the physician in charge of the two units involved, and the Supervisor of EP Unit. A continuous effort was made to keep these officials informed about the progress of the study. This made possible "holding" some patients in the units where otherwise they might have been transferred, granted trial visits or extended leaves of absence which would have

introduced contaminating variables into the study. Cooperation was also obtained from staff personnel in order to prevent their picking up any of the subjects for other group activities similar to group counseling. This was accomplished mostly by personal contact, but also by "flagging" the clinical folder of each patient with a notice that the patient was not to be transferred, discharged, or involved in any group activities without clearing with the unit Administrator or the Experimenter. These precautions seemed to pay off quite well, as only two subjects were lost due to such problems.

Of the original 52 subjects assigned to the study, 9 became drop-outs. Three of these occurred prior to the two-week deadline deemed wise as a cutting-time for use of alternates, but six were dropped after the expiration of the time limit, leaving a sample N of 46 completing the study. Of the drop-outs, three were from three different counseled groups, and six were from the non-counseled groups. Four were from CT Unit, five from EP Unit. Of the EP Unit drop-outs, one (EP Staff) requested transfer back to CT Unit, claiming inability to get along with other men; two (one from EP Trainee; one from EP Non-counseled) were removed from EP Unit for drinking; and two (both from EP Non-counseled) went AWOL. Of the four CT Unit drop-outs, two (one from CT Trainee; one from CT Non-counseled) went AWOL, and two (both from CT Non-counseled) made trial visit plans for leaving the hospital.

The specific breakdown, in terms of groups, of the 46 subjects who completed the study was (Figure 1): 23 in each unit; 13 in counseled and 10 in non-counseled groups in each unit, 7 remained in each of the groups counseled by staff psychologists, with 6 remaining in each group conducted by a psychology trainee. Three of the alternates were used: one in EP Non-counseled, prior to beginning of formal treatment period; and one in each of the non-counseled groups, EP Non-counseled and CT Non-counseled. These alternates had been numbered randomly, and were used in rotation as needed.

The Evaluation Process

Collection of the data

Since the evaluation itself provides the data needed to test the hypotheses, some detail will be given as to the procedures employed in both pre- and post-treatment testing and interviewing. All pre-treatment evaluation was completed in the one-week period prior to assignment of subjects to groups and units; and all post-treatment evaluation was completed in the week following the 12th regular group counseling session, before any indication of the possibility of discontinuing the sessions was discussed with the patients. Hathaway (1948) has written regarding what he terms the "hello-goodbye" effect. He points out that clients are prone to respond favorably to counseling when terminating because it is socially correct to express satisfaction and

appreciation for services rendered. Thus, the counseling sessions were continued a minimum of two extra sessions past those 12 sessions scheduled specifically for the present study. This enabled completion of all testing and interviewing of each subject before he knew the group sessions might be discontinued.

Since there was the possibility, too, of an "anticipatory effect" should the subjects be made aware of their role in a special research project, or of the possibility of their being transferred to EP Unit (which, for some patients, at least, seemed to be esteemed as a high honor and achievement), such information was carefully withheld. This applies to all preliminary arrangements, explanations, and the pre-treatment testing. The transfer to EP Unit was handled as routinely and casually as possible, as previously mentioned. Every care was taken throughout the treatment period and post-treatment evaluation to maintain the attitude of "routine procedure."

Three mornings, 9:00-12:00 A.M., were utilized for the major part of the testing. Each of the three test groups was composed of subjects from all six of the groups comprising the sample, in numbers proportionate to the size of their group. The test groups varied in size from 16 to 24, such variation being caused by scheduling problems. Such individuals as missed all or part of the evaluation were re-scheduled later in the week.

The testing was done in a neutral situation, in a different building. Adequate provision was made for space, tables, lighting, and ventilation. The same testing situation was used in both pre- and post-treatment evaluation.

A smaller office, conveniently located in the same building, was available for the individual interviewing, and provided a satisfactory arrangement for taping the interviews. Scheduling of the interviews was done individually during the morning testing session. Interviewing was conducted during the afternoons of the three test days and completed in the following two days.

Explanation of the purposes of the evaluation was presented in a matter-of-fact statement:

You men have been asked to come here for testing and to talk over certain aspects of your personal situation. It is felt that such information will be of assistance to the hospital staff in providing those facilities, activities, and over-all program that will best meet your needs. The testing will take most of the morning. Those scheduled for medicine will be excused, and finish afterward. Each man will be scheduled for one other time during the week for a short talk with me. Any questions?

After answering questions, the first test was administered. It was made clear to the subjects that they should feel free to smoke, go to the restroom or for a drink of water whenever desired. A 10 to 15 minute break was taken midway through the morning. A few subjects came back to complete the tests after lunch, but the majority were finished by noon.

Assistance from two other psychology trainees in procuring made it possible for the experimenter to set up the schedule of individual interviews so as to complete all testing and interviewing within a one-week period, thus making it possible to begin the treatment period the following week. All individual interviewing was done by the experimenter.

Instructions for each test were carefully read orally, and repeated as often as necessary. Special care was taken to observe each subject, to make certain he was following directions and seemed to understand what he was doing. All tests were checked immediately upon being turned in, and in some cases subjects were encouraged to complete omitted items or to "make a best guess." In a few cases tests were spoiled and repeated later in the week. Specific instructions given for each test will be presented later, in the discussion of the instruments used.

Instruments

The discussion of instruments will include reasons for choice, description, instructions, scoring procedure, statistical treatment, and limitations, as applicable to each of five categories: (1) criteria measures, (2) analysis of the group-counseling process, (3) analysis of the situation, (4) related background variables, and (5) additional data.

Criteria measures

Chapter II provided the rationale for the choice of the three major criteria and nineteen sub-criteria, as well as indicating the specific instruments which would be utilized as criteria measures in hypotheses testing. These instruments were chosen or developed in an effort to measure each criterion of change as validly as possible. Such validity, however, in some instances, must be inferred, as either (1) the instrument was newly developed, or (2) modification of the original instrument was introduced. It is believed that such inferences can be best justified by analyzing each criterion measure in terms of its operations and its correlational relationships to various other criteria measures. The experimenter assumes the face or content validity of each measure to be high enough to have warranted its use.

In addition to the consideration of validity were those of reliability, amenability to group administration (except for that instrument used to rate verbal behavior), administration-time involved, and limitations of the instrument. The criteria measures will be considered in terms of the three major criteria: "general observed behavior," "verbal behavior," and "attitude toward self in relation to others and the future."

1. General observed behavior.--This criterion was evaluated by means of an observer rating scale, the Hospital

Adjustment and Placement Scale (HAPS, Appendix II), developed by the experimenter (1961) in a pilot study relating to the selection and placement of Np patients in the most suitable hospital situation and in the community. In that study predictive validity (in terms of successful placement and adjustment in the community) based on a sample of over 100, was tentatively established. Using the Mann-Whitney U test of significance (Siegel, 1956), observer ratings of differences between "successful" and "unsuccessful" placements in the community indicated discrimination beyond the .01 level of significance. Inter-judge reliability in the present study was determined to be .39. (This is discussed in Chapter IV.) Steps were taken to at least partially ascertain concurrent validity. The Hospital Adjustment Scale (Ferguson, McReynolds, and Ballachey, 1951, 1953) had not been selected as the instrument to measure "general observed behavior," primarily because its categories did not cover all the sub-criteria the experimenter wished to evaluate. (Three categories are used in the HAS: (1) communication and interpersonal relations, (2) care of self and social responsibility, and (3) work, activities, and recreation--plus a total score.) This scale (HAS) was administered, however, during the post-treatment evaluation, providing the means for some degree of comparison with the HAPS, the major instrument for assessing this variable.

The relationship between the HAPS and HAS can be seen by comparison of the correlations of the scores on each with background variables (Appendix XV and Table 5, Chapter IV; .05 level of significance = .29). On total scores of each scale, the highest three positive correlations with background variables are with activity level ($r = .28$ on each), vocational background ($r = .25, .20$ for HAS and HAPS respectively), and marital status ($r = .22, .13$). On no variable is there a significant discrepancy between the two. Comparison of HAPS categories VII and VI with HAS I and II, respectively, and HAPS VII with HAS III also show considerable positive relationship between the two scales. Table 5 indicates that measures on both scales are strongly related to activity level and vocational background.

The HAPS was selected after consideration of various characteristics or criteria of rating scales, such as: (1) being designed to indicate decreases or increases in observable or manifested behavioral habits or actions by corresponding decreases or increases in positive or negative appraisals made by observers (Luchins, 1960); (2) providing valid and reliable descriptive information in terms of the objectives of the evaluation; (3) counteracting "halo effect," yielding results free from bias and prejudice; (4) providing results expressed in numerical terms; (5) being practical in terms of staff time required; (6) using terminology easily understood by the observers, avoiding abstractness and dealing

with terms reduced, insofar as possible, to observable operations; (7) possessing power to discriminate; and (8) providing a base or norm for standardization of comparisons.

Other rating scales were considered but disqualified on the basis of these requirements. The HAPS was believed to best fulfill the over-all requirements, in spite of its limitations, which apply in at least some degree to numbers (3) and (8) above. "Halo effect" could perhaps best be eliminated by a forced-choice scale, but the drawbacks of such a scale, for the purposes of the present study, appeared to out-weigh the advantages, as Kuhn (1956) concluded, particularly the resistance to be encountered from the relatively unsophisticated--test-wise--observers being used (nurses and nursing assistants). It is believed that such error as might have been introduced by "halo effect" was randomized in relation to the groups, if not by the fact that several judges rated each subject.

Luborsky, et al. (1962) have reported the development of what appears to be a reliable rating instrument, and have been able to meet the requirement stated in # 8, above, regarding provision of adequate base descriptions which serve as standards or norms for comparison of the individual patient. This scale, the Health-Sickness Rating Scale, defines levels of mental health by comparison of the patient with a series of patients graded in degrees of health according to several dimensions. This, they feel, provides means for

under control and preliminary psychological defenses have been established, will allow the patient to reorient his life in a meaningful way. Group counseling should provide such opportunities as reality-testing through role-play, socialization development, working through of personality problems, and sharing of information and insight--with subsequent growth of independence and realism in development of plans for the future in a life outside the hospital environment, including vocation, social relationships, and living arrangements.

Attitudes of self-worth and optimism should be enhanced in a climate where the patient's expectations are realistically geared to his present capabilities. Behavioral problems should decrease as the patient understands that others believe in him to the extent of providing additional activities and privileges. Increasing appropriateness of conversation, personal appearance, actions and habits, and of plans for movement away from the hospital should be noted.

Such considerations prompt the present investigation, which, it is hoped, may increase our ability to restore meaning and a more productive life to those who need the help of the Np hospital.

The Institutionalized Patient

Recognition came early in the mental hygiene movement that a patient, once his acute symptoms were under control,

obtaining absolute ratings, as well as an improvement measure from the difference in ratings at two stages of treatment. Their scale was not used for several reasons: (1) judgments are to be done by psychiatrists or psychologists (In this case the subjects were not well enough known by such staff persons.); (2) several hours of pre-rating instructions are required; (3) the nomenclature is quite technical; and (4) the frame of reference, essentially analytic, did not fit the "counseling" frame of reference of this study. The writer's position is that for a rating scale such as the HAPS to be an effective measure, it must be completed by one who is in closest daily contact with the patient. The nursing assistant is one such person, as is the ward nurse. The HAPS was designed for use by such personnel, who, with a minimal amount of instruction, and working with descriptive terms, can evaluate a patient in from 8 to 12 minutes.

An effort was made to meet requirement #8 by means of the observer instructions, especially supplementary instruction #1, "Rate each individual on the list below in relation to the 'typical' CT Unit patient." All raters were well acquainted with CT Unit, and such instructions were aimed at improving reliability by providing a standard of reference. The complete observer instructions for the HAPS, including supplementary instructions added for the present study, are in Appendix II. The raters (nurses and nursing assistants who best knew the individual subjects) were individually

trained, and were given enough trial runs to bring a feeling of ease with the instrument. One procedure, the use of different sets of observers for pre- and post-treatment ratings, while unavoidable, no doubt lowered inter-observer reliability.

Each of the eight categories comprising the major part of the instrument were scored on a basis of 0 to 6 points with highest weight being given to the most positive choice for the category. Items receiving 6 points were such as: (Category I. "Motivation to Leave the Hospital," a.) "Very strongly motivated to leave; actions and statements indicate strong desire to leave; agitates to leave; constantly talks to staff about leaving"; and (Category III. "Observed Behavior," a.) "Outward behavior normal; no unusual habits or quirks; actions don't bother others; always acts about the same from day to day; careful about personal appearance and habits." Items from the opposite end of the same scales, weighted "0," are: (I. "Motivation," g.) "No motivation to leave; would probably resist leaving; very much resigned to spending rest of life in hospital"; and (III. "Observed Behavior," g.) "Extremely odd, deviant behavior; bizarre, bothers others; repulsive to others; erratic--can't tell what he'll do next; very careless, sloppy about personal care."

The five categories of Part IX, dealing with more global opinions as to the readiness of the patient to return

to the community, were scored on the basis of a four-point scale, with positive ratings receiving the heavier weights.

Tabulation of data was arranged to permit analysis in terms of total score, sub-totals of Categories I-VIII and Part IX, as well as individual categories.

2. Verbal behavior.--Modification of verbal behavior was measured both pre- and post-treatment by the Judge's Rating Scale for Verbal Behavior (JRSVB, Appendix III). This scale was developed by the investigator to provide an evaluation of verbal behavior as defined by eight dimensions. These, in turn, are broken down into descriptive operations. Each interview had been taped, as previously noted. The interviews were semi-structured, with questions based, in general, on the outline provided by the "Patient Opinionnaire" (Appendix IV), but not necessarily covering each item. By following this procedure, even though the interview was brief (8 to 12 minutes), it seemed to provide an adequate basis for the judgment of each dimension.

A description of each dimension follows: (a) "Fluency, rate of talk" was based on ease and amount of talk, smoothness and length of responses, and volunteering of information; (b) "Appropriateness of remarks and affect" was judged by how appropriate the remarks seemed in the context of the interview situation, whether display of emotion was related appropriately to the topic and was spontaneously expressed; (c) "Anticipation of outcomes; optimism toward the future"

was described in terms of eagerness or optimism of remarks as related to future outlook, how "rosy" or full of promise the future seemed, and whether such expressions of optimism were communicated easily and convincingly; (d) "Attitude toward self, others" included the degree and apparent realism of the subject's regard for self and others, whether he accepts self "as is," statements of concern regarding the welfare and rights of others, and the proportion of non-self communication as compared with emphasis on "I"; (e) "Interpersonal relations; cooperation and ability to relate to the interviewer" was determined by how quickly and easily the S adapted to the interview situation, the degree of warmth and involvement achieved, cooperativeness and sharing of responsibility for carrying on the interview; (f) "Openness to experience; willingness to change, to try new ideas" was rated on the basis of flexibility of attitude, willingness to consider alternatives, reservation of judgment until "all evidence was in," and degree of insight into own condition, including relations with others and aims of the hospital; (g) "Autonomy; Independence, initiative, competence" was assessed on the basis of the degree of independence shown in relation to his present total hospital situation, as well as in the interview itself, including evidences of initiative, stability, strength, freedom of expression of own opinions, and preservation of uniqueness as judged by both the content of his communication and the process of the

interview; and (h) "Realism of plans for the future" was based on apparent realism of motivation to leave the hospital, adequacy and clarity of plans for near and long-range future, as well as how well present activities and assignments are coordinated with such plans.

Each dimension was rated on a ten-point scale, anchored at each end with descriptive operations characterizing each extremity. Scores were weighted from 0 to 9, with the heavier weights corresponding to more positive ratings. Five judges were utilized in providing three complete parallel sets of judgments. Four of the judges were doctoral candidates in Counseling Psychology, at the level of completing their course requirements or beyond; the other, also a graduate student in the area of Counseling Psychology, was completing the work on his master's degree, and had spent several months as a Psychology Trainee in EP Unit. All judges were familiar with the setting of the experiment through personal experience, and had worked in one or both of the units involved in the study.

Details of the study were withheld from the judges to avoid biasing the results. For example, the tapes were numbered and subjects identified by code numbers, so there was little chance of knowing whether the interview were pre- or post-treatment, or who the subject was. Care was taken to assign a proportionate number of interviews from each of the six groups to each judge. The experimenter judged each

of the 92 interviews, while each of the other four judges completed half this number.

Instructions to judges were:

(1) After listening to the entire interview, rate the subject on each of the following eight criteria. (2) Use "the average continued-treatment patient," such as in units I (CT Unit) or 35, as the standard, where this is necessary. (3) Think, "Is this patient above or below the average continued-treatment patient on this criterion?" Then ask yourself, "How much?" (4) Place an X at that point on the scale which best expresses your judgment.

During the training period, tapes of interviews with patients not included in the final sample were judged. Ratings were discussed to clarify individual conceptions of each dimension, and in an effort to improve validity and reliability of judgments. Over-all inter-judge reliability, based on Pearson r correlations, was .65 (Appendix XIX). Tabulation of a total score, as well as scores for each category, made possible comparison of groups by analysis of variance and inter-correlations with other criteria measures.

Major limitations of this technique in general and of the scale used appear to be (1) the time required for making the judgments--in this case requiring the splitting of the sample in order to obtain qualified judges, thereby no doubt lowering the final reliability coefficient, and (2) the matter of "assuming" validity of the categories chosen as measures of verbal behavior. The purpose of the experimenter was to obtain specimens of verbal behavior as indicators of the

presence or absence of certain attitudes and characteristics (eight in number), chosen as criteria for this study. Evidence that these criteria are really being measured must be based on (1) face validity, and (2) intercorrelations with comparable categories of the other measures.

3. Attitude toward self in relation to others and the future.--The third criterion was assessed by means of three instruments: (1) the Elmore (1962) Scale of Psychological Anomie, (2) the Corsini (1956) Standard Adjective Q Sort, and (3) the Rokeach (1960) Dogmatism Scale.

(1) Scale of Psychological Anomie (Appendix V).--By means of a factor analysis, Elmore concluded that psychological anomie, as described by his scale, contains a general factor, meaninglessness, and five sub-general factors--valuelessness, hopelessness, powerlessness, aloneness, and closed-mindedness. These factors are summarized by Elmore (1962, 164-165):

The general factor running through most of the subtests was defined by the experimenter as a feeling of meaninglessness, that is, a feeling that in the light of personal decline life is not worth living. Factor I was interpreted as a feeling of valuelessness, that the standards for behavior are contradictory and that authority figures as the source of directives are not to be depended on to bring order to the belief system chaos. Factor II, reflecting a pessimistic future outlook, was defined as hopelessness. Factor III, marked by retreat from social pressures which the individual feels are out of his control, was classified as a feeling of powerlessness. Factor IV was named a feeling of aloneness, a feeling of isolation from one's unconcerned

fellowmen. Factor V, although difficult to name, seemed to reflect feelings of constriction and resignation, plus a narrowing of the perceptual field, adding up to a type of closed-mindedness.

Validity is tentatively claimed on the basis of correlation with the Srole scale, dealing with social anomie, but Elmore (146) recognized that:

. . . while face validity seems evident, empirical validity still needs to be established
. . . Validation against some external criterion seems desirable, such as administering the test to a group of persons and correlating the results of competent judges who are well acquainted with the respondents' behaviors and feelings.

Reliability has been partially established by the inter-correlations of items in each of the seventeen subtests and the elimination of those items not correlating substantially. This insures internal consistency. However, Elmore (148) indicates, ". . . the consistency with which persons will respond over time to this scale remains to be established." Of course, for the purposes of the present study, interest centers in over-all trends, enabling comparison of change among the six groups during the treatment period.

A major drawback of the scale as used in the present study was its length. It contained 17 subscales and a total of 244 items. The decision was made to use the scale in spite of this, because of the apparent relationship between it and the major criterion "attitude toward self in relation to others and the future." Since the time of the completion

of evaluation, his scale has been further modified and shortened to seventy items, although still retaining the same factors (Elmore, 1963).

Elmore sees the scale as useful in the identification of anomic persons, leading to improved treatment procedures. He feels that anomie could be a useful framework for further research in the counseling area.

In order to describe the format of the scale as it appeared to the subjects, the directions for scoring are presented in Appendix V. It is to be noted that directions are spelled out carefully, and that provision of a five-point scale for each of the 244 items assured ease of marking.

X	X	X	X	X
Definitely agree	Slightly agree	Very undecided	Slightly disagree	Definitely disagree

Instructions were read orally to the subjects as they read silently, and opportunity was given for questions. During the testing period the experimenter or proctor circulated among the subjects to answer questions and to make sure directions were being followed. Appendix V contains the directions, the 244 items, and identification of the sub-scale and number of the original item. This is shown by the numbers in parentheses at the end of each item, the first being the number of the sub-scale, the second the original number of the item.

Items were scored on a one to five basis, with the heavier weights being assigned the less anomic responses. For example, a "definitely agree" response on an anomie item would be weighed "1". In the case of nomie (non-anomie items), a "1" was assigned to a "definitely disagree" response. ("Nomie" items are #'s 121, 132, 137, 142, 143, 147, 148, 150, 153, 155, 158, and 159-244.) Thus a higher score on the post-treatment evaluation indicated a positive change toward less anomic feelings. Two sets of scores were tabulated: (1) a total score and (2) a score based on a total of the items from sub-scales one and six. This additional analysis was made because of the experimenter's particular interest in responses dealing more specifically with orientation to the future, as these items do. The two scores are treated separately statistically, both by analysis of variance for group comparisons and to check correlations with other measures.

(2) Standard Adjective Q Sort (Appendix VI).--An examination of the literature of the past decade shows many studies utilizing Q technique as a means of assessing various aspects of the self concept (see Stephenson, 1953; Cronbach, 1953; Dymond, 1953; Rogers and Dymond, 1954; Block, 1956; Chase, 1957; Bidwell, 1959; Schmidt, 1959; Strong and Feder, 1961). Stephenson pioneered with this technique as early as 1935, but more widespread empirical studies came out in the late 1940's and 1950's. The technique makes