STATEMENT OF PERMISSION TO COPY

In presenting this professional paper in partial fulfillment of the requirements for an advanced degree at Montana State University, I agree that the Library shall make it freely available for inspection. I further agree that permission for extensive copying of this professional paper for scholarly purposes may be granted by my major professor, or, in his absence, by the Director of Libraries. It is understood that any copying or publication of this professional paper for financial gain shall not be allowed without my written permission.

Signature Viola Joyce Hockett

Date July 25, 1974

CHANGE IN SELF CONCEPT THROUGH GROUP PSYCHOTHERAPY

by

VIOLA JOYCE HOCKETT

A professional paper submitted in partial fulfillment
of the requirements for the degree

of

MASTER OF EDUCATION

with concentration in

Counseling

Approved:

Richard Horswill
Chairman, Examining Committee

Norbert J. Thiesen
Head, Major Department

Henry L Parsons
Graduate Dean

MONTANA STATE UNIVERSITY
Bozeman, Montana

August, 1974

ACKNOWLEDGMENT

I wish to thank Mr. James Dick, psychologist, and Mr. J. R. Rosenleaf, social worker, for their invaluable assistance in arranging for and assisting in the completion of this study. I am especially grateful for the post-therapy session each week and the wealth of information that was presented during those hours. I am indebted to Dr. Richard Horswill, Dr. George Hossack and Dr. Frank Seitz for giving their time and assistance.

TABLE OF CONTENTS

	Page
ABSTRACT	vi
Chapter	
1. INTRODUCTION	1
Statement of the Problem	6
Statement of the Purposes	6
Assumptions, Limitations and Definitions of Terms	7
2. REVIEW OF LITERATURE	10
Sources of the Self Concept	10
The Importance of the Self Concept	15
The Origin and Changing of Unacceptable Behavior	17
Changing Behavior Through Small Group Interaction	22
Summary	27
3. METHODOLOGY	29
Statement of Procedure	29
Selection of Therapy Group and Control Group Members	30
Selection of Measuring Instrument	32
Summary	39
4. ANALYSIS OF DATA	41
Therapy Group	41
Control Group	43
Discussion of Statistical Distortion	44

Chapter Page

Discussion of Individual Scores 46

Summary 48

5. SUMMARY, CONCLUSIONS AND RECOMMENDATIONS 49

Summary 49

Conclusions 54

Recommendations 56

LITERATURE CITED 58

APPENDIX 61

ABSTRACT

This study was done with the cooperation of residents of an open ward in a state hospital for the mentally ill, to ascertain if five months of group psychotherapy could change the members' self concepts in a measurable amount. Selection of possible group members was done according to the following inclusion criteria: age thirty or younger, diagnosed as having a functional mental disorder and having been transferred from the acute receiving ward after a period of months, to a residential open ward. Five men and three women expressed a desire to be members of the psychotherapy group. Three men and two women, matching the therapy group on age, diagnosis and length of institutionalization as closely as possible, were then chosen from the same ward. All thirteen people were given the Tennessee Self Concept Scale. The control group went on working at assigned jobs and living just as previously, during the study. The therapy group met with the primary therapist and co-therapist once a week, for an hour, for five months. At that time, the author, serving as co-therapist, was obliged to terminate with the group. The TSCS was again administered to both the four men and two women remaining in the therapy group and the two men and two women remaining in the control group.

The TSCS was chosen as the instrument to measure self concept because it is a self-administered graphic rating scale designed to measure change in self concept through psychotherapy. It consists of one hundred statements which are answered from five possibilities ranging from completely true to completely false. Twenty-nine profile scores are derived from sums of the items.

Two of the therapy group members improved dramatically during the five month period, two improved moderately, and two showed little change. None of the control group members showed a pattern of positive change. The therapy group mean scores on profile showed considerable positive improvement for the group. The control group means showed changes, but not as many in a positive direction as the profile of the therapy group. The process of averaging the scores of so small a sample obscured the true status of some of the members. A more accurate picture of the change accomplished could be seen through study of the individual profiles.

The conclusions were in support of continued group therapy as a means of changing the damaged self concepts of people defined as behaviorally deviant. A longer period of study than five months would probably yield results even more conducive to endorsing this process. More people could benefit from the process if more trained therapists were available.

Chapter 1

INTRODUCTION

Beginning as early as 1905, groups of people with various kinds of problems in living have been brought together to help each other. Experimentation went on through the 1920's and 1930's with many different techniques being tried, and the use of this method greatly increased during World War II because of the large number of military personnel needing psychiatric services and the small number of trained people to supply them. (Yalom, 1970:353-354)

In the past two decades, America has seen the decomposition of social institutions which ordinarily provide for human intimacy. Rapid decreases of multiple generation households, lifelong marriages, stable work groups and home communities, and the loss of well-known figures such as the family doctor, neighborhood merchant and church minister, reduce the resources which can be relied on in times of crisis. "Modern man is personally as well as socially alienated; he is separated from his own self and gropes for some sense of personal identity." (Yalom, 1970:361)

For individuals who lack intimate, primary relationships, group experience of one kind or another may provide a climate of trust where self-disclosure and social learning can occur. Gendlin (1970:552) also sees today's troubled people as products of culture, environment, community practices and typical situations. A few upper class people are always able to afford the luxury of individual psychotherapy but

this mode of treatment has always been incapable of reaching the mass of people who need it. Various types of social programs are coming to the fore, but they will fail unless they can build into themselves some intimate, sensitive, human interaction. Each person needs another person, but these others cannot possibly all be professionals of any kind. There will never be enough of them. We must find ways in which ordinary people can provide the therapeutic processes for one another.

A study has shown that up to 80% of the people in this country show some sort of psychological disturbances of the types that are defined as needing therapy. Is everyone sick? Or is this the human condition and our society lacks the means to provide the human interaction to alleviate the misery? The time is coming when everyone will have a small group that he feels is his own. It will be a place for sharing life, telling how things are, and finding strength in sharing. (Gendlin, 1970:556-557)

If the group experience is vital for all people who are managing to carry on their daily lives and derive some joy from them, is it also vital for those people who are not coping with life and are either isolating themselves or being forcefully isolated by others they have irritated?

> "The whole trend of current thinking has shifted to the view that human beings are interactional creatures and that the nature of psychological ills is inherently interactive. It isn't that

> something is wrong with an individual's psychic machinery, there are no loose screws inside. We don't know how and need not know how, to replace worn-out units inside him. He isn't a machine, a self-contained box, but rather an ongoing interaction process." (Gendlin, 1970:552)

If this is true, it follows that the best place to revise faulty interaction processes is in the company of other people.

However, in 1950, soon after the beginning of interest in group dynamics, Gunderson (1961:257) wrote disparagingly about this new science of human behavior.

> "Implicit in their use of the word dynamics is, of course, the analogy between physical laws of motion and the relation of forces within social groups. Exponents hypothesize 'a psychical motion' in group discussion just as physicists postulate the motion of molecules in physical bodies. If their concept is somewhat mysterious, it must remain so temporarily--for, as two of the leaders have confessed, 'The science of group dynamics is so young that only a very meagre number of scientific facts and laws have been accumulated. . . .'"

He states that a new field must have a new vocabulary and new methods of discovering new facts, but points out the use of hackneyed terms, lack of any valid research methods and use of simplistic devices such as role playing and feedback. He questions the concepts of special properties in groups that can be analyzed and measured and condemns the lack of rigor in experiments. "The observer crowds into the test tube with his experiment--but proximity to emotional flame cannot destroy his objectivity because of some magic inherent in the 'science of group dynamics.'" (Gunderson, 1961:259)

Yalom (1970:381-385) also believes outcomes should be measurable

but after twenty years of attempts to apply standard measuring devices and traditional designs, he believes it is not beneficial to use averages and norms and standard scores for measuring improvement in a person's behavior. There may be cases where a person has operated out of such a rigid defense system that what could be termed worsening of symptoms and behavior is a sign of the beginning of facing reality and dealing with the true self. An increase in expressed hostility is usually regarded as pathological but if repressed hostility has led to physical illness, then open expression may be the first sign of psychic recovery of balance.

Criteria for outcome used to be primarily restoration of a previous level of functioning and the relief of suffering. Group therapists are now considering setting goals at higher levels of subjective experience according to individual needs. Research plays a vital part, not only in learning to set goals, but in training group leaders. Research should be aimed, not at turning out technicians skilled in statistics, but people who have a questioning frame of mind and who will view each group member and each group experience as an opportunity for learning and growth for all involved. A balance must be maintained between use of data to establish principles over time, and flexibility in application of principles to meet needs. Some groups may be created solely for closeness and human contact, but therapy groups must aim for positive

changes in dysfunctioning persons. (Yalom, 1970:382-385)

Group therapy is widely used in mental institutions as a means of reaching more people in less time, but very little has been done to ascertain the effectiveness of this method. This study will attempt to measure any changes that may occur in a person's opinion about himself, which may lead to behavioral change, as a result of participation in a therapy group. The study will be limited in time and number of subjects, but may be of some value taken into consideration with other studies, past and planned.

Statement of the Problem

To discover through use of a self-administered rating scale, if the self concept of institutionalized people with behavioral disorders improved during five months of group psychotherapy.

Statement of the Purposes

To add to the body of research into the value of group psychotherapy by measuring the outcomes of one specific group.

To add to the body of knowledge about the validity of psychological tests which purport to measure aspects of personality.

To replicate a previous study of self concept change through group psychotherapy and compare results.

Assumptions

It is possible to measure self concept.

It is possible to repair damaged self concept.

Improvement in self concept will be reflected in behavior more closely paralleling societal norms.

Improvement in self concept during group psychotherapy in an institutional setting will carry over into later community living.

Limitations

Length of time within which study was done with people already identified as behaviorally deviant.

Size of sample allows for distortion of reality through imbalance of individual scores around group mean.

Inclusion criteria were loosely structured.

Control group matching was inexact in some aspects.

Validity of personality tests is difficult to authenticate.

Definition of Terms

Rating Scales are methods of grading individuals on traits such as friendliness, generosity or honesty which are difficult to measure with standardized objective tests. Graphic rating scales assign an absolute value to each trait for each person rather than comparing

one person to another on each trait. They may be self-administered or completed by other observers.

Self Concept is generally understood to be the impression or picture of himself, together with his feelings about that picture, that a person consciously holds. Some aspects of self concept may be at a low level of awareness, but can be brought out by the person under certain conditions. It has been described as the map to which a person refers when he is about to make a move. It is one's view of himself by which he tends to order and interpret his internal and and external experiences. (Shlien, 1970:119)

Behavioral Disorders or functional mental disorders are patterns of thought, emotion and action, deviant from cultural norms and not attributable to physical illness or disability. This deviance of action is also called mental illness and legal insanity. It often brings discomfort to others who take reciprocal action, rather than the subject himself experiencing discomfort as in physical disability.

Group Psychotherapy occurs when a number of people, usually less than ten, who have been diagnosed as suffering from a severe mental disorder, meet regularly with the guidance of a trained therapist, and attempt to learn to understand and change behavior to more socially acceptable patterns. Therapy groups can usually be identified apart from other kinds of groups by the setting, which is usually institutional, the size, which is usually smaller, and the duration, which is

much longer, with different termination points for each member. Members are characterized by sterile intra- and interpersonnal existences which derive from their childhoods and are of long-standing. Therapy group members are survival rather than competence oriented. (Yalom, 1970:362-369)

Primary Therapist for this study was the assistant director of Social Services at the state mental hospital, who holds a Master's degree in Social Work and special training in group therapy.

Co-therapist designates the author of this study who attended all of the group sessions and led some in the therapist's absence.

Residential Open Ward describes, in this case, the second story of a building which housed an average of thirty-eight women in one wing and thirty-five men in the second wing. Each wing had a dayroom but the door between the dayrooms was always open and the men and women mingled freely until about 11:00 PM when retirement was enforced. All of the residents of these wards, with the exception of a few older people, must hold outside jobs on the hospital grounds to remain on the wards. They are free to come and go from 6:00 AM to 7:00 PM when the outside doors are locked. It is their responsibility to arrange work and leisure schedules and attend group therapy sessions.

Chapter 2

REVIEW OF LITERATURE

"People often say that this or that person has not yet found himself. But the self is not something one finds; it is something one creates." (Szasz, 1974:55)

"The self has a character which is different from that of the physiological organism proper. The self is something which has a development; it is not initially there at birth, but arises in the process of social experience and activity." (Mead, 1934:135)

Sources of the Self Concept

In the beginning, a baby does not know where self ends and the outside commences. One of his first tasks is sensual exploration of his surroundings and establishment of ego boundaries. By the end of his first year, he has extended identification beyond his own body, included larger areas of his environment and has become aware of his dependence on his mother. He may test her with demands to see if her responses are reliable. Considerable anxiety, that can underlie the first doubts of self worth, is generated by inconsistency of presence or response by parents. By the end of the third year, he has learned to trust and begun to show some independence. The most beneficial parental stance is one of absolute power, muted, so that the child can venture out and run back to safety.

As a child's self concept becomes clearer to him, he begins to

extend independence into aggressiveness. It is extremely difficult to teach impulse control and inner tranquility in today's world, where adult aggressiveness is actively reinforced and rewarded. A child has the right to be angry but must learn control of this as well as other emotions that are part of himself as a whole person. The development of conscience and inner control accompany deeper understanding by each person of himself. This is a slow process as he attempts to define more clearly just who and what he is. The definition is a system of ideas, attitudes, values and commitments. It is a whole inner world set apart from all outer people and things. (Hamachek, 1971:8, 146)

Sullivan (1953:37-41) postulates two types of tension experienced by the newborn: the tension of needs, which is the demand of the organism for physiological satisfaction, and the tension of anxiety, which is the demand of the organism for psychological satisfaction. The tension of needs can be transmitted, understood and released through provisions of the caring adult. The tension of anxiety cannot be transmitted by the child and interpreted by the adult, and this is seldom released adequately.

As the infant becomes aware of a self outside of his body, it has three dimensions. The "good me" comes from satisfied needs, the "bad me" come from the anxiety of unfulfillment, and the "not me" comes from feelings of dread and horror too severe to be contemplated or acknowledged consciously as part of self. The "bad me" feelings

are seen in adult neuroses, the "not me" feelings as psychotic breaks with reality. (Sullivan, 1953:161)

This self system is part of a learning process and distortions can occur in the "bad me" and "not me" that may manifest themselves in the whole subsequent development of personality. Actions by parents during the first year should be characterized by consistency and modification to meet observable circumstances. Some parents seem to believe an infant has a will which at least must be guided and managed, or at worst, broken, whipped and chained. The child is subjected to all sorts of practices at direct odds with natural maturation processes. The gradual definition and clarification of self is distorted under these conditions. (Sullivan, 1953:170-172)

Erikson (1968:133) says that even in adolescence, when one of the main tasks is the beginning of heterosexual relationships, feelings called "love" may be more of an attempt to arrive at a definition of one's own identity by projecting a diffused self-image onto another and having it reflected and clarified.

Most theorists would agree with Sullivan (1953:31) that all organisms live in continuous existence with their environments, in functional activity and organization. However, there is some variation in viewpoints beyond such a basic statement. Rogers (1961: 188-190) says that most people bring a preformed self structure into daily experience and never give it up. Experiences are then crammed

down and twisted around to fit these preconceptions and most people are annoyed when all experiences refuse to be neatly catalogued and pigeonholed. Some people are living the "good life" as a process and have an openness to experiences rather than a rigid defensiveness. One way of thinking of the "good life" process of living from moment to moment, is to say that the self and personality emerge from experience, rather than experience being translated or twisted to fit preconceived self structure. A person in the process of the "good life" trusts his own concept of life and the incoming messages he receives enough, so that he does not need a rigid code by which to judge his day by day experiences.

Berne's (1972:31, 95) view of those with self concepts which need defending is similar. He says the destiny of each human being is decided by what goes on inside his skull when he is confronted with what goes on outside his skull. Each person designs his own life. He decides in early childhood how he will live and he carries this plan in his head wherever he goes. On the basis of early experience with the breast or the bottle, the bathroom, bedroom, kitchen or living room, the child acquires his convictions, makes his decisions and takes his positions. He then chooses a plan about how he will become a winner or a loser, on what grounds and what the payoff will be, and that is the first clear version of his lifelong script. Berne sees a person fitting all experience into his existing self-structure.

Reich (1970:141-152) says it matters little how excellent a job a child has done establishing a self before the age of six, because as soon as he is exposed to the public school system, the self he knows as his own begins to be squeezed into predetermined roles and in order to fit into the places he must fill to receive social rewards, he must lose or disavow quite large segments of himself and leave them behind as he goes through life. Life for a person is largely assigned from outside rather than being created from all possible potential, from the inside out. He also sees late adolescence as an excruciating time, for it requires a person to begin the choice of a career. One is expected to do what he wishes, and yet he has multiple pressures to do as others wish. It often creates such anxiety and doubt that it splits one's self into conflicting entities.

People may become ill as they live in the way society demands. Sickness may be a protest against a way of life that is not fit for the person who has been living it. It is possible to anticipate anxiety-based illness in time to change one's life, but this flexibility is largely trained out of people, if they are taught there is only one way to think and act. (Jourard, 1968:38)

Hamachek (1971:8, 42) also says a person's sense of identity is influenced by other people's appraisals of the social roles he happens to fill. He holds out more hope than some of the other writers as he states that perceptions of one's self and others can be modified. In

the accepting, understanding climate of client-centered counseling, a person can learn to change his perceptions.

Callis (1970:7) believes perception to be only one element in self concept development and change. A person starts with certain inherited capacities, and through maturation and experience, builds s behavior repertoire. The repertoire is subject to change with each new experience. The first element is the experience, the second element, perception, and the third element, generalization, or matching up this experience with a class of similar past situations and then responding from the behavior repertoire. The first thing a counselor must do when confronted with a person who is using inappropriate choices from his repertoire, is to determine whether the faulty judgment comes from lack of experience, distortion of perception or errors in generalization.

Experiencing of another person can be imaginative, not perceptual, when based on faulty generalizations of past experiences. Experiencing of oneself can be imaginative if the self concept is split or distorted. (Jourard, 1968:38)

The Importance of the Self Concept

> "The individual's concept of himself has been demonstrated to be highly influential in much of his behavior and also to be directly related to his general personality and state of mental health. Those people who see themselves as undesirable, worthless, or bad, tend to act accordingly. Those who have a

> highly unrealistic concept of self tend to approach life and other people in unrealistic ways. Those who have very deviant self concepts tend to behave in deviant ways. Thus, knowledge of how an individual perceives himself is useful in attempting to help that individual, or in making evaluations of him." (Fitts, 1965:1)

A person cannot help but be himself. We behave consistently with the sort of person we conceive ourselves to be. The closer we come to truly understanding another's primary motives and dominant values, the more we can see consistency in his behavior and unity in his personality. (Hamacheck, 1971:95)

Behavior is a consequence of perception. The organism reacts to reality as it is perceived and defined by that organism. If one wants to promote a stable change in behavior, one must change the perception of the one who is behaving. Of the whole perceptual field, a portion becomes identified as self. The self concept has dimensions and the dimensions have values. They influence behavior because they lead the self to a slanted perception of the external object. As a person experiences life, he relates it to his self structure and either incorporates from reality what is pleasurable, ignores what does not matter, or denies what is threatening. (Shlien, 1970:119-120)

Self concept is a central and critical element in human behavior. Adequate measuring devices for this element would make research into behavioral science much easier. There are great problems in measuring something so private, unique and elusive. Although much of human interaction is based on external cues, it is impossible to understand

or predict behavior without employing an internal frame of reference, as well. Even it concise measures for self concept were available, measuring is only the beginning of learning to change it. This is what rehabilitation, mental health, corrections, education and social welfare are all about. (Fitts, 1972a:1-5)

The Origin and Changing of Unacceptable Behavior

When there is more than one person together, their behaviors are different than when each is alone. They take account of each other and such an interpersonal situation can be described, either by the participants or by an observer. Such interaction between people is a necessary part of life, and satisfies a need, the thwarting of which can lead to sickness and death. When a discrepancy exists between a felt interpersonal need and the satisfaction of that need, a condition called anxiety results.

Biological needs are requirements that maintain a proper balance between the organism and its environment. Interpersonal needs are related specifically to other humans in the environment. These are the same two needs propounded by Sullivan. (1953) Neither of these categories of needs is best satisfied by unlimited gratification or by deprivation. Balance and control produce optimum results. The organism has ways of adapting to lacks in either type of need, but adaptation methods have limits and both Jourard (1968) and Durkheim

(1951) have written of the end consequences of illness and death that occur when adaptation methods fail. (Schutz, 1960:14-16)

Schutz (1960:18) has posited three concepts dealing with balance in interpersonal relations. Inclusion is the need to establish and maintain satisfactory interactions and associations with people. Satisfying the need for inclusion produces a self that feels significant and worthwhile. Control is the need to dominate and direct others and results in a self perceived as competent and responsible. Affection is the need to love and be loved by others and contributes to a self that is experienced as lovable.

A child must learn to interact as he learns any other skill. He must learn how to direct activity toward himself, how he feels about this activity, and what brings forth reward and punishment. From the earliest events, responses are reinforced or nonremembered to varying degrees depending on the strengths and types of interactions with others. These early events continue to be the model for behavior throughout adult life. Unsatisfactory ways of interacting are often continued simply through psychological economy and the threat of trying out unknown responses. When deeply felt ways of interacting are discarded, the persons who behaved in these ways and served as patterns must be discarded, too. (Schutz, 1960:83)

When people are confronted with each other, as in groups, the first formative concerns are of inclusion and identity. Any

difficulty in finding the places they best fit produces anxiety, which is often translated into observable behavior, such as overtalking or silence, exhibitionism or withdrawal. The decision-making concerns follow, with control and leadership being finally understood. Affection concerns then come to the fore, and any anxiety comes from solving the problem of the degree of intimacy and warmth to be allowed. (Schutz, 1960:168)

Many authors have written of the quandary of people as they try to live with maximum freedom and independence, incorporating the supplies seen as necessary by their own pictures of themselves, and yet needing the support and warmth of human interaction that requires limitation of freedom and dependence.

Durkheim (1951:246-257) believed that no living being can be happy or even exist unless his needs are in balance and harmony with the means of fulfilling those needs. Animals seem to find a balance without effort, taking just what they need from their environment. Man has needs other than physical ones. Even wide variations in physical wants can be satisfied in reasonable ways. Determining the limits for man's desire for well-being, comfort and luxury is a more complicated process. In this area, man apparently has the capacity for feeling insatiable. There must be some regulative force that keeps such demands in line, just as the organism limits physical needs. This is the role that society plays. It is not true that man

is comfortable and happy with complete freedom. Limitless choice without regulation is the opposite of the firm, just restraint recommended for children. It is accepted that teenagers need some type of limits and rules to give them security. All men need the restraints that interaction with other men impose upon them. Small, primary groups are one place where the comfort of limitation coupled with the comfort of intimacy and affection can be found.

At birth, man is only a very gifted animal, and becomes transformed into a person, step by step, from very early in life, through the influence of other people and solely for the purpose of living with other people in some sort of social organization. (Sullivan, 1953:5)

What a tragedy, then, when a person becomes warped and distorted through just this interaction process and, being identified as deviant, loses his place within the social organization that alone can make him fully human. Szasz (1974:50) comments on this:

> "Cooperation is contingent on mutual interdependence. An excess of both control and self-control is inimical to social cohesion. Too much control results in oppression and leads to noncooperation through rebellion. Too much self-control results in personal autarchy and leads to noncooperation through isolation. The delicate balance between control and self-control that social life requires is one of the reasons why tragedy is inherent in human existence."

Mead (1934:154) says that for the individual to develop a self in the fullest sense, there must be an integral, felt bond with the whole human social process. Only as he takes the attitudes of the organized social group to which he belongs, toward the cooperative social

activity in which that group is engaged does he develop a complete self, or possess the sort of complete self he has developed.

The human personality in development, structure and functioning is dependent upon the social group of which it is a member. A child who grows outside a social group, remains an animal, without language, the capacity to reason, or even the ability to love and hate as other men do. Those who suppose that social inheritance is a burden to be cast off, a spell from which we must be awakened, are mistaken. Without that very inheritance, the individual is nothing. He has no core of personality into which his culture has not penetrated. Yet, the more strongly the individual identifies with his own group, the more hostility he feels toward other groups. To owe loyalty to less than all men is to create adversaries. To be without a strong primary group is to risk becoming an unaffiliated faceless member of the lonely crowd. (Wolff, 1965:18-22)

Fitts (1970:10) writes that man has no choice concerning whether he will belong to groups or not. Interpersonal relationships are essential to man's existence. He could hardly survive at all, without them, and such a life would not be worth living, if it were possible. Certainly, love and esteem needs and often, physiological and safety needs are satisfied through interpersonal relationships. Behavior between people is learned. Learned behavior can be modified, extinguished, unlearned, altered and relearned. Feedback facilitates

learning. Cross-validation is one of many reasons why modification of human behavior is best accomplished in a group.

Changing Behavior Through Small Group Interaction

There are a number of curative factors at work in groups which are generally accepted as definable. These factors are given different names by different therapists and researchers but when compared and defined they are similar. One of the first factors to come into play is the instillation of hope. By inviting a person into a therapy group, it is made clear that the person is considered retrievable and of worth and value. For some people with damaged self concepts, the simple knowledge that other people are willing to spend time and effort with them, is the first step in increasing self esteem.

A second early factor is universality. To find another person who has known emotional upheaval similar to one's own, immediately lessens loneliness and despair and renders the attitude that life is hopeless because of the unique pain one has suffered, untenable. There is some re-creation of the family group that is often the cause of the person's maladaptive behavior, with the therapist seen as the dominating parent and the group members as siblings. It is possible to use the group to practice socializing techniques, even to acting out applying for a job, or dealing with superiors on the job. Discussing practical matters relating to rejoining the community gives opportunity for

members to divulge their reactions to each other, and offer positive suggestions for change. (Yalom, 1970:9-13)

There are two curative factors usually accorded priority in bringing about behavioral change. One is interpersonal learning. Yalom (1970:16-21) stresses again the dilemma of the individual man versus the social man and again concludes that man is committed to social existence. Since pathology arises from distorted interpersonal relationships, it can be repaired in the benevolent interpersonal relationships of the therapy group.

As the group members begin to trust each other, each one's particular kind of maladaptive behavior will appear. Within the safety of an accepting group, he can undo the behavior and reexperience the emotion and correct it. Other members aid with reality testing by giving feedback and helping the person to understand the basis of his emotion and why it was unsuitable in its past context. The group then acts as a social microcosm to provide the possibility for the person to test out new behavior patterns. A person is accepted back into the group after lapses of newly acquired patterns without censure, and such unconditional acceptance works to form an adaptive spiral that produces a rise in self concept in the person and more acceptance from others and another self concept increase. (Yalom, 1970:21-33)

The second major factor in therapy is group cohesiveness. Relationships between group members are more important to the members

than the member-therapist influence. Strong bonds within the group must exist to establish trust and belief in the value of other members' opinions, before self concept can be strengthened. (Yalom, 1970:36-43)

In the therapist-patient relationship, certain mechanisms for action can be recognized. The expression of feelings, reality testing and acceptance with the production of more feelings and the rise in self concept and beginning of control over one's own life is the usual progress. This course depends on the ability of the organism to expand and develop itself, given a favorable climate. In a group setting, much the same process occurs, but with the added support of peers, as well as the therapist. Popularity with the group mirrors later social acceptance and expertise in handling self. Hostility may also be comfortable handled in the group setting and aid in a person's finding ways to deal with such feelings in an acceptable way. (Yalom, 1970: 44-55)

The curative factors in group therapy vary when examined from the members' and the therapist's viewpoints. The simple caring on the part of the therapist and group may be the most important thing to some. The therapist is often left out of ratings done by group members, when listing the most important factors that were helpful. Childhood influences, often considered so important by the therapist, are usually not considered nearly so vital by the group members as experiences in the "here and now." Intellectual teaching and interactions

are often scorned by therapists, but some studies have shown this level of interchange is valued by members. Even though every group member carries the imprint of his family's effect always with him, reenactment of situations from family backgrounds and constant references to past family members, did not appeal to most group members. (Yalom, 1970: 60-78)

Even though the composition of the group may determine its successful outcome, judging which people should be included, is a difficult task. Some therapists set up definite attributes which members must show or be free of. Attributes which might be required could be minimal satisfaction of primary childhood relationships, basic ego sufficiency, full reality contact and some response flexibility. Some attributes which might prohibit membership are sexual acting out, or a fragile defense system which might be damaged by group interaction. (Kadis, 1965:53-54)

Some therapists feel inclusion criteria are unnecessary. They feel all people are suitable for group therapy with a few exceptions, such as those with brain damage, acute psychotic episodes, sociopathic behavior, or drug addiction. It is much easier to set up exclusion than inclusion criteria. It is possible to find justification for almost any decision made about group therapy in current literature, and another source which contradicts any decision. The beginning therapist may feel confident in excluding a certain type of patient only to find

a report of great success with just this type of patient. Some of this conflict is due to the great variation in background and training of therapists and some to the scarcity of dependable research into this process. (Yalom, 1970:156-157)

> "The fewer criteria for selection the therapist has, the more likely he is to learn. Such criteria usually mean: 'I only want patients who will play games I feel comfortable with or like to play.' By inviting 'unsuitable' patients into his groups, he may learn about new games. At worst, criteria may be based on mere snobbishness. . . . 'Criteria for selection are hardly ever good.' They can usually be reduced to personal prejudices of the therapist, and as such they can be legitimately applied until he gains more confidence, changes his attitude, or learns more, but they are best regarded as symptoms of professional inadequacy." (Berne, 1961:169-170)

Unfortunately, there are no solidly based research studies which relate therapeutic outcome to group composition to aid a therapist in forming a group with confidence that he is creating the most favorable climate possible in which curative factors may operate. (Yalom, 1970: 193)

There are some other practical matters which must be considered by the therapist, such as the physical setting for the group meetings, whether the group will be open to new members from time to time, or closed until termination, and the length of time for each session. Some therapists like the group seated around a table while some prefer just chairs to aid in observation of nonverbal behavior. Most groups are not able to meet for any length of time as a closed group, unless the members are institutionalized and always at hand. The open group is

far more common. It has been a tradition to hold group sessions for ninety minutes, but many other time durations have been tried. The number of members usually ranges from five to ten. The higher number is often chosen at the beginning to allow for some drop outs without reducing the group too far. Some type of interview is usually held with individual members before the onset of therapy, to dispel fears and correct any misconceptions about the method of action and the goals of the group. (Yalom, 1970:208-220)

Summary

The formation of self concept begins at birth when interpersonal relationships begin, and is formed, either in a constructive way that allows for maximum development of the individual in later years, or in a distorted way, that prevents full realization of potential and allows for possible behavioral deviance in adulthood. Man becomes fully himself only as he interacts with others.

The importance of the self concept lies in its power to shape behavior. A person's behavior that determines how he shall be known to others and how much satisfaction he will derive from living, is a direct reflection of how he feels about himself.

The origin and changing of unacceptable behavior is rooted in the basic conflict between man's need to maximize himself and yet conform sufficiently to social groups to receive the reward from interpersonal

acts, that he must have to survive. Since interpersonal experience shaped his self concept as he grew, and is necessary over his entire life, interpersonal experience such as that found in groups, can reduce and redirect deviant behavior.

The close relationships found in a small group afford an excellent setting for correcting unacceptable behavior. Interpersonal learning and group cohesiveness are important curative factors in repairing damaged self concept. The composition of groups determines successful outcomes, but there are few reliable guidelines for choosing group members so that success can be predicted. Other matters such as the setting, session length and preparation of members must be taken into account.

Chapter 3

METHODOLOGY

Statement of Procedure

This investigation was done with the cooperation of residents of an open ward at a state hospital for the mentally ill. It was begun by selecting a number of possible psychotherapy group members using file information and some loosely structured inclusion criteria. Each person chosen on this basis was approached individually by the author, and asked to become a member of the newly formed group. Five men and three women expressed a desire to join. In the week following the initial meeting of the group with the primary therapist and co-therapist, each of the eight group members completed the Tennessee Self Concept Scale. The author, who was co-therapist for the group, was able to meet with them for just five months due to college scheduling. In the week preceding the termination meeting with the group, the author again administered the TSCS. Results of the testing are shown on individual profiles and the group means on a separate profile. (Appendix pp. 62-67 and 72)

Following selection of the therapy group members, a control group was chosen, matched for age, psychiatric diagnosis, and length of institutionalization, as closely as possible. The TSCS was administered to this group at approximately the same times as it was to the therapy group. Results of this testing are shown on individual

profiles and the group means on a separate profile. (Appendix pp. 68-71 and 73)

Selection of Therapy Group and Control Group Members

There is one ultimate goal in the minds of all residents and staff personnel in a state hospital; to discharge all of the residents and render the hospital unnecessary. Numerous lesser goals are set with this one ideal in mind. Goals for this psychotherapy group were to aid the members in further modifying behavior which has proven unacceptable in the past, and to begin realistic discharge planning by discussing problems in living which might be experienced by group members when separated from the security of institutional residence.

The primary therapist for the group feels this state hospital has an excellent structure for caring for long-term, brain-damaged people who need compassionate custodial care. It also has the personnel and processes in action for giving high level care for acute, newly admitted psychotic people. However, there are a number of residents, under the approximate age of thirty, who have not recovered in the few months accorded them on the acute receiving ward, and have been assigned to long-term wards where high quality psychotherapy is a rarity. These people tend to reach a plateau of adjustment to the hospital, hold jobs, and join in recreational activities, but cannot advance any farther. As a logical outcome of these beliefs, inclusion

criteria for this group were an age of thirty or younger, a diagnosis of functional mental disorder, and assignment to a residential open ward. These criteria were used only as guidelines, not as a rigid barrier.

The eight people originally chosen for the group ranged in age from twenty to thirty-eight, were diagnosed as being schizophrenic, with the exception of two, who were diagnosed as mentally retarded behavior problems, and had been in the hospital for six weeks to one year, nine months, with four having been there for over a year.

The initial group session was used to set up the time and place for meetings and the four ground rules which must be observed. These were confidentiality, freedom to talk about anything, no physical violence against the therapists or each other, and no guests at the group sessions.

One twenty-year old man, diagnosed as a mentally retarded behavior problem, attended only the first two sessions and would not return, even though invited to do so at the next three sessions. With a tested IQ of 68, he had great trouble in following the discussion and was unable to rephrase others' comments in his own words.

One woman, who had been in the hospital for only six weeks and was included in the group at the request of her social worker, attended the first and third sessions and was then discharged.

At the eighth session, a twenty-one year old man was added to the

group and attended every session thereafter. A twenty-nine year old man, who had been in the hospital for one year, six months at the time of the group's formation, had participated in other therapy groups and came only in the role of "therapist's helper" while awaiting discharge assignment, dropped out following the tenth session. The remaining four men and two women continued until the time the author had to leave the group.

Most of the residents on the open ward who met the inclusion criteria, were included in the therapy group, making it very difficult to identify a control group with like characteristics. Many of the people approached to take part in the testing project, refused to do so. Three men and two women were eventually chosen who matched therapy group members quite well except in age. The control group members were all somewhat older. One man was transferred to an out-of-state Veterans' Hospital without the author's knowledge, leaving two men and two women at the time of the posttesting.

Selection of the Measuring Instrument

The Tennessee Self Concept Scale was chosen as the measuring instrument after extensive review of personality scales, because of the nature and stated purpose of the Scale. It was developed to meet the need for a scale which "is simple for the subject, widely applicable, well standardized, and multi-dimensional in its description of the self

concept." (Fitts, 1965:1) The test is published in two forms, Counseling, and Clinical and Research. The Counseling form has fewer variables and scores and is designed for self-interpretation and feedback to counselees. The Clinical and Research Form which was utilized for this study, is more complex and allows for greater depth of analysis and interpretation.

Development of the Scale was begun in 1955 and the present manual was published in 1965. The Scale was normed on a broad sample of six hundred twenty-six people. The sample included people from various parts of the country, and age ranges from twelve to sixty-eight. There were approximately equal numbers of both sexes, Negro and white subjects, representatives of all social, economic, and intellectual levels and educational levels from eighth grade through the Ph. D. degree. However, the norm group does not reflect the population as a whole in proportion to its national composition. The norms are over-represented in number of college students, white subjects, and persons in the twelve to thirty year age bracket. As reports using the Scale have been gathered, the evidence so far suggests that there is no need to establish separate norms by age, sex, race or other variables.

Test-retest reliability coefficients are given for each of the twenty-nine profile scores and the time score. Data was based on test-retest with sixty college students over a two week period of time, and ranged from .60 to .92 with only nine scores falling below .80. Reports

using a shortened version of the Scale still obtained a reliability coefficient of .88 for the Total Positive Score.

Determining validity of personality scales is difficult and often neglected by their authors. The TSCS Manual devotes thirteen pages to graphs, tables and discussion of this issue. Content validity is assumed because of the unanimous agreement of judges on the retention of each item included in the Scale scores.

Correlations with other scales are shown as another measure of validity. Outcomes on the TSCS show close correlation with the MMPI. In some instances where linear correlations are low, the same scores show high correlation ratios, reflecting the tendency of people with behavior disorders to use extreme answers, rather than disclosing a weakness in the Scale. Linear correlations with the Edwards Personal Preference Schedule were also low, but because of the nature of the two scales, extreme high and low scores should show correlation and a table of comparative scores from high school students in 1966 bears this out. Comparisons are reported with several other less well known scales.

Further evidence for validity is shown by the ability of the Scale to discriminate between groups on the basis of psychological status. Statistical analyses have been performed in which a large group (369) of psychiatric patients have been compared with the 626 people in the TSCS norm group. "These demonstrate highly significant (mostly at the .001 level) differences between patients and

non-patients for almost every score that is utilized on this Scale. (Fitts, 1965:17) Data has also been collected from the other extreme of the psychological continuum; from people characterized as high in personality integration. The basic hypothesis was substantiated for virtually all scores.

If the self concept is a useful approach in assessing an individual's state of mental health, it should differentiate type of disorder as well as degree of disorder. The Scale differences shown constitute a kind of clinical validity because the scores are about what would be predicted from the type of pathology and defenses represented by the diagnoses of the people tested. Expected differences in Scale scores were also seen in groups exhibiting deviant behavior, such as juvenile delinquents, unwed mothers and alcoholics.

Certain life experiences might produce a change in the way a person sees himself. Psychotherapy or other positive experiences would be expected to result in enhancement of the self concept, while stress or failure would be expected to result in lowered self esteem. Studies by Gividen and Fitts (Fitts, 1965:28), done with a group of army paratroop trainees and a therapy group of six women patients, yielded scores in the predicted directions. A study by Ashcraft and Fitts (Fitts, 1965:28) was also done with a group of thirty psychiatric patients in therapy for an average of six months and a control group of twenty-four patients who had been waiting for therapy for an average of

6.7 months. All subjects were measured on a test-retest basis with the Scale. The therapy group changed significantly and in the expected direction in eighteen of the twenty-two variables studied while the control group changed in two variables. There is considerable other evidence in recent uses of the Scale to show that peoples' self concepts do change as a result of significant experiences.

> "The Scale consists of one hundred self descriptive statements which the subject uses to portray his own picture of himself. The Scale is self-administering for either individuals or groups and can be used with subjects aged twelve or higher and having at least a sixth grade reading level. It is also applicable to the whole range of psychological adjustments from healthy, well-adjusted people to psychotic patients. . . . Most subjects complete the Scale in 10-20 minutes (mean time about 13 minutes)." (Fitts, 1965:1)

Answers to the one hundred statements may be 5-completely true, 4-mostly true, 3-partly true and partly false, 2-mostly false, and 1-completely false. Scores are transferred to the profile sheet under twenty-nine headings.

The Total Positive Score is the most important single score on the Scale. High scores show strong self concept, low scores show doubt about personal worth, and the person expresses anxiety, unhappiness and depression. The other positive scores are obtained from a grid of three rows and five columns. The rows have "what I am", "how I feel about what I am" and "how I act" items. The columns reflect different parts of the self image: physical, moral-ethical, personal, family and social.

The self criticism score is composed of ten items scattered throughout the test that are mildly derogatory and to which most people would admit. High scores indicate a normal, healthy capacity for self criticism, low scores indicate suspicious defensiveness which may affect other test scores.

The True/False score is a measure of response set and indicates the subject's tendency to agree or disagree with everything, regardless of item content. It also indicates whether the person defines himself by focusing on what he is or by rejecting what he is not. The norm shows a healthy ability to identify self in both positive and negative terms.

The Net Conflict is highly correlative with the T/F score and shows how the individual's responses to positively worded items in each area of self perception, conflict with his responses to negatively worded items in the same area.

High scores in Total Conflict show confusion, contradiction and general conflict in self perception. A score below normal presents a picture of such a tight and rigid self description that it becomes suspect as an artificial, defensive stereotype rather than a true image.

Total Variability score shows the amount of variability from one area of self perception to another. High scores show little unity or integration and small areas of self may be compartmentalized and viewed

differently than other areas. Low scores may show rigidity as in the Total Conflict Score. A "V" shaped pattern of Variability Scores is characteristic of most patient groups. This means the self evaluation across the Column Scores, which show the external frame of reference, is much more variable than across the Row Scores which represent the internal frame of reference. This may mean that disturbed people are more focused on external sources of evaluation.

The Distribution Score summarizes the way answers fall into the allowed answer categories. High scores show definiteness and certainty about self and low scores are indicative of confusion about self or guarded defensiveness. Schizophrenic people often use completely true and completely false answers most, creating high D Scores and other disturbed people often hedge and refuse to commit themselves, using a predominance of three scores and yielding a low D.

The Empirical Scale Scores are composed of items cutting across other scales and correlating with scores obtained by testing people showing deviant symptoms. The twenty-nine items included in the Defensive Positive Score were identified from data on one hundred psychiatric patients who had high total positive scores. This measure is a more subtle one than the Total Positive and tends to show negative self concept at a lower level of awareness. High scores indicate defensive distortion, low scores show a person lacking in any of the usual defences for maintaining self esteem.

General Maladjustment, Psychosis, Personality Disorder and Neurosis Scores are each obtained from totaling about two dozen of the items which best differentiate disturbed people from well-balanced groups. Personality Integration consists of twenty-five items showing average or better adjustment and integration in seventy-five people.

The Number of Deviant Signs Score is found by totaling the extents of Score deviations from the norms. A person might have all profile scores within normal limits and still have a high NDS because of wide swings above and below the 50th percentile. Just as the Total Positive Score is the most reliable estimation of self concept, the NDS is the best indicator of psychological disturbance. This score alone, has been found to identify deviant individuals with 80% accuracy. (Fitts, 1965:1-5 and 13-29)

Summary

This investigation was begun by selecting five men and three women residents from an open ward at a state mental hospital. General inclusion criteria were age thirty or younger, functional mental disorder and previous transfer away from the acute treatment center to a residential ward. The Tennessee Self Concept Scale was administered to each group member during the week following the initial group meeting. The same test was administered to five members of a control group from the same ward soon thereafter.

The TSCS was repeated as a posttest to both psychotherapy group members and control group members after five months. There were four men and two women in the therapy group at this time and two men and two women remaining in the control group.

The TSCS was chosen as the tool for measuring change in self concept through group therapy because it was designed for this purpose and had been used by the Scale author in a similar study of institutionalized people using a larger N than the present study.

The Scale consists of one hundred self descriptive statements which the subject rates from 1-completely false to 5-completely true. Twenty-nine profile scores are computed which indicate how the subject sees himself. Some empirical scores are normed on people with behavioral disorders and one on people who have been extraordinarily successful. Some scores indicate a lack of unity and integration in a person's picture of himself. The two most important scores in estimating a person's supportive needs are the Total Positive and Number of Deviant Signs.

Chapter 4

ANALYSIS OF DATA

Therapy Group

Of the twenty-nine mean scores on the psychotherapy group profile (Appendix, p. 72), only four did not change in a favorable direction. The Self Criticism Mean Score went down two points. High scores generally indicate a normal, healthy openness and capacity for self criticism and low scores show a defensiveness and a deliberate effort to present a favorable picture of oneself. This result would indicate a failure of the group to provide a safe place for expression of feelings and feedback that would enable each person to gain a more accurate picture of his own strengths and weaknesses. After five months of participating in group meetings as well as living day by day on the same ward, it should not be necessary for the group members to keep strong defensive barriers up, in an effort to project a favorable image.

The Column D-Family Self Mean Score remained unchanged. This score reflects one's feelings of adequate worth and value as a family member. It can also refer to the individual's perception of self in reference to his closest and most immediate circle of associates. Most of the people whose ability to cope with life is so damaged that they must be segregated from the community, have had damaged family relationships in their pasts. Because the damaging events were past, contacts with family members were lost through death or broken communications,

or ongoing relationships persisted in old patterns, group members saw this aspect of self as being the least open to improvement. It was almost impossible at this stage of their learning to form new ties with people who could be seen as substitute family members or to feel the trust that would be necessary to produce a rise in this profile score.

The Variability Scores, two subtotals and one total, provide a measure of inconsistency from one area of self perception to another. High scores mean that the person's self concept is so variable from one area to another as to reflect little unity or integration. Even though the group means for both the pretest and posttest are within normal limits on the profile, the rise in the row subtotal and the final total means, show a failure of the group therapy experience to contribute to greater unity and integration of self concept. The group means for Variability show a break in the expected pattern for behaviorally disturbed people, by producing a rise in the Row Score Subtotal which reflects the internal frame of reference, and an unchanged score on the Column Subtotal which reflects the external frame of reference and more often fluctuates.

The Total Positive Score is the most important single score on the profile because it reflects overall level of self esteem. The normal range for this score is 315-420. The therapy group pretest mean was 247 and the posttest mean was 288, indicating considerable positive change. The NDS score, which is the best indicator of psychological disturbance,

should be below 11. The therapy group pretest mean was 68 and the post-test mean 42, showing considerable improvement, although the mean remained far above normal.

Control Group

On the control group profile (Appendix p. 73) one mean remained unchanged, seven means moved in a more deviant direction, and the remainder of the twenty-nine profile means either moved in a favorable direction or the changes were within the normal limits and had no clear meaning, in a manner similar to the therapy group means. The unchanged mean was T/F, remaining above normal and showing strong response set in the direction of the completely and partly true answers.

The increased deviant means included net and total conflict which correspond to the elevated T/F mean in showing tendency to answer positively worded statements with true responses even though the positive statements are contradictory with ones on previous pages. Row One and Column A means were more deviant. Row One items deal with "what I am" and Column A items with the Physical Self. The empirical scales for Psychosis and Neurosis were more deviant and the Number of Deviant Signs mean increased from 51 to 53 with the normal limit below 11.

The Total Positive mean which is the best indicator of self esteem level, increased from 311 to 316 with the lowest normal score 315. This five point positive change is much less than the forty-one

point positive increase shown by the psychotherapy group, although the control group mean was almost at the lower normal limit at the time of pretest. This is a similar directional pattern shown by Fitts, (1965: 29) (Appendix pp. 74 and 75)

Discussion of Statistical Distortion

When working with large numbers of subjects, means are a valid expression, but when dealing with four to six people, reality becomes distorted by focusing attention on average scores. For instance, when averaging the net conflict scores of the control group on posttest, the four scores were 14, 20, 21 and 78. The normal range for this profile score is -30 to +13. Three of the subjects have nearly normal scores on this variable and the therapist should be aware of this difference. The same net conflict scores on the therapy group pretest were -8, -6, -1, +7, +8 and +48. In the instance of the control group posttest, the three nearly normal people are penalized by a mean of 33.25, while on the therapy group pretest, the more deviant individual is overlooked in a mean of eight.

As Lidz (1968:viii) says, medical psychology is not as interested in experiment and statistical analysis as meaningful insights and therapeutically useful knowledge. To look at each person's pretest in an effort to assess his present position and to plan which interventions might reach him more readily than others, would seem more fruitful than

manipulations of numbers which does justice to no single group member.

When using the TSCS on one hundred people diagnosed as paranoid schizophrenics, Fitts (1972:34) found very little homogeneity within the group and the crucial Total Positive and Distribution Means showed little central tendency. The test profiles seemed to show three groups according to coping skills; one in which psychodynamic defenses were working well, one group in which self esteem ranged from average to low, and one in which no defenses were apparent. Additional research is suggested on intragroup discrepancies.

Use of a test such as the TSCS to assess a person's psychological status and plan assistance may be more productive than the present method of diagnostic category labeling. Use of the internal frame of reference rather than external tends to concentrate attention on the whole person and his efforts to realize his potential. (Fitts, 1965: 100-117)

Browning (1971:9-13) presents references to several authors who have worked with clinical psychological research using N = 1 designs. He uses persuasive statements in favor of idiographic experiments. Searching out controlling factors for behavior and learning to alter them in each individual case are more important than highly literary reports in various journals. The science of personality requires procedures adequate for measuring unique traits.

"Fallacious conclusions can result from the common practice

> of averaging data from many subjects. . . . Methodological sophistication should not be so idealized that a study can never be accomplished with the current patient; nor should it be so completely renounced that the clinician relies entirely on his own subjective judgment. . . . In fact, the detailed study of a single individual can provide the evidence to disconfirm widely held generalizations about behavior." (Browning, 1971:13)

Discussion of Individual Scores

For example, R's profile (Appendix, p. 62) shows no 5-completely true or 1-completely false, answers on the pretest and only one 1-completely false answer on the posttest. During his writing of the posttest, the remark was made to the author that since he had refrained from using the two extreme answers at all on the pretest, he thought it advisable to use at least one of them on the posttest. The fact that this was a conscious decision that he was willing to articulate, provides quite a different basis for therapy, either individually or within a group, than if his answer pattern had been unconscious or denied. Recognition of this subject's inability to make a clear decision and act on it was lost when examining the therapy group means of 22 for the 5-completely true answers, and 20 for the 1-completely false answers, on the pretest, and means of 19 for the 5-completely true answers and 23 for the 1-completely false answers on the posttest.

In addition to R, P showed showed little change in profile scores over the five month period of group therapy. (Appendix, p. 63) The dramatically low Total Positive Scores coupled with Defensive Positive

Scores so low they cannot be entered on the profile, and the normal Conflict and Variability Scores, define a man who sees himself, both consciously and unconsciously, in every aspect of personality and interaction as completely worthless. This paper portrait was borne out in daily experience by his frequent attempts to commit suicide.

Group members B and C (Appendix, pp 64 and 65) showed enough positive changes in most profile areas to be encouraging to the therapist to continue group meetings.

Even though displaying uneven results, group members K and S (Appendix, pp. 66 and 67) showed the most positive movement in the period of group therapy. Many of their profile scores moved from very deviant expressions, to being within normal or nearly normal limits.

The two men and two women included in the control group (Appendix, pp. 68-71), who received no special attention of any kind during the five month time covered by the study, but simply worked at their daily jobs and lived on the ward in the same fashion to which they were accustomed, showed more changes on individual profile scores than is apparent by examining the profile means. However, the score changes are as often in the direction of being more deviant than less so. No consistent overall change in either a positive or negative direction is seen.

Summary

Four mean scores on the therapy group profile did not change in a favorable direction over the five months of therapy. Twenty-five mean scores either changed in a positive direction or fluctuated within normal limits. The Total Positive Mean increased from 247 to 288, showing considerable positive movement, although remaining below the lower normal limit of 315. The number of Deviant Signs Mean decreased from 68 to 42, showing considerable improvement, although remaining above the upper normal limit of 11.

On the control group profile, one mean remained unchanged, seven means moved in a more deviant direction, and twenty-one means either moved in a positive direction or fluctuated within normal limits. The Total Positive Mean increased only five points, 311 to 316. The Number of Deviant Signs Mean increased two points from 51 to 53, moving in a negative direction from the norm of 11.

Encouraging results from group therapy were more apparent when studying individual profiles than arithmetic means. Two of the therapy group members showed little progress during the five months, but two made measurable progress and two showed great improvement, both on the Scale profile and in subjective clinical assessment. Individual profiles of control group members showed no significant pattern of changes.

Chapter 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

Self concept is not something with which we are born, but which must grow within a caring primary group, to develop into a unified, trusting whole. Distortion in the early primary family group may cause a person to reach maturity physically and socially, without being able to depend on his own inner knowledge and interpretation of his experiential field. He believes himself to be an undependable source of judgment about life situations. He carries a script of uncertainty and views life through it.

Subject P was moderately crippled in his left hand and leg. His earliest memories of his father included being aware of his father's profound disappointment in him and being told he was a worthless cripple who would never be able to do anything he wanted or that anyone else could value. He finished high school with little difficulty because it was a circumscribed task with a well-defined goal and he was still sheltered within his family. At the time he was required to assume an identity of his own and consider leaving home, he began trying to commit suicide at frequent intervals and had continued to do so after being institutionalized. He could not accept the caring of the group and continued to wait for his father to reverse his opinions of twenty-three years and make P a valuable human being.

Self concept determines behavior. A person behaves consistently as he perceives himself to be.

Subject K was raised in a home without a father and with a mother who exhibited deviant behavior. The mother repeatedly told K that she would become crazy and never amount to anything. K had her first psychotic break at age thirteen during a party in her home where a person was attacked with a butcher knife and injured severely. She spent quite some time as a prostitute and had to be treated for weeks in a general hospital for drug overdose and alcoholism before being institutionalized. K has accepted the caring of the group and values their opinions. She left the hospital for twenty-four hours to try an assignment in a sheltered workshop but immediately came down with severe colitis, pain and diarrhea and was returned. The group accepted her back without censure or undue concentration of attention and mitigated the severity of the experience of failure.

People must maintain extensive interpersonal relationships of varying degrees of intimacy to experience lives of greatest satisfaction. Interpersonal needs are as vital as physiological needs. Each person has his own typical way of relating to groups of which he finds himself a part, but there are some general rules which seem to apply for any group of about a dozen people. The first concern is discovering each one's place relative to others. The anxiety engendered by this maneuvering may be shown in exaggerated verbal behavior at one

extreme or the other.

Subject K would have monopolized the entire session at each group meeting if allowed to do so. She talked incessantly and pointlessly. A contract was agreed upon with her at the first meeting that she wanted to improve and would accept the reprimands of both the therapist and the group in a constructive way and the group would in turn help her to keep her remarks short and to the point. She accepted group reprimands with less resentment than therapist corrections and gradually began to assert control over her own behavior, although physical signs of tension and anxiety were present as she struggled for brevity of expression.

The second concern is group leadership and control. The third, is gauging how much of oneself it would be safe to reveal within the group and still maintain their affection and regard. This struggle is a universal one for all men as they try to remain free of all encumbering relationships and yet find they must have membership in society to avoid loneliness and anomie.

Just being invited to join a group provides some with hope of learning to deal with the problems they perceive as insurmountable. They find others with similar life experiences and discover a common bond. Some find relief in the simulated family situation of the group, viewing the therapist as a parent and the group members as siblings.

The situation in this therapy group was ideal for this sort of

transference with a male therapist and female co-therapist, but even with role playing of past family situations, there was no rise in the mean score for self concept as determined by family or the closest and most immediate circle of associates. Apparently the five month period of therapy was not long enough for sufficient trust to develop, enabling members to value and integrate group support.

Because one of the group goals was to face some possible events that might prove threatening when attempting to resume a place in the community, necessary behavioral changes were suggested and the group was used to practice socializing techniques.

Interpersonal learning is one of the most important curative factors recognized in group therapy. Acceptance by the group precedes the faith of the member that he will be accepted by the community.

Subject P was absent at one group meeting because he had set his shirt sleeve on fire with a cigaret lighter and was confined to the acute receiving ward for several days. He was welcomed back at the next meeting, and allowed to freely express what feelings he wished to share without any censure or rejection from the group. Subject K and Subject R were separated on locked wards for several days between group meetings at one time, for being apprehended in the act of sexual intercourse on the shower room floor. They were not morally castigated by the group, but simply reminded that they had broken a hospital rule they were both aware of, and would receive no outpouring of

unwarranted sympathy for the punishment they had been assigned.

Cohesiveness is the second vital curative factor in group therapy. This largely subjective element was difficult to sense during the first ten sessions when the membership was fluctuating somewhat. The primary therapist was absent for the thirteenth, fourteenth and fifteenth sessions and as the group struggled with the unaccustomed nondirectiveness of the co-therapist a new sense of being a unit emerged.

The eight original members of the therapy group and the five control group members were given the Tennessee Self Concept Scale soon after the beginning of group therapy sessions and the remaining six therapy group members and four control group members were given the same Scale again after five months. The control group received no attention from a therapist of any kind, but simply continued their daily routines. The therapy group met for an hour once a week with the primary therapist and the co-therapist. The control group mean scores fluctuated between the pretest and posttest, but in no definable pattern. The individual test profiles also displayed no particular pattern of changes. The therapy group mean scores showed considerable positive changes. The individual profiles were even more dramatic in two cases where very deviant profiles became almost normal, and encouraging in two more cases where moderate positive changes were seen. Two of the profiles showed practically no change.

The results of the comparison of profiles gives ample support for the continuation of the existing group and the formation of others as trained therapists and time permits. Although group psychotherapy is sometimes used as a convenient way of contacting more people than the usual therapist-patient relationship remits, it has additional potential for providing curative factors found only where a group of people sit down together.

Conclusions

The problem posed for this study, the discovery of whether group psychotherapy for a period of five months would improve the self concepts of the group members, could be answered with a qualified affirmative. Two of the group members showed substantial improvement, two showed moderate improvement and two showed essentially no improvement. However, five months is not a very long period of therapy for people who have not responded to the initial regimen for newly admitted persons, and who have been institutionalized for many months. The two subjects who showed no improvement on the self concept scale, appeared clinically as having rigidly structured patterns of behavior. One subject was closed to all interaction beyond a superficial level and one had such a negative self image, it was impossible for him to accept the concern of others to begin the desirable adaptive spiral of interpersonal learning. This does not mean these two subjects should be

dropped from the therapy group, but that the therapist should not be disappointed over their slow rates of improvement and should continue to be accepting and show that the group members are valuable just as they are.

The first purpose, to add some additional information to the existing body of research concerning group therapy, was carried out by completing the study and organizing it into transmittable form for others.

The second purpose, to collect additional information about the validity of non-projective personality tests was completed to the satisfaction of the author but the satisfaction must remain completely subjective. The correlation between the clinical impressions of the group members and their test profiles was striking to one who could observe them over the time period of the study.

The third purpose, to compare results obtained by the author of the TSCS during a six month study of psychotherapy groups with thirty members and a control group of twenty-four subjects, with this study, can be done, by comparing the profiles from his study (Fitts, 1965:29) (Appendix, pp. 74 and 75), with the profiles showing therapy and control group means for this study (Appendix, pp. 72 and 73). The profile patterns of the therapy groups are quite similar although the absolute mean scores are different. The mean scores of the group in this study were more deviant to begin with, but showed a greater

quantitative move toward normal limits on the Total Positive, than the Fitts study. The Fitts study showed a positive increase of twenty points from 292 to 312 and this study showed an increase of forty-one points from 247 to 288. The Fitts profile Number of Deviant Signs showed a positive move of nine points from 27 to 18 and this study Number of Deviant signs showed a move of twenty-six points from 68 to 42.

The Fitts control group showed practically no change on any score while this study control group showed substantial changes but in erratic directions with no identifiable pattern.

Recommendations

1. From the outcomes of this study, both through objective test results and subjective evaluation of group therapy members' changes, it seems only positive results could occur from more groups meeting with trained therapists. Beyond the mere mechanics of exposing more people to more help for more hours a week, the group method brings a whole new experiential world within the purview of those with damaged self concepts. The difficulty of implementing this recommendation lies in obtaining trained therapists who can guide and set limits on group members to prevent further damage.

2. The group examined in this study met for only one hour a week which is not ordinarily considered long enough to accomplish anything. Late arrivers sometimes cut into the designated hour and further

decreased the time spent seriously considering problems. The recommendation is for meeting twice a week or for ninety minutes once a week.

3. The physical setting for these meetings was a small office which quickly became full of cigaret smoke. The primary therapist sat behind the desk which created a psychological barrier between the group and himself. There was a shallow extension on one end of the room, narrower than the main room, which allowed one or two members to keep themselves symbolically aloof and farther from the group although still being technically part of it. A physical setting more conducive to a circular arrangement is recommended.

4. Yalom (1970:183-192) discusses ways of predicting group behavior but limits his overview of psychological testing to projective tests and the MMPI. After becoming familiar with the group members as individuals, it was amazing how much of their particular personalities and ways of approaching problems, were apparent on their TSCS profiles. It is recommended, if not used as a determiner for inclusion, that this test be administered soon after the beginning of group meetings, as a valuable guide for the therapist in shaping his responses to penetrate mental defences and produce more self-searching among the group members.

LITERATURE CITED

LITERATURE CITED

Berne, Eric. Transactional Analysis in Psychotherapy. New York: Grove Press, Inc., 1961.

_____ What Do You Say After You Say Hello? New York: Grove Press Inc., 1972.

Browning, Robert and Donald Stover. Behavior Modification in Child Treatment. New York: Aldine Atherton, 1971.

Callis, Robert, "Toward an Integrated Theory of Counseling," Behavior Change in Counseling. ed. Samuel Osipow and Bruce Walsh. New York: Appleton-Century-Crofts, 1970.

Durkheim, Emile. Suicide. New York: The Free Press/MacMillan Co., 1951.

Erikson, Erik. Identity, Youth and Crisis. New York: W. W. Norton Co., 1968.

Fitts, William. Tennessee Self Concept Scale Manual. Nashville: Counselor Recordings and Tests, 1965.

_____ Interpersonal Competence: The Wheel Model. Nashville: Dede Wallace Center, 1970.

_____ The Self Concept and Behavior. Nashville: Dede Wallace Center, 1972.

_____ Self Concept and Psychopathology. Nashville: Dede Wallace Center, 1972

Gendlin, Eugene, "A Short Summary and Some Long Predictions," New Directions in Client-Centered Therapy. ed J. T. Hart and T. M. Tomlinson. Boston: Houghton Mifflin Co., 1970.

Gunderson, Robert, "Group Dynamics-Hope or Hoax?" The Planning of Change. ed. Warren Bennis and others. New York: Holt Rinehart and Winston, 1961.

Hamacheck, Don. Encounters With The Self. New York: Holt Rinehart and Winston, 1971.

Jourard, Sidney. Disclosing Man to Himself. Princeton, New Jersey: D. Van Nostrand Co., 1968.

Kadis, Asya and others. A Practicum of Group Psychotherapy. New York: Harper and Row, 1965.

Lidz, Theodore. The Person. New York: Basic Books, Inc., 1968.

Mead, George Herbert. Mind, Self and Society. Chicago: University of Chicago Press, 1934.

Reich, Charles. The Greening of America. New York: Bantam Books/ Random House, Inc., 1970.

Rogers, Carl. On Becoming a Person. Boston: Houghton Mifflin Co., 1961.

Schutz, William. FIRO-A Three Dimensional Theory of Interpersonal Behavior. New York: Holt, Rinehart and Winston, 1960.

Shlien, John, "Phenomenology and Personality," New Directions in Client-Centered Therapy. ed. J. T. Hart and T. M. Tomlinson. Boston: Houghton Mifflin Co., 1970.

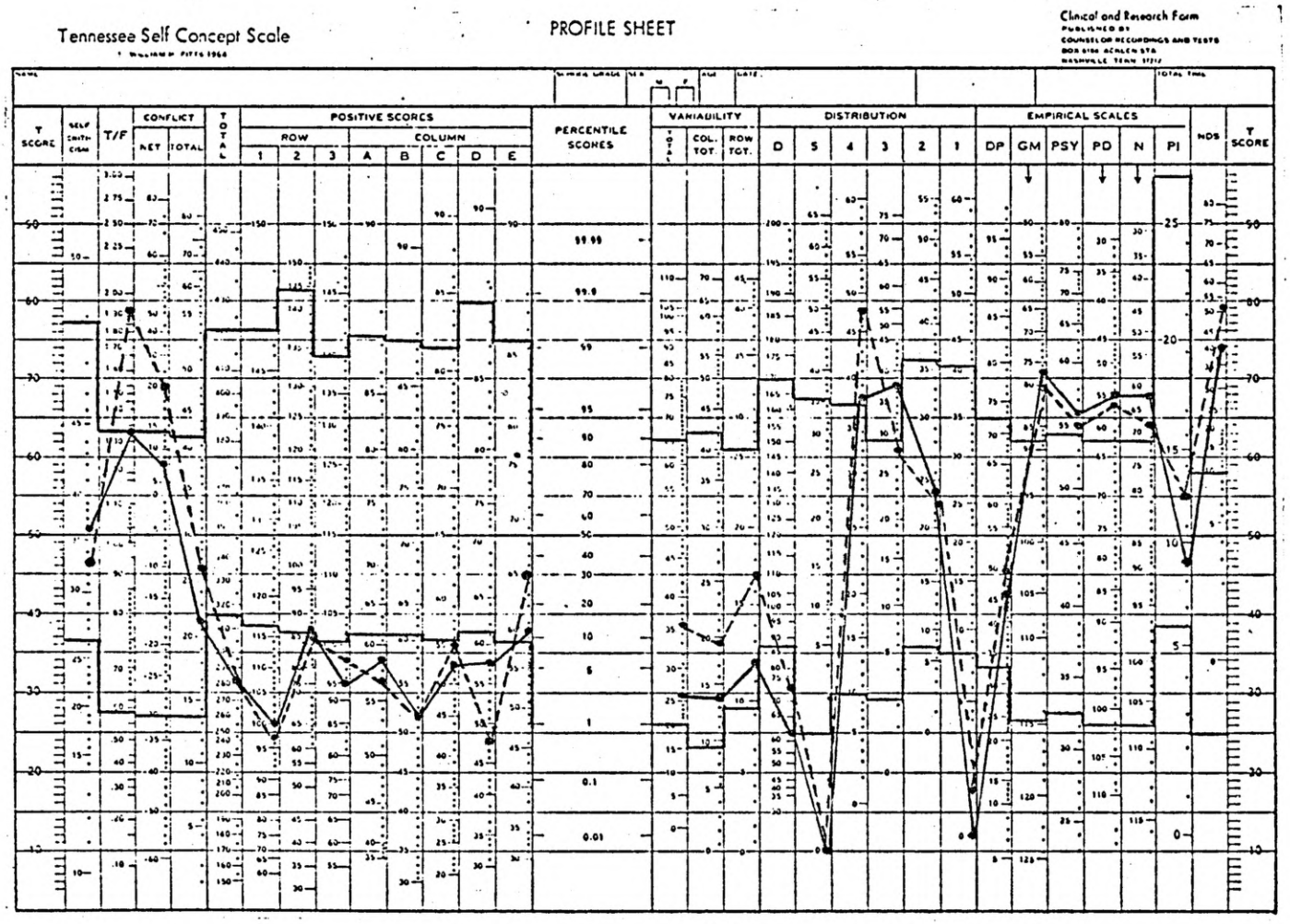
Sullivan, Harry Stack. The Interpersonal Theory of Psychiatry. New York: W. W. Norton Co., 1953.

Szasz, Thomas. The Second Sin. Garden City, New York: Anchor Press/ Doubleday, 1974.

Wolff, Robert and others. A Critique of Pure Tolerance.Boston: Beacon Press, 1965.

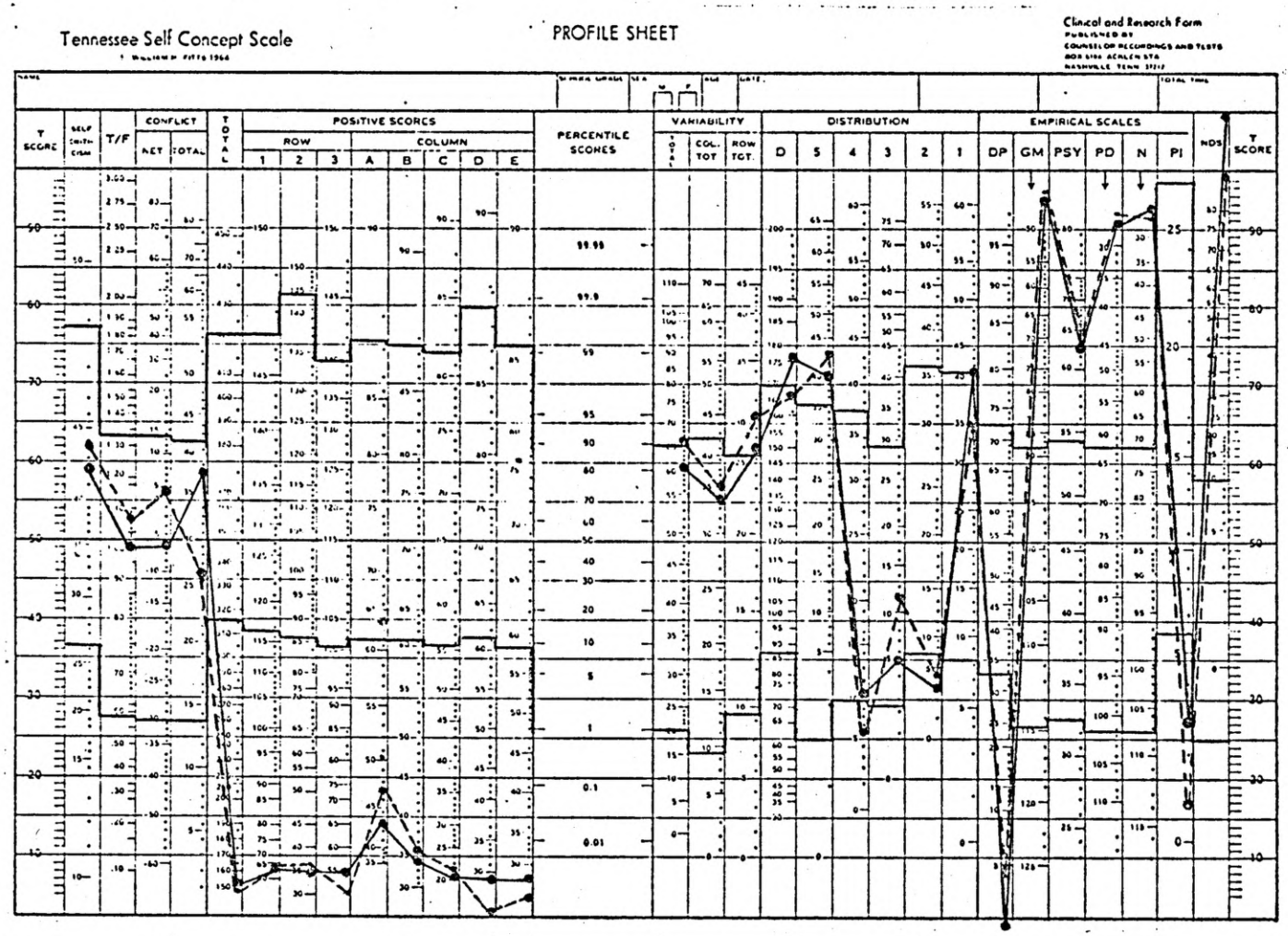
Yalom, Irvin. The Theory and Practice of Group Psychotherapy. New York: Basic Books, Inc. 1970.

APPENDIX



Subject	R
Age	30
Admission Date	2-20-73

Diagnosis	Paranoid Schizophrenia
Pretest	————
Posttest	- - - - - -



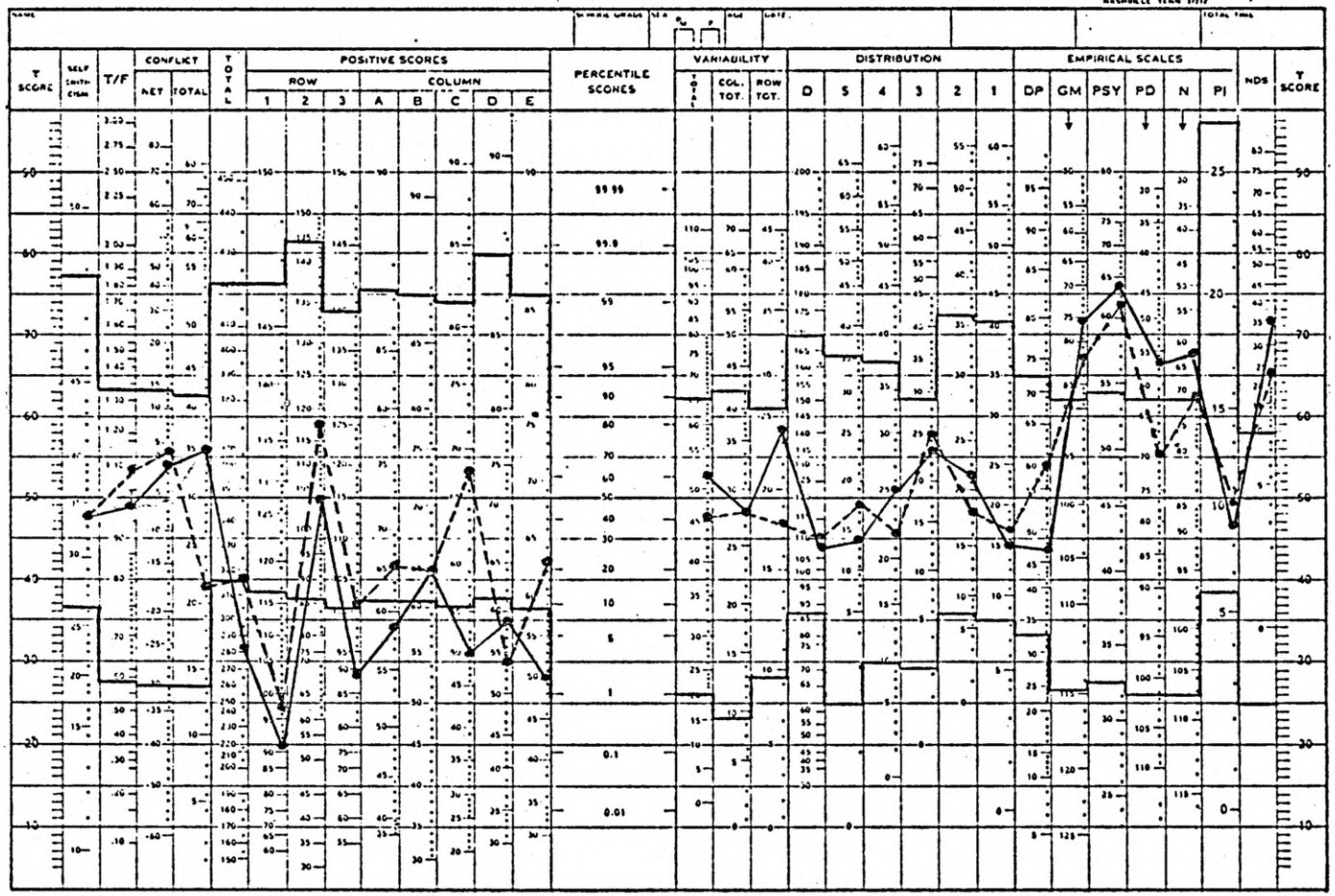
Subject P
Age 23
Admission Date 1-12-72

Diagnosis Paranoid Schizophrenia
Pretest ————
Posttest - - - - - -

Tennessee Self Concept Scale

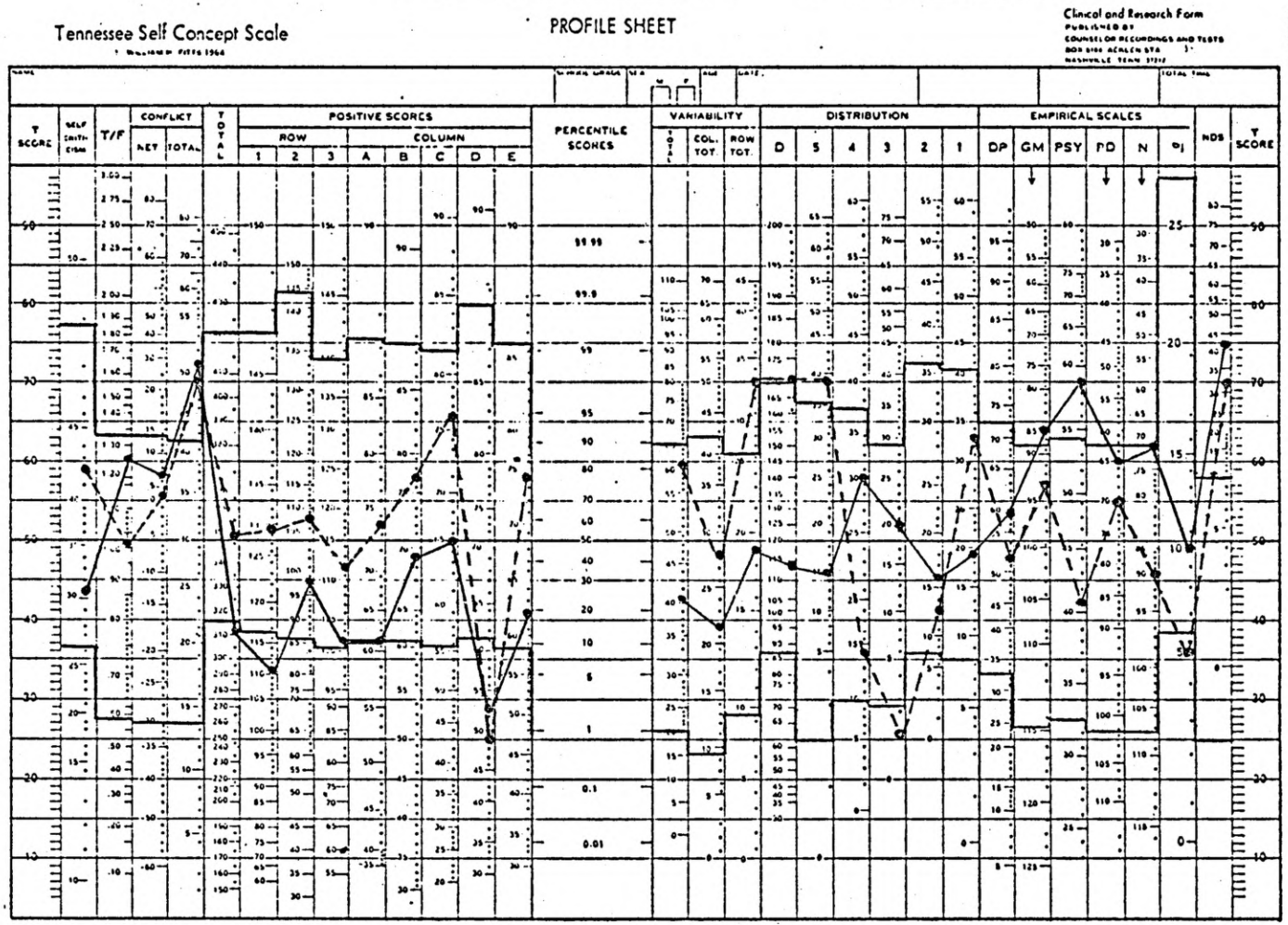
PROFILE SHEET

Clinical and Research Form



Subject B
Age 21
Admission Date 6-1-73

Diagnosis Paranoid Schizophrenia
Pretest ————————
Posttest - - - - - -



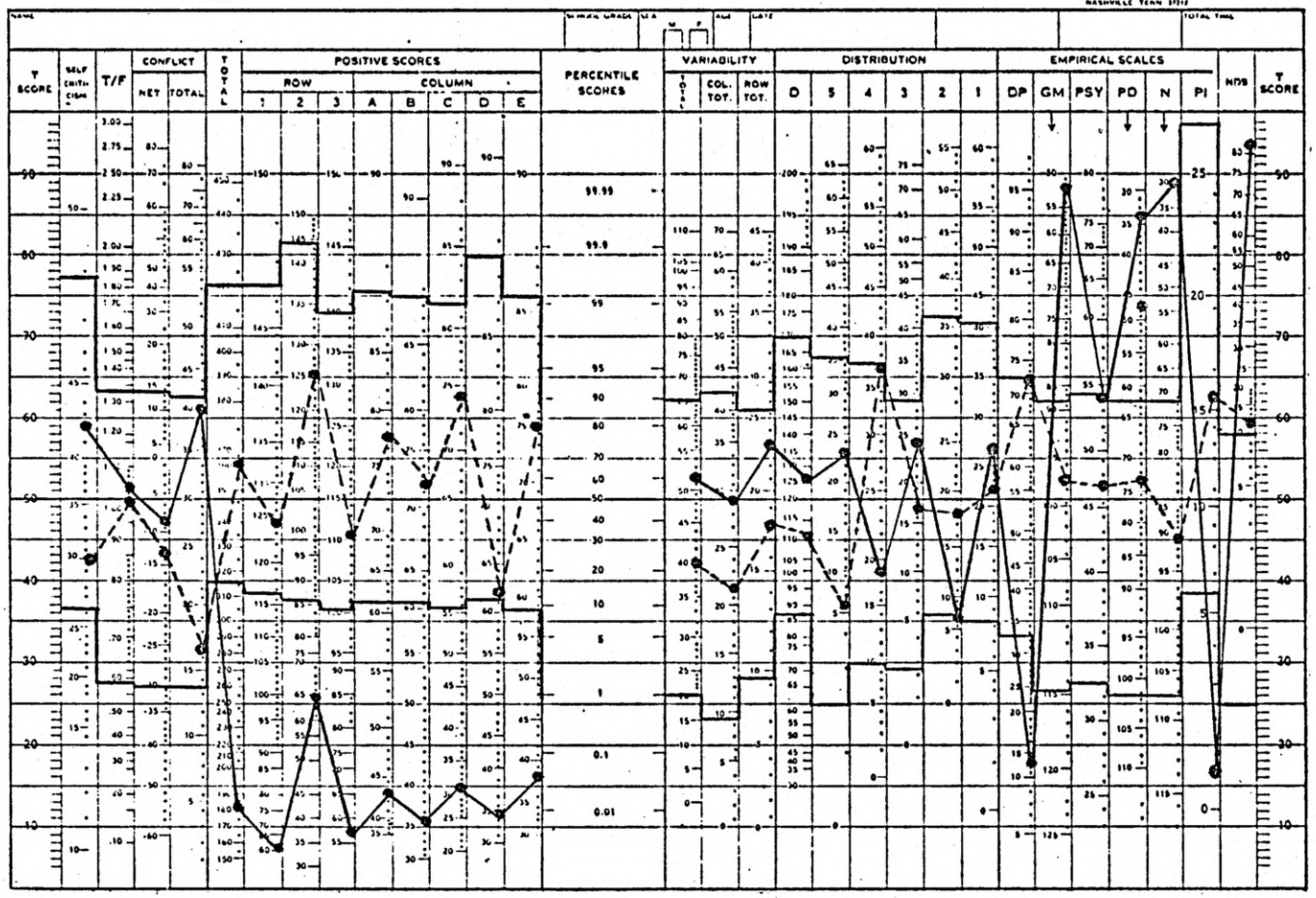
Subject C
Age 20
Admission Date 9-26-72

Diagnosis Schizophrenia
Pretest ————————
Posttest - - - - - -

Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form



Subject	K
Age	28
Admission Date	6-21-72

Diagnosis Paranoid Schizophreniz

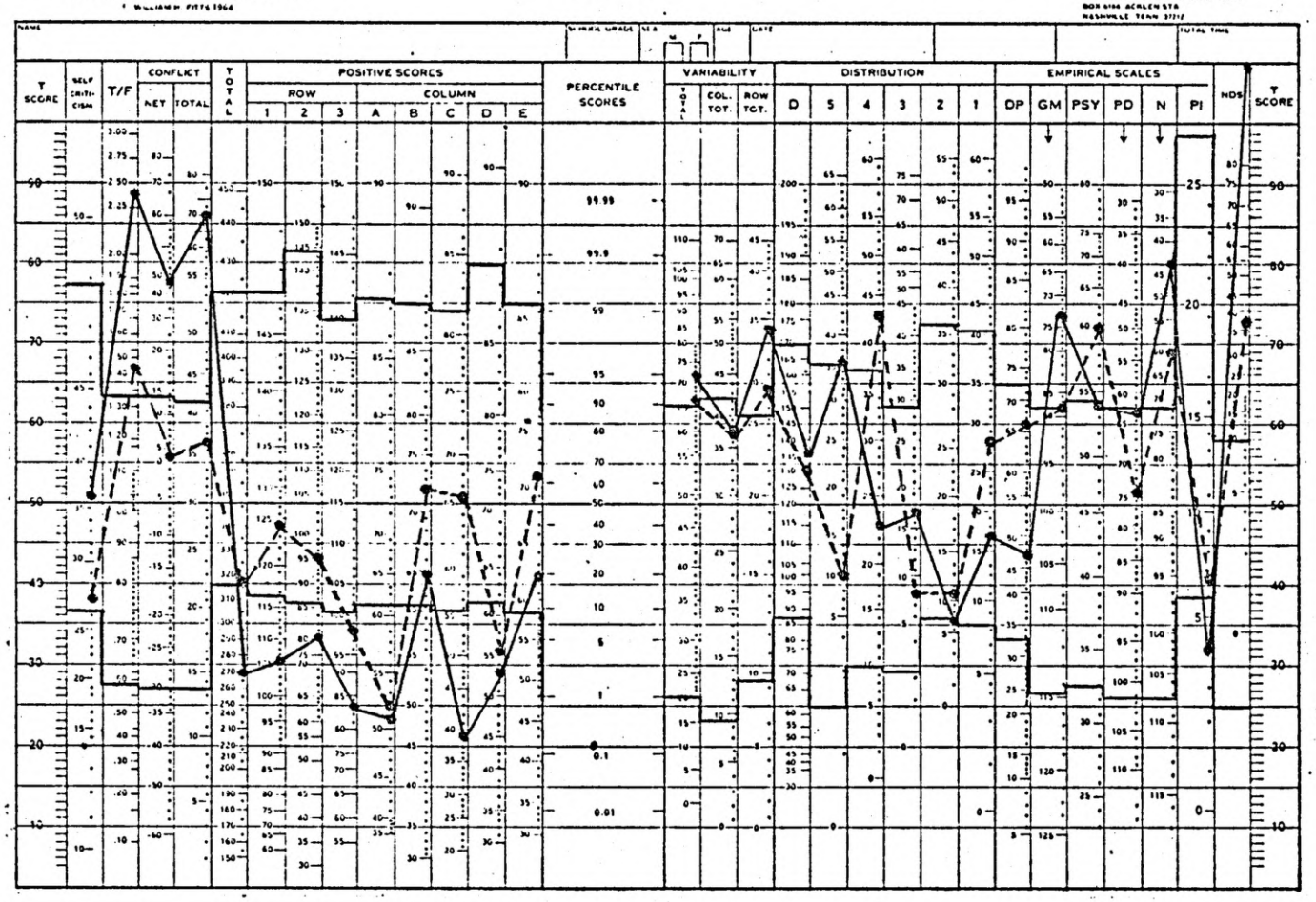
Pretest ————————

Posttest - - - - - -

Tennessee Self Concept Scale

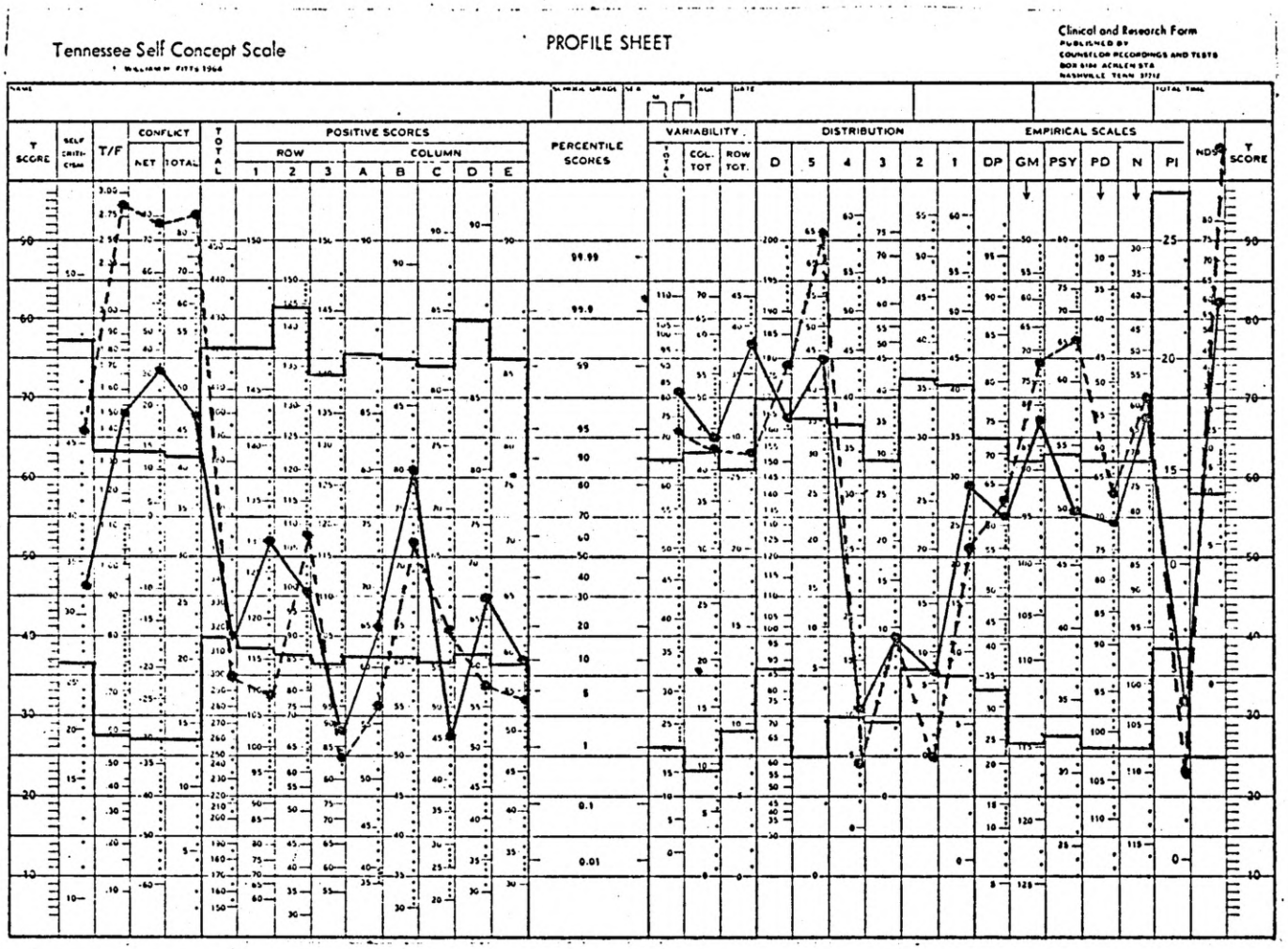
PROFILE SHEET

Clinical and Research Form
PUBLISHED BY
COUNSELOR RECORDINGS AND TESTS
BOX 6184 ACKLEN STA
NASHVILLE TENN 37212



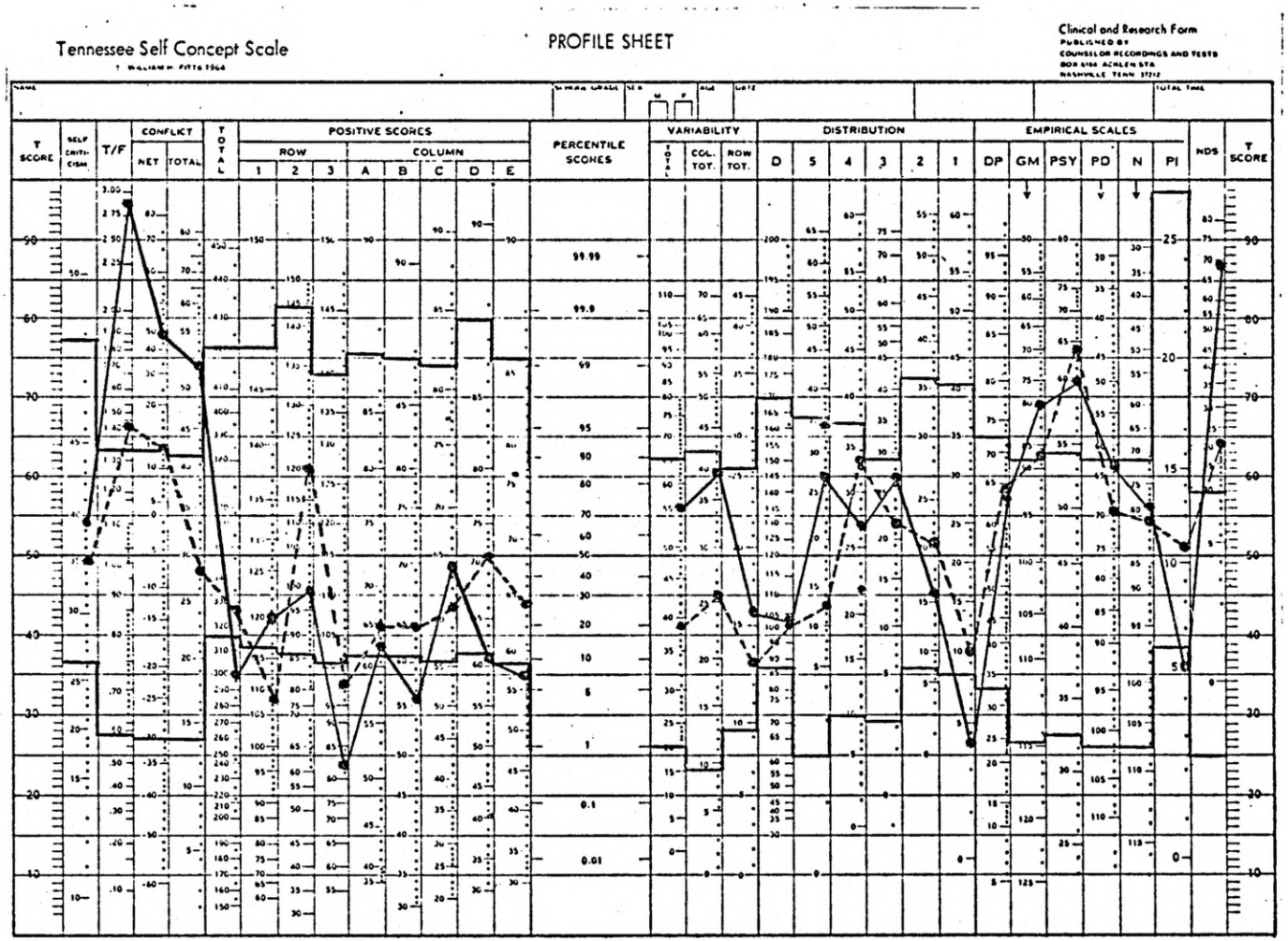
Subject S
Age 38
Admission Date 8-31-73

Diagnosis Mentally Retarded Behavior Problem
Pretest ——————
Posttest - - - - - -



Subject F
Age 36
Admission Date 6-19-70

Diagnosis Schizophrenia
Pretest ——————
Posttest - - - - - -



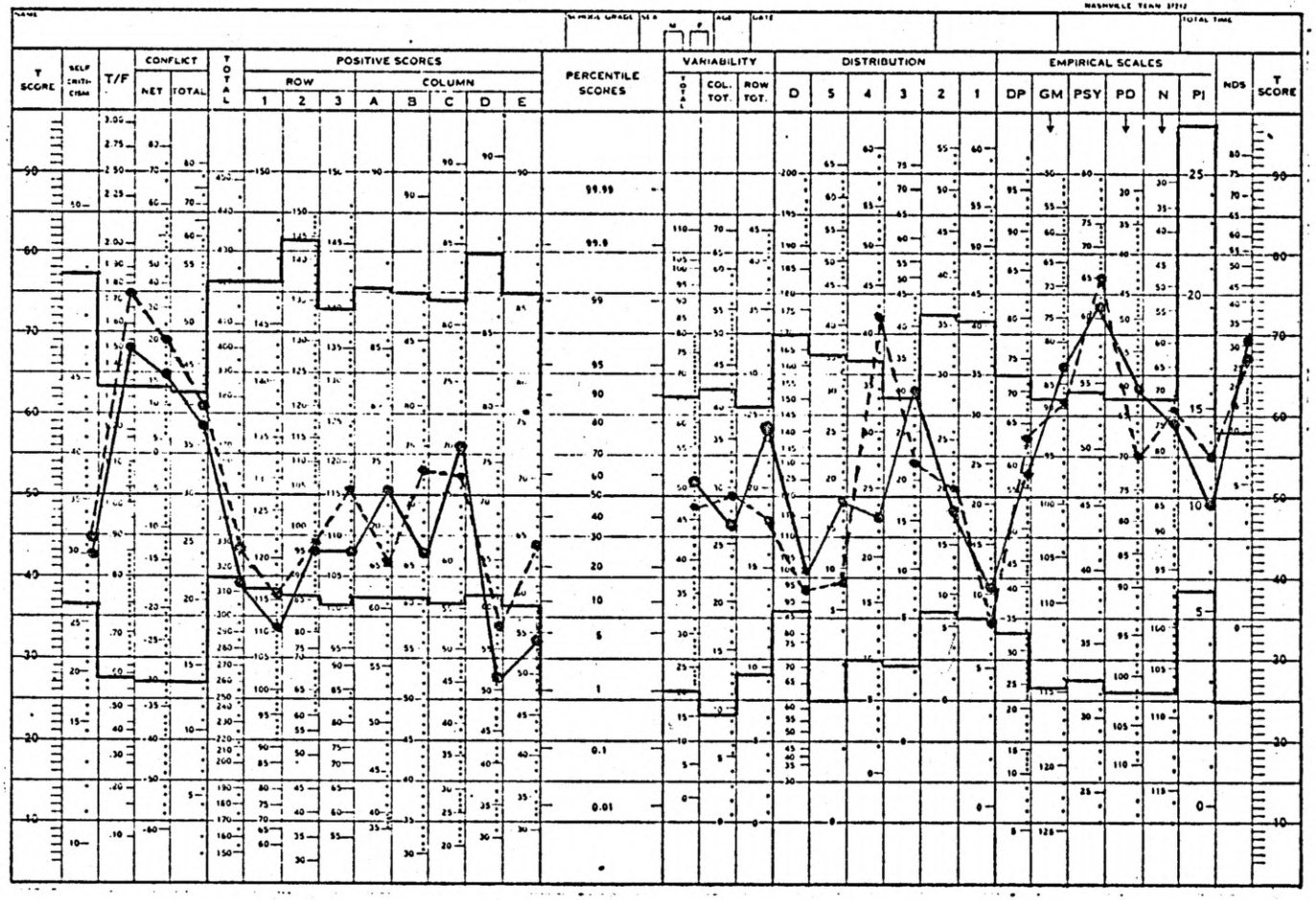
Subject H
Age 35
Admission Date 5-7-73

Diagnosis Schizophrenia
Pretest ——————
Posttest - - - - - -

Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form



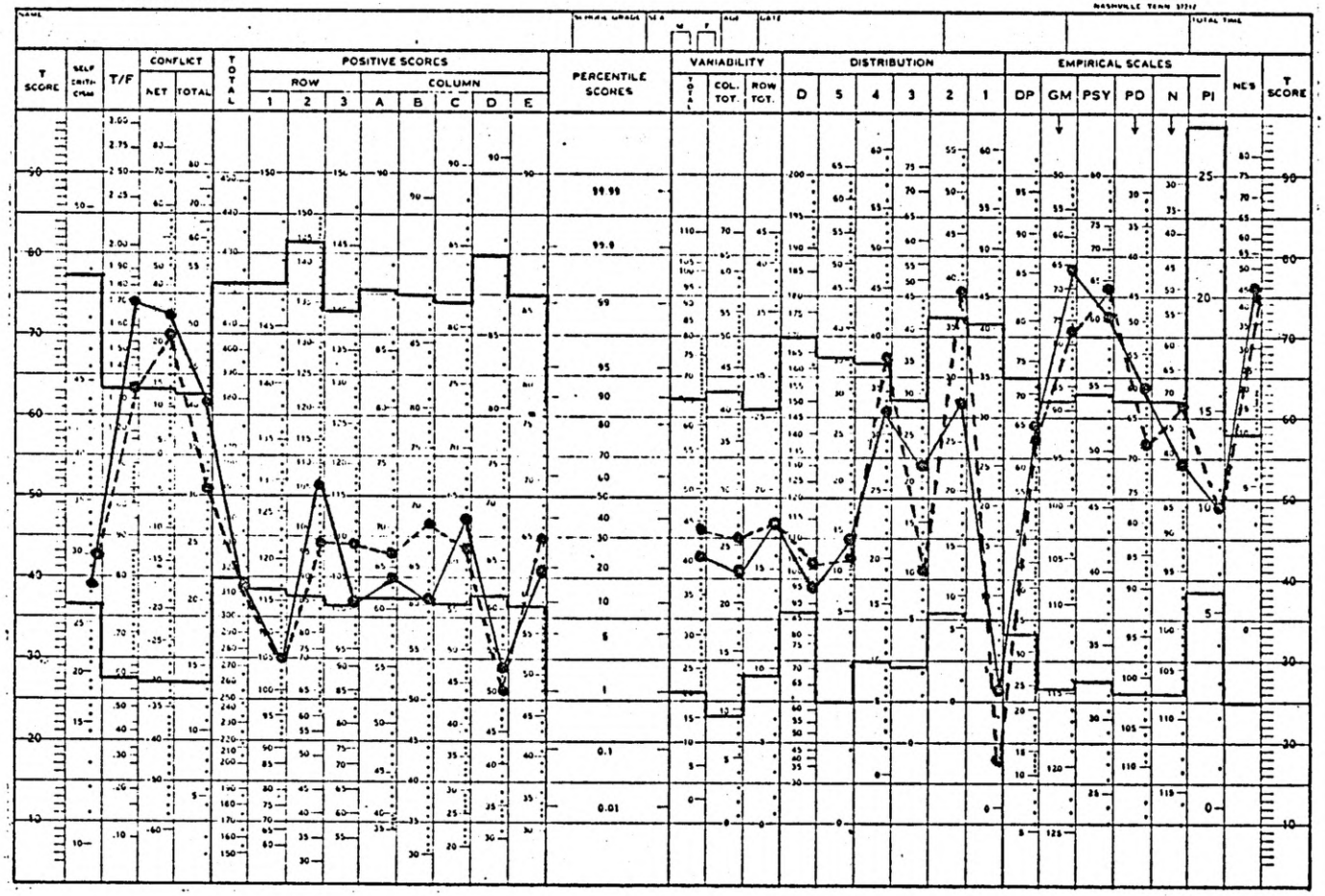
Subject KB
Age 44
Admission Date 9-9-73

Diagnosis Sexually Deviant Behavior
Pretest ——————
Posttest - - - - - -

Tennessee Self Concept Scale

PROFILE SHEET

Clinical and Research Form



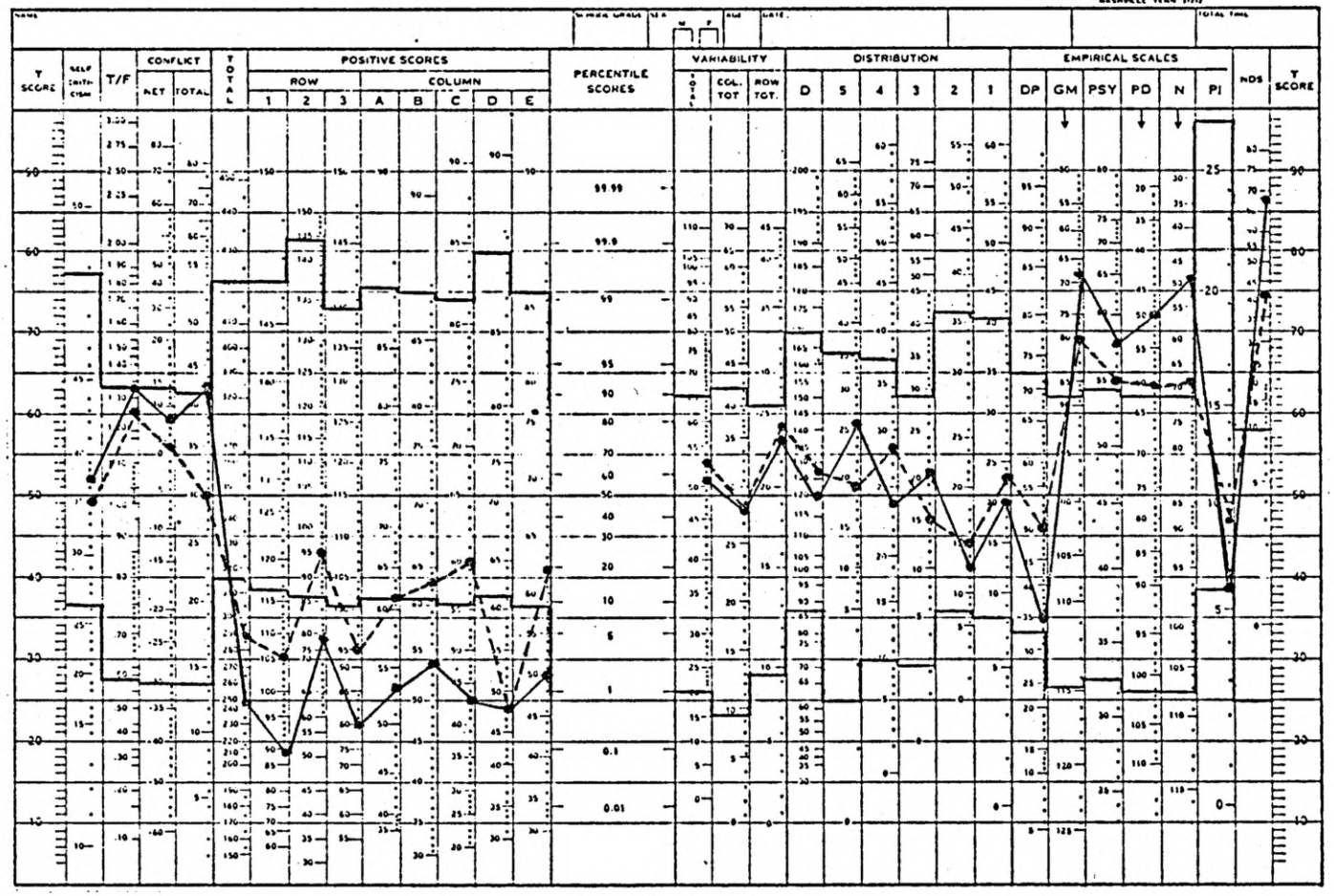
Subject M
Age 52
Admission Date 9-2-65

Diagnosis Mentally Retarded Behavior Problem
Pretest ————
Posttest - - - - - -

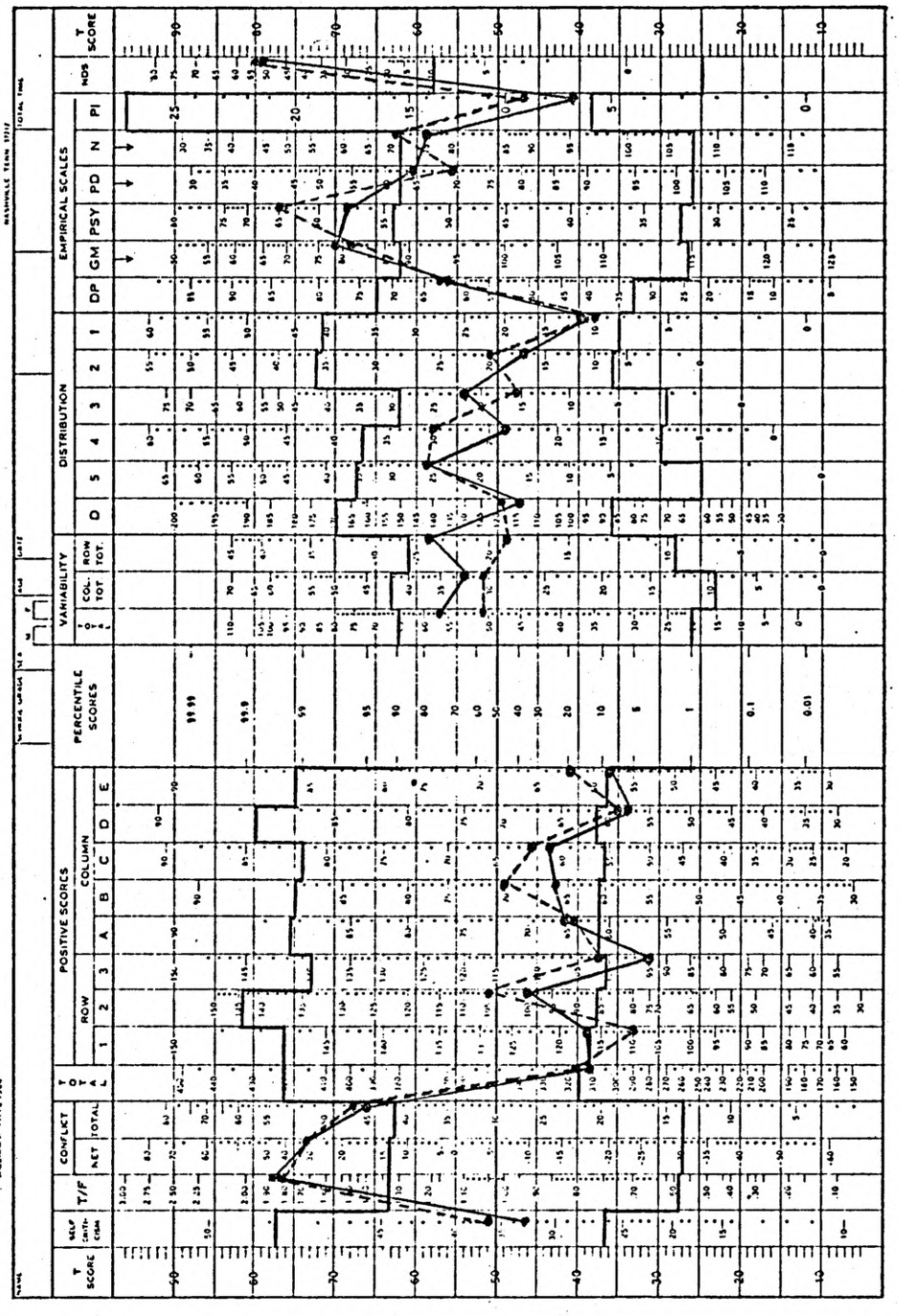
Tennessee Self Concept Scale

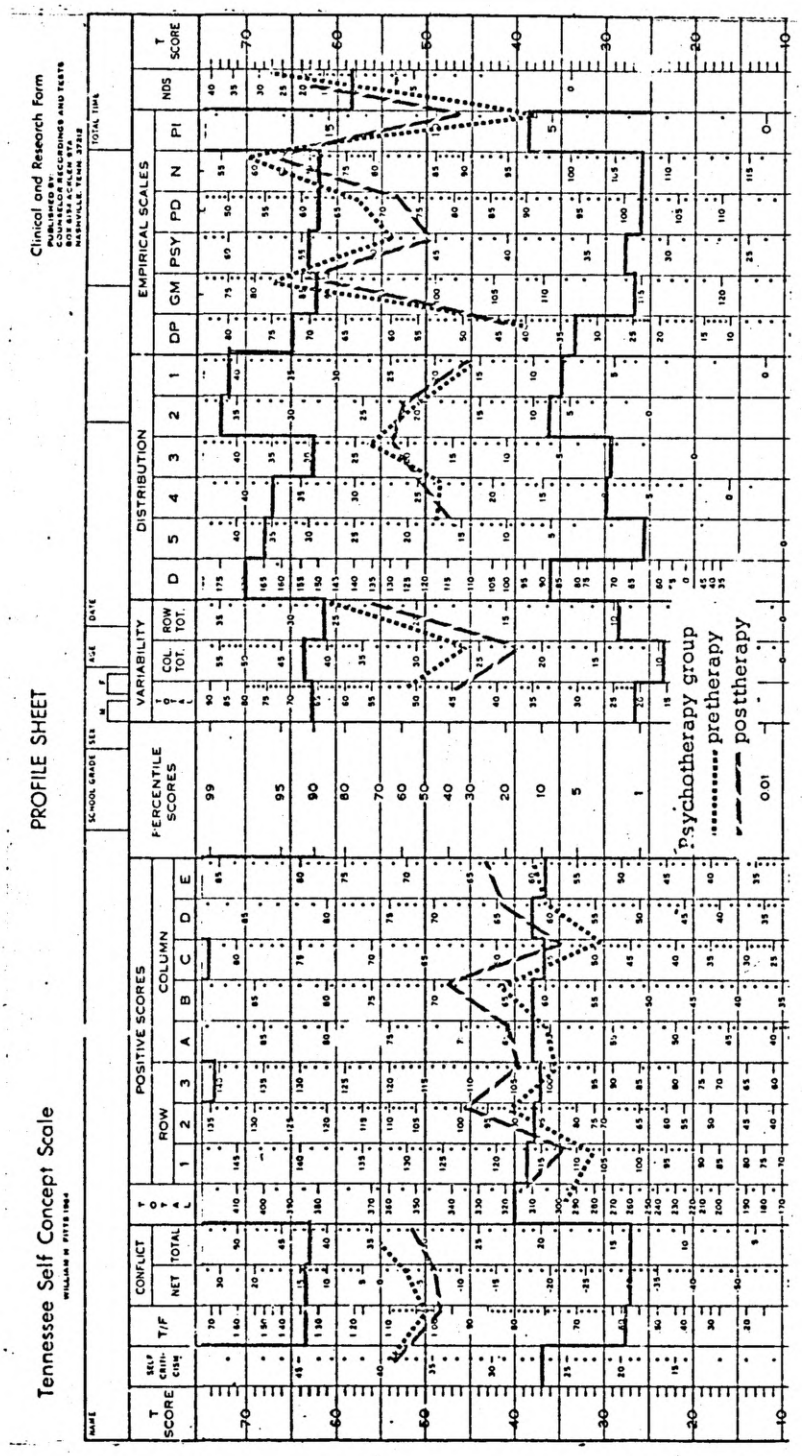
PROFILE SHEET

Clinical and Research Form

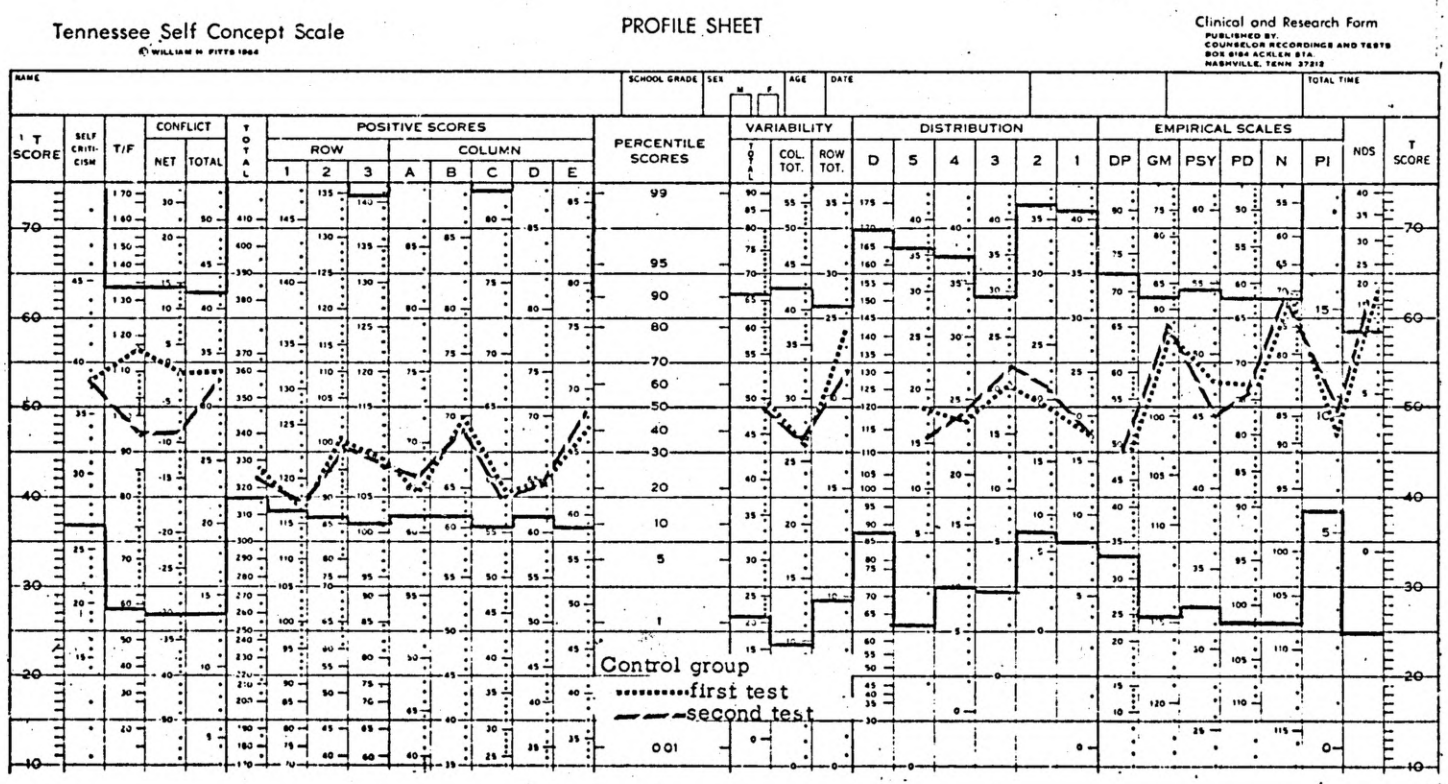


Psychotherapy Group Means Pretest ——— Posttest - - - - - -


Tennessee Self Concept Scale
PROFILE SHEET
Clinical and Research Form
POSITIVE SCORES
ROW
COLUMN
PERCENTILE SCORES
VARIABILITY
DISTRIBUTION
EMPIRICAL SCALES
T SCORE
Control Group Means
Pretest
Posttest



(Fitts, 1965:29)



(Fitts, 1965:29)