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The Fort Logan Mental Health Center is a new state hospital which will eventually serve half of the population of the state of Colorado. Its organization follows as much as possible the recommendations of the Joint Commission on Mental Illness and Health. Concepts of milieu therapy are strongly utilized, with the emphasis on expansion of professional roles and the involvement of the patient's family and his community as much as possible in treatment. The hospital is entirely open and relies heavily on transitional forms of treatment. One-half of its patients are in day care, and evening care is being instituted. Geographic and administrative decentralization are utilized, with the same psychiatric team following the patient through admission, treatment, and outpatient care.

THE DEVELOPMENT OF A PSYCHIATRIC TEAM IN THE LIGHT OF A GROUP DEVELOPMENT THEORY

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The term "team work" has been occurring with increasing frequency in the general technical literature of the many fields in which people work together toward a common goal, such as industry, business, administration, and various types of research. In the medical field reference to this term occurs most frequently, but not exclusively, in surgery, in psychiatry, and in many branches of research. The same term may have widely divergent implications. As described by Bonn and Kraft (2) the concept of team work within the therapeutic community of the Fort Logan Mental Health Center has been given special emphasis. It is assumed that the way in which the team works exerts a large influence on the effectiveness and quality of the treatment program. In this paper the author will try to define some of the relationships existing between team members by describing the process of team formation and some factors influencing team operation. Although a theoretical framework that has already been advanced in the literature has been used as a basis for this description (2), the author will draw mainly from his experience in working with such a team. An outline of the criteria used in determining the level of optimum team function will also be given later in the paper.

There is sharp contrast between a treatment team functioning within a social-psychiatric setting and a group of professionals working semi-independently not as a team. In addition to the wide difference in depth of interpersonal relationships within the two groups, their qualitative and quantitative work output seem to

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Journal of the Fort Logan Mental Helath Center, Vol. 2, pp. 101 - 115.

differ significantly. In the opinion of the author, the group which is not a team produces only the sum total of its individual contributions, and a poorly functioning member can reduce the group output only to the extent that his individual output is limited. The output of the treatment team ideally is a multiple of all individual contributions. Team members are expected to elaborate and act on stimuli, observations, or ideas, building on them as a single note is expanded in orchestration. While this aspect of team function is highly valuable, one has to remember that a serious limitation accompanies it. Just as the contributions of the members multiply, instead of merely adding up, so does the spread of interpersonal problems inhibit team function. In a team one malfunctioning member can easily and rapidly draw the total function to a level well below that single member's limitations.

There are certain basic prerequisites for establishing optimal working relationships in such a team. These include: (a) open communication at all times; (b) sharing of responsibilities as well as skills, which entails constant teaching and sharing of knowledge; (c) motivation for work beyond "job requirements;" and (d) willingness and ability to allow personal and interpersonal emotional involvement in the team. When these prerequisites are met, discernible, though not sharply delineated, stages through which the team progresses as it develops can be observed. However indispensable they are, these basic elements will not insure an automatic evolution of the team since there are other factors that can arrest, distort, or facilitate its development.

A GROUP DEVELOPMENT THEORY

The description of group process is an extremely complex task. In trying to organize a large mass of observations, it is necessary to select one of several theoretical frameworks. After reviewing the literature, the writer has found that Bennis and Shepard's theory (1) of group development can best describe what he observed in the development and functioning of a team. Their postulation as discussed by Benne (3) was based on observations made on training groups from their beginning to their termination.

These groups, led by a "trainer," were assigned tasks limited in time and scope. The treatment team at the Fort Logan Mental Health Center with which the author has been associated consists of one psychiatrist designated as team leader, one psychologist, two social workers, six nurses and a head nurse, and seven mental health technicians. The latter are workers with six months of formal training at the center in mental illness, social psychiatry, and therapeutic-community concepts and techniques. The team as a unit is responsible for the total treatment program of the patients, beginning with preadmission evaluation and ending in follow-up care.

Thus treatment teams differ from the groups in the Bennis and Shepard study (1) in that on the team tasks are constantly changing; the team works in an ongoing way, and the team leader is not usually equipped by background and experience for the role of "trainer." Nevertheless, the theory serves as a useful ground for interpreting changes in team behavior.

Bennis and Shepard described a series of developmental stages in a group. The main phases and subphases are:

A. Dependence Phase
    1. Dependence Flight
    2. Counterdependence Fight
    3. Resolution Catharsis
B. Interdependence Phase
    1. Enchantment Flight
    2. Disenchantment Fight
    3. Consensual Validation

In studying an ongoing team operation, the author felt that the Bennis and Shepard concepts could be applied to the team, even though it was not a newly organized group. The team was frequently faced with personnel changes or with new tasks which seemed to disturb the functional equilibrium of the team. Under such stress, the team would apparently regress to one or another of the phases described by Bennis and Shepard. Subsequently a reconstructive effort would be evident as the team attempted to regain its prior level of functioning. The author will now present a description of the subphases of the Bennis and Shepard theory along with anecdotal material illustrating how this theory might

be modified to understand the dynamics of an ongoing group. The author's method of study in arriving at such a formulation is comparable to the psychoanalytic technique of reconstructing genetic development from observations on regressive phenomena.

A. Dependence Phase

The first phase revolves around the conflict of dependence versus independence and its resolution. It would represent a situation very similar to the conflict a child goes through in the years before puberty. The focal issue of this phase is the team's orientation toward authority in the person of the team leader. Some members of the team gravitate toward one or the other of two opposing poles, while the conflict-free members remain in the middle. At one pole are the overdependent members, who advocate structure and submission, and at the other are the counterdependent, who advocate rebellion and shattering of boundaries. Both have similar conflicts about dependency, but exhibit opposite behavior.

Subphase 1. Dependence flight. At this stage the team, while seemingly working together, finds itself engaged in disorganized activities and in a fruitless search for a common goal. In these situations, several members of the team will converge on one task while other tasks are ignored or "forgotten." There is a high degree of anxiety and insecurity, which in reality is related to the team leader rather than to any lack of goal. Team members attempt to ward off this anxiety by activities such as intellectualization, or detachment. The team expects the leader to establish rules and to give rewards. Members might say, "I didn't do anything because I don't feel supported." When answers are not provided, the team leader is regarded as merely playing "hard to get," since he is viewed as the omniscient expert. By this fruitless search, the group indicates to the team leader its helplessness and its willingness to work under him. During this stage the team feels incompetent to make decisions, phone calls increase, and the team asks, perhaps jokingly, about establishing a means of contact at all times through some electronic device. During the first two months of the author's association with the team, phone calls averaged one a night, whereas in the next six months they averaged

one or two a month. When the psychologist later assumed the acting leadership of the team, a similar increase in phone calls occurred. The power of the leader is tested a great deal, and for some members this seems to be a major concern, almost a threat to their existence. Indeed, some consider leaving the team for this reason.

During this subphase the contributions made by team members are designed to gain approval from the leader, whose every reaction is watched surreptitiously. Members run the gamut of behavior that gained favor in the past, and seductiveness is the common game of the team in attempts to secure the approval of the leader, based on the assumption that he holds the power. The defensive nature of this behavior is obvious, as the team leader is often politely ignored. The overdependents in the team exert the greatest influence in this subphase and, if permitted, would fixate the team at this stage. The team leader can play a major and even decisive role in allowing the team to linger here or helping it to move ahead. His course depends on the extent of his own anxiety about authority and dependence. The author found it difficult, for some time, to separate appropriate gratification of temporary needs from overindulgence until the team itself brought it to his attention.

Subphase 2. Counterdependence fight. Toward the end of Subphase 1, the counterdependents make the situation intolerably ambiguous by asking for complete freedom of action and by challenging every decision. Their increased agitation may bring the group to the brink of catastrophe. Covert hostility is replaced by open challenge to the leader. The team, feeling that the leader has failed to meet their needs, may ignore or bully him or call him ineffectual. Effective team function may be brought to a standstill by the gulf between the overdependents and the counterdependents. Movement out of this counterdependent subphase is largely contingent upon the maturation of independence and the development of other leaders within the group. Discussion of techniques to facilitate this movement might well be a paper in and of itself.

The following incident illustrates movements through this, as well as through the other two subphases. During his first month with the team, the author proposed some change in scheduling and introduced an outline for division of duties and responsibilities.

Actually the idea was not new to the team, as it had been under consideration in the previous months. As the proposal was introduced, the team was asked to feel free to express any and all criticisms related to it and to ask for any clarification that they required. The discussion that followed was sober but politely restrained, and the questions were pertinent and not hostile. There was a general consensus for complete and unreserved acceptance of the proposal. This early reaction represented a dependence flight type of response. In the week that followed, the group was supposed to bring in their thoughts and deliberations on the issue. The meeting started with a strikelike nonparticipation (passive aggression). Then one member volunteered that there had been many critical comments expressed privately after the last meeting. Gradually the discussion became more critical, emphasizing the team's ability for independent action and rejecting the team leader's proposals as a counterdependent move. In spite of the fact that there was no rational reason for the rejection, some members began saying things like, "I really can't find any special thing about this plan that I can criticize, but I just don't feel comfortable with it." Then the discussion went on to, "Do we really need all these changes?" "Haven't we shared responsibilities and made decisions in the past without all this structure?" "It looks to me like we are going to be policed and supervised as if we can't be trusted anymore." The team leader then replied, "I thought we could save time this way. The team could still accept, modify, or reject the plan altogether, but if I had done it the other way it might take us six months." The apparent irritation of the team leader was enough to allow the team to strike back by stating, in effect, that the group doubted the sincerity of the team leader and rather suspected an ulterior motive behind his proposal. This denouncement, following which the team went ahead and implemented the plan, represents the transition toward the third subphase.

Subphase 3. Resolution catharsis. This is the most crucial and fragile stage in the life of the team. By the end of the previous stage the factions of the team are warring hopelessly. Interference by the team leader can only increase the cleavage, and the conflict-free independent members are ineffective. However, as this subphase develops, the independent members of the team

become active. Through the turmoil, a suggestion may come to expel the leader figuratively or symbolically. Some rationalization like, "He is holding the group back," may be used. The thought may be expressed covertly and informally, as in the coffee shop rather than in a situation like the regular team meeting. The noncommitted members, not suspected of ulterior motives, may take over and allow the leader to "come back," this time as an equal member. At this point, it is interesting to observe the ritual which the team leader must undergo to prove his "equality." Examples like, "Would you go to the dance?" or, "Will you go to occupational therapy?" or, "How about some volley ball?" are plentiful.

At the end of this phase much of the team's ambivalence about authority is resolved. Rebellion or submission are no longer necessary modes of behavior. The team shows a high degree of autonomy without the need to attribute magical powers to the leader. The group no longer focuses on who said what, but on what is said. The often spoken or unspoken thought, "There is a grab for power," suddenly disappears and the contributions of the members are seen in their relevance to shared group goals.

The anecdote described above gives a rather mild illustration of the resolution catharsis. Several months later another situation arose that ended in a more dramatic expression of this subphase. This was related to the change in the duties of the team leader from working with one team to supervising several teams. In announcing the change to the team, the author told the group that he had volunteered to stay with the team part time until a new psychiatrist was appointed, a matter which would take about six months. In the days that followed, the team reverted to the passive-aggressive behavior described previously. During this time some members made this remark: "The last time we learned about a change in team leaders, we sat around like robots for six months dragging our feet." The implication was clear to the writer, who subsequently declared in a team meeting that he would not be able to work with the team if this attitude was going to continue for "the next six months." The immediate response was, "We can't help the way we feel and your saying so is not going to change it."

In the following days, members of the team, without apparent reason, would ask the team leader over and over again if he needed any help, and there was an upsurge of counterdependent activities. Finally, in a meeting with a consultant in the absence of the team leader, the problem was discussed in heated fashion, and the group arrived at the resolution that the team did not really need the psychiatrist to be the leader, but that they might need him as a consultant to take care of medical problems. They informed the team leader that an important decision was made which they would like to discuss with him later. In the next meeting with the team leader, an interesting development took place. The group seemed very relaxed and jovial. One member said, "I don't see myself needing the team leader to depend on, but I do want to take advantage of whatever time he could give the team." Other members also indicated that what seemed to be a clear denunciation in the previous meeting did not seem pertinent anymore. Many confirmed a feeling of relief and readiness to work together. One member of the team had an expression of defeat and resignation on his face when he said, "I guess that the team feels differently now." This was the psychologist who had been assuming the acting leadership in the absence of the psychiatrist. He interpreted the previous resolution as a denouncement of the leader and a vote of confidence in him as the full-time team leader, while this apparent "change of heart" meant that he was the loser in the contest of power. Subsequent events proved that this was nothing more than resolution catharsis of conflict that arose from the new shift in the team. As a matter of fact, the team then went through all of the stages with the acting team leader before accepting his present well established role in the team. Following this episode the team resumed its previous level of functioning.

B. Interdependence Phase

During this phase attention is focused on the problem of shared responsibility. The situation may simulate that of growing teenagers who have worked through most of their conflicts regarding authority and are starting to try their talents and face up to responsibility. Cooperation, competition, and compromise are recurrent themes. The focus is on intimacy, friendship, and identification.

The cardinal struggle is for distribution of affection rather than the distribution of power which dominated Phase A.

As in Phase A, team members exhibit two opposing personality types. On the one hand are the overpersonal members, who want to share every feeling and thought, and on the other are the counterpersonal, who vehemently shy away from any interpersonal involvement. Both groups have problems in the area of confidence and self-esteem, but the division does not necessarily include the same individuals who were observed in Phase A to be overdependent or counterdependent.

In the interdependence phase we again find three subdivisions:

Subphase 1. Enchantment flight. Having resolved the authority problem, the team feels very "groupy." There is an exaggerated cohesiveness—a feeling of relaxation, happiness, and exaltation. Whenever tension rises, it is instantly dissipated by joking, laughter, or other diversionary maneuvers. A harmonious atmosphere is to be maintained at any cost. Differences are patched up quickly and every effort is made not to disturb the happy status quo. This is the time for merrymaking and partying. Decisions are unanimous and everybody must be happy, but decisions are made only on issues about which the team has no strong feelings. All this is done with much gaiety and playfulness, but underlying it is a rigid norm to which all members must conform. There is an obvious avoidance of the "painful past."

Members of the group now must cope with the same resolution catharsis that the team leader experienced previously. They must contain their disagreement and discontent and look happy or they may be accused of "rocking the boat" or betraying the team. They must suspend self-examination and cover up problems; otherwise they may be branded as disloyal and guilty of leaking problems outside the team.

The conflict here and in the subsequent subphase centers around interpersonal relations. The strong pressure not to be selfish and to love each other is counteracted by an equally strong fear of loss of identity. Therefore, the myth of mutual acceptance and universal harmony will eventually be exposed and result either in splitting the team and moving to the next subphase, or regression to the dependence phase with requests for the team leader to take

over.

Subphase 2. Disenchantment fight. This subphase again involves both the counterpersonal group, which feels that self-esteem depends on avoiding real commitment to others, and the overpersonal group, which believes that by forgiving everything one can attain self-esteem. Both fear that "familiarity breeds contempt." This is the time when one hears the opposing views, "We are not functioning as a group," and, "That is not true; we are all happy." As the difference deepens, more discouraging remarks about the team are heard. Psychology, psychiatry, and social science are attacked, and frequent comparisons with other teams are made.

Concern about self-esteem increases anxiety that, in turn, may be reflected in absenteeism, boredom, and disregard. The counterpersonal member handles fear of rejection by rejecting the others before they abandon him. The overpersonal member tries to make members indebted to each other by overindulgence and, therefore, bound by guilt. This fear of losing self-esteem and self-identity assumes vastly exaggerated proportions and seriously hampers group function.

Subphase 3. Consensual validation. The forces that work toward resolving the dilemma of the team will probably stem from the need to establish criteria for operation and the need "to do the job." In order to arrive at this, the team has first to undergo an assessment and self-critical evaluation strongly resisted by both the overpersonal and by the counterpersonal members. The former group views it as discriminatory: "We are equal, you are introducing upper and lower echelon restrictions to our group"; the latter resists the further invasion of privacy. If the resistance is sustained, the team may choose to regress to Phase A and ask the team leader to do the evaluation and to establish the rules of the game.

The conflict-free members, who feel no threat to self-esteem, will at this point play an important role in restoring confidence to the team. This may be done by requesting an independent assessment of the person's own role, thereby expressing confidence in the group, with, "I for one would like to hear from the team how you view my actions." However, this may not be sufficient and validation may be effectively blocked by those who are

strongly opposing it. The team leader's role is less crucial here than in the resolution of the dependent phase. His influence is no different from that of any other member of the group. The team at this point is "as strong as its weakest link," be it the team leader or any other member of the team.

When there is enough willingness and ability in the team members to go ahead with the assessment, members will validate their self-concept with other members and remove distortions. They will verbalize their own conceptual scheme of understanding themselves and others. This should be differentiated from the ritual "breast beating" which is just another defence to avoid self-examination. Working through this phase requires a high level of maturity, as well as advanced working ability and communicative skills.

As this level of functioning is attained, team members will accept personality differences without branding them as good or bad. Disagreements arising within the team will concern substantive rather than emotional issues. Consensus is reached through rational discussion instead of compulsive unanimity. At this time members of the team can afford greater awareness of their own involvement in the team as well as of the total function of the team without feeling threatened or overwhelmed. They will have deeper personal meaning to each other, and their expectations of each other will be based on personal abilities rather than strictly on professional roles.

DISCUSSION

In observing the team, as the author did, it was sometimes difficult to clearly delineate one phase from another. This was because of two factors: (a) Sometimes, under stress, the team would suddenly regress from its customary level of functioning to a "less mature" level. (b) Sometimes the team seemed to be expressing simultaneously elements from two different phases; i.e., some phases seemed to be coupled together.

An example of regression is the situation that arose when the head nurse was contemplating leaving the team to further her

education. Among other things, this stirred feelings about rearrangements of positions of authority among the nursing staff. One of the nurses started checking the medications and the order book to find mistakes that others might have made and report them. This went to such a degree that she started finding mistakes that did not exist, while she herself made a couple of slips. An interesting part of the behavior was the fact that in the past this nurse as well as others had established a quicker and better way of checking each other without creating all of this fuss and turmoil. The level of function returned to the cooperative and interdependent stage as soon as the conflict was resolved.

A situation that would necessitate reworking through of the interdependent phase occurs when one or more new members are brought into the team. The reaction starts with the initiation process described below and continues as the team works through its dependency conflict.

The author joined the team as a team leader, after the team had been in existence for a year. Entering the team at this point immediately posed two problems. One had to do with the reaction of the team to any person placed in an authority position (parent figure). This, the writer believes, resulted in regression. In studying this phenomenon, a method analogous to the psychoanalytic approach in reconstructing genetic material out of observing regressive behavior was used. Since this reaction is viewed as regression rather than as a starting point, the interpersonal relationships between team members that had been worked out previously were suspended upon the author's joining the team and had only to be reactivated later. The second problem has little to do with the assigned leader (authority) position on the team, but is more related to the reaction of the group to any new and and unknown member.

In the team leader's integration as a new member to the team, he goes through what can be best termed as the initiation process. During this process, the group exhibits toward him avoidance and guardedness, polite ignoring and isolation, and sizing up out of "the corner of the eye." The new member in response may choose to withdraw and withhold, or he may choose to plunge in with daring and bravado, exhibiting whatever skills he has.

These behaviors of the group and the new member are motivated by anxiety and fear of change. Each is fearful that the other will influence, control, or "mold" him.

Not uncommonly, one may observe a coupling of subphases. During the dependence flight one may hear utterings reminiscent of enchantment flight; counterdependence is sometimes coupled with the disenchantment fight; and simultaneous expression resolution catharsis and consensual validation has been observed by the writer. These pairings often have an air of superficiality to them, as if one of the pair represents an abortive attempt to find a short cut out of the other, more basic conflict.

It would be appropriate at this point to introduce some criteria through which the particular level of function or maturity of the team could be assessed. One reliable criterion is that patients often act out the team's level of functioning as a reflection of the mood of the team. This has occurred with such regularity that whenever the patients give clues of the presence of such a problem, it is clearly imperative for the team to start identifying the problem that they are faced with and resolve it.

Since cycles in the life of the team seem inevitable, an important criterion in evaluating a team's maturity is its ability to evaluate its own status, to diagnose its own difficulty, and to act quickly and effectively to remedy the troubling issue (4). This would entail an ability to detect such feelings as fatigue, tension, disinterest, hopelessness, enthusiasm, or others; ability to pick up and relay appropriate information pertaining to team feeling and function; and ability to accept and utilize these interpretations. In addition, the mature team should demonstrate an ability to detect and correct fallacies in group thinking.

Capacity for interdependence and for sharing of responsibilities are some of the criteria for efficient team function. The measure of this will depend on the degree of sharing of leadership functions, as different members could offer different resources for leadership. There should be skills and flexibility in the adjustment to members and to leaders as they evolve in the different stages of team development. There should be sensitivity to the needs and styles of these members and ability to distinguish between role contributions and personality characteristics.

The team is constantly faced with such difficulties as having to assimilate new members and new ideas, deal with internal conflict, and integrate individual needs with common group tradition and goals. This requires enough team cohesion to prevent disintegration, to insure holding to long-range goals, and to allow learning from success as well as from failure. The group must demonstrate the ability to create new groups and new functions as needed for the patients and to terminate such groups if and when appropriate. This flexibility should be differentiated from the anxiety-based changes that are not even comparable to trial and error, since in such situations the group does not learn from its errors.

SUMMARY

The author has described his observations of the behavior of the staff of a psychiatric team at the Fort Logan Mental Health Center on which he served as leader. Team behavior was related to the phases and subphases of Bennis's and Shepard's theory of group development, which are as follows:

A. Dependence Phase
    1. Dependence Flight
    2. Counterdependence Fight
    3. Resolution Catharsis
B. Interdependence Phase
    1. Enchantment Flight
    2. Disenchantment Fight
    3. Consensual Validation

The author was able to discern similar phases, often occurring in different combinations and moving in varing rapidity. In addition the theory seems useful in assessing the level of team functioning at a given time. Its usefulness in understanding group development is similar to that of analytic theory regarding personality development. As in the latter theory, it has been possible to identify phenomena of fixation and of regression in the functioning of a psychiatric team.

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ROLE CONVERGENCE IN A THERAPEUTIC COMMUNITY*

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INTRODUCTION

Although many state hospitals continue to be custodial in their approach to treating the mentally ill, community mental health programs which emphasize newer concepts of treatment are being developed. These newer treatment concepts involve "the development of a therapeutic milieu in mental hospitals, and a broader conception of what constitutes treatment" (5) and emphasize continuity of care from diagnosis to rehabilitation.

In the treatment programs of the recently developed mental health centers major emphasis is placed upon using the therapeutic milieu. In facilitating this new approach to treatment, recognition is given to the valuable contribution informed laymen and the various types of mental health workers can make in the treatment of psychotics through forming psychological or social relationships with the patients.

In the therapeutic milieu staff are considered to be interchangeable in carrying out treatment services. Thus, there may be

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considerable blurring or overlapping of roles of various treatment personnel and a de-emphasis of traditional role requirements. Greenblatt, York, and Brown, for example, state, "Personnel are to be taught that they are to use intuition, imagination, initiative, and judgment, rather than be constrained by rules of procedure." (4) In considering the importance of participation by staff in the milieu program, John and Elaine Cumming state (2):

> Staff members of treatment centers must have roles that allow them to reintroduce the patients to culturally acceptable ways of behaving and, at the same time allow them to recognize wide variations in acceptable patterns. It is not possible, in this view, for a staff member to participate in a therapeutic environment without being part of this sub-society with his patients.

Thus, it would appear that the development of a therapeutic milieu treatment program would call for a basic redefinition of traditional role expectations for various professional mental health disciplines.

The staff of the Fort Logan Mental Health Center has been concerned with reconciling the professional education and background of staff with the sometimes different and expanding roles called for in the therapeutic milieu. In discussing the identities and roles of staff at Fort Logan and how the staff give optimum help to a large number of patients, Doctors Bonn and Kraft state (1):

> We do this by expanding the roles of staff members to capitalize on each person's functioning skills and assets. Each staff person contributes what he can, not what is prescribed out of some stereotyped, preconceived dogma of roles. The summum bonum of each person's contribution is from the self, not from his training alone . . . .Clearly the significance of the professional training and background must be reconciled with the evolving roles of each team member.

In another discussion of role expansion, Dr. Gaviria concludes, "There has been a definite trend at Fort Logan toward an extensive 'blurring' of roles. Staff members may have the same duties, make the same decisions, assume similar responsibilities, and, in general, function interchangeably within the team, regardless of their professional group." (3)

PROBLEM

Consideration of such a redefinition of the role and professional identify of staff, as called for in the therapeutic community and as practiced at Fort Logan, raises a number of questions. Are we moving toward a new profession of the mental health specialist? Such a development would suggest the need for evaluating the therapeutic importance of maintaining professional identification, role clarity, and separateness of staff function, as contrasted with the interchangeability of roles and overlapping function by personnel. How appropriate are the present professional educational programs for preparing psychiatrists, psychologists, nurses, and social workers for their expanded role in the therapeutic community treatment program? Finally, in the process of redefining their operating roles, what stresses and conflicts are experienced by mental health personnel who have received professional education pointed toward a more specialized role performance?

The purpose of the study on which this paper is based was to explore the last question through an investigation of the impact and potential sources of stress in the trend toward role convergence on mental health personnel at Fort Logan. The study was focused on three major areas: (a) the extent of staff understanding and consensus regarding the goals of Fort Logan, (b) the perception of staff members of their relationships with other staff members, and (c) the staff's perspectives on the nature and extent of task structure.

PLAN OF STUDY

The Fort Logan Mental Health Center was the locale of this study. From a total of 128 staff members, 63 were chosen and interviewed in person. To have a representation of each discipline from each of the 7 treatment teams, it was decided that all psychiatrists, psychologists, and head nurses would be included in the sample. From the remainder of the staff, 1 social worker, 2 staff nurses, and 3 mental health technicians from each team were selected by stratifying the population of staff for each team

according to discipline and selecting the appropriate number by use of a table of random numbers. The 63 respondents, therefore, represented all disciplines on the 7 treatment teams. They included the 7 psychiatrists, who were the team leaders; the 7 psychologists; 7 of the 14 social workers; 8 head nurses (one head nurse had been promoted between the time her name was chosen and time of interview); 13 nurses; and 21 mental health technicians.

An interview schedule was developed for the purpose of obtaining information about staff attitudes in the three general areas of investigation, (a) goal orientation, (b) staff relationships, and (c) task structure. The schedule was pretested by interviewing a social worker and a mental health technician. The final version contained 22 questions which were open ended, ranking, rating, and multiple choice in nature. Responses were coded and the data were organized into the three major areas of inquiry. Appropriate statistical measures were used to test the statistical significance of associations between identified variables.

FINDINGS

Goal Orientation

Newer mental health centers are challenging traditional orientations by trying new treatment approaches and modifying the goals or objectives of the treatment program. In essence this means a redefinition of goals may be required by mental health personnel who have previously been oriented to custody and protection as the primary purpose of the psychiatric hospital program.

Although several factors might be identified as contributing to a higher level of possible staff conflict in a complex treatment program such as Fort Logan's, it was believed that an assessment of the extent of staff understanding and agreement regarding the institution's goals would be of primary importance.

Was there, for example, consensus among staff regarding the relative importance of perceived goals? Not only did the majority of the respondents report the "return of the patient to the community as soon as possible" as the most important goal, but the

words, "return the patient to the community," were seen in the responses of over three-fourths of the participants. It would seem that this phrase was almost a byword or platitude at Fort Logan.

Custodial care, protection of society, and care of the patient were not mentioned. In contrast, a study completed by the Veterans Administration which examined six goals of most public psychiatric hospitals reported protection of the patient and the community second in importance (6). The relative newness of Fort Logan and the possibility that there would be a lower proportion of patients with long-term chronic illness requiring protective types of care could account for the lack of emphasis on the goal of protection. The staff's perception of Fort Logan's goals might change if a chronic backlog develops and readmissions increase. The majority of the respondents, however, believed that the utilization of programs such as foster-family care for patients with limited capacity for independent functioning would prevent the build-up of a chronic inpatient population.

In summary, "return of the patient to the community" was the characteristic first goal mentioned by most staff members. The professional affiliation of personnel did not influence the emphasis placed on various goals. Any perceived stress or conflict between the staff was not caused by lack of consensus regarding goals.

Relationships Among Staff Members

Changes in the roles and the relationships which staff members maintain with one another may precipitate conflict. Is it, for example, possible for all staff members to be recognized as equal partners in patient care? Can all personnel successfully be involved in solving problems? How do individual staff members see themselves in relationship to other personnel? The answers to such questions would provide a clearer understanding of the nature of staff relationships in the therapeutic community and possible sources of stress among staff.

To determine the extent of perceived equality among the staff at Fort Logan, participants were asked to rank the various personnel categories according to their importance in treatment.

This question provided an opportunity for the respondents to indicate that all team members were of equal importance. Respondents who ranked all personnel equally were classified as "equal importance." Those who reported different degrees of importance for various personnel were classified as "unequal importance." Of the 63 participants, 49 percent considered all categories of personnel to be of equal importance. The data were further classified according to the responses given by the categories of personnel, as represented in Table 1.

TABLE 1

EQUALITY OF STAFF IMPORTANCE TO PATIENT TREATMENT AS RATED BY VARIOUS CATEGORIES OF PERSONNEL

CATEGORY OF PERSONNEL	EQUAL IMPORTANCE	UNEQUAL IMPORTANCE
HEAD NURSE	6	2
MENTAL HEALTH TECHNICIAN	12	9
NURSE	3	10
PSYCHIATRIST	5	2
PSYCHOLOGIST	3	4
SOCIAL WORKER	2	5
TOTALS	31	32

While the differences in the ratings as given in Table 1 were not statistically significant, the two supervisory categories, nurses and psychiatrists, were grouped together and compared with all other personnel. There was a significant statistical difference, ($x^2 = 4.54$, df 1, p is less than .05); supervisory personnel were found to rate staff as of equal importance more frequently than nonsupervisory personnel.

When asked if any category of personnel was most important to treatment, over two-thirds of the participants responded affirmatively. The psychiatrist was named by 32 respondents; mental health technician by 6; both nurse and mental health technician by 6; and psychiatrist, social worker, or psychologist by 1.

In investigating participation in decision-making, it was found that almost all team members believed they were able to participate, but the amount of influence they believed they were able to exert was directly related to the position of their discipline in the hierarchy of personnel which is found in a more traditional psychiatric setting (i.e., psychiatrist, psychologist, social worker, nurse, and mental health technician). There were indications of some beginning modification of this hierarchy in the middle position disciplines, but this trend was not statistically significant.

The areas of team communication opportunities, salary differentiation, and differential prestige of tasks were not found to be major sources of tension. "Professional conflict" and "personality conflict" were most often identified as sources of tension.

In commenting about specific sources of tension, mental health technicians referred primarily to tension with nurses. Their comments related to nurses and mental health technicians performing similar roles, but not receiving equal recognition or pay.

Nurses tended to refer to personality conflicts among staff as the primary source of tension. A head nurse was described as "wanting to monopolize the team leader, with just those two making decisions." One nurse referred to tension between the psychiatrist and psychologist resulting from the "psychiatrist's decision to let the social worker run team meetings." Reference was also made to the psychiatrist, psychologist, and social worker not participating in occupational and recreational therapy.

Head nurses seemed to focus on role expansion and team interaction as the primary sources of tension. Tension between the social worker and nurse was illustrated by the following comment: "The social worker finds a nurse can do what the social worker does. This is a rude awakening." Comment was also made about the "family type closeness on the team" as a source of tension.

Psychologists referred most often to tension with the psychiatrist. This was related to competition for the team leadership role. Tension with the social worker was noted as resulting from "conflict in assuming the assistant team leadership role."

Psychiatrists tended to be more general in their references to sources of tension. One psychiatrist observed, "Any time you have a group of people working together under stress, there is tension." Another referred to "communication at times breaking down, which leads to people not expressing opinions and feelings about decisions." Insecurity resulting from "jobs not being clearly defined" was also seen as a source of tension.

Task Structure

The nature of the therapeutic community requires a redefinition of the traditional expectations of mental health personnel. Greenblatt, York, and Brown, for example, state (4): "One of the principal tasks of the administrator is to reduce inflexibility in the social structure sufficiently to permit personnel to escape from the claustrophobia induced by finding themselves in little cells, occupation-wise and status-wise . . . to hold to an equalitarian philosophy regarding the potential of various categories of personnel."

In order to utilize more fully the various capacities and skills of personnel in the therapeutic community, Fort Logan has encouraged a re-examination and redefinition of the tasks various personnel are expected to perform. An attempt was made to assess the nature and extent of task structure at Fort Logan, including the extent of expansion and interchangeability of roles, the importance of structure in comprehension of roles, and the appropriateness of previous education and experience in comprehension of roles at Fort Logan.

Expansion and interchangeability of roles. To explore the extent of participation by different categories of personnel in an activity therapy, the respondents were asked to rate the extent to which personnel participated in recreational therapy. Mental health technicians and nurses were seen as participating most frequently in recreational therapy. Although nursing personnel participated most frequently, there was evidence of considerable participation in recreational therapy by all personnel. The psychiatrist was reported as participating least often, with the psychologist and social worker participating somewhat more frequently.

In some mental hospitals social workers are seen as having

primary responsibility for work with the community and the patient's family. To assess the degree of participation by staff in this more traditional social work role, respondents were asked to rate the extent of participation by staff members in working with the patient's family, making financial arrangements, and assisting with employment problems. It was found that all personnel participated in these defined tasks. Although the social worker was reported as most frequently carrying out such planning, there was evidence of considerable expansion of roles for various personnel into the area of tasks traditionally carried out by the social worker.

In a further attempt to explore the extent of role convergence as perceived by the staff at Fort Logan, the following question was asked: "Do you have a specific duty on your team not held by anyone else?" More than three-fourths of the respondents believed they had specific duties on their teams. The supervisory personnel, psychiatrists, and head nurses were the only categories of personnel in which everyone reported a specific duty. Even though the respondents reported considerable interchangeability of staff in carrying out various aspects of the treatment program, the majority continued to ascribe to their position duties which were characteristic of traditional role expectations.

Importance of structure in comprehension of roles. The therapeutic milieu minimizes imposing rules, regulations, and specific guides for action in regard to the activities of personnel as they relate to work with patients. In exploring staff perspectives as to the importance of formal rules or comprehensive guides for action, over three-fourths of the respondents believed some rules or guides for action were of importance. It would appear, therefore, that in the absence of specific ways of dealing with given situations, individuals probably develop informal ways of dealing with given situations. A question might be raised as to the extent to which solutions of this type become routinized and constrict staff members in their attempts to deal with patients as individuals. Such a possibility would suggest the importance of staff members feeling secure in having the opportunity to refer difficult problem situations to the team for collective decisions. In the absence of formal role expectations, personnel may also make demands for further organization and complain that they do not know that is expected of them. In spite of the lack of emphasis upon formal role definitions at

Fort Logan, over one-half of the respondents reported they clearly understood what was expected of them. It was interesting, however, that of the 37 who said that they understood their present roles, many stated that this had not always been true. Their comments indicated that inservice training and/or experience at Fort Logan had helped and that eventually everyone found his place.

Appropriateness of prior education and experience. As the therapeutic milieu is a relativity new treatment concept, professional education may be still primarily oriented to traditional treatment methods. The majority of staff, over three-fourths, perceived their former education and experience as adequate or at least partially so for their present tasks at Fort Logan. Of the 13 respondents who reported prior education and experience as inappropriate, 11 were nursing personnel. A psychiatrist and a psychologist also viewed their prior education and experience as inappropriate for their present tasks. Nine out of 10 staff members did report that there were gaps in their preparation prior to employment at Fort Logan. Most respondents were sufficiently concerned about the gaps to give examples of inadequacies. Social workers stated that they lacked preparation for group therapy. Psychiatrists mentioned that they had not been trained to lead groups. Most psychiatrists stated that they were not prepared for the administrative responsibilities involved in their present positions.

Table 2 shows the distribution of existence of gaps in prior education and experience reported by category of personnel.

Nurses stated that they were not prepared for the therapeutic community setting, working with groups and families, medication for psychiatric disorders, or team concepts. One nurse summed up her experience by stating, "This was entirely different from anything I had ever done." Technicians stressed their lack of knowledge about working with the mentally ill, especially in an "open hospital." One technician generalized about the areas of inadequacy in previous experience and preparation by answering, "Everything."

Orientation and inservice training have been used at Fort Logan to help fill gaps in previous education and experience of personnel and to introduce personnel to the philosophy and goals of the therapeutic community. The majority of respondents said

the inservice training program was appropriate as a method of filling gaps in previous preparation. Of the 46 respondents who received inservice training, only 4 reported such training as "not appropriate." Seventeen staff members reported they received no inservice training. There was almost common agreement that, regardless of their prior education and experience, few were completely prepared for participation in the therapeutic community. Gaps were perceived in the preparation for role convergence, the varieties of therapy, group communications, and team experiences. Most personnel believed the orientation and inservice training had been helpful, but needed to be extended to all personnel early in their employment at Fort Logan.

TABLE 2

STAFF PERCEPTION OF GAPS IN PRIOR EDUCATION AND EXPERIENCE BY CATEGORIES OF PERSONNEL

CATEGORY OF PERSONNEL	EXISTENCE OF GAPS	
	YES	NO
HEAD NURSE	8	-
MENTAL HEALTH TECHNICIAN	19	2
NURSE	13	-
PSYCHIATRIST	5	2
PSYCHOLOGIST	7	-
SOCIAL WORKER	6	1
TOTALS	58	5
PERCENT OF TOTAL RESPONSES	92	8

CONCLUSIONS

In spite of the fact that a complex combination of personnel and programming exists at Fort Logan, the staff was in agreement about the institution's goals. Lack of consensus, therefore,

regarding goals was not a primary source of stress or conflict among staff members.

Although the majority of personnel believed there were sources of tension between various categories of personnel, several commented that this was to be expected in a complex setting like Fort Logan. This finding suggests that if staff perceived a continuing level of tension, the goal would be to emphasize involvement of staff in such a manner that the tension and conflict could be used to promote organizational effectiveness.

Despite the emphasis placed in the therapeutic community upon all disciplines participating as coequals, the majority of personnel continued to ascribe varying degrees of importance to the various disciplines. Although there was some modification in the traditional status-power hierarchy of mental health disciplines, the great majority of personnel continued to view the psychiatrist as most influential and the mental health technician as least.

Approximately three-fourths of the personnel perceived their former education and experience as adequate, or partially so, for their present tasks at Fort Logan, though the majority reported significant gaps in such prior preparation. Lack of preparation for the process of group therapy was identified as the primary lack. This might suggest the need for professional schools to re-examine their curriculums as they relate to preparation for mental health careers. It would seem, however, that the majority of the personnel believed that current inservice training programs at Fort Logan were effective in filling such gaps. Such inservice training for all personnel might well include emphasis upon identifying and unlearning attitudes and ideas carried over from experience and professional education which are not consistent with concepts emphasized in the therapeutic community.

In summary, the perspectives of the personnel were strikingly positive. Although several aspects of the therapeutic community at Fort Logan were identified as sources of tension or conflict, the findings suggest that a pattern of staff relationships has developed which is not only compatible with treatment objectives but also personally gratifying for staff members.

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THE FAMILY CARE PROGRAM AT THE FORT LOGAN MENTAL HEALTH CENTER

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INTRODUCTION

The care of the mentally ill in the community is not new. As early as the Middle Ages, the townspeople of Gheel, Belgium, had learned to absorb the mentally ill, who flocked to the Shrine of St. Dymphna into their families.

This early experience in which the mentally ill lived on intimate terms with the community has been gradually modified over the centuries. At present, caring for selected patients in the community is widely used in the United States, as well as in many other countries throughout the world. An example is the family care program at the Dikemark Mental Hospital in Norway (2) in which there are more patients being treated in the community than in the hospital. Recent figures show that Dikemark had 950 patients in family homes and hostels, another 950 in nursing homes, and 800 patients actually in the hospital.

The Dikemark Hospital itself is a treatment center for the acutely disturbed, but it also serves as a diagnostic and prognostic agency. The hospital assumes the responsibility of providing medical supervision and psychiatric care in foster homes. In this way it extends its pratical treatment and teaching influence to the community. Many of the patients live in aftercare hostels, which are a cross between family care homes and boarding homes. Here they receive supervision, as well as emotional support, financial assistance, and stimulation for socialization and eventual independent living.

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PURPOSE OF THE PROGRAM

Basic to the philosophy of the Fort Logan Mental Health Center is the concept of a hospital with no backlog of chronic patients and with no building where long-term patients can be housed in isolation from the community. Family care is used as a transition from hospital residence to more independent living. The family care program is still growing, and, as we learn more about it, its focus may change. At present it is a continuation of the therapeutic-community treatment program, with the emphasis on social relearning through family living. Patients placed in family care homes from Fort Logan do not have the cultural readjustments to make that are so often necessary for patients hospitalized for long periods of time.

Through the medium of family care we hope that most patients can, in the words of Walter E. Barton(1):

> . . .gradually learn to trust people and to reappraise their ways of relating to others. In this process, the people with whom the patient lives become exceedingly important as representatives of the society in which he has been heretofore more or less unable to exist. The patient's natural family, especially if it is a parental one, continues to make the same demands upon the patient who finds himself caught in a whirlpool of expectations from which he cannot extricate himself. The patient finds himself in the dilemma of remaining in the hospital, in an artificial situation, or of returning to the very situation in which he became disturbed. Family Care promises a third alternative.

Family care also is used as a testing ground for newly found strengths and skills and for a strengthening of capabilities necessary for adjustment to the community. At the Fort Logan Mental Health Center the patient is not the passive recipient of care, but rather a participant in his treatment. His participation is extended to decision-making in regard to living in the community. He makes the investment of becoming involved as a part of the family with which he chooses to live.

In many ways the staff communicates to the patient that transition from the hospital to family care is not for the purpose of providing custodial care for one who is sick, but rather an opportunity for further rehabilitation and family living. Both patient and

family recognize that, though he is still handicapped, the patient no longer needs hospital care.

PATIENTS IN THE PROGRAM

At the time of placement in family care patients have been functioning at various levels of social behavior, from complete withdrawal from people to capable use of social skills. Some of the patients are able to work in competetive employment or in a sheltered workshop. Those who earn salaries are expected to be at least partially responsible for their support. However, the patients who cannot work are also able to take full advantage of the family care program. Patients of diverse cultural and ethnic backgrounds have made successful adjustments in family care homes, as demonstrated by their developing and maintaining social and vocational skills in their rehabilitation process. There is just about every conceivable "type" of patient in family care. The patient's diagnosis, his method of acting out (if there is one), his manner of relating or not relating to people in his environment in the past, his suicidal tendencies, his aggressive, hostile behavior, or his withdrawal, etc., seem to be less important than "a sound diagnostic understanding of what the patient is saying directly, symbolically, or through the language of projection, displacement, or denial."(3)

At the present time there are 69 patients in 34 family care homes. Since the opening of the family care program in May 1962, a total of 134 patients were placed in 39 family care homes. Twenty-one percent of these patients were discharged from the program to more independent living. Twelve percent returned to the center one or more times for further treatment and then returned to either the original family care home or a new home. About 5 percent of the patients placed in family care were returned to the center for additional treatment because the staff felt that the patient was not yet ready to function in the family care home. This may be due to insufficient planning with the patient and premature placement.

PROGRAM STAFF

The Adult Psychiatric Division of the Fort Logan Mental Health Center is presently divided into eight psychiatric teams, serving the Denver metropolitan area, which consists of approximately a million people. There is also an Alcoholism Division serving the state, and before long there will be a Children's Unit and a Geriatric Unit. We believe that all of the above units will use the family care program.

Each of the teams, whose full staffing pattern consists of a psychiatrist, a psychologist, two social workers, seven nurses, and seven psychiatric technicians, has appointed a member of the team as coordinator for team family care responsibilities. All of the team coordinators meet with the two principal family care coordinators weekly, both in a group meeting and individually.

The team coordinators who have been appointed are social workers or psychiatric technicians. Some of the psychiatric technicians do not rotate shifts and are assigned to the Social Service Department. Others of the appointed psychiatric technicians do rotate shifts and are assigned to the Nursing Department. The latter group carry their family care duties as part of the expansion of their roles and utilize the help of other team members in this work. The two principal family care coordinators for the center are social workers who are not members of any one team, but relate to all of the teams. The Social Work Department is responsible for the supervision and guidance of family care placement and follow-up.

The group of team family care coordinators are responsible for maintaining an open network of the complicated communications necessary for the successful placement of patients. That is, they serve as liaison between team and patient, team and and caretaker, team and natural family of patient, and the center and the community.

The principal family care coordinators and the team family care coordinators meet to share information and for guidance, learning, and support. The group members discuss factors involved in assisting patients to move on to family care and study how follow-up visits to the patient in the community can be used

most effectively as a therapeutic tool. Discussions between the coordinators are a part of the educational program to assist them in helping the patients relearn and socialize. The group is in a position to support its members when feelings of frustration and failure in accomplishing these difficult tasks arise.

Every patient in a family care home is visited weekly, or more often if necessary, by the team family care coordinator or by the staff member who placed the patient in the home. These visits continue as long as it is necessary to assist the patient to handle his anxieties about living in the community. Gradually, as anxieties are lessened and the patient begins to look toward the family for support, the visits by the team member are reduced.

The team determines which patients are candidates for family care and has ultimate responsibility for its patients. The team assists the team family care coordinator in all aspects of preparing the patient for placement, as well as in preparing that patient's family if placement is to be in a family care home rather than his own home. The team determines the goals of placement and through the team coordinator helps the family caretaker understand the patient's particular needs. The team family care coordinator, through guidance from the team and the family care coordinator meetings, provides ongoing stimulation for the patient to progress, if possible, from the first stage of placement to other stages of higher functioning and eventual discharge. Specifically, the team family care coordinators in approaching a patient for family care learn to be aware that the patient is confronted with the anxieties of having to deal with substitute parents and siblings and how these might best be handled.

THE CARETAKERS

The caretakers are key people in the success or failure of the program. The personality and the strengths and weaknesses of each caretaker applicant are evaluated as carefully as possible. Ability to set limits and controls in a firm yet kindly way, basic warmth, intuitive understanding, being not too threatened by acting-out behavior, aggression, or regression are

qualities which are sought.

The caretaker is expected to accept a patient into his home as a member of his family and not as a guest. The caretaker should assist the patient to involve himself as a functioning member of the family up to his capacity. The caretaker's home also is evaluated in terms of health and safety standards and adequate physical surroundings.

At the present time the caretakers are husband-and-wife teams, married couples with children of all ages, and some widowed persons.

Some of the homes have one patient, the majority two to four, and a few have as many as six patients. The homes approved for six patients are used for those patients who are fearful of a close relationship with a parent figure and need many siblings to lessen the intensiveness of the relationship.

Each caretaker accepted must have an income adequate to maintain his family without dependence on the $130 a month he receives for the care of each patient. Those caretakers who indicate that payment is a factor in their willingness to work with the program have generally been found to be the more successful caretakers, expecting the patients in their homes to involve themselves in learning and socialization through family participation. It has been necessary to work harder with the caretakers who tend to deny much interest in the money paid them, as they have tended to treat their patients as guests who need to be served, and thus foster continuing dependency.

All of the caretakers participate in learning groups. At present there are four groups of caretakers having from six to nine members. The meetings serve a supportive as well as teaching function. Concentration is mostly on feelings caretakers might have concerning "successful achievement" and anxieties regarding "failure." Both long-term and short-term goals are discussed. The caretakers discuss such things as how one handles anger, what a patient is attempting to communicate through acting-out behavior or through withdrawal, and the meaning of food to the patient. Almost equally important, the caretakers receive support, encouragement, and guidance from each other as members of these groups. There is a sense of cohesiveness, shown

in the attendance, willingness to share, and personal growth of caretakers. This is particularly evident when a new caretaker joins an ongoing group and presents the same fears and anxieties that the others have worked through. The group rallies to assist the new caretaker with supportive and encouraging explanations of their own experiences.

The caretakers feel that the center acknowledges their role in the therapeutic community and that they will be supported when it is necessary to return a patient to the center for further treatment. The caretakers understand their role as being that of helping the patient to become a functioning part of the family and the community.

The team family care coordinator also assists the caretaker to understand an individual patient's difficulty in adjustment, background deficiencies, and marginal expectations. The knowledge that the teams can be contacted at any time for clarification, support, and assistance makes caretakers more comfortable. The caretaker is not expected to flounder alone, nor does she have to take over any psychiatric function.

In order to find enough suitable homes to have as much choice as possible in matching patient to home, newspaper articles, advertisements in local papers, and speeches to lay and professional groups have been used. Caretakers have also involved friends and relatives in becoming caretakers.

PROGRAM PROCEDURE

The patient's history has revealed areas of disorder in his ways of relating to people in his environment, his efforts at reality testing, and his capacities to handle stress. Talk of placement in a family care home in the community can bring to the front old distorted patterns of behavior and produce fear, anxiety, regression, and aggression, as well as feelings of being abandoned by the protective and tolerant hospital. The team member suggesting placement must also be aware of this, as well as the patient's ambivalent feelings of fear and desire for closeness to a family. The patient's past and his personal and family experiences are of great significance in considering the type of family

care home placement. It is necessary to have an understanding of parental and sibling experiences and of the effect of these experiences on the patient, if placement is to have best chance of succeeding.

Frequently, the patient's best chance for help is through the substitute means of living with a healthy foster family where there is opportunity for reworking of old experiences and where relearning can occur. The caretaker needs interpretation and guidance from the team coordinator in understanding the patient's behavior and his needs. The original family also needs clarification and support at this time in working through feelings of failure, frustration, and guilt, so that they can allow the patient to receive as much assistance as possible from the caretaker family and not attempt to undermine the placement.

The technical procedures for referring a patient to family care are few. Once the team has explored alternate living arrangements and is satisfied that family care is indicated, referral is sent to the principal family care coordinators. The referral indicates the patient's needs, adjustment in the hospital, past social history, and goals for the patient in family care. Meanwhile, the team member attempts to enlist the patient's ego strengths and his planning capacities for the placement process.

The principal family care coordinator and the placing person from the team then discuss appropriate homes that are available. The placing person and patient try to visit two or more homes which the team believes will meet the patient's needs, and the patient selects the home in which he feels most comfortable.

The caretaker has been made aware of the patient's needs, difficulties, and the team goals. She decides if she feels comfortable in working with the patient, and, if so, the patient is placed in the home. Depending on his relationship to his original family and on his needs, the patient will be permitted by the team to visit relatives when it is felt he has adjusted to his foster family.

In the follow-up procedure, patients in a family care home are seen either individually or in groups by the team member. This is done usually either at a Community Mental Health Center or other community facility, rather than in the caretaker's home or at Fort Logan. The purpose of these visits is to provide the

basis for ongoing rehabilitative care through use of community services.

WEAKNESSES IN THE PROGRAM

Approximately 75 percent of the placements from Fort Logan Mental Health Center to family care homes are made as described above. Unfortunately, in the other 25 percent of the placements there are difficulties in the patient adjusting to the home or in the family care home being unable to help the patient move toward better socialization. However, follow-up evaluations indicate that in these situations one of several things occurred, and in some instances a combination of several: (a) a weakness in adequate patient preparation and working through of his anxieties and fears before leaving the hospital; (b) a breakdown of communication – either between team and patient, team and caretaker, team and family of patient, or team and principal coordinator; and (c) a mismatching of the patient's needs and caretaker's ability to fulfill these needs.

SUMMARY

Through the above complicated processes, and despite some difficulties and failures which, hopefully, we can understand and from which we can learn, the family care program at Fort Logan Mental Health Center has been used successfully to place many patients in homes in the community. These patients range from those grossly disturbed to those on the verge of independent living. The degree of disturbance does not seem to be as important in the eventual prognosis toward growth as is the careful preparation of the patient for this treatment method, the skill of matching patients' needs to the assets of the caretaker, good all-around communication, and the continuing support and learning the team family care coordinators and the family caretakers receive individually and in their groups.

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FORT LOGAN STAFF OPINIONS ABOUT MENTAL ILLNESS

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Cohen's and Struening's (1) Opinions about Mental Illness Questionnaire (OMI) is generally administered to new staff members at the Fort Logan Mental Health Center. This report compares the relative standings of the clinical disciplines on the OMI to the authors' VA Hospital standardization population.

The questionnaire is composed of five factors, briefly described as follows:

Factor A. Authoritarianism. People agreeing with these items tend to advocate coercive handling of the mentally ill and to view patients as inferior to "normal" people.

Factor B. Benevolence. High scorers on this factor tend to see the mentally ill as poor unfortunates for whom society is responsible. Unlike Factor A, this feeling toward patients is sympathetic, but it still does not allow for crediting them with the capacity for mature adult behavior.

Factor C. Mental hygiene ideology. Individuals scoring high on the positive pole of this factor feel that patients are able to remain in open hospitals and can assume much responsibility for their own behavior. The negative pole bears a somewhat authoritarian cast.

Factor D. Social restrictiveness. Here mental patients' prognoses are seen as hopeless. They are seen as people who are socially incompetent, from whom society must be protected and who should not be permitted to marry and bear children.

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Factor E. Interpersonal etiology. This factor reflects a belief that the mentally ill failed in childhood to develop wholesome interpersonal experiences.

Each of the five factors of the OMI will yield standard scores with which to compare individual or group relative standings across factors. Standard scores are based on a sten system, expressed in one digit ranging from 0 to 9, with a mean of 4.5 and a standard deviation of 2. The sten score system was derived from a standardization population of 3,149 employees in 12 VA mental hospitals, including workers in physical medicine, rehabilitation services, and special services, physicians and dentists, psychiatrists, psychologists, nursing assistants, nurses, and social workers.

Table 1 presents average sten scores on each of the five factors for various disciplines at Fort Logan. Low scores on Factors A and D are, of course, desirable, while high scores on the other factors are desirable.

The findings in Table 1 appear to agree with the authors' comments about the OMI and its relationship to education (1). That is, with regard to *authoritarianism*, the discipline most divergent from the others is the psychiatric technician group, which is more authoritarian than any of the nurse groups, the psychiatrists, psychologists, or social workers of the standardization population. However, since more than 72 percent of the standardization population score higher than the psychiatric technicians, the group as a whole was not considered highly authoritarian.

The authors' comment that Factor B bears an inverted U-shaped relationship with education, being low both at the "more than 15 years of education" and at the "less than 13 years of education" levels. All of the nurse groups employed at the center are in the middle, while the psychiatric technicians are closer to the nurses who have left employment on the one extreme, and to the psychiatrists, social workers, and psychologists on the other. Psychologists are clearly less benevolent than any of the groups, and this finding is again consistent with previous studies.

TABLE 1

AVERAGE STEN SCORES

	FACTORS									
	A		B		C		D		E	
	M		M		M		M		M	
Employed Techs. (N=62)	3.32	72.2	5.82	25.5	5.84	25.1	2.60	82.9	4.02	59.5
Employed Master's-Level Nurses (N = 7)	1.29	94.6	7.00	10.6	7.28	8.2	1.57	92.9	5.86	24.8
Employed Bachelor's-Level Nurses (N=11)	2.00	89.4	6.45	16.5	5.91	23.9	1.87	90.7	3.18	74.5
Employed 3-Year Nurses (N=11)	2.09	88.7	6.27	18.7	6.27	18.8	1.82	91.0	4.09	58.1
Psychiatrists** (N=12)	1.33	94.4	5.17	36.9	7.67	5.7	0.42	97.9	5.00	40.1
Psychologists** (N=11)	2.27	86.8	3.82	63.3	7.18	9.0	1.00	96.0	5.09	38.4
Social Workers** (N=20)	1.55	93.0	4.95	41.1	7.50	6.7	9.85	96.6	4.20	56.0
Nurses Who Left Employment (N=40)	2.35	85.9	5.60	29.1	6.08	21.5	2.18	87.7	4.18	56.4

*Percent of standardization population which exceeds the mean sten score.

**These groups include both employed and separated Fort Logan personnel. At the time of analysis, no distinction was made between employed and unemployed because of the reduced N thus available.

Table 2 ranks the various disciplinary groups' mean sten scores. Ranks are presented so that the most "favorable" score has a rank of 1, etc. On *authoritarianism*, therefore, since a low score is "good," master's-level nurses have a rank of 1, while on *benevolence*, where high score is preferable, the master's-level nurses again have a rank of 1.

TABLE 2

RANKED OMI AVERAGE STEN SCORES

	AUTHOR-ITARI-ANISM	BENEV-OLENCE	MENTAL HYGIENE IDEOLOGY	SOCIAL RESTRIC-TIVENESS	INTER-PERSONAL ETIOLOGY
DISCIPLINE:					
Master's-level Nurses	1	1	3	4	1
Psychiatrists	2	6	1	1	3
Social Workers	3	7	2	2	4
Bachelor's-Level Nurses	4	2	7	6	7
3-Year Nurses	5	3	5	5	6
Psychologists	6	8	4	3	2
Unemployed Nurses	7	5	6	7	5
Technicians	8	4	8	8	8

Using Kendall's *tau*, out of the ten possible relationships between the five sets of rank, the following agreements between ranks are significant: between *authoritarianism* and *mental hygiene ideology* and *authoritarianism* and *social restrictiveness* ($p = .031$); between *authoritarianism* and *interpersonal etiology* ($p = .054$); between *mental hygiene ideology* and *social restric-*

tiveness ($p = .00087$); between *mental hygiene ideology* and *interpersonal etiology* ($p = .016$); and between *social restrictiveness* and *interpersonal etiology* ($p = .054$). In other words, favorable or low scores on *authoritarianism* are related to favorable or high scores on *mental hygiene ideology* and *interpersonal etiology*. Low scores on *authoritarianism* are related to low scores on *social restrictiveness*. High or favorable scores on *mental hygiene ideology* are associated with high scores on *interpersonal etiology* and with low and favorable scores on *social restrictiveness*. Favorable scores on *social restrictiveness* are also related to favorable scores on *interpersonal etiology*. It is noteworthy that *benevolence* did not produce any significant correlations.

Results of a study requested by the director of nursing education at Fort Logan showed that psychiatric technicians who left employment at the center tended to score somewhat less well on the OMI than those who stayed, although the average mean difference between the two groups did not quite reach statistical significance. For the technicians who are still employed, however, some predictable shifts have taken place. The assumption is that Fort Logan's philosophy toward mental illness is most like the favorable role of the OMI factors; therefore, one would hypothesize that with completion of Fort Logan's six-months training course for psychiatric technicians and with increasing familiarity over time with the center's philosophy and method of operation, technicians' scores on the five factors would become lower on *authoritarianism* and on *social restrictiveness*, and higher on *mental hygiene ideology*, *interpersonal etiology* and *benevolence*. Using the sign and the Wilcoxon matched-pairs signed ranks tests (2), it was found that over a period of several month's employment more psychiatric technicians became less authoritarian and socially restrictiveness, and more psychiatric technicians became inclined toward an interpersonal-etiology view of mental illness.. On *benevolence*, there were fewer people who increased their scores than these who decreased their scores, but the size of the positive changes outweighed the negative ones. Thus this factor also shows a favorable alteration over time with exposure to the center's philosophy and treatment policies. *Mental hygiene ideology* was the only

factor which showed no appreciable change.

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A SHIFT-CHANGE REPORT FORM

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The exchange of information, which occurs three times each day at the time of shift change on an adult psychiatric team at the Fort Logan Mental Health Center, communicates data about specific patients and about the mood of the treatment unit as a whole. The author and other members of the Denver I Team felt that much of that information was being lost to further scrutiny because of the traditional, primarily verbal mode of reporting. Furthermore, we were aware of the significance of patient-to-patient interactions, patient-to-staff interactions, and the general mood patterns of the unit as determinents of behavior. However, we were rather at a loss as to how to investigate these factors systematically. We felt we should try to devise an orderly form which would be available for those staff people who "give report" and which would

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also record and preserve a daily cross section of the behavior of the team.

After five months of use and modification, we have arrived at a single-page form which records patterns for each 24-hour period. Judgments are made for each inpatient about his sleep and awakening patterns by the night shift. Judgments about his behavior during day and evening shifts are made on the following patterns: usual behavior, patient seeking patient, staff seeking patient, and patient seeking staff. The recorder for each shift also notes whether the shift was "good, bad, or indifferent" and records those teamwide feelings which seemed most characteristic during that work period, (euphoric, angry, anxious, compassionate, optimistic, "blah," distant, depressed, or pessimistic). In addition the staff group patterns, i.e., whether staff was with the patient group, clustered in the nursing station, or busy elsewhere, are recorded. The patient group patterns are noted with reference to whether patients were shadowing the staff and whether the patients were together or distant. Finally, an estimate of the treatment cottage patterns is obtained by evaluating whether the two treatment teams, housed together on the unit, cooperated and whether members of one team staff encountered gripes about the behavior of the other team.

It takes considerably longer to describe this form than to actually complete it, since it is designed as a check list open-ended enough so that the staff can record the minimal data and then elaborate wherever they wish. So far, the check list seems to be working reasonably well, and its acceptance by the staff is apparent in their concern when the mimeographed stock becomes low.

We foresee three general, clinical research areas with this particular tool. First, we will study it as a simple introductory technique for quantifying some of those interpersonal behaviors and feelings which are of major significance. Hopefully, this technique will offer the beginnings of a more systematic understanding and prediction of the mood swings and other large group dynamics in our setting. Secondly, since we will obtain repeated estimates by the same rater, we will have an opportunity to consider the

factor of individual staff members. We will be better able to see if certain staff have stereotyped attitudes toward certain patients, or toward the entire situation, and how these attitudes influence the situation, especially on evenings and nights when the rater is the only team-staff representative on the unit. Lastly, the check list offers an estimate, three times a day, of the behavior of individual inpatients along continua which are not routinely recorded in each of their charts. If we can devise some manageable fashion of compiling the data from the check list, we may develop an individual social behavior graph and/or some sort of nonindividualized, teamwide graph which would take the place of nursing notes in the patients' charts.

The present technique is not fully developed or comprehensive in that it does not sample the behavior of all the people on the team, such as day patients. However, it is not feasible to obtain recordings to that extent at this time because of limited staff time. Nevertheless, the least that the check list does (aside from the minimal data recorded) is to keep our staff alert to the "feel" of the unit and to the social patterns of certain patients, and it is encouraging us to look for better ways of recording.

VALUES MEETINGS

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Several months ago, one of the psychiatric teams at the Fort Logan Mental Health Center conceived the idea of initiating a new kind of patient-staff meeting. It was to be one in which a discussion would focus on personal goals, values, and beliefs. The

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author was asked to lead the meetings. Since then, the name "Values Meetings" has come to be applied to them, and other teams have also developed similar discussions.

As staff and patients engage in such a discussion, an assumption is made that might be stated as follows: Everyone is trying to earn, find, or receive meaning for their lives, and in the attempt develops certain values--social, religious, moral, political, or economic. This search for meaning is not to be thought of as pure and singlehearted; it often pulls persons in more than one direction at once, and values can become conflicted. It is felt that it is helpful to patients to discuss this search, to share with each other the anxiety of being human in the search and the sometimes desolate feeling of failure, and to examine together the values that guide them.

The meeting is conducted without agenda, and the participants are encouraged to introduce concerns that are current for them. The raw material, then, is the present feelings and experiences of the participants, and it is the task of the leader to help clarify how these relate to the matter of values. Any member of the group, of course, might offer this leadership, and it is the responsibility of the entire group to participate as well as they are able in this theme-setting. Theoretically, no material is extraneous to a values meeting, but part of the contract is to try to ask how the concerns introduced might be a reflection of the values of the individual, the group, or the culture. The author has tried to introduce specific topics for discussion, but in general this is only effective if the topic is closely connected to a concern the group shares at the time. It seems likely that this phenomenon is a function of the close-knit nature of the Fort Logan Mental Health Center team and may not be true of every group.

Guilt, trust, self-esteem, feelings toward church and synagogue, and suicidal thoughts are among the issues that have been dealt with in the meetings. One meeting began with: "This morning before coming to the hospital, I left my children with my mother as usual, but she had a cold and didn't feel like keeping them. Frankly, I feel guilty." Another opened like this: "I don't know

whether I have values or feelings or anything. I just feel very empty." Perhaps the most recurring question of the patients, asked in religious and nonreligious ways, is: "How can I possibly earn my worth, especially when I'm a patient in this hospital?" Although in many cases an answer to that question is available in the patient's own religious faith, he often cannot utilize the answer.

The values meetings are a promising way of inviting patients to examine their lives from a particular perspective; yet often at the end of a meeting, the author wonders how it has differed from the team's regular group therapy sessions. As Chaplain, the author also asks himself how his role affects the nature of these groups and how they might differ if the designated leader were of another discipline. He is convinced, though, that staff need to be aware of the values, beliefs, and goals of patients, because these are sometimes areas of conflict and equally because they are sometimes sources of strength. The values meetings represent one way to achieve this awareness, and to work with it.

PSYCHOTHERAPY THROUGH THE GROUP PROCESS. By *Dorothy Stock Whitaker* and *Morton A. Lieberman*, New York, New York. Atherton Press, 1964, pp. 305. $8.50.

The past two decades have witnessed a dramatic expansion in the use of group psychotherapy and a marked increase in the experience and skills of its practitioners. The maturation of group psychotherapy as a treatment modality has been accompanied by increasingly divergent views in regard to its theory and practice. Much interest and controversy has been generated around one particular issue. Many group therapists see group psychotherapy as an extension of individual therapy in which the theories and techniques of individual therapy can be appropriately applied. They are likely to see the primary therapeutic agent in group therapy as the dyadic relationship of the therapist and the individual patients. They see group dynamics and group processes as either incidental or antagonistic to the therapeutic process. The contrasting position views group psychotherapy as a treatment modality unique in its own right. These practitioners feel that in order to benefit individuals in group therapy, the therapist's major attention and effort must be directed towards the group and group processes rather than individual patients within the group. They feel that group processes are central to the therapeutic process.

In this controversy, Whitaker and Lieberman favor the latter position. Their view is succintly summarized in the following statement: " . . . we suggest that the group forces are a potent element in determining the nature of the patient's therapeutic experience, that the group can work for good or ill, and that the therapist who is in touch with group forces is in an optimal position to utilize the group situation for maximum therapeutic benefit." *Psychotherapy through the Group Process* represents an attempt to construct a theoretical framework which gives meaning to the seemingly disconnected sequence of events in the group. By comprehending the dynamics of the group process, the therapist is then in a position where he can influence this process through

his participation so as to aid the group in becoming an effective therapeutic agent.

Whitaker's and Lieberman's theory of group process is based on three assumptions: (a) There is continuous covert communication being carried on in the group therapy session. (b) Seemingly disconnected manifest contents of the session are actually linked to each other by way of the covert communication or the latent content. (c) The covert communication focuses upon shared feelings in the group at any particular minute, i.e., the continuous covert communication is concerned with shared feelings in the "here and now." These shared feelings may be differentiated into two aspects called "disturbing motives" and "reactive motives." The disturbing motives consist of impulses and wishes operating in the current group situation. The opposing motive, the reactive motive, consists of fears and apprehensions associated with the expression of the disturbing motive. For example, a common disturbing motive in a group is the shared wish to express or reveal personal problems. The reactive motive or fear is commonly an apprehension of ridicule by the peers in the group. The disturbing and reactive motives together are referred to as the "group focal conflict." The group focal conflict arising from the opposing motives monopolizes the covert communication of the group as they seek a resolution to the conflict. Such a resolution to the group focal conflict is called the "group solution." The primary aim of group solutions is to relieve the anxiety generated by the group focal conflict. This is done primarily by creating solutions which reduce the reactive fears or motives. The secondary aim of group solutions is to satisfy the disturbing impulse or motive as much as possible. However, this latter function of the group solution is clearly secondary to its primary orientation of reducing the anxiety in the group. Group solutions lie along a continuum with poles which may be labled as "enabling" and "restrictive." Enabling solutions are those that alleviate anxiety, but at the same time allow for some satisfaction, expression, or exploration of the disturbing motive. Restrictive solutions are also directed towards alleviating anxiety, but do so at the expense of satisfying, expressing, or exploring the disturbing

motive. The goal of the group therapist is to influence the group process in such a way as to move the group whenever possible towards the more enabling solutions.

Most schools of psychotherapy suffer from a discontinuity between the theory of pathology and the theory of treatment. Whitaker and Lieberman attempt to avoid this pitfall by presenting a personality theory utilizing the same constructs as their theory of group dynamics. Consequently, their theory is internally consistent in that it provides a framework wherein the individual with his own focal conflicts can find solutions to these conflicts through his participation in parallel group focal conflicts and the group solutions.

Whitaker and Lieberman extrapolate from this basic theory to explore its ramifications for a variety of issues. They examine the relevance of their theory to such questions as homogeneous vs. heterogeneous groups, what conditions lead to success or failure in group psychotherapy, what benefits are available to the silent member of a group, which techniques can and which cannot change an existing group culture, and the characteristics of different phases of group development. The theoretical structure is surprisingly versatile in providing rationales for commonly perceived group dynamics, as well as answers to frequently raised questions regarding groups. Part of this versatility is due to the fact that the authors have drawn from their observations of both inpatient and outpatient groups, as well as from their experiences with the T-Groups of the National Training Laboratories. The authors do an excellent job of providing excerpts from actual group sessions to illustrate their points. The practicing clinician, however, will wish that the authors had provided even more examples of the therapist's activity.

Psychotherapy through the Group Process is not a primer for the beginning group therapist. It does not provide the concrete dos and don'ts that the neophyte often seeks and needs. Rather, this book is directed towards the more experienced therapist who is seeking alternative frameworks through which to perceive and comprehend the multiplicity of events in group psychotherapy. For the thoughtful therapist, regardless of his particular theoretical

persuasion, this book will be both useful and stimulating.

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The *Journal of the Fort Logan Mental Health Center* invites contributions in the areas of milieu therapy, social psychiatry, and related fields.

Manuscripts should be submitted in triplicate in the form in which the author wishes the paper to appear. Copy should be double-spaced, with margins of at least one and one-fourth inches.

References should be indicated by numbers in parentheses that refer to the list of references at the end of the article. The list should be alphabetical, and the names of the journals should not be abbreviated. The following format should be observed:

JAHODA, MARIE, Current Concepts of Positive Mental Health, New York, Basic Books, 1958.

RIESMAN, D., "Some Observations on Interviewing in a State Mental Hospital," Bulletin of the Menninger Clinic, Vol. 23, pp. 7-19, 1959.

The author should include an address to which inquiries regarding the article should be sent, in the form of a footnote indicated by an asterisk on the first page of the article.

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