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The Social Dimensions of Personality:
Group Process and Structure

By

Timothy Francis Leary
A.B. (University of Alabama) 1945
M.S. (State College of Washington) 1947

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

Psychology

in the

GRADUATE DIVISION

of the

UNIVERSITY OF CALIFORNIA

Approved:

Hubert Stanley Coffey
Jean Walker Macfarlane
Dorothy B. Nyswander

Committee in Charge

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SUMMARY OF THE DISSERTATION

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PSYCHOLOGY

SEPTEMBER 1950

COMMITTEE IN CHARGE:
Associate Clinical Professor HUBERT STANLEY COFFEY, *Chairman*,
Professor JEAN WALKER MACFARLANE,
Professor DOROTHY BIRD NYSWANDER.

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BIOGRAPHICAL

1920 —Born in Springfield, Massachusetts.

1945 —A.B., University of Alabama.

1947 —M.S., State College of Washington.

1946–1950—Graduate Student, University of California.

1946–1950—Clinical Psychology Intern, United States Veterans Administration.

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DISSERTATION

The Social Dimensions of Personality: Group Process and Structure

This dissertation is concerned with one aspect of a joint research into the Social Dimensions of Personality done by Mervin Freedman and Abel Ossorio. The aspect herein reported concerns the measurement of change in a group therapeutic situation. The basic assumptions of this research followed those of Harry Stack Sullivan who holds that awareness of and changes in interpersonal behavior are the crucial factors of the psychotherapeutic process.

The questions raised in this dissertation are: (1) can the interpersonal behavior of patients and a group therapist be used to test hypotheses about (a) temporal sequences in the treatment process, (b) the correlates of therapist activity, and (c) the nature of therapeutic "improvement"? and (2) are the schema and methodology reported by Freedman-Leary-Ossorio effective for such research objectives?

The data on which this research is based include pre- and post-therapy projective tests, subjective judgments of improvement by the patients and group leader, and typed transcriptions of 24 two-hour group treatment sessions. Seven male college students participating in a group therapy program were the subjects who furnished the experimental data. The protocols of the therapy sessions were analyzed into some 8,000 action units, according to the methodology described by Freedman, which includes operationally defined variables of interpersonal activity (process variables) and intrapersonal traits attributed by the patient to himself (structural variables).

The findings show that the Freedman-Leary-Ossorio methodology for measuring interpersonal behavior is an effective tool for testing hypotheses about therapy process. The generality of the findings is restricted because of the limited sample of subjects. The following relationships are, however, statistically significant for this population.

There were three different temporal sequences (phases) in the group therapy process. Defensive, resistant interpersonal mechanisms were most frequent in the first phase of treatment. The mechanisms of participant observation (confiding personal material) showed a significant increase in the second phase. Interpretive and therapeutic mechanisms showed a definite increase in the third phase.

Changes in interpersonal behavior were significantly related to other indices of improvement during the therapy period. Role changes during therapy from hostile resistance to friendly confiding were significantly related to subjective sociometric ratings of improvement and change as measured by the Rorschach. Changes in role behavior were not related to changes in the patients' self-descriptions. The therapist's ratings of improvement were closely related to changes in patient behavior. On the contrary, the patients' ratings of improvement in each other were much more closely related to changes in patients' self-descriptions.

Variation in therapist interpretive activity was concomitant with patient improvement or increased resistance. Interpretation of patient role, in contrast with interpretation of topical content, was significantly related to change in subsequent patient behavior and to the other indices of improvement.

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M673172

GRADUATE STUDIES

Field of Study: PSYCHOLOGY.

Seminar in Projective Techniques. Professor R. E. Harris and Mrs. J. H. Ranzoni.

Seminar in Research Methodology. Professor David Krech.

Seminar in Psychotherapy. Doctor A. S. Schumacher and Professor A. C. Sherriffs.

Seminar in Childhood and Society. Professor E. H. Erickson.

Seminar in Clinical Research. Professor J. W. Macfarlane.

Seminar in Group Dynamics. Professor H. S. Coffey.

Research in Measurement of Interpersonal Relations. Professor H. S. Coffey.

PUBLICATION

Community service and social research: Group psychotherapy in a church setting (with H. Coffey, M. Freedman, and A. Ossorio). *Jour. of Soc. Issues,* Vol. VI, No. 1, 1950, pp. 1–65.

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ACKNOWLEDGMENTS

The research project upon which this thesis is based was accomplished in collaboration with Dr. Mervin B. Freedman of the University of California and Dr. Abel G. Ossorio of Washington University, St. Louis. Professor Hubert S. Coffey of the University of California, the director of the research program on the Social Dimensions of Personality, made the venture possible through his unfailing counsel, support, and long-range vision. Gratitude is expressed to Reverend J. Raymond Cope, Minister of the First Unitarian Church in Berkeley, California for contributing his facilities, his time, and his tolerant wisdom without which the research would not have been initiated. Professor Jean Walker Macfarlane, University of California, lent her empirical and systematic guidance to the research since its inception and is particularly to be thanked for the time and energy she devoted to the preparation of the thesis. Mrs. Helen Lane and Mrs. Edna Adelson, both of Berkeley, California, have contributed generously to the technical aspects of data collection and treatment. Gratitude is expressed to Professor Dorothy Nyswander, University of California, member of the thesis committee and to Dr. Allan Thrasher Dittman, University of Michigan, who contributed to the theoretical aspects of the study.

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CHAPTER I

INTRODUCTION

This dissertation is concerned with the development of objective measurements of interpersonal behavior in group therapy.[1] The process of group therapy is to be studied as a social exchange in which several people are interacting. The nature of these interactions and their changes from session to session are seen as the crucial factor in the treatment process.

It has long been a consensual opinion that every type of psychotherapy helps "some of the people some of the time."

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[1]The present research is part of a collaborative investigation into the Social Dimensions of Personality which has been carried on over a period of three years by Hubert S. Coffey, Ph.D., Mervin B. Freedman, Timothy Leary, and Abel Ossorio. This joint research project has two general purposes: 1. the development of objective measurements of personality, 2. the development of a systematic representation of personality including interpersonal behavior. In the paper "The Social Dimensions of Personality: Concepts and Quantification Methods," Freedman (7) presents a methodology for measuring interpersonal activity in terms of operationally defined mechanisms and for coding the content of therapy sessions and test protocols in terms of coordinate variables. The present dissertation utilizes these variables to test certain hypotheses about the interpersonal behavior of therapy patients and its relationship to changes occuring during therapy. In a second collaborative research, "The Social Dimensions of Personality: Individual Process and Structure," Ossorio (23) utilizes the variables described by Freedman to develop a systematic approach to personality.

Practitioners of widely divergent, even contradictory, techniques of treatment claim to have removed identical symptoms and brought about similar personality changes. The lack of objective criteria for measuring therapeutic results has been discussed by several authors. (21)(10)(2)(22) Burchard (2) concludes a systematic review of criteria for the evaluation of group therapy with the comment:

> "1. A review of the literature on group psychotherapy revealed wide divergences in orientation, goals, technics, and methods of reporting.
>
> "2. The omission of pertinent variables from many reports and the lack of any generally accepted vocabulary and frame of reference made any comparison of methods or evaluation of differential success almost unsurmountable."

Subjective reports by the therapist have been the classic means of reporting on the patients' progress. Therapists' claims couched in such phrases as "attainment of genital primacy," "resolution of the oedipal conflict," "more self acceptance" are often legitimate extensions of a theoretical position and have some didactic merit. They admittedly lack scientific worth.

A summary of the methods available for the evaluation of therapy can be classified under three headings: 1. Subjective reports, 2. Objective measurement of changes in personality structure, and 3. Objective measurement of changes in process.

1. Subjective reports can come from three sources: the opinion of the patient as to his improvement, the opinion of the therapist, and the opinion of fellow patients. The first two are the standard sources of our information about how therapy works and provide the data for the staff conferences, seminars, and most articles published in the field. Reports based on the judgments of fellow patients are restricted to group therapy and have been suggested by Burchard (2) and by the work of Moreno. Even when there is high agreement among the patient, his fellow group members, and the therapist, the subjective nature of such reports, the likelihood of "halo" effects and contamination of opinion renders this approach an unsatisfactory one for scientific purposes.

2. Objective measurement of changes in personality structure of the patient, resulting from treatment, have been published in recent years. These tend to be cross-sectional samples of the personality before and after treatment and ratings of sequential changes in the patient's behavior.

Harris (13) and Ruesch (27) have commented on the differences between cross-sectional and processual studies of therapy. To describe the cross-section of personality structural variables is necessary. Most of the variables used to describe personality refer to postulated areas or processes, internal defense mechanisms, perceptual traits or images, perceptions of self, behavioral traits or diag-

nostic classifications. Some of these have defied objective measurement. A majority of them can be related with some validity to projective tests and inventory data.

Comparison of pre-and-post therapy tests have been made by several workers (21)(16)(3). Muench, in his well-known evaluation of non-directive counseling, administered the Rorschach, the Kent-Rosanoff word association list, and the Bell Adjustment Inventory before and after non-directive therapy. The Rorschachs, for example, were rated on twenty-two "signs of adjustment," half of which referred to personal adjustment patterns and half to social adjustment. The changes in these ratings in the direction of improvement for a group of twelve patients were significant at the one per cent level.

Muench summarizes the therapeutic progress of each patient under the headings "statement of the problem," "development of the problem," and "outcome of therapy." A definite disadvantage is apparent in studies of this type. The "signs of adjustment" are based on the Rorschach variables of personality ("critical attitude," "social awareness of a mature nature," "ratio between crude, immature control and refined, mature control," etc.). These vague empirical variables are not systematized or related to each other nor to the variables on the Kent-Rosanoff ("breadth of interest," "abnormal functioning," etc.) or the Bell inventory (home adjustment, health adjustment, etc.). Most important, none of the test variables is clearly or systematically related to the crucial activities of the therapeutic process. In-

vestigations of this type utilize the classical techniques of physical science--pre-measurement followed by experimental change and post-measurement without any assurance that the measurement instruments are at all related to the intermediate process. Without a control there is no definite answer to the objection that changes in post-tests may be a function of familiarity with the test situation or changes in morale unrelated to treatment. Studies of this sort can lend some substantiation to the therapist's hope that change does result from treatment, but they cannot throw light on the crucial question--what is the process of therapy and personality change.[1] This problem requires, first, measurements of patient and therapist behavior (process variables) which can be related directly to cross-sectional measurements of personality (structural variables).

3. Objective Measurement of Changes in Process: A more direct approach to the problem of evaluating therapy has been made by studies of sequential changes in the patient's behavior during treatment. Several such studies have been made of changes in patients' self-conceptions during non-directive counseling. Snyder (33) categorized the responses

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[1]A research project carried out at the Institute of Child Welfare, Berkeley, California, has cast some doubt upon the validity of Rorschach adjustment signs. Ives et al (15) compared the Harrower-Erickson and Davidson adjustment signs of normal adolescents between the ages of 11 and 18 and found this group to be high in "neurotic signs" and low in adjustment signs. When the adjustment ratings were correlated with 36 other indices of adjustment they obtained 34 insignificant coefficients, one significant positive, and one significant negative coefficient.

of the therapist along a directive-non-directive continuum. Client responses were classified under two headings--content categories and feelings. The basic content categories have to do with statements of the problem, insight, and action-taking verbalizations. The feeling categories are divided into positive, negative, or ambivalent feelings towards self, counselor, or others.

Seeman (28) used Snyder's categories to study "process" in therapy. He reports that:

> "The category "statement of problem" showed consistent decrease during therapy, while the categories "insight and understanding" showed consistent increase. (p.167.)
>
> "There is a describable course of therapy in terms of the relative incidence of positive and negative attitudes; positive attitudes increase as therapy proceeds and negative attitudes decrease. (p.168.)
>
> "The tense in which attitudes are expressed shows significant trends during the course of therapy. At the beginning of therapy positive attitudes tend to be expressed in the past tense and negative attitudes in the present tense. As therapy proceeds this relationship is reversed; positive attitudes are expressed increasingly in the present tense and negative attitudes in the past tense." (p.168.)

Studies of this type have shown the feasibility of objective research in counseling, and credit is due to the

Rogerians for their research devotion and pioneering attempts to measure process in therapy. This dissertation is based upon techniques (e.g. wire recordings) and in part upon concepts (perception of self and world) which have been developed by the non-directive school.

The work of Rogerians has been criticized for being "shallow" (non-dynamic) and overly pragmatic. Rogerian research has been interested less in the personality structure than in techniques for changing it through counseling and methods of demonstrating over-all change. There is no Rogerian theory of personality, no attempt to list the crucial variables of behavior. The lack of such theory leads to a rather crude empiricism in terms of positive and negative feelings (33), mature and immature behavior reported by clients (14), and acceptance and rejection of self (31).[1]

Similarly, Muench coded and scored specific Rorschach variables to obtain over-all ratings of social and personal adjustment. He was interested primarily in amount of over-all change in personality structure since there are no Rogerian variables for conceptualizing what is personality and for

---

[1]This disadvantage has been recognized by Rogerians. Seeman (29) states: "...the client categoriesused in this study do not appear to tap adequately the most crucial variables in therapy, if therapy is conceived in terms of reorientation of self rather than in the solving of problems. The client content categories in particular fall short of this concept, since they are oriented towards a problem-statement-and-solution type of investigation. The client attitude categories seem to come closer to a description of process in basic terms, though even here the categories do not penetrate deeply into the type of analysis required."

measuring it in action.[1]

Research projects, however rigorously quantitative, can be no more sophisticated than the theory on which they are based. Rogers (25) is aware of the need for more detailed variables of personality and for progress in the more risky areas of unconscious motivation. Haight (12) has progressed in this direction in his study of defensive behavior in client-centered therapy. Although there is some evidence that Rogerians are undecided at this stage of their research as to the necessity for postulating unconscious processes, their interest in more dynamic concepts is apparently growing. Rogers (25, p.150) reports that one of his colleagues, Hogan, is "developing an operational theory of defensiveness, tackling, from a research point of view, the difficult problem of unconscious material....the question is continually in the mind of the clinician--can research be done on the intangible, on the subtle, on such aspects of therapy as the ideas which are 'repressed' because they are too dangerous?"

Variables Used in this Research

The research reported in this dissertation is essentially based on the interpersonal theories of Harry Stack Sullivan (35). While the importance of intrapsychic activity

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[1] The published Rogerian experiments disregard specific motivations (dependency, deference, dominance), specific mechanisms (repression, projection), and the less conscious aspects of behavior except as they become reflected in the patient's statement of problems or self descriptions. The collaborative research directed by Coffey (4)(7)(23), of which this paper is a part, attempts to classify the basic interpersonal motivations at the behavioral and symbolic levels (see Chapter III).

(repression, rigidity, etc.) and structural variables (traits and self-perceptions) is not minimized, the basic assumption of this research is that a personality theory should lead to definition, measurement, and prediction of interpersonal e-vents. The Rogerian variables were held to be insufficient because their measurement of process in therapy not only neg-lects the nature of interpersonal behavior but also fails to relate client and therapist activity to a structural concep-tion of personality.

A collaborative paper (7) has presented a systemative way of measuring social interactions in terms of a continuum of 16 interpersonal variables. Sixteen structural variables (interpersonal traits attributed to self and others) which correspond to the interaction variables are used to measure the pre-and-post therapy personality and the changes in self conception as they sequentially occur during the course of therapy. These variables which are defined in Chapter III of this dissertation, provide a method for measuring the behavior of both therapist and patient during therapy and for relating it to changes in the patient's perceptions of himself and his world.

Purposes of this Research

This research has two general purposes. The first aim is to chart the changes in the interpersonal behavior of seven patients in 24 sessions of group therapy, and to com-pare and relate these with changes as measured by 5 different methods of evaluating treatment results: (a) the opinion of

the therapist, (b) the opinion of the patient immediately after therapy, (c) the opinion of fellow patients immediately after therapy, (d) objective and projective personality tests taken before and after treatment, and (e) sequential analysis of changes in the patient's perception of himself and the world during therapy. The second research purpose is to evaluate the effects of the leader's role and interpretive techniques on therapeutic success.

Outline of Following Chapters

To place this research in context with other developments in the field of group therapy, a brief historical account is presented in Chapter II. A more detailed description of the research plan and a statement of the specific hypotheses to be tested will be found in Chapter III. The fourth Chapter reports the findings which relate to the therapy group. Hypotheses concerning "changes in patient behavior" will be considered in Chapter V. Chapter VI reports the findings which relate to the therapist's role and the hypotheses concerning treatment technique. The final chapter restates the generalizations about group process and therapist activity in group therapy and suggests applications of our findings to the practice of psychotherapy and to further research.

CHAPTER II

THEORY AND PRACTICE OF GROUP THERAPY--A HISTORICAL REVIEW

The development of group therapy has closely paralleled that of individual psychotherapy. Group leaders have always borrowed heavily from the theories and techniques of the psychiatric schools then current. A history of group therapy, therefore, is in danger of becoming a chronological account of the development of the psychiatric profession.

Psychiatric expediency during World War II promoted an interest in group therapy, and the post-war years have seen increasing use of the technique. Kotkov (17), as early as 1947 reported a bibliography of 433 articles on group therapy.

This chapter will summarize the major theoretical and technical developments in the field. The methods and concepts which predate the Freudian "era" will be presented first. They will be followed by a discussion of the most typical psychoanalytic papers. The influence of the interpersonal theories of Harry Stack Sullivan on group therapy, which are those to be tested in this research, will be treated in the concluding section of this chapter.

Inspirational-Repressive (Pre-Analytic) Group Therapy

Pre-analytic psychotherapy tended to be symptomatic,

directive, rational, mechanical. Charcot, Janet, McDougall, Breuer, and Freud (pre-1900) attempted to remove symptoms with little concern for the underlying causation. Interpersonal relations were minimized if not absent as a concern of the theorist. The therapist was autocratic. A study of the techniques of these early therapists translated into social mechanisms shows that they suggested (Janet, McDougall, Bernheim, Coue), reasoned (DuBois), persuaded (Dejerine), and ordered (Riggs). They gave hypnotic commands (Charcot, Janet, Bernheim, Freud, Breuer), and inspirational lectures (Mitchell, Riggs).

Theories of group behavior were built on these psychiatric notions. LeBon and McDougall wrote influential texts explaining phenomena of group and crowd behavior in terms of imitation, suggestibility, credulity, submission to the leader, loss of rational will.

Techniques of group therapy followed the same pattern. Marsh, taking his cue from LeBon, used repressive-inspirational methods encouraging identification with the leader. His groups were large, numbering in the hundreds, and often were marked by the spirit of a revival-meeting or a lecture hall. For Marsh and his contemporary Pratt, repression of symptoms and increase in morale, rather than change in basic personality structure, were the apparent goals.

Freudian-inspired Group-therapy

Increasing acceptance of Freudian theory has brought about changes in treatment methods. Unconscious motivation

replaced the symptom as the focus of attention. The irrational nature of neurotic phenomena and the inadequacy of reason and logic in effecting personality change became apparent. The static concepts of Charcot gave way to dynamic forces such as repression and projection. The task of the therapist was no longer to direct or inspire. His role became that of a passive listener encouraging the associations and transference projections of the patient and that of an interpreter teaching the patient to recognize his irrational perceptions and unconscious processes.

Freud's theory of group behavior (8) accepts LeBon's description of the credulity, impulsivity, and unrestraint of crowds, but rejects "suggestion" as the explanatory concept. Freud insists that libidinal ties between the leader and members brings about an identification. The members, recognizing that they share the same love of the leader, show a cohesive mutual identification. A predisposition to group formation has survived in the unconscious from early human history. "Thus the group appears to us as a revival of the primal horde....the primal father had prevented his sons from satisfying their directly sexual tendencies; he forced them....into group psychology. His sexual jealousy and intolerance became in the last resort the causes of group psychology." (8)

Freudian group therapists have based their techniques upon the methods and theories of individual psychoanalysis. Wender (36), Lazell (18), and Luchins (19) have lectured to groups ranging from six to forty and encouraged discussion

and confidences on the part of the patients. Relationships among members and leader was not a prominent part in their accounts. Insight and understanding of unconscious content seems to have been the primary aim of these workers.

Schilder (28), and Shaskin (30) have reported their experiences with analytically oriented therapy groups of six to twelve patients. They remark on the familial feeling aroused in the therapy group and have encouraged this by seeing themselves "in loco parentis" to the patients. These two analysts, working with smaller groups, have paid more attention to interpersonal factors, transferences and group acceptance, but in general appear to be "content oriented" stressing insight as the major therapeutic goal.[1]

Group Therapy from the Interpersonal Orientation

Fenichel has written two authoritative texts which serve as a bridge between classic psychoanalysis and the interpersonal approach to psychotherapy. His "Psychoanalytic Theory of Neurosis" (5) gives a definitive coverage of the genesis, structure, and aberrations of personality from the standpoint of Freudian theory. His conceptions of psychoanalytic therapy are presented clearly and succinctly and come close to a consideration of the interpersonal role in "Prob-

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[1] Slavson (32), working in an analytic framework, has developed specific modifications of technique; he employs activity therapy with children and interview therapy with neurotic adults. Perez (24), employing Rogerian methods, organized groups along permissive lines and restricted his participation to reflection of feelings and clarification of content.

lems of Psychoanalytic Technique" (6):

> "There are persons who assume a certain defensive attitude only in certain situations (external or internal situations involving the mobilization of certain instincts), and other persons who persist in a defensive attitude and thus act as if there were continually present instinctual temptations that need to be warded off. Such persons are for defensive purposes impudent or polite, empty of affect or always proving that it is another person's fault; <u>always</u> and <u>unspecifically</u> and with reference to all or to nearly all people. Such attitudes may be designated as 'character defenses' in a narrower sense in contrast to other modes of defense. We have already said that where this type of defense prevails, it is particularly urgent that we work first to release the personality from its rigidity because it is in this that the pathogenic energies are really bound."

Recent advances in psychoanalytic theory have minimized the instinctual and psychosexual aspects of personality and have emphasized ego function, the social dimensions of behavior, and the interpersonal significance of the therapeutic relationship.

A far-reaching step in the history of psychotherapy was taken by Harry Stack Sullivan (35) in defining psychiatry as the "study of interpersonal relations." He views person-

ality as the sum of the interpersonal relations of the individual and sees the therapy situation first and always as an interpersonal relationship in which both patient and therapist are interacting. The task of both is "participant observation" of their interactions. The basic data of therapy is the interpersonal behavior of the patient in the present and in the past.

The Washington School of Psychiatry with Sullivan as its spokesman has shifted the focus of therapy to the interactions between the patient and therapist. The content of _what_ the patient says is constantly examined by both participants for the underlying meaning. "Why are you saying this?", "What is the interpersonal purpose of this statement?", "What are you really expressing when you tell me this?"--are the questions which the therapist poses for consideration. Treatment is concerned with tracing to the past the irrational (projective and parataxic) roots of the interpersonal techniques of the present.[1]

In addition to its therapeutic implications the Sullivan theory has a second heuristic advantage. Interpersonal activity as a datum is especially congenial to operational investigation since it combines elements of social (interper-

---

[1]The importance of the interaction between patient and therapist has become recognized by many converging theoretical systems. Fenichel's dictum "resistance must be analyzed before content" comes close to the Sullivan position, as do the "relationship" conceptions of Rank and Allen. Similarly, Rogers (24, p.152) speaks of the "delicate and fragile web of interrelationship which is therapy."

sonal) reality with motivational and perceptual (view of self) aspects of behavior.

Ackerman (1) has employed interpersonal techniques in group therapy. He comments on the therapeutic force inherent in the group acceptance and the "testing of...interpersonal reality as dramatized in the group relationships..." He minimizes the importance of content and the teaching function of the therapist: "interpretation was employed only when the expression of specific emotional trends was sufficiently solidified."

The English psychiatrist, Foulkes (9) while not identifying himself with the Sullivan camp, urges participant observation as the leader's task in therapy. "If the psychotherapist resists the temptation to be made a leader, he will be rewarded by their growing independence, spontaneity, responsibility, and personal insight into their social attitude. ... The psychiatrist leaves the lead to the group, acting mainly as a catalyst and observer.... The group can be used to put the emphasis of treatment not upon past history but upon the immediate present--a desirable shift when time is short and one of the most important aspects of this approach."

The comments of Coffey, Freedman, Leary, and Ossorio (4) on the process of group therapy lend further support to the interpersonal theory:

> "With increasing experience, several implications for therapy have evolved. First, it becomes clear that, during the initial sessions, <u>content</u> (what

the person says) is not of prime importance as such but can be seen as serving the social role the patient is establishing."

"The interpersonal theory of personality holds that crucial human behavior is centered in the roles displayed in social interaction. During the course of group therapy each patient becomes involved in several thousand social interactions with other group members and with the leader. The consistent interpersonal actions typical of each member make up his <u>social role</u>. Examples of such roles are the dependent-abasive, nurturant-dominant, and the aggressive-dominant....the social role must be interpreted and brought to awareness before the content can be interpreted. Analysis of resistance must precede analysis of content..."

"Group members have a strong therapeutic power which the leader can smother or encourage. Our early leaders preserved the interpretive function for themselves as omnipotent psychologists. They viewed the group as an appreciative audience for their psychodynamic fireworks. We have increasingly invested the interpretive function in the group members. Patients do sense the unconscious meaning of their fellows' behavior. They can describe the social role of a patient in naive and everyday terms, that are sometimes more accurate and

certainly more effective than the more scientific terms of the psychologist. Our present interpretive procedure goes somewhat as follows--first the patient is urged to produce his interpretation of his own behavior; then the group members are called upon for their impressions of the role and behavior of the patient. Finally, the therapist summarizes, basing his comments as much as possible on the patient's interpretations and using his exact words where possible. In actual practice, of course, this sequence is often varied to meet the particular needs of the group."

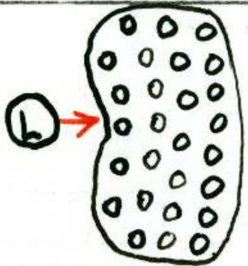
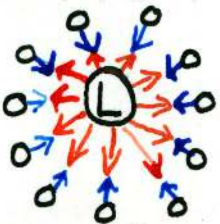
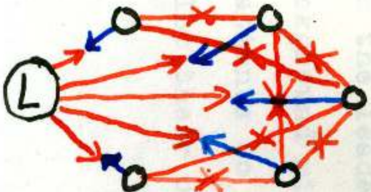
Summary

This historical summary points to several consistent trends in the technique of group therapy which are summarized in Table I (see p.20). It will be noted that the size of groups diminished over the years. Pre-analytic therapists, Marsh for example, saw the group as a passive audience to be exhorted and inspired. Interpersonal aspects were obviously minimized.

The Freudian therapists, Lazell and Wender, stimulated group discussion by lecturing on the theory of personality. This situation encouraged patient reaction to the leader rather than interaction among themselves. Shilder and Shaskin, working from a Freudian orientation with smaller groups, obtain more patient interaction and emphasize unconscious content and the transference (Father-Mother-sibling)

TABLE 1

HISTORICAL TRENDS IN GROUP THERAPY TECHNIQUE

	PRE-ANALYTIC	ANALYTIC	INTERPERSONAL
			
SIZE OF GROUP	15 TO 500 MEMBERS	8 TO 65 MEMBERS	5 TO 8 MEMBERS
ACTIVITY OF LEADER	Teaches inspires, exhorts	Teaches, interprets content	Teaches, interprets both content and interaction; participant observation, stimulates group interaction
ACTIVITY OF PATIENT	Passive listener No interaction	Receives therapist's interpretation; participates by confiding content	Participates through expression of his own social role
FOCUS OF DISCUSSION CONTENT	Impersonal Discussion centered on symptoms	Personal Discussion centered on content and "structure" of personality	Interpersonal Discussion based on the "processes" of social role in action in the group

In these diagrams the leader is designated by the symbol (L), group members by O; the therapist's interpersonal interactions are shown by the symbol (red arrow) and the interaction of patients by (blue arrow).

relations to the leader. Group therapists with an interpersonal background minimize active leadership functions and encourage patients to establish their spontaneous social roles and to develop their own interpretive functions.

CHAPTER III

RESEARCH PLAN: SPECIFIC HYPOTHESES

The primary task of this research is objective measurement of the interpersonal behavior of seven patients in group therapy.[1] The second purpose is to show that patients change their roles in treatment, moving from defensive, resistive behavior to confiding, insightful, and interpretive behavior. A third aim is to demonstrate that role change in group psychotherapy is related to changes in personality structure as measured by cross-sectional and subjective evaluative techniques.

Changes in interpersonal role during therapy will be

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[1] A caution to the reader concerning the generalizations made in this dissertation is in order. Reference has been made to a methodology for measuring interpersonal activity developed by Freedman (7) in collaboration with Coffey, Ossorio and the present author. This dissertation reports the results obtained when this methodology was applied to the behavior of seven patients in a therapy group. The joint research team has collected data on 84 group therapy patients. The scope of this dissertation has been restricted to the study of seven patients because the application of Freedman's methodology is the prime concern. The generalizations made in the following chapters are, therefore, tentative in that they are based on seven male college students. Where statistical tests show significant relationships between variables they can be held as valid for this population. Where statistically insignificant relationships are reported, future studies based on larger samples may well show significance.

compared with other indices of change--ratings of improvement and cross-sectional measures of personality in order to determine the relationship between role changes in the group situation and changes in personality structure. The relationships between changes in role, changes in self-perception, changes in cross-sectional tests, and the ratings of change by the patients and therapist will provide an answer (tentative due to the low number of cases) to the question--what is the nature of change in group therapy. Therapist activity will be measured and related to subsequent patient behavior to suggest an answer to the question--how did this therapist bring about change in these seven patients.

This chapter will present a description of the subjects, the measurement methods, the techniques of data collection and a list of the hypotheses to be tested.

<u>Subjects</u>

The seven subjects used to develop the methods to be described were male college students referred to the therapist by the minister of a "liberal" church in the vicinity of a state university. The patients ranged in age from 19 to 28. As regards psychiatric diagnosis, the patients ranged from operational "normal" to schizoid personality and were closely similar to the male population of the university out-patient clinic.

The patients were, in one sense, all self-referred, since they all had approached the minister of the church requesting counseling for emotional problems. He explained his

inability to conduct personal counseling and offered them the opportunity to participate in the group therapy program. The patients who signified a desire to enter treatment then met as a group for an orientation discussion conducted by the minister, the therapist, and the "research director" of the project. The minister explained the church's sponsorship of the program, the therapist presented a description of the purpose and goals of the therapy. The research director described the research aims of the project and outlined the nature of data collection (psychological tests, wire recordings, sociometrics).[1]

The seven patients studied in this paper were homogenous in several respects. They were all male college students associated with a liberal church. They tended to be more intellectual, more "progressive," and more restrained in expression of sex and aggression than the general student population.[2] One member of the group was married and all but one member were enrolled in social science curriculum in the university.

Description of Measurement Methods Used in this Research

The rationale, reliability, and a detailed description of the variables used in this study has been presented by Freedman (7) in a previous paper. The following brief definitions

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[1]A detailed discussion of the overall design of this research project as well as a presentation of initial findings is described in "Community Service and Social Research--Group Psychotherapy in A Church Program," Journal of Social Issues, Vol. VI (No.1, 1950). This issue includes a description of the project, a discussion of results, therapeutic techniques, social implications, and the problems of collaboration involved in combining research with service.

[2]An extended description of the psychological traits common to members of this cultural sub-group is contained in the article mentioned in footnote 1.

of the more important concepts and variables seems advisable.

Structure and process are terms that recur in this research. To describe the structure of personality (intra-personal) we use structural variables--traits measured by the cross-sectional tests or obtained from the patient's self descriptions of himself and his world. To describe the personality in action (inter-personal) different variables are needed.[1]

Language usage requires us to describe performance in terms of verbs (e.g. dominates, criticizes, obeys, etc.), while trait names or structural attributes are classically adjectives. The structural (trait) ratings are taken from the content of the therapy discussion or the content of the tests. The process ratings are made by observation of the subjects' performance. The verbs used to describe social interaction are called interpersonal mechanisms. The adjectives used to describe the structural aspects of personality are designated as traits.

Interpersonal mechanisms are verbs which reflect the interpersonal purpose of social interactions. They are inferred variables which answer the question: "Why is he doing or saying this?" Purposive social mechanisms have been divided into three classes: task-oriented mechanisms, therapeutic mechanisms, and ego-oriented mechanisms. (See table 2.)

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[1] By analogy, we use structural variables to describe the condition of an auto engine at rest, e.g. eight cylinders, four wheels, stripped gear. We use process variables to describe the performance of the engine, e.g. miles per hour, gas consumption per mile, motor knock. Our knowledge of the engine (or the personality) should allow us to make predictions as to the performance on the road (or in a social situation).

TABLE 2

INTERPERSONAL MECHANISMS USED IN THIS RESEARCH

Ego-oriented Mechanisms

A Commands, Directs

B Resists, Disagrees

C Challenges

D Condemns, Disapproves

E Submits, Defers

F Asks for help, Asks for direction

G Agrees, Accepts

H Approves, Affiliates

I Supports, Sympathizes

J Offers help, Offers suggestion

K Teaches, Gives Opinion

Task-oriented Mechanisms

L Calls (for response from member)
Passes (refuses to speak)

M Participates, Gives (non-personal) information

N Asks for information

O Informs (about self)

P Confides

Therapeutic Mechanisms

Q Structures

R Summarizes

S Clarifies

T Reflects

U Interprets

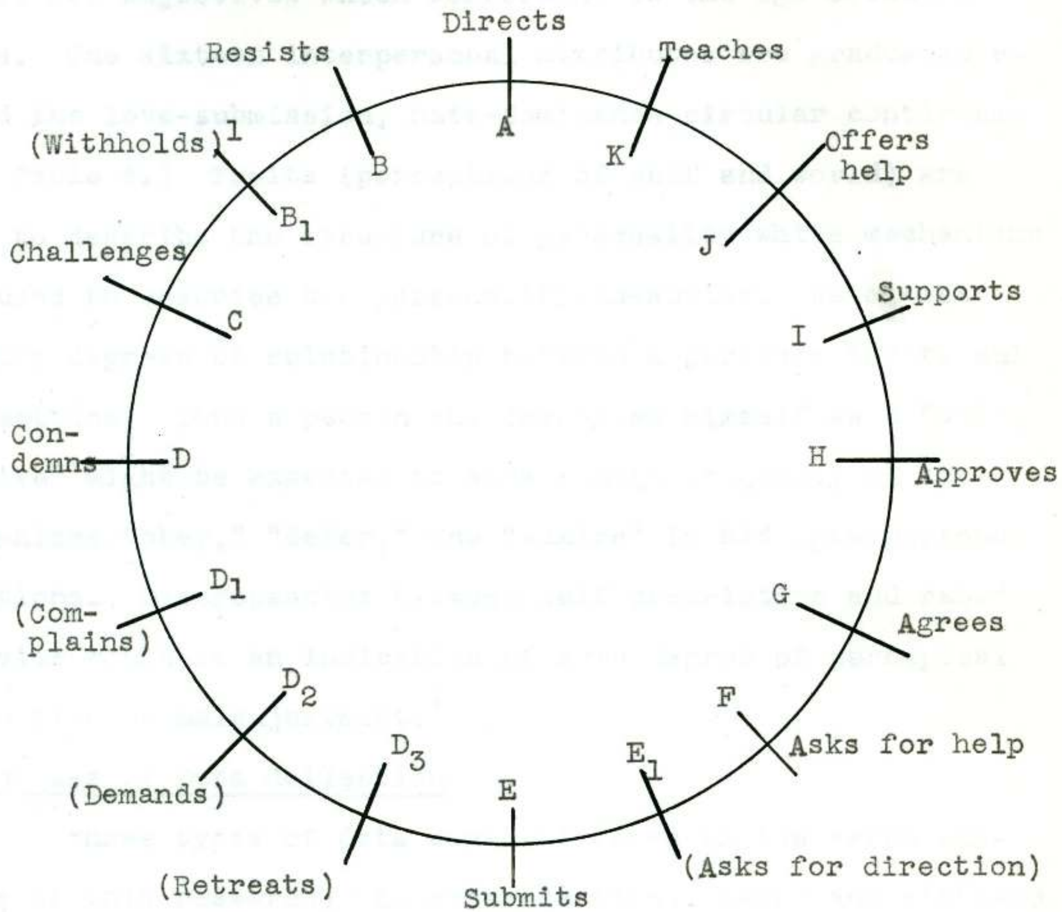
Task-oriented mechanisms are interpersonal actions which are motivated not so much by personal need as by a concern with the problem or task held in common with the other. The main task for the patient in therapy is participant observation of his own behavior in the past or the present. The interpersonal mechanisms used by the patient to describe his perceptions of himself and his world are "to confide" and "to inform." (See Table 2.)

Therapeutic mechanisms are a special type of task-oriented behavior. They are interpersonal actions which are motivated primarily towards offering therapeutic observations to other patients in the group. (See Table 2.) Two types of interpretations have been described in papers on psychoanalytic technique (6)--interpretations of resistance and interpretations of content. The therapeutic mechanisms of patients and therapist in this study have been classified in this manner in order to test the validity of Fenichel's dictum (6, p.45) "interpretation of resistance precedes interpretation of content."

Ego-oriented mechanisms are interpersonal actions motivated by personal need or tension. Ego-oriented mechanisms in therapy are usually aimed at preserving the patient's isolating, defensive role and resisting or avoiding the emotional closeness of the therapeutic relationship. Ego-oriented behavior has been classified into sixteen variables which are graduated along a circular continuum, each point of which represents a blend of power (dominance-submission) and friendly (love-hate) motivation. (See Table 3.)

TABLE 3

EGO-ORIENTED MECHANISMS



[1]The mechanisms in parentheses have been developed after the scoring for this research had been completed. These verbs are, therefore, not used in the scoring of interpersonal behavior for this paper.

It was stated above that structural variables are adjectives that describe or elaborate the personality in terms of traits. Two classes (dimensions) of traits are described by Freedman (7), interpersonal traits and modal traits. However, only the former are used in this research. Interpersonal traits are adjectives which correspond to the ego-oriented verbs. The sixteen interpersonal attributes are graduated around the love-submission, hate-dominance circular continuum. (See Table 4.) Traits (perceptions of self and world) are used to describe the structure of personality while mechanisms are used to describe the personality-in-action. We expect varying degrees of relationship between a person's traits and his actions. Thus a person who describes himself as a "submissive" might be expected to show a high frequency of the mechanisms "obey," "defer," and "admire" in his interpersonal relations. Discrepancies between self description and rated behavior would be an indication of some degree of perceptual distortion or maladjustment.[1]

Techniques of Data Collection

Three types of data were collected on the seven subjects of this research: A. cross-sectional tests administered before and after therapy, B. sociometric judgments of role and role change made during and after therapy by each patient

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[1]This relationship between the patient's self-descriptions and his mechanisms is an operational restatement of Sullivan's hypothesis "One achieves mental health to the extent that one becomes aware of one's interpersonal relation." (p.102)

and by the leader, C. typed transcriptions of every session providing a complete account of the verbal behavior during therapy.

A. Cross-Sectional Measurements of Improvement

The following tests were administered before and after the group therapy: Rorschach, Minnesota Multiphasic Personality Inventory, Stein Sentence Completion, and the Thematic Apperception Test. These tests were selected at the beginning of the research because they were assumed to tap different levels and areas of personality, not because they fitted into any theoretical system of interpersonal variables. The psychological variables measured by these four tests are markedly different. The verbal responses to the semi-structured stimuli of the Sentence Completion test and the Thematic Apperception Test can be scored according to several interpretive systems but changes in these symbolic productions are quite ambiguous unless they are interpreted in terms of a personality gestalt. Evaluation of change on the Minnesota Multiphasic Personality Inventory is also quite risky. For example, an increase in aggressive feelings attributed to heroes on the TAT stories might indicate that repressed hostility has been made tolerable to the self as the result of successful therapy. Similarly, an increase in the number of depression items on the Sentence Completion or the MMPI may indicate a malignant lowering of self-evaluation as the result of therapy or, in the case of hysterical personality, may indicate a more realistic picture of the self transitory to improved adjustment.

The projective perceptions tapped by the Rorschach, however, have been classified according to a complex interpretive system which provides measures of global adjustment. A conceptualization of the total personality (including interpersonal, intra-psychic, and expressive variables) is necessary to handle the complexity of changes that occur in the human being during therapy. Such a systematic approach to the measurement of personality has been presented in a collaborative paper (23). For this research, changes in overall adjustment as measured by the Rorschach will be used as the cross-sectional evaluation of improvement, and the use of the verbal and symbolic test results must be postponed until the completion of the systematic schema for representing personality in preparation by Ossorio, Freedman and Leary.

B. Subjective Judgments of Change in Adjustment

A sociometric test administered at the close of therapy required the subjects to rank all the patients in the group (including themselves) according to improvement in adjustment as the result of treatment. The therapist did the same. Thus, eight judges who have participated in the 24 sessions rate the patients on a seven point scale of improvement. Averaging the ranks assigned to each patient by the eight judges (including himself) provides a combined rating of change which can be compared with the objective measures of improvement.

C. Changes in Process Obtained from Typed Transcriptions

The typed transcriptions of the 24 sessions make pos-

sible many measures of patient and therapist activity. Each statement by the patients and the therapist has been scored for its interpersonal purpose. These interpersonal mechanisms have been classified in the preceding section into task-oriented, therapeutic, and ego-oriented. (See Table 2.) Thus, it is possible to chart the behavior of each patient to determine <u>role change</u> during the 24 sessions. The therapist's activity is rated in the same way to determine the effect of his behavior on the patients' responses.

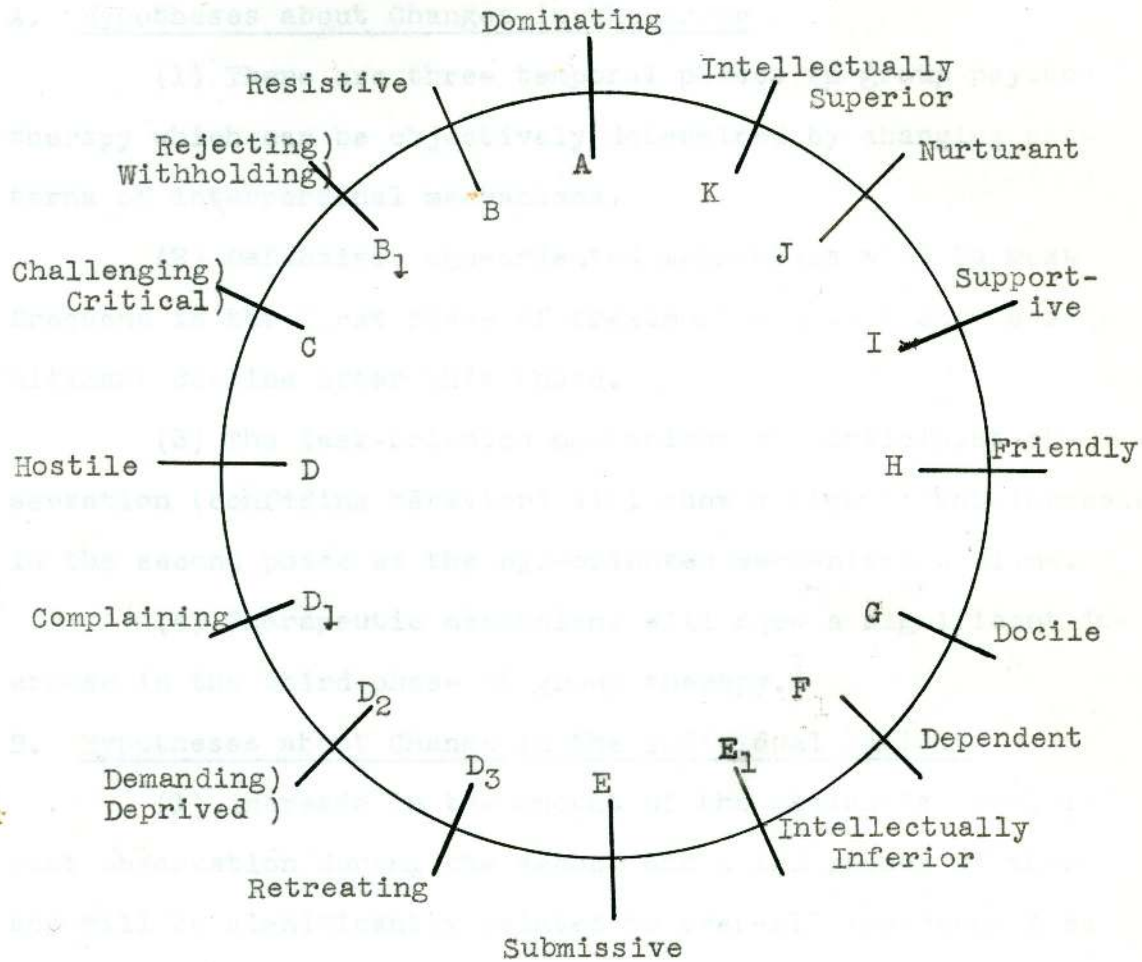
The <u>content</u> of the discussions (what the patient says about himself and his world) is rated according to structural (trait) variables which correspond to the interpersonal mechanisms. (See Table 4.) By studying the traits which the patient assigns to himself and his world during the 24 sessions it is possible to chart changes in self-perception and to determine statistically the relationship of these changes to changes in role or to changes in the cross-sectional and subjectively judged ratings of improvement.

<u>Hypotheses to be Tested</u>

While group therapy is primarily concerned with changes in the individual members who comprise the group, it is of interest to study the interpersonal behavior of the group-as-a-group. Combining the ratings of the individual members provides an over-all picture of group activity during the 24 sessions. Sequential changes in the group-totals will indicate general trends in this sub-society. These findings can be related to the therapist's activity to determine their rela-

TABLE 4

INTERPERSONAL TRAITS



tionship to his leadership role. To explore these relationships we shall consider: A. Hypotheses about the group behavior, B. Hypotheses about individual change, C. Hypotheses about the relationships between therapist activity and group and individual behavior.

A. Hypotheses about Changes in the Group

(1) There are three temporal phases in group psychotherapy which can be objectively determined by changing patterns of interpersonal mechanisms.

(2) Defensive, ego-oriented mechanisms will be most frequent in the first phase of treatment and will show a significant decline after this phase.

(3) The task-oriented mechanisms of participant observation (confiding behavior) will show a significant increase in the second phase as the ego-oriented mechanisms decline.

(4) Therapeutic mechanisms will show a significant increase in the third phase of group therapy.[1]

B. Hypotheses about Change in the Individual Patient

(1) Increase in the amount of the patient's participant observation during the second and third phases of therapy will be significantly related to over-all improvement as measured by the tests, judgments, and the rated changes in role and self-perception.

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[1] The transition point from one phase to another is objectively determined from ratings of the leader's interpretations and structuring activity in relation to the group. (See hypotheses concerning therapist activity.)

(2) The amount of role change during the 24 sessions (change in the type of ego-oriented mechanisms e.g. from hostile to friendly) will be significantly related to over-all improvement.

(3) The amount of change in self-description during the 24 sessions (diminishing of hostile-dominating traits attributed to the self) will be significantly related to over-all improvement.

C. Hypotheses about the Relationships between Therapist Activity and Patient Behavior

(1) Correct interpretations of role to the group-as-a-group will result in a significant decrease in ego-oriented behavior and an increase in confiding behavior.

(2) Interpretation by the therapist of the patient's role (interpersonal behavior in the group) will show a significantly higher relationship to the objective measurements of improvement than will interpretations of content.

(3) Improvement from therapy will be significantly related to the degree to which the therapist's interactions with the patients are positive, supportive, interpretatively helpful (interpersonal mechanisms K, J, I, H, and Q through U), and negatively related to the degree to which the therapist's interactions are hostile and coercive (interpersonal mechanisms B, C, and D).

CHAPTER IV

TEMPORAL PHASES IN GROUP THERAPY

This chapter will examine the hypotheses concerned with temporal changes in the interpersonal behavior of <u>the group</u> over 24 sessions of therapy. The general purpose is to determine whether there are statistically significant phases in the sequential progress of the group.

Every statement made during the course of treatment was scored in terms of the 26 interpersonal mechanisms (listed in Table 2 and defined in Appendix Table VIII) according to the underlying purpose implied. Of these mechanisms, 16 are ego-oriented and reflect the defensive and resistive techniques of the patient. Two mechanisms are directly concerned with the patient's task of <u>participant observation</u> which involves production of significant information about oneself in the present, past, and future. The two mechanisms which are used to score this type of task-oriented activity are "to confide" and "to inform" (about oneself). The five therapeutic mechanisms are used to indicate varying types of interpretive concern with other patients in the group. In Sullivan's terms this is participant observation of the other one.

Since the hypotheses to be tested in this chapter are

all concerned with temporal phases in group therapy, it was necessary to determine the time-units which divide the phases before the statistics for each unit could be calculated. For this purpose the 24 sessions were divided into three units: Phase I consisting of sessions 1-6, Phase II consisting of sessions 7-16, and Phase III including sessions 17-24.[1]

Table 5 presents a graphic description of the percentage of resistive (red), confiding (blue), and interpretive (green) behavior of the combined group and provides the test for four hypotheses.

Hypothesis A-2: "Defensive, ego-oriented mechanisms will be most frequent in the first phase of treatment and will show a significant decline after this phase." is accepted. The resistive mechanisms are clearly the most common Phase I behavior for this group and their decline in Phase II (from 70 to 53) is statistically significant (CR of 9.2).

Hypothesis A-3: "The task-oriented mechanisms of participant observation will show a significant increase in the second phase as the ego-oriented mechanisms decline." This is accepted for this group. They average 27% during the first phase and 44% during the second phase. The CR for this difference is 9.2.

Hypothesis A-4: "Therapeutic mechanisms will show a significant increase in the final phase of therapy." is ac-

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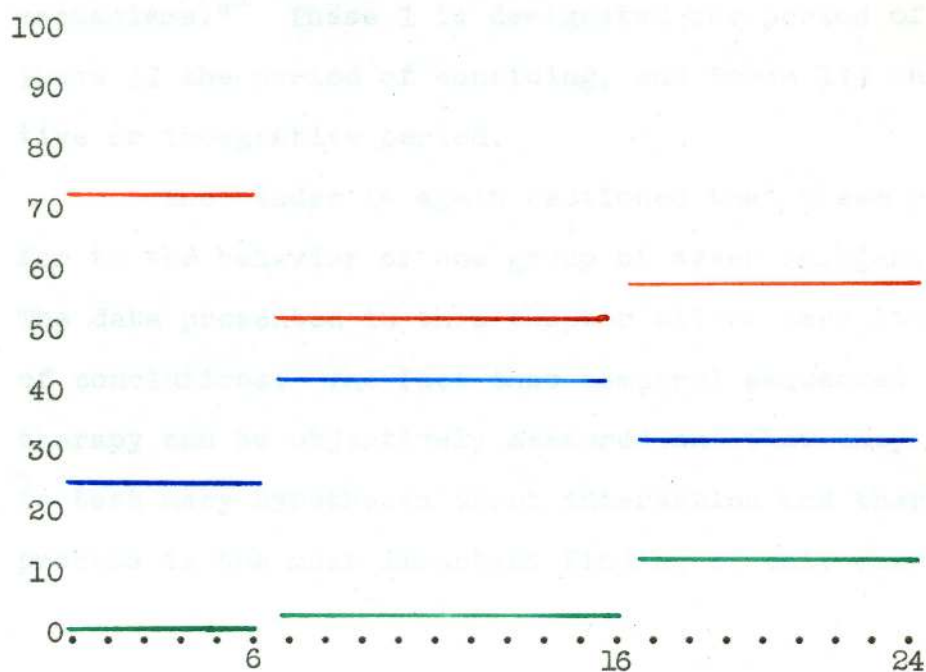
[1]This division into time units was arbitrarily selected on the basis of inspection of the data before calculation. It will be noted later that the inclusion of session 6 into Phase II would add to the positive findings.

TABLE 5

PERCENTAGE OF RESISTANT, CONFIDING, AND THERAPEUTIC MECHANISMS OF GROUP DURING THE THREE PHASES OF THERAPY



Resistant Mechanisms

Confiding Mechanisms

Therapeutic Mechanisms

cepted. They average 3% during the first two phases increasing to 13% during the final phase. This difference is statistically significant (CR of 6.3).

Hypothesis A-1, which is merely a summary generalization based on Hypotheses A-2, A-3, and A-4, is therefore, accepted for this group. It is demonstrated that, "There are three temporal phases in group psychotherapy which can be objectively determined by changing patterns of interpersonal mechanisms."[1] Phase I is designated the period of resistance Phase II the period of confiding, and Phase III the interpretive or integrative period.

The reader is again cautioned that these results refer to the behavior of one group of seven homogenous patients. The data presented in this chapter allows very limited types of conclusions. The fact that temporal sequences in group therapy can be objectively measured and that they can be used to test many hypotheses about interaction and therapeutic process is the most important finding of this chapter.

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[1]This generalization is restricted to the type of group which lasts for approximately 24 sessions. Longer therapeutic periods would be expected to show different temporal patterns.

CHAPTER V

CHANGES IN INDIVIDUAL PATIENTS DURING GROUP THERAPY

The preceding chapter has presented evidence that the therapy group-as-a-group changed behavior during the temporal sequences of the 24 sessions. The purpose of any psychological treatment process including group therapy is, however, to bring about changes in the individual patients. This chapter considers the degree and kind of changes demonstrated by each patient during and after group therapy.

Three general methods for measuring improvements in therapy have been discussed in this paper: A. Pre-and-post cross-sectional tests, B. Subjective judgments, and C. Changes in process (which include changes in role and self-perception). The following sections will provide specific definitions of the rating systems used to obtain these evaluations of improvement.

A. Cross-sectional Evaluations of Improvement

The cross-sectional technique for assessing changes in personality used in this study is the Rorschach. This test was selected because it provides global ratings of "over-all improvement in adjustment." Several techniques for rating Rorschach records have been employed (20)(21)(16).

The rating system published by Muench[1] (21) was designed specifically to evaluate changes resulting from psychotherapy and was, therefore, selected as one of the basic measures of objective change.

It seemed advisable to establish the stability of the Rorschach measure of change by comparing the Muench scoring system with a second independent rating technique. The pre-and-post therapy Rorschach protocols of the seven patients were, therefore, scored for a second time according to the maladjustment ratings devised by Ross (26). This system includes a list of 30 "neurotic" signs. Weights ranging from 1 to 6 are assigned to each sign depending on its significance in determining neurosis. For example, "no form-color" has a maladjustment weight of 2; "failures on card VI or on card IX" are each weighted 6.

The total possible neurotic score on the Ross scale is 73. Scores for this research sample on the pre-testing ranged from 9 to 26 with a group mean of 14. A score of 14 is considered to be moderately meurotic according to estimates from Ross' published data.

The Muench scoring of "signs of maladjustment" was applied to the pre-and-post therapy Rorschachs of the seven patients. By subtracting the post-therapy maladjustment score from the pre-therapy score an index of improvement was obtained. (See Table 6.) The Muench indices for improvement

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[1] For a description of this rating method see page 4 of this paper.

have been rank-ordered to give a comparative estimate of change based on the population of seven patients in the group.[1] The Ross indices for maladjustment were handled in similar fashion to provide a second rank-order of improvement. A rank-order based on the combined Ross and Muench indices is used as the "Combined Rorschach Improvement" rating. (See Table 6.)

B. Subjective Evaluation of Improvement

After the last session each patient ranked all other members of the group for improvement from therapy.[2] The therapist did the same. These rankings are presented in Appendix Table I. By averaging the ranks it is possible to derive a consensual rank-order of improvement based on six judges, which is designated as the rank-order of "Patients' Subjective Judgments." (See Table 7.)

The opinion of the therapist as to improvement in his patients has often been used as a criterion of recovery. To determine the relationship between the therapist's judgments and the independent measures of improvement, the rank-

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[1]The generalizations about improvement in therapy are thus limited to the sample of seven patients studied. As larger numbers of patients are included in this research large sample statistics including standard scores for improvement will be possible. This thesis is an exploratory study on seven patients. The statistic which reflects differences among seven subjects is the rank method. Relationships among the variables measured are, therefore, in terms of rank-order correlation (Rho).

[2]The sociometric form on which ranking of improvement was indicated is not available for one patient, GG.

order as rated by the group leader immediately after therapy is also included in Table 7 and in the inter-correlation matrix to follow.

TABLE 6

RANK ORDER OF IMPROVEMENT FROM THERAPY BASED ON MUENCH AND ROSS RATINGS OF PRE-AND-POST THERAPY RORSCHACHS

	MUENCH RATINGS		ROSS RATINGS		
PATIENT	NUMBER OF SIGNS OF IMPROVED ADJUSTMENT	RANK-ORDER OF IMPROVEMENT	DECREASE IN SCORE OF MALADJUSTMENT	RANK-ORDER OF IMPROVEMENT	COMBINED RANK-ORDER OF IMPROVEMENT BASED ON RORSCHACH
AA	4	3.5	11	2	3
BB	0	6	6	5	5
CC	12	1	9	3	2
DD	9	2	12	1	1
EE	4	3.5	7	4	4
FF	3	5	0	7	6
GG	-3	7	5	6	7

C. Changes in Process

The wire recording data make possible several indices of change during the 24 sessions. The measurements used in this study include: 1. Changes in participant observation, 2. Changes in role (e.g. from hostile to friendly), and 3.

Changes in self-perception (patient's perception of his own role). The operational definition of these changes will be presented along with the resulting rank-orders of improvement and the relationship to external measures of change (Rorschach and subjective ratings).

TABLE 7

RANK ORDER OF IMPROVEMENT FROM THERAPY BASED ON COMBINED SUBJECTIVE JUDGMENTS OF SEVEN PATIENTS AND THERAPIST*

PATIENT	AVERAGE OF PATIENTS' JUDGMENTS OF IMPROVEMENT	THERAPIST'S JUDGMENTS OF IMPROVEMENT
AA	1.5	1
BB	4	2
CC	5	4
DD	3	3
EE	1.5	6
FF	7	5
GG	6	7

*Each patient ranked all members of the group including himself.

1. Changes in Participant Observation

Participant observation which, according to Harry Stack Sullivan, is the task of the patient in therapy, consists in confiding significant material about oneself.[1] In the termin-

[1]Participant observation in the group therapy situation in-

ology of this research participant observation is measured by the mechanism "to confide." Confiding of emotionally toned personal material in therapy is always blocked to some extent by resistant techniques which are the protective, isolating, interpersonal techniques exhibited by the patient in anxiety-laden situations. Resisting interactions are measured by the ego-oriented mechanisms. The first measure of therapeutic progress to be studied concerns changes in participant observation. We are interested in charting the decline of ego-oriented resistances and the increase in confiding behavior.

Table 8 indicates the number of confiding responses for each patient during the first, second, and third phases and the percentage of such responses in Phase I as compared with Phase II plus Phase III. The larger the percentage in Phases II plus III the greater the increase in participant observation. Also included in Table 8 are the ranks of the patients in order of increase in percentage of confiding behavior. Patients AA and BB, for example, who rank highest

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volves an additional factor. In addition to confiding and observing one's own behavior, the patient is also requested to participate in the therapeutic growth of his fellow patients. Thus, participant observation includes not only the mechanism "to confide," but also the interpretive mechanisms through which the patient observes and assists his fellow patients. The statistic used to rank participant observation in this chapter is based on changes in confiding behavior alone. To test the relationship of the confiding to the therapeutic mechanisms the two were combined and the change for the combined behavior ranked. The Rho between change in confiding and change in confiding-plus-interpreting is .81. This correlation is highly significant. The rank-order for "change in confiding" alone is used in the intercorrelation matrix to avoid duplication of results.

in increase of participant observation showed no confiding behavior in Phase I and displayed 34% and 51% of confiding responses respectively during Phases II and III.

TABLE 8

NUMBER OF CONFIDING MECHANISMS AND RANKED CHANGE IN PERCENTAGES BETWEEN PHASE I AND PHASES II PLUS III

PATIENT	NUMBER OF CONFIDING MECHANISMS PER PHASE			% OF CONFIDING MECHANISMS IN PHASE II PLUS III	RANKED INCREASE IN PARTICIPANT OBSERVATION
	PHASE I	PHASE II	PHASE III		
AA	0	21	13	100%	1.5
BB	0	28	23	100%	1.5
CC	1	42	4	98%	3
DD	10	31	42	88%	4
EE	9	26	20	84%	5
FF	8	12	26	83%	6
GG	20	45	10	64%	7

Change in confiding behavior in therapy has little meaning unless it is related to independent criteria of change. Table 9-A presents the rank-order of improvement for each patient based on six measures of change of which three (1. change measured by the Rorschach, 2. change measured by the group's judgments, and 3. change in participant observation) have

been thus far defined.

TABLE 9-A

RANK ORDER OF IMPROVEMENT

FROM PSYCHOTHERAPY BASED ON SIX MEASURES OF CHANGE

	1	2	3	4	5	6
PATIENT	TOTAL RORSCHACH CHANGE	TOTAL OF PATIENTS' SUBJECTIVE JUDGMENTS	CHANGE IN PARTICI- PANT OB- SERVATION	ROLE CHANGE	CHANGE IN SELF PER- CEPTION	THERAPIST'S JUDGMENTS OF CHANGE
AA	3	1.5	1.5	2	2	1
BB	5	4	1.5	1	3	2
CC	2	5	3	3.5	6	4
DD	1	3	4	3.5	5	3
EE	4	1.5	5	6	1	6
FF	6	7	6	5	4	5
GG	7	6	7	7	7	7

TABLE 9-B

RHO CORRELATIONS BETWEEN

SIX MEASURES OF IMPROVEMENT FROM PSYCHOTHERAPY*

ρ 12=.56(.18)				
ρ 13=.54(.18)	ρ 23=.54(.18)			
ρ 14=.49(.20)	ρ 24=.56(.18)	ρ 34=.99(.01)		
ρ 15=.11(.26)	ρ 25=.71(.13)	ρ 35=.42(.21)	ρ 45=.31(.26)	
ρ 16=.56(.18)	ρ 26=.45(.22)	ρ 36=.92(.04)	ρ 46=.95(.03)	ρ 56=.36(.23)

*The probable error figures for each correlation are contained in parentheses.

It will be seen from Table 9-B that increase in participant observation (#3) shows a Rho correlation of .54 (PE=18) with improvement as measured by the Rorschach and .45 (PE=22) with improvement as judged by the group. There is, therefore, an insignificant relationship between increase in confiding and subjective ratings of improvement by fellow group members. There is a "fairly certain" (11, pp.61 and 333) relationship between improvement as measured by the Rorschach and as measured by increase in confiding.

When ratings of improvement based on increased participation are compared with improvement as judged by the therapist, a striking relationship is obtained (Rho = .92). This suggests that the leader's subjective criteria for rating amount of gain during therapy is concerned with the patient's growing ability to relate himself to his fellow group members and to the leader in a task-oriented manner.

2. Changes in Role

We have seen that decrease in percentage of resistant behavior is related to external criteria of improvement. A second measure of role behavior concerns the type of interpersonal mechanism used by the patient. A patient's behavior in the group can change not only in terms of the amount of resistance, but also in terms of the kind of resistant mechanisms displayed. The ego-oriented mechanisms are classified according to eleven interpersonal purposes which are blends of power-submission and love-hate. The isolating roles displayed by this liberal, college group were those of intellect-

ual dominance. Examination of the group totals shows that 68.5 of their ego-oriented behavior is included under the three mechanisms K-teach, B-resist, and C-challenge (see Appendix Table II). Twenty-four percent of the group total was included under the supportive, friendly, and agreeable mechanisms (I, H, G, F, and E).

TABLE 10-A

CRITICAL RATIOS FOR PATIENTS' ROLE CHANGE
DURING THE THREE TEMPORAL PHASES OF GROUP PSYCHOTHERAPY

PATIENT	DECREASE IN:	PHASE I ROLE VERSUS PHASE II ROLE	PHASE II ROLE VERSUS PHASE III ROLE	PHASE I ROLE VERSUS PHASE III ROLE
AA	Dominance	3.1	-0.3	3.0
	Hostility	3.0	1.9	4.8
BB	Dominance	0.8	3.8	4.8
	Hostility	2.6	1.3	4.8
CC	Dominance	3.8	-0.2	2.8
	Hostility	3.6	-1.7	2.1
DD	Dominance	-1.8	3.5	1.1
	Hostility	-0.4	3.6	2.1
EE	Dominance	-0.4	0.5	0.0
	Hostility	-1.1	2.9	1.2
FF	Dominance	1.1	0.8	2.1
	Hostility	1.1	0.3	1.5
GG	Dominance	-0.1	0.1	0.0
	Hostility	1.2	-1.2	0.1

TABLE 10-B

RANK ORDER OF DOMINANCE AND HOSTILITY ROLES

FOR THE THREE TEMPORAL PHASES OF GROUP PSYCHOTHERAPY

RANK FOR DOMINANCE				PATIENT	RANK FOR HOSTILITY			
Phase I	Phase II	Phase III	Change I vs III		Phase I	Phase II	Phase III	Change I vs III
1	1	1	0	AA	1	1.5	4	3
4	3.5	6	2	BB	4	7	7	3
2	7	4	2	CC	2	5	1	-1
7	3.5	7	0	DD	5	3	6	1
6	6	5	-1	EE	6.5	1.5	5	-1.5
3	2	2	-1	FF	3	4	2.5	-5
5	5	3	-2	GG	6.5	6	2.5	-4.0

TABLE 10-C

COMBINED ROLE CHANGE

BETWEEN PHASE I AND PHASE III

PATIENT	RANKED ROLE CHANGE*
AA	2
BB	1
CC	3.5
DD	3.5
EE	6
FF	5
GG	7

*This rank ordering of role change shows a Rho Correlation of .99 when the CR's for role change between the same phases are ranked.

To measure change in role during the three phases the ego-oriented mechanisms were combined into four groups to provide ratings of hostility, dominance, friendliness, and docility. The dominance score was obtained by combining mechanisms B, A, and K. The submission-docility score was obtained by combining mechanisms E, F, and G. The hostility score included mechanisms B, C, and D, and the friendliness rating included G, H, and I. Appendix Table III presents these scores for each patient during the three phases of therapy. Every patient displays a greater amount of hostility and dominance during the first phase. The friendliest patient, for example, showed almost twice as many hostile as positive mechanisms (24:13); the least dominant patient was almost twice as dominant as submissive in this first phase (49:29).

When Phase III is compared with Phase I, every patient shows a decrease in dominant and hostile mechanisms and an increase in positive and docile behavior. Over a third of these differences in role are significant at the .01 level, and over half are significant at the .05 level. (See Table 11-A.)

Table 10-B presents the rank-order of the patients for each phase in terms of the dominance and hostility percentages. Thus, patient AA was the most dominant member of the group in every phase. Patient BB was ranked fourth in dominance during the first phase and dropped to sixth during the final phase. By combining the total change in ranks between Phase I and Phase III, an overall ranking of role change is obtained.[1]

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[1]The term role change as used in this paper, therefore, indicates the decrease in combined dominance-hostility mechanisms in the direction of friendliness and docility.

This rank order (Table 11-C) is taken to be stable and significant since it correlates .99 (Rho) with the ratings of role change as obtained by ranking the CR figures.

The correlation matrix in Table 9-B shows the relationship between role change in the group and the other measures of improvement. Role change is most significantly related to increase in participant observation (Rho=.99 PE=10), i.e. the patient whose confiding behavior increased the most showed a corresponding decrease in hostile and dominating defensiveness. Conversely, the patients who showed the least amount of increase in participant observation showed the least increase in friendly and cooperative behavior.

Role change shows a fairly significant relationship to improvement as rated by the judges (Rho=.56 PE=.18), and there is some relationship between changes in role and Rorschach ratings of improvement (Rho=.49 PE=.20).

3. <u>Changes in Self-Perception</u>

Changes in role and in amount of participant observation during therapy are directly concerned with "what the patient does" in the group. We shall now turn to "what the patient says" in treatment to determine the meaningfulness of changes in self-perception.

The content of every statement made by the patient during the 24 sessions was studied in terms of the interpersonal traits attributed to the self. These statements were coded in terms of the 16 trait variables listed in Table 4. A combined rating of self description in terms of dominance

(traits A, K, and B), submission (D_3, E, and E_1), hostility (traits B, C, and D), and friendliness (G, H, and I) was obtained for each phase of therapy. Appendix Table IV presents the numbers of these combined traits attributed to the self and the dominance-submission, love-hate ratios for the three phases.

TABLE 11-A

CRITICAL RATIOS FOR CHANGES IN SELF PERCEPTION DURING THE THREE TEMPORAL PHASES OF GROUP PSYCHOTHERAPY

PATIENT	DECREASE IN:	PHASE I ROLE VERSUS PHASE II ROLE	PHASE II ROLE VERSUS PHASE III ROLE	PHASE I ROLE VERSUS PHASE III ROLE
AA	Dominance	3.6	0.5	2.4
	Hostility	1.3	1.5	2.6
BB	Dominance	0.4	0.3	0.9
	Hostility	-0.2	0.8	0.6
CC	Dominance	-1.0	-0.9	-1.6
	Hostility	0.1	-1.8	-1.4
DD	Dominance	-1.2	1.7	0.1
	Hostility	-1.3	1.6	0.3
EE	Dominance	0.7	-0.6	0.3
	Hostility	2.3	-0.3	3.2
FF	Dominance	-0.2	1.6	1.6
	Hostility	-0.7	0.1	-0.7
GG	Dominance	0.9	-4.0	-3.6
	Hostility	2.5	-2.0	-0.2

TABLE 11-B

RANK ORDER OF DOMINANCE AND HOSTILITY TRAITS ATTRIBUTED TO SELF FOR THE THREE TEMPORAL PHASES OF GROUP PSYCHOTHERAPY

RANK FOR DOMINANCE				PATIENT	RANK FOR HOSTILITY			
Phase I	Phase II	Phase III	Change I vs III		Phase I	Phase II	Phase III	Change I vs III
1	1	2.5	1.5	AA	3	5	6	3
2	3	4	2	BB	1	1	2	1
4.5	2	2.5	-2	CC	4	3	1	-3
7	5	7	0	DD	7	2	5	-2
3	7	5	2	EE	2	7	7	5
4.5	4	6	1.5	FF	6	4	3	-3

TABLE 11-C

COMBINED CHANGE IN SELF-PERCEPTION BETWEEN PHASE I AND PHASE III*

PATIENT	RANKED CHANGE IN CONTENT
AA	2
BB	3
CC	6
DD	5
EE	1
FF	4
GG	7

*This rank ordering of content change shows a Rho correlation of +1.0 with the rank-order of CRs for content change for the same phases.

Although these patients displayed roles that were markedly resistant (dominant and hostile) in the initial phases of therapy, their self-descriptions when coded according to the same dominant-hostility ratios were at some variance (see Appendix Tables III and IV). The patients described themselves percentage wise as less dominating and less hostile than the percentage ratings of their actual behavior. The self-descriptions in terms of dominance (A, B, K), submission (D_3, E, E_1), hostility (B, C, D), and friendliness (G, H, I) during the three phases were tabulated (see Appendix Table IV) and the patients ranked in order of increase in friendly and deferent self-perceptions (see Table 9, column 5).[1]

The correlation matrix (Table 9) makes possible the following generalizations: change in self description (i.e. change in what patients say about themselves) is highly related to improvement as measured by the subjective judgments of the total group (Rho=.71 PE±.13). It shows a slight (non-significant) relationship to change in role (Rho=.31) and in participant observation (Rho=.42). It is apparently unrelated to improvement as measured by the Rorschach.

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[1]A second tabulation for these four generic self-perceptions was also employed using the following summed traits: hostile-dominance (A, B, C, B_1, D), hostile-weakness (D, D_1, D_2, D_3, E), friendly-weakness (E_1, F, G, H) and friendly-dominance (K, J, I, H). The rank-order of increase in friendly-dominance and friendly-submission was calculated and correlated with increase in self-perception based on the original tabulation with a Rho of .93. This indicates that the ratings for change towards a more positive self-perception is a stable measurement, not an artifact of the tabulation process.

This suggests that the subjective judgments of improvement made by fellow-patients are more directly based on "what" the patient says than upon the way that he acts in therapy. The therapist was apparently much less concerned with changes in self-description (Rho=.34) and based his ratings on changes in role (Rho=.95).

Hypotheses About Changes in Individual Patients

This chapter has, thus far, presented operational definitions of six measurements of improvement resulting from therapy. Tables 10-A and 10-B have summarized the rank order of change for each of these measurements and Rho correlations between them. It will be necessary to keep in mind that these rank-orders are obtained from a sample of seven patients. The generalizations which follow are based on statistical tests of significance which are restricted by the size of the sample.

We can now consider the hypotheses about change in the individual patient.

Hypothesis B-1 which holds that "Increase in the amount of the patient's participant observation during the second and third phases of therapy will be significantly related to overall improvement as measured by the tests, judgments, and the rated changes in role and self-perception," is accepted in part. Increase in confiding is significantly related to change in role (.99). It is related with a "fair" degree of certainty to change as measured by the Rorschach (.54) and as rated by the judges (.54). It is not significantly related to change in self-description (.42). It is correlated most highly with

the therapist's ratings of improvement (.92).

Hypothesis B-2, which holds that "the amount of role change during the 24 sessions will be significantly related to over-all improvement," is accepted in part. Role change shows a very meaningful relationship to change in participant observation (.99) and to improvement as judged by the therapist (.95). Its relationship to improvement as measured by the Rorschach (.49) and increase in positive self-descriptions (.31) is not significant.

Hypothesis B-3 which states that "the amount of change in self-perception during the 24 sessions will be significantly related to over-all improvement" cannot be accepted. Changes in view of the self are highly correlated with subjective judgments of change by fellow members (.71) but show no significant relationship with the other measures of improvement. It is of interest to note that the therapist's ratings of changes varies very closely with changes in role and participant observation. The therapist, apparently, was much more impressed with the way the patient behaved (.92) and less concerned with changes in view-of-self (Rho_{56}=.36). The fellow-group members, on the contrary, were more impressed by changes in self-description as suggested by the Rho_{25} which is .71.

Table 9 provides an interesting sidelight on the relationship of objectively scored Rorschach ratings to other measures of change. The Rorschach rankings agree most closely with the therapist's rankings and with increase in participant observation (both are fairly significant). It shows a fairly

certain relationship with change as judged by the group and an insignificant relationship with role change and content change.

CHAPTER VI

SOME EFFECTS OF THERAPIST BEHAVIOR ON PATIENT'S IMPROVEMENT FROM PSYCHOTHERAPY

The preceding chapters have examined hypotheses concerning changes in group behavior, individual-patient behavior, and their relationship to external measures of improvement. The next area to be studied concerns the effects of the therapist's interpretive and ego-oriented activity.

Every statement by the therapist was scored according to the inter-personal mechanisms used to score patient behavior which are presented in Table 2. This provides an objective rating of his interactions with each member of the group and with the group-as-a-group.

1. <u>Relationship of Role Interpretations to Group Behavior</u>

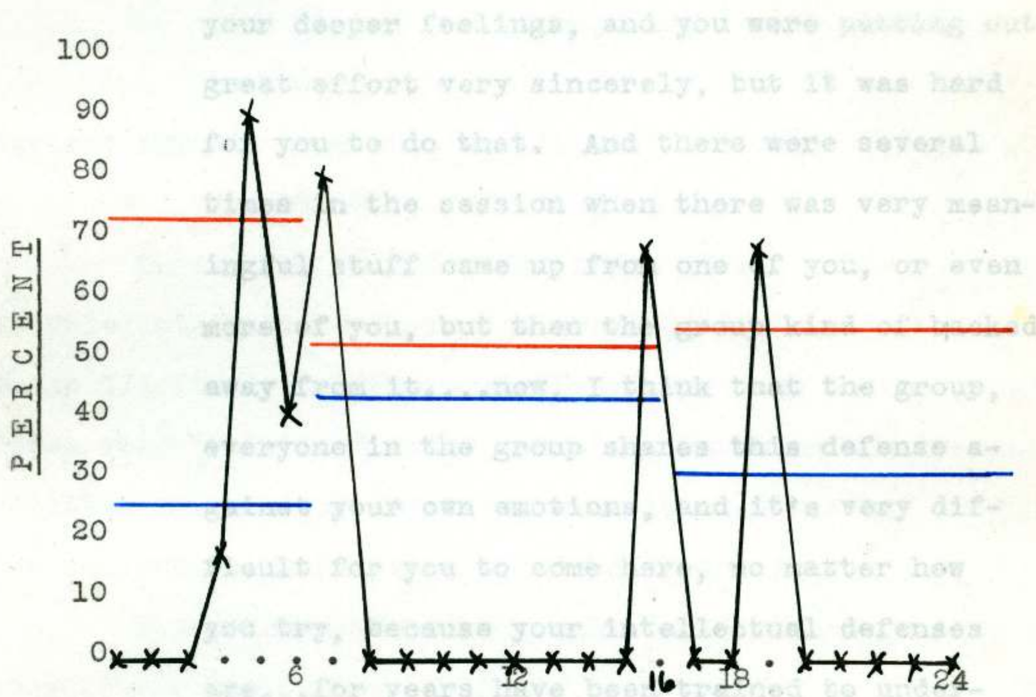
We shall first compare the therapist's interpretations to the group with the subsequent group behavior. Table 12 presents a graph of the group's resistant (red) and confiding (blue) activity for each session and averaged for the three phases. It is seen that a marked shift in participant observation occurred around the sixth session. The increase in confiding and decrease in resisting has been established as highly significant (see p.37).

We have (p.27) defined two types of therapist activity--interpretations of role and interpretations of content.

The ratio between role and content interpretations in each session has been calculated and the percentage of role interpretations is graphed in Table 12.

TABLE 12

PERCENTAGE OF THERAPIST ROLE INTERPRETATIONS AND PATIENT RESISTANT AND CONFIDING BEHAVIOR DURING GROUP THERAPY



KEY: RED - % OF RESISTANT MECHANISMS
BLUE - % OF CONFIDING MECHANISMS
X-X - % OF THERAPIST ROLE INTERPRETATIONS

Thus, we observe that the therapist's interpretations during the first four sessions were almost entirely directed to content. A cluster of role interpretations occurred in

sessions 5-7. In Session 5, for example, ten role interpretations were made to the group--of which nine referred to the intellectualized defensiveness which had characterized their behavior during the first four sessions. Two samples of this interpretive interaction directly quoted from the protocol of Session 5 may serve to illustrate:

Therapist: (At beginning of session, referring to previous hour) "...you were trying very hard to express your deeper feelings, and you were putting out great effort very sincerely, but it was hard for you to do that. And there were several times in the session when there was very meaningful stuff came up from one of you, or even more of you, but then the group kind of backed away from it....now, I think that the group, everyone in the group shares this defense against your own emotions, and it's very difficult for you to come here, no matter how you try, because your intellectual defenses are...for years have been trained to underemphasize this."

Therapist: (At the end of the session) "Patient X made a very frank statement about his own personal experience, which took, I am sure, a great deal of courage. It showed great confidence in the group, and doing that was probably the best example of letting down defenses. He showed

trust in you by confiding. Then the whole group--X as much as any of you--started talking like a group of anthropologists or theologians, or moralists, and..you gave your own theories about sex. And "What is normal?" and anthropology, and "Is it better for a person to have premarital relations or remain a virgin until your marriage?" and so forth. And, by God, we ran the gamut, didn't we? (general laughter)

Patient DD: "We were sure worried stiff today!" (more laughter)

During the remainder of Phase II the therapist made no role interpretations to the group-as-a-group. During Phase III four role interpretations were made to the group. These were "relating" interpretations in which the therapist recalled their early defensive behavior and related it to the content which had been confided during Phase II.

Thus, Table 12 gives graphic evidence suggesting that role interpretation was followed by a statistically significant decrease in resistance and an increase in confiding. Hypothesis C-1, which states that correct interpretations of role to the group-as-a-group will result in a significant decrease in ego-oriented behavior and an increase in confiding behavior, is, therefore, in the absence of statistical evidence, tentatively accepted.[1]

[1]Statistical data to test this hypothesis is not available due

2. Relationship of Role Versus Content Interpretation to Change in Individual Patients

We have tentatively established the fact that role interpretations to the group-as-a-group are related to changes in group behavior. If this generalization holds for the individual patient we should expect to find a relationship between the amount of interpretation of role and change in role behavior.

The therapist's interpretive interactions with each patient were classified according to whether they were directed towards the content of the patient's verbal statements or towards his role behavior. The ratio of role-to-content interpretations received by each patient was calculated and the patients were ranked in order of percentage of role interpretations received. (See column 7 in Table 13-A.)

Thus, we see that patient CC received the highest ratio of role:content interpretations while patient FF received the highest ratio of content: role interpretations. The rank-order of role-interpretations received was correlated with the six measures of improvement which were presented in the preceding chapter. It is possible to relate percentage of role interpretations to change in therapy and thus, to test Hypothesis C-2, which reads "Interpretation by the therapist of the patient's role will show a significantly high relationship to the objective measurements of improve-

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to the small number of interpretations to the group-as-a-group. A recent revision of the list of interpersonal mechanisms which provides a more specific handling of interpretations should provide a more rigorous testing of this hypothesis in the future.

ment than will interpretations of content." Table 13-B indicates that role interpretation is significantly related to change in participant observation (Rho=.73 PE=.12), to change in role (Rho=.67 PE=.14), and to improvement as rated by the therapist (Rho=.64 PE=.16). It is related with "fair" certainty to change as measured by the Rorschach (Rho=.57 PE=.17). Role interpretation shows some positive relationship (Rho .48 not significant) to change as judged by the total group.

TABLE 13-A

RANK-ORDER OF PERCENTAGE OF THERAPIST'S ROLE-INTERPRETATIONS AND NURTURANT-INTERPRETATIONS RECEIVED BY EACH PATIENT

PATIENT	#8 NURTURANT AND INTERPRETIVE REMARKS BY THERAPIST TO EACH PATIENT	#7 PERCENTAGE OF ROLE INTERPRETATIONS BY THERAPIST TO EACH PATIENT
AA	5	2
BB	4	3
CC	1	1
DD	2	4
EE	7	6
FF	3	7
GG	6	5

A statistic of interest is the minus correlation (Rho = -.11 PE=.26) between role interpretation and changes in con-

tent.[1] While this is a non-significant figure it suggests that patients who receive more content interpretations show more change in self perception, whereas, we have seen, the reverse is significantly true--patients who receive the largest ratio of role interpretations show most role change in the group.[2]

Hypothesis C-2, therefore, is accepted in part. The larger the ratio of role interpretations received by a patient the more he changes in the direction of increased participant observation, increased positive interpersonal mechanisms, and the greater his improvement as judged by the therapist. The percentage of role interpretations shows no relationship to increase in positive self-description.

3. Effects of Nurturant Behavior by Therapist on Patient Improvement

Since the therapist's ego-oriented interactions with each group member were scored, it is possible to compare his supportive and interpretive mechanisms (K, J, I, H, Q, U, R, S, T) with his hostile and coercive interactions (A, B, C, D).

The ratio of positive-nurturant-interpretive mechanisms received by each patient (from the therapist), i.e. the nurturance:hostility ratio, was obtained. The patients were then ranked according to the percentage of nurturant remarks received from the leader. (See Table 14-A, column 8).

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[1]It will be remembered that the rank-order for role interpretation is based on the ratio of role:content interpretations received by each patient.
[2]The Rho between content change and the rank-order based on ratio of content interpretations received is .14.

TABLE 13-B

RHO CORRELATIONS BETWEEN TWO TYPES* OF THERAPIST INTERPRETATION AND SIX MEASURES OF IMPROVEMENT FROM PSYCHOTHERAPY

	7. PERCENTAGE OF ROLE INTERPRETATIONS TO EACH PATIENT	8. NURTURANT INTERPRETATIONS TO EACH PATIENT
1. TOTAL RORSCHACH CHANGE	ρ 71 = .57 (.17)	ρ 81 = .54 (.18)
2. TOTAL SUBJECTIVE JUDGMENTS	ρ 72 = .48 (.20)	ρ 82 = -.05 (.27)
3. CHANGE IN PARTICIPANT OBSERVATION	ρ 73 = .73 (.12)	ρ 83 = .28 (.25)
4. ROLE CHANGE	ρ 74 = .67 (.14)	ρ 84 = .42 (.21)
5. CHANGE IN SELF PERCEPTION	ρ 75 = -.11 (.26)	ρ 85 = -.46 (.20)
6. THERAPIST'S JUDGMENTS OF CHANGE	ρ 76 = .64 (.15)	ρ 86 = .32 (.24)

*The probable error figures for each correlation are contained in parentheses.

This ranking was then correlated with the measurements of improvement. Table 13-B, column 8 contains the Rho correlations that make possible a test of the final hypothesis. Hypothesis C-3 states that improvement from therapy will be significantly related to the degree to which the therapist's interactions with the patients are positive, supportive, interpretively helpful. This cannot be accepted. Nurturance on the part of the therapist appears to have no relationship to role change, content change, or subjective judgments of im-

provement. There is a "fairly" certain relationship between therapist nurturance and Rorschach improvement. It is of interest to note that nurturance does not significantly effect the therapist's tendency to make role interpretations (Rho_{78}= .43 PE = .21).

The data presented and analyzed in this chapter points to the importance in this particular group of role interpretation in therapy and lends objective support to Fenichel's statement that analysis of transference must precede analysis of content. It is further suggested that positive interpersonal behavior on the part of the leader was not in itself significantly related to the help obtained by the patients studied in this research.

CHAPTER VII

SUMMARY AND CONCLUSIONS

This dissertation is concerned with the objective testing of the interpersonal theories of Harry Stack Sullivan. The primary task was to determine the feasibility and usefulness of measurements of interpersonal activity in therapy. The interactive behavior of seven patients and a group therapist was scored, and these ratings were related to indices of improvement from treatment. In a small sample study of this sort the purpose is not to establish generalizations about social interaction or therapeutic process, but to demonstrate that these important areas can be objectively measured.

Historical Context for this Research

This concern with the interpersonal aspects of personality and therapy is consistent with converging trends in psychology and psychiatry over the past 50 years. The pre-analytic therapists and personologists (e.g. Janet, Breuer, Pratt) have been described as non-dynamic and symptom-oriented. Their treatment techniques, in particular, were therapist centered. The psychiatrist suggested, lectured, and reasoned. The patient's role behavior in and out of the con sulting room was not the focus of attention.

Classic Freudian theory with its emphasis on unconscious motivation and transference phenomena provided a framework in which the patient was seen as a complex resolution of dynamic forces. The psychoanalytic techniques of group therapy (e.g. Lazell, Wender) were, however, content-oriented. The therapist addressed his interpretations to the topical content of "what the patient said."

During the 1930's Fenichel emphasized the complex, diverse nature of resistance and transference and the importance of interpreting the interpersonal activity before the topical content.

The interpersonal theories of Harry Stack Sullivan have made the patient-therapist relationship the focus of treatment. Group therapists working within the Sullivan framework have seen group interactions as a rich source of interpersonal data available for increased insight and socialization on the part of the patient and for definitive research purposes on the part of the psychologist.

The Research Methodology

Objective testing of the Sullivan tenets has awaited the development of a systematic methodological schema for measuring interpersonal behavior. Such a methodology has been developed by Freedman, Leary, and Ossorio. This schema includes two types of personality variables--interpersonal mechanisms (process or action variables) and interpersonal traits or self perceptions (structural variables).

The mechanisms are 16 generic verbs which classify

interpersonal action along a love-power-hate-submission continuum. The interpersonal traits are 16 generic adjectives which correspond to the mechanisms. Each recorded verbal interaction of the patients and therapist is assigned an interpersonal mechanism according to the inferred purpose. Thus the interpersonal mechanisms answer the question, "Why does he say this?", irrespective of content. Three types of mechanisms are defined: ego-oriented mechanisms reflecting personal need or tension, task-oriented mechanisms consisting of confiding or informing about self (participant observation), and therapeutic mechanisms which are nurturant interpretive remarks.

The topical content of the therapy sessions is evaluated by means of the continuum of 16 interpersonal adjective traits. Each statement that the patient makes about his interpersonal behavior was assigned to an interpersonal trait category. Thus, the trait scores answer the question, "How does he see himself?", irrespective of his actual behavior.

Changes in interpersonal behavior (i.e. role change) and changes in self description (content change) during the course of the 24 sessions have been studied. Patients show varying amounts of role change during the therapy, particularly in respect to increase in friendly-confiding activity and decrease in hostile resistance. Some patients show significant changes in self description, attributing less hostile coerciveness and more friendly cooperativeness to themselves over the course of treatment.

The rank-order for role and content changes was correlated with changes as measured by the Muench Rorschach ratings and subjective judgments of the patients and the therapist.

Results

The main emphasis of the research is to test the adequacy of the Freedman-Leary-Ossorio system for measuring interpersonal relations. This methodology is applied to seven patients from a homogenous sub-culture--male, white, Unitarian college students. The generalizations about change in therapy are, therefore, limited. The fact that statistically significant results were obtained for this sample demonstrates the usefulness of the measurement method and provides tentative substantiation of the theories of Harry Stack Sullivan.

Hypotheses were made about three aspects of the therapy process: A. temporal patterns of group behavior, B. change in individual patients as measured by Rorschach ratings, subjective judgments, and change in role and content, C. the relationship between therapist activity and patient change.

A. Hypotheses about Change in the Group

A study of the combined interpersonal mechanisms of the seven patients demonstrated that in 24 sessions "There are three temporal phases in group psychotherapy which can be objectively determined by changing patterns of interpersonal mechanisms." Defensive, ego-oriented mechanisms were more frequent in the first phase (sessions one to six) and their decline in Phase II (from 70 percent to 53 percent) is statistically significant (CR = 9.2). The task-oriented mechanisms

of participant observation show a significant increase in the second phase (sessions seven to sixteen). They number 27 percent during the first phase and increase to 44 percent during Phase II. The CR for this difference is 9.2. The therapeutic mechanisms show a significant increase in the third phase of therapy (sessions 17 to 24). They average 3 percent during the first two phases and increase to 13 percent in Phase III. (CR = 6.3.) These findings are highly significant for this one small group which ran for 24 sessions. Additional groups are now being studied to determine whether different types of patients and varying numbers of sessions modify these generalizations.

B. Hypotheses about Change in the Individual Patient

The patients were ranked for the amount of increase in participant observation (confiding behavior) during the second and third phases of therapy, and this rank order was compared with the ranked amount of change as measured by other indices. The following relationships were established for this group: Increase in participant observation is closely related to improvement as judged by the therapist and insignificantly related to improvement as judged by the fellow patients. Increase in confiding shows a fairly certain relationship with Rorschach ratings of improvement.

Increase in friendly cooperativeness (role change) during therapy shows a correlation of .99 with increase in participant observation and of .95 with the therapist's judgments of improvement. Role change (in the direction of more friendly and cooperative behavior in the group) is related

with fair certainty to improvement as judged by fellow patients, but shows insignificant relationship to Rorschach ratings and to increase in positive self-perceptions.

Change in self-descriptions (i.e. change in _what_ patients say about themselves) is highly related to improvement as measured by subjective judgments of group members, but shows insignificant correlations with every other index of change. This suggests that fellow-patients base their judgments of improvement upon the topical content of the sessions rather than upon the interpersonal behavior, whereas, we have seen that the therapist's judgments and the Rorschach ratings are more closely tied to change in patient's role.

C. Hypotheses about the Relationship of Therapist Activity to Improvement in Patients

It has been demonstrated that a marked shift in the group's activity occurred around the sixth session. A significant increase in confiding and decrease in resistance took place at this point. Examination of the therapist's activity shows that his interpretations during the first four sessions were almost entirely directed to the content of the meetings. A cluster of role interpretations occurring in sessions 5-7 gives tentative, qualitative evidence suggesting a relationship between role interpretation and decrease in resistance.

When the rank order for the percentage of role interpretations (as compared with content interpretations) was correlated with the other indices of improvement the following results were obtained: The amount of role interpretation is

significantly related to change in participant observation, to change in role, and to improvement as rated by the therapist. It is related with fair certainty to change as measured by the Rorschach and insignificantly related with change in content and the ratings of improvement by fellow patients.

Improvement from therapy is not significantly related to the degree of nurturance and support received from the group therapist.

Limitations of this Research

This research as an investigation of the process of group psychotherapy has several limitations. The most obvious limitations of the design of the research reported in this paper have to do with the sample. Further investigation on subjects of different ages, sex, social status, and source of referral is clearly required in order to establish generality to the findings. Groups involving different types of leadership and of varying durations are now being studied to determine whether these variations change the findings suggested in this paper.

Another limitation of this study concerns the types of variables studied. We have in the preceding chapters been concerned with the changes in role and in self perception as measured by interpersonal mechanisms and traits. This is in line with the Sullivan emphasis on social interaction. There are, however, problem areas and personality traits which are not directly interpersonal. Two general categories of non-interpersonal variables which are not considered in this dis-

sertation are the intra-personal defense mechanisms and modal variables. The intra-personal defense variables include some of the well-known defense mechanisms of the Freudian school. They are inferred variables which explain discrepancies among different levels of the personality and which serve to establish equilibria between discrepant self-perceptions and actions. Examples of these mechanisms are repression, projection and denial.

Modal variables are expressive tendencies or styles of behavior. They can best be expressed as adverbs which describe or modify the way in which the subject acts, e.g. impulsively, rigidly, lethargically. They can also be expressed as adjectives or traits which modify the subject's perceptions of himself or the world--e.g. impulsive, rigid, lethargic.

The current and future work planned by the joint research team includes these areas which are noticeably neglected in this paper.

A final revision suggested for future research involves the interpersonal mechanisms. The circular continuum of mechanisms has been revised by eliminating the distinctions between ego, task, and therapeutic mechanisms and by incorporating the latter two types within the circular continuum. The circle is no longer conceived as a diagram of ego-oriented mechanisms but rather as a matrix for all interpersonal mechanisms. The task-and-ego-oriented mechanisms are now seen as appropriate types of interpersonal behavior

the inappropriate extremes of which become the former ego-oriented mechanisms. Teaching behavior, for example (K behavior) is scored along a spoke of the circle--the outer perimeter of which is ego-oriented, the inner area reflecting more appropriate types of teaching, clarifying, summarizing, informing, etc. In this revised system "confides" is scored as appropriate cooperation (G behavior), while over-docility is scored as inappropriate G; "interpret" is scored as appropriate supporting (I) behavior while ego-oriented pity and sympathy is scored as inappropriate I. Revisions of this sort should provide more adequate and sharper definitions of interpersonal role and simplify the testing of hypotheses about the personality organization and about the nature of therapeutic change.

Implications of this Paper

This research which is in the nature of a pilot study demonstrates that the interpersonal activity of patients and group therapist can be objectively scored by the Freedman-Leary-Ossorio methodology. It is further shown that these measures can be related to other indices of improvement during therapy in a way that is significant for the sample studied.

Generalizations about results of psychotherapy are in one sense limited by the small sample. The facts that statistically meaningful relationships were obtained and that the results are based on a sample of 8000 interaction units provide an impressive demonstration of the method's usefulness.

We can safely conclude that the use of objective systems of this sort for categorizing interpersonal behavior will make public, reliable, and communicable the complexities of human relationship which have previously remained intuitive, subjective, and speculative.

APPENDIX TABLE I

SUBJECTIVE RANKINGS OF IMPROVEMENT FROM THERAPY

PATIENT AS RATED		PATIENT AS RATER							THERAPIST RANKING	TOTAL SUBJECTIVE JUDGMENTS
		AA	BB	CC	DD	EE	FF	GG*		
	AA	3	2	2	1	6	4		1	1
	BB	2.5	1	4	4	7	5		2	2.5
	CC	5.5	5	3	6	2	7		4	5
	DD	5.5	4	6	3	4	1		3	4
	EE	2.5	3	5	2	3	3		6	2.5
	FF	7	6	7	5	5	2		5	6
	GG	4	7	1	7	1	6		7	7

*GG did not turn in final sociometric ranking sheet.

APPENDIX TABLE II

PERCENTAGES
OF GROUP TOTALS FOR INTERPERSONAL
MECHANISMS DURING 24 SESSIONS OF GROUP THERAPY

MECHANISM	PERCENTAGE
A	3.5
B	12.5
C	11.0
D	3.5
E	4.0
F	2.5
G	13.0
H	1.0
I	3.5
J	1.0
K	45.0

APPENDIX TABLE III

NUMBER AND PERCENTAGE OF DOMINANT, SUBMISSIVE, HOSTILE, AND FRIENDLY MECHANISMS FOR EACH PATIENT DURING THREE TEMPORAL PHASES OF GROUP PSYCHOTHERAPY

PATIENT		NUMBER OF MECHANISMS			PERCENTAGE OF MECHANISMS		
		PHASE I	II	III	PHASE I	II	III
AA	Dominant	60	167	200	97	87	88
	Submissive	2	25	27	3	13	12
	Hostile	12	52	43	96	73	58
	Friendly	1	19	31	4	27	42
BB	Dominant	100	91	130	80	76	57
	Submissive	25	36	100	20	24	43
	Hostile	49	30	62	73	51	41
	Friendly	19	29	89	27	49	59
CC	Dominant	38	62	30	93	69	71
	Submissive	3	28	12	7	31	29
	Hostile	27	27	41	90	57	73
	Friendly	3	20	15	10	43	27
DD	Dominant	49	120	62	64	76	56
	Submissive	28	38	49	36	24	44
	Hostile	24	72	40	65	70	45
	Friendly	13	31	49	35	30	55
EE	Dominant	45	68	89	68	71	68
	Submissive	21	28	42	32	29	32
	Hostile	29	64	47	64	73	53
	Friendly	16	24	42	36	27	47
FF	Dominant	54	52	96	87	80	75
	Submissive	8	13	32	13	20	25
	Hostile	26	28	46	79	68	65
	Friendly	7	13	25	21	32	35
GG	Dominant	98	62	46	73	74	73
	Submissive	37	22	17	27	26	27
	Hostile	42	22	26	64	52	65
	Friendly	23	20	14	36	48	35

APPENDIX TABLE IV

NUMBER AND PERCENTAGE OF DOMINANT, SUBMISSIVE, HOSTILE, AND FRIENDLY TRAITS-ATTRIBUTED-TO-SELF BY EACH PATIENT DURING THREE TEMPORAL PHASES OF PSYCHOTHERAPY

PA-TIENT		NUMBER OF TRAITS-ATTRIBUTED-TO-SELF			PERCENTAGE OF TRAITS-ATTRIBUTED-TO-SELF		
		PHASE I	II	III	PHASE I	II	III
AA	Dominant	11	31	11	100	79	73
	Submissive	0	8	4	0	21	27
	Hostile	7	15	21	77	56	38
	Friendly	2	12	31	23	44	62
BB	Dominant	16	9	28	53	47	43
	Submissive	14	10	38	47	53-	57
	Hostile	19	17	30	83	85	77
	Friendly	4	3	9	17	15	23
CC	Dominant	6	19	8	43	59	73
	Submissive	8	13	3	57	41	27
	Hostile	16	24	27	67	65	85
	Friendly	8	13	3	33	35	15
DD	Dominant	2	7	8	22	44	21
	Submissive	7	9	30	78	56	79
	Hostile	11	9	14	48	69	44
	Friendly	12	4	18	52	31	56
EE	Dominant	7	4	4	44	27	40
	Submissive	9	11	6	56	73	60
	Hostile	15	1	7	79	25	33
	Friendly	4	3	14	21	75	67
FF	Dominant	14	11	8	43	46	25
	Submissive	19	13	23	57	54	75
	Hostile	11	14	21	52	63	62
	Friendly	10	8	13	48	37	38
GG	Dominant	20	5	32	40	29	74
	Submissive	30	12	11	60	61	26
	Hostile	34	8	11	53	27	55
	Friendly	30	21	9	47	73	45

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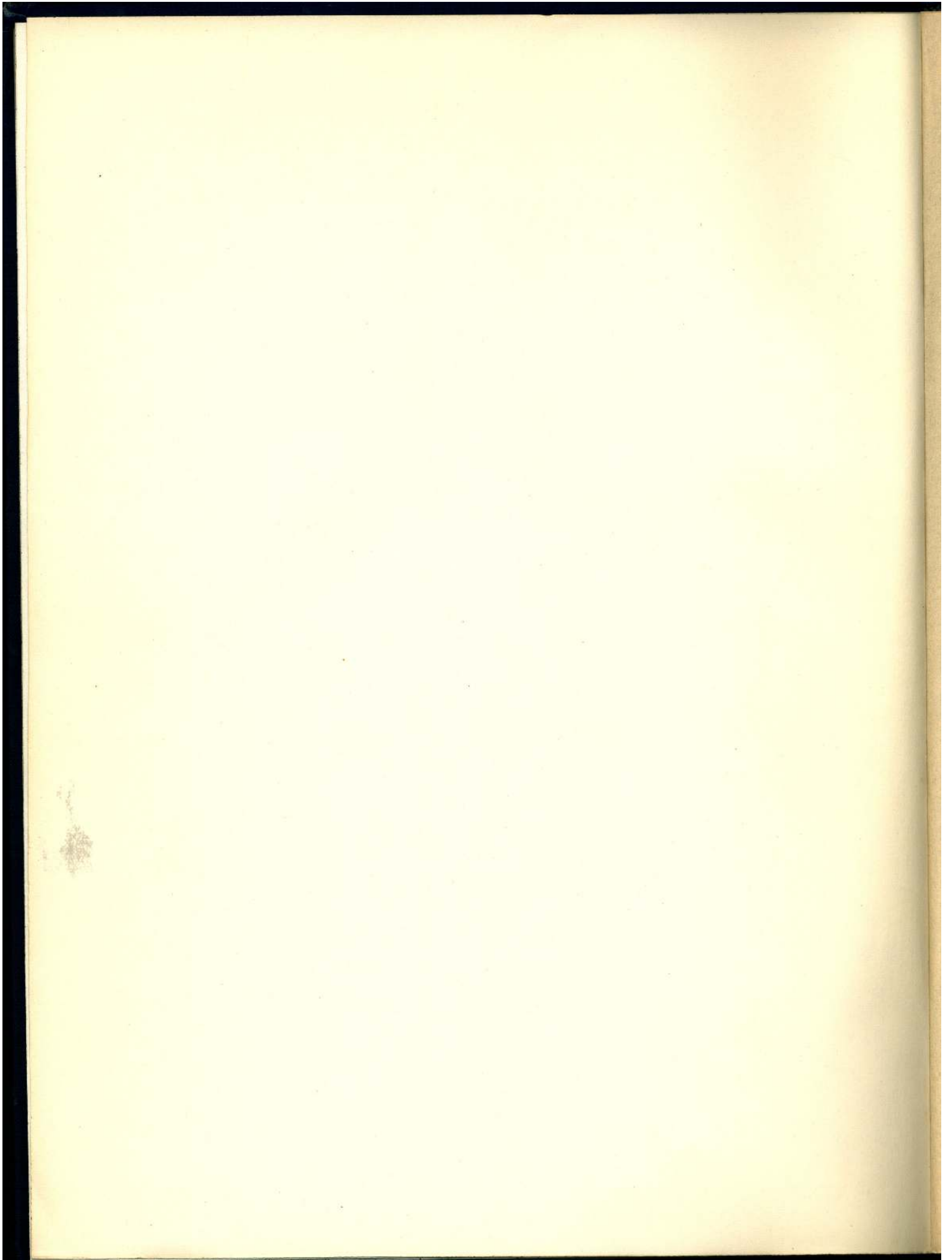

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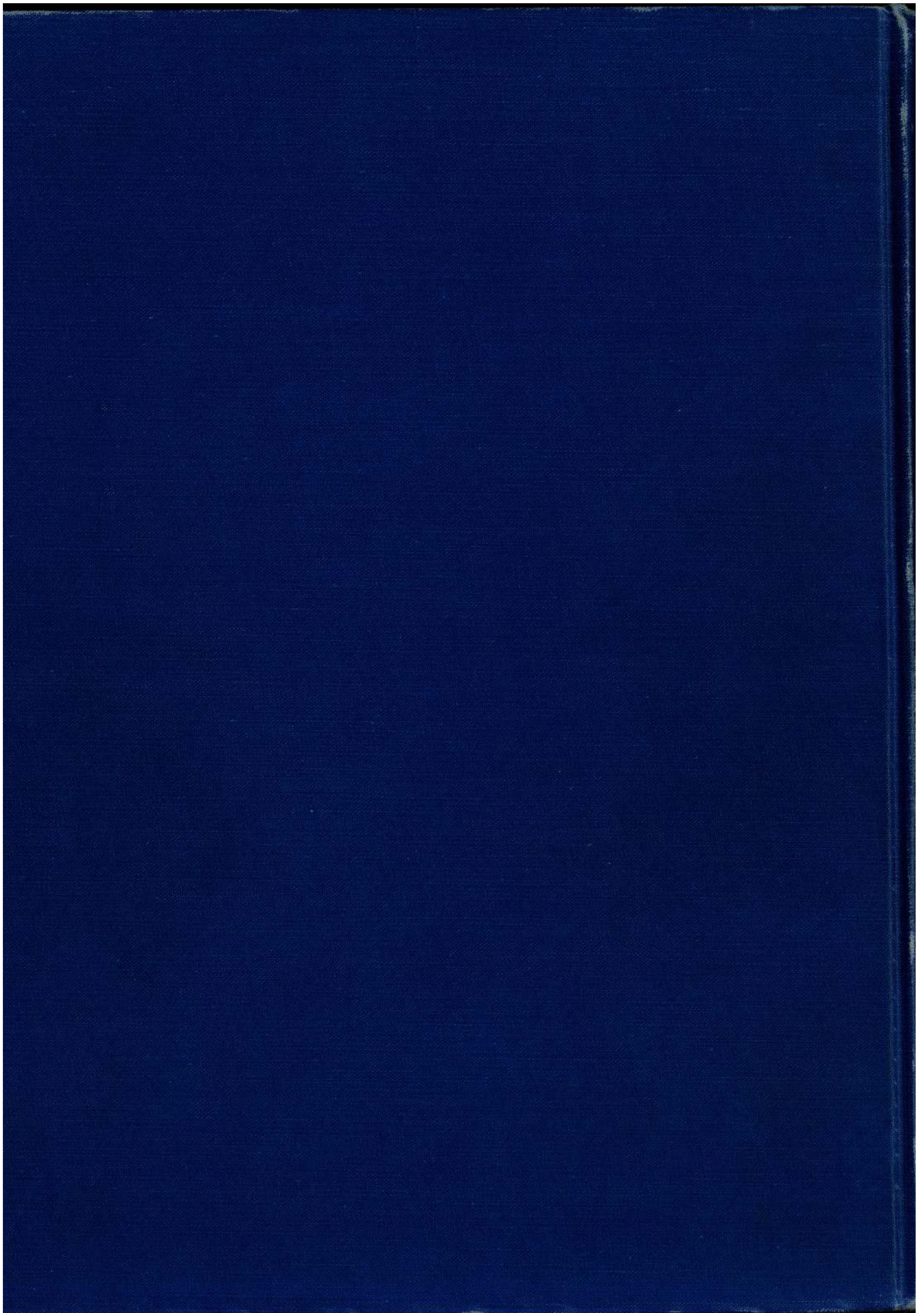

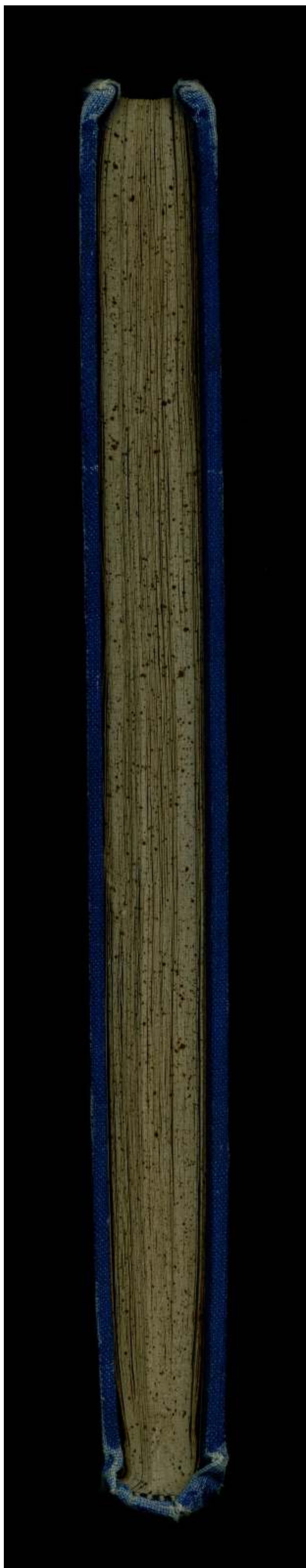

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