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WORK WITH RELATIVE GROUPS: PROBLEMS AND ERRORS*

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INTRODUCTION

During this past year I have acted as consultant to several caseworkers involved as cotherapists with groups. In two instances the cotherapists were psychiatric residents; in two other situations the cotherapists were nurses. The setting was a university-affiliated, small state-supported psychiatric hospital with a major focus on diagnosis and short-term treatment. The more chronic patients requiring long-term help were transferred to a large state hospital or to other facilities. Three of the groups were composed of relatives of patients—usually spouses and occasionally one or both parents. In one instance the members were recently discharged women patients and their husbands.

The focus of this paper will be on some common problems faced and errors made by caseworkers undertaking the use of the group as a treatment modality.

PREPARATION OF THE GROUP WORKER AND GROUP MEMBERS

Taking on a group is not a simple procedure, but one that requires some self-inquiry into why one wants to use this treatment

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modality, what goals one wants to work toward, what one perceives as his role, as well as consideration of composition of the group, content, and numerous other group facets. I made it a practice to inquire of the caseworker desiring to work with a group about his motivation for so doing. Sometimes there was a lack of clarity, sometimes a sense of conviction, and sometimes a disarming candor in the response, "Because everybody is doing it and it's expected of me." My next questions to the caseworker usually were, "What do you hope to accomplish?" and, "What are your goals and purposes in establishing the group?" These queries usually were answered by such responses as, "What do you mean?" or, "To assist people to gain support from one another." My purpose for asking these questions was to help the worker think about some of the problems, develop conviction about this treatment device, and seek some solutions for relieving the initial anxiety in working with groups.

Workers having limited knowledge of groups tended to overlook and minimize the effect of such factors as changes in composition, group instability, and lack of cohesion. This gap in their understanding caused them at times to set goals and purposes for groups that were largely unrealizable and could only lead to frustrating experiences for the worker and the group members. For example, some workers indicated that as one of their goals they expected to help the relatives in their group modify their behavior. They then would advise me that some group members probably would not be together for more than several weeks and that there would be several changes in the composition of the group. It is questionable whether one can expect more than ventilation and support through such a group experience. Those workers who seek a more intensive experience for their group members of necessity must think of developing a more stable group which will meet over an extended period of time. No value judgment on which group is more helpful is intended, but it should be clear that there is a relationship in this instance between goals, time orientation, and group stability.

Another facet of the matter of goals and preparation of the group is the kind of interpretation given to the relative of the

worker's expectations for the use of the group. Many workers talked about the opportunities for support inherent in the group, or the possibility of hearing what others say about their hospitalized relatives. For the long-term group much less was said about the group affording its members the possibility of examining their parts in the process leading to illness or of expressing feelings. Relatives, as they accept involvement in the group, ought to know that the workers are concerned with *their* activities as well as the patients'. With this orientation there may be less risk of group members externalizing and focusing on the hospital patient being the sole client. Stated epigrammatically, perhaps there is a difference between induction and seduction to a group.

Another question which caused considerable concern to the caseworker working in a setting where the relatives were seen individually was how to handle the individual in these two treatment modalities. Problems arose around resistances in sharing one's worker with others, around feelings of rejection, and around lack of clarity about content to be channeled into the dyadic and multiple relations.

Clarity of purpose and goals and adequate interpretation in the preparation of individuals for groups should be underscored as strongly as possible in those situations where people are seen individually and in groups. The worker should be able to state simply and with conviction the reason for the use of the two treatment methodologies. If the worker plans to continue with individual interviews, this should be made clear to the client. If he proposes to taper off the one-to-one relationship, the client should know this as well. The purpose for the group may be interpreted as an opportunity for the sharing of thoughts and feelings, for relieving feelings of isolation, and for permitting the examination of interpersonal relations as they are revealed in the group as a means of better understanding the home situation. Failure to clarify the reasons for the use of both methods may arouse feelings of rejection, concerns that perhaps the client's situation is much worse than he had perceived it to be because he is getting additional help, or a sense of relief in moving into what may appear to be a less intensive way

of work. One should be alert to these varied emotions as they emerge in individual and group treatment and take adequate time to handle them. Feelings of rejection may manifest themselves through verbal expressions of anger and through silence and withdrawal; increased anxiety may show itself through absence and late arrival; and for those who experience relief in becoming a member of the group a diminution of the content and an attenuation in the dyadic relationship may ensue.

Frequently both the worker and client perceived the use of group and individual methods as two separate and distinct modalities, rather than as parts of the total treatment plan. When seen in this fragmented way, there was confusion on the part of the worker and client about what was to be discussed in the group and what was to be discussed in individual interviews. This was further complicated by the worker's deep concern about the private, confidential nature of the one-to-one relationship and his feeling bound not to introduce material from the interview situation which might clarify a situation and correct distortions. The client, too, may be influenced by the "cult of privacy" not to bring material to the group for fear of the worker's wrath, or out of feelings of loyalty to the worker. As part of the preparation for groups, this matter of the use of individual and group content must be explored and clarified thoroughly. As part of the agreement to enter the group, it should be made clear that (a) the additional treatment modality is part of the total treatment scheme and that (b) the worker will encourage and the client may feel free to introduce content from either individual or group sessions. Hopefully, with this explicitly stated, there would be an alleviation of anxiety around this issue and an atmosphere created in which the two methods would supplement rather than weaken each other.

Another situation which *may* arise is one in which one worker sees the client individually and another sees the same person in the group. Again, it would seem to me of great importance that there be adequate understanding by all people involved of how content is to be used and of the nature of the relationship between the two workers. Management is eased considerably where the same worker

is both the individual and group therapist.

There are several other facets in the preparation for work with groups which are relevant. It would be helpful for group members to see the room and, of course, to know the day and time of meeting. If observers and/or recorders are to be used, this should be shared with the client, and any concern about this should be handled with him. In interpreting the use of observers and recorders, most group members are able to understand the fact that one person cannot see and hear everything going on with several people, so that the observers and recorders are helpful in assisting the worker perform more adequately with them. It would also be of import to let the clients know that sessions will be tape recorded, if this is planned. Again, the interpretation may be used that since one is not always aware of all that may be taking place, the tape recording by providing an opportunity to listen and learn what may have been missed fosters the goal of being most helpful to each and every person.

I do not think it amiss for the worker to indicate to each prospective group member that he is expected to attend regularly and that he is responsible for advising the worker and the group of inability to attend any group meetings. Questions of socialization of members may depend on the goals of the group and one's philosophy with respect to this matter. A recent book by James Johnson, Jr. entitled *Group Therapy, A Practical Approach* (3) deals in depth with the issue of contractual arrangements between the therapist and group members.

THE INITIAL MEETINGS OF THE GROUP

One of the phenomena that was observable early was the effort of the group members to set up a pattern of behavior that was a response both to a fear of involvement and to past associations with other groups. On another occasion I noted (4):

> There are few of us, indeed, whose group associations are other than recreational, social or educational in nature. There is little in these experiences to prepare us for group therapy. If anything,

> previous group experiences seem to make one's adjustment in group therapy somewhat difficult. In most of the groups many of us belong to, relationships are not deep, efforts are made to move away from too personal discussions, and anxiety levels are normally low. The major objectives of most groups are social, educational and recreational in nature. My thesis is that with this background of group life, most people entering group therapy try to fashion this group after the group models with which they have been previously associated.

The evolvement then of early patterns of group behavior is affected by previous group experiences. Patterns also are affected by the defenses set up by the group members against the anxieties engendered by involvement and closeness. Fear of exposure, retaliation, and loss of control are evocative of emergency defensive maneuvers. If one has been involved in individual therapy there is the further effort to demean the group and wean away the worker.

One pattern which emerged in the beginning stages of group life was the teacher-pupil or doctor-patient relationship. This was characterized by efforts of the group members to involve the worker in question and answer sessions with the admonition, "You're the expert, you know what's wrong, you tell us!" There was often a magical expectation, a desire to assume a dependent position, and an effort made to defend against involvement. There was also a relationship between the development of this pattern and old memories of groups in which an authority figure was present. I believe many of us find it easy to move into the teacher-pupil relationship; it tickles our egos, it serves to keep some discussion going, and it relieves our anxiety when we're not quite sure how to involve other group members.

Another modification of the above pattern was focusing on one individual to the exclusion of other group members. To the member who may wish to keep the worker as his own and not share with others this pattern is most gratifying. This also may be satisfying to the client who wishes to destroy the group because of anxieties generated by this treatment modality. The worker who lends himself to this type of group structure may also have some questions about the ability of the group members to help one another and difficulty

in giving up his controlling position. Hyman Wiener in a paper given last year made these perceptive comments with respect to the caseworker and groups (6):

> The experienced caseworker often has more difficulty learning to work with groups than the novice. It is difficult indeed to tread on uncertain ground after a self-image of professional competency has been developed. Fear of not having control over the group appears to be one predominant concern of the experienced social worker. Since we are not engaged in open heart surgery – a "live dangerously" attitude would go a long way toward comfort in work with groups. Frankly, many caseworkers do not really believe that patients can help each other. The hard-won conviction that if casework is to be effective the client must help himself, must be relearned in a group context. This conviction is gradually transmitted to the group, whose participants at the outset cannot imagine that they can actually be of help to one another.

Another observable pattern was the drive to make the group into a social gathering – that is, the conversation was usually about trivia with little or no effort made toward mutual analysis of common problems. Here again past group associations came into play as the members sought to mold the group into a social rather than a therapeutic club. The worker who may be comforted by the fact that there is a good deal of interaction or who may not be quite sure how to break up this pattern may inadvertently reinforce this group norm by permitting this behavior to continue over a period of time.

The danger is not the emergence of these patterns, since it is difficult if not impossible to prevent, but rather that if the worker lends himself to the development of these norms of behavior they may become frozen. That is, the pattern will continue until it becomes increasingly problematical whether it is possible to unfreeze these behaviors and set the group on another course of action. When this occurs it can be a most frustrating experience to the worker.

MODES OF HANDLING GROUP TRENDS

It is of importance for the worker to be sensitive to and aware of the anxieties generated by the group situation – anxieties rela-

tive to closeness, exposure, rejection, loss of control, and poor previous relationships, among others. These feelings reveal themselves in the group patterns described and in individual behaviors such as absence, lateness, hostile comments, and silence. The worker's recognition of these concerns should be manifested by supportive comments as, "Is it difficult to talk to strangers?" or, "Have you questions whether you can get help from one another?"

Group members show their concerns in many ways, sometimes quite openly by absence, lateness, or silence, but at other times by talking of other situations which appear to be separated from what is going on in the group but when examined further have a direct relationship to the content of group experience. For example, this vignette is taken from the second meeting of a relatives' group in which a social worker and nurse were coworkers:

Mrs. C: "What goes on in group therapy in the ward?"
Nurse: "Essentially the same kinds of things as go on here. The showing of feelings and experiences."
Mrs. C: "Do the patients counsel one another? I saw a TV program once on group therapy where there were a lot of aggressive people. It made me wonder what really does happen."
Mrs. M: (laughing) "It reminds me of a kindergarten group."

There is no question that there may have been concern on Mrs. C's part about group therapy on the ward and what was happening to her son. It is equally true, I believe, that Mrs. C and Mrs. M were revealing their own anxieties about the present situation by telling about something that appeared to be outside of the group. It would have been helpful in this situation for the worker to have wondered with the group whether they were bothered by what might happen within their present experience.

In a later meeting of the same group, Mrs. M commented on the nursing home where she was working. "It's the awfullest, dumbest thing to me in that nursing home – we need a dietician; an ordinary cook just doesn't know how to plan a meal." There are two ways of looking at this comment: (a) that it is simply a remark revealing some frustration at work, or (b) that in a setting where the psychiatrist was perceived as the most expert authority (dietician), she and the other members were being served by a social worker and nurse

(ordinary cooks). The worker, I believe, would have done well to raise the question with group members of their feelings about getting help from ancillary staff when their husbands were seeing a psychiatrist.

Whenever and wherever possible the worker should turn back possible problems to the group, rather than carry on an individual interview within the group setting. Dr. Johnson in the book previously mentioned (3) refers to group-constructive and group-destructive techniques, indicating that group-constructive efforts are those directed toward greater and greater group involvement. I believe this is probably the most difficult step for caseworkers to take because their training is focused on the development and use of dyadic relationships rather than on nurturing and assisting the growth of multiple interpersonal relationships. This is further enhanced by the caseworker being superbly sensitive to what goes on between himself and the client, but much less aware of the impact of what he or a group member might say on others. If one believes in the capacity of people to help one another and if one wishes to reinforce the constructive powers of the group, then every opportunity has to be seized to involve the group members. Whenever possible, individual problems should become group problems.

For example, in a group composed of women who had been discharged from the hospital and their spouses, the last few sessions were characterized by one of the women doing a considerable amount of talking while the other group members talked among themselves. Further, when this woman had finished with her comments the group did not relate to them. It would seem to me that this was a group problem with which its members had to come to grips. The leaders should have shared their observations of what was going on and turned the problems to the group for further remarks. This procedure might have produced insight into: (a) how hostility may be suppressed and anger avoided and (b) what was going on in the home where the talkative wife complained of a lack of communication between her husband and herself. It also might have given the group an opportunity to learn how the "here and now" of group life can be used effectively to understand the behavior of its

members. Such questions as, "What are your thoughts about this situation?" or, "Have any others of you experienced the same feelings?" or, "Are there questions you would like to ask?" hopefully will convey to the group members that the worker has confidence in their ability to help one another.

Another most important reason for the encouragement of the sharing of feelings, experiences, observations, and impressions of the group members toward one another is the development of cohesion. Jerome Frank remarks (1):

> Members' sense of belongingness to a group, more simply termed group cohesiveness plays an analogous role in therapy groups to the relation between therapist and patient in individual treatment. That is, it supports the self-esteem of the members and so increases their tolerance for unpleasant emotions and their ability to function as free and responsible persons. The intensity of emotional interplay which members can stand without excessive anxiety is largely a function of the cohesiveness of the group. Since emotions supply the motive power for change of attitudes, fostering of group cohesiveness is a major goal in group therapy.

In a most interesting article Jean Munzer (5) reports on an experimental effort to induce cohesion early with the hope that (a) such groups would make more frequent use of "we-terms," (b) the members would turn to the group more often than to the worker for information and support, (c) there would be earlier and freer expression of affect, particularly negative affect, (d) there would be an increased production of "depth" content, and (e) it would lead to greater satisfaction amongst its members. For the techniques used I refer to the article.

The re-education of the client toward the development of new attitudes and modes of thinking and the relearning of better ways of coping with life situations is an ever-present task facing the worker with groups. Some of the literature (2) alludes to the fact that it is imperative that a sense of belonging (cohesiveness) emerge if the members are to conceive of the group as an important, meaningful experience from which new and modified behavior and attitudes may come into being. For example, as the group members share experiences, develop a sense of responsibility toward one

another, and feel free to discuss their feelings more openly, there will be less need to utilize old patterns of functioning in interpersonal relations, and new group norms which put a premium on open discussion rather than on "hidden agendas" can be built up.

SUMMARY

This paper delineates some of the problems faced and technical errors made by the caseworker as he moves from the dyadic relationship to a group approach. Although this paper addresses itself primarily to groups made up of relatives of hospitalized patients, some of the points singled out may be equally pertinent to other kinds of groups.

Aside from matters of conviction about the efficacy of the group method, problems appear to cluster around the unrealistic goals set for the group by the worker, preparation of the group members for the experience, concurrent use of individual and group approaches, and the beginning phase of group development.

Frequent changes in group composition and the short-term nature of some groups make it impractical to think of a major goal — the modification of behavior. Under such circumstances, it may be sounder to focus primarily on support and ventilation.

When relatives are to be involved in the group for an extended period of time, the worker should make explicit in the preparation for the group his concern that content focus not only on the hospitalized patient and his activities but on the relative and his interaction with the patient. This may help to lessen somewhat the tendency to externalize and pinpoint the hospital patient as the sole client.

Utilizing individual and group approaches concurrently may elicit problems for both the worker and client. The necessity for the worker and client to understand the advisability of using both methods at the same time is discussed. The article also comments on how the one-to-one relationship and multiple relationships in concurrent use may be practiced to the advantage of the client.

With the completion of the preparatory period, the paper then spotlights some phenomena of the beginning phase of group life. The evolution of group patterns is stressed, with an admonition to the worker to be sensitive to its unfolding and to guard against the freezing of specific coping styles. Several group styles were noted as examples. Finally, discrete modes of handling these group trends are remarked upon, together with discussion of the place of group cohesion in the treatment situation.

REFERENCES

1. FRANK, JEROME D., "Group Therapy in the Mental Hospital," in Group Psychotherapy and Group Function, Rosenbaum and Berger, eds., New York, Basic Books, 1963, p. 458.

2. HARE, PAUL D., Handbook of Small Group Research, New York, The Free Press of Glencoe, 1962, pp. 146-147.

3. JOHNSON, JAMES A., JR., Group Therapy, A Practical Approach, New York, McGraw-Hill Book Company, Inc., 1963.

4. KAPLAN, IRVING H., The Role of the Worker in Beginning with a Group, Fifth Institute on Group Work in Psychiatric and Medical Settings, University of Illinois.

5. MUNZER, JEAN, "The Effect on Analytic Therapy Groups of the Experimental Introduction of Special 'Warm-up' Procedures during the First Five Sessions," International Journal of Group Psychotherapy, Vol. XIV, No. 1, p. 60.

6. WIENER, HYMAN J., Social Work with Groups: Preliminary Considerations, Sixth Institute on Group Work in Medical and Psychiatric Settings, University of Illinois.

SOME CONSIDERATIONS IN BUILDING AN EFFECTIVE GROUP*

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INTRODUCTION

A basic characteristic of therapy groups seems to be that they are frightening to both patients and therapists. Most group therapists, those with experience as well as neophytes, feel inadequate and insecure in doing group therapy. They have many doubts about what they are actually doing, how they are doing it, and why they even started practicing group therapy in the first place. This is not necessarily a negative thing. The therapist who is not a little frightened, the therapist who has found the "right way" to do therapy, has shut off the opportunity to learn and grow. In contrast, it is hoped that the person who has self-doubts will seek new learning in order to relieve his concerns. There are no experts in group therapy who have that particular bit of knowledge to help the therapist overcome his anxieties in groups. There is no single "right way" to build an effective group.

The history of group therapy is a very short one. There are references in the literature citing examples of group therapy as far back as the nineteenth century (7). However, the popular use of groups as seen today began around World War II. Thus, the widespread practice of group therapy only dates back about twenty years. These twenty years have seen a tremendous growth in

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thinking about groups and in practice with groups. This rapid blossoming has brought a host of experts, literally hundreds, each proclaiming his way to do group therapy, and each challenging all the other "right ways" that the other experts espouse.

In this presentation I shall first review some of the issues and variables that must be considered in starting a therapy group. This will lead into a discussion of my own criteria for evaluating group effectiveness and finally into some of my views on group leadership.

THEORETICAL CONSIDERATIONS

The first issues deal with why the group is being started. What is the goal of the group? Why group therapy? What is going to be talked about? What is going to be done with what is said? These are the most difficult questions to deal with, because there is a wide range of possibilities of what group therapy should be and how it will be used. There is tremendous variation in types of groups and the ways in which they are used. There are analytic group therapy and nonanalytic group therapy, as well as directive group therapy and nondirective group therapy. There are activity groups, remotivation groups, educational groups, etc. The kind of group and its objectives must be determined before the group begins.

For some groups, particularly the analytically-oriented groups, the appropriate content of the sessions is genetic and historical material. Much of the discussion may be concerned with dreams and fantasies produced in free association. In nondirective groups, patients may talk about whatever they want to talk about. In some process-oriented groups, it is considered to be a sign of resistance if one talks about the past; one must talk only about the present.

A major question along this line, a question being raised more and more frequently, is whether the therapist's orientation should be towards the group or towards the individual. Is the goal to treat individuals or is the goal to build a healthy group which would then treat the individual members? There are many group therapists who sit on the fence saying, "I can do both; I will

integrate both aspects.''I doubt that it can be done. Many therapists tell themselves that they are doing it, but in actually functioning they appear to lean in one direction or the other. There are many small crises that occur in group therapy, many choice points arising continuously in the group situation, and each time one of these comes up, the group leader must make a decision. Is his immediate concern the individual or the group, and which is the focus of his treatment effort?

Most of the group therapy that has been done until the last few years has been individually oriented. Analytically-oriented groups have been among the more prevalent types and have to a large extent focused on individual problems. Some of these analytically-oriented therapists have made flat statements that group dynamics have no place in group therapy and that group cohesiveness is a form of resistance to group therapy (2,8,10). These therapists see group therapy as individual therapy with an audience, and many of them practice it this way. More recently, increasing favor is being accorded to the process-oriented group therapists, who focus more of their attention on the group and direct their efforts towards developing the group (3,9). These therapists see group cohesiveness and group dynamics as essential elements in group therapy, and certainly not as the anathema perceived by others.

STRUCTURAL CONSIDERATIONS

The question of how one gets patients is more concrete. In an inpatient setting things are usually easier in terms of the availability of patients. There is, in effect, a captive audience from which to draw. One very natural way of selecting patients in an inpatient setting is to set up what has been called a community treatment method, where the natural grouping of the patients on the wards is used as the basic group therapy unit. Then, of course, there is the alternative of selecting only certain patients. In the outpatient setting, the clinic or agency setting, usually certain clients or patients are selected for the group.

Then the question of who is to be selected comes up. There has been much writing on which patients profit most from group therapy and which patients profit least or not at all. In this area no one agrees with anyone. I cannot think of any diagnostic category—neurotic, psychotic, alcoholic, drug addict, or criminal—about which there is not some claim that group therapy is of major benefit. The literature abounds with all sorts of prohibitions: Do not mix psychotics with neurotics (not that it is catching, but just not a good idea to mix them). Do not mix character disorders with schizophrenics, for this is the worst of all. If you have a group of schizophrenic patients, by all means include a couple of character disorders; it is the best way to get it going.

I personally prefer mixed groups—mixed in terms of diagnosis, mixed in terms of sex, mixed in terms of age. I see a group as being like a person; the individuals making up the group are the resources—the hands, brain, and heart of the group. The greater the diversity among individual members, the broader the range of resources available to the group. I believe that when one builds a homogeneous group, one builds a narrow, restricted kind of person. When the members of a group are too similar in diagnosis or too similar in problems, one runs into the difficulty of their supporting each other's pathology. They often unite against the therapist and form a very formidable kind of resistance in the group situation.

In selecting patients, a decision about how many patients are wanted in the group must be made. Here there is a wide range of choices. Some people have said that the best group numbers three patients, and some have recommended four, five, six, twenty, or thirty patients (4,5). Some people have actually worked with groups numbering up to a hundred patients.

To me, there are two questions involved. First, what is the goal for the group? If the aim of the group is to provide individuals with insight into their own dynamics, then an effective job cannot be done with more than six or eight members. For other purposes, quite different upper limits would be appropriate. The other question, perhaps the most important question, is with how many individuals does the group leader feel comfortable. I think that if there is any *sine qua non* for group therapy, it is that the group

leader has to feel comfortable in spite of his anxiety. This is not as paradoxical as it seems. The therapist will be anxious, but his level of anxiety must be within tolerable limits. Often the anxiety level of a person in a group is proportionate to the number of people in the group. The group leader's anxiety tolerance is a major criterion of how many patients should be in the group.

As anxious as the therapist may be, it is only a fraction of the threat that the patients feel. Patients, initially at least, panic at the mere mention of the word *group*. This is a problem in starting groups. An inpatient service is the easiest setting in which to start groups. The patients are there, and it is harder for them to miss appointments. In addition, there is more support available in the milieu for patients going to their initial group session. The outpatient setting does not have these benefits. The clients will have tremendous anxiety, apprehension, and resistance as they begin group therapy. Assuming that the commonly used number of eight has been decided upon for the number of people in the group, in an inpatient setting eight patients, or maybe nine or ten in case someone might be discharged soon, are chosen. In an outpatient setting, it would be better to select twelve to fourteen patients. There is a much higher dropout rate in group therapy than there is in individual therapy, and there is a much higher dropout rate in group therapy in an outpatient setting than there is in an inpatient setting. This should be anticipated in the initial selection of patients.

In the inpatient setting, when the patients have been selected, one is ready to begin. It is fairly easy to establish a meeting time and call the group together. It does not work this simply in an outpatient setting; the patients lack any common support or identification to help relieve their anxiety. As one solution for this, many therapists prefer to begin with individual sessions for the twelve or fourteen people they have selected. This, however, creates some complications, for when the patients begin with individual relationships, they are reluctant to give them up for a group experience. Often, however, it is the only way to help them get started, and many therapists will use one, two, or three individual sessions prior to the first meeting of the group.

Once the decisions on how to select patients, where to get them, and how many patients to include have been made, the next step is to make some decisions on how the group is going to work. There are a number of dimensions to consider. There is a question of whether to have an open or a closed group. A closed group is one which starts out with a set of particular patients and in which no new members are added. In some cases no one leaves until everyone is ready to leave. In an open group, there may be people coming and going continuously. One variation on this theme is a compromise between the two, which may be considered as a modified open group or a modified closed group. It is a situation where groups are essentially closed, except that they have reregistration periods when they reopen for brief periods, add new members, and then close again. My own preference is usually for the open group, which is a much more natural situation. Most of the groups one belongs to are open groups, with the major exception being the family unit. Regardless of which choice is made, however, it is necessary to decide before group therapy starts. Many problems are created when the issue is brought up with the patients after starting.

In terms of the group's operation, the duration and frequency of meetings will have to be decided. Is the group session going to follow the sacred fifty-minute hour, or will it last an hour and a half or two hours, as some groups do? Sessions over an hour in length are too taxing for me, and, I prefer the fifty- or sixty-minute hour. I sometimes feel that therapists who insist on longer sessions are reacting to their own guilt feelings. Often they seem to be apologizing for not being able to give enough individual attention in the group situation, and they try to compensate for this by extending the length of the session. But that is my particular bias. In terms of meeting frequency, a fairly standard arrangement for outpatients is once or twice a week. For inpatient settings, the range varies from once a week to once a day, or even twice a day. I have no strong feelings on this question. In the inpatient setting, it is sometimes artificial to have sessions once or twice a week when the same group of people are together twenty-four hours a day. In some ways it is more natural for the inpatient setting to have daily group sessions, but of course, this is contingent on the time available

and on the type of group desired.

On the occasion of the first meeting, there are more problems, more questions, more choice points. The first session is quite an experience, fraught with tremendous anxiety and tension. Anxiety can be alleviated to a large extent by bringing structure into the situation to decrease the ambiguity. To structure the situation, patients might be told why they are there, how often they are going to meet, how long the sessions are going to run, and what the ground rules will be. Many therapists refuse to do this, feeling that the group's need for structure can be capitalized upon by having the group work together to reach agreements on the ground rules. The process-oriented group therapists are likely to see this as necessary for therapy and accordingly start off with a problem-solving task which generates group process. Resolving this question of how much structure the therapist is going to provide and how much structure the group is going to provide for itself is partly a matter of one's position on the directive or nondirective continuum.

Some of the questions that have to be decided in this first session, either by the therapist or the group, are, as mentioned earlier, the length and frequency of meetings, whether the group will be open or closed, and how outside contact between various members of the group will be handled. In some groups the therapist insists that there be no outside contacts, while others insist that any time there is a meeting between patients outside the group, it has to be presented in the very next therapy session. This technique is employed in order to prevent the outside relationships that may develop from being a diversion from the group process. The question of confidentiality has to be decided very early. Do people talk outside the group about what is going on in the group, can they tell their spouses, and may they tell the other patients in the ward who are not in the group? Some groups decide very early that everything is confidential. Some groups refuse to reach a rigid decision and decide that everyone, being mature and trustworthy, can use his own discretion. The related question is, what does the therapist do about outside contacts with his patients. What is done with phone calls from patients; does the therapist insist that patients bring the matter up in the group; will the therapist meet with the patient if a

crisis occurs in the family, or do patients have to wait until the next group therapy session? The more the therapist thinks about all these issues and questions before the group meets, the less the strain will be after the group is started.

CRITERIA OF EFFECTIVENESS

An effective group is a group that accomplishes its goals, and the therapist is the person who must decide those goals. Consequently, criteria of effectiveness may well vary according to the orientation and inclinations of the therapist. In the group orientation that I prefer, there are two interrelated characteristics which I feel are basic to group effectiveness: one is cohesiveness, and the other is trust.

Although some group therapists think that cohesiveness is a deterrent to group therapy, I feel that there cannot be group therapy without cohesiveness. I see cohesiveness as a feeling of mutuality, an *esprit de corps*, a sense of togetherness, belongingness, communality. One way of looking at a group is as "something with outsiders." Groups must have some type of boundary (membership requirements) to identify and separate those who are "in" from those who are "out." A real group cannot exist without these boundaries and "outsiders." If everyone and anyone can belong to a given group, there is no togetherness or communality. There has to be something in common for the patients that makes them separate or different from other people. This goes for any group, whether it is a therapeutic, social, religious, or political organization; there must be insiders and outsiders. The stronger the membership boundary, the more cohesive the group will be (e.g., the Marine Corps, fraternal organizations, some religious sects). This means that the members of the therapy group are going to have to feel that they either have characteristics in common with each other (which often they are very reluctant to admit), or at least that they each share a common purpose that is not generally shared by other people. How to create this feeling of common purpose or shared characteristics is not clear-cut. I have seen group leaders,

including myself, tell the group, "You have things in common; you are a group." This approach is not particularly successful. They will not accept this; they have to determine it for themselves. The basic task of the beginning group is a process of mutual exploration to discover what "we have in common and where we want to go together."

Trust is very closely associated with cohesiveness. Again, I am not sure at what point trust comes into the group or exactly how it enters. A number of writers (1,6,9) have described phases of group development. Some feel that the group evolves through certain predictable stages, which consistently can be seen in the growth and maturation of any group. Bennis and Shepherd have formulated a theory of group development emphasizing that the group must first work out its relationship with its leaders before they can work out peer relationships in the group. The group must first get to know the leader, explore and test his responses, and become comfortable with him. Usually the leader or therapist is the greatest source of threat to the group. It is upon him that the members first focus their attentions and their anxieties. It is here they find the first commonality to unite them—the threat of authority. It is here they first do their testing operations.

Groups test all the time and they particularly test their leaders all the time. The members want to know what powers the leader has and what he does not have. They need to know what kinds of problems he can handle and what kinds of problems he can not handle; they push and test him until they find out. No group leader passes all their tests. The patients try to find the leader's limits, which they probably come to accept. They know that this is the safe ground on which the therapist feels comfortable, and, therefore, they feel protected here. After this initial testing occurs, the group finds an habitual level, a plateau on which to operate. Periodically, it has to retest the therapist to see whether the limits which he has set are still there. Sometimes the therapist grows in therapy with the group and perhaps becomes able to handle new and different material. So the members go through a retesting period,

again they find their limits and those of the leader, and again establish a plateau. This is a continual process which is necessary for growth and movement.

There is a beginning phase of group therapy that is very much focused on testing the group leader. If things go well, this phase is culminated by the group's ventilating considerable anger at the leader. This is a part of the testing procedure, a final exam, to see whether he can take it. At the same time, however, it is a graduation certificate, a vote of confidence: "We feel comfortable with you, we feel safe with you, we can express our negative feelings at you and with you." I think that generally in the typical group this often occurs between the sixth and eighth sessions. In the first meeting of the group, the members are angry at the leader for not providing more structure, for failing to meet many of their expectations, and for getting them into this kind of meeting in the first place. They may do some talking about these feelings, but the style is defensive and the affect is moderated by intellectualization. A few sessions later, if they have proceeded with their testing operations and feel more comfortable, they express their anger in open attack and criticism of the leader. Once this happens and has been worked through, the group is on its way. I see this as a separation between the beginning group and the working group. The way in which the therapist responds to the attack will, of course, shape the nature and course of the group. This is not the last time the leader will be attacked, but it is the most crucial and the most significant time.

Not all groups will progress through this phase with its dramatic graduation exercise. Some groups, no matter how long they have been meeting, never get off the ground. This can happen when the group members are so defensive that they can never learn to trust the leader, or when the leader is so defensive that he can never learn to trust the group. The growth of the group from a sorry collection of frightened individuals into an effectively functioning group can only be accomplished through the development of trust and cohesiveness.

LEADERSHIP CONSIDERATIONS

I do not believe that anyone can tell anyone else exactly how to lead group therapy. There is a definite reason for this. I think that part of the pressure that group therapists feel comes from knowing that a phony therapist shows up more quickly in this setting than in any other therapy situation. The individual therapist using standard techniques can often cover up and get by. This is much harder to do in group therapy. To be a good group therapist one can not be phony. As one example of this, a good group therapist can not use a style that is not natural for him. I do not think he can be nondirective when he is an opinionated person. I do not think he can be directive in a group when he is a noncommittal person. I think the group spots this contradiction and pretense, sees it as phony or as a mask, and reacts negatively to it. This becomes particularly true when the pretense is not just in leadership style, but also in the emotions he communicates to the group. First of all, they do not like it because it insults their intelligence. Secondly, and perhaps more important, they ask: "Why this mask? What is he afraid of? If *he* is afraid, *I'm* terrified." They go nowhere; they are too frightened to move. The therapist is communicating the message that he must cover up and guard himself, and the group follows his example.

Thus the leadership style depends on the individual, and my feeling is that one should be whatever he is. I do not like very directive therapists; I do not like extremely nondirective group therapists, but I think it is much better for them to be this way than try to be something that is not natural for them. Most experienced therapists know this, but I think it is a particular problem for the neophyte. Because the textbook states that one should do such-and-such, one goes through the motions, and looks like a third-rate actor. It's stiff, stilted, and artificial, and the group recognizes it. I think the good group therapist, and perhaps the individual therapist too, has to throw the book out sometimes and use his intuition, his good judgment, and his clinical skills to do what he sees as being right for him in the situation.

This course of action, of being oneself, can lead into dangerous waters. The danger is lessened, however, if the therapist's personality has a range of flexibility. It disturbs me to see a directive group therapist who is always directive whether or not his group needs it. It distresses me to see a nondirective therapist rigidly being nondirective when his group is crying for some support and structure. I think he has to be flexible and provide what his group needs. There will be times when it needs structure, there will be times when it needs support, and there will be times when it needs to have its hands slapped. Hopefully he will do what his group needs and not what he needs. This is particularly critical in the beginning phases of the group. In order to help the group cope with its initial anxiety, it is often appropriate and necessary for the group leader to be more active and to provide more structure in the beginning than later. If he is going to be nondirective, no matter what, he will sometimes find himself left without a group.

The question of multiple therapists often arises when starting a group. I think that the main purpose of having more than one therapist in the group is so that they can support one another. Usually multiple therapists do not like to see this as the main reason, although they will concede that it may be secondary. The group leader, in order to have a well-functioning group, has to be relatively comfortable in the situation. If having another staff person there will make him feel more comfortable, I think it is all to the good. I believe they should keep in mind, however, that they are kidding themselves when they talk about cotherapists. I do not think that there is such a thing. I do not think that there can be two group leaders of equal status in one group. Something has to give, and one will gain ascendency over the other. One will be the primary therapist and one will be the secondary therapist. If they recognize that this will happen and can accept it without competition between themselves, then things will go smoothly.

Besides the aspect of support, there are certainly other reasons for having more than one therapist. Reasons commonly mentioned include the problem of what will happen to the group if the therapist becomes ill or goes on vacation. If there is a cotherapist already in the group, then under these circumstances, meetings

can continue without interruption. Also using a secondary therapist is an excellent training method. Another point frequently raised has to do with providing a broader range of transference possibilities for the members of the group. The patients may see one therapist as "good mother" and one as "bad mother," one as more supportive and one as more examining or interpretive. Each therapist has a unique role in the group, and the group relates itself to him differently than to the other therapist. This situation stimulates a broader range of behavioral responses in the group situation.

SUMMARY

I have reviewed some of the many aspects that go into building an effective group. This presentation has considered briefly theoretical approaches, group characteristics, and leadership styles. The beginning group has been given more attention than the ongoing, working group; the group's relationship with the therapist has been given more attention than peer relations within the group. This has been done intentionally in the hope of encouraging the beginning group therapist to become more aware of the impact of his decisions before beginning and his early interactions on the eventual effectiveness of the group.

REFERENCES

1. BENNIS, W. G. & SHEPARD, H. A., "A Theory of Group Development," Human Relations, Vol. 9, pp. 415-437, 1956.

2. BERNE, E., Transactional Analysis in Psychotherapy, New York, Harper & Row, 1963.

3. BION, W. R., Experiences in Groups, and Other Papers, New York, Basic Books, 1961.

4. FOULKES, S. H. and ANTHONY, E. J., Group Psychotherapy: The Psychoanalytic Approach, Baltimore, Penguin Books, 1965.

5. GELLER, J. J., "Concerning the Size of Therapy Groups," in ROSENBAUM, M. and BERGER, M., Group Psychotherapy and Group Function, New York, Basic Books, 1963.

6. KAZZAZ, D., "The Development of a Psychiatric Team in the Light of a Group Development Theory," Journal of the Fort Logan Mental Health Center, Vol. 2, pp. 101-115, 1964.

7. ROSENBAUM, M. and BERGER, M., Group Psychotherapy and Group Function, New York, Basic Books, 1963.

8. SLAVSON, S. R., Analytic Group Therapy with Children, Adolescents, and Adults, New York, Columbia University Press, 1959.

9. WHITAKER, D. S. and LIEBERMAN, M. A., Psychotherapy through the Group Process, New York, Atherton Press, 1964.

10. WOLF, A., "The Psychoanalysis of Groups," in ROSENBAUM, M. and BERGER, M., Group Psychotherapy and Group Function, New York, Basic Books, 1963.

PROFESSIONAL ATTITUDES TOWARD FORT LOGAN MENTAL HEALTH CENTER

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After almost three years of operation, the Fort Logan Mental Health Center undertook a study to determine its image in the community.** This study was administered among the professional groups in the center's receiving area because these groups were expected to have had contact with Fort Logan.

Leo Crespe, in discussing his observations about images (2), states that images are built both on fact and on appearance, that the person perceiving views the objects through his own perspective of values and purposes. "An individual's perception of reality is a complex psychological product involving as much the individual's contribution as the external stimuli." Two conclusions can be drawn from this statement: (a) Images are not necessarily changed by the method of obtaining new facts, since they have a basis in the person's own psychological perceptions. (b) The image held by different individuals vis-à-vis the same object may be different, but it is expected that groups of individuals with similar perspectives of values and purposes will share an image perception.

Alexander Leighton, in discussing the problems and procedures of developing a new psychiatric clinic in a community (3), speaks of the emerging sentiments that arise within the community and the meaning of the direction of sentiments to the new

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**Fort Logan Mental Health Center began in 1961. This study took place in June 1964.

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organization. His theory, which is similar to that of Crespe, is that positive sentiments originate in a group of people who have a desire for perceived or expected benefits from the organization. Indifferent or neutral sentiments can be an asset to the organization, since the group having these sentiments will not press unrealistic demands and will not oppose the organization. Leighton stresses that this neutral group is a practical target for information and publicity about the organizations. He further states that negative sentiments may be based on inaccurate perceptions and false ideas regarding purposes and functions, or on consideration of the organization as a threat to ideals, aspirations, or security. Leighton further feels that where misperceptions are involved, communication of information may be helpful. Although he also believes that it would be almost impossible to change the direction of sentiments of those seeing the organization as a threat with any rational approach, there were some Fort Logan staff who did not take this fatalistic approach.

It was expected that there would be a good deal of negative feeling toward Fort Logan and a number of specific criticisms from a variety of sources. It was expected because a new organization inevitably generates many criticisms about its philosophy and operational methods. Fort Logan is imposing a new culture and language in the treatment of the mentally ill. It is a threat to long-standing mores. It was anticipated that criticism would come from those who had a substantial investment in existing theories and methods. Nevertheless, the center proceeded to ask for a critical appraisal of itself.

The study was planned to assess the attitudes and opinions held by professional colleagues and to evaluate how widely held were the criticisms of specific areas of services and operations. As noted above, knowledge of general criticisms based upon actual facts and true perceptions can be potentially helpful to an organization. Well-founded criticism can highlight policies and procedures for administrative attention, and the evaluation of criticized areas

can reveal that changes should be made. If no change is necessary or possible, justification of the practice to the critics may be undertaken. Thus, attention to valid criticism can lead to planned change and organizational improvement or can pinpoint necessary educational efforts toward the public.

A questionnaire containing 20 questions including forced-choice and open-ended items was mailed to approximately 1400 professionals. In recognition of the potential helpfulness of this group, questions solicited suggestions and criticisms. Problems and issues already known to be of concern to colleagues were specifically included in order to determine how widespread such concerns were.

Approximately 450 or 32 per cent of the questionnaires were returned within three weeks. Composition of the respondent group consisted of 77 per cent who were attached to an organization, with the remainder being self-employed. Males represented 55 per cent and females 45 per cent. The professional breakdown of the respondent group was: 40 per cent, social workers; 18 per cent, nonpsychiatric physicians; 14 per cent, psychiatrists; 13 per cent, nurses; 9 per cent, psychologists; and 5 per cent vocational counselors and others.

RESPONDENTS' DIRECT PERSONAL CONTACT WITH FORT LOGAN

Seventy seven per cent of the responding group had been in professional contact with Fort Logan and had used one or more of its services. One question listed a series of service areas and asked for the degree of satisfaction with each service. Comparisons among services made in relationship to how much contact the group had had with each service and the direction of general satisfaction and dissatisfaction are shown in Table 1.

TABLE 1

DISTRIBUTION OF THOSE USING EACH SERVICE AND DEGREE OF SATISFACTION

SERVICE	NUMBER USING	PER CENT USING	VERY SATIS-FIED	SATIS-FIED	NOT SATIS-FIED
Referral of Clients	250	55.9%	20.8%	56.0%	20.8%
Information about Clients	214	47.8%	25.7%	45.3%	27.1%
Educational Meetings . . .	150	33.5%	45.3%	49.3%	2.7%
Case Consultation	113	25.2%	30.1%	61.9%	7.1%
Diagnostic Evaluation . . .	80	17.9%	27.5%	56.3%	13.8%
Joint Therapy of Patients	58	10.7%	22.4%	46.6%	27.6%
Research Data.	29	6.0%	31.0%	55.2%	10.3%

Proportionally more respondents were dissatisfied with joint therapy programs (therapists from two agencies involved in treating patients and families). However, knowledge of this service was limited and its application was not fully expanded. More than half of the social workers who participated in this program were satisfied. Of the larger number of professionals acquainted with the service of referral of clients, a relatively large proportion were not satisfied with referral procedures. Many criticisms of this service were made in conjunction with lack of feedback of the referrals, delays in setting up appointments with patients for preadmission evaluations, and rejection of referred patients who did not need inpatient or partial hospitalization.

Since Fort Logan was not operating as the usual type of state hospital, the community was finding it difficult to accept its operational methods.

RESPONDENTS' SUGGESTIONS FOR AREAS OF APPRAISAL AND CHANGE

The results from the previous question were further substantiated by the responses to another question, which asked for opinions about the need for consideration of change in several areas of operation (communication, admission and treatment procedures, philosophy of treatment, etc.). Comments were requested when the need for change was indicated. Nearly two-thirds of the respondents indicated at least one area in need of change.

Table 2 reports the number of persons and per cent of total respondent group indicating changes needed by area.

TABLE 2

PER CENT OF RESPONDENTS SUGGESTING CONSIDERATION OF CHANGE IN POLICY OR OPERATION, BY AREA OF OPERATION

AREA OF OPERATION	NUMBER OF PERSONS	PER CENT INDICATING CHANGE NEEDED
Communication and Cooperation with Other Resources	160	36%
Admission Procedure	142	32%
Treatment Procedures	71	16%
Philosophy of Treatment	69	15%
Referral of Patients to Other Resources	53	12%
Other	31	7%

Communications, admissions, and treatment procedures were the main problem areas.

Comments were requested to obtain the specific problems involved in the areas needing changes. In the area of communication, problems included the need for general information about Fort Logan, its operation and services, as well as the need for information about shared clients or patients. Comments about admission procedures referred to lack of emergency care, the "drying-out" period required before admission of alcoholic patients, the length of time involved in the admission procedure, the selectivity, and denial of admission to some patients.

PROFESSIONALS' RANKING OF GOALS OF MENTAL HOSPITALS

The respondents were given a list of eight objectives of mental hospitals, which they were asked to rank in order of importance to them. Since there were some differences among the different mental health professions, Table 3 includes a breakdown by profession, as well as the results for the total group.

A similar but not identical list for ranking was given to the Fort Logan staff in June of 1964 (1). The following ranking was obtained:

1. Return of the patient to the community as soon as possible.
2. Achievement by patient of understanding of himself and problems in inter-relationships.
3. Prevention of recurrence of emotional problems.

4.5. Education and training of mental health professionals.
4.5. Education of public about mental illness.
6. Research.
7. Protection of society.
8. Provision of a home away from home for patient.

The items to be ranked are not identical. However, if the items are generalized into treatment, training, public education, research, protection of society, and custodial care, the two rankings can be compared. Treatment was first in both studies. The professional group in the community placed research above training and education, while the Fort Logan staff indicated that training and education of staff preceded research. Both groups placed protection of society and custodial care of patients as the two lowest objectives.

TABLE 3

RANK ORDERING OF GOALS AND FUNCTIONS BY PROFESSIONS AND TOTAL GROUP

OBJECTIVES	TOTAL GROUP	PSYCHIATRISTS	PSYCHOLOGISTS	SOCIAL WORKERS	NON-PSYCHIATRIC PHYSICIANS	NURSES	OTHERS
Treatment of Mental Illness	1	1	1	1	1	1	1
Treatment of Alcoholism	2	2	6	2	2	3	3
Research	3	5	2	3	5	2	2
Training	4	3	3	4	3	5	5
Consultation Services	5	4	4	5	4	6	4
Community Education	6	6	5	6	6	4	6
Protection of Community	7	7	7	7	7	7	7
Custodial Care	8	8	8	8	8	8	8

KNOWLEDGE OF SPECIFIC METHODS AND PRACTICES OF FORT LOGAN PROGRAM

In order to determine how well professionals were acquainted with the specifics of Fort Logan's operational methods, a series of concepts and methods were listed, and respondents were asked whether Fort Logan had these programs in operation.

Table 4 gives the percentage responses.

TABLE 4

PERCENTAGE RESPONSES TO ITEMS OF METHODS AND PRACTICES

METHODS AND PRACTICES	YES	NO	DON'T KNOW
Group Therapy	88.6%	2.0%	9.4%
Day Hospital	88.6%	1.1%	10.1%
Outpatient Services	82.3%	5.6%	11.9%
Open Door Hospital	75.4%	3.1%	17.7%
Casework Services	74.9%	4.9%	20.1%
Educational Seminars, Workshops	72.5%	2.0%	25.5%
Research	65.1%	2.7%	32.2%
Locked-Door Hospital	5.6%	64.9%	29.3%
Milieu Therapy	63.5%	2.7%	33.1%
Consultation	62.0%	8.1%	30.0%
Treatment of the Criminally Insane	3.6%	60.0%	36.5%
Treatment of Patient's Relatives	52.6%	8.1%	39.1%
Intensive Treatment of the Acutely Disturbed Patient	48.3%	24.8%	26.0%
Demonstration Hospital	45.2%	5.6%	49.0%
Individual Psychotherapy	44.5%	30.0%	25.5%
Emergency Service	18.1%	38.0%	43.6%
Insulin-Shock Therapy	9.4%	32.7%	57.7%
Hydrotherapy	5.1%	28.9%	64.2%
Longer-Term Hospitalization	29.3%	37.1%	33.3%

In each case the greater proportion answered "yes" or "no" correctly, as seen by Fort Logan, with the exception of the item *longer term hospitalization.* Fort Logan does see itself as responsible for those patients needing longer term hospitalization in relation to other community resources. This response may indicate a difference between the community's conception of longer term hospitalization and a newer conception.

A large majority of the respondent group were aware of certain aspects of the program, but there was a surprising proportion of "don't knows" and incorrect responses. This certainly indicates a need for further education of professional colleagues.

THE FORT LOGAN IMAGE

Respondents were asked, "When you think about Fort Logan Mental Health Center, what image comes to your mind?" A majority of respondents, 359 in all, answered this provocative question in a variety of ways. Some used one or two descriptive words, others took a page or two. The following are some of the typical or more interesting of the comments.

1. Chiefly an attractive young girl, apparently innocent and angelic, but known to her family and close friends as capricious, disrespectful of authority, untidy and really not very nice. Let's hope the neighbors won't find out, at least until she has grown a little.
2. New, bright, enthusiastic and idealistic effort by the state to help the mentally ill. Somewhat choosy and "exclusive" with perhaps "group therapy" concept over-used where individual one-to-one therapy is needed.
3. A modern therapeutic community that endeavors to return the patient to his environment as quickly as possible and makes an effort to avoid the development of the chronic patient.
4. Old army post now a mental hospital where many alcoholics are treated.
5. Warm, accepting atmosphere. Interested, enthusiastic, dedicated.
6. A confused octopus, lots of id, lots of ego, very little super-ego.

7. Pleasant surroundings, "permissive" atmosphere, group effort, especially in therapy, demonstrated cooperation of various professions.
8. A struggling institution that is trying to change the concept of the custodial hospital into a more dynamic and therapeutic setting.
9. Group therapy, team approach, volleyball and bridge.
10. A unique mental health facility which is integrated with appropriate agencies in the community and which seems unbound by anachronistic custom and is a prime moving force for better care of the mentally ill.
11. A modern facility, decentralized day care arrangements, staffed with a variety of professional people who are willing to experiment with the latest ideas in treatment.
12. Ivory tower, 25 years ahead of the community. Isolated physically and in community relationships.
13. Modern facility. Staff dedicated and enthusiastic but somewhat anxious and defensive. Unusually effective alcoholic facility.
14. Ambitious honeymoon.
15. Progressive, well oriented, professional, research oriented and patient centered.

The comments were coded according to the expressed attitude toward Fort Logan, with the results shown in Table 5.

TABLE 5

EXPRESSED ATTITUDES CODED

ATTITUDES	NUMBER OF RESPONSES	PER CENT
Positive	128	36%
Neutral	112	31%
Negative	63	18%
Mixed	56	16%

GENERAL RESULTS

From an over-all point of view, the responses to the questionnaire indicated a lack of knowledge about Fort Logan among the group surveyed. This lack of knowledge was exemplified by the large proportion of "don't know" answers for most questions. Also, responses to the question concerning knowledge of specifics of the methods and techniques revealed a lack of certainty about the program. The third indication was the admission by a number of respondents that they knew very little about the center. Since 66 per cent of the referrals of patients to Fort Logan for the first three years were made by professionals like the survey group, this lack of knowledge is unfortunate.

The survey was also designed to obtain information about how well Fort Logan was meeting the expectations of the professional groups working with it. The majority of respondents were usually positive about the present operation. Negative comments were related to Fort Logan not encompassing all of the services fitting to the model of a comprehensive community mental health center as described by federal regulations. The gaps commented upon included the lack of services for all age groups, the absence of complete emergency services, the inability to care for patients with major physical problems (subsequently changed), and the need for more community education and consultation.

Some professional groups were more critical than others, and, in general, some areas received more criticism. However, for the most part, the survey indicated a substantial level of satisfaction with the services provided to patients and the community. There were many areas of misunderstanding about policies, procedures, and services; other indications were that information was incomplete.

The results of this survey were examined very carefully. The center was concerned about the criticisms and how to deal with

them. It sought consultation from members of its own staff, its Citizens' Advisory Committee, and the Colorado Association for Mental Health.

Some of the criticism was directed at certain limitations which were out of the control of the center. For instance, some respondents criticized Fort Logan for not providing treatment services for children, adolescents, and geriatric patients. (Since the time of the survey, children's and geriatric services have been added.) Another major criticism was directed at hospital policies and professional practices. It was argued that there was too little individual psychotherapy and too much group therapy. While these criticisms were not dismissed, it was felt that the center had placed great importance on the use of group therapy in its program in order to provide psychotherapeutic treatment to the large number of patients who come to a state hospital. As a prerequisite to radically altering a major treatment philosophy, the staff considered it to be both necessary and feasible to review the treatment program, as well as treatment approaches used in general for the mentally ill. The staff felt that through its own research program it would be able to evaluate the effectiveness of using group processes in combination with the therapeutic community.

It was generally recognized that Fort Logan needed to do a better and more thorough job in informing the professional community of its programs. Although nonpsychiatric physicians were the least informed, other professionals also demonstrated vagueness. In order to solicit their help with the Fort Logan program, the staff considered it necessary to make them more knowledgeable about the center.

Some of the things Fort Logan started doing to achieve this goal have been: hosting a meeting of the Denver Medical Society in the Spring of 1965, encouraging more open-house orientation programs and tours, inviting the community professionals to visit and spend time with treatment teams, encouraging staff to participate more actively in professional organizations and to involve themselves in community relations, and participating in inservice training programs of various allied agencies. In addition, results of the survey have been shared and discussed with professional organizations.

Another major problem recognized by Fort Logan was the need to educate its own staff. Through the process of geographic decentralization, in which individual teams interact with the community, there have been conveyed multiple interpretations about the role of Fort Logan. Therefore there is a need to clarify the role of Fort Logan and re-educate its own staff. The survey also demonstrated that such a relatively simple matter as telephone inconveniences were obstructing good extramural relationships, and consequently modifications were made which included an educational effort with the staff. The survey also provided valuable feedback on staff attitudes with which the supervisory staff could now work. Other kinds of communication (referrals, notifications, summaries, etc.) pointed up the community's reaction, and Fort Logan has embarked on a long-range program to improve itself in these areas.

REFERENCES

1. CARLSON, VICTOR IVAN et al., Role Convergence in a Therapeutic Community, (unpublished thesis), Denver, The University of Denver, Graduate School of Social Work, June, 1964.

2. CRESPE, LEO P., "Some Observations on the Concept of Image," Public Opinion Quarterly, Vol. 25, pp. 115-120, 1961.

3. LEIGHTON, ALEXANDER, Explorations in Social Psychiatry, New York, Basic Books, Inc., 1964.

EDITORIAL

A PROGRESS NOTE

Now in our third year of publication, we thought we would take a few minutes to see where we have been and where we might go. A little over four years ago the Fort Logan Mental Health Center was opened as Colorado's second state hospital; its mission was to serve the needs of the mentally ill in the Denver metropolitan area. The mode for treatment was to be somewhat different, somewhat experimental—geographic decentralization, the use of transitional phases of treatment in continuity, a hospitalwide therapeutic community, and administrative decentralization. Nothing so new and startling, but put together a little differently, perhaps. Various aspects of these programs have been described in this Journal as well as others (1,2). Though some questions have been answered from these initial months, there are many more still left unresolved, and, as in most clinical settings, every day brings new ones.

A little over two years ago the *Journal of the Fort Logan Mental Health Center* was first published to report some of the observations that were being made here and elsewhere. The aims were twofold: (a) to provide a medium for the sharing of information having to do with the fields of social and community psychiatry, and (b) to publish creditable material from any person working in the field of mental health or allied areas.

With regard to the first aim, results have been quite good, as attested to by our authors and readers. There is still some concern about our second goal, however. Author response from psychiatrists, psychologists, social workers, and behavioral scientists has been good. Though we have received some articles from nursing personnel, it seems as though the latter, as well as activity or adjunctive therapists, volunteers, nonclinical administrative personnel, and others, are still underrepresented. It is a little difficult to say

exactly why this should be. Maybe they do not know that the Journal has this policy. Perhaps, many from these groups do not conceive of themselves as being writers; yet listening to them assures us that there is no paucity of good ideas. Or, it could be more complicated. Perhaps they do not see ascribed to their roles the function of teacher for the perceived "professional." Then, again, maybe they see all too clearly the message in what Alex Inkeles (3) has so aptly described:

> It is perhaps a reflection of the intellectual insecurity of social scientists that they spend an inordinate amount of time and energy defining the 'boundaries' of their respective fields as if these were holy lands which had to be defended against expansive, barbaric, and heathen invaders. This need for a clear professional identity leads to a striving for ideological purity, and often from their earliest student days those entering the field are carefully watched for signs of dangerous pantheistic belief. The discipline's name designates not so much a focus of study or a mode of analysis as a banner around which the faithful rally.

We are not sure what the answer is, but their contributions are encouraged, because they represent such a large proportion of those engaged in treatment efforts.

A progress note usually implies a description of past events, an historical review. It can, however, be seen as a plan for the future, a glimpse at things to come. As you might have noted on the inside of the front cover, a new group of names has been added as editorial consultants. These people will be contributing their time and energies to allow for even better service to our authors and readers. There were undoubtedly others who could have been and should have been asked to join us in our efforts, because a great many people share our interests and concerns. We mentioned the fields of social and community psychiatry, and regardless of whose concepts are used—Caplan's, Jones's, Wilmer's, Schwartz's, Stanton's, Reissman's, Rennie's, Bernard's, Ruesch's, or others'—the concerns are the same, to make the best possible preventive measures and treatment available to all patients, potential or actual, who require it. This means the utilization of old resources and those never tapped previously, and, particularly, a reaching out to those who have had difficulty attaining what measures are to be offered.

If one idea could be borrowed temporarily from some of the people mentioned above, as an editor I would like to assess the communication needs of the readership community. Thus far the format of the Journal has been essentially that of a recording publication, not a medical news publication, to use the distinction of Sir Theodore Fox (4). Our primary obligations are to you, our authors and readers, but is this meeting your requirements? A current and common plaint from the busy practitioner, researcher, or teacher is that he does not know where to start in his reading or how to keep up with the voluminous literature. Our collective information overload may be causing increasingly selective inattention or other means of discrimination which could be inopportune.

Would a change of format be useful or helpful? Would an alteration of content be constructive? Should there be more of the abstracted type of material? More brief reports? Is there interest or need for initial or preliminary reports on new programs or research projects, although results might admittedly still be lacking or tentative at best? Should the Journal provide a means of two-way communication and not merely one-way? A page or two by readers for their opinions of discussion of previous articles? Which of these, or other possibilities, would be helpful for brevity or speed of communication?

Some of our readers have sent a number of letters expressing their opinions about what has been done. What else might be done? In other words, what do YOU want?

Samuel B. Schiff, M.D.

REFERENCES

1. BONN, ETHEL M. and KRAFT, ALAN M., "Fort Logan: Genesis and Development," Journal of the Fort Logan Mental Health Center, Vol. 1, pp. 17-27, 1963.

2. BONN, ETHEL M. and KRAFT, ALAN M., "Implementing a New Community Mental Health Center: A Three-Year Report," Presented at The First International Congress of Social Psychiatry, London, 1964.

3. INKELES, ALEX, "Personality and Social Structure," in MERTON, ROBERT K., BROOM, LEONARD, and COTTRELL, LEONARD S., Sociology Today, Basic Books, New York, 1959, p. 249.

4. FOX, THEODORE, "Crisis in Medical Communication," Medical World News, Vol. 6, No. 39, pp. 122-133, 1965.

The Fort Logan Mental Health Center is Colorado's second state hospital. Currently serving almost half the population of the state, 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 emphasis on expansion of professional roles and the involvement of the patient's family and his community in treatment. The hospital is entirely open and relies heavily on transitional forms of treatment. Approximately one-half of its patients are admitted directly to day care, and evening care is offered. Geographic and administrative decentralization are utilized, with the same psychiatric team following the patient from the time of admission through all phases of treatment.

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