Symposium on Preventive and Social Psychiatry (1958)

Pages
545

Size
5 x 9

ISBN
0309339405

National Research Council; Walter Reed Army Institute of Research; Walter Reed Army Medical Center

SYMPOSIUM ON

PREVENTIVE AND SOCIAL PSYCHIATRY

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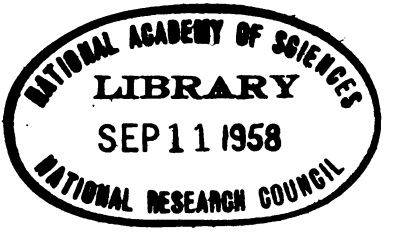

15–17 April 1957
Walter Reed Army Institute of Research
Washington, D. C.

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PREFACE

At intervals a number of symposia have been held at the Walter Reed Army Institute of Research to provide opportunity for multidisciplinary discussions of comprehensive subjects which are important in military medicine. This is the seventh symposium in the series. As in previous symposia, the material presented is primarily directed toward the needs of personnel on duty in the Armed Forces and of faculty members of medical schools in the program of Military Education for National Defense. The importance of preventive and social psychiatry to the military services is attested by the fact that, in recent years, a number of highly significant contributions to this field have come from the efforts of psychiatrists and social scientists in the Armed Forces to improve the psychiatric services provided. In contrast with psychiatric practice in civilian life, both the formal and informal social structure of the Armed Forces emphasize the roles of the group and of social communication in mental health and of social isolation as a combined result and determining agent in mental illness.

The object of the Symposium on Preventive and Social Psychiatry is to bring together data from a number of specialized fields of social science and clinical psychiatry in order to provide a comprehensive survey of the developments during the past few years. Attention in the Symposium is directed to social factors currently operative rather than to those of historical significance in the lives of patients. This arbitrary selection of subject matter has been made in the hope of stimulating operational research on modifications of the external (social) milieu to influence favorably the mental health of members of organized groups. Such groups include university faculties, industrial corporations, military units, and so forth. The problem of differentiating factors which are modifiable primarily by changes in organizational structure from those requiring personal treatment-training is of particular interest.

The Symposium is arranged in six sessions, each session dealing with human group problems from overlapping but different points of view. In the first two sessions of the Symposium the basic science aspects of social psychiatry are considered. These

aspects may be thought of as analogous to the preclinical sciences in the medical curriculum, in particular to functional anatomy and pathophysiology. Experimental and descriptive research on interpersonal phenomena in human groups and on group structure—with consideration of communication, influence, values and subgroup differentiation—is briefly reviewed in the first session. In the second session recent studies on the ecology and epidemiology of mental illness are discussed. In the third session the general subject of ecology of mental illness is continued but with particular reference to industrial and bureaucratic organizations. Current trends in industrial psychology and psychiatry, with emphasis on human responses to organizational and technical developments, are considered. In the fourth session attention is directed to the wide variety of phenomena ordinarily included in the concept of "leadership" and data from a variety of situations are discussed in the light of the leader-follower relationship. The last two sessions of the Symposium are devoted to organizational, therapeutic and other clinical developments of social psychiatry in recent years. The fifth session, thus, is concerned with what may be called the decentralization of psychiatric treatment and the relationship of psychiatric services to the community as a whole. In the final session the principles of milieu therapy and their practical application in various institutions are presented.

It is of both theoretical and practical interest that the discussions of the data provided in this Symposium indicate the emergence of a consistent theoretical orientation which, in a number of respects, differs from classical psychiatric theory. Whereas the early developments of modern psychiatry were concerned with the personal history and early life experiences of patients, the emerging theories lay emphasis upon current social roles and social environmental contingencies. It is clear, however, from the discussions presented here that the newer trends are not revolutionary. They are rather to be regarded as evolutionary, being founded on the broad base of data derived from individual studies of persons.

Washington, D. C.
January 1958

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COMMUNICATION AND INFORMATION AS LIMITING FACTORS IN GROUP FORMATION

GEORGE A. MILLER, PH.D.

During the past decade there has been remarkable development of those areas in social psychology and sociology that are concerned with the structure and function of small groups of people.* One consequence of this development has been an increased interest in the processes of interpersonal communication, because the occurrence of communication between members is one of the defining characteristics that distinguishes a social group from a chance collection of bodies assembled by geographical coincidence. I intend to begin my remarks with a few samples of research on the communicative behavior of small groups and then go on to consider, against this social background, one of the psychological factors which seems to me to have an important influence on the way an individual can conduct himself in a group enterprise.

The Amount of Participation

As a starting point I will take the practically universal observation that whenever several people get together as a group, some of them talk a lot more than others. One of the earliest attempts to study this fact in a quantitative manner was Chapple's [1] development of the interaction chronograph, a device which enables him to record the temporal pattern of communication between two participants in a conversation; when both are silent, when one talks, or when both talk at once. Chapple observed that two strangers are usually very polite. Neither interrupts the other, but both wait for the other to finish whatever he is saying before they start to talk. As the two people get to know each other, however, the rate of interaction increases and interruptions become

* Two convenient anthologies of papers in this area have been published, one by Cartwright and Zander, *Group Dynamics, Research and Theory,* Row, Peterson, Evanston, Ill., 1953; and another by Hare, Borgatta, and Bales, *Small Groups, Studies in Social Interaction,* Knopf, New York, 1955. The 96 articles and essays in these two books provide an excellent sample of current research on small groups.

more frequent. The fraction of the total time that each member spends talking usually settles down to a relatively constant value after 2 or 3 hours of talking; the two people approach a stable equilibrium in their conversational pattern. When the same person is paired with several different partners, it appears that each individual has his own personal constant that locates him along a scale from loquacious to taciturn, even though his behavior in any given situation will be modified by the personal constant of his particular partner in that situation.

A much more elaborate method of describing group interaction was developed later by Bales,[2] who extended the technic to groups larger than two and who developed a comprehensive system for categorizing the various types of interaction that occur in the group. With this refined technic of observation it was again confirmed that some people talk a lot more than others.[3] An interesting feature of these results, however, was that the relative amount of participation by the different members looked very similar from one group to another, regardless of who the individuals were in the particular groups. That is to say, if you count the number of times each individual participates in the group activity and then rank the members in order from the one who participates most down to the one who participates least, it seems that a simple mathematical equation will serve to describe the amount by which participation decreases as the rank increases.[4] In fact, if new groups are constructed in such a way as to bring together several active participators or several reluctant participators, these specially fabricated groups also tend to show similar distributions of participation. Perhaps it is obvious that when a group of talkative people get together someone must "shut up," because there simply isn't time for everyone to say all he would like. But it is less obvious why some quiet individual suddenly begins to participate actively when he is thrown together with other reluctant talkers.

The "Who-to-Whom" Matrix

The discovery of an empirical regularity is an invitation, of course, to look more closely at what is going on. And as soon as we look more closely at these data, we are struck by the fact that it is very easy to distinguish two kinds of communicative acts: (1) those addressed to the group as a whole, and (2) those directed to some particular member of the group. For example, it was found that about 57 percent of the remarks made in six-man discussion groups were directed at specific members of the group.[3]

It is a simple matter, therefore, to keep a record of who talks to whom in a small group. Thus we can ask who it is in the group who receives the most messages. When such data are compiled and the members of the group are ranked in order from the one who receives the most down to the one who receives the fewest messages, it is nearly always true that this ordering corresponds perfectly with the ordering in terms of who generated the most messages. The person who talks the most is most often talked to. In fact, the entire "who-to-whom" matrix can be predicted from two sets of numbers, one set representing the initiating strength of each member and the other set representing his receiving strength.[5] (In the language of mathematics, the "who-to-whom" matrix is simply the product of a row matrix and a column matrix.) The point is that the set of numbers which describe each individual's initiating strength is very similar to the set of numbers describing each individual's receiving strength.

The number of messages directed at the group as a whole also shows the same pattern. The person who most often gives and receives directed messages is also the person who most often makes undirected comments to the whole group. In a typical group, therefore, all the measures of participation give us the same picture of who is active and who is passive.

Thus we come back again to the notion that each individual has his own personal constant which determines the extent to which he will interact with other members of the group. In any particular group, however, an individual's rate of interaction will depend upon the personal constants of the other members. If the others are very active, they will tend to depress the individual's contribution, or if the others are characteristically quiet, they will permit the individual to increase his contribution. Thus it seems that a competitive situation exists in most discussion groups. Each member would like to say more than he does, but he is held in check by respect for the participation of the others. Borgatta and Bales[6] have summarized this situation by saying that, in the absence of resistance, the individual tends to his maximum rate of participation. Thus what we see the individual do in any particular group situation is a reflection of his personal maximum rate, more or less depressed by the activity of the other participants.

It is interesting to speculate what a group would be like which did not show this pattern of interaction. Suppose, for example, that there was a person who made many contributions to the discussion, but who was never addressed directly by any of the

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other members. Or suppose that some person makes many general remarks to the whole group, but never addresses a remark to any particular individual. When I try to imagine small groups like this I get the feeling that there would have to be something unusual about a person who deviated from this natural pattern. He might be a social outcast who is receiving the "silent treatment" from his fellows, or he might be in a position of authority so that individuals address remarks to him and he makes his replies to the entire group, etc. In such cases we feel that there is something unique or special about this group or this individual. In other words, these data on the typical pattern of participation in small groups provide a kind of norm against which particular groups can be compared. Only by knowing what is customary can we discover what is remarkable.

The Structure of the Group

The discussion groups that were used in the studies I have been considering were quite informal and consisted of relatively transient meetings among people of relatively equal status. Even under these unstructured conditions, however, some kind of structure quickly emerges. One person takes the lead in the discussion, presumably because he is especially active or especially competent, and this puts its special mark on the group's behavior. But many other factors influence the way such informal groups behave. For example, the seating arrangement has some noticeable effects. Ordinarily, an informal discussion group will arrange their chairs in a crude circle, unless they are prevented from doing so, because the participants like to see the person they are talking to. Even so, there is a tendency for people who face each other across the circle to interact more frequently than do the people who sit side by side.[7] A little attention to the seating arrangement can have significant effects on the kind of discussion that results. No doubt other factors, ranging all the way from the temperature and noise level in the room up to very subtle aspects of the members' personalities, could be isolated and studied for their effect on the group's discussions.

In many groups, however, definite constraints are placed upon the kind and amount of interaction that can occur between the members. Sometimes these constraints are adopted in order to make the group more efficient, sometimes they reflect the different abilities and interests of the members, sometimes they are imposed by geography. Whenever a group persists over any extended period of time it is likely to develop such a system of constraints.

This is more apt to happen in America, of course, where we dearly love to organize and reorganize ourselves, but it happens in other cultures, too. Whenever such a system of constraints and responsibilities is imposed on the members of a group, it is convenient to say that the group has a structure.

Actually, a single group may have several structures simultaneously. Thus we speak of the communication structure, the power structure, the sociometric structure, or the locomotion structure of a group.[8] The "who-to-whom" matrix is one way of looking at the communication structure of a group. When groups become formally organized, the communication network connecting the various members may become much more explicit and limited than it is in a discussion group. The power structure of a group is determined by who can give orders to whom. In informal groups a certain limited amount of power may be invested spontaneously in someone who acts as a leader. In other cases—military or business organizations, for example—the power structure may be explicitly indicated by written documents specifying the positions to be filled in the structure. The sociometric structure of a group depends upon the pattern of personal likes and dislikes among the members. It was Moreno [9] who pioneered in the study of personal choices among the members of different groups, and his technics have been widely applied in much recent research. The locomotion structure is concerned with the possibilities of movement by an individual from one position to another in an organization. The locomotion structure is a matter of considerable interest in planning the careers of young men who enter an organization for which they may work for the rest of their lives.

A comprehensive analysis of small-group behavior would have to consider all these structural aspects and the relations among them. My aim is less ambitious; I shall confine my remarks entirely to the communication structure. You should keep in mind, however, that what I say about the communication structure will require modification or amplification in the light of the other structural aspects of the group.

The Communication Structure

As I have said, there is a primitive communication structure even in face-to-face discussions among peers; remarks are aimed at particular people and not all of the face-to-face channels are used equally often. When we consider larger groups—a business firm, a hospital, a college faculty—we find even stronger preferences for some channels and neglect of others. It is usually a

tedious and expensive job to collect data on the amount of communication between members of such large organizations, but a rough picture can be obtained rather quickly by a simple trick. Ask each member of the organization to list all the telephone extension numbers of other members that he can think of.[10] From these lists it is possible to construct a graph that approximates the communication structure, with arrows between numbers to indicate what channels are frequently used.

There is an important difference between the situation in which a direct channel exists between two members but is never used and the situation in which no direct channel exists. Many years ago Simmel [11] pointed out that the feeling of isolation is rarely as intense when you are physically alone and no channels of communication exist as it is when you are able to interact, when channels are available, but the group ignores you. The person who is all alone by his telephone seems far more pathetic than the person who is all alone on a camping trip.

This important psychological effect needs to be kept in mind when we shift our attention to groups in which direct communication is impossible between some of the members. Such groups can occur in military organizations, or where different members do not all speak a common language, but they are relatively infrequent in the ordinary affairs of the ordinary citizen. In spite of their rather special nature, however, these groups with limited channels between members offer many advantages to an experimenter who wants to explore the effects of different communication structures on group behavior. By giving or withholding certain channels between the members, an experimenter is able to create whatever communication structure he likes. If the group is then given some simple task to perform by using this arbitrary network of channels, he can watch the group adapt to these strange conditions and possibly discover what kinds of networks promote efficient and satisfying cooperation.

A large number of these experiments with restricted nets have been conducted. Rather than to try to survey them all in the brief time available, I think you would get a clearer picture of this kind of research if I describe one example in some detail. The one I have selected was conducted by Leavitt,[12] and was inspired by the work of Bavelas.[13]

In Leavitt's experiment, five men were seated around a table, but separated from one another by vertical partitions. There were slots in the partitions through which written notes could be passed. By varying the slots that were open, the channels among the five

could be manipulated into any desired communication structure. Four structures were tested: (1) In the *circle* each person could pass notes to the person on his right or left; (2) the *chain* was identical to the circle except that one link in the circle was broken by closing a slot, so the men on either side of this closed slot found themselves at the two ends of the chain; (3) the *fork* was a four-man chain, and the fifth man could exchange notes with one of the two inner members of this chain; and (4) the *wheel* put one member at the center of the structure in such a way that he could exchange notes with all the other four members, but they could not communicate with each other except through the central member.

Each man was given five different symbols out of a possible set of six symbols. Their task was for the entire group to discover as rapidly as possible the one symbol held in common by all five members. Records were kept of speed, errors, and number of messages. At the end of the experimental session the subjects were given a questionnaire to answer before they talked to one another.

Each of the structures settled into its own pattern of interaction. In the wheel, for example, the peripheral men always sent their information to the central man, who discovered the answer and sent it back to each peripheral position. The circle, on the other hand, showed no consistent method of operation. Members of the circle simply sent messages repeatedly until they received the answer or could work it out for themselves.

The different structures all took about the same amount of time to solve the problems, but they did differ significantly in the number of errors they made. The circle made the greatest number of errors. The fork and the wheel made the fewest.

From the questions asked at the end of the test session it was found that the men who occupied the most central positions in the structure enjoyed the work and were recognized as "leaders" by the others, whereas the men in the peripheral positions had the lowest morale.

If we contrast the circle with the wheel, we find that the circle was unorganized, unstable, passed the greatest number of messages, made the most mistakes, and was leaderless but satisfying to its members, whereas the wheel was well organized, stable, sent few messages and made few mistakes, had a recognized leader, but left four of its five members quite dissatisfied with their jobs.

This experiment, and the numerous others that followed its general design, is an interesting demonstration and serves to

stimulate our thinking about the communication structure of different groups. In my opinion, however, these studies have not fulfilled the promise they seemed to hold when they first appeared back about 1950. I will not try to defend this negative opinion of mine, except to say that premature formalization can sometimes blind us to important features of a problem which do not happen to be represented in our formal abstraction. Too much of the baby disappears with the bath water.

The Size of the Group

So far, I have carefully ignored a very important dimension of social groups that has been lurking in the background, but now it is time to consider the importance of the size of the group.

The major effect of size upon the communicative behavior of a group is purely mechanical. As the number of members increases, the number of interpersonal relations that must be maintained also increases, but the amount of time available to each individual for maintaining these relations is correspondingly less. Bales [2] reports that in his studies of discussion groups the optimal size appears to be five. In two-member groups the problem of a deadlock is rather threatening, because there is no way to resolve the deadlock except to end the discussion. With three members the problem of coalitions arises; any two members can agree to exclude the third, who is then left with no support for his position in the group. Two against one is usually an overwhelming majority. A group of four members faces the deadlock problem again, but now each person has a partner available as a source of support and gratification. With five members a strict deadlock is not possible, yet being in the minority does not isolate an individual from the rest of the group. Furthermore, with five members it is possible for each member to shift roles easily and to withdraw from an awkward position. Above the size of five, however, mechanical limitations of time and complexity begin to take their toll; members find their participation is restricted and they complain that the group is too large.

The greater variety of opinion that is available to a large discussion group is often a temptation to increase the size of a group, but it has its price in the greater difficulty of reaching consensus. The development of a leader, or *ad hoc* chairman, or moderator—call him what you like—is one solution to the problem of increasing size. When the group gets larger than about 30, the members

become more and more willing to accept direction from a leader,[14] but the larger group demands more skill from its leader.[15]

Task-oriented groups run into the old phenomenon of decreasing returns as the size of the group is increased. For example, Taylor and Faust [16] compared single individuals with groups of two and four in playing the game of 20 questions. The groups are faster, need fewer questions, and succeed more often than do the individuals. But if the data are analyzed from the point of view of the result obtained per man-hour invested, the groups appear far less efficient. In general, therefore, increasing size leads to increasing problems of organization, a situation that has led one author [17] to propose a "Principle of Least Group Size:" A group should be no larger than is necessary in order to have represented all the skills necessary for its task.

The Span of Control

In a large, heirarchical organization there is usually a question about how large a subgroup one man can directly supervise. If an effort is made to keep each supervisor's subgroup as small as possible, the result will be an extremely long chain of command between the top and bottom levels of the heirarchy. On the other hand, if the supervisor's subgroup is too large, he runs into all the problems of group efficiency and morale that we have just discussed for large groups, plus the fact that his own ability to keep all his different assistants and their jobs in mind simultaneously is quite limited. In the Army, for example, these problems become quite complex. Problems of administration and logistics can usually be simplified by adding more units to each officer's command, but problems of communication and leadership get more complicated.

An important element in finding the optimal organization chart is the individual's limited span of attention, or, as it is usually called in this context, his "span of control." Even in small discussion groups the experimenters report that it is difficult to notice and record all that is going on when there are more than five or six members, and there is every reason to suppose that the members are having similar difficulties. The mental bookkeeping involved in remembering who knows what, who holds which opinion, who has which special skills, etc., becomes increasingly complicated as the group grows larger.

The question of the limits on our ability to process information is not a uniquely social problem, of course, and many psychologists have studied it. I would like to take a few minutes to survey some

of the results, because I think their relevance to the problems of group formation is direct and obvious.

A variety of different limits on our ability to absorb and remember information can be distinguished. One of these is the so-called "span of attention." In a typical experiment,[18] a haphazard pattern of dots is exposed very briefly—long enough for the observer to take a single glance at them—and the problem is to report how many dots there were. It is found that up to about five or six dots it is possible to apprehend directly, without counting, how many dots there are, but with more than six dots the errors become more frequent.

Another example is the "span of absolute recognition," where the observer's task is to recognize which value of a simple, unidimensional stimulus—which level of brightness of a spot of light, which pitch of a pure tone, etc.—is being presented. Up to about five or six values along the stimulus dimension, the subject performs quite accurately, but when he tries to recognize which one of eight or ten values he sees, he begins to make errors. This result is comparable to the old rule-of-thumb that says a seven-point rating scale requires about as fine discrimination as a rater can make.

Still another limit is the "span of immediate memory," which is probably familiar to you from its wide use on intelligence tests. A random series of digits is read aloud and the subject attempts to repeat what he has heard. The longest string that an average adult can repeat without error is about seven digits. It is interesting that all these measures yield spans in the neighborhood of six or seven; at present it is not clear whether this is due to some common, underlying limit, or whether it is pure coincidence. Nevertheless, we are left with the generalization that the average man can handle no more than about seven pieces of information at a time.

Such a cognitive bottleneck would be intolerable if there was nothing we could do about it, but in each case we have developed certain special tricks for using our limited span more efficiently. The simplest place to demonstrate what I mean is for the "span of immediate memory." [19] Suppose I test your memory span by using strings of decimal digits and find that it is 8. Then I test you again using strings of binary digits—zero and one—and find that it is 9, which would make you about as good as the average college student. Having done this, I now teach you a simple trick

for remembering binary digits: Group them into successive triplets and then give each triplet a decimal name, as follows:

000 = 0	100 = 4
001 = 1	101 = 5
010 = 2	110 = 6
011 = 3	111 = 7

Now remember the new symbol, and then translate back again into binary digits when I ask you to recall. This trick reduces three binary digits to one decimal digit; you can remember 8 decimal digits, which is the equivalent of 24 binary digits. With this simple trick, therefore, you are able to almost triple your memory span for binary digits.

At first glance this example looks like another simple mnemonic trick devised along familiar lines. But I think it is worth analyzing as an example of something we do all the time, more or less accurately, in our attempts to deal with large amounts of information. The first step is to group the digit into triplets. Certainly grouping is a ubiquitous mental operation, as the Gestalt psychologists demonstrated many years ago. The second step is to give each triplet a name. And naming things is another pervasive activity of the adult, human mind. The point of the example, therefore, is that it illustrates one way these common mental operations of grouping and naming can serve to increase our cognitive efficiency. We have many such devices for dealing with large amounts of information [20] and I would enjoy telling you about some of them, but time is pressing and this one example will have to serve to carry my point: As soon as the number of items of information that we must process grows too large, we resort to various ways for reorganizing and abstracting the information so that we fit it into our limited mental span.

With this psychological principle in mind, let us turn our attention back again to the problem of group formation. A number of relations appear suggestive. We note that the optimal size of a face-to-face group seems to be very close to the size of the various cognitive spans we have just discussed. This suggests that the natural way to organize the events that are taking place in a group is in terms of the individuals who are participating. When the number of people in a group exceeds our cognitive span, we have to find new ways to organize it. The individuals are too numerous to serve as organizational foci, so we begin to put them together into subgroups in our mind and to react to all members of the subgroup in a uniform, stereotyped fashion. If all the members of a large group mentally reorganize it in about the same

way, these subgroups may be given formal recognition and responsibility.

Whenever we draw conclusions about social organization from psychological laws that are presumed true for all mankind, we must be prepared to say that these laws are true for every culture, not just for the culture we happen to live in. Thus, in spite of the apparently direct relation between cognitive span and the optimal size of face-to-face groups, there is a danger that we may prove too much and that some culture somewhere may exist which violates our expectation. The anthropological evidence, however, does not seem to contradict the idea. The so-called nuclear family —consisting of husband, wife, sons and daughters—is a universal social group [21] of about the size we would expect. Thus we are sure to find at least one kind of social group in every society whose size is appropriate to the limits of our cognitive spans.

Conclusion

In conclusion, therefore, let me summarize what I have said about communication and information as limiting factors in group formation. I began with the assumption that the process of communication is essential to the very existence of a social group. But communication is expensive and there are limits on our time and our ability to maintain adequate communication with every member. Thus we prefer to talk and work and live in small groups. On the occasions when we cannot avoid the larger groups, we try to organize them, or our conception of them, in such a way that we can deal with them as we deal with smaller groups. Thus our various ways of processing information—grouping, categorizing, evaluating, abstracting, organizing, naming—all leave their special mark on our social behavior, and the narrow limit of our cognitive span casts a pale shadow of thought over all our fellow men.

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DISCUSSION

Dr. David Solomon, Department of Sociology and Anthropology, McGill University: Dr. Miller commented on some of the studies which traced these communication networks. He mentioned the studies in which people are in a circle or in a Y, and so forth; and the study of who talks first, who talks second, who talks how much and who how little. He commented that these studies have not lived up to the promise that at first it was felt they had, and I wonder if I might add an additional comment to that and ask him a question at the same time. While I appreciate that in experimental situations you cannot and do not try to make them precisely the same as real life, the reason for the unsatisfactory results may be that most of the groups in which we participate are groups that have some stable expectation as to who will speak first, who will speak second, and who will remain silent. Likewise, there is some stable and on-going expectation as to who will speak about what subjects and who will speak and lead in one situation or another. If you know the rank of the people involved, then you know that the top ranking one speaks first, and the second ranking one speaks second, unless there happens to be some difference in the knowledge they have. Also, if some very high ranking person comes around they both fall silent. It seems to me that it is this discrepancy between the stable expectations which we encounter in most normal groups *vis a vis* the lack of such stability in experimental groups that takes some of the sting out of these very tidy experimental situations. I wonder if Dr. Miller would like to comment on that?

Dr. Miller: I don't really feel that that needs more comment than just "Amen." We are constantly dealing with small groups and carrying out the assessments Dr. Solomon mentions. I got extremely excited some 5 or 6 years ago about the possibility that we were going to be able to do a laboratory type of research. I thought we would have everything under control, that we would know exactly what was going on, could measure everything—heart rate if you wanted. We could do personality tests on the people who participated. We could have all the information you would want—just specify the task. It would be marvelous. I felt science could really march into this area. The first thing I found out was that when you work in this area you do a tremendous amount of work with the expenditure of a great deal of money, and with many assistants, to get one point, or perhaps one-tenth of a point. Just as a matter of collecting science it is pretty inefficient. There ought to be some way of getting more data out of studies of this sort than I was able to get.

Another thing is that when you get through it all seems perfectly reasonable, given the conditions that you imposed on them, that people would behave in the particular ways found. You feel that you should have known the outcome before you ran the experiment at all. The generalizations you can draw are limited by the fact that it is a transient group. It has no expectation, it is not going anwhere, it is just there at the pleasure of the experimenter. At the end of the experiment it is destroyed. It does make a nice little point that the network of communication links between the people influences the way the group will operate. Having made that point, however, I think we can close our chapter and go on to another type of research.

Dr. John Mabry, Sociologist, of the Upstate Medical Center, Syracuse, N. Y.: I would like to point out that I think we are confusing perhaps three levels in talking both about small groups and about the ability to abstract and reorganize data. We mentioned the ideal family size as five children, which to me comes out as a group of seven, not five, when their parents are included. We talked also about the 15,000 to 24,000 words that people use. It seems to me that we confused two things. One is the number of individuals that you can deal with; second is the behaviors—verbal and otherwise—that these individuals are exhibiting. I wonder if you would care to try to bring those two things together—that is, the number of discrete units and, secondly, the behavior which they exhibit?

Dr. Miller: I agree that perhaps I have tended to confuse these in a rather careless way of talking here. Rather than trying to bring them together, I will try to pull them apart. In regard to two types of memory, I think this: Perhaps it can be illustrated best in terms of the computing machine which has two types of memory. One is a large, permanent store which it takes a while to get into the machine and out of it. The other is a transient, immediate type of memory it is working with *right now*—that is, what is on the stage that it is going to add and subtract right at this instant.

I think people are pretty much the same way. As you are sitting here there are certain things that are in the span of conscious attention for you now and which you are able to work on. There are other things that are available to you but which you don't happen to be thinking about right now—such as, where is the top of your head? or what is your hotel room number? or something of this sort. As soon as I mention them, this material can come into awareness. I didn't mean to say that the total bound memory was limited to seven things; for example, that in your lifetime you can learn only seven words, or something of this sort.

AN EXPERIMENTAL INVESTIGATION OF GROUP INFLUENCE *

SOLOMON E. ASCH, PH.D.

The rationale of the investigation I am about to describe was simple and also extreme. We placed a person in the position of a minority of one within a majority that contradicted him about an obvious, easily perceived matter of fact. The object of judgment was present in the field of observation, and the members of the majority were also directly present. The minority and majority were required to announce their judgments publicly. These circumstances generated a conflict within the minority of one, who was the critical subject. The object of the study was to trace the course and outcome of the conflict, and to observe its dependence upon a number of conditions that were systematically varied.

Plan of Investigation

The plan of the investigation required a special kind of majority, one that cooperated with the experimenter. The members of the majority had been instructed in advance to announce judgments (from time to time) that were in fact wrong, and to do so unanimously. This was a *wrong* majority. The critical subject was the only member of the group naïve to these proceedings. Thus, whenever the majority and the minority of one were in disagreement, the former was going contrary to observation and the latter was reporting faithfully.

The object of judgment was of little interest *per se* except for the consequences it engendered. The task was one of matching the lengths of lines under optimal conditions. The group was shown a line, which we will call the standard, and next to it three lines of clearly different lengths, one of which was equal to the standard. The instructions were to select, from among the three

* This account is based on the following published studies: (1) S. E. Asch, *Social Psychology*, ch. 16, Prentice Hall, 1952; (2) "Effects of Group Pressure upon the Modification and Distortion of Judgments," *in Groups, Leadership and Men* (H. Guetzkow, ed.), Carnegie Press, 1951; (3) "Studies of Independence and Conformity: I. A. Minority of One Against a Unanimous Majority," *Psychological Monographs*, Vol. 70, No. 416, 1956.

comparison lines, the one equal to the standard. The comparison lines were numbered 1, 2, and 3, and the members of the group announced their judgments, by calling out the correct number, in the order in which they were seated. When the judgments were completed, the stimuli were removed and replaced by a new set of standard and comparison lines (see figure 1).

The critical subject was seated toward the end of the group. He always heard all but one of the majority report their judgments before his turn came to respond.

The task of discrimination was easy, the comparison lines differing substantially in length. The errors of the majority were considerable, ranging between ¾ inch and 1¾ inches. Further, the majority was not consistent in its errors on successive occasions; it both underestimated and overestimated. Table 1 contains the lengths of the lines and the judgments of the majority.

Table 1. Majority Responses to Standard and Comparison Lines on Successive Trials. (from Asch.[3])

Trial	Length of standard (in inches)	Length of comparison lines (in inches)			Majority error (in inches)	Type of error
a*	10	**8¾**	10	8	0	
b*	2	2	1	1½	0	
1	3	**3¾**	4¼	3	+¾	Moderate.
2	5	5	4	6½	−1	Do.
c*	4	3	5	4	0	
3	3	**3¾**	**4¼**	3	+1¼	Extreme.
4	8	6¼	8	**6¾**	−1¼	Moderate.
5	5	5	4	**6½**	+1½	Extreme.
6	8	**6¼**	8	6¾	−1¾	Do.
d*	10	**8¾**	10	8	0	
e*	2	2	1	1½	0	
7	3	**3¾**	4¼	3	+¾	Moderate.
8	5	5	4	6½	−1	Do.
f*	4	3	5	4	0	
9	3	**3¾**	**4¼**	3	+1¼	Extreme.
10	8	6¼	8	**6¾**	−1¼	Moderate.
11	5	5	4	**6½**	+1½	Extreme.
12	8	**6¼**	8	6¾	−1¾	Do.

* Letters of the first column designate "neutral" trials, or trials to which the majority responded correctly. The numbered trials were "critical," i.e., the majority responded incorrectly. Boldface figures designate the incorrect majority responses. Trials d to 12 are identical with trials a to 6; they followed each other without pause.

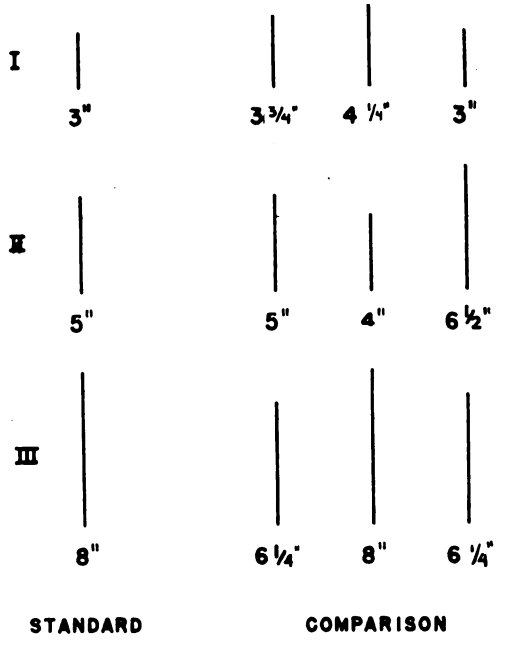

Figure 1. Critical comparisons. (From Asch.[3])

The subjects were male college students, ranging in age from 17 to 25; the mean age was 20. They were drawn from three educational institutions. The members of the majority, who numbered in size from 7 to 9, were also students drawn from the same institutions. There were 123 critical subjects.

To complete the present account it should be mentioned that each subject was interviewed carefully at the conclusion of the experiment, and that in the course of the interview a full disclosure and explanation of the reasons for the procedure was made.

Contradictory Demands of Situation. This situation placed contradictory demands upon the critical subject. On the one side was a clearly perceived relation to which he had direct access, and which he had undertaken to judge correctly. On the other side was the unanimous opinion of a majority of peers, whose competence and trustworthiness he had reason to take for granted. Further, the contradiction was irreconcilable; there was no alternative or compromise that might overcome the disagreement. Since there was no discussion during the experiment, there was no possibility of persuading or of being persuaded. The contradiction was also in an important respect ununderstandable; as long as the subject remained naïve, and this was the rule, there was no

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possibility of explaining the disagreement. Since the situation was self-contained, it was not easy to refer the disagreement to outed conditions. Finally, the subject was under the necessity of taking a stand. He could not escape, postpone, or delegate responsibility.

These circumstances defined the alternatives open to the critical subject. He could stand by the evidence of his senses, but this was tantamount to declaring that the unanimous majority was in error. Or he could follow the majority, but this he could do only by suppressing the testimony of his experience.

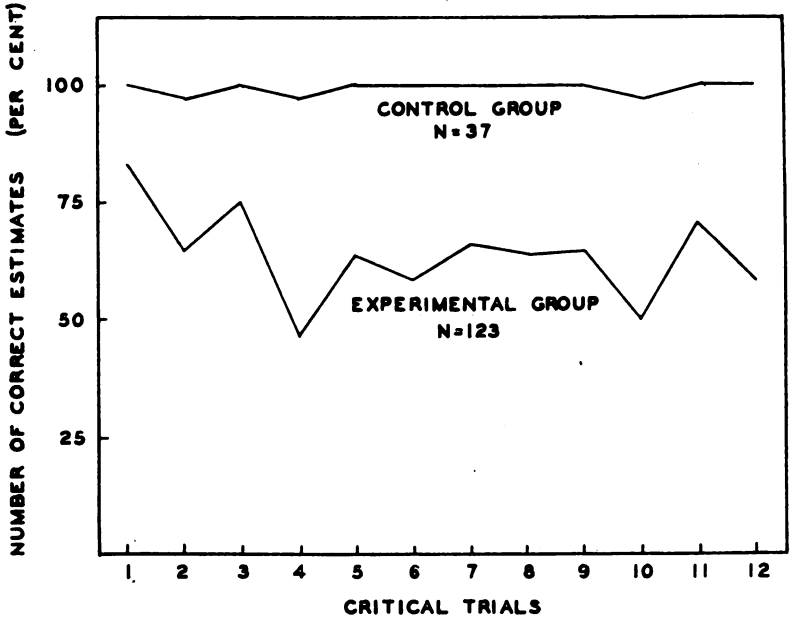

Figure 2. Correct estimates on successive critical trials: experimental and control groups. (From Asch.[3])

Results

The main results are summarized in figure 2. (1) Let us note first that a control group, judging the relations in question without the benefit of a misleading majority, was overwhelmingly accurate; under this condition errors comprised less than 1 percent of all judgments. (2) The unanimous majority produced a marked distortion: one-third of the judgments were errors in the direction of the majority. This is an important result when one considers the character of the task and the quality of the subjects.

One should not, however, ignore the fact that the preponderance of judgments was independent under this condition of stress. (3) Perhaps more significant was the great range of individual differences. A proportion of the subjects remained independent throughout the experiment; others vacillated between the majority and independence; still others went with the majority as often, or almost as often, as the conditions permitted. The data concerning individual differences appear in table 2.

Table 2. Distribution of Errors in Experimental and Control Groups. (from Asch.[3])

Number of errors	Control group	Experimental groups			
	(N = 37)	Group I (N = 70)	Group II (N = 25)	Group III (N = 28)	All experimental groups (N = 123)
0	35	17	5	7	29
1	1	4	2	2	8
2	1	7	1	2	10
3		12	1	4	17
4		3	1	2	6
5		5	2	0	7
6		2	4	1	7
7		3	0	1	4
8		7	4	2	13
9		3	2	1	6
10		4	1	1	6
11		2	0	2	4
12		1	2	3	6
Mean	0.08	4.01	5.16	4.71	4.41
Median	0.00	3.00	5.50	3.00	3.00
Mean percent	0.7	33.4	43.0	39.3	36.8

The performances of the subjects showed a high degree of internal consistency. Those who were independent in the early part of the experiment tended to remain independent, and similarly for those who went with the majority at the outset.

Effect of Variation in Size of Majority. The effect here described was also studied with majorities differing in size. In successive experiments we varied the size of the opposition from 1 to 15; each condition required, of course, different critical subjects. The results may be summarized as follows: (1) The full effect was obtained with a majority of three. An increase of the majority beyond this point, up to the limit of 15, failed to alter the level. (2) An opposition of two, the smallest majority, reduced the compliance to one-third of the maximum. (3) An opposition of one produced a small but telltale effect. The level of errors was 2.7 percent of all judgments, a slight but nevertheless distinct increase in comparison with the control conditions.

From these findings we may draw a few conclusions. First, the sheer size of majority opposition, while an important condition, is not wholly decisive. Beyond a point that is soon reached, further increases of size are without effect. This statement refers, of course, to the present conditions, but it may have implications for other situations. Second, the data confirm and extend the conclusions reached earlier about the scope of individual differences. There were individuals who acted more independently against an opposition of 15 than others who faced an opposition of 2.

Discussion

From a theoretical and from a human point of view the writer is inclined to regard seriously the following experimental variations. The conditions described earlier were retained exactly, except for one detail. There were now two critical subjects in the experimental situation, opposed by a majority of seven to nine. (In a further variation the naïve subject was provided with a "partner" who was instructed to respond accurately without exception.) In short, we altered the situation of the critical subject by putting him in the position of a minority of two. This seemingly small alteration had a profound effect; indeed, it robbed the erring majority of most of its power. Although the critical subjects continued to face the opposition of a substantial majority, they maintained in the presence of a partner a high level of independence. Not only did conforming responses drop to 10.4 and 5.5 percent, respectively; the degree of compliance of any one subject was strictly curtailed under these conditions. There were very few individuals who went with the majority more than two or three times when another person sided with them. The majority was still exerting a measurable effect, but one that had been drastically reduced.

We conclude that the vulnerability of the minority-of-one condition is to be traced to the special quality of loneness it created. The presence of one other voice testifying to the individual's sense of rightness sufficed to strengthen and protect him from the opposition of an arbitrary majority.

We have spoken of a special, indeed an unusual, situation. It follows that we have studied independence and conformity under highly particular conditions, and that the content and significance of these terms will alter strongly with changing circumstances. It is not hard to think of independence that is irresponsible, of conformity that requires courage. Nevertheless, the present observations make contact with processes of consequence in social life, and investigations of this order may sharpen our thinking and help in finding answers to questions that are important. There are circumstances when the welfare of the individual and the group requires that each should act according to his conviction. Indeed, a human community depends on its members to contribute of their thinking and feeling. When this source of mutual correction and enlightment is weakened, the social process is disturbed at its foundations; both the individual and the group are damaged.

We have seen that even a comparatively mild form of group pressure can induce persons, not the least promising of our kind, to call white black. What conditions in the social field or in the processes of education contribute to this outcome, and what conditions are capable of overcoming it? What are the grounds of the extreme individual differences we have found? The questions are a challenge to the science of psychology and to the other disciplines concerned with man.

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DISCUSSION

Dr. Hans Lowenbach, Department of Psychiatry, Duke University: I have a rhetorical question, a question of method, Dr. Asch. I take it your subjects were college students and that the experiments were conducted over a number of weeks. How did the naïve partners remain naïve since a group of the non-naïves was in communication with the other students? Second question: When you paired a naïve partner with a supporting partner, did you work out whether there was an influence if the supporting partner was older than the naïve partner?

Dr. Asch We pledged the people who took part in the experiments to respect the confidence of our procedings, and we had better success than I would have believed possible. We worked actually, in a number of institutions, some of them quite large, where this news did not travel so fast. However, we also worked in a smaller institution and were able to go for a fairly considerable time before our subjects had previous knowledge of the details of the experiment. Occasionally a few would slip in and then tell us at the end that they had heard about the experiment and, wanting to see what it was like, had pleaded naïveté. It is a question of being very careful. It is also a question of having the cooperation of those who are taking part in the experiment. It is not easy to control, but not impossible.

As to the second question, we made no particular efforts to pair individuals in a controlled way. In a sense, this is unnecessary if one works in a given range of ages and sex. The behavior of the people in the partnership situation was remarkably homogeneous. They did not become substantially independent. This happened irrespective of the various differences that were undoubtedly part of the situation that we studied. Whether any finer differences would emerge under other differences of control I cannot say.

Edward Wetter, Sociologist, Office of the Secretary of Defense: I am a little concerned about the sociological implications inherent in your subject group. This is a group of college students who are very much concerned about being recognized by their peers, as going along with the majority, something like Riesman's "Other Directed." I wonder, if the subjects had been older, more mature, more used to independent judgment and if they were not so heavily reliant, in their normal social situation, on the approval of their peers, if there might have been a difference in your findings?

Dr. Asch: We do have evidence concerning some age groups. It is possible, fortunately, to do this experiment with children who take the situation far more easily, without the anguish of late adolescence. I do not know about adult groups, but I will say this, that those who went with the majority in these experiments of college age did not do so easily or glibly.

VALUES AND THE PROCESS OF COMMUNICATION

JURGEN RUESCH, M.D.

Man uses the process of valuation to bring order into randomness, to resolve conflict, to connect expectations and memories of past events with actual and ongoing behavior, and to compare on a unitary scale that which is otherwise incomparable. Now for the details.

DEFINITION AND USAGE OF THE TERM

In the field of value theory and in daily usage, the term "value" is employed in several different ways. The most frequent usage is that which identifies value with preferential behavior or with what Dewey [8] has called "selective-rejective behavior." It can be studied by directly observing behavior, and Morris [10] aptly refers to this aspect of valuation as "operative values."

However, the term "value" is not used only to qualify certain aspects of social or physical behavior; it frequently is employed to refer to anticipatory behavior [2]—that is, to what is desired, valued and esteemed. These conceptual values are studied by examining the individual's choice of symbols. Inasmuch as all symbolic behavior influences action, conceptual values control the course of events in an indirect way.

There is a third version of the term "value" which is concerned with what is preferable for a given purpose. Here the notion of value is identified with appropriacy, efficiency and fit, which factors in turn are defined by the situation, the properties of the object, or the physiology of the human being. "Value" used in this sense indicates the best or only solution for a given problem—for example, that which must be done if a fire is to be controlled. Object or objective value is a convenient way of describing this particular usage.[10]

There is a fourth usage of the term "value" which is largely identified with price and is related to the idea that value can be ascribed to any object or action and is a quantity which makes comparative evaluation possible.[14] Used in this sense, value does not indicate a preferred action or a prescribed anticipation or a

"must" born out of the situation but rather an arbitrary, often numerical, magnitude which has been assigned to objects or services in order to render seemingly incomparable things comparable. Thus in any shop the $5 articles can be compared to each other—dolls with music boxes, mittens with toy trains.

In illustrating these four kinds of values, I shall draw upon scientific, technological and social procedures. In individual psychology the notion of habit or trait and in anthropology the concept of custom or tradition are based upon the study of preferential behavior. What in the individual are referred to as ideals and conscience and in the group as rights, privileges and obligations are founded upon the study of desirable or valued behavior; conceptual values as embodied in the Constitution thus assume a normative function. The structure of man, beast and thing, natural laws, social institutions and legal codes are based upon the investigation of objective or realistic values which in essence define human possibilities and limitations. Numerical values, finally, are the expression of man's verbal-digital codification system which enables people to go beyond analogic thinking, to translate imagination into communicable terms, and to build a cumulative body of knowledge.[11] [12]

VALUES AS END STATES

Without values, the exchange of messages would hardly rise above the level of chance. Only the order which is introduced through the intrapsychic process of valuation enables us to select and discard stimuli, to make decisions, and to express our choices to others. When we study these human values, we conveniently assume that they are the somewhat stable end product of individual or group experience and that they are the result of a complex learning process.

Value as Cultural Orientation

Kluckhohn [6] distinguishes three fundamental types of experiencing: what is or is believed to be (existential); what I and/or others want (desire); and what I and/or others ought to want (the desirable). All three ways of experiencing contribute toward the reshaping of normative propositions which when shared by a group can be referred to as a cultural orientation. These orientations reflect the cumulative body of knowledge, the collective experience, and all the rectifying desires and expectations of the group. The picture of the world as it should be and as it is, and

the ways the individual might adjust to it thus are contained in what is transmitted from parent to child and from teacher to pupil. An illustration of how to analyze such generalized orientations has been given by Florence Kluckhohn,[7] who distinguishes five dimensions:

The orientation toward man's innate predisposition—whether he is good, mixed, or evil

The orientation toward man's relation to nature and surroundings—subjugated by it, in it, or master of it

The orientation toward time—past, present, or future

The orientation toward living—being, becoming, or doing

The orientation toward man's relationship to others—individual person, lineage or descendents, or contemporary group

Value as a Premade Decision

Some of the values held by a group require that these be accepted by the individual as premade decisions. Not only taboos but all laws, regulations and traditions fall into this category. Conventions about primogeniture, certain crimes, pregnancy and polygamy, for example, are not to be broken, and the individual is not allowed to make his own decisions in these matters. In military, aristocratic, or gangster circles, the honor code often forces the individual and the group to act in certain ways even if it be against their better judgment. The decision, as it were, is made before the question ever arises. This peculiar situation is frequently exploited in diplomacy, in warfare and in psychotherapy. People deliberately play into values which force automatic response. The only successful defense against such an attack is to indicate to the aggressor that one knows what he is up to and that one is not an automaton. The therapist who is not afraid of a psychotic reaction in the patient, the diplomat who does not react to an insult, and the commander who is not deceived by a fake withdrawal are all superior to those who react automatically and do what the opponent wants them to do. Unfortunately, personnel in the upper echelons often are elected or selected because they hold to certain value principles or adhere to premade decisions. Hence they fall prey to their internal or external enemies who use this reflex type of behavior to force action when it is most inopportune. Survival in a world with a fast rate of change seems possible only when premade decisions are minimized and when the decision makers retain the freedom to choose the operationally best suited action.

Value as Statement of Probability

The cumulative knowledge and experience of the group leads to the development of prescribed behavior. In teaching preferential behavior, the parent trains the child not only for the probabilities with which certain situations are to be expected but also in the solutions which in the past have had reasonable probability of success. The most rigid adherence to prescribed behavior is observed on the occasions of birth, death, marriage, or coming of age. These events, which in most cultures are celebrated with what are called *rites de passage*,[13] designate the occurrence of irreversible changes in the life cycle of man.

The rigid reinforcement of values which bear upon irreversible changes indicates that the group has had sufficient experience to establish probabilities of survival. For example, in our civilization certain rules about the control of infectious diseases are rigidly reinforced in order to avoid epidemics. The probabilities expressed in these values thus bear upon the well-being of the group, which can be insured only if the individual is thoroughly indoctrinated and is constantly controlled from without. Groups thus make sure that the individual does not set up values based upon his private experiences which might insure only his own survival. In wartime, for example, desertion may be punishable by death.

Value as a Telescoping Device

Values also have a time-binding and space-condensing function. For example, when we talk about attitudes, hope, faith and disposition, we are really stating the probability that a given behavior may occur in the future. And when we talk about traits, personality and character features, we refer primarily to statistically established frequencies of past events. In both instances, values are used to connote in the present the events that happened in the past or are expected in the future. This impression is augmented by the fact that events that happen at different places can be telescoped to create the illusion that they happened in the same situation. For example, the statement "He is unreliable" may mean that on two different occasions, perhaps years apart, a man fell short of the expected, and that these two shortcomings prejudice the outlook for years to come. The connotative fusion of temporal and spatial aspects of events thus gives values their compelling flavor of timelessness and extension into eternity. The sermon usually embodies these very qualities.

Value as Cumulative Body of Knowledge

Through its cumulative experience over generations, any group adapts to the prevailing climate, geography, food supply and neighbors. These experiences are then gradually embedded in certain values which seem to insure the best chances of survival. The shapes of boats and the kind of horses bred for a given terrain and purpose are pertinent illustrations. But in recent decades, our technical civilization has developed so fast that often there is not time to develop a cumulative body of knowledge which can find its repercussion in the value system of the group. Airplanes are obsolete before they leave the drawing board; time-honored occupations like that of the blacksmith disappear and new ones arise. The result is a society that constantly experiments with new actions and new materials whereby the experience of the older generation is used only in a limited way by the younger one. Today, students who are a few years apart have little in common. Being exposed to other songs, dances, books, ways of dressing, places to meet and educational methods, they cannot learn from and share with their elders except in the field of decision-making, a process which is relatively independent of specific subject matter and material culture. In previous centuries, learning was tied to the sharing of activities with age superiors. Today the youngsters must protect themselves against contact with the older generation whose values do not keep pace with the rapidly changing environment.

Value Systems, Social Structure and Psychopathology

But what, may we ask, takes the place in our world today of those values which were developed over centuries? The continuity of culture and civilization, which in the 18th and 19th centuries was insured through moral and character training of the individual, is now being replaced step by step, by impersonal external controls.

With the present early separation from home, the trend toward the two-children system, and the concomitant disintegration of the closely knit community structure, the individual has found himself without an external source of support that reassures, helps and sometimes threatens. In the past, the individual was controlled from without by people with whom he had spent much of his life. This continuity and consistency in human contact resulted in the establishment of a sense of belonging and responsibility and favored the development of controls from within. The

vacuum left by the vanishing of outside controls—people who were personally known to the individual—and by the weakening of internal controls is being filled by a peculiar kind of impersonal tie. Intimacy is being replaced by parapsychological relations [5]—the actor on the television screen walks into the living room, shares the family life, and sets standards as if he were really there. Urban as well as suburban living has become somewhat impersonal —families and faces quickly come and go, and real friendship or kinship groups are being replaced by casual, opportunistic neighborhood or pleasure-seeking groups.

On an organizational level, this tendency toward impersonal relations is expressed in the accumulation of rules and regulations formulated by the State, the large corporation, or the labor union and designed to govern modern living.[20] Implemented by a bureaucracy that controls everything from health to employment and from thinking to the choice of a marriage partner, the freedom of the individual is being progressively restricted. We live in the age of highly organized corporate empires [9] which are spread all over the globe and are interconnected by means of communication. And the psychiatrist has become part of this machinery—the trouble-shooter of society, as it were. In the old system, people were either "in"—that is, they participated in the family and community life as regular members—or they were "out" and became adventurers, criminals, or insane. Today this division is blurred, and the "ins" and the "outs" are almost overshadowed by the "in-outs"—that ever-growing array of marginal people, neither sane nor insane, neither criminals nor upright citizens, but persons who did not manage to get on or to hang on to their respective bandwagons. With this change in social structure goes the disappearance of the classical syndromes of psychopathology and their replacement by an increasing array of borderline cases, atypical or heterogeneous conditions, or immature and unidentified individuals, as the ever-increasing rate of juvenile delinquency demonstrates. This is the picture of today.

VALUES IN ACTION

Because of the characteristics of the learning process, one perception paves the way for future similar perceptions, and an action that has been carried out successfully once is easier to repeat.[19] Habitual perception and expression therefore are synonymous with preferential perception and expression. From the way in which a person formulates and reports the events which he has observed and from the repetitiousness and intensity of his actions,

we infer the values which govern his reactions. Since man can only observe behavior—that is, the contraction of muscles—such factors as timing, direction, points of origin and destination, appropriateness, and impact of the action are the foundations upon which conclusions are built.[17] In observing actions or statements, the observer relies upon his knowledge of what is optimally possible under the given conditions, comparing the chosen action against the alternative solutions available.

Since in human experience values represent intervening variables that enable the individual to telescope events separated in time as if they had happened together and events scattered in space as if they had happened at the same place, the observer must have an opportunity to consolidate upon his observations. When an individual is participating in an activity, at any given moment his values and those of the other people are not experienced as choices but only as actions or statements which require adaptation and response. In that instant, the individual is not aware of his or the other person's selectivities because the whole concept of value is one which necessitates observation in many places over a period of time. For example, when a centerboard sailboat turns over on its side, many an inexperienced sailor may lose his life by attempting to swim ashore. The dominant value of reaching solid ground compels him to react as he does instead of clinging to the floating hull and waiting for rescue.

Value as Assumption

If a person wishes to talk to a stranger, he must make a number of a priori assumptions concerning the identity of the other person, the nature of the situation, and the form of language to be used. In the course of the exchange of messages, these assumptions may or may not be modified. There exists an interesting analogy to this procedure of assuming a position in the absence of concrete evidence in the field of celestial navigation. In the determination of the Sumner Line of position by the Saint Hilaire method, the navigator measures the altitude of the sun and compares this figure with the altitude as read from a table for the assumed position. By computing the difference, he arrives at his line of position. Similarly, in communication any participant makes assumptions about where he stands vis-à-vis the other person. And in observing the difference between actual behavior of self and other and the assumed or anticipated behavior, he obtains a clue as to how to communicate and behave. Interpersonal difficulties can arise if people are inflexible and cannot modify their

initial assumptions.[4] In this case, the anticipatory or conceptual values have gained dominance over the actually observed values. But in the ordinary case, an assumption made in the course of communication is appropriately corrected as the result of communicative exchange.

Filling in Background Information

When a human experience is represented by a word or a gesture, the multidimensional quality of the experience and its far-flung ramifications are lost. The experience is compressed, as it were, into a symbol, and the condensation seriously limits the amount of information transmitted. But in spite of this handicap, communication can take place, provided that the missing information is filled in.

When two people communicate, neither of the participants is quite sure who perceived what, nor is there information available about the range of responses that an individual or group could consider at that moment. All that is evident is the impact that an action or statement has. But this lack of information does not mean that the participants do not speculate about what stimuli might have been perceived or what other responses might have been chosen by the other person. As a matter of fact, if people do not speculate about these possibilities they cannot communicate efficiently. Thus it is well to remember that any preferential or value statement not only implies that which was chosen but evokes in the listener certain associations about that which was not chosen. If a person traveled by air, the implication is present that he did not take the train, drive, bicycle, walk, or ride on horseback. Since limitations of time prevent any person from sketching all the possibilities he has rejected, the observer has to fill in the missing information from his own background of memories. It is obvious that correct appraisal of another person's message is contingent upon the receiver's scanning through the same universe of stimuli, memories and possible implementations as the sender did.

This process of filling in is the better the more all the participants have been trained alike, have been exposed to the same experiences, and have been conditioned in the same normative values. But since identical training is hardly ever achieved, the technical question has to be raised as to how people who possess different backgrounds of experience and association can understand one another at all. The answer is that understanding hinges upon the exploration of the other person. If one has time to ob-

serve or listen to people over a period of time, one can observe the range of their activities and statements. The observer now bundles his observations into a universe which he tentatively labels the "scanning universe" of the other person. By trial and error, he eventually gets a pretty good facsimile of the other person's way of proceeding. This technic has been used for millennia in the understanding of animals in the hunting field. The hunter or fisherman knows exactly what the range of possibilities of a species—or even of an individual animal—is, and by understanding the scanning universe of the animal the outdoor man eventually gets his prey.

The Change of Values

In order to understand another person, a participant in a communication network must also know which values will supersede which, when and where. This is obviously a function of the situation and its phase of development. In other words, preferential behavior of an individual or a group is time bound to biological and social processes which have their own cyclic properties. In a committee session, for example, a man may stand for a given value; but as the hour gets late, his need for food or sleep may alter his views and he may vote with the majority in order to get the meeting adjourned. What is commonly called morale is nothing else but the maintenance of one set of values and its defense against the danger of displacement by another set of values. The moment the morale breaks, the well-established behavior—both the actual and the ideal—is replaced by another system of preferences. Objective values dictated by fear, panic, hunger, or similar realistic considerations now become dominant.

The hierarchy of established values—that is, the prevailing social order—is maintained with the support of the group, and violations call for retribution, punishment, exclusion, or even death. But such is not the case if the whole group engages in a forbidden activity. Mutiny and revolution, for example, are successful when enough men agree. After a period of transition—usually after the emergency is over, peace has been declared, or the revolution has been concluded—the new values are imposd by the groups that have accepted them upon the groups which resist change.

The change of values is much harder when individuals have to undergo such change alone. Culture change as it affects people who migrate from one country to another or from rural to urban settings, who move from one social class to another or who change

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from civilian to military life represents a source of stress.[15] Not only do people become isolated because communication becomes difficult, but they also are confronted with intrapsychic conflicts involving ideals and norms. What they learned to expect in the old culture is no longer acceptable as ideal in the new culture. This conflict is more pronounced when the new value system is fluid and in the making, as in the American West; it is less outspoken in New England, for example, where the puritanical value system has been dominant for a long time. The newcomer can adapt more easily to a new but well-defined system of values than he can to a new and conflictual system of values. He can accept or reject an outspoken system of values, but he tends to float in an ambiguous system, usually reverting (in part, at least) to his original set of values.[3] Such circumstances are present in the great harbor cities of the world where all kinds of marginal people find refuge.

Value Judgment as Disruptive Reply

When nations, political parties or pressure groups clash at a parley, one can frequently observe that a heretofore operational exchange of information is suddenly countered by a value judgment. The same procedure can be observed in the family circle when parents condemn a child's statement because they did not understand his intentions, or in a psychiatric hospital when a nurse berates a patient for using vile language.

When understanding diminishes or is nonexistent, people tend to give value judgments in response to the other person's statements or actions. More likely than not, such a response will have further disruptive effects upon the ongoing process of communication. Under such circumstances, denotative statements are omitted, choices are not explained or understood, and correction cannot occur. The perniciousness of the value judgment in ordinary interaction thus is bound to the fact that it is introduced to change the form or content of the communication.[1] The replier, without ascertaining the possible choices of the speaker, simply makes a judgment—based upon his own universe of possibilities—that the choice made is good or bad. And he does this because he presses for a conclusion of the ongoing exchange—the end state. This arbitrary point is marked by the introduction of a reward or punishment which signals the termination of an action sequence.[18]

If Johnny, age five, comes to his father and asks, "Daddy, what does 'bitch' mean?" and father replies, "That is a bad word; don't use it," the child still does not know what the word means. The father, instead of replying meaningfully to the question, compares

the child's statement to the standards of acceptance, pins the universal value of "bad" upon it, and then announces the result of his deliberations. The child is puzzled at the reply because the father did not verbalize his standards and did not explain the complicated process that it involved in the transfiguration of a particularized statement into generalized value terms.[18]

The Nonverbal Transmission of Values

In advertising and propaganda an almost universally understood language is used, which through the medium of cartoons, slogans and billboards denotes values in an attempt to influence the choice of prospective customers. The language of advertising is so well known that most listeners have learned to disregard "commercials" automatically. Recently, however, the symbol manipulators have begun to camouflage their statements in such a way that their advertising is taken for a cartoon, news report, or a movie. The identification of a "commercial" occurs usually by means of its nonverbal components—that is, context, configuration and intensity. Likewise, the transmission of values in ordinary communication is bound to nonverbal signals. The appreciation of regularity, repetition, patterning, direction, selectivity, omission, and intensity is not bound to verbal signals but is tied to the analogic codification system of man.[16 17] The transmission of values in the nonverbal mode, therefore, is one of the foremost processes in cross-cultural communication where people have to convey to another both their system of preferences and their actual choices.

In intracultural communication, where people share the ideal system of preferences, only the choices actually made have to be transmitted. This is exemplified well when a stranger joins a group of natives. When observing them, he often does not understand their communicative exchange because they do not convey to each other explicitly the particulars of their system of preference. But if they talk to him directly, he may begin to understand because they will include instructions about their value system.[14]

Values and Psychotherapy

In psychotherapy, psychoanalysis and group therapy, or in brief, in all forms of human exchange which utilize communication, values partake in the process of communication. For example, in the United States, doctors are generally middle-class persons who view the world with the distortions characteristic of middle-

class society. To these are added the distortions introduced through training in science, medicine and psychiatry. Ultimately, then, the doctor has a composite view which is made up of his life experiences as an individual and of his collective experiences as a member of a certain social class, religion, ethnic group, geographical locality, age group, sex, and professional group. These views strongly influence therapeutic operations. Let it be said here that no man can communicate without the use of such values and that any attempt to appear "objective" is an additional distortion which complicates matters. When the therapist meets his patient, who exhibits another set of values and tries to live up to the stereotype of "a good patient," the difficulty begins. Seen from the standpoint of values, therapy can be likened to an exercise in acculturation. The doctor explores the value system of the patient, and the patient learns about the values of the doctor, both falling somewhat into the stereotype provided by the culture for such occasions.

There are two schools of thought in psychiatry—those that believe that the patient can be successfully rehabilitated only by revamping his system of values, and those that hold that therapy and psychoanalysis should leave these cultural matters untouched.[4] Seen from the standpoint of therapeutic communication, the issue of values in the process of therapy would appear as follows: Since nobody can deny his own values, objectivity is impossible; but it may be possible to tackle those assumptions and those values which directly interfere with the process of communication. For example, when patients hold to the value that all secret thoughts of aggression, of lust and of intrigue should be kept to the self and that only conventional things should be expressed, this value obviously interferes not only with therapy but with successful communication as a whole. In operation, therefore, the patient is shown those values that interfere with feedback, with correction of information, with expression, and with all the other communicative functions. Here two values clash—the value of the therapist who says communication must take place, and the value of the patient who says communication shall not take place. But since the patient came to the therapist to be helped and since the therapist's tool is communication, the patient will, on the force of the therapist's authority and skill, usually accept the latter's position.

Once the patient has accepted the fact that communication must take place, most of the culturally determined values and their correction can be left to extratherapeutic exchanges. If, for

example, a patient adheres for religious reasons to certain sexual or dietary practices, it is hardly the task of the psychiatrist, who may belong to another group, to overrule the patient. Otherwise, therapy results in a progressive alienation of the patient from his own group, and the patient, by accepting the therapist's values, thus becomes more maladjusted than ever before. Instead, the patient who now has been helped to regain or relearn certain ways of communication can discuss and work through some of these matters with his peers and with those leaders who determine the ethics of behavior in his own group. In this sense, the therapist acts as an engineer. He helps the patient to introduce corrective and self-corrective procedures, and these in turn take care of the patient's values. And as an engineer the therapist helps the patient to become tolerant of values of other people. This he does by setting the example of not attacking the values of the patient himself but by trying constantly to translate values into operational terms. By pointing out the results that values have, by trying to see them as they would look in action, the patient obtains a living understanding of what values are about in daily life. And, equipped with this experience, he is better able to live with his fellow men.

VALUE THEORY AS THEORY OF THEORIES

Just as the theories of communication, of homeostasis and of steady state transcend particular universes of discourse, so does value theory lend itself as a theory of theories. Any two universes of discourse can be compared and united by value theory. This is amply made use of in jurisprudence, politics, economics and science.[12] In psychological research, the method of assigning universal values to certain data and then processing these according to the rules of statistics has enjoyed great popularity. Any coefficient of correlation is based upon the comparison of magnitudes or values, enabling the investigator to compare, for example, the incidence of suicides with the length of the days. Statistics thus are the mathematical counterpart of man's empirical operations with values which he uses to establish quantities, to determine relationships, to figure out probabilities, to rule about first things first, or in brief, to bring order into his rather confusing array of experiences.

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DISCUSSION

Dr. Butler, Director of Mental Health of Idaho: Dr. Ruesch, I'm concerned about the way in which values are shared and reflected in small groups that are working together. There has been an observation made, by myself and others, that groups, when they are working together, do not really bring out into the open certain of the values that they might share at the latent level. This sometimes causes conflicts within the groups themselves. I wonder if you have some comment about the way in which values which, though they might be shared if they were brought out into the open, being held somewhat at the latent level, might influence the psychological behavior of individuals in groups?

Dr. Ruesch: In this case the values are used as assumptions—assumptions about a variety of things, such as, let us say, whether or not material has to be saved; or about whether money matters; or assumptions about whether life matters; or whether status matters; or assumptions about other things. I give you an example from an experience I had recently on the psychiatric service. Our residents used to take about an hour to present cases. Everybody suggested that this be cut short, until a nurse popped up and said, "It seems to me we have these long presentations because we want to please our supervisors." The assumption was that the presentation was there to please the supervisor and to make a good grade. Apparently it was not quite clear that this was a task and that the presentation was there for work, discussion of therapy, and so on.

Dr. Weinstein, Bethesda, Md.: Dr. Ruesch mentioned that the purpose of value is to solve conflicts, make judgments, bring order. I wonder if one of the biggest things isn't being overlooked? This would be: Value as a means of relating one socially. I was thinking of Dr. Asch's experiments in which the value is given in a faulty fashion on the relative size of the different lines. It would seem there that the outstanding function of value is to identify one with his group.

Dr. Ruesch: Well, social relation has to be implemented, and as far as I can tell, can only be implemented by communicative exchange. Social relation is another one of those transcendental terms which includes everything and nothing and everybody makes different connotations. If we stick for a moment to the operational definition that by a social process, we understand communicative exchange or the exchange of signals with each other, then certainly we arrive at a recognition of values in the other person. When he makes a statement or when he proceeds with an action we have to scale it against the universe, and this enables us to recognize what the man says or does.

CHARACTERISTICS OF TOTAL INSTITUTIONS

ERVING GOFFMAN, PH.D.

Introduction

Institutions. Social establishments—institutions in the everyday sense of that term—are buildings or plants in which activity of a particular kind regularly goes on. In sociology we do not have an apt way of classifying them. Some, like Grand Central Station, are open to anyone who is decently behaved. Others, like the Union League Club of New York or the laboratories at Los Alamos, are felt to be somewhat "snippy" about the matter of whom they let in. Some institutions, like shops and post offices, are the locus of a continuous flow of service relationships. Others, like homes and factories, provide a less changing set of persons with whom the member can relate. Some institutions provide the place for what is felt to be the kind of pursuits from which the individual draws his social status, however enjoyable or lax these pursuits may be. Other institutions, in contrast, provide a home for associations in which membership is felt to be elective and unserious, calling for a contribution of time that is fitted in to more serious demands.

In this paper another category of institutions is recommended and claimed as a natural and fruitful one because its members appear to have so much in common—so much, in fact, that if you would learn about one of these institutions you would be well advised to look at the others. My own special purpose in examining these institutions is to find a natural frame of reference for studying the social experience of patients in mental hospitals. Whatever else psychiatry and medicine tell us, their happy way of sometimes viewing an insane asylum as if it were a treatment hospital does not help us very much in determining just what these places are and just what goes on in them.

Total Institutions. Every institution captures something of the time and interest of its members and provides something of a world for them; in brief, every instiution has encompassing tendencies. When we review the different institutions in our Western society we find a class of them which seems to be en-

compassing to a degree discontinuously greater than the ones next in line. Their encompassing or total character is symbolized by the barrier to social intercourse with the outside that is often built right into the physical plant: locked doors, high walls, barbed wire, cliffs and water, open terrain, and so forth. These I am calling total institutions, and it is their general characteristics I want to explore.[1] This exploration will be phrased as if securely based on findings but will in fact be speculative.

The total institutions of our society can be listed for convenience in five rough groupings. *First,* there are institutions established to care for persons thought to be both incapable and harmless; these are the homes for the blind, the aged, the orphaned, and the indigent. *Second,* there are places established to care for persons thought to be at once incapable of looking after themselves and a threat to the community, albeit an unintended one: TB sanitoriums, mental hospitals, and leprosoriums. *Third,* another type of total institution is organized to protect the community against what are thought to be intentional dangers to it; here the welfare of the persons thus sequestered is not the immediate issue. Examples are: Jails, penitentiaries, POW camps, and concentration camps. *Fourth,* we find institutions purportedly established the better to pursue some technical task and justifying themselves only on these instrumental grounds: Army barracks, ships, boarding schools, work camps, colonial compounds, large mansions from the point of view of those who live in the servants' quarters, and so forth. *Finally,* there are those establishments designed as retreats from the world or as training stations for the religious: Abbeys, monasteries, convents, and other cloisters. This sublisting of total institutions is neither neat nor exhaustive, but the listing itself provides an empirical starting point for a purely denotative definition of the category. By anchoring the initial definition of total institutions in this way, I hope to be able to discuss the general characteristics of the type without becoming tautological.

Before attempting to extract a general profile from this list of establishments, one conceptual peculiarity must be mentioned.

[1] The category of total institutions has been pointed out from time to time in the sociological literature under a variety of names, and some of the characteristics of the class have been suggested, most notably perhaps in Howard Roland's neglected paper, "Segregated Communities and Mental Health," in *Mental Health Publication of the American Association for the Advancement of Science,* No. 9, edited by F. R. Moulton, 1939. A preliminary statement of the present paper is reported in the *Third Group Processes Proceedings,* Josiah Macy Foundation, edited by Bertram Schaffner, 1957.

None of the elements I will extract seems entirely exclusive to total institutions, and none seems shared by every one of them. What is shared and unique about total institutions is that each exhibits many items in this family of attributes to an intense degree. In speaking of "common characteristics," then, I will be using this phrase in a weakened, but I think logically defensible, way.

Totalistic Features. A basic social arrangement in modern society is that we tend to sleep, play and work in different places, in each case with a different set of coparticipants, under a different authority, and without an overall rational plan. The central feature of total institutions can be described as a breakdown of the kinds of barriers ordinarily separating these three spheres of life. *First,* all aspects of life are conducted in the same place and under the same single authority. *Second,* each phase of the member's daily activity will be carried out in the immediate company of a large batch of others, all of whom are treated alike and required to do the same thing together. *Third,* all phases of the day's activities are tightly scheduled, with one activity leading at a prearranged time into the next, the whole circle of activities being imposed from above through a system of explicit formal rulings and a body of officials. *Finally,* the contents of the various enforced activities are brought together as parts of a single overall rational plan purportedly designed to fulfill the official aims of the institution.

Individually, these totalistic features are found, of course, in places other than total institutions. Increasingly, for example, our large commercial, industrial and educational establishments provide cafeterias, minor services and off-hour recreation for their members. But while this is a tendency in the direction of total institutions, these extended facilities remain voluntary in many particulars of their use, and special care is taken to see that the ordinary line of authority does not extend to these situations. Similarly, housewives or farm families can find all their major spheres of life within the same fenced-in area, but these persons are not collectively regimented and do not march through the day's steps in the immediate company of a batch of similar others.

The handling of many human needs by the bureaucratic organization of whole blocks of people—whether or not this is a necessary or effective means of social organization in the circumstances—can be taken, then, as the key fact of total institutions. From this, certain important implications can be drawn.

Given the fact that blocks of people are caused to move in time,

it becomes possible to use a relatively small number of supervisory personnel where the central relationship is not guidance or periodic checking, as in many employer-employee relations, but rather surveillance—a seeing to it that everyone does what he has been clearly told is required of him, and this under conditions where one person's infraction is likely to stand out in relief against the visible, constantly examined, compliance of the others. Which comes first, the large block of managed people or the small supervisory staff, is not here at issue; the point is that each is made for the other.

In total institutions, as we would then suspect, there is a basic split between a large class of individuals who live in and who have restricted contact with the world outside the walls, conveniently called *inmates,* and the small class that supervises them, conveniently called *staff,* who often operate on an 8-hour day and are socially integrated into the outside world.[2] Each grouping tends to conceive of members of the other in terms of narrow hostile stereotypes, staff often seeing inmates as bitter, secretive and untrustworthy, while inmates often see staff as condescending, high-handed and mean. Staff tends to feel superior and righteous; inmates tend, in some ways at least, to feel inferior, weak, blameworthy and guilty.[3] Social mobility between the two strata is grossly restricted; social distance is typically great and often formally prescribed; even talk across the boundaries may be conducted in a special tone of voice.[4] These restrictions on contact

[2] The binary character of total institutions was pointed out to me by Gregory Bateson, and proves to be noted in the literature. See, for example, Lloyd E. Ohlin, *Sociology and the Field of Corrections,* Russell Sage Foundation, New York, 1956, pp. 14, 20. In those special situations where staff too is required to live in, we may expect staff members to feel they are suffering from special hardships and to have brought home to them a status-dependency on life on the inside which they did not expect. See, Jane Cassels Record, "The Marine Radioman's Struggle for Status," *American Journal of Sociology,* Vol. LXII, 1957, p. 359.

[3] For the prison version, see, S. Kirson Weinburg, "Aspects of the Prison's Social Structure," *American Journal of Sociology,* Vol. 47, 1942, pp. 717–726.

[4] An illustration may be found in Mary Jane Ward's fictionalized record of her sojourn in a mental hospital. *The Snake Pit,* Signet Books, New York, 1955, p. 72.

"I tell you what," said Miss Hart when they were crossing the dayroom. "You do everything Miss Davis says. Don't think about it, just do it. You'll get along all right."

As soon as she heard the name, Virginia knew what was terrible about Ward One. Miss Davis. "Is she head nurse?"

"And how," muttered Miss Hart. And then she raised her voice. The nurses had a way of acting as if the patients were unable to hear anything

presumably help to maintain the antagonistic stereotypes.[5] In any case, two different social and cultural worlds develop, tending to jog along beside each other, with points of official contact but little mutual penetration. It is important to add that the institutional plant and name comes to be identified by both staff and inmates as somehow belonging to staff, so that when either grouping refers to the views or interests of "the institution," by implication they are referring (as I shall also) to the views and concerns of the staff.

The staff-inmate split is one major implication of the central features of total institutions; a second one pertains to work. In the ordinary arrangements of living in our society, the authority of the workplace stops with the worker's receipt of a money payment; the spending of this in a domestic and recreational setting is at the discretion of the worker and is the mechanism through which the authority of the workplace is kept within strict bounds. However, to say that inmates in total institutions have their full day scheduled for them is to say that some version of all basic needs will have to be planned for, too. In other words, total institutions take over "responsibility" for the inmate and must guarantee to have everything that is defined as essential "layed on." It follows, then, that whatever incentive is given for work, this will not have the structural significance it has on the outside. Different attitudes and incentives regarding this central feature of our life will have to prevail.

Here, then, is one basic adjustment required of those who work in total institutions and of those who must induce these people to work. In some cases, no work or little is required, and inmates, untrained often in leisurely ways of life, suffer extremes of boredom. In other cases, some work is required but is carried on at an extremely slow pace, being geared into a system of minor, often ceremonial payments, as in the case of weekly tobacco ration and annual Christmas presents, which cause some mental patients to stay on their job. In some total institutions, such as logging camps and merchant ships, something of the usual relation to the world that money can buy is obtained through the practice of "forced saving"; all needs are organized by the institution, and payment is given only after a work season is over and the men

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that was not shouted. Frequently they said things in normal voices that the ladies were not supposed to hear; if they had not been nurses, you would have said they frequently talked to themselves. "A most competent and efficient person, Miss Davis," announced Miss Hart.

[5] Suggested in Ohlin, *op. cit.*, p. 20.

leave the premises. And in some total institutions, of course, more than a full day's work is required and is induced not by reward, but by threat of dire punishment. In all such cases, the work-oriented individual may tend to become somewhat demoralized by the system.[6]

In addition to the fact that total institutions are incompatible with the basic work-payment structure of our society, it must be seen that these establishments are also incompatible with another crucial element of our society, the family. The family is sometimes contrasted to solitary living, but in fact the more pertinent contrast to family life might be with batch living. For it seems that those who eat and sleep at work, with a group of fellow workers, can hardly sustain a meaningful domestic existence.[7] Correspondingly, the extent to which a staff retains its integration in the outside community and escapes the encompassing tendencies of total institutions is often linked up with the maintenance of a family off the grounds.

Whether a particular total institution acts as a good or bad force in civil society, force it may well have, and this will depend on the suppression of a whole circle of actual or potential households. Conversely, the formation of households provides a structural guarantee that total institutions will not arise. The incompatibility between these two forms of social organization should tell us, then, something about the wider social functions of them both.

Total institutions, then, are social hybrids, part residential community, part formal organization, and therein lies their special sociological interest. There are other reasons, alas, for being interested in them, too. These establishments are the forcing houses for changing persons in our society. Each is a natural experiment, typically harsh, on what can be done to the self.

Having suggested some of the key features of total institutions, we can move on now to consider them from the special perspec-

[6] An interesting reflection of the no-payment world of total institutions is found in the culture of State mental hospitals in the practice of "bumming" or "working someone for" a nickel or dime to spend in the canteen. This practice is indulged in, often with some defiance, by persons who would consider such actions beneath their self-respect were they on the outside. Staff persons, interpreting this begging pattern in terms of their own outsider's orientation to earning, tend to see it as a symptom of psychological sickness and one further bit of evidence that inmates really are unwell persons.

[7] An interesting marginal case here is the Israeli kibbutz. See, Melford E. Spiro, *Kibbutz: Venture in Utopia*, Harvard University Press, Cambridge, 1956.

tives that seem natural to take. I will consider the inmate world, then the staff world, and then something about contacts between the two.

The Inmate World

Mortification Processes. It is characteristic of inmates that they come to the institution as members, already full-fledged, of a *home world,* that is, a way of life and a round of activities taken for granted up to the point of admission to the institution.[8] It is useful to look at this culture that the recruit brings with him to the institution's door—his *presenting culture,* to modify a psychiatric phrase—in terms especially designed to highlight what it is the total institution will do to him. Whatever the stability of his personal organization, we can assume it was part of a wider supporting framework lodged in his current social environment, a round of experience that somewhat confirms a conception of self that is somewhat acceptable to him and a set of defensive maneuvers exercisable at his own discretion as a means of coping with conflicts, discreditings and failures.

Now it appears that total institutions do not substitute their own unique culture for something already formed. We do not deal with acculturation or assimilation but with something more restricted than these. In a sense, total institutions do not look for cultural victory. They effectively create and sustain a particular kind of tension between the home world and the institutional world and use this persistent tension as strategic leverage in the management of men. The full meaning for the inmate of being "in" or "on the inside" does not exist apart from the special meaning to him of "getting out" or "getting on the outside."

The recruit comes into the institution with a self and with attachments to supports which had allowed this self to survive. Upon entrance, he is immediately stripped of his wonted supports, and his self is systematically, if often unintentionally, mortified. In the accurate language of some of our oldest total institutions, he is led into a series of abasements, degradations, humiliations, and profanations of self. He begins, in other words, some radical shifts in his *moral career,* a career laying out the progressive changes that occur in the beliefs that he has concerning himself and significant others.

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[8] There is reason then to exclude orphanages and foundling homes from the list of total institutions, except insofar as the orphan comes to be socialized into the outside world by some process of cultural osmosis, even while this world is being systematically denied him.

The *stripping processes* through which *mortification of the self* occurs are fairly standard in our total institutions. Personal identity equipment is removed, as well as other possessions with which the inmate may have identified himself, there typically being a system of nonaccessible storage from which the inmate can only reobtain his effects should he leave the institution.[9] As a substitute for what has been taken away, institutional issue is provided, but this will be the same for large categories of inmates and will be regularly repossessed by the institution. In brief, standardized defacement will occur. In addition, ego-invested separateness from fellow inmates is significantly diminished in many areas of activity, and tasks are prescribed that are *infra dignitatem*. Family, occupational, and educational career lines are chopped off, and a stigmatized status is submitted. Sources of fantasy materials which had meant momentary releases from stress in the home world are denied. Areas of autonomous decision are eliminated through the process of collective scheduling of daily activity. Many channels of communication with the outside are restricted or closed off completely. Verbal discreditings occur in many forms as a matter of course. Expressive signs of respect for the staff are coercively and continuously demanded.[10] And the effect of each of these conditions is multiplied by having to witness the mortification of one's fellow inmates.[11]

We must expect to find different official reasons given for these assaults upon the self. In mental hospitals there is the matter of protecting the patient from himself and from other patients. In jails there is the issue of "security" and frank punishment. In religious institutions we may find sociologically sophisticated theories about the soul's need for purification and penance through

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[9] This is certainly not a new practice, and can be clearly illustrated from such documents as Saint Benedict's Holy Rule (ch. 58):

> Then forthwith he shall, there in the oratory, be divested of his own garments with which he is clothed and be clad in those of the monastery. Those garments of which he is divested shall be placed in the wardrobe, there to be kept, so that if, perchance, he should ever be persuaded by the devil to leave the monastery (which God forbid), he may be stripped of the monastic habit and cast forth.

[10] A further statement of these mortifications is given in Schaffner, *op. cit.*, and they are considered in detail in a forthcoming paper, "The Moral Career of Mental Patients."

[11] Wider communities in Western society, of course, have employed this technic too, in the form of public floggings and public hangings, the pillory and stocks. Functionally correlated with the public emphasis on mortifications in total institutions is the commonly found strict ruling that staff is not to be humiliated by staff in the presence of inmates.

disciplining of the flesh. What all of these rationales share is the extent to which they are merely rationalizations, for the underlying force in many cases is unwittingly generated by efforts to manage the daily activity of a large number of persons in a small space with a small expenditure of resources.

In the background of the sociological stripping process, we find a characteristic authority system with three distinctive elements, each basic to total institutions.

First, to a degree, authority is of the *echelon* kind. Any member of the staff class has certain rights to discipline any member of the inmate class. This arrangement, it may be noted, is similar to the one which gives any adult in some small American towns certain rights to correct and demand small services from any child not in the immediate presence of his parents. In our society, the adult himself, however, is typically under the authority of a *single* immediate superior in connection with his work or under authority of one spouse in connection with domestic duties. The only echelon authority he must face—the police—typically are neither constantly nor relevantly present, except perhaps in the case of traffic-law enforcement.

Second, the authority of corrective sanctions is directed to a great multitude of items of conduct of the kind that are constantly occurring and constantly coming up for judgment;[12] in brief, authority is directed to matters of dress, deportment, social intercourse, manners and the like. In prisons these regulations regarding situational proprieties may even extend to a point where silence during mealtime is enforced, while in some convents explicit demands may be made concerning the custody of the eyes during prayer.

The third feature of authority in total institutions is that misbehaviors in one sphere of life are held against one's standing in other spheres. Thus, an individual who fails to participate with proper enthusiasm in sports may be brought to the attention of the person who determines where he will sleep and what kind of work task will be accorded to him.

When we combine these three aspects of authority in total institutions, we see that the inmate cannot easily escape from the press

[12] The span of time over which an employee works at his own discretion without supervision can in fact be taken as a measure of his pay and status in an organization. See, Elliot Jacques, *The Measurement of Responsibility: A Study of Work, Payment, and Individual Capacity,* Harvard University Press, Cambridge, 1956. And just as "time-span of resopnsibility" is an index of position, so a long span of freedom from inspection is a reward of position.

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of judgmental officials and from the enveloping tissue of constraint. The system of authority undermines the basis for control that adults in our society expect to exert over their interpersonal environment and may produce the terror of feeling that one is being radically demoted in the age-grading system. On the outside, rules are sufficiently lax and the individual sufficiently agreeable to required self-discipline to insure that others will rarely have cause for pouncing on him. He need not constantly look over his shoulder to see if criticism and other sanctions are coming. On the inside, however, rulings are abundant, novel, and closely enforced so that, quite characteristically, inmates live with chronic anxiety about breaking the rules and chronic worry about the consequences of breaking them. The desire to "stay out of trouble" in a total institution is likely to require persistent conscious effort and may lead the inmate to abjure certain levels of sociability with his fellows in order to avoid the incidents that may occur in these circumstances.[13]

It should be noted finally that the mortifications to be suffered by the inmate may be purposely brought home to him in an exaggerated way during the first few days after entrance, in a form of initiation that has been called *the welcome.* Both staff and fellow inmates may go out of their way to give the neophyte a clear notion of where he stands.[14] As part of this *rite de passage,* he may find himself called by a term such as "fish," "swab," etc., through which older inmates tell him that he is not only merely an inmate but that even within this lowly group he has a low status.

Privilege System. While the process of mortification is in progress, the inmate begins to receive formal and informal instruction in what will here be called the *privilege system.* Insofar as the inmate's self has been unsettled a little by the stripping action of the institution, it is largely around this framework that pressures are exerted, making for a reorganization of self. Three basic elements of the system may be mentioned.

First, there are the *house rules,* a relatively explicit and formal

[13] Staff sometimes encourages this tendency for inmates to stand clear of one another, perhaps in order to limit the dangers of organized inmate resistance to institutional rule. Through an interesting phrase, inmates may be officially encouraged to "do their own time."

[14] For the version of this process in concentration camps, see, Elie A. Cohen, *Human Behaviour in the Concentration Camp,* Jonathan Cape, n. p., 1954, p. 120. For a fictionalized treatment of the welcome in a girls' reformatory, see, Sara Norris, *The Wayward Ones,* Signet Pocket Books, New York, 1952, pp. 31–34.

set of prescriptions and proscriptions which lay out the main requirements of inmate conduct. These regulations spell out the austere round of life in which the inmate will operate. Thus, the admission procedures through which the recruit is initially stripped of his self-supporting context can be seen as the institution's way of getting him in the position to start living by the house rules.

Second, against the stark background, a small number of clearly defined *rewards or privileges* are held out in exchange for obedience to staff in action and spirit. It is important to see that these potential gratifications are not unique to the institution but rather are ones carved out of the flow of support that the inmate previously had quite taken for granted. On the outside, for example, the inmate was likely to be able to unthinkingly exercise autonomy by deciding how much sugar and milk he wanted in his coffee, if any, or when to light up a cigarette; on the inside, this right may become quite problematic and a matter of a great deal of conscious concern. Held up to the inmate as possibilities, these few recapturings seem to have a reintegrative effect, re-establishing relationships with the whole lost world and assuaging withdrawal symptoms from it and from one's lost self.

The inmate's run of attention, then, especially at first, comes to be fixated on these supplies and obsessed with them. In the most fanatic way, he can spend the day in devoted thoughts concerning the possibility of acquiring these gratifications or the approach of the hour at which they are scheduled to be granted.[15] The building of a world around these minor privileges is perhaps the most important feature of inmate culture and yet is something

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[15] Melville's report of life on a man-of-war in the mid-nineteenth century (*White Jacket,* Grove Press, New York, n. d., pp. 62–63, 140) contains a typical illustration:

> In the American Navy the law allows one gill of spirits per day to every seaman. In two portions, it is served out just previous to breakfast and dinner. At the roll of the drum, the sailors assemble around a large tub, or cask, filled with the liquid; and, as their names are called off by a midshipman, they step up and regale themselves from a little tin measure called a "tot." No high-liver helping himself to Tokay off a well-polished sideboard smacks his lips with more mighty satisfaction than the sailor does over his tot. To many of them, indeed, the thought of their daily tot forms a perpetual perspective of ravishing landscapes, indefinitely receding in the distance. It is their greatest "prospect in life." Take away their grog, and life possesses no further charms for them.
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> * * * * *
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> It is one of the most common punishments for very trivial offences in the Navy, to "stop" a seaman's grog for a day or a week. And as most

that cannot easily be appreciated by an outsider, even one who has lived through the experience himself. This situation sometimes leads to generous sharing and almost always to a willingness to beg for things such as cigarettes, candy and newspapers. It will be understandable, then, that a constant feature of inmate discussion is the *release binge fantasy,* namely, recitals of what one will do during leave or upon release from the institution.

House rules and privileges provide the functional requirements of the third element in the privilege system: *punishments.* These are designated as the consequence of breaking the rules. One set of these punishments consists of the temporary or permanent withdrawal of privileges or abrogation of the right to try to earn them. In general, the punishments meted out in total institutions are of an order more severe than anything encountered by the inmate in his home world. An institutional arrangement which causes a small number of easily controlled privileges to have a massive significance is the same arrangement which lends a terrible significance to their withdrawal.

There are some special features of the privilege system which should be noted.

First, punishments and privileges are themselves modes of organization peculiar to total institutions. Whatever their severity, punishments are largely known in the inmate's home world as something applied to animals and children. For adults this conditioning, behavioristic model is actually not widely applied, since failure to maintain required standards typically leads to indirect disadvantageous consequences and not to specific immediate punishment at all.[16] And privileges, it should be emphasized, are not the same as prerequisites, indulgences or values, but merely the absence of deprivations one ordinarily expects one would not have to sustain. The very notions, then, of punishments and privileges are not ones that are cut from civilian cloth.

Second, it is important to see that the question of release from the total institution is elaborated into the privilege system. Some acts will become known as ones that mean an increase or no de-

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seamen so cling to their grog, the loss of it is generally deemed by them a very serious penalty. You will sometimes hear them say, "I would rather have my wind *stopped* than my grog!"

For examples of the same process in POW camps, see, Edgar H. Schein, "The Chinese Indoctrination Program for Prisoners of War," *Psychiatry,* Vol. 19, 1956, pp. 160–161.

[16] See S. F. Nadel, "Social Control and Self-Regulation," *Social Forces,* Vol. 31, 1953, pp. 265–273.

crease in length of stay, while others become known as means for lessening the sentence.

Third, we should also note that punishments and privileges come to be geared into a residential work system. Places to work and places to sleep become clearly defined as places where certain kinds and levels of privilege obtain, and inmates are shifted very rapidly and visibly from one place to another as the mechanisms for giving them the punishment or privilege their cooperativeness has warranted. The inmates are moved, the system is not.

This, then, is the privilege system: a relatively few components put together with some rational intent and clearly proclaimed to the participants. The overall consequence is that cooperativeness is obtained from persons who often have cause to be uncooperative. A typical illustration of this model universe may be taken from a recent study [17] of a State mental hospital:

> The authority of the attendant in the person of his control system is backed up by both positive and negative power. This power is an essential element in his control of the ward. He can give the patient privileges, and he can punish the patient. The privileges consist of having the best job, better rooms and beds, minor luxuries like coffee on the ward, a little more privacy than the average patient, going outside the ward without supervision, having more access than the average patient to the attendant's companionship or to professional personnel like the physicians, and enjoying such intangible but vital things as being treated with personal kindness and respect.
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> The punishments which can be applied by the ward attendant are suspension of all privileges, psychological mistreatment, locking up the patient in an isolated room, denial or distortion of access to the professional personnel, threatening to put or putting the patient on the list for electroshock therapy, transfer of the patient to undesirable wards, and regular assignment of the patient to unpleasant tasks such as cleaning up after the soilers.

Immediately associated with the privilege system we find some standard social processes important in the life of total institutions.

We find that an *institutional lingo* develops through which inmates express the events that are crucial in their particular world. Staff too, especially its lower levels, will know this language, using it when talking to inmates, while reverting to more standardized speech when talking to superiors and outsiders. Related to this special argot, inmates will possess knowledge of the various ranks and officials, an accumulation of lore about the establishment, and some comparative information about life in other similar total institutions.

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[17] Ivan Belknap, *Human Problems of a State Mental Hospital,* McGraw-Hill, New York, 1956, p. 164.

Also found among staff and inmates will be a clear awareness of the phenomenon of *messing up,* so called in mental hospitals, prisons, and barracks. This involves a complex process of engaging in forbidden activity, getting caught doing so, and receiving something like the full punishment accorded this. An alteration in privilege status is usually implied and is categorized by a phrase such as "getting busted." Typical infractions which can eventuate in messing up are: fights, drunkenness, attempted suicide, failure at examinations, gambling, insubordination, homosexuality, improper taking of leave, and participation in collective riots. While these punished infractions are typically ascribed to the offender's cussedness, villainy, or "sickness," they do in fact constitute a vocabulary of institutionalized actions, limited in such a way that the same messing up may occur for quite different reasons. Informally, inmates and staff may understand, for example, that a given messing up is a way for inmates to show resentment against a current situation felt to be unjust in terms of the informal agreements between staff and inmates,[18] or a way of postponing release without having to admit to one's fellow inmates that one really does not want to go.[19]

In total institutions there will also be a system of what might be called *secondary adjustments,* namely, technics which do not directly challenge staff management but which allow inmates to obtain disallowed satisfactions or allowed ones by disallowed means. These practices are variously referred to as: the angles, knowing the ropes, conniving, gimmicks, deals, ins, etc. Such adaptations apparently reach their finest flower in prisons, but of course other total institutions are overrun with them too.[20] It seems apparent that an important aspect of secondary adjustments is that they provide the inmate with some evidence that he is still, as it were, his own man and still has some protective distance, under his own control, between himself and the institu-

[18] For example, see, Morris G. Caldwell, "Group Dynamics in the Prison Community," *Journal of Criminal Law, Criminology and Police Science,* Vol. 46, 1956, p. 656.

[19] There are some interesting incidental social functions of messings up. First, they tend to limit rigidities which might occur were seniority the only means of mobility in the privilege system. Secondly, demotion through messing up brings old-time inmates in contact with new inmates in unprivileged positions, assuring a flow of information about the system and the people in it.

[20] See, for example, Norma S. Hayner and Ellis Ash, "The Prisoner Community as a Social Group," *American Sociological Review,* Vol. 4, 1939, p. 364 ff. under "Conniving Processes;" also, Caldwell, *op. cit.,* pp. 650–51.

tion. In some cases, then, a secondary adjustment becomes almost a kind of lodgment for the self, a churinga in which the soul is felt to reside.[21]

The occurrence of secondary adjustments correctly allows us to assume that the inmate group will have some kind of a *code* and some means of informal social control evolved to prevent one inmate from informing staff about the secondary adjustments of another. On the same grounds we can expect that one dimension of social typing among inmates will turn upon this question of security, leading to persons defined as "squealers," "finks," or "stoolies" on one hand, and persons defined as "right guys" on the other.[22] It should be added that where new inmates can play a role in the system of secondary adjustments, as in providing new faction members or new sexual objects, then their "welcome" may indeed be a sequence of initial indulgences and enticements, instead of exaggerated deprivations.[23] Because of secondary adjustments we also find *kitchen strata,* namely, a kind of rudimentary, largely informal, stratification of inmates on the basis of each one's differential access to disposable illicit commodities; so also we find social typing to designate the powerful persons in the informal market system.[24]

While the privilege system provides the chief framework within which reassembly of the self takes place, other factors characteristically lead by different routes in the same general direction. Relief from economic and social responsibilities—much touted as part of the therapy in mental hospitals—is one, although in many cases it would seem that the disorganizing effect of this moratorium is more significant than its organizing effect. More important as a reorganizing influence is the *fraternalization process,* namely, the process through which socially distant persons find themselves developing mutual support and common *counter-mores*

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[21] See, for example, Melville's extended description of the fight his fellow seamen put up to prevent the clipping of their beards in full accordance with Navy regulations. Melville, *op. cit.,* pp. 333–347.

[22] See, for example, Donald Clemmer, "Leadership Phenomenon in a Prison Community," *Journal of Criminal Law, Criminology and Police Science,* Vol. 28, 1938, p. 868.

[23] See, for example, Ida Ann Harper, "The Role of the 'Fringer' in a State Prison for Women," *Social Forces,* Vol. 31, 1952, pp. 53–60.

[24] For concentration camps, see the discussion of "Prominents" throughout Cohen, *op. cit.;* for mental hospitals, see Belknap, *op. cit.,* p. 189. For prisons, see the discussion of "Politicos" in Donald Clemmer, *The Prison Community,* Christopher Publishing House, Boston, 1940, pp. 277–279, 298–309; also Hayner, *op. cit.,* p. 367; and Caldwell, *op. cit.,* pp. 651–653.

in opposition to a system that has forced them into intimacy and into a single, equalitarian community of fate.[25] It seems that the new recruit frequently starts out with something like the staff's popular misconceptions of the character of the inmates and then comes to find that most of his fellows have all the properties of ordinary decent human beings and that the stereotypes associated with their condition or offense are not a reasonable ground for judgment of inmates.[26]

If the inmates are persons who are accused by staff and society of having committed some kind of a crime against society, then the new inmate, even though sometimes in fact quite guiltless, may come to share the guilty feelings of his fellows and, thereafter, their well-elaborated defenses against these feelings. A sense of common injustice and a sense of bitterness against the outside world tends to develop, marking an important movement in the inmate's moral career. This response to felt guilt and massive deprivation is most clearly illustrated perhaps in prison life: [27]

> By their reasoning, after an offender has been subjected to unfair or excessive punishment and treatment more degrading than that prescribed by law, he comes to justify his act which he could not have justified when he committed it. He decides to "get even" for his unjust treatment in prison and takes reprisals through further crime at the first opportunity. *With that decision he becomes a criminal.*

A more general statement [28] may be taken from two other students of the same kind of total institution:

> In many ways, the inmate social system may be viewed as providing a way of life which enables the inmates to avoid the devastating psychological effects of internalizing and converting social rejection into self rejection. In effect, it permits the inmate to reject his rejectors rather than himself.

Adaptation Alignments. The mortifying processes that have been discussed and the privilege system represent the conditions that the inmate must adapt to in some way, but however pressing,

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[25] For the version of this inmate solidarity to be found in military academies, see, Sanford M. Dornbush, "The Military Academy as an Assimilating Institution," *Social Forces*, Vol. 33, 1955, p. 318.

[26] An interesting example of this re-evaluation may be found in a conscientious objector's experience with nonpolitical prisoners, see Alfred Hassler, *Diary of a Self-Made Convict*, Henry Regnery, Chicago, 1954, p. 74, 117. In mental hospitals, of course, the patient's antagonism to staff obtains one of its supports from the discovery that, like himself, many other patients are more like ordinary persons than like anything else.

[27] Richard McCleery, *The Strange Journey*, University of North Carolina Extension Bulletin, Vol. 32, 1953, p. 24. Italics are McCleery's.

[28] Lloyd W. McCorkle and Richard Korn, "Resocialization Within Walls," *The Annals*, May 1954, p. 88. See also p. 95.

these conditions allow for different ways of meeting them. We find, in fact, that the same inmate will employ different lines of adaptation or tacks at different phases in his moral career and may even fluctuate between different tacks at the same time.

First, there is the process of *situational withdrawal.* The inmate withdraws apparent attention from everything except events immediately around his body and sees these in a perspective not employed by others present. This drastic curtailment of involvement in interactional events is best known, of course, in mental hospitals, under the title of "regression." Aspects of "prison psychosis" or "stir simpleness" represent the same adjustment, as do some forms of "acute depersonalization" described in concentration camps. I do not think it is known whether this line of adaptation forms a single continuum of varying degrees of withdrawal or whether there are standard discontinuous plateaus of disinvolvement. It does seem to be the case, however, that, given the pressures apparently required to dislodge an inmate from this status, as well as the currently limited facilities for doing so, we frequently find here, effectively speaking, an irreversible line of adaptation.

Second, there is the *rebellious line.* The inmate intentionally challenges the institution by flagrantly refusing to cooperate with staff in almost any way.[29] The result is a constantly communicated intransigency and sometimes high rebel-morale. Most large mental hospitals, for example, seem to have wards where this spirit strongly prevails. Interestingly enough, there are many circumstances in which sustained rejection of a total institution requires sustained orientation to its formal organization and hence, paradoxically, a deep kind of commitment to the establishment. Similarly, when total institutions take the line (as they sometimes do in the case of mental hospitals prescribing lobotomy [30] or army barracks prescribing the stockade) that the recalcitrant inmate must be broken, then, in their way, they must show as much special devotion to the rebel as he has shown to them. It should be added, finally, that while prisoners of war have been known staunchly to take a rebellious stance throughout their incarceration, this stance is typically a temporary and initial phase of reaction, emerging from this to situational withdrawal or some other line of adaptation.

Third, another standard alignment in the institutional world

[29] See, for example, the discussion of "The Resisters," in Schein, *op. cit.*, pp. 166–167.

[30] See, for example, Belknap, *op. cit.*, p. 192.

takes the form of a kind of *colonization.* The sampling of the outside world provided by the establishment is taken by the inmate as the whole, and a stable, relatively contented existence is built up out of the maximum satisfactions procurable within the institution.[31] Experience of the outside world is used as a point of reference to demonstrate the desirability of life on the inside; and the usual tension between the two worlds collapses, thwarting the social arrangements based upon this felt discrepancy. Characteristically, the individual who too obviously takes this line may be accused by his fellow inmates of "having found a home" or of "never having had it so good." Staff itself may become vaguely embarrassed by this use that is being made of the institution, sensing that the benign possibilities in the situation are somehow being misused. Colonizers themselves may feel obliged to deny their satisfaction with the institution, if only in the interest of sustaining the counter-mores supporting inmate solidarity. They may find it necessary to mess up just prior to their slated discharge, thereby allowing themselves to present involuntary reasons for continued incarceration. It should be incidentally noted that any humanistic effort to make life in total institutions more bearable must face the possibility that doing so may increase the attractiveness and likelihood of colonization.

Fourth, one mode of adaptation to the setting of a total institution is that of *conversion.* The inmate appears to take over completely the official or staff view of himself and tries to act out the role of the perfect inmate. While the colonized inmate builds as much of a free community as possible for himself by using the limited facilities available, the convert takes a more disciplined, moralistic, monochromatic line, presenting himself as someone whose institutional enthusiasm is always at the disposal of the staff. In Chinese POW camps, we find Americans who became "pros" and fully espoused the Communist view of the world.[32] In army barracks there are enlisted men who give the impression that they are always "sucking around" and always "bucking for promotion." In prisons there are "square johns." In German concentration camps, longtime prisoners sometimes came to adapt the vocabulary, recreation, posture, expressions of aggression, and clothing style of the Gestapo, executing their role of straw-boss

[31] In the case of mental hospitals, those who take this line are sometimes called "institutional cures" or are said to suffer from "hospitalitis."

[32] Schein, *op. cit.*, pp. 167–169.

with military strictness.[33] Some mental hospitals have the distinction of providing two quite different conversion possibilities—one for the new admission who can see the light after an appropriate struggle and adapt the psychiatric view of himself, and another for the chronic ward patient who adopts the manner and dress of attendants while helping them to manage the other ward patients with a stringency excelling that of the attendants themselves.

Here, it should be noted, is a significant way in which total institutions differ. Many, like progressive mental hospitals, merchant ships, TB sanitariums and brainwashing camps, offer the inmate an opportunity to live up to a model of conduct that is at once ideal and staff-sponsored—a model felt by its advocates to be in the supreme interests of the very persons to whom it is applied. Other total institutions, like some concentration camps and some prisons, do not officially sponsor an ideal that the inmate is expected to incorporate as a means of judging himself.

While the alignments that have been mentioned represent coherent courses to pursue, few inmates, it seems, carry these pursuits very far. In most total institutions, what we seem to find is that most inmates take the tack of what they call *playing it cool.* This involves a somewhat opportunistic combination of secondary adjustments, conversion, colonization and loyalty to the inmate group, so that in the particular circumstances the inmate will have a maximum chance of evenutally getting out physically and psychically undamaged.[34] Typically, the inmate will support the counter-mores when with fellow inmates and be silent to them on how tractably he acts when alone in the presence of staff.[35] In-

[33] See, Bruno Bettelheim, "Individual and Mass Behavior in Extreme Situations," *Journal of Abnormal and Social Psychology,* Vol. 38, 1943, pp. 447–451. It should be added that in concentration camps, colonization and conversion often seemed to go together. See, Cohen, *op. cit.,* pp. 200–203, where the role of the "Kapo" is discussed.

[34] See the discussion in Schein, *op. cit.,* pp. 165–166 of the "Get-Alongers," and Robert J. Lifton, "Home by Ship: Reaction Patterns of American Prisoners of War Repatriated From North Korea," *American Journal of Psychiatry,* Vol. 110, 1954, p. 734.

[35] This two-facedness, of course, is very commonly found in total institutions. In the state-type mental hospital studied by the writer, even the few elite patients selected for individual psychotherapy, and hence in the best position for espousal of the psychiatric approach to self, tended to present their favorable view of psychotherapy only to the members of their intimate cliques. For a report on the way in which Army prisoners concealed from fellow offenders their interest in "restoration" to the Army, see the comments by Richard Cloward in Session 4 of *New Perspectives for Research on Juve-*

mates taking this line tend to subordinate contacts with their fellows to the higher claim of "keeping out of trouble." They tend to volunteer for nothing, and they may even learn to cut their ties to the outside world sufficiently to give cultural reality to the world inside but not enough to lead to colonization.

I have suggested some of the lines of adaptation that inmates can take to the pressures that play in total institutions. Each represents a way of managing the tension between the home world and the institutional world. However, there are circumstances in which the home world of the inmate was such, in fact, as to *immunize* him against the bleak world on the inside, and for such persons no particular scheme of adaptation need be carried very far. Thus, some lower-class mental hospital patients who have lived all their previous life in orphanages, reformatories and jails, tend to see the hospital as just another total institution to which it is possible to apply the adaptive technics learned and perfected in other total institutions. "Playing it cool" represents for such persons, not a shift in their moral career, but an alignment that is already second nature.

The professional criminal element in the early periods of German concentration camps displayed something of the same immunity to their surroundings or even found new satisfactions through fraternization with middle-class political prisoners.[36] Similarly, Shetland youths recruited into the British merchant marine are not apparently threatened much by the cramped arduous life on board, because island life is even more stunted; they make uncomplaining sailors because from their point of view they have nothing much to complain about. Strong religious and political convictions may also serve perhaps to immunize the true believer against the assaults of a total institution, and even a failure to speak the language of the staff may cause the staff to give up its efforts at reformation, allowing the nonspeaker immunity to certain pressures.[37]

Culture Themes. A note should be added here concerning some of the more dominant themes of inmate culture.

First, in the inmate group of many total institutions there is a

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nile Delinquency, ed. by Helen L. Witmer and Ruth Kotinsky, U. S. Department of Health, Education and Welfare, Children's Bureau Bulletin, 1955, especially p. 90.

[36] Bettleheim, *op. cit.*, p. 425.

[37] Thus, Schein, *op. cit.*, p. 165 fn., suggests that Puerto Ricans and other non-English-speaking prisoners of war in China were given up on and allowed to work out a viable routine of menial chores.

strong feeling that time spent in the establishment is time wasted or destroyed or taken from one's life; it is time that must be written off. It is something that must be "done" or "marked" or "put in" or "built" or "pulled." (Thus, in prisons and mental hospitals a general statement of how well one is adapting to the institution may be phrased in terms of how one is doing time, whether easily or hard.[38]) As such, this time is something that its doers have bracketed off for constant conscious consideration in a way not quite found on the outside. And as a result, the inmate tends to feel that for the duration of his required stay—his sentence—he has been totally exiled from living.[39] It is in this context that we can appreciate something of the demoralizing influence of an indefinite sentence or a very long one. We should also note that however hard the conditions of life may become in total institutions, harshness alone cannot account for this quality of life wasted. Rather we must look to the social disconnections caused by entrance and to the usual failure to acquire within the institution gains that can be transferred to outside life—gains such as money earned, or marital relations formed, or certified training received.[40]

Second, it seems that in many total institutions a peculiar kind and level of self-concern in engendered. The low position of inmates relative to their station on the outside, as established initially through the mortifying processes, seems to make for a milieu of personal failure and a round of life in which one's fall from grace is continuously pressed home. In response, the inmate tends to develop a story, a line, a sad tale—a kind of lamentation and apologia—which he constantly tells to his fellows as a means of creditably accounting for his present low estate. While staff constantly discredit these lines, inmate audiences tend to employ

[38] Much material on the conception of time in total institutions may be found in Maurice L. Farber, "Suffering the Time Perspective of the Prisoner," part IV, pp. 155–227 of *Authority and Frustration*, by Kurt Lewin *et al.*, Studies in Topological and Vector Psychology III, University of Iowa Studies in Child Welfare, Vol. 20, 1944.

[39] The best description that I know of this feeling of not-living is Freud's paper, "Mourning and Melancholia," where the state is said to come about as a consequence of losing a loved object. See, *Collected Papers of Sigmund Freud*, Hogarth Press, London, 1953, Vol. 4, pp. 152–170.

[40] Thus, one of the virtues of the doctrine that insane asylums are treatment hospitals for sick people is that inmates who have given up 3 or 4 years of their life to this kind of exile can try to convince themselves that they have been busily working on their cure, and that once cured the time spent getting cured will have been a reasonable and profitable investment.

tact,[41] suppressing at least some of the disbelief and boredom engendered by these recitations. In consequence, the inmate's own self may become even more of a focus for his conversation that it does on the outside.

Perhaps the high level of ruminative self-concern found among inmates in total institutions is a way of handling the sense of wasted time that prevails in these places. If so, then perhaps another interesting aspect of inmate culture can be related to the same factor. I refer here to the fact that in total institutions we characteristically find a premium placed on what might be called *removal activities,* namely, voluntary unserious pursuits which are sufficiently engrossing and exciting to lift the participant out of himself, making oblivious for the time to his actual situation. If the ordinary activities in total institutions can be said to torture time, these activities mercifully kill it.

Some removal activities are collective, such as ball games, woodwork, lectures, choral singing and card playing; some are individual but rely on public materials, as in the case of reading, solitary TV watching, etc.[42] No doubt, private fantasy ought to be included too. Some of these activities may be officially sponsored by staff; and some, not officially sponsored, may constitute secondary adjustments. In any case, there seems to be no total institution which cannot be seen as a kind of Dead Sea in which appear little islands of vivid, enrapturing activity.

Consequences. In this discussion of the inmate world, I have commented on the mortification processes, the reorganizing influences, the lines of response taken by inmates under these circumstances, and the cultural milieu that develops. A concluding word must be added about the long-range consequences of membership.

Total institutions frequently claim to be concerned with rehabilitation, that is, with resetting the inmate's self-regulatory mechanisms so that he will maintain the standards of the estab-

[41] See, for example, Hassler, *op. cit.*, p. 116: "Even more impressive is the almost universal delicacy when it comes to inquiring into another man's misdeeds, and the refusal to determine one's relations with another convict on the basis of his record." Similarly, in our State mental hospitals inmate etiquette allows one patient to ask another what ward and service he is on and how long he has been in the hospital, but questions about why one is "in" are not quickly asked and are rarely answered openly.

[42] Such activity is, of course, not restricted to total institutions. Thus, we find the classic case of the bored and weary housewife who "takes a few minutes for herself" to "put her feet up" and removes herself from home by reading the morning paper over a cup of coffee and a cigarette.

lishment of his own accord after he leaves the setting.[43] In fact, it seems this claim is seldom realized and even when permanent alteration occurs, these changes are often not of the kind intended by the staff. With the possible exception presented by the great resocialization efficiency of religious institutions, neither the stripping processes nor the reorganizing ones seem to have a lasting effect.[44] No doubt the availability of secondary adjustments helps to account for this, as do the presence of counter-mores and the tendency for inmates to combine all strategies and "play it cool." In any case, it seems that shortly after release, the ex-inmate will have forgotten a great deal of what life was like on the inside and will have once again begun to take for granted the privileges around which life in the institution was organized. The sense of injustice, bitterness and alienation, so typically engendered by the inmate's experience and so definitely marking a stage in his moral career, seems to weaken upon graduation, even in those cases where a permanent stigma has resulted.

But what the ex-inmate does retain of his institutional experience tells us important things about total institutions. Often entrance will mean for the recruit that he has taken on what might be called a *proactive status*. Not only is his relative social position within the walls radically different from what it was on the outside, but, as he comes to learn, if and when he gets out, his social position on the outside will never again be quite what it was prior to entrance. Where the proactive status is a relatively favorable one, as it is for those who graduate from officers' training schools, elite boarding schools, ranking monastaries, etc., then the permanent alteration will be favorable, and jubilant official reunions announcing pride in one's "school" can be expected. When, as seems usually the case, the proactive status is unfavorable, as it is for those in prisons or mental hospitals, we popularly employ the term "stigmatization" and expect that the ex-inmate may make an effort to conceal his past and try to "pass."[45]

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[43] Interestingly enough, staff is expected to be properly self-regulating upon first coming to the total institution, sharing with members of other kinds of establishments the ideal of needing merely to learn procedure.

[44] The strongest evidence for this, perhaps, comes from our knowledge of the readjustment of repatriated brain-washed prisoners of war. See, for example, Lawrence E. Hinkle, Jr., and Harold G. Wolff, "*Communist* Interrogation and Indoctrination of 'Enemies of the State'," *Archives of Neurology and Psychiatry*, Vol. 76, 1956, p. 174.

[45] As Cloward, *op. cit.*, pp. 80–83, implies, one important kind of leverage staff has in regard to inmates and one factor leading inmates to act convertible in presence of staff is that staff can give the kind of discharge that

The Staff World

Humane Standards. Most total institutions, most of the time, seem to function merely as storage dumps for inmates, but as previously suggested, they usually present themselves to the public as rational organizations designed consciously, through and through, as effective machines for producing a few officially avowed and officially approved ends. It was also suggested that one frequent official objective is the reformation of inmates in the direction of some ideal standard. This contradiction, then, between what the institution does and what its officials must say that it does, forms the central context of the staff's daily activity.

Within this context, perhaps the first thing to say about staff is that their work, and hence their world, has uniquely to do with people. This people-work is not quite like personnel work nor the work of those involved in service relationships. Staffs, after all, have objects and products to work upon, not relationships, but these objects and products are people.

As material upon which to work, people involve some of the considerations characteristic of inanimate objects. Just as an article being processed through an industrial plant must be followed by a paper shadow showing what has been done by whom, what is to be done, and who last had responsibility for it, so human objects moving, say, through a mental hospital system must be followed by a chain of informative receipts detailing what has been done to and by the patient and who has most recent responsibility for him. In his career from admission suite to burial plot, many different kinds of staff will add their official note to his case file as he temporarily passes under their jurisdiction, and long after he has died physically his marked remains will survive as an actionable entity in the hospital's bureaucratic system. Even the presence or absence of a particular patient at a given meal or for a given night may have to be recorded so that cost-accounting can be maintained and appropriate adjustments rendered in billing.

Other similarities between people-work and object-work are obvious. Just as tin mines or paint factories or chemical plants may involve special work hazards for employees, so (staffs believe

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may appear to reduce stigmatization. Prison barracks officials can hold up the possibility of the inmate's "restoration" to active duty and, potentially, an honorable discharge; mental hospital administrators can hold up the possibility of a "clean bill of health" (discharged as cured) and personal recommendations.

at least) there are special dangers to some kinds of people-work. In mental hospitals, staffs believe that patients may strike out "for no reason" and injure an official. In army prisons, staff "is ever haunted by the spectre of riot, revolt or mutiny. . . ." [46] In TB sanitariums and in leprosoriums, staff feel they are being specially exposed to dangerous diseases.

While these similarities between people- and object-work exist, it is, I think, the unique aspects of people as material to work upon that we must look to for the crucial determinants of the work-world of staff.

Given the physiological characteristics of the human organism, it is obvious that certain requirements must be met if any continued use is to be made of people. But this, of course, is the case with inanimate objects, too; the temperature of any storehouse must be regulated, regardless of whether people or things are stored. However, persons are almost always considered to be ends in themselves, as reflected in the broad moral principles of a total institution's environing society. Almost always, then, we find that some technically unnecessary standards of handling must be maintained with human materials. This maintenance of what we can call humane standards comes to be defined as one part of the "responsibility" of the institution and presumably is one of the things the institution guarantees the inmate in exchange for his liberty. Thus, prison officials are obliged to thwart suicidal efforts of the prisoner and to give him full medical attention even though in some cases this may require postponement of his date of execution. Something similar has been reported in German concentration camps, where inmates were sometimes given medical attention to tidy them up into a healthier shape for the gas chamber.

A second special contingency in the work-world of staff is the fact that inmates typically have statuses and relationships in the outside world that must be taken into consideration. (This consideration, of course, is related to the previously mentioned fact that the institution must respect some of the rights of inmates qua persons.) Even in the case of the committed mental patient whose civil rights are largely taken from him, a tremendous amount of mere paper work will be involved. Of course, the rights that are denied a mental patient are usually transferred to a relation, to a committee, or to the superintendent of the hospital itself, who then becomes the legal person whose authoriza-

[46] Cloward, *op. cit.*, p. 82.

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tion must be obtained for many matters. Many issues originating outside the institution will arise: Social Security benefits, income taxes, upkeep of properties, insurance payments, old age pension, stock dividends, dental bills, legal obligations incurred prior to commitment, permission to release psychiatric case records to insurance companies or attorneys, permission for special visits from persons other than next of kin, etc. All of these issues have to be dealt with by the institution, even if only to pass the decisions on to those legally empowered to make them.

It should be noted that staff is reminded of its obligations in these matters of standards and rights, not only by its own internal superordinates, by various watchdog agencies in the wider society, and by the material itself,[47] but also by persons on the outside who have kin ties to inmates. The latter group present a special problem because, while inmates can be educated about the price they will pay for making demands on their own behalf, relations receive less tutoring in this regard and rush in with requests for inmates that inmates would blush to make for themselves.[48]

The multiplicity of ways in which inmates must be considered ends in themselves and the multiplicity of inmates themselves forces upon staff some of the classic dilemmas that must be faced by those who govern men. Since a total institution functions somewhat as a State, its staff must suffer somewhat from the tribulations that beset governors.

In the case of any single inmate, the assurance that certain standards will be maintained in his own interests may require sacrifice of other standards, and implied in this is a difficult weighing of ends. For example, if a suicidal inmate is to be kept alive, staff may feel it necessary to keep him under constant deprivatizing surveillance or even tied to a chair in a small locked room. If a mental patient is to be kept from tearing at grossly irritated sores and repeating time and again a cycle of curing

[47] Thus, some attendants in mental hospitals prefer to work on regressed wards because patients there tend to make fewer time-consuming requests than do patients on better wards who are in good contact.

[48] The visiting rooms in some total institutions represent a nice attempt to resolve this problem. Decor and conduct in these places are typically much closer to outside standards than what prevails in the actual living quarters. The view that outsiders get of inmates functions then to decrease the pressure these outsiders might otherwise bring against the institution. It is perhaps a melancholy human fact that after some time all three parties to the fiction—inmate, visitor, staff—realize that the visiting room presents a dressed-up view and realize that the other parties realize this too, and yet all tacitly agree to continue with the fiction.

and disorder, staff may feel it necessary to curtail the freedom of his hands. Another patient who refuses to eat may have to be humiliated by forced feeding. If inmates of TB sanitariums are to be given an opportunity to recover, it will be necessary to curtail freedom of recreation.[49]

The standards of treatment that one inmate has a right to expect may conflict, of course, with the standards desired by another, giving rise to another set of governmental problems. Thus, in mental hospitals, if the grounds gate is to be kept open out of respect for those with town parole, then some other patients who otherwise could have been trusted on the grounds may have to be kept on locked wards. And if a canteen and mailbox are to be freely available to those on the grounds, then patients on a strict diet or those who write threatening and obscene letters will have to be denied liberty on the grounds.

The obligation of staff to maintain certain humane standards of treatment for inmates represents problems in itself, as suggested above, but a further set of characteristic problems is found in the constant conflict between humane standards on one hand and institutional efficiency on the other. I will cite only one main example. The personal possessions of an individual are an important part of the materials out of which he builds a self, but as an inmate, the ease with which he can be managed by staff is likely to increase with the degree to which he is dispossessed. Thus, the remarkable efficiency with which a mental hospital ward can adjust to a daily shift in number of resident patients is related to the fact that the comers and leavers do not come or leave with any properties but themselves and do not have any right to choose where they will be located. Further, the efficiency with which the clothes of these patients can be kept clean and fresh is related to the fact that everyone's soiled clothing can be indiscriminately placed in one bundle, and laundered clothing can be redistributed not according to ownership but according to rough size. Similarly, the quickest assurance that patients going on the grounds will be warmly dressed is to march them in file past a pile of the ward's allotment of coats, requiring them

[49] Extremely useful material on TB sanitariums as total institutions will be available in the forthcoming work by Julius A. Roth, Committee on Human Development, University of Chicago. Preliminary statements may be found in his articles "What is an Activity?" *Etc.*, Vol. XIV, Autumn 1956, pp. 54–56, and "Ritual and Magic in the Control of Contagion," *American Sociological Review*, Vol. 22, June 1957, pp. 310–314.

for the same purposes of health to throw off these collectivized garments on returning to the ward.

Just as personal possessions may interfere with the smooth running of an institutional operation and be removed for this reason, so parts of the body itself may conflict with efficient management and the conflict resolved in favor of efficiency. If the heads of inmates are to be kept clean and the possessor easily identified, then a complete head shave is efficacious, regardless of the damage this does to appearance. On similar grounds, some mental hospitals have found it useful to extract the teeth of "biters," give hysterectomies to promiscuous female patients, and perform lobotomies on chronic fighters. Flogging on men-of-war as a form of punishment expressed the same conflict between organizational and humane interests:[50]

> One of the arguments advanced by officers of the Navy in favor of corporal punishment is this: it can be inflicted in a moment; it consumes no valuable time; and when the prisoner's shirt is put on, *that* is the last of it. Whereas, if another punishment were substituted, it would probably occasion a great waste of time and trouble, besides thereby begetting in the sailor an undue idea of his importance.

I have suggested that people-work differs from other kinds because of the tangle of statuses and relationships which each inmate brings with him to the institution and because of the humane standards that must be maintained with respect to him. Another difference occurs in cases where inmates have some rights to visit off the grounds, for then the mischief they may do in civil society becomes something for which the institution has some responsibility. Given this responsibility, it is understandable that total institutions tend not to view off-grounds leave favorably. Still another type of difference between people-work and other kinds, and perhaps the most important difference of all, is that by the exercise of threat, reward or persuasion human objects can be given instructions and relied upon to carry them out on their own. The span of time during which these objects can be trusted to carry out planned actions without supervision will vary of course a great deal, but, as the social organization of back wards in mental hospitals teaches us, even in the limiting case of catatonic schizophrenics, a considerable amount of such reliance is possible. Only the most complicated electronic equipment shares this capacity.

While human materials can never be as refractory as inanimate ones, their very capacity to perceive and to follow out the plans

[50] Melville, *op. cit.*, p. 139.

of staff insures that they can hinder the staff more effectively than inanimate objects can. Inanimate objects cannot purposely and intelligently thwart our plans, regardless of the fact that we may momentarily react to them as if they had this capacity. Hence, in prison and on "better" wards of mental hospitals, guards have to be ready for organized efforts at escape and must constantly deal with attempts to bait them, "frame" them, and otherwise get them into trouble. This leads to a state of anxiety in the guard that is not alleviated by knowledge that the inmate may be acting thusly merely as a means of gaining self-respect or relieving boredom.[51] Even an old, weak, mental patient has tremendous power in this regard; for example, by the simple expedient of locking his thumbs in his trouser pockets he can remarkably frustrate the efforts of an attendant to undress him.

A third general way in which human materials are different from other kinds and hence present unique problems is that, however distant staff manages to stay from them, they can become objects of fellow-feeling and even affection. Always there is the danger that an inmate will appear human. If what are felt to be hardships must be inflicted on the inmate, then sympathetic staff will suffer. And on the other hand, if an inmate breaks a rule, staff's conceiving of him as a human being may increase their sense that injury has been done to their moral world. Expecting a "reasonable" response from a reasonable creature, staff may feel incensed, affronted and challenged when this does not occur. Staff thus finds it must maintain face not only before those who examine the product of work but before these very products themselves.

The capacity of inmates to become objects of staff's sympathetic concern is linked to what might be called an involvement cycle sometimes recorded in total institutions. Starting at a point of social distance from inmates, a point from which massive deprivation and institutional trouble cannot easily be seen, the staff person finds he has no reason not to build up a warm involvement in some inmates. The involvement, however, brings the staff members into a position to be hurt by what inmates do and by what they suffer, and also brings him to a position from which he is likely to threaten the distant stand from inmates taken by his fellow members of the staff. In response, the sympathizing staff

[51] For comments on the very difficult role of guard, see, McCorkle and Korn, *op. cit.*, pp. 93–94, and Gresham M. Sykes, "The Corruption of Authority and Rehabilitation," *Social Forces*, Vol. 34, 1956, pp. 257–262.

member may feel he has been "burnt" and retreat into paperwork, committee work or other staff-enclosed routine. Once removed from the dangers of inmate contact, he may gradually cease to feel he has reason to remain so, and thus the cycle of contact and withdrawal may be repeated again and again.

When we combine together the fact that staff is obliged to maintain certain standards of humane treatment for inmates and may come to view inmates as reasonable, responsible creatures who are fitting objects for emotional involvement, we have the background for some of the quite special difficulties of people-work. In mental hospitals, for example, there always seem to be some patients who dramatically act against their own obvious self-interest. They drink water they have themselves first polluted; they rush against the wall with their heads; they tear out their own sutures after a minor operation; they flush false teeth down the toilet, without which they cannot eat and which take months to obtain; or smash glasses, without which they cannot see. In an effort to frustrate these visibly self-destructive acts, staff may find itself forced to manhandle these patients. Staff then is forced to create an image of itself as harsh and coercive, just at the moment that it is attempting to prevent someone from doing to himself what no human being is expected to do to anyone. At such times it is extremely difficult for staff members to keep their own emotions in control, and understandably so.

Moral Climate. The special requirements of people-work establish the day's job for staff, but this job must be carried out in a special moral climate. For the staff is charged with meeting the hostility and demands of the inmates, and what it has to meet the inmate with, in general, is the rational perspective espoused by the institution. It is the role of the staff to defend the institution in the name of its avowed rational aims—to the inmate as well as to outsiders of various kinds. Thus, when inmates are allowed to have incidental face-to-face contact with staff, the contact will often take the form of "gripes" or requests on the part of the inmate and of justification for prevailing restrictive treatment on the part of the staff. Such, for example, is the general structure of staff-patient interaction in mental hospials. Further, the privileges and punishments meted out by staff will often be couched in a language that reflects the legitimated objectives of the institution, even though this may require

that inmates or low-level members of staff translate these responses into the verbal language of the privilege system.[52]

Given the inmates over whom it has charge and the processing that must be done to these objects, staff tends to evolve what may be thought of as a *theory of human nature.* This verbalized perspective rationalizes the scene, provides a subtle means of maintaining social distance from inmates and a stereotyped view of them, and gives sanction to the treatment accorded them.[53] Typically, the theory covers the "good" and "bad" possibilities of inmate conduct, the forms that messing up take, and the instructional value of privileges and punishments. In army barracks, officers will have a theory about the relation between discipline and obedience under fire, about the qualities proper to men, about the "breaking point" of men, and about the difference between mental sickness and malingering. In prisons, we find currently an interesting conflict between the psychiatric and the moral-weakness theory of crime. In convents, we find theories about the way in which the spirit can be weak and strong, and the ways its defects can be combatted. Mental hospitals, it should be noted, are especially interesting in this connection because staff members pointedly establish themselves as specialists in the knowledge of human nature who must diagnose and prescribe on the basis of this philosophy. Hence, in the standard psychiatric textbooks there are chapters on "psychodynamics" and "psychopathology" which provide charmingly explicit formulations of the "nature" of human nature.[54]

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[52] A clear example of this is provided by Belknap, *op. cit.*, p. 170, in describing what happens when a patient breaks a rule and is punished:

> In the usual case of this kind, such things as impudence, insubordination, and excessive familiarity are translated into more or less professional terms, such as "disturbed" or "excited," and presented by the attendant to the physician as a medical report. The doctor must them officially revoke or modify the patient's privileges on the ward or work out a transfer to another ward where the patient has to begin all over to work up from the lowest group. A "good" doctor in the attendants' culture is one who does not raise too many questions about these translated medical terms.

[53] I derive this from Everett C. Hughes' review of Leopold von Wies's *Spätlese,* in *American Journal of Sociology,* Vol. LXI, 1955, p. 182. A similar area is covered under the current anthropological term "ethnopsychology," except that the unit to which it applies is a culture, not an institution.

[54] The engulfing character of an institution's theory of human nature is nicely expressed currently in progressive psychiatric establishments. The theories originally developed to deal with inmates are being applied more and more in these places to the staff as well, so that low-level staff must do its penance in group psychotherapy, and high-level staff in individual psychoanalysis. There is even some movement to bring in consulting sociological therapists for the institution as a whole.

Given the fact that the management of inmates is typically rationalized in terms of the ideal aims or functions of the establishment and that certain humane standards will form part of this ideal, we can expect that professionals ostensibly hired to service these functions will likely become dissatisfied, feeling that they are being used as "captives" to add professional sanction to the privilege system and that they cannot here properly practice their calling. And this seems to be a classic cry.[55] At the same time, the category of staff that must keep the institution going through continuous contact with inmates may feel that they too are being set a contradictory task, having to coerce inmates into obedience while at the same time giving the impression that humane standards are being maintained and that the rational goals of the institution are being realized.

Institutional Ceremonies

I have described total institutions from the point of view of inmates and from the point of view of the staff. Each of these two perspectives contains as one crucial element a role-image of the other grouping; but while this role-image of the other is held, it is seldom sympathetically taken, except perhaps on the part of those inmates, previously described, who take a trusty role and seriously "identify with the aggressor." When unusual intimacies and relationships do occur across the staff-inmate line, we know that involvement cycles may follow, and all kinds of awkward reverberations are likely to occur.[56] Every total institution, however, seems to develop—whether spontaneously or by imitation—a set of institutionalized practices through which staff and inmates come together closely enough so that each may have an image of the other that is somewhat favorable and also be able to take the role sympathetically that this image suggests. Instead of differences between the two levels, we will then find that unity, solidarity and joint commitment to the institution are expressed.

In form, these institutionalized get-togethers are characterized by a release from the formalities and task orientation that govern

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[55] For example, Harvey Pawelson and Reinhard B. Bendix, "Psychiatry in Prison," *Psychiatry*, Vol. 14, 1951, pp. 73–86, and Waldo W. Burchard, "Role Conflicts of Military Chaplains," *American Sociological Review*, Vol. 19, 1954, pp. 528–535.

[56] See, Erving Goffman, *Presentation of Self in Everyday Life*, University of Edinburgh, Monograph 2, Social Sciences Research Centre, Edinburgh, 1956, pp. 127–29; McCorkle, *op. cit.*, pp. 93–94.

inmate-staff contacts and by a softening of the usual chain of command. Often participation is relatively voluntary. Given the usual roles, then, these activities represent "role releases";[57] of course, given the pervasive effect of inmate-staff distance, any alteration in this breach in the direction of solidarity expressions would automatically represent a role-release. It is possible to speculate on the many functions of these comings-together, but the explanations so far suggested seem much less impressive than the singular way in which these practices keep cropping up in every kind of total institution and in what would seem to be the poorest possible soil. One is led to feel that there must be a very good reason for these practices even though none has yet been found.

One of the most universal forms of institutional ceremony occurs through the medium of what is sometimes called the *house organ*—typically a weekly newspaper or a monthly magazine. Usually all the contributors are recruited from within the inmate ranks, resulting in a kind of mock hierarchy of those so engaged, while supervision and censorship are provided by a member of the staff who is relatively congenial to inmates yet reliably loyal to his fellow officials.

Two kinds of material that appear in the house organ may be mentioned. *First,* there is "local news." This includes reports on all recent institutional ceremonies, as well as reference to "personal" events such as birthdays, promotions, trips, deaths, etc., occurring to members of the institution, especially high-placed or well-known members of staff. This content is of a congratulatory or condolence-offering character, presumably expressing for the whole institution its sympathetic concern for the lives of the members. Here, it may be noted, is an interesting aspect of role segregation. Since the institutionally relevant roles of a member tend to set him off against whole categories of other members, it is not these roles that can be used as a vehicle for the expression of institutional solidarity. Instead, use must be made of nonrelevant roles, especially roles such as parent and spouse that are imaginable, if not possible, in all camps.

Second, there is material that can reflect an editorial view. This includes news from the outside world bearing on the social and legal status of inmates and ex-inmates, accompanied by appropriate comment; original essays, short stories and poetry; and editorials. This material is written by inmates but expresses

[57] This term was suggested by Everett C. Hughes and is employed in an unpublished paper on institutional catharsis by Joseph Gusfield.

the official view of the functions of the institution, the staff's theory of human nature, an idealized version of inmate-staff relationships, and the stance an indeal convert ought to take. In short, this material presents the institutional line.

The house organ, however, survives in the delicacy of a nice balance. Staff allows itself to be interviewed, written about and read about by inmates, thus coming under some slight control of the writers and readers; and at the same time inmates are given an opportunity to show that they are high enough on the human scale to handle the official language and the official line with educated competence.[58] Contributors, on the other hand, guarantee to follow the official ideology, presenting it for inmates by inmates. Interestingly enough, inmates who make this compact with staff often do not cease to affirm the counter-moves. They introduce whatever open criticism of the institution that the censors will permit; they add to this by means of oblique or veiled writing; they employ pointed cartoons; and among their cronies, they may take a cynical view of their contribution, claiming that they write because this provides a "soft" setting and job or a good route for release recommendations.

While house organs have been known for some time, it is only recently that a somewhat similar medium for role release has appeared in total institutions. I refer here to the several forms of "self-government" and "group therapy." Typically, the inmates speak the lines, and a congenial member of staff performs the supervision. Again, a kind of compact between inmate and staff is found. The inmates get the privilege of spending some time in a relatively "unstructured" or equalitarian milieu and even the right to voice complaints.[59] In return they are expected to become less loyal to the counter-mores and more receptive to the ideal-for-self that the staff defines for them.[60]

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[58] The scholarly legal petitions which circulate in many prisons and mental hospitals, and which are written by inmates, seem to serve the same function.

[59] As with contributors to the house organ, inmate use of the official staff language and staff philosophy in discussing gripes is a mixed blessing for staff. Staff becomes open to manipulation by inmates of staff's own rationalization of the institution, and in general, social distance between the groupings is threatened. Hence, in psychotherapy at mental hospitals we find the engaging phenomenon of staff using stereotyped psychiatric terminology in talking to each other, but chiding patients for being "intellectualistic" and for avoiding the issues when patients use this language too.

[60] Perhaps the distinctive thing about this form of institutional role release is that a group of academically oriented professionals are interested in it, and so there is already more literature on this aspect of total institutions than on most other aspects combined.

A somewhat different type of institutional ceremony is found in the *annual party* (sometimes held more than once a year) at which staff and inmates "mix" through standard forms of sociability such as commensalism, party games or dancing. At such times staff and inmates will have the license to "take liberties" across the caste line, and social reaching may be expressed through sexual ones.[61]

Often linked with the annual party in total institutions, we find the *Christmas celebration.* Once or twice a year inmates will decorate the establishment with easily removable decorations partly supplied by staff, in this way banishing from the living quarters what an extra-special meal will then banish from the table. Small gifts and indulgences will be distributed among the inmates; some work-duties will be canceled; visitor time may be increased and restrictions on leave-taking decreased. In general, the rigors of institutional life for the inmates will be relaxed for a day.[62]

An interesting institutional ceremony, often connected with the annual party and the Christmas celebration, is the *institutional theatrical.* Typically the players are inmates and the directors of the production are staff, but sometimes "mixed" casts

[61] Of course, the "office party" found in establishments not of the total kind has similar dynamics, and was the first no doubt to give rise to comment. See, for example, Gusfield, *op. cit.* The best reports on these events are still to be found in fiction. See, for example, Nigel Balchin's description of a factory party in *Private Interests,* Houghton-Mifflin, Boston, 1953, pp. 47–71; Angus Wilson's description of a hotel staff-guest party in his short story "Saturnalia" in *The Wrong Set,* William Morrow, New York, 1950, pp. 68–69; and J. Kerkhoff's version of the annual party in a mental hospital in *How Thin the Veil: A Newspaperman's Story of his Own Mental Crack-up and Recovery,* Greenberg, N. Y., 1952, p. 224.

[62] A prison version is reported in Anthony Heckstall-Smith, *Eighteen Months,* Allan Wingate, London, 1954, p. 199:

> The authorities did their best to cheer us. On Christmas morning we sat down to a breakfast of cornflakes, sausages, bacon, beans, fried bread, margarine and bread and marmalade. At Midday we were given roast pork, Christmas pudding and coffee, and at supper, mince pies and coffee, instead of the nightly mug of cocoa.
>
> The halls were decorated with paper streamers, ballons and bells, and each had its Christmas tree. There were extra cinema shows in the gymnasium. Two of the officers each presented me with a cigar. I was allowed to send and receive some greeting telegrams, and for the first time since I had been in prison, I had enough cigarettes to smoke.

See also Hassler, *op cit.,* p. 157. For Christmas license in a mental hospital, see Kerkhoff, *op. cit.,* pp. 183–185, 256. The same on a man-of-war is presented by Melville, *op. cit.,* pp. 95–96.

are found. The writers are usually members of the institution, whether staff or inmate, and hence the production can be full of local references, imparting through the private use of this public form a special sense of the reality of events internal to the institution. Frequently the offering will consist of satirical skits which lampoon well-known members of the institution, especially high-placed staff members. If the inmate-community is one-sexed, as it frequently will be, then some of the players are likely to perform in the costume and burlesqued role of members of the other sex. Limits of license are often tested, the humor being a little more broad than some members of the staff would like to see tolerated.[63] In addition to satirical sketches, there may be dramatic presentations recounting the bad historical past of like total institutions, as a contrast to the presumably better present.[64] The audience for the production will pointedly contain both inmate and staff, although often ecologically segregated, and in some cases even outsiders may be permitted to come.

The fact that the institutional theatrical is sometimes presented before an outside audience no doubt provides inmate and staff with a contrasting background against which to sense their unity. Other kinds of institutional ceremony fulfill this function too, often more directly. Increasingly there is the practice of the annual *open house* during which the kinfolk of members or even

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[63] See Kerkhoff, *op. cit.*, p. 229, and Heckstall-Smith, *op. cit.*, pp. 195–199. Melville, *op. cit.*, p. 101, in commenting on the relaxation of discipline during and immediately after a theatrical on board ship, has the following to say:

> And here White Jacket must moralize a bit. The unwonted spectacle of the role of gun-room officers mingling with *the people* in applauding a mere seaman like Jack Chase filled me at the time with the most pleasurable emotions. It is a sweet thing, thought I, to see these officers confess a human brotherhood with us, after all; a sweet thing to mark their cordial appreciation of the manly merits of my matchless Jack. Ah! they are noble fellows all around, and I do not know but I have wronged them sometimes in my thoughts.

Melville proceeds then to comment bitterly that soon after this role release, the officers seemed to have a capacity to revert fully to their usual strictness.

[64] Neither the "before" nor "after" need have much relation to the facts, since each version is meant to clarify a situation, not to measure it, and in any case the "past" may be slyly presented because of its similarity to the present. I have seen mental patients from good wards give a well-advertised public stage performance of conditions which presumably used to prevail in backward mental hospitals. Victorian costumes were used. The audience consisted of psychiatrically enlightened well-wishers from the environing city. A few buildings away from where the audience sat, equally bad conditions could be observed in the flesh.

the public at large may be invited to inspect the premises. They can then see for themselves that high humane standards are being maintained. At such times, staff and inmates tend to be on visibly good terms with one another, and the price for this usually is that some reduction of ordinary stringencies will be allowed to occur. In the guise of being shown all, of course, visitors are likely to be shown only the more prepossessing parts of the establishment and only the more prepossessing, cooperative inmates. In large mental hospitals, in fact, modern treatment such as psycho-drama or dance therapy may come to play a special role in this regard, the practitioners and patients developing the kind of capacity to perform before strangers that comes from constant experience.

If open house allows outsiders to see that everything is all right on the inside, other institutional practices offer the same opportunity. Thus, for example, there is an interesting arrangement between total institutions and stage performers who were amateurs or ex-professionals. The institution provides a stage and guarantees an appreciative audience; the performers contribute a free show. There can be such a compelling need of each for the services of the other that the relationship may pass beyond the matter of personal taste and become almost symbiotic.[65] In any case, while the members of the institution are watching the performers, the performers are present to see that staff-inmate relations are sufficiently harmonious to allow for what looks like a voluntary assembly of both bent on an evening of unregimented recreation.

Institutional ceremonies that occur through media such as the

[65] We appreciate how needful total institutions are of entertainment charity, but we tend to be less aware of how desperately nonprofessional entertainers need audiences for whom to be charitable. For example, the mental hospital I studied apparently had the only stage in the vicinity large enough for all the members of a particular dancing school to perform on at once. Some of the parents of the students did not particularly like coming onto the hospital grounds, but if the school was to have any ensemble numbers, the hospital stage had to be used. In addition, fee-paying parents expected their child to appear in the annual school show, regardless of how much training the child had had, or even in fact whether she was old enough to absorb training. Some numbers in the show, then, required an extremely indulgent audience. Patients can supply this since most patients in the audience are marched to the auditorium under the discipline of an attendant; once there, they will watch anything under the same discipline, since infraction of rules may lead to cancellation of the privilege of leaving the ward on such occasions. The same kind of desperate bond ties the hospital audience to a group of mild office workers who belong to a bell-ringing choir.

house organ, group meetings, open house, and charitable performances presumably fulfill latent social functions, and some of these seem surprisingly clear-cut in the case of another kind of institutional ceremony, *intermural* sports. The inside team tends to be a group of all-stars chosen by intramural contest among all the inmates. By competing well with outsiders, the all-stars take roles that palpably fall outside the stereotype of what an inmate is—since team sport requires such qualities as intelligence, skill, perseverance, cooperativeness, and even honor. And these roles are taken right in the teeth of outsiders and staff observers. In addition, the outsider team and any supporters it has managed to bring into the grounds are forced to see that there are natural places on the inside where natural things go on.

In exchange for being allowed to demonstrate these things about themselves, inmates through their intermural team convey some things about the institution. In pursuing what is defined as an uncoercible endeavor, the inmate team demonstrates to outsiders and observing inmates that the staff, in this setting at least, is not tyrannical and that a team of inmates is ready to take on the role of representing the whole institution and is allowed to do so. And by supporting the home team, both staff and inmates quite vocally show a mutual and similar involvement in the institutional entity.

Sunday services and Sunday amusements are sometimes set in opposition to each other; in total institutions this can partly be understood in terms of an unnecessary duplication of function. Like sports and charity performances, a service is a time when the unity of staff and inmates can be demonstrated to each by showing that in certain nonrelevant roles they are members of the same audience *vis-à-vis* the same outside performer.

In all instances of unified ceremonial life that I have mentioned, staff is likely to play more than a supervisory role. Often a high-ranking officer attends as a symbol of management and (it is hoped) of the whole establishment. He dresses well, is moved by the occasion, and gives smiles, speeches and handshakes. He dedicates new buildings on the grounds, gives his blessing to new equipment, judges contests and hands out awards. When acting in this capacity, his interaction with inmates will take a special benign form; inmates are likely to show embarrassment and respect, and he is likely to display an avuncular interest in

them.[66] In the case of our very large and benevolently oriented mental hospitals, executive officers may be required to spend a goodly portion of their time putting in an appearance at these ceremonial occasions, providing us with some of the last places in modern society in which to observe a lord-of-the-manor feudal role.

A final note should be added about these institutional ceremonies. They tend to occur with well-spaced periodicity and to give rise to some social excitement. All the groupings in the establishment join in and have a place regardless of rank or position, but a place that expresses this position. These ceremonial practices then ought to bear strong witness to the value of a Durkheimian analysis. A society dangerously split into inmates and staff can through these ceremonies hold itself together. Staff and inmates are the two ends of the arch, and these ceremonies are needed for the keystone.

But, except for the claims sometimes made for the effctivness of group therapy, in many cases it is a nice question whether these role releases hold up anything at all. Staff, to other members of the staff, typically complain of their boredom with these ceremonies and that they have to participate because of their own *nobless oblige* or, worse still, because of that of their superiors. And inmates often participate because, wherever the ceremony is held, they will be more comfortable and less restricted there than where they otherwise would be. A total institution perhaps needs collective ceremonies because it is something more than a formal organization, but its ceremonies are often pious and flat, perhaps because it is something less than a community.

Institutional Differences

In this paper, total institutions have been considered from the point of view of a single basic articulation: inmates and staff. I think this is the first thing to do, partly because once this has been done we are in a good position to consider some of the limitations of this view. An important and interesting question in a closer study of total institutions would be to ask about the typical differentiation of role that occurs *within* each of the two main groups and to ask about the institutional function of these

[66] He can do this, of course, because, like all uncles, he does not have direct responsibility for disciplining inmates, this job being left to lesser members of staff. Interestingly enough, one of the functions of well-known inmates is to provide ranking members of staff with subjects whom they know enough about to use as reciprocals for the avuncular role.

more specialized positions. Some of these special roles have been mentioned in passing, but in a closer treatment they should be given systematic attention.

Another limitation in the present discussion should be mentioned. When total institutions are brought together and examined by means of a conceptual framework derived from their striking similarities, differences among these institutions are brought to light, too. One difference has to do with the degree (and kind) of role and status differentiation within each of the two groupings, inmate and staff. Other differences have been incidentally mentioned. I would here like to note a few more.

One important difference among total institutions is found in the spirit in which recruits enter the establishment. At one extreme we find the quite involuntary entrance of those who are sentenced to prison, committed to a mental hospital, or impressed into the crew of a ship. It is perhaps in such cases that staff's version of the ideal inmate has least chance of taking hold among the inmates. At the other extreme, we find religious institutions which deal only with those who feel they have gotten the call and, of these volunteers, take only those who seem to be the most suitable and the most serious in their intentions. In such cases, conversion seems already to have taken place, and it only remains to show the neophyte along what lines he can best discipline himself. Midway between these two extremes we find institutions like the army barracks whose inmates are required to serve, but who are given much opportunity to feel that this service is a justifiable one required in their own ultimate interests. Obviously, significant differences in tone will appear in total institutions, depending on whether recruitment is voluntary, semivoluntary or involuntary.

Another dimension of variation among total institutions is found in what might be called their *permeability,* that is, the degree to which the social standards maintained within the institution and the social standards maintained in the environing society have influenced each other sufficiently to minimize differences.[67] This issue, incidentally, gives us an opportunity to consider some of the dynamic relations between a total institution and the wider society that supports it or tolerates it.

[67] If the analogy were to be carried out strictly, we would have to say of course that every total institution had a semipermeable membrane about it, since there will always be some standard equally maintained on the inside and outside, the impermeable effects being restricted to certain specific values and practices.

When we examine the admission procedures of total institutions, we tend to be struck with the impermeable aspects of the establishment, since the stripping and leveling processes which occur at this time directly cut across the various social distinctions with which the recruit entered. St. Benedict's advice [68] to the abbot tends to be followed:

> Let him make no distinction of persons in the monastery. Let not one be loved more than another, unless he be found to excel in good works or in obedience. Let not one of noble birth be raised above him who was formerly a slave, unless some other reasonable cause intervene.

Thus, the new cadet in a military school finds that discussions "of wealth and family background are taboo," and that, "Although the pay of the cadet is very low, he is not permitted to receive money from home." [69]

Even the age-grading system of the wider society may be stopped at the gates, as nicely suggested in a recent memoir [70] of an ex-nun:

> Gabrielle moved to the place that would ever be hers, third in line of forty postulants. She was third oldest in the group because she had been third to register on that day less than a week ago when the Order had opened its doors to new entrants. From that moment, her chronological age had ceased and the only age she would henceforth have, her age in the religious life, had started.

It is, of course, by suppressing outside distinctions that a total institution can build up an orientation to its own system of honor. There is a sense then in which the harshest total institution is the most democratic, and in fact the inmate's assurance of being treated no worse than any other of his fellows can be a source of support as well as a deprivation.

But regardless of how radical a total institution appears to be, there will always be some limits to its reshuffling tendencies and some use made of social distinctions already established in the environing society, if only so it can conduct necessary affairs with this society and be tolerated by it. Thus, there does not seem to be a total institution in Western society which provides batch living completely independent of sex; and ones like convents that appear to be impervious to socioeconomic gradings, in fact tend to apportion domestic roles to converts of rural peasant background, just as the patient garbage crews in our prize inte-

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[68] St. Benedict, *op. cit.*, Ch. 2.

[69] Dornbusch, *op. cit.*, p. 317. The classic case of this kind of echelon leveling is found perhaps in the fagging system in British public schools.

[70] Kathryn C. Hulme, *The Nun's Story*, Little, Brown & Co., Boston, 1956, pp. 22–23.

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grated mental hospitals tend to be wholly Negro.[71] More important, perhaps, than the fact that total institutions differ in overall permeability to outside standards, we find that each is permeable with respect to different social standards.

One of the most interesting differences among total institutions is to be found in the social fate of their graduates. Typically, these become geographically dispersed; the difference is found in the degree to which structural ties are maintained in spite of this distance. At one end of the scale we find the year's graduates of a particular Benedictine abbey, who not only keep in touch informally but find that for the rest of their life their occupation and location have been determined by their original membership. At the same end of the scale, we find ex-convicts whose stay in prison orients them to the calling and to the nation-wide underworld community that will comprise their life thereafter. At the other end of the scale, we find enlisted men from the same barracks who melt into private life immediately upon demobilization and even refrain from congregating for regimental reunions. Here, too, are ex-mental patients who studiously avoid all persons and events that might connect them with the hospital. Midway between these extremes, we find "old-boy" systems in private schools and graduate universities, which function as optional communities for the distribution of life-chances among sets of fellow graduates.

Conclusion

I have defined total institutions denotatively by listing them and then have tried to suggest some of their common characteristics. We now have a quite sizable literature on these establishments and should be in a position to supplant mere suggestions with a solid framework bearing on the anatomy and functioning of this kind of social animal. Certainly the similarities obtrude so glaringly and persistently that we have a right to suspect that these features have good functional reasons for being present and that it will be possible to tie them together and grasp them by means of a functional explanation. When we have done so, I feel we will then give less praise and blame to particular superintendents, commandants, wardens and abbots, and tend more to understand the social problems and issues in total institutions by appealing to the underlying structural design common to all of them.

[71] It seems to be true that within any given establishment the topmost and bottommost roles tend to be relatively permeable to wider community standards, while the impermeable tendencies seem to be focused in the middle ranges of the institution's hierarchy.

SUMMARY AND DISCUSSION OF PAPERS ON COMMUNICATION, VALUES, INFLUENCE AND GROUP STRUCTURE

Dr. Saul Sells, the School of Aviation Medicine, Randolph Field, Texas: I would like to add a few comments on the work that Dr. Asch presented this morning. We have conducted some similar research on a contract at the University of Texas with Drs. Harry Elson and Robert Blake, in which the results, although similar, point out certain additional relationships that I think are worthy of mention, namely, that the behavior of the subject is a function not only of the group pressure, but also of the characteristics of the stimulus and of the personality of the subject responding. I know that Dr. Asch will agree with this, but I think that the nature of these relationships is important.

In this research, instead of a face to face group, the background was provided by a tape recording. The subject was led to believe that there were other subjects in other booths, but these were actually recorded on the tapes, so that the social stimulus was constant for all the subjects. Now, with factual types of stimuli, such as judging the length of lines or doing arithmetic problems such as subtracting 2.7 from 2.6 or counting metronome beats, the effects of the background in moving the subject toward the average of the group response was shown. However, this was greater with nonfactual material such as responding to attitude statements. In one of the experiments they used the Thurstone-Chane attitude scale and the attitudes toward war from this scale.

The movement toward the group was greater in the case of attitude or unstructured material than in the case of factual material. With regard to personality, the subjects were tested in the attitude experiment on the Allport-Vernon Ascendance-Submission scale and submissive subjects moved toward the group more than ascendant subjects, so that the behavior at any given time is actually a function of the interaction of these three sets of variables. Although our results are similar to those of Dr. Asch, I think that the interactional concept and the idea that the behavior at the moment is a resultant of all the forces that are employed rather than focusing just on the group, is perhaps an important consideration.

Dr. Asch: The fact that in the same external situation one obtains results as diverse as those I have reported, ranging from complete independence to complete compliance, of course, shows that there are conditions in the person that are responsible in

good part for the outcome, and it may well be that these conditions are among the most important. I have not spoken about those, limiting myself to the group conditions only.

As to the stimulus situation, I have studied that side of the problem rather extensively and was able to predict the effect of group pressure by changing the stimulus conditions from almost complete compliance with the majority to very high independence. I hoped before completing these investigations to succeed in reaching one situation in which all would be completely independent, and to do so, I increased the magnitude of discrepancy for which the majority stood to gargantuan proportions. Unfortunately I was not completely successful. Even when the majority compared, say, a 3-inch line with an 8-inch line, a condition that threw most of the people into the independent camp, there were still a few who out of panic turned to the majority and then went with it completely. I agree that we have three main conditions that are at work here, one the actions of the group itself, second, the actual issues at stake, and third that complex of still elusive circumstances that we call personality.

Captain Hilmar, Office of The Surgeon General, Department of the Army: I have a great admiration for the work you have been doing and I think it is extremely promising for getting at the crux of the mechanics of group pressure upon the individual's judgment or upon the individual's public utterances. However, it seems to me that this is a substantially cruel way of getting this material. I don't know how it could be avoided, but it seems to me that your naïve subjects were, in a sense, stripped of their integrity in the presence of their peers. They must have confronted them later on in many cases on campus and have always recognized themselves and been recognized by the stooges in the experiment as men who yielded. Now in a society such as ours where independence and individualism are basic values in terms of integrity, it seems to me there are some dangers in doing this, especially to a young group of people such as you had. I am not sure that any of the rest of us here could take it any better, but this would be a rather horrible experience for those who did yield and who yielded publicly and who later were confronted with this, as I know you did in your interviews. Would you care to comment on how we could perhaps minimize the effect on the tender egos of these young subjects and still get at the phenomena that you are very rightfully exploring?

Dr. Asch: This is a serious question about which I have thought a good deal. First of all, I do not see a way of avoiding the pain

of the situation and I would say that one does such investigations only if one feels justified that there is a point in doing them and that something of importance might be gained. As to your specific question, I have never conceived of this experiment as either *producing* independence or compliance. What we are doing here is to reveal something that is of long standing and that has a long history. No person is made independent or compliant by the situation. As to the subsequent consequences of being in this situation, of course those who are independent have no reason to worry. They will go out, and be proud. I might add that there were no differences among my subjects, whatever their performance was, as to the values of independence and compliance. They were one on that score.

Our main problem is that of the effect on those people who failed to be independent in the situation. In a number of them the reactions were actually very different and to me of the greatest interest. A number of them rather profited from it, I think. They were ready, willing and anxious to talk, recognized certain features in their behavior about which they were aware, and saw the point and felt that they had learned something. In the more serious cases, I had the very strong feeling that there was a natural protection going on. Those people who complied deeply with the majority were not able to face the fact and were able to veil from themselves the significance of what happened. It was not unusual for people who went with the majority completely to report later that they had done so once or twice. I am sure that they felt that they were reporting fairly accurately. They fastened upon those occasions when they were independent.

There is one particular thing that I try to do in these experiments and that is to people my majority as the investigation was proceeding with those who had been subjects previously and who had not been completely independent previously, so that they were able to see the situation. But the main thing that I would like to say, in answer to this rather important question, is that everything depends upon the way in which the experimenter conducts this investigation, how he deals with the subject, how he explains the procedure to him and the worthwhileness of doing it. This is about as far as one can go.

Question: We seem to have arrived at a value judgment that this indication of independence is necessarily good. If we looked at the independent speakers, we might find that there is some pathologic condition in a number of them. Perhaps the in-between group who were consciously aware of being compliant could be

thought of as somewhat more flexible. I wonder if the members of the group and the naïve subjects were advised of the overall results of these experiments afterwards?

Dr. Asch: Every subject was interviewed in a very careful way, immediately following the experiment, and in the course of this discussion, the entire purpose of the experiment was disclosed and discussed with him. If the subject had gone with the majority often but had not shown an awareness of doing so, we did not disillusion him. Of course, frequently they ask how they did, and in that case we were lenient and not too precise. In regard to this whole question, I want to repeat that I cannot think of anything that compares in importance to the way in which the experiment is conducted—to the personal manner in which the experimenter acts vis-à-vis the subjects.

Question: I have been interested in Dr. Asch's work for some time and this morning it reminded me of some admonitions that Edward Glover has written pertaining to psychiatric education and possibly to all education. I can't resist being sure that everybody in the audience at least sees the implication for those of us who are responsible for training medical students and psychiatric residents. It might not be a very big stretch of the imagination to conceive of many training situations as being quite analogous to Dr. Asch's experiment.

Dr. Ruesch: In this discussion of decision making, I think we have to be aware that everybody who is faced with a decision has always to choose in a social situation between what we might call person orientation and subject matter orientation. Now I think it would be making a false assumption to say that there is one way of making decisions, because there isn't. Some people make decisions by taking the cues from others. Some people make decisions by looking at the subject matter. Some people vary this, depending on the occasion, depending on their own mood, or on their upsets or on a number of other factors. I think that in education, to answer your question, we have simply to be aware that there are students who will take their cues from other people, and there are others who, being subject oriented, will behave otherwise. We need both and I think it is a complementary phenomenon, the more you are person oriented, the less you are subject matter oriented. The more you are subject matter oriented, the less you are person oriented and this goes all the way through up to psychopathology.

Dr. Sperling, Office of The Surgeon General, Department of the Army: Dr. Asch has partially answered the question I wanted

to raise for Dr. Ruesch. It has been said that in our educational system we tend to inculcate the values of honesty and of courtesy in our children but that we tend to overload in the case of courtesies so that we really are not sincere in a great many of the things that we as adults do. We tend to invite people for dinner, and we really don't mean it, or we say, "It is a pleasure to meet you," and we don't mean it, or we tend to agree with people, rather than honestly taking a different stand. I wonder if Dr. Reusch would comment on that especially with reference to the impact of this sort of thing on the psychotherapeutic process?

Dr. Reusch: When you deal with a culture that is group oriented, the person orientation becomes dominant because this is the way the group functions. Furthermore, this tendency is reinforced by propaganda and advertising practices and the present attitude is that, for example, a man really doesn't need to be good as long as he can buy himself enough advertising or the product doesn't need to be superior in any way as long as it can be advertised. In such a culture I think we will find a person orientation.

When you deal with a culture in which people are trained to deal mostly with subject matter and to disregard the, shall we say, politeness aspects or the person orientation, of course, you will have advantages of one kind. The advantage is that people are familiar with the subject matter and treat it on its merits, but that they will tend to make judgments which you may at times call autistic, at other times peculiar, and at other times very original. In a culture that is person oriented, and this applies to psychotherapy, people will tend more to weigh decisions in favor of agreement and to say that if a number of people agree to it that is the right answer. I think that you are asking me to make a value judgment and I am trying to get out of it.

Dr. Nehemiah Jordan: I don't really want to ask a question but to express an opposing opinion, and I don't necessarily expect an answer but I don't mind a rebuttal. I am talking about Dr. Ruesch's presentation. It seems to me he opened up the argument by saying that the conjunction of phonemes "value" serves as homonyms to designate sundry objects and/or concepts; therefore, value is useless. I don't buy that. The various objects and/or concepts designated by a homonym have a meaning in themselves, and the fact that they are designated by a homonym doesn't affect them. The net result of this is throwing value out of the window, which I don't like. I like values, I don't like to consider them arbitrary. I like to consider the Decalogue as being something more than the probablistic induction of a long series

of previous successes and failures and I think it can be done on a scientific level.

In order to do this, I would like to introduce two concepts which would help us very much to study value, I would say on a scientifically respectable basis and still not emasculate it. One concept is one developed by Fritz Heider called the "Think in Medium, Think Processes and Medium Processes." This paper served as one of the cornerstones for Egon Brunswick's general psychological system. Heider differentiates between things and medium processes. Rather than define this conceptually, I will give an analogue. All scientific measurement is an aspect of mediating processes. We measure temperature in many ways depending on the situation. The fact that the various measurements which mediate temperature are different doesn't mean the temperature is not the same thing. I submit that much of the variation of value behavior is a function of a mediating process and if we were to disentangle the mediating processes from the real causal processes, value may turn out to be a simple, well organized process which is meaningful and probably beautiful.

Another concept I would like to submit is the one of Levine using force fields. Value has been characterized, according to Levine, as a field force which coexists with other field forces in a given situation. I submit that if we were to look at it this way, and analyze behavior in a systematic manner, taking into account the various field forces that are given a person at a given time, again value will emerge as a relatively simple, meaningful, organized process.

Dr. Ruesch: Thank you for your comments. The topic of my presentation wasn't values. It was the communication of values. I am not a value expert and I doubt that I can illuminate the nature of values more than you can or anybody else can. As far as the communication of values is concerned, I think we have to keep in mind that all our inferences about values are received from the communicative process and as far as the other inferences are concerned, they are in perspective. Now, methodologically it has been shown that the implementation by which you arrive at these inferences about values influences the outcome as much perhaps as that thing which is inferentially called value.

Comment: I feel that Dr. Ruesch's point about people learning either by being subject oriented or teacher or person oriented needs possibly the kind of value statement that he presented in his paper, which might terminate an argument. It seems to me that in psychiatry we need a good deal more subject orientation

in our teaching practice and research, and I am afraid that we have had too little of this, in contrast to the teacher orientation, so that I would like to make a value judgment here and urge more subject orientation.

Dr. Stanton, McLean Hospital, Waverley, Mass.: I am interested in the very original presentation of Dr. Goffman regarding the total institution. I have in that connection one question that has bothered me a bit. We are faced with the fact that a certain number of patients, and I suspect it is true in the other total institutions, do show a rather sharp improvement in their gross condition shortly after hospitalization, in a matter of a very few days, and this raises quite a serious question about the concept which I have not been able to think through. I wonder if Dr. Goffman has something to say about it?

One of the important characters of a total institution, I suppose, would be the degree to which the inmate and perhaps the staff foresee that the inmate will be in the institution for a considerable period of time and this certainly would not coincide with the propaganda that most of us would like to present about mental hospitals. I would wonder, however, if in view of the considerable variation in length of time, this would not be of considerable importance or at least complicate the discrimination of institutions into total as opposed to others. Take for instance a general hospital where nowadays people can expect to stay for a week or so. This is also a total institution but its character would seem to be often quite different socially than that of the other institutions which were the focus of the study. Related to the foregoing is this question: Is it likely that there is a period of time that it takes a person to get into a total institution, which is somewhat different than the physical entrance into it?

Dr. Goffman: I would like to spend more time than I guess I have on your questions and I am not sure I can divide them properly. First about the indefinite sentence. What we know about it now, it seems to me, is that people don't like it very much. When I study the patient in a mental hospital and when they compare mental hospitals to jails as, of course, they are always doing, one thing they persistently point out about a jail is that at least you know when you are getting out. Insofar as we know about these things, I think the feeling is that the indefinite sentence is one of the disorganizing or disorienting processes of an institution.

But let me go on again to an even more intriguing part of your question—this business of the people who come in and suddenly

have a dramatic shift in their symptom pattern. So far as I have been able to gather, you can divide patients into the three classes: the organics who presumably don't alter very much, and then the two classes of functionals, the ones who come in and don't alter their symptom pattern much and the ones who come in and very radically and suddenly alter their symptom pattern. I don't necessarily mean there is a remission when they come in, but at least an alteration. This alteration is often talked about by the staff. As a sociologist I tend to look upon this interesting body of patients as evidence of the sense in which persons can come into institutions for no particularly profound reason, psychologically speaking. They either get shifted into mental hospitals because they have been legally delinquent in some way and there aren't other mechanisms for handling this kind of delinquency, or the kind of symptom that they manifest on the outside is an immediate and surface one like hallucinations and it gets them suddenly into the hospital and then there is a remission.

My conclusion about this group of persons is that it should lead us to look again at some of our more dramatic symptoms—the kind of dramatic symptoms that get a person out of the free society into the mental hospital community. The implication is that these symptoms aren't very profound and if the patient had another cooling-off place or if he didn't happen to get tripped up at this particular point, there would have been remission anyway. I take this body of persons who alter their symptoms as soon as they come into the institution as evidence of the fact that the mental hospital is not so much dealing with sick people as it is dealing with a yet unanalyzed differing group of individuals who get caught up in the sorting and sifting institutions of our society.

Now let me add one last point to your questions, if I may. I refer to the business about whether the short stay in the medical hospital makes a medical hospital a total institution in the sense in which I am using it. We seem to have institutionalized in our society an understanding that you can drop out of circulation for a brief period of time and become totally under the control of a medical person and this doesn't seem to alter very much the self that you came in with. There are all kinds of technics. For instance, men in medical hospitals tend to employ very much a joking relationship to the nurses so that the self that they have brought into the hospital is not a very serious self, or a self that they can easily alienate themselves from and disidentify with. With women this situation is somewhat different. The image that is presented to these patients when they come into the hospital—

that they are coming here because they are sick, that they deserve to come into the hospital, that they are going to be correctly diagnosed and then they are going to be treated and that all this is rational, done to the end of making them better—is a line that isn't very much discredited if the patient doesn't stay in a hospital very long. If the stay, I imagine, is under a week, this line is relatively acceptable. For one thing it is relatively true.

When a medical man says, "Don't eat this because it will have bad effects on you," there is often some evident basis for this and the patient who is receiving this instruction doesn't have to get mortified and demoralized and discredited in accepting this kind of physician. On the other hand, when he goes into a hospital where he has to stay for a longer period of time, there become more and more areas of life which the hospital staff tries to rationalize as being medical, which he comes to see quite clearly are not medical at all, but just a matter of his being managed.

I think Kai Erikson's material bears some of this out and some interesting work now done in TB hospitals touches on it, too. In other words, TB patients have a much more difficult time rationalizing or accepting the rationalization of medical treatment, than do short-term patients. So I would argue and conclude that if the stay is something under a week and if something obvious is done, then the patient coming in has a way of holding off the potentially deprivational effect of coming under somebody else's control, etc., and not having these affect him very much. If the stay is longer, as in a mental hospital, or to some degree in the TB sanatorium, then you get more of the total effects.

MONDAY AFTERNOON SESSION

15 April 1957

ECOLOGY AND EPIDEMIOLOGY OF MENTAL ILLNESS

MODERATOR

Frederick C. Redlich, M.D.

THE ECOLOGY OF MENTAL DISORDERS

JOHN A. CLAUSEN, PH.D.

Ecology is the study of living things in relation to their environments. The term was coined in 1869 by the biologist Haeckel; it was a product of the era of evolution and of the concept "struggle for existence." The effect of the struggle for existence is to bring about a distribution of species and of indviduals so that each lives finally in the place where it can best come to terms with competition in meeting survival needs. Animal and plant ecology have studied the range of species, the complex interdependencies of different species and the mechanisms whereby equilibria are established among them.

Human ecology may be defined as the relationship between man and his environment—physical, biological, and social. Sociologists have often used the term in a narrower sense, to denote only those aspects of man's relationship with environment that have a spatial referent—those that are brought about by the competitive struggle for a place to live. Urban sociologists have been especially concerned with processes affecting population groupings—concentration, centralization, segregation, invasion, and succession. For the purpose of this Symposium, however, I should like to hold to broader usage and to include processes that relate to the sorting and distribution of behaviors and of symbols. Perhaps a better title for this presentation would be "mental illness in the context of human ecology and social organization."

The terms "ecology" and "epidemiology" are often used interchangeably or by different groups to refer to the same phenomena. Ecology seems to be favored by social scientists, epidemiology by public health and medical specialists. John Gordon, Professor of Preventive Medicine and Epidemiology at Harvard, has suggested that the "part of human ecology relating to health and disease is medical ecology, and as it concerns groups and communities of people it is epidemiology."[1]

Mental illness may be viewed as a product of the interplay of

[1] Gordon, John E: "The Newer Epidemiology," in *Tomorrow's Horizon in Public Health.* Tr. of Conference, Pub. Health Assoc., New York, 1950, p. 18.

biological and social factors in the life process. In some instances it can be said to be a mode of adaptation, albeit a faulty mode. In *all* instances it markedly affects the kind of adaptation that the individual makes to his social environment. In the long run, mental illness is thus a determinant of position in the social order.

As a first step toward an ecology of mental illness one may ask where mental illness tends to be concentrated—in what types of persons, in what groups, at what times, under what circumstances? But this first step is enormously difficult. Mental illness is visible primarily in behaviors, and usually in behaviors which overlap the normal range. Clearly recognizable organic symptomatology is usually lacking. We deal, most often, not with data on the concentration of mental illness, but with data on its visibility. Inferences from such data about the etiological significance of specific environmental factors can be made only after assessment of the various determinants of the visibility of mental illness. This in itself is a formidable undertaking. Alternatively, one may seek to ascertain the true incidence or true prevalence of mental illness through psychological screening and psychiatric examination of population groups. The cost and difficulty of mobilizing an adequately qualified staff to undertake such research has, however, limited past efforts to relatively small population groups, with a consequent limitation on generalizability.

For present purposes, let us confine our attention to mental illness that is recognized as such by qualified professional personnel. This may be psychiatrically treated mental illness—persons hospitalized or under outpatient treatment—or behavior which is regarded by psychiatrists as symptomatic of mental illness and which is either observed by members of a research team or reported to them by informants for any population group. We cannot, of course, assume that the prevalence or incidence of even the most severe mental illness is adequately indexed by treated mental illness alone; we know that the amount of treated mental illness in a community depends more on the level of treatment facilities than on true prevalence. We can, occasionally, make crude comparisons based only on treatment data, when we know that facilities available to the groups being compared are roughly equivalent.

Prevalence of Mental Illness in Different Environments

At the most gross level of inquiry into the bearing of social environment on the prevalence of mental illness, we may ask: Are there more mentally ill persons now (relative to total population)

than there were a century ago? Man's environment has changed greatly in the past century. If mental illness is a product of biological and social interactions, we might expect substantial changes in illness rates over a century. Goldhamer and Marshall[2] have attempted to answer this question for an area in which the possibility of hospitalization for acute psychiatric disturbance was relatively high over the century—the State of Massachusetts. True, in the early portion of this period many mentally ill persons were hospitalized in county almshouses rather than in mental hospitals, but the surprisingly good records describing these patients and still available have permitted reasonably adequate diagnostic classification. Below age 50 there seems to have been no increase in the incidence of hospitalization for mental illness in the population studied.

This answer to our question is not, however, as conclusive as we would wish. The State whose facilities and records permitted the cogent analysis of Goldhamer and Marshall was in 1850 our most highly urban State. The factory system was already several centuries old. The competitive struggle in mid-19th century Massachusetts probably entailed as much stress in the quests for economic survival and for personal identity as is entailed today.

Comparisons between the incidence of mental illness in rural areas and incidence in urban areas have likewise been inconclusive. Even among the Hutterites, a communally organized religious group living in harmony and prosperity in several North Central States, Eaton and Weil found about the same rate of occurrence of mental illness as is reflected by hospitalization rates in New York State.[3] The Hutterites did not hospitalize their mentally ill, but did provide a measure of confinement for acutely disturbed persons. The rates of illness for this group were based on reports by village leaders of instances of severe disturbance, which could then be assessed by the team's psychiatrist. Perhaps the most significant positive finding of this research was that the pattern of psychotic disturbances appeared to be different from that of neighboring populations. The Hutterites appeared to have a higher incidence of depressive reactions and a lower incidence of schizophrenic reactions.

It appears, then, that at the present time we cannot clearly specify the relationship of prevalence or incidence of psychosis

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[2] Goldhamer, Herbert, and Marshall, Andrew: *Psychosis and Civilization.* The Free Press, Glencoe, Ill., 1953.

[3] Eaton, Joseph, and Weil, Robert: *Culture and Mental Disorders.* The Free Press, Glencoe, Ill., 1955.

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to even grossly differing types of environment within a single culture. This is not, however, to say that we cannot specify the relationship of incidence of treated psychosis to any significant aspect of the social environment. Probably most of you are familiar with the research of Faris and Dunham in Chicago in the late 1930's.[4] You will recall that they plotted on a map of Chicago the addresses of all persons hospitalized for mental illness in public or private mental hospitals. They then computed rates of hospitalization, relative to the base population of the neighborhoods and subcommunities into which the city could be divided. These rates varied tremendously from very high levels found in and surrounding the central business district to very low levels in most of the better residential areas. In part, this concentration reflected the tendency of alcoholics, paretics, and schizophrenics to drift into the rooming house and flophouse areas. Drift was not, however, an adequate explanation for concentration in many of the areas that showed high rates of hospitalization. In general, highest rates of schizophrenia were found in areas characterized by high residential mobility, low socioeconomic status and extreme ethnic heterogeneity of population.

One could, with a little effort, cite a hundred correlates of rates of hospitalization for mental illness—a hundred characteristics in which the populations of neighborhoods with high rates differ from the populations of areas with low rates. The majority of these correlates are, of course, the manifold reflections of socioeconomic status. They range from the physical characteristics of the areas to the diet and physical status of the residents, their social activities and group identifications, and even their time perspectives and the goals to which they aspire. Ethnic group patterns and the social meanings of minority group status are intertwined with the correlates of rates of hospitalization and with socioeconomic status. How, then, shall we interpret findings such as those of Faris and Dunham and of their many successors who have studied the ecological patterning of hospitalized mental illness in urban areas?

Before attempting to answer this question, we may note that the same problem is entailed in interpreting differences in the treated prevalence or incidence of mental illness by social class or ethnic group categorizations. Hollingshead and Redlich, in a thorough study of the prevalence of treated mental illness in New

[4] Faris, Robert, and Dunham, H. W.: *Mental Disorders in Urban Areas.* University of Chicago Press, Chicago, Ill., 1939.

Haven, found tremendous differences between the upper and lower social classes in rates of treated schizophrenia.[5] They found schizophrenia to have a relative frequency nearly ten times as high in the lowest social status group as in the top two strata. They delineated their class strata on the basis of occupation, education and area of residence. These objective indices are easily ascertained. Their potency does not derive from the fact that occupation, education or area of residence necessarily determine one's development, but from the fact that they index psychologically significant differences in style of life.

Phrasing the Question of Etiology

The crucial question in attempting to interpret in an etiological framework any observed difference in the incidence of treated or psychiatrically observed mental illness between two population segments (whether these be social classes, ethnic groups, or subcultures) is: Do some discernible aspects of life processes in one of the segments *produce* more cases of mental illness than are produced by life processes in the other? Or, restated, if the two subcultures do differ in the amounts of mental illness produced, what are the specific social and cultural variables or constellations of variables involved, and how do they exercise their effect? The answer, for the present, cannot be sought primarily from findings of ecological or epidemiological research on mental illness. To date, most such research has either attempted to establish the existence of correlations between rates of recognized mental illness and gross characteristics of population groups or has sought to relate cultural emphases to the patterning of personality development and of symptomatic behavior among the mentally ill.

The most ambitious projects thus far undertaken are, however, now approaching publication. The research within the metropolis, of the team organized by the late Thomas Rennie and represented at this Symposium by Dr. Opler, and the closely related program of Alexander Leighton and his associates in a rural county in Maritime Canada may take us much closer to significant etiological linkages. On the whole, however, our best hypotheses about the bearing of social environment on mental illness are likely for some time to come to be derived from the theoretical formulations of the behavioral sciences (buttressed increasingly by research

[5] Hollingshead, A. B., and Redlich, F. C.: "Social Stratification and Psychiatric Disorders," American Sociological Review, Vol. 18, April, 1953, pp. 163–169.

data) and from the careful clinical study of psychopathology relative to the sociocultural context.

The Need for More Adequate Theory

The designs of epidemiological studies of mental illness have not, by and large, proceeded from carefully delineated theories of personality development or of psychopathology. Interpretations of correlations are often made on a post hoc basis and presented as though self-evident. We are beginning, in current studies of the mental disorders of later life, to recognize that the biological organism and the social organism must be studied simultaneously if we are to understand the ability of the older person to sustain various role functions. Ultimately, the model for studying the ecology of schizophrenia or of neurotic states must also incorporate the organism and its life processes.

At any given moment, personality reflects the interplay between constitutional and experiential (biological and psychosocial) factors. Dominant models of orienting perceptions, responding to social stimuli, and initiating action tend to be organized in infancy. Though subject to change thereafter, a high degree of continuity in these modes is usual. Certain relationships and experiences in infancy may indeed be so frequently linked to subsequent development of disease as to be designated etiological factors for such disease. Even here, however, it is clear that such factors are only a part of etiology. When we come to later experiences—to the forging of identity and to confrontations of adult responsibility—certain typical stresses may serve to expose vulnerabilities and to precipitate mental illness, but it is far more difficult to discern the precise nature of the etiological factors involved in the illness.

Let us turn briefly to the problem of interpreting the finding that hospitalization for schizophrenia is ten times more frequent in one area or social class than in another. In another paper, Melvin Kohn and I have examined three alternative frames of reference which afford plausible interpretations of such findings: the genetic, the cultural, and the interactional (or ecological, in the narrower sense in which sociologists often use the term).[6] Here, I shall merely touch on the dominant themes.

The Genetic Interpretation. The evidence gathered by Kallmann, Book, and other researchers into genetic linkages in schizophrenia has demonstrated beyond reasonable doubt that here-

[6] Clausen, J. A., and Kohn, M. L.: "The Ecological Approach in Social Psychiatry," American Journal of Sociology, Vol. 60, Sept. 1954, pp. 140–151.

dity plays a substantial role in much of the illness diagnosed as schizophrenia, whether this category designates one or a number of different disorders.[7] Insofar as competitive skills are impaired by the illness itself or by other consequences of the genes which transmit vulnerability to schizophrenia, one may assume that social mobility over generations will tend to be downward rather than upward. Conceivably, then, lower socioeconomic strata of the population come to contain a higher proportion of vulnerable persons. Note, however, that to the extent that there is such a genetic basis for finding higher rates of schizophrenia in the lower socioeconomic classes, it is the resultant of an interaction between social and biological processes. This is obviously a far more complex interaction than can be adequately dealt with in this discussion. Moreover, past research leaves us with little more than a basis offering this hypothesis.

The Cultural Interpretation. Few students of human behavior would at present deny that the content and organization of personality are significantly influenced by the general orientations of the culture. Perhaps there is less clear recognition of the fact that subcultural differences may be enormous and of special significance for the understanding of personality deviance. Economic and ecological processes sift and distribute subcultural groups, especially in larger cities, just as they distribute service functions in large cities and in regions. Powerful, prestigeful and highly lucrative businesses can compete successfully for space on the Wall Streets, the Time Squares, the Fifth Avenues. Fancy restaurants can find a place to nestle near the theater district, while at the periphery of the central business district will be the supply depots, the less prestigeful businesses, and the lunchrooms that cater to persons working in or passing through such areas.

Ethnic groups and social classes are likewise sorted out in available residential areas. They may evolve further differentiations from other subcultural groups as a consequence of this process. The patterning of relationships within the family—the composition of the household, the availability of various persons to attend to the biological and social needs of the child, the continuities of child care and the modes of child training—these are all elements of subcultural differences associated with social class

[7] Kallmann, Franz J.: *Heredity in Health and Mental Disorder*, W. W. Norton & Co., New York, 1953, esp. pp. 178–181. See also Kallmann's *The Genetics of Schizophrenia*, J. J. Augustin, New York, 1948, and J. A. Book's "A Genetic and Neuropsychiatric Investigation of a North-Swedish Population," Acta genetica et statistica medica, Vol. IV, 1953, pp. 1–100.

status in the United States. Beyond this, social class and other bases of subcultural differentiation bestow dominant value orientations, attitudinal sets, and social and technical skills. These in turn affect the probability of a person's achieving goals honored in the subculture or in the larger society. Strains toward deviance may arise from the fact that some goals are shared by almost all segments of the society—for example, monetary success in contemporary America—but members of some population segments are markedly disadvantaged in their striving to attain these goals.[8] Again, however, the relationships between cultural orientations and psychopathology are not simple. Culture conflict and feelings of deprivation may lead to behavior disorders, but we lack any conclusive evidence that they are conducive to psychosis.

It appears that the phenomena of social class as subculture are related to those of mental illness in two ways. There are class differences in the degree to which vulnerable personalities are produced (presumably because of early deprivations and frustrations) and differences in the degree to which adults are exposed to types of stress against which they are unable to defend themselves. There are different ways in which vulnerability may come about and different modes of defense, both patterned to some degree by the cultural milieu but both also depending almost certainly on constitutional make-up and later organic processes as well.

We may note, before moving on, that variables such as socioeconomic status, education, and area of residence may index somewhat different series of subcultures in various communities. There is, for example, some evidence that socioeconomic status is much less closely associated with rates of hospitalization for schizophrenia in a small city than it is in a metropolis.[9] The fact that indices may in some settings yield highly significant correlations must not lead us to assume that these indices are themselves *the* significant variables.

Interpretation in an Interactional Framework. The settings into which individuals or groups are sorted by ecological processes, and sorting processes themselves, have a special significance apart from subcultural differentiation. They markedly affect the

[8] For a thorough discussion of this topic see Robert K. Merton, "Social Structure and Anomie," Ch. 4 in his *Social Theory and Social Structure.* The Free Press, Glencoe, Ill., 1949.

[9] Clausen, J. A., and Kohn, M. L.: "The Relation of Schizophrenia to the Social Structure of a Small City." Paper presented at the Symposium, The Epidemiology of Mental Illness, at the Annual Meeting of the American Association for the Advancement of Science, New York, December 1956. (To be published in the proceedings of the Symposium.)

nature of the individual's relationship to psychologically significant groups. They tend to determine the frequency and diversity of opportunities for contact with others, the duration and intensity of contacts, the continuity of relationships. Large-scale migrations and also the day-to-day movements of persons and families seeking occupational, residential and recreational opportunities may lead to the disruption of emotional ties and of meaningful communication networks for the persons on the move. Especially within the metropolis, aggregates of persons not integrated into stable primary group relationships make up the "lonely crowd."

Since Durkheim's classic analysis of suicide, sociologists have been concerned with the problem of *anomie* or normlessness which seems so often to characterize the person detached from family and other significant social ties.[10] Social isolation may lead to a withdrawal into phantasy, alcoholism, or apthetic drifting. In its origins, however, social isolation may be a consequence of feelings of alienation from others rather than reflecting an actual deprivation of the opportunity for relationships. Here again, then, we need to know the process, and the process begins with an organism of a specified type in a network of relationships embedded in a cultural setting with certain dominant themes.

Thus far, we have touched on hypotheses that would explain real differences in the incidence of schizophrenia in various population groups. But the rate differentials which are based on treated cases of mental illness may not adequately reflect the actual amounts of mental illness which would be found if a population could be examined with a valid test for schizophrenia. Several questions must be raised about rate differentials based on treated cases assigned to the population segment (social class, neighborhood group) in which persons were situated just before coming to treatment: (1) Are there significant differences in the way mental illness is defined and dealt with in different strata and communities? (2) Is the setting from which patients are hospitalized in general the setting in which pathogenesis occurred? (3) Are characteristics noted at the time the patient enters treatment significantly related to etiological factors, or are they largely representations of the illness process? There have been several recent efforts to assess these questions as they bear

[10] Durkheim, Emile: *Suicide,* English edition. The Free Press, Glencoe, Ill., 1951, esp. pp. 241–276.

on specific findings of ecological and epidemiological studies.[11] Here, I should like to comment primarily on the possible significance of social response to mental illness and to behaviors perceived as deviant in various settings.

Social Response to Deviance

Identical behaviors stemming from basically similar motivations and modes of expression may be defined and responded to in grossly different ways by groups or by individuals of divergent value orientations and attitudes. The sensitive, not grossly masculine young man portrayed in "Tea and Sympathy" comes to doubt whether he really is normal, as a consequence of the attitudes and reactions of father, headmaster, and peers who conform to the cultural stereotype of maleness. In another family or with a different set of peers, his musical talents might have made him wholly acceptable and secure in his identity. At the same time we recognize that in a culture which abhors and fears homosexuality as inordinately as ours does, the person who departs from the sexual sterotype is likely to evoke ridicule and other hostile reactions.

Several writers on the ecology of mental disorder have observed that the number of persons brought to treatment for mental illness may, in part, reflect the community's tolerance for various kinds of deviance.[12] Accumulating evidence indicates that the social status of the mentally ill person tends to influence the perception by family and others of the nature of his problem, the modes of dealing with him prior to his entering medical-psychiatric channels, and the kinds of services offered to him by psychiatric clinics or hospitals.[13] Few would deny that the statistics generated by counting persons, social settings, and psychological states at the end of this complex sorting process do not constitute an adequate record of the relationship between the social environ-

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[11] See, for example, Dunham, H. Warren: "Some Persistent Problems in the Epidemiology of Mental Disorders," American Journal of Psychiatry, Vol. 109, Feb. 1953, pp. 567–575. Also reference 6 above.

[12] See, for example, Erwin Lemert: *Social Pathology*, Ch. 11, "Mental Disorders and the Insane," McGraw-Hill Book Co., New York, 1951.

[13] Especially noteworthy here is the research of Redlich and Hollingshead and their associates. See, for example, Jerome K. Meyers and Leslie Schaffer: "Social Stratification and Psychiatric Practice: A Study of an Outpatient Clinic," American Sociological Review, Vol. 19, June 1954, pp. 307–310.

ment and the biosocial process of illness. Is it not possible that societal response to slight manifestations of psychological vulnerability may itself be a partial determinant of whether such vulnerability actually results in full-blown mental illness? That is, tolerance (or any other response to forms of deviant behavior) may in the last analysis determine not only who is brought to treatment, but also whether the person does indeed *need* to be hospitalized.

In our own research on the families of mental patients, we have encountered instances in which an accepting and nurturant wife has been able to sustain a schizophrenic spouse for 5 to 10 years before symptomatic manifestations in the work situation caused him to be brought to treatment. In other instances, we have seen the utter rejection of a husband within a few days or even hours of his manifesting far less deviant symptomatology. Such instances are often followed by a period of acting out which brings the patient to the hospital and a regime of isolation and control which leaves its own imprint on his personality.

Every community has some members who are regarded by their fellow citizens as "queer," "mean," "shy," "offensive," etc. In many instances, psychiatrists would diagnose these persons as neurotics and in a few instances as psychotics, even though community members may never regard these persons as mentally ill. It is not unlikely that persons whose cultural background is grossly divergent from that of the psychiatrist (e.g., lower-class persons) will often be seen as sicker than those whose attitudes and behaviors are closer to the middle-class outlook of the psychiatrist. Projective tests, standardized on the middle-class, and used by middle-class psychologists, are likely to exhibit the same bias.[14] Unless and until there are valid tests for the diagnosis of schizophrenia and other mental illnesses, studies of so-called true prevalence will be subject to the class-linked biases of professional labeling of mental illness, just as studies of treated prevalence are subject to biases of community response. We need, then, to know both professional diagnoses and the peer and family responses to members of populations under study. How do members of various subcultures label and attempt to deal with males and females at various age levels suffering from such diverse conditions as simple retarded depression, delusions of persecution, anxiety states? And what are the therapeutic or antitherapeutic consequences of such responses to the symptoms of mental illness?

[14] Haase, William: *Rorschach Diagnosis, Socio-Economic Class and Examiner Bias.* Unpublished doctoral dissertation. New York University, 1955.

In conclusion, I would emphasize again the importance of the models of personality development and of psychopathology underlying ecological and epidemiological studies of mental illness. We have a great deal of evidence that different aspects of the sociocultural environment are implicated in the etiology of different types of psychopathological illness and in subsequent responses to the manifestations of such illness. As we learn to make more meaningful classifications of illness, whether we are dealing with disease entitities or reaction tendencies, it will be possible to delineate more clearly the social ecology of particular types of mental illness. Ecological and epidemiological studies can themselves contribute to improvements in classification insofar as they reveal the social processes which influence recognition of constellations of cases. If this assessment is correct, we face a long period of research seeking successively better approximations to adequate classification and understanding.

DISCUSSION

Mr. Albert Deutsch, Journalist: I have been bothered by that study of Goldhamer and Marshall that you referred to, the one about the incidence or prevalence of mental disease in Massachusetts one hundred years ago and now. I wanted to ask you, firstly, if the investigators looked at the census of the mentally ill in jails at the time because as you may recall, Dorothea Lyon Dix and others found a large proportion of the mentally ill in the 1840's in jail. Secondly, did they take account of what one might presume to be a large number of mentally ill persons who never went to institutions at that time, whether it was a mental hospital, a jail, or a poorhouse, because of the fact that the stigma on the poorhouses and the jails was even greater than the stigma on mental hospitals? I would imagine that their figures would be skewed if they did not take this latter point into consideration.

Dr. Clausen: As I recall, the study did include jails along with almshouses, and any other places that were known to be accepted places of disposition for the mentally ill, particularly back in the beginning of the century. As I recall, they began back in 1848 and they analyzed the statistics for each period separately. Now I think with reference to the effect of stigmatization and the fact that more people may have been kept in the community and not sent anywhere, their data do not bear on this. All they were able to show was that if you take people who have been institutionalized one place or another, then the proportion institutionalized back in the 1850's and 60's was just as great as the proportion institutionalized today. That is, there seems to be no evidence that there was any less psychosis in the population at that time. Their data do not really bear on the question as to whether there conceivably might have been more. They say that they have bent over backwards at each stage of their analysis in order simply to bring their data to bear on the question: Was there less mental illness at that time? Of course when it comes to the age group above 50, they did find that far fewer people went to any form of institution then, whether almshouses, or homes for the aged. As I recall, at the end of that period there were at least three or four times as many older people institutionalized for the mental diseases of senility as there had been in the early period.

EPIDEMIOLOGICAL STUDIES OF MENTAL ILLNESS

Methods and Scope of the Midtown Study in New York

MARVIN K. OPLER, PH.D.

Brief accounts of social psychiatric studies operating throughout a complete population can only furnish the highlights. This one is no exception. It is not a summary of data nor a final report, nor is it even delimited to an expansion of views on the special perspectives of cultural anthropology in the realm of preventive and social psychiatry.* These last I have considered elsewhere, and at length, in several papers [2 5-8 10 11 16] and a book.[9] (I trained in philosophy and scientific method before becoming an anthropologist.) In the general framework of social psychiatry, and in the light of the particular assignment of this Symposium, I will pivot my discussion on how the behavioral sciences are used, how they may interrelate, and what the scope or intent of such research may be.

What is the intention of this type of social psychiatric study? Our answer begins by stating that social and preventive psychiatry is a part of psychiatry in general. As such, it links integrally with medicine and, equally, with all the behavioral sciences. These are its fundamental resources, but they are not its problem. Concerning the last, the humanistic answer, that is the one centering distinctively on human interests and ideals, begins by pointing, however vaguely, to psychiatric needs that exist somewhere and somehow on human frontiers of this same research process. Where? Certainly we know the needs exist within individuals, families, hospitals and communities. Concerning how these needs

* This paper, for publication, is part of the author's research in the Midtown Study. The study is supported by grants from the National Institute of Mental Health, National Institutes of Health, United States Public Health Service, and from the Milbank Memorial Fund, the Grant Foundation, the Rockefeller Brothers Fund, and the Corporation Trust Co. Grateful acknowledgments are hereby made. The author directs the Anthropological Section of the Study. Reference to all current senior personnel or principal investigators, and to Dr. Rennie and Dr. Leighton, is made later. The views expressed herein are the author's.

arose (that is, their causes by which we imply personal, family and sociocultural etiologies), this is what I regard as the most central and crucial scientific question.*

Philosophy, Methods and Scope of a Social Psychiatry

An orderly approach to the problem of social psychiatry, whether it be a healthy, newborn infant of neurotic parents, a troubled but still active citizen, or a delusional schizophrenic in a State hospital, recognizes that each of these makes a claim on the aims or goals and the requirements of preventive or socially ameliorative interests. By allowing them this compelling claim on our attention, we cannot at the same time blithely assume that we have expended or furnished anything more than the sympathy, a luckily abundant commodity, generally common in human beings. We are not even yet scientists in this troubled world of disorders, and no certificates, so claiming, need be awarded. One becomes a candidate and novice in social psychiatry, only when he becomes dedicated to the broad, and by no means exclusive, search for the actual locus of mental disorders. Perhaps fortunately for the patient or the troubled citizen, this locus, by all the lights we have, appears to have many facets, many of them connecting with family, community and culture beyond any doubt at this stage in our knowledge.

However, we are still confronted with the citizen or patient and he has, after all, his own specific nature. In a physician-patient relationship, one may learn that his illness is interwoven and affected by that of parent, sibling, spouse or child and that this is important in treatment. Further, one may place a patient in group therapy, or the physician may work with more than one family member. Then, while the currents and interactions of pathology under treatment are increased many fold, more facets appearing, the *locus* of disorder and aim of treatment are still the individual, a complex and irreducible minimum. Consider then, as a next step, plunging into the total community of citizen and patient. The voltages and facets increase, but the individuals, partly unique and partly biological and cultural products, remain.

The biological focus, in the etiology of mental disorders, we were never equipped to handle in the sense of laboratories and

* Dr. Thomas A. C. Rennie, an esteemed colleague and friend, both originated and directed the Midtown Study from 1952 through May 21, 1956, the date of his death. An attempt to preserve a striking parallelism in our views is made by quotation and includes this central point in both our writings.

physical examinations. Even presumably psychosomatic ailments were only reported, or possibly went unreported, by individual respondents. Genetic studies, in the sense of adequate lineages, studies of collateral relatives, or *probands* and parish records such as are used in certain Scandinavian researches into social psychiatry seemed impossible in the light of population mobility in our community. No less important, those in the project staff most concerned with an irreducible minimum, the individual, and etiology and dynamics within the individual and his family, tended to view these elements as the "qualitatively rich" or "personality dynamics" or family "patterns" part of the study.* These phrases will be encountered later in abundant quotation from both Dr. Rennie and me. But we shall have to assess further why etiology and dynamics cannot be separated in any kind of psychiatry, and why the *locus* of disorder, the individual and his family, are vastly different from connected facets of behavior, like his culture.

Before attempting to analyze these groupings (etiology-dynamics and individual-family), let us see how the first grouping appears in Dr. Rennie's last definition of social psychiatry.[14] For this discussion, his final, summary definition is most apposite:

> Social psychiatry is therefore the study of the etiology and dynamics of persons seen in their total environmental settings. The findings of various similar researches . . . under way in such different settings as rural Nova Scotia, urban Syracuse, New Haven, New York, Baltimore, etc., and the possibility of sharing and comparing such diverse data should enable us to move forward in the understanding of the total forces significant in human adaptation.

The Midtown Study incorporates several approaches to etiology and dynamics. It is worth adding that Dr. Rennie's conception, and my own, is to use various behavioral sciences appropriately in order to extend and deepen these kinds of understanding.

How shall one analyze the first grouping (etiology-dynamics) as an approach to the "irreducible minimum," the individual seen in his total environmental setting? The nature of etiology, in social psychiatry, forces us to consider investigations of mental diseases as a special part of the realm of causality in general. The simplest approach to causality is to take occurrences and ex-

* The senior project staff consists of Dr. Alexander H. Leighton, Director since 1956, and also currently Dr. Thomas S. Langner, sociologist, Dr. Stanley T. Michael, psychiatrist, Dr. Marvin K. Opler, anthropologist, and Dr. Leo Srole, sociologist. Dr. Rennie had seen the Study through all four phases of data gathering, here discussed. Dr. Leighton's Stirling County Study in Nova Scotia was our immediate precursor and analogue.

plore possibly relevant antecedents or causes which might account for the events. This is the presumption of many of the most elementary considerations of probability theory. In tossing coins—the usual analogue given for personal life vicissitudes—we could calculate completely and accurately the behavior of any coin or event about it if only all the physical data on size, weight, thumb, etc., were made easily accessible. We are tempted to call this the "rule of thumb" when applied to mental disorders by the impetuous or quixotic. To continue the analogy, correct for coin tossing, we fail to predict not because of a flaw in the determinism of nature, but because of hidden parameters which may be overcome, and even inferred, with the aid of probability statistics.

I have long believed that this application of one kind of probability is useful, in mental health research, in locating the initial and roughest kinds of hidden parameters, as for instance how much gross disturbance by class and culture group. Even here it may explore therapy needs rather than etiologies at all. It may be commenting, many times, on the education and alertness of respondents to a questionnaire on mental health, or if it is dealing with those in treatment and others in publicly supported hospitals, it may have far more reference to the availability of brakes on the illness process, real treatment unfortunately not always guaranteed in the public facility. These matters we have mentioned many times before.

But what if this kind of rough search in the realm of therapy needs could be pushed no further? What if it applied only to rough and cross-sectional indications of therapy needs alone? What if it were only, and in the same sense as the foregoing, appropriate to epidemiology and not an approach to etiology? The determination rests on etiological considerations concerning the phenomena to be investigated. That is, it depends on the kind of system under investigation. The newer physics, unlike the tossed coin example, recognizes, in addition, systems in which such events, far more complex than who is treated and who not, are involved. For example, there are some systems, not unlike personality deterioration entirely, in which other events like neutron and proton activities within the nucleus eventuate into disintegrations according to a given law of probability, but are *not* individually determined by the strict and simple principle of causality. Such systems are said to be *stochastic*.[18]

Psychiatry has for long seemed to be working with stochastic systems, precisely when it turns etiological and psychodynamic. For it, in the "irreducible minimum" case of individual and fam-

ily, or parental surrogates, the hidden parameters no longer exist as in the break-up of the radium atom. In psychodynamics, as for example in the therapy of schizophrenia, the once-hidden, as it were, parameters are increasingly viewed as surmountable. We are more aware that these disintegrations and others *do not* "occur in a determinate fashion," [18] and we can only work with probabilities of weeks, months and years. I have suggested [9] that the psychiatrist works with probabilities, and that the complex context of mental activity, in the human case, is at once physical, psychological and cultural. Social and cultural factors are not epiphenomena of biological "givens." They are given too, and must be analyzed for their distinct effects on human biology and mental activity. This focus again narrows down on the individual-family grouping, and we must turn again to the individual.

Unfortunately, we are not quite ready yet to consider the individual. All we have demonstrated are these basic points. *First,* the individual and his family are "irreducible minimums" in which psychodynamics and etiology take place. *Second,* simple causality approaches in probability statistics may be appropriate to estimates of therapy need where the determinants of such needs have at first hidden parameters, but where these inferred boundaries are, at least inferrible, that is, they have relatively determinate or fixed points. Perhaps a reason for this is that psychiatry can today diagnose, or comment on the seriousness of a disorder, more readily and in more instances than it perceives etiologies, which require a whole psychodynamic and psychotherapeutic process for their determination. Even the man on the street, with his refreshing naïvete about scientific matters, guesses and presumes that an Italian, when sick, may act differently from the Irish person, that there is some root in background accounting for this. But what we note about his naïvete, we may also look for in ourselves: Do we know and apply the correct tools of analysis to properly typified phenomena?

However tempting it is to press the differences, which have appealed to Whittaker, Pauling and many others, between easily determinate probability systems like therapy need and complex *stochastic* ones in which probability lies in less readily determinate levels of the psychodynamic balances in individuals and families, let us hurry on. We can assure the "man on the street," in passing, that something more is involved which may have escaped his notice for the moment. Some Italians and some Irish have sick balances, and their families also are in states of disequilibrium. The same is true with classes. However, it can be

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demonstrated that other families and individuals show fairly stable equilibria and do not produce disturbed children. No research in social psychiatry, worthy of the name, flies blind. The locus of illness is resident in balances or imbalances within families and individuals, as Cannon, Bernard and Freud each claimed, and the sociocultural facets have to be searched for effects on the illness process, not merely assumed. In the light of methods and scope, what are the necessary related technics of research that apply, first to etiology, and second to epidemiology?

Let us begin by restating that a method appropriate to the need for therapy may not carry down paths connected with incidence, that is the first incursion of an ailment. That is, the nonstochastic system and its appropriate method may be measuring rough prevalence in therapy-need and not etiology at all.[9] Let us consider etiological and epidemiological approaches together in instances where a germ or virus theory of disease proved crucial. In a vaccine which prevents a disease and mitigates its incursion or first course in the human organism, such developments, from Pasteur or Jenner to Salk, point up a difference between disease control in more absolute terms and the medical knowledge of disease management after the course of illness has started. Need-therapy belongs to the post-incidence phase, and one thinks again of diagnosis and management. The purpose and the technics of research here are different. It may be the difference between warm bath and passive exercise regimen for a crippled human being, and the vaccine which makes that crippling unnecessary. It is important to note, for this instance, that purely epidemiological strategies aimed at certain determinate parameters—a survey of inoculated and noninoculated—sufficed to test the effectiveness of the etiological tool once it was developed. Our concern is not with so determinate a scheme as in a virus or a "germ specific" ailment.

Let us leave these perspectives and return to our long-neglected individual. At an early stage in our Midtown Study, I became convinced of the necessity that entirely different probabilities, etiological and psychodynamic, should be explored directly in samples of schizophrenics from the New York area representing cultural groups. The cultural contours were readily accessible in our communities. We had evidences of family forms varying between cultures, healthful and poor equilibria within them and typical emotional balances or imbalances associated with each kind of differential family structure.

In schizophrenias, to continue our earlier contrast, we hypothe-

sized that the cultural facets or connections were not lost, but that the actual cultural boundaries (parameters) were buried in a history of pathology, or the live cultural affinities were highlights, distortions, over-learned and uncontrollable impulses or perhaps even delusional fantasies. Even this did not describe our culturally differentiated hypotheses, which depended on etiological and psychodynamic considerations so greatly that even delusional fantasy was separated from uncontrollable impulse. Since we felt that live or valid and normative cultural affinities were being set aside, and only cultural facets retained in the different emotional economies of Irish and Italian patients, I was forced to become a phenomenologist concerned with the natural history of these subjective states in which a cultural relationship of man to his fellow man, man to himself, and man to nature had to be traced. It was decided that only a full and direct study of emotional balances within the schizophrenic and his family sufficed. Locus and facets led to consideration of integrative balances and imbalances.

The leading paper which emanated from this study, and which I wrote, had "psychopathology" in its title, referring not to symptoms, as is so common, but to history and development of kinds of pathology. Because we were interested in a time-oriented disease course, the terms "etiology" and "psychodynamics" were not only used but exemplified throughout. This was done to point up the life-history orientation of psychodynamics, as exemplified in practically every viable, leading and current approach used in psychiatry today.

This life-history orientation, applied to an individual seen in his family and cultural background, was put in motion as a rich and qualitative study of extremely ill individuals, albeit a sample of them. One went from a normative cultural background study, or set of these, to direct observation and exploration of the ill to see where, psychodynamically speaking, persons in intensively studied samples may have departed from this normative stream of culture. If the classical Freudian theory could be based on the handful of the original cases fortunately known to Freud's penetrating genius, then I with no such certitude about my insights from other previous cases in the "well" to "sick" continuum, could at least study samples of schizophrenics as individuals.

At that time, we were interested in why we were making this addition to our community studies of well and ill. Why add such "irreducible minimums" as schizophrenics to an already long and complex continuum of disorder? There were many reasons, but besides the anthropologist's interest in tracing cultural connec-

tions or facets into extreme forsaken illness balances or emotional economies, he was interested as an investigator in social psychiatry in applying various tests and measures to these balances within. This was, in simpler terms, an interest in studying the total schizophrenic personalities with cultural tools of analysis, but as total personality balances as well. In the latter sense, the patients were, like all of us, psychological repositories of forces often called cultural also—emotional styles, mental habits, life adjustments, family influences. One could not miss the point that the mental context was at once physical, psychological and cultural. With the patients' often curious sense of time, the investigation of causes as antecedent events required recalculations in the light of their distinctly human ability immediately to apprehend past, present or future, and their apprehensions about present and future fed into the style of emotional balance like a feedback system. Far from feeling that an antecedent cause, like culture, sufficed without qualification as to how the cultural map was read, we were willing to grant freely that no single determinate points within that matrix—the father's failure, the broken home, the mother's neurosis, or a traumatic weaning—accounted etiologically for the monstrous result. Instead, a holistic method of analysis, concerned simply with balances and psychodynamics within the individual, was substituted.

Earlier,[9] I had dealt with the improbability that either global determinants, like slums, or abstract determinants, like "the broken home" were fixed etiologically significant factors. The well-adjusted come also from slums, and broken homes often have unusually remarkable people in them. These are obvious cautions, but the overwhelming consideration about stress is how it is handled in the total psychic economy. Such etiology and dynamics can only adequately be studied in relational systems or integrated ones, like families, individuals and cultures in the holistic and qualitatively richer side of mental health research. They can be families in a sample and individuals in appropriate number within families (and should be), but they must be such "irreducible minimums" if, in Rennie's words, "social psychiatry . . . the study of the etiology and dynamics of persons seen in their total environmental setting" is "to move forward in the understanding of the total forces significant in human adaptation." Since stress, like adjustment, has some organization and integration, it lies resident in organized and integrated systems. This is the real meaning of the inseparability of psychodynamics and etiology on the one hand, and their connection, through the locus of illness in

individuals and families with integrated meanings, like the facets of culture and community, on the other. This is what we mean by relational and integrated systems.

Since stress also, in mental health research, occurs in fluid and personally meaningful forms like voltages, tides of emotional current, tracings of memory on oceans of symbolized events, it is no mere mechanical structure having fixed, determinate points. Today, treatment of mental disturbance depends on understanding the individual's psychodynamics and psychopathology, with reference to his history, his setting, and his needs, conflicts and defenses. Freud and many others influenced this modern approach to therapy, and the fitting of treatment to the personality of the patient requires especially the Freudian and Neo-Freudian conceptions of more or less integrated systems of emotional needs and behavior. As stated in a recent work [15]:

> Since his (Freud's) patients came from a relatively homogeneous social background, he was able to observe their similarities and to generalize concerning the dynamic factors which they held in common. What he was not able to observe, however, was the close dependence of their dynamics on the parameters of their common social milieu. To Freud the physician, steeped in the biological sciences, personal needs appeared to spring from constant instinctual sources, and might, therefore, be regarded as universal in human nature. In order to keep psychotherapy abreast of developments in the social sciences, it is necessary to extend the study of psychodynamics to different cultures and subcultures.

In such different total environmental settings, the psychopathology and the psychodynamics may vary. We wish to focus next on the psychodynamics specifically, by which we mean the fluid and personally meaningful forms that agree with minimal conflict in a more total psychopathology or adjustment state. The psychopathology is the integrated structure of a mental disease, and its historical occurrence and transformations. For similar purposes of definition, the psychodynamics is the fluid and meaningful state connoting balances and imbalances in the individual. As such, psychodynamics has daily traffic and connection with culture.

What image suffices to capture the sense of an analytic and conceptual model for psychodynamics? I have already hinted broadly that the various aspects of social psychiatry, like behavioral sciences today, need metaphysics and philosophy of science approaches. Psychiatry, as an inevitable part of the field of medicine which *par excellence* needs metaphysics, has possibly even delayed too long in selecting its models for explanation and

analytic exploration. As already suggested, if we enter the labyrinth of various Freudian models for an answer we may protract the delays in time and explanation. In this fruitful, but difficult area, as Kubie has been reminding us all recently, there is considerable unfinished business, some of it fundamental. Besides, in Neo-Freudianism which is personally attractive to me, one is acutely aware of the recently added cultural dimensions (cultures in the plural) which have hardly been basically incorporated or reconciled even in various schools of revisionism. Besides revisionism, there is enough dissension in all these ranks, taken together, to suggest that wisdom may lie in selecting another course entirely for the next scientific breaking-through. Moreover, why attempt *total* typologies for mental activity at this juncture in a far more particularized discussion? One thinks instead, of simpler exploratory kinds of topological relationships that are suggestive for the human mind, even if sweeping and to date still tentative. After all, metaphysics, as William James refreshingly puts it, is just "an unusually stubborn effort to think clearly."

The model we select, as so many before us, is the feedback system. We select it, but with a difference. That difference has been brilliantly stated by the biologist, von Bertalanffy.[17] Speaking of the dangers of a loosely used concept of homeostasis, much in vogue today, he writes:

> The notion of homeostasis is meant to signify that the organism, biological, mental or sociological, tends to maintain some sort of equilibrium . . . However, the theory of homeostasis implies a machine model of the organism. The basic model is not a simple stimulus-response scheme with one-way processes as in classical reflexology where the brain is considered a sort of gigantic telephone exchange, with myriads of wires, switches and connections. Rather it is the feedback model, the prototype of which is the thermostat, with circular processes, which provides for the constancy of organismic variables in the face of changes outside, so allowing for teleological behavior and granting the maintenance of the organism. But a machine model it remains, that is, an explanation in terms of prearranged structure. But this, as I have emphasized elsewhere, does not account for a very important and basic class of biological regulations, namely, those by a dynamic interplay of forces within the living system as a whole and without fixed homeostatic mechanisms.

However, consider a feedback system without fixed past, present and future demarcation, as in a Freudian view, and in which the changes outside, the facets of culturally integrated systems, are constantly registered within. Lids and containments are off such systems. Essentially, as in feedback, there are cultural learnings to be selected from a wide accretion of traditionally stored mean-

ings, none of which are invested with a guaranteed optimum or beneficial series of uses. We know, from anthropology and a humanistic view of history, that man's unique achievement and undisputed monopoly lies in the evolution of symbols and the characteristics of language and purely human communication in the broadest sense. The innermost dimension of this more highly relational, sensitive, and many-faceted feedback system is ordinarily self-correcting or partially so, but it fails in its constant striving for integration if there is inordinate stress, excessive in time or grave in amount, or some physical dislocation.[10]

The Freudian unconscious approaches such a model, but misses the varying cultural facets and the elements of fluid forms of stress quantification. Its symbolisms are almost determinate constants, with little room for the differential feeding into the system in the sense of integrated but varying cultural meanings. Bernard's internal environment and Cannon's homeostasis have less reference to mechanical and material determinations of instinct, but the broader conceptions of a biological and psychological integration have even less reference to symbolism than the Freudian assumption of a pan-human system applicable to all. What has been needed, apparently for some time, are consciously directed studies of psychodynamics in individuals in which anthropological ideas developed on the integration and pattern of social structures, including family types, and relations between cultural setting and personality, are conceived of more minutely in terms of balances and integrations in the locus of the person and his milieu. We turn next to possible exemplifications of philosophy or approach to method in the actual methods and scope of a series of studies.

METHODS AND SCOPE OF THE MIDTOWN STUDY

Methodology does not end when empirical practice begins. In the Midtown Study, the aim of social psychiatry was still the study of the etiology and dynamics of persons in various environments. This research was conceived of as passing through four necessary phases. Each stage, consequently, was designed to further the contribution to a more rounded and valid analysis of social and cultural variables in mental disorder. The overall continuity and total coherence in research perspective suggest immediately that no single part of the Midtown Study can cogently be discussed separately from any other stage. Since each part makes its contribution in the light of a larger totality and the final aim

of social psychiatry, the successive research operations are intended to deepen the analysis, adding new dimensions to the understanding of etiology and dynamics.

Reasons for this continuity and interdependence of an additive series of research operations are twofold. Besides the operational necessity of constructing one research platform for viewing the problems that lie beyond the purview of each successive scaffolding, there are substantive and inherent problems in the structure or construction of each stage in the building. In the first place, the incidence or how much mental illness occurs in given time-periods and "in given social and cultural groups depends ultimately on processes best called etiological and answering the questions *how* and *why*." In the same source [9] where this appears, I immediately added:

> At the same time, epidemiology, if careful, provides clues to how and why, baselines for research into further etiological questions, and if linked with prevalence studies in modern communities, some knowledge for the planning of mental health resources, preventive measures, educational and therapeutic programs.

In this sense, it is gratuitous to assume, as some do, that etiology is some mechanical part of a larger explanatory whole, called epidemiology, or with others equally partisan, that etiology includes epidemiology. Operationally they link, but their substantive and inherent problems are different as to kinds of data required and the methods which apply.

In the following listing of germ-specific and also other quite contrasting but organic illnesses, the epidemiological method was frequently the clue to central facts about the growth, development or spread of these disorders. As all know, Haven Emerson wrote in 1931 on ethnic or cultural differences in measles, diphtheria and scarlet fever rates which proved immediately important in understanding the transmission of these communicable diseases. The year following, Clifford Abbott used the same method, essentially, to explain endemic developments of simple goiter. W. L. Aycock and J. W. Hawkins surveyed family and regional cultural relationships in leprosy, and R. D. Friedlander did so for pernicious anemia. A fuller list might adduce M. Calabresi, H. F. Dorn, M. E. Patno, F. R. Smith or E. L. Kennaway with ethnic rates respectively for a range of varying organic disturbances like heart disease, pneumonia and tuberculosis, or the sites at which cancers develop.

My point is that the core of these studies was epidemiological in which rate differences served as baselines for further etiological

research. They were linked with etiological considerations, approached etiology, but did not substitute for it. Also, the time-determinate points in these organic and germ-specific ailments have relatively greater fixity and the cultural facets depend less on the integrative functions of culture and personality than on mental disorder. While balances and imbalances within the locus point of the individual may be crucial in organic illnesses, they are central in a different sense, with less cultural connection and more fixity in temporal determinations.

However, how much mental illness occurs is *a fortiori* a function of growth and development of such disorders in family and community contexts. At least operationally, this hypothesis must be explored. As with our germ-specific and organic list, it is presumptive to conclude that epidemiology directly mirrors and reflects immediately into etiology. It may do so even less than in the manner of some of the ailments just listed. In the cervical cancers, for example, we seem to have at present more in the way of suggestion than real etiological implementation. Thus our second reason for a continuous and additive series of studies moving in a definite etiological direction is a belief that qualitatively richer studies of this growth and development may well be based on quantitatively more secure baselines of a statistical approach.

This, too, has been stated several times by Rennie and me in previous publications. In Rennie's statement [14]:

> Social psychiatry, therefore, is not to be viewed only as an extension of psychiatric knowledge to groups of persons. It is merely the mass analysis of mass phenomena. It is not only the ascertaining of how many individuals in a given society are emotionally or mentally crippled, though such studies are worthy enough and are important for the mental health planning for a community or a nation. Nor is social psychiatry limited to the study of the distribution of mental illness in particular groups of differing socio-economic and cultural backgrounds. . . . Social psychiatry is etiological in its aim . . . To approach such a task clearly calls for the participation of cultural anthropology, urban and rural sociology, individual and social psychology, psychiatric social work, biostatistics, and the particular insights of clinical psychiatry.

My parallel statement, from the same period, is strikingly similar:

> It is our feeling that epidemiological studies can only furnish the roughest clues and simplest baselines for such cultural and psychodynamic studies. As regards incidence rates, they must cut the life cycle into such questionable abstractions as "precipitating events" and "onset of illness" determinations. If the study is one of prevalence, while administratively useful data may result for action programs, these difficulties are compounded by such germinal questions as the types and

> adequacy of facilities for treatment, for education, for social rehabilitation, or even the attitudes towards such illness prevailing in the community. . . . The anthropological section has therefore proposed two theorems for elaboration into basic hypotheses to be tested in relation to both epidemiological and etiological data. The first holds that human psychological processes must be studied in relation to psychiatrically known case situations and histories of normal and ill within a context of cultural realities affecting patients and respondents.

Obviously, then, terms like epidemiology and etiology have special meanings in mental health research. If used loosely and incorporatively to include one another, one assumes that because they are not "mutually exclusive," they have no intrinsic difference. In social psychiatry, if series of studies are arranged so that one scaffolding leads to the next superstructure, and that in turn is so constructed that it leads into the next, and so on, the operational necessities set an order and a temporal priority in motion. One cannot confuse matters of order and time-priority with matters of aim, goal or direction. Social psychiatry is, as Rennie much earlier indicated, a series of related studies, linked in purpose and ultimately reinforcing. Thus, as I suggested in the last quotation, it is difficult to imagine psychiatrists, confronted with their practical problems of therapy, struggling with such questionable abstractions as "precipitating events and onset of illness determinations."

If one does not confuse administrative planning for action programs with the therapeutic aims of psychiatry, it becomes obvious that no therapist in mental health can apply epidemiological findings alone to a given patient. However, it is conceivable that a combination of epidemiological findings *and* etiological knowledge has uses at any point in the human life cycle. This being the case, I begin by summarizing the successive epidemiological and etiological stages of our research. After discussing four temporally overlapping but structurally distinct phases in research design, I shall, from a methodological and anthropological point of view, deal more selectively with our particular interest in cultural approaches within the broader framework of social psychiatry. The latter have constantly affected conceptual schemes and analytic models in our work.

The scene in New York City which forms our study area has been, for over a century, the setting of ethnic group settlement. Approximately in 1845 for Irish, hard pressed by the potato famine abroad, and in 1848 upheavals for Germans, Midtown's first influx occurred, leading with striking persistence to the set-

tlements of these two largest groups in the selfsame geographic areas their descendants and followers today inhabit.

Generally later and peripheral, a Gold Coast began to arise on their western and southern borders. But even before this concentration of wealth was firmly fixed on the horizon, three more ethnic groups had moved into Midtown, again into distinct sections, the same ones as today, south of "Germantown." There were, first, a Hungarian neighborhood just south, next door a Czech community, and nearby, somewhat interpenetrating, a Slovakian district. Each stage in research design recognized social and cultural variables which, in the 1950s, were even more strongly established in terms of numbers and descendant generations, in terms of population increments to each group and in the building of shopping centers, ethnic or elite, for each group.

By the time our study began, a South Italian-Sicilian community had been added on the southernmost side of the area and dated from the turn of the century; a novel called *Sicilian Street* had even been written with many warm allusions to "Midtown." Puerto Ricans had, in two decades, become a dominant population in the northernmost fringe of blocks.

Considering the two most populous original groups, and their supplementation by five more (Hungarians, Czechs, Slovakians, Italians and Puerto Ricans), what was the ethnic composition of Midtown when our study began? Two-thirds of Midtown population, belonging to these seven ethnic groups, each residing chiefly in distinct areas, illustrated this tenacious clinging to original community areas of settlement. This two-thirds figure is computed on the basis of sample and comprises only first, second and third generations. If one adds census figures in successive decades, one sees the two-thirds in finer variations, a dwindling community like the Hungarian being counterbalanced by a growing population like the Puerto Rican. These are the two examples of old, decreasing population, Hungarians obviously leaving the area, and new, increasing population like Puerto Ricans coming in; but aside from these examples of old and new population, the five other ethnic components of the area showed remarkable stability in numbers, decade after decade.

The Hungarian, Czech and Slovakian communities averaged between 70 and 80 years of age. To this period belongs the real Gold Coast development which developed to accommodate the residences, distinctive apartments and exclusive shops of the affluent. The wealthy area comprised mainly two tiers of blocks running north to south along the western edge of the study area;

it included relatively few scattered, elite enclaves elsewhere. Strongly contrastd with the ethnic slum areas of Old Law tenements, warehouses, settlement houses, ethnically related shops and the cultural association buildings, this juxtaposition of a much smaller, wealthier area, which Zorbaugh termed classically "the Gold Coast," provides the second variable of complete socioeconomic range from the poor and the middle class to some of the wealthiest people in the world. However, the ethnic slums dominate the area both in space and numbers. The variables of socioeconomic and cultural diversity are not in equal proportions or even balance. The poor and the seven dominant ethnic populations largely coincide.

Each ethnic group, in census tract analyses of 1940–50, showed stable settlements of foreign-born with the fluctuations noted for Hungarians and Puerto Ricans. The foreign-born of each group were found in given areas in 30 to 40 percent population concentrations. This meant that the entire study area, with a foreign-born representation of one-third of its total population, by 1940–50 Censuses and random sample, showed concentrations of one particular group in given districts. One could note this by inspection of the area in detail, but the 1940–50 Censuses, by tracts, showed that each specific group in an area was maintaining such concentrations with the two exceptions (Hungarians and Puerto Ricans) above noted. Moreover, census tract information underestimated this phenomenon of ethnic group segregation since tract boundaries did not conform with cultural ones.

From a central core of blocks, surrounding well-known ethnic group "Main streets" and shopping centers, these concentrations would of course attenuate until one reached the boundary where a new ethnic concentration began. Over 60 percent of the later random sample consequently proved to be from first to third generation of these same seven ethnic groups, and only 13.5 percent for the area as a whole represented families which had been in the United States for over three generations. The proportion of non-ethnic New Yorkers, born in the city and of fourth generation or more in the United States, was a mere 4 percent of the total sample population. The majority of the conglomerate "Old American" group composed of fourth generation or later generations was Southern or New England, if Yankee for the latter extraction, and also in categories like fourth generation Irish, German, etc.

The first step, or Stage 1 of research, beyond such survey and census comparisons in demography, was to plunge into field work

in this basic two-thirds of ethnic populations. For the second factor, that of socioeconomic status, while the area disclosed both in census and later in sample those extremes and intermediate stages of wealth and poverty mentioned above, the ethnic group replacements from the port of entry showed only slight upward mobility over time. But this is true of the Midtown area and not true of the city as a whole. Our groups constituted the larger, lower and lower middle class segments of the district, but the more successful of some groups (Germans, Irish, middle Europeans, and Italians) showed a certain tendency to move out into given parts of other boroughs viewed as suburbs. One could discern Czech and Slovakian districts on Staten Island, or find Czechs in Rosewood. Such borough maps had been constructed in the project.

One community, the Hungarian, was distinctly becoming a residual one with an attrition of area, associations and institutions going on most rapidly. Thus, over time, one conceives of more successful Hungarians moving out. Another, the Puerto Rican, was moving in and as yet had not had the time to achieve upward social mobility to any great extent as indicated in our comparative data. In addition, Puerto Ricans had few cohesive community associations compared with the other groups. The Hungarians were losing theirs. When we consider that the residual population of Hungarians, and the Puerto Ricans in the throes of rapid acculturation were two of our groups, and further that all our groups represented, not "Germans," "Irish," etc., either abroad or in the city as a whole, certain further points are thrown into bolder relief.

We were studying the least upwardly and geographically mobile Hungarians, Puerto Ricans, Germans, Irish, etc. These formed a huge segment of the lower economic strata of the area. If lower socioeconomic strata show greatest disturbance by number of people disturbed or numbers showing the greatest amounts of more serious disturbance, then we are well advised that these figures may be achieved by adding to the ethnic group disturbance in its aggregate form, the disturbances of additional numbers of "Old Americans" in the lower economic strata of our area. Besides this, ethnic counts which include the seven major groups and even add a few, may still miss in such rigid counts the Sarajevo, Sasebo, or Sao Paulo migrant and his offspring who are not in major ethnic groupings. Midtown had 7 major ethnic groupings, but 11 minor and distinct additions which could not be adequately studied. These last, or even the Old Americans in

lower socioeconomic strata, cannot sensibly be counted in class unless they are added in on the "cultural side of the ledger" as well. By eliminating children and aged, fourth generation and cultural isolates from such ethnic survey, one may weight a sample away from ethnic components. In our study, one thing was certain: The various ethnic components heavily weighted any lower or lower middle class cross-sections of the area.

The total study area also showed varying tempos of acculturation for the seven groups and also certain evidences of a port of entry replacement process. The question was how to account for this in the conceptual framework. Early I spoke of this as an advanced trend of urbanization such as Eshref Shevky and Marilyn Williams have pointed out for cities generally in their work, *The Social Areas of Los Angeles.* With greater urbanization of an area as a whole, there is dispersion of social rank or status into discrete areas, along with emergence of the familiar patterns of ethnic segregation. Earlier comment [3] on the Shevky and Williams statistical indices for extreme urbanization and its status and ethnic segregation was as follows:

> . . . Parts of this picture of social change are familiar to all of us. One hundred years ago, the typical American family was a unit of different size, activity and outlook from what it is today. From a fair-sized unit, whose members labored together in rural districts, it has shifted in size, location, mobility and functions from a relatively stable unit, self-sufficient and self-contained. There is the transference of basic economic activities to outside agencies. There is the more complete dependence on factory-made goods and urban services. There are the extra-familial agencies of recreation. There is the multiple family dwelling, the tenement and apartment house. There is the diversity of occupational level, income and degree of education—but within a new setting, the city. There is the segregation of "ethnic and national minorities". . . . Within the area as a whole, high degrees of urbanization tend to go spatially with low social rank and high sex ratios. . . . Within the urban areas, family size is small, but increases with a lowering of social rank. There is an increased proportion of women, fewer children and more old age population. A large proportion of the labor force is blue collar in type or associated with the service industries. . . .

My point is that in such extreme examples of urbanism, where the basic two-thirds of population is composed of ethnic groupings, partly residual and partly newcomers, these may constitute most of the larger lower and lower middle class segments of the district. If one is estimating therapy need, one need only consider rapid acculturation, economic deprivation, intergeneration conflict, the social mobility that leaves residual populations behind or others at the bottom of the ladder, and sharp rural to urban shifts in geographic mobility. Here one may hypothesize high propor-

tions of psychiatric disturbance, both as to numbers and type. After initial field work, we did so. We suggested that prevalence rate differences would obtain in proportionate number and seriousness, for a more residual Hungarian community or for Puerto Ricans, more in the throes of faster and more dislocating acculturation processes. This, too, later proved to be the case. In fact, the lower class social segments of ethnic groups across the board are those population segments with least education about psychiatric disability. With least treatment also, their pattern of medical need is varied only in our upper class and status enclaves.

Anthropological field work in each ethnic group went beyond demography and initial community mapping of institutions. I began with a range of ethnic group representatives or leaders, but soon decided that average, "grassroots" people, well and ill, would have to be added. In initial fieldwork we had no sample, though one was being planned. It was my feeling that no ardent attachment to a single socioeconomic frame of reference or analysis alone sufficed to explain the historical persistence of the cultural groups, like Germans or Irish, the splits and schisms in the Hungarian community and its residual characteristics, or the particular problems of the Puerto Rican population. Equally, as this field work progressed, and the vitality of cultural group attachments became better known, it became obvious that beyond the demographic statement of cultural group continuity, these affinities in Midtown did not melt rapidly or completely into an overarching class framework.

In 1956, I wrote [9] of the necessity to "refine global notions of ecology" in the setting of discussions of class, social mobility and the like" in such a way that etiological and dynamic psychiatric questions could be tested and answered while attempting to draw epidemiological considerations and conclusions to the fore." This meant that class frameworks without concomitant cultural group content appeared useless for a more complete etiological and psychodynamic inquiry, however helpful they might be in indicating gross therapy needs for action programs by class levels. It meant that on etiological phases of research and analysis, class and culture would have to be considered simultaneously. This also was drawn into the later plan of research. Since Midtown's majority was both ethnic and lower or lower middle class, initial anthropological field work was directed substantially into these channels, leading to my first staff reports after almost 2 years of field work. These cultural group studies were not finalized, but require corrections and elaborations to the present, 3 years later.

The latest survey of two cultural groups, a supervised study, is dated 1957.

Stage 1 in field work led to conceptual models for analytic purposes and to research models appropriate for this analysis. These appeared in book form.[9] According to Kluckhohn's review in the *American Anthropologist,* I repeatedly drew attention "to the danger in multidisciplinary research involving relational causal systems of so abstracting 'the individual from his meaningful cultural background that he ceases to be a responsive or live subject for diagnosis, case formulation or psychotherapy.' " Kluckhohn continues:

> He inveighs equally against social science approaches that rely too exclusively on social structure and interactional systems, neglecting the "meaning of cultural conduct." . . . This leads of course into his central premise that cultural standards or values are responsible for the historical, regional and group differentiations that in turn influence the epidemiological picture.

Kluckhohn's review did not miss the central conclusion, already being drawn in 1954 from field data, that culture, personality and status are related systems and must be studied in combination in the individual through sampling procedures, and then in depth. As to the point I have indicated earlier, on the importance of both cultural and historical changes within any area or its population, Kluckhohn quoted approvingly my point that: "The ecological approach . . . must rid itself of a static quality not merely in terms of human drift within its framework, but in terms of substituting processual analysis (the history of an urban area) for the more static cross-sectional view used so constantly."

Similar and parallel conclusions are prominent in Rennie's paper of 1955.[14] Continuing the repeated theme of his interest in etiology and dynamics, he stated incisively:

> Social psychiatry is concerned not only with facts of prevalence and incidence, it searches more deeply into the possible significance of social and cultural factors in the etiology and dynamics of mental disorder . . . All too often, however, this line of development (intensive intra-psychic studies, MKO) was gained at the expense of a relative neglect of the total family dynamics and of the cultural *milieu* from which the patient came.

Quite characteristically, Rennie's unusual flair for describing psychodynamics, and the use of the latter in therapy was exhibited at this point. Immediately, he added:

> This is seen in its extreme form in the practice of some psychiatrists who are preoccupied with the intricacies and subtleties of the transference situation as a therapeutic tool, and who refuse to see relatives or to draw them in any fashion into the treatment situation. These psy-

> chiatrists are fully aware of the tremendous impact of family dynamics but prefer to elicit the facts exclusively through the reconstruction of the patient—a reconstruction which often deals with fantasy distortions of remembered dynamics. . . . We have not always, however, been sufficiently aware of the total family as a homeostasis. The illness of one member will inevitably upset this balance, leading to a realignment of all other members. . . . Many psychiatrists find it therapeutically advantageous to work with the other key members of the family in the therapeutic process. Failure to do so sometimes spells disaster for the patient under therapy.

How may one begin to study this importance of family setting and dynamics? In Stage 1 of research, with no sample yet available, the methodology used was frankly exploratory and led largely to partially attested hypotheses. Besides interviewing community organizational leaders and residents, I was led early into study of such diverse materials as samples of psychiatric and social service records in the hospital out-patient department, in settlement houses, day care centers for children, with Dr. Rennie in the Clinic, and with student assistance in agencies serving Midtowners such as the Catholic Charities Guidance Institute, the Puerto Rican Commonwealth of Labor, case records, adult and aged persons programs in settlement houses (also observed for months), summer camps for children, or indeed, wherever observation was possible and psychiatric or family case records were available under usual rules of professional confidentiality.

Beyond student surveys and theses, and my own observations, I found it important to locate and observe community families with disturbed children or evidences of some degree of psychiatric disorder in other family members. Within each ethnic group, the equilibria observed in putatively "well" or "well organized" families could be compared with equilibria observed in problematic ones on the same levels of generation, status, age and other criteria. With the aid of translators, there was some slight "content analysis," based on counts of subject matter and treatment of it in the ethnic papers subscribed to for year periods. Brief seminar reports in anthropological staff included ethnic radio programs, TV, and such mass media of communication as the typical literature in various languages vended in the area. The foreign language cinema in the area was reported on, and Sokols, Turnvereins and kinds of associations were studied. One participated in ethnic holidays or observed the *rites of passage* and the expression of affect displayed.

The most helpful studies of all were inconclusive samples of cases derived in the clinic and a veteran's facility additionally,

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and then studied jointly by Dr. Rennie and me. At first, these stemmed from the latter's out-patient cases analysis, again an inconclusive sample. However, the cases were instructive from both the psychiatric and anthropological vantage points since they illustrated syndrome patterns, symptom clusters and psychodynamics on which both the psychiatrist and anthropologist might comment.

Even in such exploratory phases during Stage 1, we made no assumptions that one national culture group was intrinsically more ill than another, or that acculturation phenomena did not count heavily in the groups we were studying. However, intergeneration conflicts were only magnified in such instances. Also significant in the cases, it seemed, was that the acculturation conditions under which one migrant grouping operated were less advantageous for one group than another. These points concerning intergeneration conflict, as a variable, and the conditions under which a culture operated were made in a series of papers [9-11] in 1955 and had appeared in theoretical form [2, 4] even earlier. In them, I distinguished such efforts in acculturation studies from being confused with national character-and-personality critiques, on the one hand, or the critiques of infant-discipline explanations of adult personality, on the other. I had, myself, dissociated from such views in my paper [8] of 1942. The critiques which were appearing (Inkeles and Levinson,[1] Orlansky,[12] for example) were similar to my already avowed views, and seemed consistent also with the cases studied. However, to illustrate typical dynamics and related special problems, some small effort was expended to describe psychodynamics in such disadvantaged groups as Puerto Ricans, and themes of this sort appear as a thread in references 6–9.

Even to glimpse seven cultural communities, this two-thirds of a population of over 170,000 Midtown residents, required a staff of assisting anthropologists, some few postdoctoral, but the majority predoctoral graduate students who spoke the requisite languages. The latter group contained a majority who had either done some field work or lived previously from the time of birth, or on later travels, in the various cultures represented. This field work of myself and a dozen assistant anthropologists was coordinated through an ambitious field-training and fellowship program, aided by grants to the individual students from the National Institutes of Health, the John Hay Whitney Foundation and the Dickinson Research Memorial. The development of a field team, seminars, theses and the fellowship program followed my first

summary reports, delivered to staff, on each ethnic group. As the field teams were formed, the ethnic studies containing historical, psychological, acculturation and social organization materials, comprised a file of methodological, descriptive and analytic data available for field teams and the subsequent phases of research.

As these first descriptive and analytic studies of the area were being developed, Stage 2 of research was being designed by Project Staff as a whole. Dr. Rennie's 1954 report of progress to the National Institute of Mental Health, 2 years after the project began, is instructive for earlier research phases to this point. In his statement, the 1953 report had decided on "four major approaches" aimed at "possible etiological factors inherent in the social setting which might throw light on the question of incidence and the nature and dynamics of personality, and emotional health or illness."

Stage 2 involved a randomized probability sample of adult population, some 1,660 persons, ages 20 through 59. The basic instrument was a home interview questionnaire to which, besides the coded form, were added any significantly useful remarks offered by the respondent. There was a coded form also for trained interviewers' observations. This questionnaire was an interdisciplinary product, designed from the outset by interdisciplinary staff. In addition to Dr. Rennie, it was developed by two other contributing psychiatrists, three persons in the field of anthropology and sociology, a psychologist and two psychiatric social workers. Approximately a dozen major drafts were prepared if one counts anthropological and sociological sections separately required. For example, a basic core was psychiatric in intent and for this purpose total staff considered for months the nature of various items contributed by all. Sociological items, of course, stressed such elements as socioeconomic status, social mobility, anomie, or rural-urban differentiations. The anthropological items, some of them in an ethnic section and some throughout, emphasized in parallel fashion such materials as ethnic and religious participation, acculturation, areas of intergeneration conflict, and bases of personal identification at different points in the life cycle.

The bulk of all efforts, however, went to construct questions of psychiatric significance. These were difficult to achieve across class and cultural boundaries. Possibly no instrument (objective or projective) is entirely free of cultural content or status assumptions. Ours was at times a subjective statement of attitude and at others allowed the respondent to report items of health history or sense of well-being, some of which may have been

highly objective. In the process of successive drafts, one attempted to disguise the kinds of items which, to the sophisticated, more intelligent or better educated, might signal the purpose of a mental health inquiry. Even this general purpose had to be suppressed since this was hardly a "captive" population or one in which the doctor-patient relationship wholly obtained. There is no doubt since interviewers reported it, that some suspiciousness occurred, some blocking, some concern over the nature of the inquiry. It might even be debated that education, certainly a class or status-related phenomenon, can guide or control respondents' reports in topics like mental health which has considerable popular appeal or interest, and a no less widespread literature, some of it reflecting increasing sophistication.

Interviewers were therefore trained in establishing rapport, recording certain observations and gathering spontaneous remarks. The instrument covered areas connected with childhood anxieties, adolescent attitudes, marital adjustments and self-conceptions of health status, the last including psychosomatic illnesses. It was pretested as a special project of psychiatric social workers using an outside area. The staff participated in its use among known neurotics, psychotics and with persons outside of our study area. In a final stage, it was coded by a sociologist newly added to the Project Staff, and a psychologist and sociologist took items already contributed to build up a series of categories (childhood anxiety dimension—as remembered, tension anxiety dimension, psychosomatic illnesses, nervousness, withdrawal, etc.) for arrangement into lists or scales. An anomie scale of the staff sociologist was incorporated for another example. Similarly, there were specific cultural areas of intergeneration conflict, of interest to me. In organizing all of these last efforts, it was hoped to aim at a series of scales involving sociocultural items on the one hand, and indicia of personality disturbances or arrays of symptoms on the other.

This development of separable sociocultural and symptom-impairment features allowed for a further coded psychiatric summary and a separated sociocultural one on each respondent. Therefore, the psychiatrists rating these were able to consider the more psychiatric and more social dimensions independently. We shall not dwell on interviewer training or the special measures taken to include full community support. The former included trained psychiatric social workers. Nine anthropologists and three assistants helped in constructing uniform translations of the questionnaire into Czech, Slovakian, Hungarian, into north and south

German dialects, into Sicilian and South Italian dialects, and into the Spanish (Puerto Rican dialect) urgently required in our communities. For example, Puerto Ricans viewed English as an official or investigatory language, or else did not speak it at all. French and Russian translations were also needed, for our study bordered upon such minor enclaves or included them. All translations were checked and were uniform, the checking being done by linguistic experts. One German-speaking interviewer doubled in Polish since we had stopped at three Slavic language translations. Otherwise the written format of a language translation was taken into the field and the answers recorded on an English blank form by the interviewer. Ten anthropologists carried such translations into the field for verbal interview though more anthropologists participated. Social workers, sociologists and psychologists were added to the interviewing staff to develop a uniformly trained, professionally backgrounded and *pro tempore* group. Specially designed approaches by letter or call (the letters also translated) for different ethnic and class segments were decided upon. Committees were formed and letterheads were printed.

The final net of such procedures is, of course, a rough indication of the prevalence of mental disorders in terms of interviewee's reports of symptoms, their seriousness in the aggregate and in certain scaled dimensions, and the psychiatrists' evaluations of degree of symptom formation and degrees of impairment in life adjustment. No one supposes that a physician-patient relationship over time is achieved in even the most carefully designed instrument taking from an hour and a half to two hours. Yet for once we felt a structured and uniform home interview had been designed for a specific area after initial and exploratory field work. It had been extended to full potentialities. It allowed us to narrow down upon a probability sample and add to knowledge of hospital admissions necessary information about the ambulatory ill, the previously treated and neglected, or in short, that larger population suffering disabilities but receiving no current public or private institutional care. It was necessary through the psychiatric social work staff* to check these data against social service exchange, adding information concerning those in treatment and known to agencies who fell into our sample.

A parallel investigation, conducted by the psychiatric social workers, was an elaborate canvassing of private psychiatric and psychological services which then reported in quarterly periods

* This staff was composed of Mrs. F. Taran and Miss Margaret Bailey.

on the number of their patients. Approximately 1,200 practicing psychiatrists, clinical psychologists and psychiatric social workers contributed to this patient census for Midtown. Those from Midtown in private and public institutions were likewise tabulated within a time period corresponding to questionnaire cross-section of community. The total final prevalence included those treated and untreated, those putatively well and those ill, those in public and in private facilities, all ranging in a basic or overall continuum from the symptom-free to those seriously disturbed. Without the patient census, conducted by psychiatric social work staff, or without the survey of the random probability sample, one could not have considered the whole problem of mental health and illness through a complete population.

In both Stage 1 and Stage 2, whether in the study of ethnic communities, the launching of the questionnaire, the social workers' case-finding methods, or in Stages 3 and 4 of more intensive studies of families and of patients, we had developed hypotheses of both an epidemiological and etiological sort. It was recognized that evaluations of psychiatric disturbance as to emergence or degree must, in a questionnaire method, depend on interviewer observations, respondents' spontaneous remarks, and on the special pertinence of the psychiatric-oriented queries. Such questions and related data may be called in the aggregate "personality disturbance indicators." We had several precedents to follow like known indices (the Minnesota Multiphasic, the Cornell Medical, the Army Neuropsychiatric) and all these provided some grist. But perhaps the development, by interdisciplinary methods, of new and searching items gave the psychiatrists some profile of a range of behavior and attitude.

In the present state of social psychiatry, the existence or degree of disturbance, according to questionnaire information plus interviewers' observations, would constitute a crucial step forward, one dependent on ratings or evaluations. Such ratings are best made by psychiatrists themselves. Three psychiatrists of varying background and training independently rated questionnaire summaries, described above as containing a psychiatric and a sociocultural dimension. They could first rate the psychiatric section alone, not knowing the social background initially. The parameters of a seven-point scale included the seriousness of symptoms reported and the degree of life-adjustment impairment. With these factors in mind, the psychiatrists could again rate the respondent, knowing the contours of social and cultural back-

ground. Two psychiatrists separately rated the entire 1,660 series of summaries, and Dr. Rennie rated a few hundred in addition.

Such ratings are not, nor are they intended to be, diagnoses and neither are they limited to what in clinic settings might be called "presenting complaints." Since they are not diagnostic end-products of cases intensively studied over a period of time, they are cross-sectional and require the extreme care in evaluation which was expended. No matter how much ratings of two independent judges will be similar or identical, total consensual judgments cannot be guaranteed for each respondent. It is possible, however, to combine ratings into a single expanded figure and to describe this range and the points of differentiation within it. Statistically, the 7-point original scale was combined into a 12-point scale for such purposes of combining ratings. If one emerges with indicators of symptoms ranged as to amount and apparent seriousness, plus notions of the relative degrees of life-adjustment impairments, then in terms of patient census one has analogues of those hospitalized in "those hospitalizable." One also has further analogues for those less seriously disturbed and also for those who are not in treatment and do not seem to require it. So long as rough prevalence is not confused with actual diagnostic procedures, the difference between methods used etiologically or in therapy and those having epidemiological uses in estimating the prevalence of therapy need is made clear.

This process of defining a single rating, combining or more inclusive of two judgments, cannot be developed further here, but suffice it to say an attempt was made to preserve the opportunity of rechecking some original ratings in a later, intensive family study process. Meanwhile, hypotheses developed for each cultural group in stage 1 of research were further tested by anthropological field staff in the home interview phase of research. Indeed, anthropologists initially exploring ethnic samples with the questionnaire began to report differential sets of reactions, by ethnic group, to this type of instrument. Besides, as might be expected, questionnaire data on ethnic participation, identification and acculturation process showed group differences as had Stage 1 of research. One heard repeatedly of first-generation respondents who, if lacking citizenship and coming from Slavic-speaking countries, showed related concerns about the home interview.

Some better educated Old American interviewees were credited by the questionnaire staff with knowing the right answers, and with intellectualistic rationalizations rather than frank replies. A Puerto Rican anthropologist, born and educated on the Island,

found the questionnaire abstract, to say the least, when asking Puerto Ricans in Spanish about degrees of cultural participation, or in the anomie series about how they felt on the topic of political figures, or elsewhere about intergeneration conflicts in crowded apartments where the answers were abundantly evident before the questions were asked. He and others were anxious to move ahead to focused and unstructured interviewing, or to participant observation technics. When later he did, he reported learning far more about the respondent's sexual and social identifications by observing him in peer group situations, or could discover another's oral deprivations and aggressions better in a helpful trip to a hospital clinic than in a room and 2-hour formal interview dominated throughout by an agressive and rejecting mother.

Stage 1 of research, however, had been strengthened only occasionally by a few quantitative studies. Concerning the same Puerto Ricans, a directed study of almost 300 job-adjustment histories of migrants to Midtown had produced important materials, substantiating central hypotheses concerning the better economic opportunities for Puerto Rican women, and consequently the greater social role alignments necessitated for the men. Consequences in family dislocations in our area were already manifest, and by questionnaire means we had determined poorer mental health ratings in this group than for any other. Rapid acculturation, economic deprivation and poor ratings require other etiological and psychodynamic materials to see the entire picture. How exactly is mental health affected in this group? Though men and women shared in the poor ratings both as to number and seriousness, the social role positions of both sexes had changed in diametrically opposite directions from the originally Spanish-oriented culture. What were the special problems of men and of women? The interdisciplinary questionnaire was, after all, one method and that contained in a 2-hour technic of inquiry. Sciences, particularly the interdisciplinary ones such as social psychiatry, grow up and come of age in the measure that they show flexibility in applying various tools of analysis.[2]

In discussing this necessity for a Stage 3 of research, Dr. Rennie succinctly emphasized in his 1955 report [13]:

> This operation has four major purposes: 1. To secure deeper and more comprehensive data on personality dynamics and family patterns than was possible with the two-hour questionnaire employed with the entire probability sample.
>
> 2. To assess on a more qualitative basis the etiological connections between cultural factors and mental health.

3. To check on hypotheses suggested by analysis of the questionnaire data.

4. By means of a larger and richer body of data from each respondent, to test the validity of staff psychiatrists' evaluations of mental health based on the information secured by the questionnaire method.

One need not dwell upon Dr. Rennie's use of the terms, "etiological" linked with "more qualitative basis"; his strictures on "the two-hour questionnaire" as requiring "more comprehensive data on personality dynamics and family patterns" in smaller, selected or purposive subsamples; or his interest, "by means of a larger and richer body of data" in testing "the validity of staff psychiatrists' evaluations of mental health" in questionnaire respondents. In comparing with his 1953 report, quoted earlier, we note that he had there stressed four research stages aiming ultimately at "possible etiological factors inherent in the social setting which might throw light on the question of incidence and the nature and dynamics of personality, and emotional health or illness." In the 1955 report, this etiological interest was stated as "etiological connections between cultural factors and mental health."

Stage 3, to continue his discussion, was termed the "Intensive Follow-up Study" of purposive subsamples of respondents selected from the Stage 2 probability sample survey. From the original randomized sample, seven major cultural groups were selected as appropriate for this study. An Italian subsample study was at first attempted in addition, but was discontinued on the subsample basis because of insufficient help; interviewing among Italian probability sample respondents continued nevertheless. Other than this case, no anthropologist picked his subsample respondents at will from the probability sample group. Instead, the categories for further study represented a continuum from well to seriously ill respondents, according to original psychiatric ratings, plus differentiations across the board as to generation, sex, and at least two socioeconomic groupings. Since religious typologies existed in ethnoreligious clusters (Catholics, for example, predominating in some groups like Irish, South Italian or Southern German), the religious factor was heeded in subsample selection; German Protestants, for example, were included with Catholics to explore the relevance and variance of this specific factor in the first German subsample drawing, but Irish Protestants, less numerous in their group in Midtown, were not.

The segmentation of each purposive subsample into mental health (rating) groups along with sex, generation, socioeconomic and sometimes religious criteria, did not fill each category with an equal number of persons because of mental health rating

variations, total size of group and variations in each demographic characteristic. The Hungarians, for example, and as we have suggested above, had few third generation representatives to begin with; an original sample in this group was so thinly spread for such characteristics that religious differentiation had to be dropped from subsample selection, the sample redrawn, and this factor studied *in situ* in remaining respondents. In purposive subsample selection, however, our intention of holding to categories of age, sex, and a generation and socioeconomic differentiation could be preserved for the necessities of intercultural comparisons controlling such important variables, along with mental health ratings, within the cultural framework. On the factor of age, for example, this was not included in the original grid-system of subsample selection, but we hoped to obtain fairly regular representation of old and young across the board through the device of generation selection. To some extent we emerged with old and young, but in the Puerto Rican probability, or original, sample survey we knew in advance that this population contained practically no second generation, aged 20 to 59, a skewing in mental health ratings towards the problematic ill or seriously disturbed categories, and little socioeconomic range. Here the entire probability sample had to be aimed at, but the example illustrates the ethnic group differences which in one form or another were prominent.

Immediately following the Stage 2 research, each ethnic group selected for further study was demographically summarized as to profiles of age, sex, generation, socioeconomic status, status mobility, rural-urban differentiations (place of birth), and like characteristics. Each was discussed in seminar and staff reports. We might know, for a trite example, that a third generation Puerto Rican is a rarity in any borough of New York. The profiles, however, brought out the integration of ethnic group characteristics and convinced us that our prime interests in cross-cultural comparison would be the leading variables we selected for control, that is, mental health, sex, generation and status or status mobility. In the Old American group alone, the profiles convinced us that the three major class levels, upper, middle and lower, should be included.

We have mentioned that the mental health ratings were the core and basis of selection for the ethnic subsamples drawn. How, in Dr. Rennie's terminology, were we going "to test their validity," or "check on hypotheses suggested by analysis of the questionnaire data"? The general process for these two points

in his 1955 report might suggest at first glance a reliability test with some of the same respondents on minutiae of questionnaire data. This, however, was not our aim although all the anthropologists, in intensive follow-up studies, made some corrections in fact for the 2-hour questionnaires. On the other hand, even without stopping for the formality of a complete reliability test, we all sensed that the questionnaire data were not crucially lacking in reliability. We simply needed, in Dr. Rennie's words, "deeper and more comprehensive data on personality dynamics and family patterns than was possible with the two-hour questionnaire."

In both the follow-up studies and the re-rating process which followed, the anthropologists were now trained as a team to study the family and individual settings more intensively. They used freshly constructed "anthropology summary forms," guides and manuals to achieve greater aim and uniformity in their work. Seminars continued, first with the group as a whole, later by individual "ethnic group teams." Stage 1 materials, the questionnaire group-profiles, discussion in each team of the field work as it progressed, and some instruction by psychiatrists aiding in the supervision of each team helped to extend the framework of a respondent follow-up study to what Dr. Rennie, in 1955, had written of as "total family dynamics and. . . . . the cultural *milieu* from which the patient came."

The sense of additive and qualitatively richer field work was pointedly suggested in that each anthropologist, with only a few exceptions, was often the original questionnaire interviewer now seeking fuller and more qualitative data. Beyond this, we wished to encourage anthropologists, psychologists and also psychiatrists to re-rate the respondent, but now in the sense of a full case review in which, besides questionnaire, all the additive information and insights could be brought to bear on individual and family dynamics. To do so, the anthropologist had access to the filed questionnaire and after more intensive field work methods, introduced a clinical psychologist into the home scene for later formal "testing."

Every effort was made to keep the clinical psychologists, who entered last into the field work phase, from knowing questionnaire materials, anthropological data, ratings or indeed anything about the respondent other than name and address. The "psychology summary form," however, ran parallel to the anthropological form to record, in advance of any case review, independently arrived-at conclusions concerning a variety of

matters such as effects of family, of orientation history, and psychodynamic balances. The psychologists, perhaps the most uncontaminated members of the follow-up teams of researchers, based their independent ratings on the Rorschach, certain Thematic Apperception Test cards. Holsopple-Miale Sentence Completions, and, where necessary to test for brain damage or elaborate on dynamics connected with parental images, the Bender-Gestalt or draw-a-person methods. While Dr. Rennie was able, two psychiatrists were charged with full case reviews, organized as a pattern by me. Staggering in of cases from various ethnic groups was used as a device to insure against assuming patterns to exist, or to prevent any one team in a given group from weighting conclusions towards one cultural pattern. New data were contributed for the first time, certainly from the vantage point of clinical psychology. Beyond these methodological cautions, the chief validity of which Dr. Rennie had spoken earlier was achieved by better knowledge of the family and individual psychodynamics in each case, and of cultural facets influencing the case as well. The case reviews, begun in all cultural groups as a "trial run," were finally, for reasons of time, limited to four main groups: German-Americans, Puerto Ricans, the Slovakian-American subsample, and Old Americans. The total number of cases for review is approximately 80.

In an initial series of case reviews, some re-ratings differed markedly from the original ratings, some remained the same or substantially so though qualitative variations were added (for example, a different sense of prognostic indicators), and some, in the notes of case review conferences, showed varying opinions between psychological test ratings and all other ratings achieved. It is still too early to comment fully on this complex process. In general, it is my opinion that a trend in rating can even now be discerned in such second runs, but I also think that original ratings and the re-ratings are distinctly based on different modes of research. My chief concern is whether one learned more about psychodynamics by incorporating more knowledge of the cultural facets—the impacts of culture upon personality; and also by adducing psychological test methods. As an anthropologist, I found the experience richly rewarding.

Stage 4 of research, already completed, was designed to run parallel to Stage 3. Earlier we have indicated it involved anthropologically focused interviewing with patients, along with a broader study of independent psychological testing, psychiatric consultations on the cases, and a formalized structure of obser-

vations and analysis. This part of the research design was concerned with schizophrenic patients from selected ethnic groups, studied both as individuals and as samples. Here the variety of psychological instruments could be expanded. Again, as with studies in community subsamples, the general convergence of psychiatric insights, anthropological materials and psychological tests has been a most interesting feature of research design and analysis.[16] Here also, the independent gathering of such data, with no cross-reference or contamination in the research process, has strengthened exploration and analysis of conclusions that are essentially interdisciplinary. Any final concordance of data, when intercompared in the last stages of this process, argues for a multidisciplinary assessment of patients or respondents in the light of their meaningful social and cultural contexts.

Psychiatric, anthropological and psychological methods appear to be complementary in the total assessment of such etiological problems as are contained in terms like "psychodynamics" or "psychopathology," and it is doubtful whether, for such purposes, fewer methodologies can be used. Such methods, together, deepen the analysis and test the validity. However, without field work in cultural groups, and a quantitatively ascertained continuum of well to ill, proper hypotheses are more difficult to erect for intensive follow-up studies of respondents or patients. This is why, despite difficulties, both Stages 3 and 4 were designed to follow upon the quantitative baselines of prevalence findings in Stage 2. In all of this, a baseline in education and fundamental training is also needed as where it became necessary to teach or guide anthropologists in psychological and psychiatric theory, and to involve psychiatrists, to the extent of their time and interests, in the team operations of an anthropological group.

SUMMARY

The four major phases of research have been sketched only in general outline, but it is obvious that they were designed to be almost concurrent parts of a larger totality. This larger whole we have discussed in the Introduction and at various later points aware that treatment of particular applications can easily get lost in details. Since Stage 4, for example, was termed by Dr. Rennie (1954 report) "An Intensive Clinical and Anthropological Study of Cases from Two Psychiatric Hospitals," but has been at least initially reported in four papers, two published and two in press, it seems unnecessary to comment further on

it here. It seems gratuitous also to repeat my feeling, shared with Dr. Rennie, that a complete view of social and cultural backgrounds of psychiatric disorder must utilize all four approaches: community field work, sample and subsample studies deepening in intensity, and combinations of psychiatric, anthropological and psychological inquiry generously used in the last type of cross-cultural studies.

Stated in summary, our purpose has been to move from community and from sample, most preliminary bows to the human scene, through several research strategies and on to psychiatrically oriented studies maximizing an etiological interest and having inevitable psychodynamic content. Our conceptual and analytic models narrow down to representative patients and community families, but in the latter sense the horizons can widen. It is a tribute to Dr. Rennie that both perspectives were envisaged intentionally and spontaneously, now one and now another: the intentional interest in the massive scenes of culture, class, migration and human vicissitudes, and the no less great interest in troubled people and their problems. The stakes, judging from statistics we have gathered, and family disasters we have uncovered in all stages of incubation, seem large indeed.

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DISCUSSION

Dr. Leslie Shaffer, National Institute of Mental Health: I would like to share some of my confusion about epidemiological studies. With reference to one particular point which I think was illustrated by Dr. Goffman's talk this morning, the reverse of the position taken in the two papers we heard this afternoon, one thing puzzles me very much: Is the function of this kind of thing sufficiently obvious? That is, people bent on investigating whatever is subsumed under the gross category of mental disorder in terms of communities as a whole or institutions as a whole, carry with them a conceptual frame of reference which may or may not be useful in the clinic but which I think is of probably very limited use in terms of studies of institutions or of communities. As an example, the symptoms of the patients are investigated at great length but we are asked to refine our diagnostic tools. It seems to me that much more sense may come out of studies like this if the dynamic behavior of the psychiatrist is also included in the legitimate range of operations of the investigator. I think this is perhaps one common characteristic of all studies.

There are two other areas in psychiatry in which I think the usefulness of this more extended vista has proved itself. First, the inclusion of the psychotherapist in the arena of investigations of psychotherapy is comparatively novel and so perhaps more relevant than it might be. Second, how much more sense is made, or apparently made, in studies of schizophrenic behavior when they include both the context of the hospital and the context of the family of the schizophrenic? We can now, legitimately, it seems, investigate the families of the schizophrenics in rather the same terms that one investigates the phenomenology of the schizophrenic.

Dr. Opler: I think that is a very sensible comment. I would like to see, as a matter of fact, in the study of the interaction between psychiatrist and patient, not only the psychiatrist's cultural background as well as characteristics counted in, but a total evaluation of his work too, in, let's say, schizophrenia. When I was studying schizophrenics according to cultural typology I noticed that the categories that I set up—emotional styles, mental habits, life adjustments, family influences—were all categories that cut right across the human continuum. In our Midtown studies after we were well along studying people in the community as to the seriousness of disorder, how many in the population were disordered and so forth, I became very much interested in studying schizophrenics *per se.* This was not just to add

another complexity to the study, but to find out within this more precise diagnostic category whether you could find these frameworks working.

Since I had to work closely with the psychiatrist who knew these patients best, I also found that I was constantly making judgments about the psychiatrist. I used the same list: emotional styles, mental habits, life adjustments, family influences. In other words, he was listed as one of the parts of the human predicament and one that applies to any illness state or any well state. These categories that we call psychological can be looked at as psychological repositories of forces often called cultural or social also. They are social and cultural as well as individual, both at the same time.

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THE ROLE OF TRANSITION STATES—INCLUDING DISASTERS—IN MENTAL ILLNESS

J. S. TYHURST, M.D.

Over the past 8 years we have carried out field studies of circumstances representing significant change, often sudden or intense, in the life situations of individuals. These have included civilian disaster,[25 28] migration [24] and industrial retirement.[26 27] Out of these studies has come an interest in the significance of states of transition in individual growth and in mental illness.

The derivation of the word "transition" is from two Latin words meaning "to go across." The word refers to a "passage or change from one place or state or act or set of circumstances to another." [19] Thus in music there can be "a change from key to key or from major to minor keys," or in art a "change from one style to another." [19] In using the term "transition states," it is our intention to focus not so much upon the change itself as upon the state of change, upon the social and psychological circumstances of being in a state of going from one situation to another.

The relevance of change to mental illness has been suggested in studies of stages of maturation in the human life cycle as in adolescence, the menopause, marriage, childbearing, promotion and aging. Attention also has been paid to effects of large-scale social change, spontaneous or planned. The effects of introducing extensive technological change have been studied in a number of societies and there has been a long-standing interest in cultural change and social mobility. Our society itself is said to be characterized by rapid social change and this proposition itself has been related to the emotional climate of our "Age of Anxiety" and to the incidence of mental illness. As one observer has remarked,

> The individual is asked (now) to recast his ideas once or even twice within the space of his active waking life . . . acceleration of the rate of human evolution . . . (and) . . . speeding up has been particularly noticeable during the past three hundred years, owing to the impact of the new change-accelerating techniques of modern science—the process of digestion (of change) must now be accomplished within a decade. This is something new in history.[8]

Actually, we know comparatively little about the epidemiological significance of rapid social change for mental illness. The most that might be said is that the concern of investigators with problems of change may reflect our contemporary cultural compulsions.

In the material that follows, it is intended to focus mainly upon the natural history of states of transition as observed in individuals in disaster, migration and retirement. Following this brief descriptive outline of the data, certain consistent features will be commented upon, some speculation will be made about relevant conceptual models, and finally, some conclusions will be drawn concerning the preventive and therapeutic implications of the concepts developed.

Civilian Disaster

From the study of individual responses* to community disaster, we have been able to define a pattern of three overlapping phases: (a) a period of impact; (b) a period of recoil; and (c) a post-traumatic period. Each of the three periods may be defined further according to: stress, time (duration and perspective), and psychological phenomena.

Stress. The first period (a) is characterized by the impact of initial stresses and continues until these stresses are no longer operating upon the individual or group. It is the period of maximal and direct effect of initial stresses. The period of recoil (b) is characterized by a suspension of initial stresses, and thus begins when the individual has succeeded in avoiding their direct effect for the moment at least, by one maneuver or another, such as escape. Some stresses may continue during this period (e.g., cold, injuries incurred during the first period, etc.) but from a psychological point of view, and relatively in terms of intensity and type, the stresses are suspended during this period.** The stresses of the post-traumatic period (2) are deriva-

* The social consequences which are also of relevance are not taken up here. Some description of them and their significance for individual responses may be found elsewhere.[28]

** Further stresses may be of such a type and severity as to impose a prolongation of the first period of impact; or put in another way, as to produce a second impact immediately following the first, and thereby postponing the period of recoil for varying periods of time. In this discussion, however, the progression following an acute stress is described, and the progression in the event of prolonged or repeated stresses will be taken up at another time.

tives of those of the initial period of impact and are more obviously "social" in nature. This is the period during which first full awareness is possible of what the disaster has "meant" in terms of loss of home, belongings, financial security, and particularly of bereavement. It begins after the security from initial stresses has been fully established, and when the individual comes to face, once again, the matter of daily living but in an environment altered in one or several crucial aspects.

Time. First with regard to duration, (a) that of the period of impact may vary within fairly wide margins. However, for the acute catastrophe it may last for only 3 to 5 minutes or up to 1 hour. The period of impact in the case of the marine fire was about 3 to 6 minutes; in the case of the flood, about ½ to 1½ hours. (b) The time duration of the period of recoil also varies, but to a smaller extent apart from abnormal reactions, being determined more by individual differences than by the nature of the stresses. (c) The post-traumatic period lasts, hypothetically at least, for the remainder of the person's life, and includes the period of rehabilitation.

Second with regard to perspective, it appears that there are differences from one period to another which raise some interesting and possibly important questions. These differences in time perspective go hand in hand with the way in which stresses become apparent to the individual. (a) The time perspective of the period of impact concerns the immediate present, responded to automatically. (b) That of the period of recoil concerns the immediate past, responded to by the first overt emotional expression. (c) The time perspective of the post-traumatic period concerns the past, the present, and the future. A consideration of this concept raises further questions. For example: Is there any difference in the time perspective between those who show "appropriate" responses to the stresses and those who respond inappropriately or abnormally? Is there any difference in this regard between the "predisposed" and those "not predisposed," and are any certain habitual time perspectives identifiable in the "predisposed?" What are the factors involved in the determination of time perspective? Has the knowledge of such factors any application for the management of an acute stress situation?

Psychological Phenomena. The following is a summary of the main trends observed. (a) During the period of impact, reactions separate into three main groups. One group, about 12 to 25 percent, are what might be described as "cool and collected" during the acute situation. They are able to retain their

awareness, make an "appreciation" of the situation, formulate some plan of action, and carry it though. A second group, representing what might be called the "normal" reaction to the period of impact and making up about three-fourths of the survivors, are stunned and bewildered. They show certain characteristics during this period: a definite restriction of the field of attention; lack of awareness of any subjective feeling or emotion although manifesting the physiological concomitants of fear; and automatic or reflex behavior. The last group, about 10 to 25 percent, show manifestly inappropriate responses—states of confusion, paralyzing anxiety, inability to move out of bed, "hysterical" crying or screaming, and so on.*

(b) During the period of recoil, the majority of survivors are seeking shelter, sitting in or pacing about hotel lobbies, moving into the homes of friends or relatives, driving in taxicabs or ambulances, obtaining temporary shelter and care, or giving an account of their experiences for the first time. During this period there is a gradual return of self-consciousness and awareness for the immediate past. Subsequent recall is more complete for this period, but still not absolutely so. It is the period during which, for the majority, the first overt emotional expression occurs, and during which they first experience a subjective awareness of feeling or emotion—anxiety, fear, anger. Women may have typical alternate periods of crying and laughing, with some disturbed overt behavior. While being driven away from the disaster, they may have a "good cry." These reactions have been described before, in part, and it appears that this is the period in which they occur.

During the period of recoil, the majority of survivors achieve their first awareness of what they have just passed through, and the disaster first achieves this limited perspective. One man, who had behaved adequately during the period of impact, dragging his unconscious wife along a smoke-filled hallway and down several flights of narrow, smoke-filled stairways, was unable to describe any feelings, to give any account of what he had seen or done, or how he came to do what he did. Going into a hotel

* The psychological phenomena of this period, as described, have an important bearing upon other developments, both during this period and subsequently. These include the evolution of hostility and its attendant scapegoating, the dynamics of initiative and leadership, the dynamics of guilt as may develop subsequently, and the function of group dynamics with respect to the individual. Because of limitations of space, these considerations have been omitted from this outline.

lobby, he at first appeared calm though uncommunicative, unresponsive and preoccupied. He went to use the phone to call some friends and found himself unable to talk, experiencing an acute surge of subjective anxiety. He burst into tears, cried for several minutes, then said he felt better, showing a good deal of trembling and a need to talk of his experience. This is typical, although subjects may not burst into tears, and there is a need to talk or "ventilate" during this period, to get angry at someone or to express themselves in some way.

The need to "ventilate" is associated with a childlike attitude of dependency, which is an essential ingredient of the phase. Dependency may be precipitated in previously uncommunicative and unresponsive survivors by any genuine act of reassurance or aid on the part of people dealing with them. They want to be given something—coffee or a blanket—or to be looked after, and the importance of the giving and nursing appears not so much related to the actual kind of aid as to the psychological meaning of being cared for. When one talks to survivors some time afterward, they describe these attitudes with some amusement, at the same time stressing the real and compulsive character of their needs during the earlier phase. In most, the period of dependency is transitory and even 1 or 2 days later the survivor may be quite unwilling to talk as freely as he had earlier. His manner is again fairly independent and he may be quite unwilling to accept help even though he needs it badly.

These attitudes of childlike dependency during the period of recoil are associated also with a need to be with others and a disinclination to be left alone. Although group formation is an important feature of individual responses to disaster, group characteristics are quite different during the various periods. During the period of recoil, the group behavior is based upon the needs of the survivors to seek out other people; and yet at the same time, it is characterized by the instability of the groups so formed among the survivors. There is a definite desire and need to be with others, and to achieve a stable, supporting interpersonal environment. The initiative for this, however, must come from persons other than the survivors who, though needing others, need them purely for themselves. Their social behavior among themselves at this time resembles that of very young children during the phase of play in shifting groups.

This is only a brief outline, but the present impression is that the period of recoil represents a most important part of this process of response to disaster. Both the character of individual

responses during this period and their management by personnel engaged in rescue and relief work would appear to have a crucial significance for subsequent psychological events. The emphasis in this outline has been upon the general characteristics of the period rather than upon individual difference, or upon the various seemingly pathological deviations that have also been observed.

(c) The reactions of the post-traumatic period are closer to those phenomena with which psychiatrists are familiar and which are described in the literature as post-traumatic reactions. They include temporary anxiety and fatigue states, psychotic episodes, recurrent catastrophic dreaming, depressive reactions, etc. The more severe and prolonged reactions that are included in the general terms "traumatic syndrome" or "post-traumatic neuroses" become apparent during this period.

Migration

In field studies of individuals following immigration, a fairly consistent pattern can again be defined.[24]

Initially, the person is concerned with the immediate present, with an attempt to find work, make money, and find shelter. These features are often accompanied by restlessness and increased psychomotor activity, with interest limited to and directed toward the fulfillment of these immediate needs—food, shelter, work. As action in the new setting leads to an increasing sense of incongruity between the individual's frame of reference and the society around him, the second phase—that of "psychological arrival"—begins. Characteristic of this are increasing anxiety and depression; increasing self-preoccupation, often with somatic preoccupations and somatic symptoms; general withdrawal from the society in contrast to previous activity; and some degree of hostility and suspicion. The sense of difference and helplessness becomes increasingly intense and the period is characterized by marked discomfort and turmoil. This period of more or less disturbance may last for a period of one to several months.

What might roughly be described as the third phase begins with either the decrease of turmoil and the establishment of some level of adaptation and socialization; or with the development of more severe disturbances manifested by more intense disorders of mood, the development of abnormal mental content and breaks with reality.

With regard to *time perspective,* it has been noted that the first period appears characterized mainly by an intense orienta-

tion in the present. The individual concerns himself little with the past, which he has just left, and little also with the future. In the second phase, although there may be some continuing preoccupation with the present, there is often the appearance of an increasing preoccupation with the past, experienced with an intense nostalgia.[25] Under these circumstances, the past is often idealized in contrast to the alien present.

Industrial Retirement

We have studied a number of retired pensioners fairly intensively.[26 27] For those in whom retirement from work represented a transition, it was possible to describe a fairly characteristic pattern of individual response.

At the time of retirement, a characteristic initial response is the living out of the retirement myth with its emphasis upon new-found leisure, relaxation, a holiday trip, a possible change of residence, and the idea that one will be able to do what one wants. In a few, the *denial* that has characterized the preretirement period may continue into the early phases of retirement, the individual simply refusing to come to grips psychologically with the fact that he has no longer an occupational role, despite the fact that he may not be going back to work.

After a variable period, whatever the initial orientation, the person finally has to settle into living as a retired person and to deal with the psychological and social consequences of being retired from his lifetime occupation. It is with this that a period of turmoil begins which may last for many months as the man re-establishes or creates a set of significant, functioning roles and relationships for himself in his newly defined situation. Anxiety, depression, a marked increase in self-preoccupation and somatic symptoms, feelings of inadequacy and irritability may characterize this period. We have observed that the pensioners, during this period of turmoil, are characteristically quite accessible once rapport has been established, and appear to benefit from the research interviews themselves, although these are specifically not designed along therapeutic lines.

This period of turmoil either may develop into a chronically unsatisfactory situation, possibly with more overt psychiatric or physical symptomatology and even the development of a "sick role," or may subside gradually as the individual finds a new orientation and set of functioning roles.

Again, we have been struck by the characteristic time perspective of these various phases, beginning initially with an emphasis

upon the present, followed by an increasing preoccupation with the past, and then finally returning to the time perspective that has been characteristic for the individual throughout his life.

Dynamics and Conceptual Models

Next, I would like to refer briefly to some of the conceptual models we might invoke in our formulation of the underlying dynamics in this process. The conditions to which we have applied the term "transition states" tend to be those in which there is actually some sign of disequilibrium or turmoil. It should be quite clear, however, that we are constantly dealing with changing circumstances and that coping with change is an integral feature of living.

We daily experience change, but we do so within the supporting framework of a coherent system of certain personal values, assumed roles, definable expectations and responses which we take for granted. We may come up against changing circumstances, but our premises about ourselves, our views of the world and our relation to it are not affected. We deal with the new situation on the basis of the premises and values which are not questioned. Change tends to be subjectively experienced most intensely when the person's premises are called into question. This has been observable in each of the transition states already described, and one way of phrasing it may be taken from an experience with migration.

> . . . . Cultural pattern. . . . is not an instrument for disentangling problematic situations, but is a problematic situation itself. . . .[21]

In analyzing this situation further,

> All the obstacles which the stranger meets in his attempt at interpreting the approached group arise from the incongruity of the contour lines of the mutual relevant systems; and, consequently, from the distortion the stranger's system undergoes within the new surroundings. Any social relationship, and especially any establishment of new social contacts, even between individuals, involves analogous phenomena, although they do not necessarily lead to a crisis.[21]

The effect of mobility upon the individual has also been a central concern of Karl Mannheim and both he and Park have commented upon the social and psychological consequences.

Questing a way in which critical awareness and control of evaluations may be accomplished, Mannheim remarks upon the effects of social mobility.

> . . . . The intensification of social mobility. . . . destroys the earlier illusion . . . prevalent in a static society, that all things can change, but thought remains eternally the same . . . as long as . . . the traditions

> of one's national local group remain unbroken, one remains so attached to his customary ways of thinking, for the ways of thinking which are perceived in other groups are regarded as curiosities, errors, ambiguities, or heresies. At this stage one does not doubt either the correctness of one's own traditions of thought or the unity and uniformity of thought in general . . . Vertical mobility is the decisive factor in making persons uncertain and skeptical of their traditional view of the world . . . but decisive change takes place . . . when that stage is reached in which the previously isolated strata begin to communicate with one another and social circulation sets in. The most significant stage of this communication is reached when the forms of thought and experience, which have hitherto developed independently, enter into one and the same consciousness impelling the mind to discover the irreconcilability of the conflicting conceptions of the world. . . . . The person . . . subjects the objects of his world to a fundamental questioning.[14]

In another context concerned with an analysis of contemporary society, Mannheim uses the phrase "the crisis in valuation" to describe these developments in society as a whole. This concept of a "crisis in valuation" also has some value for our analysis of individual transition.[15] The sociologist, Robert Park, in his descriptions of the "marginal man," has given some classic descriptions of the effects of migration upon society and personality. He says:

> . . . . The consequences of migration and mobility seem, on the whole, to be the same. In both cases the "cake of custom" is broken and the individual is freed for new enterprises and for new associations. One of the consequences of migration is to create a situation in which the same individual . . . finds himself striving to live in two diverse cultural groups. The effect is to produce an unstable character—a personality type with characteristic forms of behavior. This is the marginal man. It is in the mind of the marginal that the conflicting cultures meet and fuse. It is, therefore, in the mind of the marginal man that the process of civilization is visibly going on, and it is in the mind of the marginal man that the process of civilization may best be studied. . . . Migration as a social phenomenon must be studied not merely in its grosser effects, as manifested in changes in custom and in mores, but it may be envisioned in its subjective aspects as manifested in the changed type of personality which it produces.[20]

W. L. Thomas in his writings has introduced the idea of the "crisis" and he clearly considered this to be a fundamental conception in individual and social development.

> Situations are not to be thought of as static sets of conditions. As they are experienced by individuals in groups, they are fluid and dynamic, permitting the entrance of new stimuli which may affect their definition and the resulting behavior. Whether the behavior is organizing or disorganizing depends upon the point of view: that which is disorganizing from the standpoint of traditional norms may have the germs of a new type of organization, a new definition of the situation which in turn may be accepted and become a part of the culture.

> In this connection Thomas' use of the "crisis" concept assumes importance. In a sense, he fused the notion of "crisis" with that of "siuation" and "definition of the situation." So long as social life runs smoothly, so long as habits are adjustive, "situations" can scarcely be said to exist. There is nothing to define when people behave as anticipated. When influences appear to disrupt habits, when new stimuli demand action, when the habitual situation is altered, or when the individual or group is unprepared for an experience, then the phenomenon assumes the aspect of a "crisis."
>
> A crisis is a threat, a challenge, a strain on the attention, a call to new action. Yet it need not always be acute or extreme: Of course a crisis may be so serious as to kill the organism or destroy the group or it may result in failure or deterioration. But "crisis," as I am employing the term, is not to be regarded as habitually violent. It is simply a disturbance of habit, and it may be no more than an incident, a stimulation, a suggestion.[28]
>
> Thomas regarded "crises" as among the most significant of human experiences, affecting the definitions of individuals and groups, their behaviour, and finally influencing the content of culture and personality, as well as the rate and direction of social change. . . .
>
> The significance of "crisis" lies in the fact that it may produce a fundamental outlook, a principle of life organization, which is incorporated into the culture on the one hand and the personality on the other. The reaction to crisis often develops a far-reaching definition, a base line from which a variety of other situations are viewed. Thus, in personal and social development, crisis is a catalyst, disturbing old habits, evoking new responses, and becoming a major factor in charting new developments.[29]

There are a number of other conceptual models that might be invoked, but finally, a particularly valuable one is that taken from the transactional functionalism of Ames and Cantril. The concept of "crisis" of Thomas which has just been outlined is quite similar to the concept of "hitch" defined by the transactionists. In their psychological theory, they define concepts of an "assumptive form world," of "hitches," and of "action" in leading to a revision of our on-going value systems. They point out that what we see and what we do are based upon the character of what they call our "assumptive form world"—that is, all the presently existing assumptions of an individual which serve as guides and bases for future actions.[1] They point out that,

> Successful actions can only confirm what we already know. Unsuccessful actions, hitches or obstacles, provide the occasions for increasing the scope and adequacy of our assumptions. . . . A hitch arises if we do not experience the significance which we expected to experience. . . . Every hitch is either the result of a failure to achieve a particular goal, that is, inadequate "how-to-do" predictions, or else the result of a failure to experience a hoped-for satisfaction, resulting in an incorrect "what-for" prediction. On whatever level the actual lack of correspondence

> between externalized and encountered significance may occur, whether on the level of things, on the level of sequnces, or on the level of our own actions, hitches are always experienced in terms of the frustrations of our purposes.[9]

Besides this conceptualization of the expectancies that the individual brings to any situation, their theory also emphasizes that it is only when the individual attempts to *act* with respect to the new situation that inadequacies in his assumptive form world are revealed. These propositions have been demonstrated experimentally and the detailed descriptions may be secured elsewhere.[9]

Besides these conceptions of a "crisis in valuation," of the social and psychological significance of "marginality," of the "crisis" and the "definition of the situation," and finally of the "assumptive form world" and the "hitch," there are certain additional concepts which might be mentioned. Terms which are often used in this connection are those of "ambiguity," "uncertainty," and "disorientation." Defining the kind of situation likely to be stressful and to lead to rapid personality change, Wallace refers to:

> Loss of perceptual contact with a familiar system of environment that the organism has learned to manipulate to reduce stress.[30]

He goes on:

> Bereavement constitutes a classic example of the phenomenon; it may be observed also in such diverse contexts as hospitalization in infants, depression or anxiety attending geographic movement and changes in job and social status (and generally, changes in role), the disaster syndrome, disillusion and situations of cultural change. The Princeton experiments with distorted rooms and other visual illusions indicate that environmental unfamiliarity, even in limited laboratory situations, evokes extreme anxiety in many persons.[30]

Similar concepts of uncertainty, unfamiliarity and disorientation may be invoked for the confusion and delirium of the aged patient [31] in the postoperative psychosis.[13 32 33]

It can be seen, then, that one way of viewing the situation of transition is to say that it begins with the lack of congruity between the map of reality—physical, physiological, psychological and social—that is brought to the situation and the experienced reality. Conceptualizing this, we require some idea of what is brought to the situation in terms of operant expectancies—"the assumptive form world," "the frame of reference." We need a conception of the character of the developing state—"the crisis," "the hitch," "the crisis in valuation"—that is experienced through attempts to act. Finally, we require some conceptualization of a

subjective state which is often experienced as anxiety—of ambiguity, lack of certainty, disorientation or unfamiliarity.

There does seem to be some conceptual convergence here, and there is the possibility of developing a fairly coherent conceptual theoretical framework for the conceptualizing of the transition state. It can be seen that so far we have tended to lean fairly heavily upon perceptual theory to conceptualize the problem, and that much more clinical and experimental research of this state is required to sharpen existing concepts and develop additional ones.

General Comments

Each of these different examples of transition states has its own characteristics, and it would not be justifiable to say that the natural history of each duplicates exactly that of another. However, there are some general features which I would like to refer to briefly.

1. In each of these situations there has been the *consistent appearance of a phase of disturbance or turmoil.* This seems to be a feature of the normal natural history of the crisis, and a review of the literature indicates that similar periods of turmoil have been observed in other transition situations, as in connection with bereavement and grief,[12] and in the resettlement of POW's.[4 5] There is evidence to suggest, furthermore, that absence of such reaction may mean either that the individual has not been touched by the event* or that pathological delay has occurred.

2. Characteristic of this period are disturbances in body function, mood, mental content and intellectual function. It is possible that different types of transition may be accompanied by specific types of transition syndrome. For example, the transition syndrome of migration may be characterized by somatic symptoms of a hypochondriacal sort arising from intense self-preoccupation, by suspicion and paranoid trends, and by anxiety and a depression with intense nostalgia. The transition syndrome of disaster may be characterized by tensional somatic symptoms, by anxiety, diffuse hostility and restlessness. The transition syndrome of acute grief has been said to be "remarkably uniform":

* This may be either because the event truly does not represent any crisis or transition for the individual, or because he has succeeded by defenses of denial to avoid recognition of the situation for a time.

> . . . Sensations of somatic distress occurring in waves lasting from 20 minutes to an hour at a time, a feeling of tightness in the throat, choking with shortness of breath, need for sighing, and an empty feeling in the abdomen, lack of muscular power, and intense subjective distress described as tensional mental pain . . . The sensorium is generally somewhat altered. There is commonly a slight sense of unreality, a feeling of increased emotional distance from other people (sometimes they appear shadowy or small), and there is intense preoccupation with the image of the deceased . . . Another strong preoccupation is with feelings of guilt . . . In addition there is often disconcerting loss of warmth in relation to other people, a tendency to respond with irritability and anger, a wish not to be bothered by others at a time when friends and relatives make a special effort to keep up friendly relationships . . . The activity throughout the day of the severely bereaved person shows remarkable change . . . There is restlessness, inability to sit still, moving about in an aimless fashion, continually searching for something to do . . . These five points—(1) somatic distress, (2) preoccupation with the image of the deceased, (3) guilt, (4) hostile reaction, and (5) loss of patterns of conduct—seem to be pathognomonic for grief.[12]

3. Those symptoms and signs of disturbed psychological functioning must probably, within this context of transition, be regarded as *normal.* As already noted, their absence may, in fact, be a more ominous sign for that person's future health. Our tendency to regard the appearance of symptoms as invariable signs of illness, and therefore a need for psychiatric treatment, requires some revision. It would be probably more appropriate if we regarded the transition state and its accompanying disturbance as an opportunity for growth. When an impasse develops in the resolution of the "hitch," we may speak of illness. Signs of psychological distress—somatic, emotional or intellectual—are thus not necessarily equivalent with that person's being a case of mental illness. It means that the individual is growing and developing. Thus, for example, prevalence surveys of such symptoms as those described above can have little meaning for the incidence of mental illness unless the *contextual relevance and timing* of the symptoms is determined at the same time. If symptom incidence is not close to 100 percent in such surveys, this is probably because the survey has been incomplete in some way or the memories of informants were faulty.

4. It might be noted from the description of transition states given above that we have been quite interested in what appear to be characteristic time perspectives at different stages of the natural history. For example, the period of recoil in disaster is characteristically the one in which the time perspective is entirely concerned with the past and with events during the previous

phase. In the transition state of migration, the period of "psychological arrival" is characterized by a past time perspective and a nostalgic preoccupation with the idealized homeland. Lindemann, in his description of the "grief reaction," refers to the "intense preoccupation with the image of the decreased." [12]

Just what the significance of "time perspective" is, is hard to say. It may be that this primary orientation toward the past during the period of recoil has some adaptive value, but it may also simply be a manifest of the underlying process and have little more than a prognostic value. That is, if the individual does not show a primary orientation toward the past during the period of recoil, then this may be suggestive of some developing difficulty in the individual's management of the transition state. In the studies of retirement, we have noticed that time perspectives are also characteristic of the individual's past history of action and that the person comes to the transition state with a characteristic time orientation.[26] This has been discussed in more detail elsewhere and will be the subject of further, more focused investigation.

Implications for Preventive Psychiatry

It has been our impression that the data from these field studies of transition states provide an empirical basis for making several specific points in connection with the management of transition states and for the prevention of subsequent mental illness. This view is further strengthened by the rationale provided by the conceptual formulations already outlined.

With regard to primary prevention, the emphasis must be upon preparation and planning. In terms of our formulations, this would involve an attempt to bring the individual's assumptions as closely in line as possible with the new situation, to attempt to define the new situation accurately in advance, and with this altered view in mind, to indicate the specific things that must be done to cope with the new situation. It should be noted that the changing of assumptions occurs for the majority of us only through action; although for some fortunate few, verbal participation may be the equivalent of action. This means that the majority must prepare and plan through trial actions in a setting as closely resembling or representing the changed circumstances as possible. It might be noted, furthermore, that one of the major hindrances to preparation for impending transition is the tendency of some to deny any early signs of change so that small

changes accumulate and the individual finally is faced by great changes.

A great number of crises are not predictable, or if they are, the exact nature of the problems posed for particular individuals by the new situation cannot be foreseen. The value of preparation and planning can be only limited. Under these circumstances, our main opportunity for preventive action will have to come after the event. We can therefore be certain that primary prevention before change can have only limited application to a large number of potential transition areas relevant to mental health.

The necessity for focusing attention upon prevention at some time following or during change is not so unfortunate. In such transitions as disaster, migration or retirement, we have not been impressed by the value of preparation and planning. Unpredictability in disaster, unfamiliarity in migration and denial in retirement have, for example, all interfered with realistic preparation. Instead, as already described, we have been much more impressed by the importance of preventive measures during the period of recoil in disaster, and during analogous periods in migration and retirement. During these phases of turmoil, the individual has tried to act, his assumptions have been in question, and developments at this time will have a crucial bearing upon subsequent psychological events and upon his future health or illness.

We therefore have become concerned with the *timing of intervention* for preventive psychiatry, and with the conception of an optimum time of intervention in the natural history of transition —and by extension possibly in the natural history of mental illness. The timing of intervention in this sense is therefore put forward as a crucial preventive concept.

To repeat, then, with regard to *the optimum time of intervention,* it is our belief that increasing emphasis will have to be placed upon attempts to intervene during the period of turmoil that is so characteristic of transition states. Our studies indicate that this period of disurbance is a crucial one during which future modes of adjustment are determined.

Besides the timing of intervention and the emphasis upon an optimum time of intervention during the phase of turmoil, there are two additional questions to be asked, "Who should intervene?", and "How should they intervene—that is, what should they do?"

With respect to the question, "Who should intervene?", it

should be noted that we are describing a phase in the natural history of growth or illness that few physicians ever see.* In disaster, for example, during the period of recoil, survivors are usually in the hands of rescue or relief workers, friends, relatives or welfare and first-aid personnel. In retirement, pensioners may be with relatives or friends, or may come to the attention of a family physician because of their somatic complaints. In migrants, besides family or community agencies, the employer is often the one who has to try to deal with the person at this time. Throughout life, too, there are other "crises," "hitches" or "crises in valuation." In resolving these, people turn to various resources in their social environment only one of which is the medical profession. These resources initially may include family, friends, employer, physician, minister or members of various helping agencies. Any one or several of these may assist the person to define his problem, to review his assumptions, and eventually to take another step in growth.

Some persons in turmoil, under circumstances we do not yet understand at all well, come to the attention of the social institution called "psychiatry." When they do, they are defined usually as "ill"; and that they are so defined appears often largely a matter of social convention. Turning to the psychiatrist may represent an impoverishment of resources in the relevant social environment as much as an indication of the type or severity of disorder.**

It can be seen that for many crises, those present will be members of the family, employers, friends and physicians, and much will depend upon how these people behave. How much we can educate or train these portions of the public for first-aid functions in such circumstances is questionable.*** In some transitions,

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* Particularly those specialists in university teaching hospitals who come to view illness as what is seen on the examination of patients in hospitals and hospital beds.

** What we call illness is also an opportunity for growth however severe the impasse may appear. Too often, with its emphasis upon symptomatic treatment, present-day psychiatry denies the patient this opportunity. Relief of distress is the first obligation of the physician, and this is the justification for much symptomatic treatment. Too much of our symptomatic treatment goes beyond the relief of distress to a single-minded campaign to get rid of symptoms at any cost, including the opportunity for the individual to benefit from his troubles by dint of personal growth and development in relation to the problem.

*** For those dealing with children and adolescents I suggest: *A Manual of First Aid in Mental Health,* by S. L. Green and A. B. Rothenberg, The Julian Press, New York, 1955.

particularly those we have studied—disaster, migration and retirement—it should be possible to identify the personnel who are likely to be dealing with the individual during this time and provide them with training. A *Psychological First-Aid Manual* is now in preparation and will be used to test this possibility in disaster. The fact that somatic symptoms are so often the way in which turmoil is expressed, will probably mean that many people will be seen by their family physicians so that they will have a key role early in prevention [28] as will the nurse.*

Turning next to what might be done, we have at least two considerations: the face-to-face relationship with the individual and the use of the relevant social environment.

The description of individual management is a detailed affair outside the scope of this presentation. Several principles should be mentioned.

1. Intervention should *avoid removal* of the individual from his life situation wherever possible. In combat, this principle is observed by treatment of the man as close to the front as possible. The same principle holds for disaster,[28] and in ordinary life, similar removal should be avoided as much as possible—unless turmoil is really intolerable or certain elements in the relevant social environment are too rigid. The person should attempt to act in the situation which has led him to question his assumptions in the first instance. Only through continued attempts to act will he be able to revise his views and grow.

2. The *acceptance* of disordered affect, irrational attitudes and negative responses is essential. The placing of such emotions and behavior in some rational context by means of an understanding of the natural history of such reactions in relation to the stress is important.

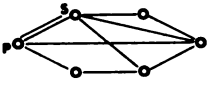
3. The *level of activity* on the part of personnel dealing with the individual does not have to be high. It has to be rationally directed on the basis of an understanding of the processes involved.

4. A major effect of intense change seems to be to effect a *discontinuity* between present, past and future. The breaking down of this discontinuity is an important function. This can be materially assisted by encouraging the person to talk, to reconstruct the past in relation to the present, and to construct a future in light of the past and the present that is being defined.

* "Nursing in Community Disaster: Psychological and Social Aspects." Canadian Nursing Journal (in press).

The individual is thus assisted to bring his assumptions into greater continuity, to revise old conceptions and to integrate new elements.

5. The model of intervention in the face-to-face relationship would be of this sort



P = personnel

S = subject

rather than of this sort

$$PO = O_S$$

Personnel should see themselves as intervening in a social system, in a network of relationships—not conducting a one-to-one relationship.

The social factors bearing upon the severity or persistence of psychological turmoil in transition of disaster, migration and retirement have been reviewed elsewhere.[24-28] Two general points will be mentioned in closing: the concept of ritual and the concept of the transitional community.

The supportive value of ritual in coping with crises long has been institutionalized in our society. There is an increasing tendency today to depreciate ritual in our society and although this may be a positive gain in one sense, it represents a loss of support from which much benefit has been received in the past. Again, some of our rituals may prepare individuals for a situation which is essentially a fiction. An example of this is the retirement ritual in industry in which the future pleasures of rest, relaxation and leisure are extolled without reference to any of the really significant problems.

The conception of a transitional community that will assist people to deal with change has been described in connection with the rehabilitation of POW's through Civil Resettlement Units.[3,4] It would be helpful if our hospitals could be viewed as transitional communities, and if hospitalization were viewed as a phase in a treatment plan formulated on the basis of a knowledge of the individual's life situation in the community. In disaster, it would be useful to think of temporary shelter and care, of evacuation communities, as transitional communities and to organize them and run them with these ideas in mind.

Summary

Consistent patterns of individual reaction to several transition situations have been described, together with a brief sketch of concepts used to formulate the underlying dynamics. Several important features from the natural history of these states have been discussed and conclusions have been drawn concerning principles for primary and secondary prevention.

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DISCUSSION

Dr. Grissom, Department of Psychiatry, Lackland Air Force Base, Texas: Your transition syndrome is quite reminiscent of many of the problems that we face in following recruits arriving at basic training. In the past our assumption, in dealing with these people, has been that these syndromes indicated a lack of adaptability which required our dismissing these people in one way or the other from the Service. I wonder if you would comment on that, please?

Dr. Tyhurst: Well, in view of the description I have just given, I would say that I would consider this a normal phase of a transition process. Does this answer your question?

Dr. Grissom: I wonder if the concept has applicability to the military situation?

Dr. Tyhurst: Well, there are degrees of it, but I would say yes, very definitely. I think that, as I have described it, one must consider the natural history of this transition process and that the phase of turmoil is actually a normal phase of the natural history. I am not quite clear on the point—do you want to send the man along while he is still in turmoil?

Dr. Grissom: No, no. Not that at all, but the point is, we use the occurrence of this type of symptomatology as the criterion as to whether the individual is going to be able to adjust to the military service.

Dr. Tyhurst: I would suggest the psychiatrist examining the person incorporate the concepts that I have outlined into his frame of reference.

Lieutenant Colonel Bushard, Mental Hygiene Service, Fort Dix, N. J.: We have a similar problem, in perhaps larger quantities. I am very pleased with this paper. I think it beautifully describes the problem we deal with. I would like to comment that this notion of the discontinuity of past, present and future is exactly where our problem—and I suspect, Lackland's problem —lies. A good deal of what you see is the somewhat magical conviction on the part of the patient that to return to his past is going to be the solution to his problem. I suspect that perhaps the answer the doctor from Lackland is looking for is that the therapist, the psychiatrist, may have the function, by whatever technic he may, of simply making it necessary for the individual to remain in the present situation and to master the transition state. This notion that the soldier must go home is at least not a tenable one until he has actually spent a time attempting to master the transition state. This is a paper of great applicability, I think, to the military service.

Dr. Small, University of Buffalo, School of Medicine, Buffalo, N. Y.: At the risk of appearing rather näive about some of these comments, I would like to point out that many of the questions that have been raised here today are things that are pretty routine in the teaching of medical students and in the teaching of residents. For example, the sociological and cultural implications that have been mentioned earlier today and this afternoon are part and parcel of the teaching of psychopathology. For example, in the definition of psychopathological terms such as "delusion," sociological and cultural factors enter into the very definition of the term. One does not call something a delusion when it is more correctly called a superstition or religious belief on the basis of certain sociological, cultural or educational factors that enter into the person's background. So, the same thing applies in terms of various cultures. For example, if one sees a first generation or an immigrant Italian who is just fresh off the boat from Sicily, who comes in with an idea he is being persecuted because he found some dust on the shoulder of his coat, we fully recognize what ideas he might have in regard to magic potions and magic powders. We certainly do not refer to that as a delusion and classify him as a schizophrenic with perhaps a more chronic or long-term prognosis rather than the acute form which he turns out to have in actual practice.

By the same token, in terms of genetic, environmental and hereditary factors it is not at all uncommon for us to be faced by our residents who complain bitterly about the relatives of the patients in the hospital. Our usual answer to them is, "Why are you so surprised about this? These things don't come out of thin air. They come from somewhere." In this particular form, you do take cognizance of cultural factors, of sociological factors, of genetic factors, and it is not at all an unusual thing. Perhaps 50 years ago, this might have been unusual in the teaching of psychiatry, but today it is commonplace. Today it is common currency insofar as every student in any grade A medical school is concerned.

In regard to transition states, which Dr. Tyhurst spoke about, we not only teach our medical students, but in institutes for the clergy, and so forth, we definitely point out the significance of these transition states. We do not advise any goal of suppression of these emotional situations, but rather, we point out that this is specifically contraindicated. Of course, we also point out the psychopathological differences between mourning and melancholia and insist upon the recognition of certain psychopatho-

logical states supervening. I would like to clarify this particular point of view because it seems to me, while not directly, but perhaps by intimation, the role of the clinical psychiatrist has been sold down the river today. We actually do not practice what might have been intimated by some of the speakers. We do take all of these things into account. I realize that no one has pointed the finger particularly at psychiatrists, but just for the record I would like to point it out here.

Dr. Tyhurst: I have no comments to make, except simply that all the remarks I have made are essentially remarks made by a clinician about clinical problems. There has been no other source of data except clinical observation. I might say, too, that our observation usually has been that these are not well handled and I must say that, in view of the present lack of data, I admire your curriculum very much because these are so well incorporated.

MILITARY ORGANIZATIONS AND SOCIAL PSYCHIATRY

LT. COL. F. G. HARRIS, MC
CAPT. R. W. LITTLE, MSC

Between 1952 and 1955, three studies were made on American troops in the Far East. Two of these were under combat conditions in Korea, and one was under garrison conditions in Japan.[1] All of these studies were essentially exploratory and were conducted in a sociological and ecological framework, with a view, however, toward a utilization of the results in practical military psychiatry.

Both to introduce the subject of this paper, as well as to anticipate one of the conclusions derived from these studies, an old joke seems appropriate. There were two ladies who happened to meet in a graveyard one day. One was an American, the other a Chinese woman. The American lady, having placed a wreath of flowers on her husband's grave, noticed that the Chinese lady had placed a bowl of rice on her husband's grave, and remarked derisively, "And when do you think your husband is going to come up and eat that bowl of rice?" The Chinese lady, in order not to be outdone by this particular viewpoint of the occasion, answered at once, "When your husband comes up to smell that wreath of flowers."

What we would wish to point out in this familiar joke is that the differences in question are not just personality differences between two individuals. More basically, they are differences between two sentiments originating in different social systems

[1] A full report of the first two of these studies is contained in the following publications. Little, R. W.: Collective Solidarity tnd Combat Role Performance. Unpublished doctoral dissertation, Michigan State University, 1955. Harris, F. G., Mayer, J., and Becker, H. A.: Experiences in the Study of Combat in the Korean Theater. I. Report on Psychiatric and Psychological Data. Walter Reed Army Institute of Research, Research Report WRAIR–43–55, November 1955. Harris, F. G.: Experiences in the Study of Combat in the Korean Theater. II. Comments on a Concept of Psychiatry for a Combat Zone. Walter Reed Army Institute of Research, Research Report WRAIR–165–56, October 1956. The third study in Japan is in process of being written.

and, in both instances, operative at a completely nonrational level.[2] The manifestations of this process are clearly evident, for instance, in the changes in styles of cars and clothes, in which case, even the sane individual is affected over a period of time. What was looked upon by all as the epitome of desirableness and "beauty" becomes, in time, relegated to the old-fashioned and the outmoded.[3]

Our purpose here is to introduce the sociological concept of status groups with their value systems, which, in military organizations, are of immediate practical importance so far as regards the functioning of men—*neurotic or not*—in their capacity as soldiers. It is to be noted in this connection that the tendency of military psychiatrists nowadays is to recognize no human form of mental illness, in itself, as precluding adequate performance *as a soldier*. Personal unhappiness may reign supreme, one may have symptoms in connection with all kinds of difficulties; yet it is possible that one may still be able to function adequately in a military setting and get or not get ("on the side," so to speak) help for his troubles. The proposition here being proposed is essentially that the greater proportion of malfunctioning in the Army is borne by the "normal" no less than by the "pathological" individual. This burden is primarily in the nature of a sociological problem, but one which psychiatrists in the military must consider in evaluating both their own and others' ideas of what can and cannot be accomplished with the psychiatric technics in use.

To convincingly demonstrate this is not easy, though it must be our task now to attempt it on a small scale. This demonstration is conveniently given in three parts: The raw ecological data, the interpretation of these data in the light of a social system, and the examination of individual problems in the context thus constructed.

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[2] The nonrational order, as distinguished from the rational and irrational orders, is a term which deserves wider use. Pareto defined the nonrational order as consisting of those phenomena which are not subject to empirical tests and yet have significance in human behavior. The nonrational order is thus synonymous with the symbolic order. For a full discussion of this concept, see Henderson, L. J.: *Pareto's General Sociology: A Physiologist's Interpretation.* Cambridge, 1935.

[3] Besides the cultural basis here implied, the biological basis for this behavior has been dealt with under the concept of "mimesis," in animals by E. A. Armstrong and in man by A. J. Toynbee.

Raw Ecological Data

As a preliminary, therefore, let us examine, as a basis, two aspects of the ecological situation in a particular military setting.

A. *The social characteristics of an infantry regiment as a population.* It is commonly assumed that military units are comparable to segments of the larger society. Inferences drawn on this basis are doomed to inaccuracy. When analyzed as a population, characteristics emerge that distinguish the regiment from other large-scale organizations. For example, in one population studied by us almost all individuals were males, over 86 percent were under 26 years of age, and 77 percent were unmarried. Over 86 percent had been with the regiment for only 1 year or less, at the time our study began, and 73 percent had less than 3 years of total military service. These factors suggest a high degree of instability in a population of youthful, unattached males.

B. *How the organization is adapted to deal with this type of population.* In the absence of wartime conditions, the regiment, as an organization, had to provide efficient motives for participation. At the same time, they had to control deviant patterns of behavior that may be considered "normal" for a population of this nature. However, the sanctions employed and the standards used by the organization to control behavior assumed that (1) combat motivation existed, and that (2) the organization consisted of so-called adult members of the community. There was no provision made for a particular age grouping, as in larger society where deviant behavior patterns are dealt with permissively or at least differently.

The standard measures of deviance were examined to determine the context in which they occurred and what meaning they had as indices of "morale." For example, the sick record of each man was recorded, his complaint, and the action taken at the dispensary, if any. We found little evidence of sick call as an "escape resource." Of over 2,200 men in the population, 62 percent never went on sick call, 19 percent went once, 13 percent went two or three times, 5 percent went four to six times, and only 3 percent went more than seven times. (The 3 percent category was mostly skin diseases.)

One conclusion from these data is that sick call is much less functional for the soldier than it is for the medical service. Adequate epidemiological control requires constant surveillance of "sickness" in the regiment. But what sick call "catches" is primarily colds, cuts, and bruises that persons could, and probably

would, care for themselves, if they had the ordinary facilities of home. It appears, also, that the "goofing off" theory is a displacement of attitudes of medical personnel toward these relatively minor diseases, as well as toward a few remarkable individuals.

The records of all formal punishment were also collected by individual. The offenses were divided into two major categories: (1) those involving persons, such as fights, insubordination, and theft of personal possessions; and (2) those consisting of rule-breaking, such as missing bed check, AWOL, and inspection gigs. A total of 730 punishment records were collected. Thirty-three percent were for only one company punishment under Article 15; 10 percent were for two or more Article 15's and 12 percent for other types of court-martial during the field period. Seventeen percent had evidence of one court-martial in their service record only; 28 percent had courts-martial both in the service record and during the field period.

As an index of morale, these punishment records of a "court-martial rate" reveal little. But the offenses for which the punishment was given are more significant. For example, the major offense involving persons consisted of insubordination of men in their relations to NCO's. Among the rule-breaking offenses, of 101 men who got inspection gigs, only 28 percent also went AWOL. Among 320 men who went AWOL chronically, only 18 percent also got inspection gigs when they were present for duty.

The company commander appeared to be an important variable. One company contributed 30 percent of the company punishments during the 5-month field period. This contribution was made on one Saturday inspection. (The following Monday, the company commander was admitted to hospital with infectious hepatitis.) Another company had no company punishments. Although as many delinquency reports were submitted on men in this company, the company commander found excuses for not acting on them. This company commander also received a delinquency report for "obstructing military justice."

The foregoing may be looked upon as a sample of the raw data obtainable in a typical infantry unit in overseas garrison. For the meaning of these data we must return to the theme of status groups. We note beforehand, however, that research in this field has traditionally viewed the social organization to which an individual is assigned, as a random variable. Although, on the one hand, much has been said about the significance of "group support," the concept is used very loosely and mainly as a "catchall" explanation when predictions made on the basis of developmental

history or personality features fail. That is, for psychiatric research, the soldier has been viewed as a personality with varying degrees of adaptive capacity in any component of military organization. Yet, at the same time, few psychiatrists would say that an upper-class child would adapt readily to lower-class family life or that a person reared as a Mormon would be well adjusted in a Catholic community.

Nor, on the other hand, are soldiers just so many homogeneous individuals collected together and behaving all in the selfsame manner. We cannot even say this about lower social animals, which as individuals do have a great deal of homogeneity. For they, too, form distinct groups within their own species; even some of the lowest of them are occupied with incessant efforts to achieve some kind of differentiation between their social groups.[4] How much more so this must be with human beings, with their highly developed sentiments, is not difficult to surmise.

Interpretation of Data

The interpretation of the sample of raw data given above indicates the need for a typology of military units, based upon their dominant value systems. At least three dimensions are suggestive.

First, there is the total military organization as a distinct institution in our culture, setting apart those who belong and those who do not belong to it. Within the military organization itself, as we have seen, there is abundant opportunity for the rapid formation of populations with distinct and limited characteristics. One of the most striking of these populations is the great concentrations of youthful, unattached males, residing for relatively short periods in a foreign country.

Some of the aspects of this situation as a whole are as follows. First, there is to be met in the Army an attitude toward young men that is virtually the opposite of that to which they are accustomed in civil life. This may be epitomized as that attitude by which the soldier is conceived as existing for the Army, not the Army for the soldier. Second, in many overseas situations, such as Japan, there is placed before the American soldier a double temptation, an active catering to his impulses, and this out of a morality that is in many ways freer, more novel and more stimulating than his own. This is especially marked in the sexual sphere and produces no end of difficulty, not only between the men

[4] W. M. Wheeler, e.g., was one of the first to point this out among the social insects.

themselves, but between men and command. Third, in a group so young there is to be expected a great number of problems derived from lack of well-formed identity. As a matter of fact, there was in our studies evidence that what at first seemed to be a problem of leadership and authority (because one member held a nominal position of leadership or authority) turned out on closer inspection to be a problem between persons both of whom were behaving essentially as adolescents in competition for the favors of a third party who was the oldest and real leader or authority. Not only did this take place between the lower and upper three grades of enlisted men, but in a few cases between enlisted men and officers. These situations frequently led to psychiatric consultation and/or court-martial, and in either case without resolution of the difficulty.

Another problem related to identity, which was particularly striking in combat situations, was the fact that those who broke down were characteristically youthful, inexperienced in many areas of life, and possessed of a relatively clear recognition of the as yet "unlived" part of their lives. They could not accept death or any possibility of it. But their only alternative was to face the disapproval and rejection of those, mostly behind the front lines, who found it easy to admit death to their system of values and could therefore not understand this conduct. A better reception was accorded these men in their own front-line units.

Second, we note that some units have value systems organized around their relative positions in the total scheme of military organizations or the echelon to which they are assigned. Rear-echelon and front-line troops are characteristic terms for these positions. Even in garrison, the lettered company of a regiment is viewed at higher levels as a resource for exploitation. They perform the details, furnish individual members for special activities, and are the most closely supervised. The consequent reaction is a defensive value system which affects commander and troops alike. The high rate of deviance in these units can be partly explained by their inability to control a significant portion of their activities through legitimate channels.

Echelon values appear to cut across lines of functional specialization. Regimental medical officers typically view themselves as getting little help from higher medical echelons. There is often a running conflict between the station hospital and the unit surgeon. The consultation report, when negative, is often a medium for transmitting the condescending attitudes of the higher echelon.

As one regimental surgeon expressed it, "An elegant letter from someone one step removed from an interne."

A *third* dimension is the relative degree of power, both legal and economic, that one unit can employ over another. The use of legal power is exemplified by the military police. All rates of delinquency are based on their behavior. But we are not aware of what kinds of behavior they are sensitive to and how often the deviant military policeman is an *agent provocateur* in the locale by his intolerance of petty delinquency. It is especially crucial that off-post behavior be viewed as an opportunity to play, away from the rigid routines of organizational life. If the military policeman sees his function as an extension of organizational control, he issues more delinquency reports, but what is more important from a psychiatric viewpoint, he creates an intolerable climate for play.

Within the military police group, we have noted particular emphasis on masculinity values. The tall, muscular physique is the most valued type, and those who deviate from it have little chance of remaining in the military police unit. There is a high degree of functional solidarity, as with civilian police units, so that conflicting testimony is rarely evoked at courts-martial. The impact of this value system on indexes of group behavior cannot be ignored.

Another power group consists of those units charged with the issuance and storage of supplies. Despite rigid rules for supply services, there is a large area of discretion in which the supply agent can give or withhold according to his attitudes toward the potential recipient. Whether realistic or not, the supply officer (and the members of his unit) is conceived of as a person with whom affection is more effective than legitimate claims.

Suppose we could specify the value systems of units like these. Would not psychiatric prediction be more effective if we could relate the potential adaptive capacity of a particular personality type with the value system of the unit to which he is assigned? In evaluating conditions of "morale" or collective disturbances, the conflict between these value systems might prove significant.

Examination of Individual Problems

Let us now briefly examine the case of a single individual, in the context we have been describing: An 18-year-old boy of Catholic-Italian descent, who had been with his outfit about 10 months before he got into trouble. It is noteworthy that this soldier stood out on the sociogram of his unit as a nodal charac-

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ter, choosing a large number of buddies and in turn being chosen by a large number of other soldiers.[5] Records reveal that the subject had been in two minor scrapes, about 1½ months apart, with the military police who served his regiment, the last of which landed him in the stockade by courts-martial, for 3 months, for "disorderly conduct, disrespect and attempted assault on two military policemen." There was no record of other difficulty and none of sick call attendance. After he was in the stockade, both his first sergeant and platoon sergeant evaluated him as a "stockade character," rebellious toward authority, undependable and smart in getting along with his peers. His commanding officer rated him as one of the five men most likely to go AWOL and to get venereal disease, and one of the five men he could depend on least in combat. Thus all authority figures rejected him because of his conduct. There was, incidentally, no record of AWOL or venereal disease.

On psychiatric interview in the stockade, this soldier was felt to be immature, of normal intelligence, fairly relaxed and warm, very frank, and with fairly good relationships with his peers. He was rather small in stature, single and with a very poor family background and overt hatred of his father. He nevertheless seemed to be a fairly healthy person who had gotten into trouble and was now bitter about being in the stockade. He was adjusting well under the conditions. He revealed a good deal of insight into the cause of his difficulties. Not excusing his own conduct, he nevertheless pointed out a number of facts which our observations confirmed. He clearly recognized the power of status group attributes in his criticism of the military police when he stated: "They're not on the regiment's side." In truth, the military police unit was not on the side to which he belonged. They were not part of the regiment but were under a separate regional command.

The same complaints about the military police were regularly, though less explicitly, voiced by many other members of the regiment. Many went further by pointing out that things had gone much better when the unit had been in another location and had their own military policemen. Then military policemen were more helpful and gave less trouble. This soldier also blamed the regimental and the battalion commanding officers for interfering with his company commander and getting him court-martialed. This

[5] No one whom the subject chose and no one who chose the subject as a buddy had been or were subsequently, for an observed period of 3 months, in any notable difficulty.

was, in fact, a frequent undercurrent in the complaints of company officers themselves. Otherwise, the subject liked his company and his job as wireman and wanted to go back to it when he got out of the stockade.

It might be objected that this soldier was marked, from childhood on, and was of course predisposed to act in the way he did. He would be, in the prevalent Army terminology, a case of "character and behavior disorder." This is a perfectly justifiable view to take, only it is far from complete. From a social point of view, his predisposition merely rendered him, in his overt behavior, one of the most outstanding spokesmen for sentiments widely shared among his peers. It would thus be impossible to treat him psychotherapeutically with so powerful a set of reality factors supporting his behavior. If he had not been supported in his attitude and actions, he would not have been able to behave in the manner he did and still feel justified. It remains an open question whether, not thus supported, he would adjust to the social system or, assuming that he could not adjust, be compelled to internalize his difficulties, operationally dissociate or reverse them in his thinking, and become neurotic. But only in the latter instance could psychotherapy, in the conventional sense, be expected to have any influence.

We would now like to use psychiatrists, themselves, as our final example. Taking into consideration all our projects, both in combat and in garrison, it became clear that we could, with respect to social role, place military psychiatrists in either of two categories. One we will call the role of the division psychiatrist and the other the role of the clearing company psychiatrist. These correspond to the table of organization for a division, which calls for two psychiatrists. There are never enough psychiatrists to fill both these positions. Hence, one psychiatrist customarily serves for both positions. It was noted, however, that in garrison situations the psychiatrist was located with the division headquarters, along with the division surgeon and his staff. There he was socially active with many line officers and members of the division staff. In this setting, the psychiatrist's advice and participation was most frequently invoked to reinforce or support personnel decisions originating in command or administrative channels *after* they had been initiated. In the two instances thus observed, the psychiatrist was reluctant to make adverse recommendations in command problems. This reticence we interpreted as related to the group with which the psychiatrist felt solidarity. But the maintenance of solidary relationships with line and staff officers

required a high degree of acceptance of their normative standards and a corresponding compromise with technical or professional (i.e., non-normative) standards in situations requiring the psychiatrist's professional judgment. This role is that of the division psychiatrist, strictly speaking.

By contrast, in combat situations, the psychiatrists assigned to divisions did not ordinarily function in the way just described. Though they were by title called division psychiatrists, they lived in the division clearing company with their medical-professional colleagues. They shared the sentiments of this group rather than the sentiments of the line and staff group at division headquarters. Their decisions were thus more often reinforced by an obligation to render a "scientific" (non-normative) judgment in personnel problems. This role is that of the clearing company psychiatrist, strictly speaking.

We may conclude from these studies that there is an enormous chasm between what we, as professional psychiatrists or their allies, view as "psychopathology" so-called, and what the layman uses as basis for his actions. We tend to treat the individual aspects as *primary* and the social aspects as *secondary*. But people, by and large, still treat social factors as primary, in what is called a "normative" fashion. The validity of psychiatric theory and practice in the Army is here not in question. What is in question is the extent of ground this psychiatry often presumes to cover. Insofar as the measures used to treat individuals in relative isolation (psychotherapy in the conventional sense) do not fit the normative patterns prevailing, so far may we expect only tenuous conformance to or failure of our efforts. This, of course, calls for a social type of military psychiatry—if, indeed, military psychiatry is going to take on the task.

DISCUSSION

Dr. Fiedler, Department of Psychology, University of Illinois: I would like to emphasize a point which Colonel Harris raised which perhaps needs some amplification. We have conducted four different studies on adjustment in small groups, two of which were on college populations and two on military organizations. One of the problems which has concerned us is the question of adjustment—that is, how we could possibly measure adjustment. We have taken 6 to 12 measures and indices of adjustment, among which were some of those which Colonel Harris mentioned: sick call and disciplinary ratings, how the individual feels about himself, sociometric ratings, etc. We have also obtained indices of change in adjustment, and we have found no intercorrelation whatsoever among these adjustment indices other than those which would be spurious.

In other words, there is no evidence on any of these four studies that adjustment can be treated as a unitary concept. We have evidence only that there are many types of adjustment and that each of these adjustment indices which have been used in many of the studies are just different types of adjustment, and the same goes for changes in adjustment. That is, here again the individual does not adjust across the board. He just adjusts perhaps in one or two particular aspects. I think this is confirmatory of some of Colonel Harris's statements.

Dr. Caudill, Department of Social Relations, Harvard University: I wonder if Colonel Harris would care to amplify a little bit his concept of the need for play, since I had the opportunity of working with him in this particular garrison situation, in Japan as the anthropologist who was working in the Japanese communities around the post. I think we have data on both the post situation and, fortunately, on the surrounding situations, so that we have gotten something that we can move back and forth on, and in this particular situation, I felt that the needs for play in the regiment were certainly highly kept down, and not adequately allowed.

Lieutenant Colonel Harris: I really don't know how much I can add to the statement that I have already made. Play is play and has many facets. It was cut down tremendously in this particular regiment that I was talking about, really drastically. These men were really suffering. If they wanted to, they couldn't stay on the post without working, and it wasn't safe to go off the post. Many of them went out in the back areas and hid in the grass with a portable radio or some writing material. If they stayed on the post, they were usually picked up to do some detail, even

though they were supposed to be off duty. But if they went off the post, they only got in trouble with the military police. Their passes were actually too short for them to get out of the area that the military police were operating in. Dr. Caudill, why don't you add something on that?

Dr. Caudill: My interest there was both in terms of the regimental situation and, strangely enough, in terms of studies of hospitals. In this particular situation in Japan there were forces (which are too detailed to go into here) on the part of the Military, for keeping this small community, which is right outside of the post, in existence. This small area could be supervised adequately by the MP's but represented the sort of allowable area of play for the men. There were, equally, forces on the part of the Japanese society, also making for keeping this small circumscribed area there which resulted in the men not having sufficient opportunity for feeling free, and I think this happens also in hospitals in terms of the problems that patients have in satisfying this particular kind of need. This would relate to some of the things that Dr. Goffman was talking about this morning.

OBSERVATIONS UPON THE EPIDEMIOLOGY OF MENTAL ILLNESS IN TROOPS DURING WARFARE

COL. ALBERT J. GLASS, MC

Any epidemiological approach is faced with the task of reasonably identifying the particular disease category to be studied. This requirement is especially difficult in the mental illness of troops during warfare because various behavioral and symptom disorders not recorded as mental disease nevertheless occur as related and often interchangeable phenomena.[1] These allied psychiatric problems include: (1) self-inflicted wounds and similar "accidental" injuries; (2) illegal avoidance of combat by desertion, and refusal to obey orders; (3) somatic symptom disorders without evidence of disability; and (4) passive participants in battle who contribute little firepower or aggressive activity. The appearance of such covert psychiatric cases, like the more obvious battle neuroses, is highly correlated with the presence or absence of active combat. Moreover, they tend to occur in increased numbers among combat troops when, for one reason or another, there is a decreased frequency of overt mental disease.

It is apparent that mental illnesses of combat troops can subsume a variety of psychologically induced behavioral and symptom abnormalities, all of which have in common an inability to cope adequately with the combat situation. However, most available information in this sphere has been related to cases diagnosed as mental illness. Therefore, this presentation will mainly consider epidemiological observations based upon so-called NP rates, with the understanding that this index measures only one component of the total emotional disorders of combat troops. In this connection, it should be noted that states of discomfort during warfare, that may include objective and subjective manifestations of anxiety, autonomic overactivity, and increased muscle tension, are not considered abnormal if individuals so affected render reasonably satisfactory service. Similarly, transient episodes of dazed or disorganized behavior following exposure to intense battle trauma are not regarded as mental illness if they do not persist beyond the usual period of recoil to effective action, which generally is only minutes in duration.

Battle Stress

From an empirical standpoint, battle stress should constitute the most pertinent causal relationship to the mental illness of troops during warfare. This reasoning has been confirmed beyond doubt by repeated wartime experiences which indicate that the intensity of combat, as measured by the WIA (wounded in action) rate is most significantly related to the NP rate. Figures 1 to 3 demonstrate this relationship at theater, army, and division levels. The effect of accumulated battle stress is less susceptible of confirmation. Continuous exposure to intense combat for more than several days produces such a high rate of attrition from battle casualties and sheer physical exhaustion that its effect upon psychiatric breakdown becomes only an academic question since so few survivors remain. Actually, troops seldom fight continuously, and episodic exposure to combat is the rule.

Under these circumstances, a number of variables occur that include the length of rest periods, circumstances of the tactical situation, the intensity of combat, adequacy of supplies, efficiency of communication, weather, terrain, group cohesiveness, and support by buddies and leaders. These multiple and varying aspects of the battle situation make it difficult to equate the duration of

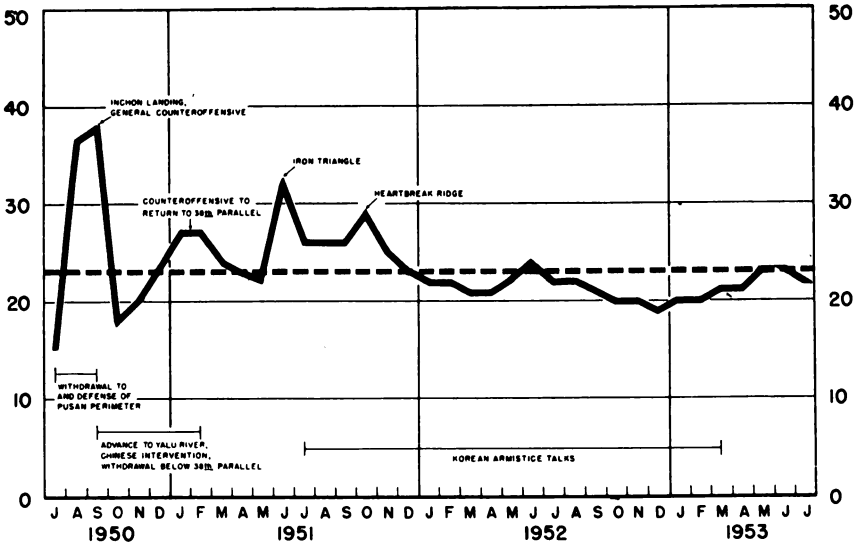

Figure 1. Trend of neuropsychiatric incidence during the Korean conflict, total Army (rate per 1,000 per year). (Prepared by: Medical Statistics Division, OTSG, Nov. 1953. Source: Preliminary data, based on Statistical Health Report WD AGO Form 8–122 and Morbidity Report DD Form 442.)

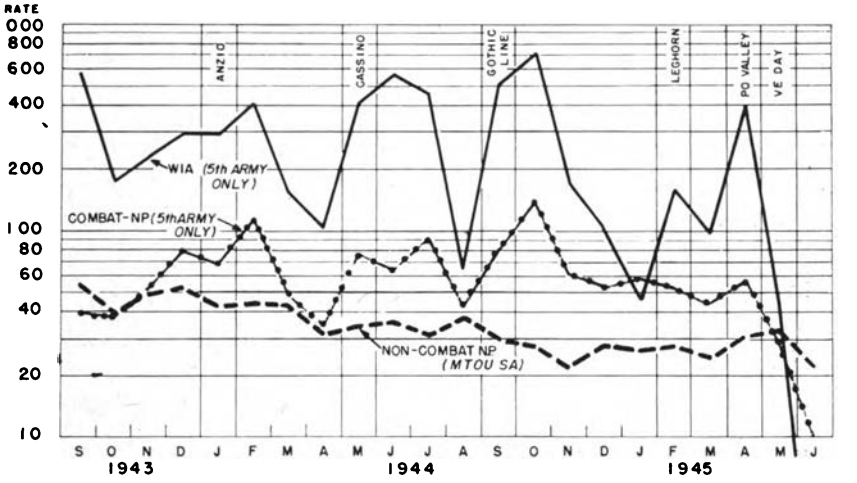

Figure 2. Wounded in action and neuropsychiatry rates, 5th Army (rate per 1,000 per year).

combat with vulnerability to psychiatric breakdown. However, there are some data and observations that support such a contention: (1) Unpublished studies of Appel and Beebe,[2] who analyzed these phenomena in World War II combat troops of the Mediterranean Theater. They concluded that in infantry troops approximately 100 days of intermittent exposure to battle was the average limit of endurance before noneffective behavior became frequent. These investigators employed as a standard combat day any 24-hour period in which the company of the individual had at least one battle casualty. (2) It is commonly observed that the longer a unit, such as one of division size, remains engaged in active combat, the more progressive is the attrition from nonbattle causes, even though various elements of the division are permitted brief periods of rest and recuperation (fig. 4). In these instances, while the NP rate generally is not progressively increased, there seems little doubt that the accumulation of psychological and physiological strain facilitates the production of organic disease and injury. Men who have been held in the combat area for prolonged periods seem tense, irritable, or apathetic; and unit commanders openly verbalize the need of prolonged withdrawal for rest and recuperation.

The deleterious effects of repeated episodic exposure to combat became a popular conviction early in World War II and was responsible for the well-known phrase that "every man had his breaking point" even though there were many exceptions to the

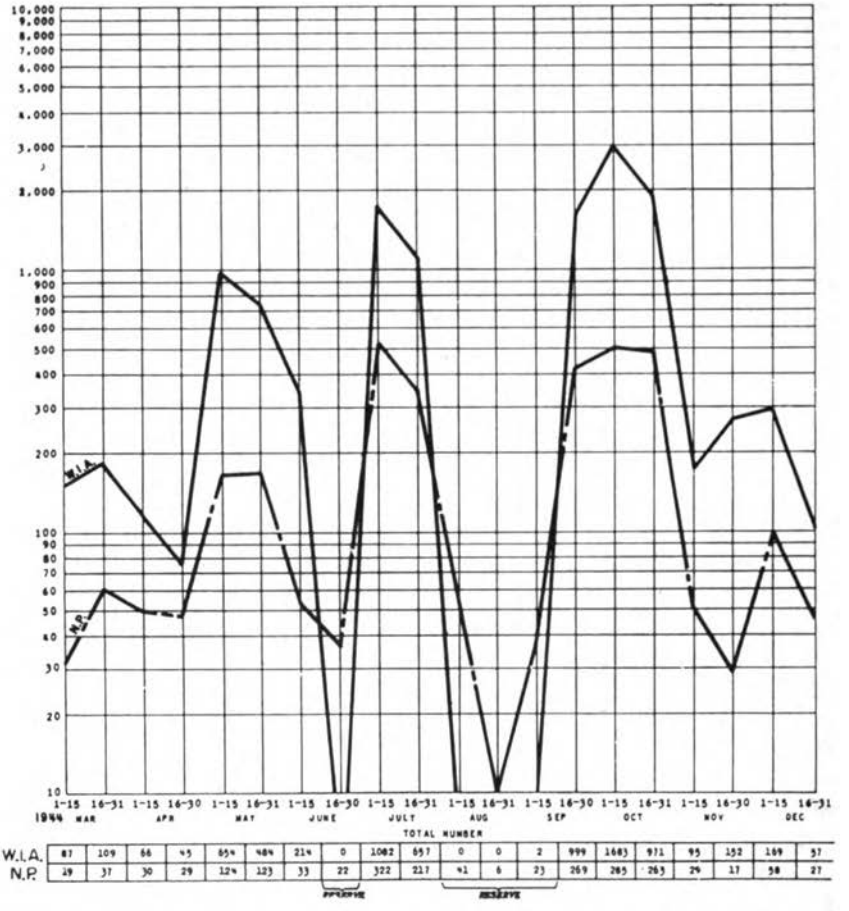

Figure 3. Wounded in action and neuropsychiatry casualties, 88th Infantry Division (rate per 1,000 per year). (Bull. U.S. Army Med. Dept., Sup. No., Nov. 1949.)

rule. Undoubtedly this concept originated from the men in combat, but it was also shared by medical and other observers. Perhaps this viewpoint arose as an association to the easy observation of battle participants that mathematically there were certain diminishing chances of survival with continued exposure to combat. At any rate, the presumed psychological traumatic effect of repeated intermittent exposure to battle resulted in efforts to establish a rotation policy that was discussed in World War II and actually placed into operation during the Korean conflict.

In this connection, it is of interest to note that the number of combat days which can be endured may be dependent, in part at

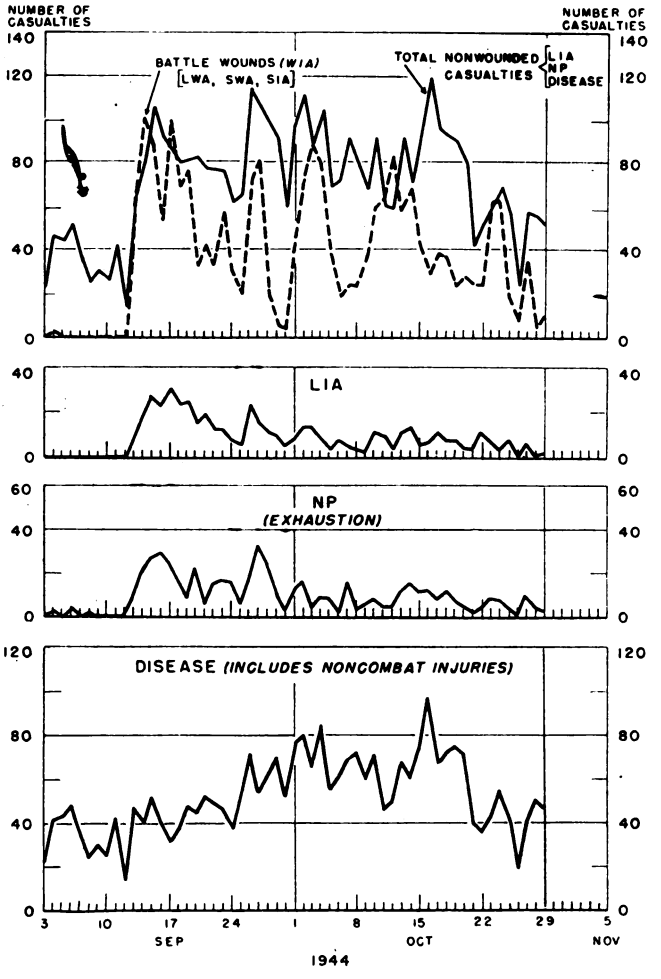

Figure 4. Battle casualties and disease, 85th Infantry Division, 3 September to 5 November 1944. (Bull. U.S. Army Med. Dept., Sup. No., Nov. 1949.)

least, on what the individual believes is expected of him, particularly by his combat group. For example, many groups who participated in the North African Campaign of World War II believed that they had "gone the limit" and expected prolonged relief from battle after the fighting ended in May 1943. Rumors became widespread that they had done their part and would be sent home, and were accepted by both officers and men despite the absence of any orders to this effect. When ordered into the Sicilian Campaign of July and August 1943, NP casualties from

these groups strongly verbalized recriminations and anger at what they considered to be un unwarranted further exposure to combat. As World War II progressed, the group concept of the number of combat days that could be endured gradually increased. When an approximate number of combat days is accepted by the group as sufficient to reach the breaking point, this expectancy seems to have an important determining effect upon the ability to endure further combat. With British troops, whose objective was the end of the war before relief from battle could be obtained, there was much less talk of the inevitable breaking point and more of resignation to a long drawn-out conflict.

Perhaps the best example of the effect of this anticipatory set pattern occurs when a time limit of combat days is officially proclaimed, as was done with the 9 months' rotation policy in Korea. Soon the "short-timer's" syndrome developed. Here the involved individual, who previously had suffered only the usual battle discomfort, became progressively tremulous in the last weeks or days of his combat tour, to a point of disabling tension or phobic reactions to the frontline area. This syndrome was well understood by all as a rational phenomenon and handled accordingly. Such individuals were placed in rear, nondangerous assignments or, if symptoms were too severe, medically evacuated to the clearing company of the division. In almost all instances they were held within the division until normal rotation could be accomplished, rather than returned home through medical channels.

In sharp contrast to the significant relationship between battle intensity and the so-called war neuroses is the negative influence of combat on the frequency of psychotic disorders. Figures 5 and 6 demonstrate clearly that the incidence of psychosis (mainly represented in the young military population by schizophrenia) is similar both in peace and war. This finding is further confirmed by evidence that external traumatic situations are not associated with an increased rate of psychosis.[3] For example, massive aerial bombardment of population centers in England, Germany, and Japan during World War II did not produce more than the usual number of mental hospital admissions. Similarly, psychoses did not result from spontaneous civil disasters, from hurricane, tornado, fire, and the like, that had been studied, nor were they noted following the atomic attacks on Hiroshima and Nagasaki. Clearly, the psychoses are not the result of external danger. When units new to combat are exposed to severe battle stress, not infrequently there occur instances of severe behavioral disorganization that may manifest disorientation, hallucinations, and even mute,

catatonic-like states. However, these conditions are transient and usually subside in from 1 to 3 days to become typical tremulous neurotic-type cases. These cases have been termed pseudopsychoses, terror states, or dissociative reactions, but represent severe types of so-called combat fatigue. Such bizarre behavior rarely occurs in veteran combat units.

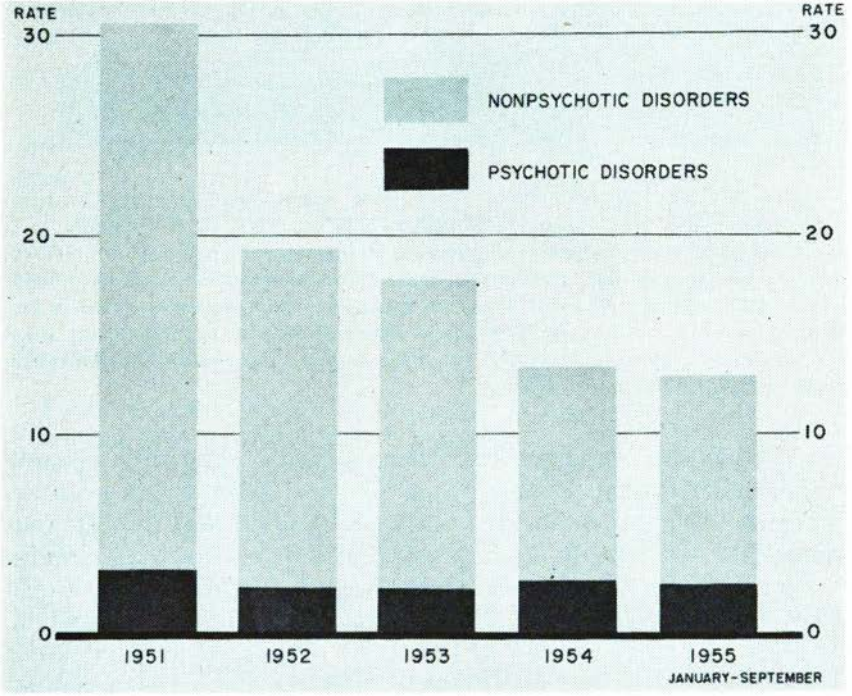

Figure 5. Excused from duty incidence rates for psychiatric disorders, total Army, 1951–1955 (rate per 1,000 average strength per year). (Health of the Army, Oct. 1955. Also shown at U.S. Army Medical Service exhibit at 1956 Annual Convention of American Psychatric Association in Chicago.)

Physical strain has been considered a major factor in the causation of mental illness among combat troops.[4] Indeed, the psychiatric terminology developed in World War II, namely: combat fatigue, flying fatigue, combat exhaustion, and operational fatigue, indicated that strenuous physical exertion, lack of sleep and food, and the fatiguing properties of battle tension, played an important role in psychiatric breakdown. Many psychiatric patients give the impression of physical exhaustion because of their drawn and haggard appearance, slowed gait, and tendency to sleep promptly

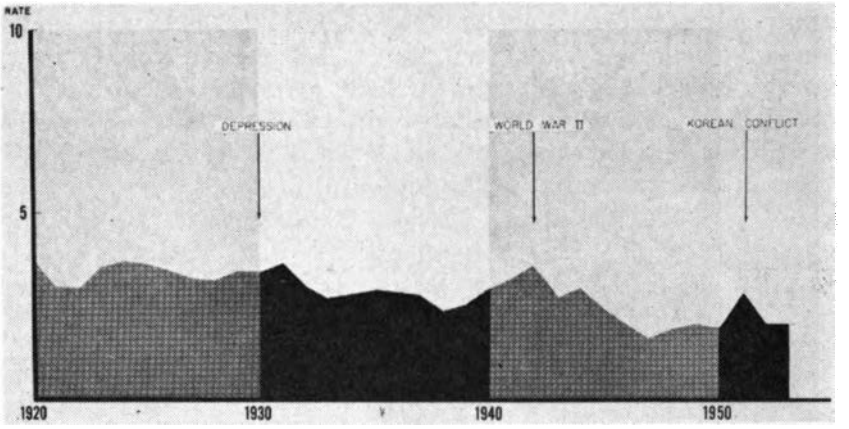

Figure 6. Psychosis admission rates, total Army, 1920–53 (rate per 1,000 average strength per year). Psychosis admission rates have remained relatively constant over the years. Changes in composition of population involved, changes in policies and procedures, and common stresses such as combat service and economic changes have not affected Army psychosis rates in any identifiable way. (Shown in U.S. Army Medical Service exhibit, "Statistical Trends in Military Psychiatry," at 1955 Annual Convention of American Psychiatric Association in Chicago.)

when given the opportunity. Such patients commonly respond with dramatic improvement when physical fatigue has been relieved by sleep and food. It is also well known that intercurrent illness may secondarily produce psychiatric breakdown apparently by means of the same mechanism of physical fatigue. In World War II and Korea it was common for individuals with malaria, hepatitis, or other febrile illness to be evacuated as psychiatric casualties because they manifested symptoms and signs of combat fatigue.

The above evidence strongly suggests that physical fatigue acts to precipitate psychiatric illness. But, it is also certain that physical fatigue, in itself, is not the primary cause of psychiatric breakdown, for the following reasons: (1) Units advancing against slight enemy opposition may continue without sleep or food for several days and, although obviously suffering from physical fatigue, rarely become psychiatric cases since there are few battle casualties and therefore little emotional stress. (2) Typical psychiatric breakdown may occur early in combat or even prior to battle, before there has been any appreciable element of physical fatigue. It is likely that there are two major types of combat psychiatric cases. First are those originating after one or more days of severe combat, in which the men exhibit a definite

physical fatigue component. These men, suffering from what is often referred to as "genuine" combat fatigue, usually improve rapidly after brief rest and recuperation. Second are those cases in which the men have had little or no participation in battle but manifest disabling psychiatric symptoms with no evidence of physical fatigue. This syndrome occurs prior to expected battle or after initial contact with the enemy. These patients suffer from an anticipatory or phobic-type anxiety which is not benefited by simple recuperative measures.

One may summarize the factor of physical fatigue in combat neurosis by stating that it is highly likely for the tiring soldier to become more vulnerable to psychiatric breakdown since fatigue lowers one's ability to cope with the battle environment by the only means available; namely, physical activity. When bereft of this means of flight or fight, the individual can only passively manage the external environment.

Predisposition

From a commonsense standpoint, it has seemed plausible to postulate that the "weaker" individual would succumb more rapidly to the stress of combat, whereas the less predisposed, or stronger person, could resist external stress at least for some time. This attractive stress predisposition formula was popular in World War II but could not be substantiated simply because there was no dependable method of identifying the weaker or predisposed persons except after the fact. For some time in World War II it was assumed that so-called passive or dependent individuals who were incapable of externalizing aggression constituted such vulnerable individuals. However, this concept is based mainly on retrospective history data of psychiatric patients who have good reason for displacing blame for combat failure on causes beyond their control.

From careful background studies of psychiatric casualties,[5] attempts to predetermine combat effectiveness of replacements,[6] and predictive efforts made on military personnel soon after induction,[7] it can be concluded that individuals who were exposed to unfavorable circumstances during their early formative years and/or exhibited an impaired adjustment to school, work, and other social requirements, rendered less effective combat as well as noncombat service than persons whose past history was relatively negative for such difficulties. However, these findings demonstrated that differences between vulnerable and nonvulnerable groups were not large and certainly insufficient for practical

utilization as a psychiatric screening procedure for general mobilization.

Certain single individual characteristics stand out from the mass of personal history data as pertinent to vulnerability or predisposition to combat stress; namely, (1) *Age.* The older combat soldier is more susceptible to psychiatric breakdown than his 18- to 21-year-old colleague. After 35 years, age becomes particularly significant in increasing vulnerability to combat stress which is due to lessened capacity for strenuous physical activity. Obviously there are many exceptions to this rule, particularly among officers and noncommissioned officers. (2) *Educational level.* It would seem reasonable to believe that intellectual ability should be related to combat effectiveness. This hypothesis has not been substantiated because individuals with marked or severe degrees of mental retardation are generally rejected for military service. However, all studies agree that limited educational achievement of less than the eighth grade is significantly related with noneffective performance in both combat and noncombat assignments. No doubt characteristics other than intelligence are involved in the level of schooling attained, such as capacity to conform and ability to work with others. (3) Other single criteria, such as race, religion, economic status, cultural origin, civilian occupation and marital status, show no significant relationship with combat psychiatric breakdown.

Before considering the relationship between overt and disguised combat psychiatric disorders, it should be recognized that both symptoms and behavioral abnormalities represent a meaningful effort at adaptation under stress. Inability to cope with threatening or dangerous situations evokes substitute behavior of an evasive or regressive pattern in an effort to reach some satisfactory compromise solution for both internal needs and external demands. Even in the bizarre types of combat psychiatric breakdown, such as mutism or uncontrolled panic flight, one can discern primitive attempts to withdraw or escape from a terrorizing environment. Less severe abnormalities, such as hysterical paralysis, self-inflicted wounds, and AWOL from battle, more readily portray their purposeful nature. In the more mild forms of combat fatigue, characterized by tremulousness, tearfulness and verbal surrender, a childish dependent adaptation is quite evident.

The form or type of psychological noneffective behavior displayed in combat is not determined so much by individual personality characteristics as it is dictated either by the practical circumstances of the battle situation or by group (including med-

ical) acceptance of such symptoms or behavior. To illustrate the effect of the combat situation on the manifestations of noneffectiveness are the following examples.

Only few psychiatric casualties were reported during the day of attack upon Pearl Harbor from either Army or Naval personnel who were involved.[8, 9] Here was a situation in which this type of behavior served no useful purpose. For the same reason, psychiatric breakdowns, as such, are uncommon in Naval personnel engaged in battle at sea.[10] Psychiatric cases were also few in number during the hazardous retrograde action that occurred in the difficult withdrawal from North Korea in late November and early December 1950, when medical facilities were also under attack and it was obviously best to remain with the combat group.[11] Seldom does a psychiatric case become manifest during a patrol action but it does occur after the patrol has reached the safety of its own lines. None of the foregoing should leave the impression that noneffective behavior cannot occur under these situations as listed, but rather that the manifestations of such ineffectiveness are determined by whether or not they are appropriate in the combat situation. A final example illustrating this point concerns the frequency of AWOL's from combat. For obvious reasons this type of noneffective behavior was rarely observed in the island-hopping campaigns of the South Pacific Theater of World War II and in the dangerous guerilla-infested rear areas of South Korea during the early phases of that campaign. In sharp contrast, however, were the relatively common instances of desertion and AWOL in the Mediterranean and European Theaters of World War II where the rear cosmopolitan cities of Rome, Paris, and Naples offered safety and comfort.

The influence of the combat group on frequency and type of noneffective behavior is demonstrated by the following observations. Combat units in their first severe battle engagement usually have their highest incidence of psychiatric casualties in which there occur the largest number of bizarre syndromes such as gross hysteria and disassociative reactions. As these units become battle-hardened, and group cohesiveness and group standards for conduct are developed, not only is there a decrease of psychiatric casualties, but their manifestations become more or less stereotyped, with little of the dramatic qualities previously displayed. These casualties merely exhibited mild trembling, noise sensitivity, and sympathetic overactivity, and verbalized an inability to "take it" or "stand them shells," which was accepted by the combat group of World War II as a proper or sufficient expression

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of the end stage or breaking point. Bizarre behavior was not considered a necessary prerequisite for evacuation or temporary relief from battle.

Another example of group acceptance of behavior occurred with ROK (Republic of Korea) troops. Early in the Korean campaign, when most ROK troops and their officers were relatively untrained and new to combat, psychiatric casualties from these units were rare since such behavior was not accepted and there was a relative dearth of ROK medical facilities. However, other types of noneffectiveness were quite common. When ROK soldiers were integrated into American units, they incurred psychiatric breakdown with the same frequency and manifestations of their American buddies.

Medical recognition of this or that symptom or behavior as a valid reason for removal from battle is a major determinant of its acceptance by the combat group. Indeed, as in civilian life, popular medical syndromes exert a powerful suggestive influence upon those who seek the rationalization of an incapacitating illness as a reason for inability to cope with frustration and hardship. For example, symptoms of flat feet (pes planus) and neurocirculatory asthenia were accepted as disabling in World War I whereas their validity as true organic syndromes was largely discounted by the medical officers in World War II. As a result, removal from combat for these disorders was far less common in World War II, although there undoubtedly was a similar incidence of painful feet, palpitation, and cardiac consciousness. Early in World War I, proximity to blast from a nearby shell explosion was believed to cause an organic brain disorder, "shellshock." Later in World War I and in World War II, shellshock was discarded as an organic entity and recognized as a psychological disorder or war neurosis. However, shellshock persisted in World War II and Korea to a lesser extent under the more scientific term, "concussion." This now-acceptable syndrome influenced the prevalence of headache, irritability, giddiness, poor memory, and the like, none of which could be correlated with proximity of shell explosion or the finding of organic brain damage.

During the first winter of the Korean conflict,[11] frostbite became a major cause for medical evacuation. At this time there arose also the syndrome of coldness and numbness of the feet, which mimicked frostbite symptoms and was unquestionably suggested by usual foot discomfort which occurred in most individuals who were about in the cold winter of 1950.

A notable example of suggestion in the production of somatic

syndromes occurred in World War I,[12] when a single shell exploded near troops who were placed in a rear blocking position. Within 8 days, 500 "gas" casualties appeared for treatment at forward medical facilities, and all of them had characteristic symptoms of cough, chest pain, tearing of the eyes, and smarting of the throat. However, it was promptly ascertained that the so-called gas shell was quite innocuous and all patients were promptly returned to duty.

From the foregoing data it would be erroneous to conclude that malingering is common among American troops. Actually, malingering—the simulation of an illness—is quite rare among American troops. Suggestibility and exaggeration by individuals who suffer from real physical and psychic discomfort is quite common, particularly if such syndromes have been given the aura of medical respectability and, thus, acceptance by the combat group.

Summary

Available epidemiological data indicate that the mental illness of troops in warfare, exclusive of psychotic disorders, is more significantly related to circumstances of the combat situation than to any personality attributes or characteristics of the individuals who are exposed to battle stress. Pertinent combat circumstances include the intensity and duration of battle which can be measured by the battle casualty rate and the days of continuous action. However, of equal importance in determining the frequency of psychiatric cases are less measurable elements of battle; to wit, the degree of support given the individual by buddies, group cohesiveness, and leaders. These less tangible influences explain the marked differences that may occur in combat effectiveness and the frequency of psychiatric cases among units which are exposed to the same intensity and duration of battle.

Both the overt and disguised forms of psychiatric breakdown result from an inability to cope adequately with the terrorizing battle environment. But in this failure there is a meaningful effort to defend against anxiety by consciously or unconsciously utilizing evasive or regressive patterns of behavior, the manifestations of which are dependent on the practical exigencies of the combat situation and social pressures of the group.

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SUMMARY AND DISCUSSION OF PAPERS ON ECOLOGY AND EPIDEMIOLOGY OF MENTAL ILLNESS

Dr. Russell Monroe, Tulane University: Dr. Clausen very dramatically presented some of the problems in interpreting epidemiological data. I think we have two interesting findings: One—the idea that psychosis apparently does not change much in incidence, either with slow sociological change that is reported in the Massachusetts report, or under acute stress, the material that Dr. Glass presented. On the other hand, if we look at the neurotic reactions as Dr. Glass just mentioned, there seemed to be fashions that vary from year to year, from war to war. I wondered if it would be fair to direct a question to Dr. Redlich, the moderator, along these lines. I think, if I remember rightly, you were quite cautious in interpreting your data on your epidemiological studies, in print, but perhaps you would care to comment or make some speculations or interpretations here today. Would you comment on this problem of the seemingly stable rate of phychosis and why it appears in the lower socio-economic groups? Are there social-cultural factors in this group, or is there some difference in response to the deviant behavior in different social classes?

Dr. Redlich: Dr. Monroe, I feel that there were so many interesting things brought out by these papers that I somewhat hesitate to talk about this. However, if I can be very brief about it, I would like to say this. The New Haven study has really not brought out anything which is of etiological significance in explaining differences in prevalence, and prevalence in itself is not a very good measure from an epidemiological viewpoint. It is a measurement of incidence and duration, in a very complex fashion. We found, as far as the accumulation of schizophrenics in the lower classes is concerned, that although not entirely, it is mostly due to the fact that the lower socioeconomic groups get different treatment and have different opportunities for rehabilitation. The only study which I think at the present time is dealing with prevalence in a much more advanced fashion, and I would say in a satisfactory fashion, is the Yorkville study. Probably, however, it will prove that prevalence in the lower socioeconomic groups is greater than in the upper groups. This still does not prove what the incidence is. I would like to refer in terms of

criticism of all this, however, to the papers of Lemkau and to more recent publications by John Clausen.

Dr. Opler, Cornell University: This is only hazarding a guess about Dr. Monroe's question. I think, from the point of view of the current data and knowledge in psychiatry, that psychosis is perhaps exaggerated if you think about it as an entity. First, of all, there are many subgroupings and many variations within that category, and I think you could speak of the concepts as containing some fallacies of over-generalization. But that isn't what I wanted to comment about. I wanted to suggest that within this perhaps over-generalized category, you are dealing much more with things that are end-states. It would seem to me that ordinary stress of wartime duration might very well produce much more in the way of neurotic breakdown under stress that it would produce of these end-states. These, I think, are recognized as illnesses of long duration, as well as being end-states. So that might be a suggestion along these lines.

The alternative suggestion, that I seem to feel in the air, was a sort of genetic kind of explanation. I don't think it is necessary. I am thinking here again of Dr. Rennie's studies about malignant prognosis in neurotics where people went into the psychotic state, sometimes even after treatment. This was a follow-up study at the Phipps Clinic.

Dr. Hamburg, Michael Reese Hospital, Chicago: I would like to ask Colonel Glass about the distinction which he made between the pseudo-psychosis and the true psychosis. Is there any evidence as to whether this can be predicted at the time, or is it a distinction that can only be made retrospectively?

Colonel Glass: At first, it was made retrospectively but it got to be such a common phenomenon and the guessing became so good that it would recover within a few days, that we began to make it before the fact. Now occasionally you would find a psychotic schizophrenic, but he was much more apt to appear when the troops were in a rear area, removed from the combat zone, or he appeared from troops who were not actually engaged in combat. Generally, when we saw a psychotic reaction right out of a battle situation, with past experience, we felt it wasn't a true psychosis and would soon resolve so that we made the diagnosis of servere combat exhaustion. You would be proven right practically all the time.

Dr. Hamburg: Was this prediction based on some difference in the behavior, or simply the situational context, that if it was a front-line case, you could safely estimate a quick recovery?

Colonel Glass: It was, I think, based also on the type of manifestations. The content of his delusions or his attitude was associated a lot with the combat area. But if you removed him from that area and put him down here at Walter Reed, I am sure anyone would make the diagnosis of schizophrenia, or panic state, or some diagnosis like that. At first we did make such diagnoses, but later changed them.

Dr. Lifton, Harvard Medical School: I have a question I would like to direct to Dr. Tyhurst, but I think it also applies to most of the other papers this afternoon. In some of my own work with people who had been exposed to what is known as brainwashing or thought-reform, I think the model follows very closely this concept of discontinuity, or transition states. One of the ways that I have looked at it, which I think is very close to what you brought out, has been the development of an identity crisis, a period you call the recall period. I believe there is again a kind of identity crisis, as the individual must adjust to something like his old way, on coming out of the stress situation. One of the things that I notice, and I would like to ask if it is common to the sorts of transition states you encountered, was the carrying over of formidable barriers to re-establishing a satisfactory identity or the resymbolization process after the stress, mainly a sense of guilt and a sense of shame over how well one had behaved during the acute stress. This seemed to be, at least in what I saw, more formidable than almost anything else in any sort of satisfactory future adjustment, and I would also emphasize that it seemed to be most able to be handled during that immediate post-stress period.

Dr. Tyhurst: In discussing with you the whole natural history of a confession experience and its subsequent history, I think the question of shame and guilt is probably characteristic of that particular experience because of the loading involved. We saw it very clearly in disaster and also in the case of bereavement. Particularly in disaster, people never behave as they think they would or should. Most of us behave rather poorly, actually. Susequent to this, particularly during the period of secondary elaboration or attempt to re-elaborate the situation following the disaster, as none of us ever see what really did happen, there is often an attempt to reconstruct it in terms that are quite false. Of course, it is out of this that rumor formation occurs, because these newly elaborated pictures then form a basis of rumors. Now in disaster the features of guilt are quite prominent in this re-elaboration or this reconstruction.

Dr. Lifton: A lot of this post-disaster behavior is an attempt to really reinforce one's integrity and somehow convince himself that he behaved reasonably well, overcoming the doubts that he really has about this.

Dr. Tyhurst: Yes, this is very characteristic, of course, and is one of the areas in which the persons dealing with survivors often make fairly major errors. They engage in argument, or correction, or this kind of thing, whereas actually the details are quite unimportant and maybe a week later or 2 weeks later a new picture of what has happened has arisen, new assumptions have been established, and a new self-conception emerges and the person then goes on again.

Dr. Robinson, University of Buffalo Medical School, Buffalo, N. Y.: I would like to address a question to Colonel Glass. I wonder, as we look at these figures on the combat troops and the incidence of psychosis among them, if we should stop to consider the ones who do not break down in combat, but who break down after they leave the Army, or the Service. We see quite a few of those in civilian hospitals, and I have found that sometimes the very dynamics that make a man really serve in a brilliant capacity in the field are the same ones that perhaps make him break down when he gets out and is unable to make the transition back to society. This same thing brings up the question of the transitional states that are involved in a man, getting back into his civilian society when he functioned very well in the Service.

Colonel Glass: What you have stated is a common statement: these individuals do well in combat and can't make the adjustment when they get out. We see evidences of combat troops coming off the front lines and being very quarrelsome, and fighting, giving forth all sorts of hostile behavior, as a corollary to what Colonel Harris described. I remember one division that did very well in the Tunisian campaign and was removed quite a distance away for a rest and recuperation period to a good-sized town. The men so tore up the town that they had to get their own MP's to patrol the town. They listened to their own MP's, but wouldn't listen to base unit's MP's. Yet, data to support your statement are very fragmentary. Everyone knows about a case. I think it is very true that psychotics have fought well. People whom we would call latent or ambulatory schizophrenics in isolated areas have fought quite well.

It is also true that some of the closeness and human relation factors that occur in a combat group are missed very sorely by the individual after he leaves the combat area. He is kind of lost

for a while. But I don't know, I just wonder how many people there are who cannot adjust after a combat experience. You must remember that you are dealing with a young group and the fact that this young group may have had schizophrenia, in itself, is not a surprising matter. Whether it is related to their experiences in combat is a question.

I suppose we ought to get some data on this. I think we all have anecdotal data, that we have all seen cases in which this has occurred. I know from personal experience that there has been many a psychotic in combat, in fact, I kept a couple of them in combat because they were doing so well, but I saw them only in a tangential manner for other things when they were out of combat. They did so well, whatever mechanisms they were utilizing, schizophrenic mechanisms, these enabled them seemingly to be supported. Yet we hear of this common supposition that when they come out they have this difficult transition. I know that normally there is something of a transition to most people who get out of combat. They have nightmares and a good many other nervous phenomena in adjusting. I think we need some data on how many of them actually are "injured" or cannot adjust from a combat experience.

Dr. Tyhurst: In respect to this question of the discharge situation, we are in the process right now of winding up a study of a number of dependent veterans who have what we call pension neurosis. By "dependent" I mean not psychologically dependent, but simply those people who applied for some kind of economic assistance or domiciliary care. Now this whole question of veterans' rights is a great social institution within our society which has its own rules and regulations and so on within this dependent veterans' group, and we were much impressed by the fact that these people might have been better handled at the time of discharge from the Army. When, for example, they had had a good job up until the time they went into the Army, had had Army experience for 5 years and then had come out again, the situation would have been different if some time had been spent with them for help over this period of transition that I have been speaking about.

Dr. Nanser, Public Health Service: We hear very much about the importance of the first 6 years in the development of personality. Have there been any studies at all that correlate the value of a soldier with his early environment?

Colonel Glass: There was a predictive study done by a group who examined 500 newly inducted soldiers in 1951 and then let-

ting them go for their period of Army service, checked on their performance afterwards. They noted such things as broken home, absence of parents, the presence of poverty, and things of this nature. They didn't get into more detailed explanations. They did note such information as to whether they were close to their mother, ambivalent towards their father, etc. None of these data correlated at all.

This is not so much, I think, because there isn't something to it perhaps, but when you ask an adult person questions of this nature at any time, the type of information you get is not very reliable and when you code it out it doesn't give you anything. The individual, if asked how well he loved his mother or how he got along with his father and siblings, etc., generally gives conventional answers. Coding those who didn't give conventional answers, against those who did, there didn't seem to be any difference. For example, people who recorded the fact that they were adopted or their parents were divorced or separated or there was no parent at home, or who were raised under those circumstances, though we only had a few, did better than the average. So, we could conclude that, maybe, parents are a misfortune here. We got absolutely nothing out of this area.

We got better data out of how they adjusted to school, in their adolescence, more things that they could recall, work adjustments, school adjustment, educational level. Things of this sort gave us some significant correlations, but they weren't very high. By that I mean, of our most marginal group, still 70 percent were effective as compared to our best groups which were 95 percent effective.

Dr. Harold Lief, Tulane University Medical School: I would like to address this question to Dr. Glass. When working in the 7th Army NP Center during World War II, we were struck by the infrequency of Nisei casualties. I may be wrong about that, but the Japanese-American troops rarely came to our center for psychiatric attention despite the fact that they were in very tough fighting. They were often used to bail out other regiments. At one time, for example, they went in and got the 36th Division out of a hole and despite the fact that there were a large number of casualties, there were very few NP casualties. We attributed it at the time to the cohesiveness of the group. Here was a situation in which, in a large sense, they were an out-group in the Army itself. I was wondering whether the Nisei were ever studied from this point of view?

Colonel Glass: Well, your experience in the 7th Army was exactly like ours in the 5th Army, where we had the 100th Battalion

and the 442d Combat Team which went to France. We rarely saw NP casualties out of that group, and when we did see them, they tended to be hysterical casualties, mimicking a physical illness. I think there are two factors. One is that they were a cohesive group, by any manner in which we can judge. They had even their own language, which they gloried in using in talking to one another. They were an out-group, and it seemed incumbent upon that group not to display any evidences of "cowardliness" or any failure to perform for psychological reasons. It had to be an organic reason and we were quite struck by the same thing. Their rate was very low. This was also paralleled by another unit in Italy, an elite unit, the First Special Service Force, who also had very few psychiatric casualties, and none of any other type, incidentally, AWOL or anything like that. So these kinds of data, where you had elite units or special units like the 442d Combat Team, would convince one that the various factors which cause NP casualties, to a large extent, are the intangible ones in the unit—how they feel, the type of groups you are dealing with, and all these other factors that occur.

Dr. Redlich: Dr. Caudill, do you have any comments on the Nisei?

Dr. Caudill: I don't believe so, except to underscore what Colonel Glass said about their not wanting to show psychiatric difficulties, anxiety, fear, and so on. This would be not only, I think, because the 442d felt itself as a special unit, but because these are also general Japanese cultural values. So in a sense you had two things which were reinforcing the suppression or the keeping down in some way or the nonexistence of these things in the 442d.

Dr. Opler: From studying Japanese in the War period, in one of the relocation centers, as a matter of fact, the one that was called the "Disloyal Center" in California at Tooele Lake, I would entirely agree with Colonel Glass and Dr. Caudill. However, I would like to add another factor about the 442d and 100th, and that is that the boys that volunteered in these two groups—those from Hawaii, as well as the mainlanders—were an extremely select group. That is, they were the kind of Japanese, second generation Nisei that were strongly identified with their parents, their parents' problems in the Center, their parents' problems in Hawaii, and they were out, in their own phraseology, "to go for broke" as it were, in proving that the whole Japanese group was basically a loyal group or a good group on the United States scene. I think you are dealing here with the cream of the crop, and I

don't say that to engender any stereotype about the other parts of the Japanese community. I think, however, that you are dealing with a group that were most representative of Dr. Caudill's suggestion of the cultural values of sincerity in carrying through and willingness to sacrifice for the family, plus well-integrated-in-family-connection kind of people. They were people who wanted to represent their families in their groups. I think it is quite a thrilling example but it is very selective.

Dr. Redlich: In connection with this I would like to say that we developed a concept to how people appraise psychological disorder. This differs greatly from class to class and from one ethnic group to the other, so that the Nisei have a different kind of appraisal from ours, if there is such a thing as a stereotype, different from the Japanese, different from the Germans, different from the Russians. During times of war, as far as we had records about all this, I think this could be ascertained to a certain degree.

TUESDAY MORNING SESSION

16 April 1957

INDUSTRIAL PSYCHOLOGY AND PSYCHIATRY

MODERATOR

Winfred Overholser, M.D.

SOME PROPOSITIONS ABOUT HUMAN BEHAVIOR IN ORGANIZATIONS *

CHRIS ARGYRIS, PH.D.

During the past 5 years I have been interested in trying to acquaint myself with the empirical research pertinent for understanding human behavior in on-going organizations. As my reading progressed (in fields such as personality, clinical, social, and industrial psychology; industrial sociology; public administration; scientific management, etc.), I became increasingly aware that the integration of this seemingly diverse and scattered literature would help to provide some useful insights into the *why* of human behavior in on-going organizations, thereby enlarging our scope of understanding. It seems unfortunate that relatively little attention is being paid to the process of integrating existing, discrete parts of research into more meaningful wholes. Too often the importance of integrating existing research is subserviated to so-called individual research. But as Professor Neils Bohr correctly points out, the extension of knowledge can be increased by the recognition of relations between formerly unconnected groups of phenomena.[1]

A most difficult problem is to find an appropriate framework to integrate the many highly heterogeneous multilevel studies. The existing frameworks within any one academic discipline seem to be too narrow in scope to be useful. Those that cross the traditional discipline lines seem to be limited, primarily because they are too abstract and their concepts lack operational definitions by which to tie them to empirical reality.

The minimum requirements of a desired framework are that it show how one might cope with (1) organizational variables

* The results here summarized are abstracted from a recent review of the literature made by the writer under a generous grant from the Foundation for Research on Human Behavior, Ann Arbor. Professor E. W. Bakke of the Labor and Management Center gave much constructive help throughout the project. Professor T. T. Holme of the Department of Industrial Administration made available important typing assistance required by the writer. The report is to be published by Harper & Bros. in May 1957. It is tentatively entitled, *The Behavioral Sciences Organization: An Integrated Review of the Literature.*

that exist on many different levels of analyses, (2) whose existence depends on their interrelatedness in which each variable is (directly or indirectly) influencing, and is being influenced by, every other variable, (3) resulting in a state of balance of the variable that has been variously called the organization's "homeostasis," "equilibrium," or "steady state."

After much experimentation and discussion, a simple framework was devised which seemed to be most suitable for integrating the literature, keeping the above requirements in mind. The reasoning behind the choice of this framework may be outlined as follows:

1. It is agreed that organizational behavior is composed of many variables on different levels of analyses and with many interrelationships.

2. Even though organizational behavior looks like it is a "bloomin' buzzing confusion," some causal trends must be plotted if understanding is to be achieved. To plot these trends in terms of the traditional independent-dependent variable model would seem to do violence to the complexity of the phenomena under study.

Some Properties of the Human Personality

The research on the human personality is so great and voluminous that it is indeed difficult to find agreement regarding its basic properties.* It is even more difficult to summarize the few agreements that may be inferred from the existing literature. Because of space limitations it is only possible to discuss in detail one (of ten agreements) which seems to the writer to be the most relevant to the problem. The others may be summarized briefly as follows. Personality is conceptualized as (1) being an organization of parts in which the parts maintain the whole and the whole maintains the parts, (2) seeking internal balance (usually called adjustment) and external balance (usually called adaptation), (3) being propelled by psychological (as well as physical) energy, (4) located in the need systems, and (5) expressed through the abilities. (6) The personality organization may be called "the

* The relevant literature in clinical, abnormal, child, and social psychology, personality theory, sociology and anthropology was investigated. The basic agreements inferred regarding the properties of personality are assumed to be valid for most contemporary points of view. Allport's "trait theory," Cattell's factor analytic approach, and Kretschmer's somatotype framework are not included. For lay description, see the author's *Personality Fundamentals for Administrators*, rev. ed. Yale Labor and Management Center, New Haven, Conn., 1954.

self," which (7) acts to color all the individual's experiences, thereby causing us to live always in our "private worlds," and which (8) is capable of defending (maintaining) itself against threats of all types.

3. The task might be accomplished by assuming that the complex organizational steady state that is the focus of the study evolved from simple beginnings. Then one might attempt to reconstruct the (assumed) process by which this present complexity evolved. To put it in terms of a question, is it possible that the complex organizational steady state began as a result of a simple relationship between a few variables and then grew into the complexity with which the researcher is presently faced?

4. If it is assumed, for the moment, that the answer to the question above is in the affirmative, it follows that these initial few variables must be found, and the process by which their simple relationship evolved into the present complexity must be demonstrated. Moreover, if the framework is valid, the process which leads to the present organizational steady state must be evolved primarily from what is "inherent" in the relationship of the initial variables.

5. If such a framework is to have general applicability then it is further assumed that all of the organizations within the scope of inquiry have similar beginnings and go through a similar developmental process.

Having outlined some of the reasoning behind the framework chosen, a description of it is presented as follows:

1. The two basic variables to be dealt with are the individual and the formal organization.

2. It follows that in the relationship between these two initial variables lies the process by which the organizational complexity evolves.

3. The first step toward understanding the nature of this relationship is to ascertain the nature of each variable. Knowing the properties of these initial component variables should make it possible, therefore, to derive the nature of their relationship.

In the next section, a discussion of some of the basic properties of personality will be followed by a similar discussion regarding formal organization, from which an attempt will be made to derive some of the basic characteristics of the relationship that will tend to arise when these two initial components are "married" to form the beginning of a social organization.*

* This discussion is a short summary of the detailed analysis to be found in the book cited in footnote on page 209.

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The self, in this culture, tends to develop along specific developmental trends or dimensions which are operationally definable and empirically observable. The basic developmental trends may be described as follows. Human beings, in our culture:

1. Tend to develop from a state of being passive as an infant to a state of increasing activity as an adult. (This is what Erikson [2 3] has called self-initiative and Bronfenbrenner [4] has called self-determination.)

2. Tend to develop from a state of dependence on others as an infant to a state of relative independence as an aduit. Relative independence is the ability to "stand on one's own two feet" and simultaneously to acknowledge healthy dependencies.* It is characterized by the individual's freeing himself from his childhood determiners of behavior (e.g., family) and developing his own set of behavioral determiners. This individual does not tend to react to others (e.g., the boss) in terms of patterns learned during childhood.[5]

3. Tend to develop from being capable of behaving in only a few ways as an infant to being capable of behaving in many different ways as an adult.**

4. Tend to develop from having erratic, casual, shallow, quickly dropped interests as an infant to a deepening of interests as an adult. The mature state is characterized by an endless series of challenges in which the reward comes from doing something for its own sake. The tendency is to analyze and study phenomena in their full-blown wholeness, complexity and depth.[8]

5. Tend to develop from having a short time perspective (i.e., the present largely determines behavior) as an infant to a much longer time perspective as an adult (i.e., behavior is more affected by the past and the future.) [9 10]

6. Tend to develop from being in a subordinate position in the family and society as an infant to aspiring to occupy a more equal and/or superordinate position relative to one's peers as an adult.

7. Tend to develop from a lack of awareness of the self as an infant to an awareness of and control over one's self as an adult. The adult who tends to experience adequate and successful con-

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* This is similar to Erikson's sense of autonomy and Bronfenbrenner's state of creative interdependence.

** Lewin [6] and Kounin [7] believe that as the individual develops needs and abilities, the boundaries between them become more rigid. This explains why an adult is better able than a child to be frustrated in one activity and behave constructively in another.

trol over his own behavior tends to develop a sense of integrity (Erikson) and feelings of self-worth.[11]

These dimensions are postulated as being descriptive of a basic multidimensional developmental process along which the growth of individuals in our culture may be measured. Presumably, every individual, at any given moment in time, could have his degree of development plotted along these dimensions. The exact location on each dimension will probably vary with each individual and even with the same individual at different times. Self-actualization may now be defined more precisely as the individual's plotted scores (or profile) along the above dimensions.*

A few words of explanation concerning these dimensions of personality development:

1. They are only *one* aspect of the total personality. All the properties of personality described to date must be used in trying to understand the behavior of a particular individual. For example, much depends on the individual's self-concept, his degree of adaptation and adjustment, and the way he perceives his private world.

2. The dimensions are continua in which the growth to be measured is assumed to be continuously changing in degree. An individual is presumed to develop continuously in degree from the infant end to the adult end of each continuum.

3. The only characteristic that is assumed to hold for all individuals is that, barring unhealthy personality development, they will be predisposed toward moving from the infant end to the adult end of each continuum. This is a model (a concept) describing the basic growth trends. As such, it does not make any predictions about any specific individual. It does, however, presume to supply the researcher with basic developmental continua along which the growth of any individual in our culture may be described and measured.

4. It is postulated that as long as one develops in a particular culture, one will never obtain maximum expression of these developmental trends. Clearly, all individuals cannot be maximally independent, active, and so forth, all the time and still maintain an organized society. It is the function of culture (e.g., norms, mores, etc.) to inhibit *maximum* expressions and to help an individual adjust and adapt by finding his *optimum* expression.

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* Another related but discrete set of developmental dimensions may be constructed to measure the protective (defense) mechanisms which individuals tend to create as they develop from infant to adulthood. Exactly how these would be related to the above model is not clear.

A second factor that prevents maximum expression and fosters optimum expression is the individual's own finite limits set by his personality. For example, some people fear the same amount of independence and activity that others desire. Also, it is commonplace to find some people who do not have the necessary abilities to perform specific tasks. No individual is known to have developed all known abilities to their full maturity.

Finally, defense mechanisms also are important factors operating to help an individual to deviate from the basic developmental trends.

5. The dimensions described above are constructed in terms of latent or genotypical characteristics. If one states that an individual needs to be dependent, this need will probably be ascertained by clinical inference because it is one that individuals are not usually aware of. Thus, if one observes an employee acting as if he were independent, it is possible that if one goes below the behavioral surface, the individual may be quite dependent. The obvious example is the employee who seems to behave always in a manner contrary to that desired by management. Although this behavior may look as if he is independent, his contrariness may be due to his great need to be dependent on management, which he dislikes to admit to himself and to others.

One might say that an independent person is one whose behavior is not caused by the influence others have over him. Of course, no individual is completely independent. All of us have our healthy dependencies, i.e., those which help us to maintain our discreteness, to be creative, and to develop.

One operational criterion to ascertain whether an individual's desire to be, let us say, independent and active is a true manifestation is to ascertain the extent to which he permits others to express the same needs. Thus, an autocratic leader may say that he needs to be active and independent; he may also say that he wants subordinates who are the same; however, there is ample research to suggest that his leadership pattern only makes him and his subordinates more dependence-ridden.

Some Basic Properties of Formal Organization

The next step is to focus the analytic spotlight on the formal organization. What are its properties? What are its basic "givens"? What probable impact will they have on the human personality? How will the human personality tend to react to this impact? What sorts of "chain reactions" are probable when these two basic components are brought together?

Formal Organizations Are Rational Organizations. Probably the most basic property of formal organization is its logical foundation or, as it has been called by students of administration, its essential rationality. It is the "mirror image" of the planners' conception of how the intended consequences of the organization may be best achieved. The underlying assumption made by the creators of formal organization is that man within respectable tolerances will behave rationally, i.e., as the formal plan requires him to behave. Organizations are formed with particular objectives in mind, and their structure mirrors these objectives. Although man may not follow the prescribed paths, and consequently the objectives might never be achieved, Simon[12] suggests that, by and large, man does follow these prescribed paths. As he points out:

> Organizations are formed with the intention and design of accomplishing goals; and the people who work in organizations believe, at least part of the time, that they are striving toward these same goals. We must not lose sight of the fact that, however far organizations may depart from the traditional description . . . nevertheless most behavior in organizations is intendedly rational behavior. By "intended rationality" I mean the kind of adjustment of behavior to goals of which humans are capable—a very incomplete and imperfect adjustment, to be sure, but one which nevertheless does accomplish purposes and does carry out programs.

Most of these experts emphasize that although no organizational structure will exemplify the maximum expression of the principles, a satisfactory aspiration is for optimum expression, which means modifying the ideal structure to take into account the individual (and any environmental) conditions. Moreover, they urge that the people must be loyal to the formal structure if it is to work effectively. Thus Taylor* emphasizes that scientific management would never succeed without a "mental revolution." Fayol has the same problem in mind when he emphasizes the importance of esprit de corps.

However, it is also true that these experts have provided little insight into *why* they believe that people should undergo a "mental revolution," or why an esprit de corps is necessary if the principles are to succeed. The only hints usually found are that resistance to scientific management occurs because human beings "are what they are," or "because it's human nature." But, *why* does "human nature" resist formal organizational principles? Perhaps there is something inherent in the principles which causes human resistance. Unfortunately, there exists too little

* For a provocative discussion of Taylor's philosophy, see reference 13.

research that specifically assesses the impact of the formal organizational principles on human beings.

The formal organizational experts believe that logical, rational design, in the long run, is more human than creating an organization haphazardly. They argue that it is illogical, cruel, wasteful, and inefficient not to have a logical design. It is illogical because design must come first. It does not make sense to pay a large salary to an individual without clearly defining his position and its relationship to the whole. It is cruel because, eventually, the participants suffer when no clear organizational structure exists. It is wasteful because, unless jobs are clearly predefined, it is impossible to plan logical training, promotion, resignation and retirement policies. It is inefficient because the organization becomes dependent on personalities. The "personal touch" leads to "playing politics," which Mary Follett has described as a "deplorable form of coercion." [14]

Unfortunately, the validity of these arguments tends to be obscured in the eyes of the behavioral scientist because it implies that the only choice left, if the formal, rational, predesigned structure is not accepted, is to have no organizational structure at all, with the organizational structure left to the whims, pushes and pulls of human beings. Some human-relations researchers, on the other hand, have unfortunately given the impression that formal structures are "bad" and that the needs of the individual participants should be paramount in creating and administering an organization. However, a recent analysis of the existing research points up quite clearly that the importance of the organization as an organism worthy of self-actualization is now being recognized by those who in the past have focused largely on the individual.[15]

In the past, and for the most part in the present, the traditional organizational experts based their "human architectural creation" on certain basic principles (more accurately, assumptions) about the nature of organization. These principles have been described by people such as Urwick,[16] Mooney,[17] Holden *et al.*,[18] Fayol,[19] Dennison,[20] Brown,[21] Gulick,[22] White,[23] Gauss *et al.*,[24] Stene,[25] Hopf,[26] and Taylor.[27]

Although these principles have been attacked by behavioral scientists, the assumption is made in this paper that to date no one has defined a more useful set of formal organization principles. Therefore, the principles are accepted as "givens." This frees us to inquire about their probable impact on people, *if they are used as defined.*

In introducing these principles, it is important to note that, as Gillespie suggests, the roots of these principles may be traced back to certain "principles of industrial economics," the most important of which is the basic economic assumption held by builders of the industrial revolution that, "the concentration of effort on a limited field of endeavor increases quality and quantity of output." [28] It follows from the above that the necessity for specialization should increase as the quantity of similar things to be done increases.

Task (Work) Specialization. If concentrating effort on a limited field of endeavor increases the quality and quantity of output, it follows that organizational and administrative efficiency is increased by the specialization of tasks assigned to the participants in the organization.[29] Inherent in this assumption are three others. *First,* that the human personality will behave more efficiently as the task becomes specialized. *Second,* that there can be found a one best way to define the job so that it is performed at greater speed.[30] *Third,* that any individual differences in the human personality may be ignored by transferring more skill and thought to machines.*

A number of difficulties arise with these assumptions when the properties of the human personality are recalled. *First,* the human personality, as we have seen, is always attempting to actualize its unique organization of parts resulting from a continuous, emotionally laden, ego-involving process of growth. It is difficult, if not impossible, to assume that this process can be choked off and the resultant unique differences of individuals ignored. This is tantamount to saying that self-actualization can be ignored. *Second,* task specialization requires the individual to use only a few of his abilities. Moreover, as specialization increases, it tends to require the use of the less complex doing or motor abilities which, research suggests, tend to be of lesser psychological importance to the individual. Thus the principle violates two basic "givens" of the healthy adult human personality. It inhibits self-actualization and provides expression for few, shallow, skin-surface abilities that do not provide the "endless challenge" desired by the healthy personality.

Chain of Command. The principle of task specialization creates an aggregate of parts, each performing a highly specialized task. However, an aggregate of parts busily performing their

* Friedman [31] reports that 79 percent of Ford employees had jobs for which they could be trained in 1 week.

particular objective does not form an organization. A pattern of parts must be formed so that the interrelationships among the parts create the organization. Following the logic of specialization, the planners create a new function (leadership) whose primary responsibility is to control, direct and coordinate the interrelationships of the parts, and to make certain that each part performs its objective adequately. Thus the assumption is made that administrative and organizational efficiency is increased by arranging the parts in a determinate hierarchy of authority in which the part on top can direct and control the part on the bottom.

If the parts being considered are individuals, then they must be motivated to accept control, direction and coordination of their behavior. The leader, therefore, is assigned formal power to hire, discharge, reward and penalize the individuals in order that their behavior is molded toward the organization's objectives.

The impact of such a state of affairs is to make the individuals dependent on, passive and subordinate to the leader. As a result, the individuals have little control over their working environment. At the same time, their time perspective is shortened because they do not control the information necessary to predict their future. These requirements of formal organization act to inhibit four of the growth trends of personality because to be passive and subordinate and to have little control and short time perspective exemplify dimensions, in adults, of immaturity, not adulthood.

The planners of formal organization suggest three basic ways to minimize this admittedly difficult position. *First,* ample rewards should be given to those who perform well and who do not permit their dependence, subordination, passivity, etc., to influence them in a negative manner. The rewards should be material and psychological. Because of the specialized nature of the job, however, few psychological rewards are possible. It becomes important, therefore, that adequate material rewards are made available to the productive employee. This practice can lead to new difficulties, since the solution is, by its nature, not to do anything about the on-the-job situation (which is what is causing the difficulties) but to pay the individual for the dissatisfactions he experiences. The end result is that the employee is paid for his dissatisfaction while at work and his wages are given to him to gain satisfactions outside his immediate work invironment.

Thus the management helps to create a psychological set which leads the employees to feel that basic causes of dissatisfaction are

built into industrial life, that the rewards they receive are wages for dissatisfaction, and that if satisfaction is to be gained, the employee must seek it outside the organization.

To make matters more difficult, there are three assumptions inherent in the above solution that also violate the basic "givens" of human personality. *First,* the solution assumes that a whole human being can split his personality so that he will feel satisfied in knowing that the wages for his dissatisfaction will buy him satisfaction outside the plant. *Second,* it assumes that the employee is primarily interested in maximizing his economic gains. *Third,* it assumes that the employee is best rewarded as an individual producer. The work group in which he belongs is not viewed as a relevant factor. If he produces well, he should be rewarded. If he does not, he should be penalized even though he may be restricting production because of informal group sanctions.

The *second* solution suggested by the planners of formal organization is to have technically competent, objective, rational, loyal leaders. The assumption is made that if the leaders are technically competent, presumably they cannot have "the wool pulled over their eyes"; which should lead the employees to have a high respect for them. The leaders should be objective and rational and personify the rationality inherent in the formal structure. Being rational means that they must avoid becoming emotionally involved. As one executive states, "We try to keep our personality out of the job." The leader must also be impartial. He does not permit his feelings to operate when he is evaluating others. Finally, the leader must be loyal to the organization so that he can inculcate the loyalty in the employees that Taylor, Fayol and others believe is so important.

Admirable as this solution may be, again it violates several of the basic properties of personality. If the employees are to respect an individual for what he does rather than for who he is, the sense of self-integrity, based on evaluation of the total self which is developed in people, is lost. Moreover, to ask the leader to keep his personality out of his job is to ask him to stop actualizing himself. This is not possible as long as he is alive. Of course, the executive may want to *feel* that he is not involved, but it is a basic "given" that the human personality is an organism always actualizing itself. The same problem arises with impartiality. No one can be completely impartial. As has been shown, the self concept always operates when we are making judgments. In fact, as May has pointed out, the best way to be impartial is to be as partial as one's needs predispose one to be but to be aware of this

partiality in order to "correct" for it at the moment of decision.[32] Finally, if a leader can be loyal to an organization under these conditions, there may be adequate grounds for questioning the health of his personality make-up.

The *third* solution suggested by many adherents to the formal organizational principles is to motivate the subordinates to have more initiative and to be more creative by placing them in competition with one another for the positions of power that lie above them in the organizational ladder. This solution is traditionally called "the rabble hypothesis." Acting under the assumption that employees will be motivated to advance upward, the formal organizational adherents add another assumption: that competition for the increasingly (as one goes up the ladder) scarcer positions will increase the effectiveness of the participants. Williams,[33] conducting some controlled experiments, shows that the latter assumption is not necessarily valid for people placed in competitive situations. Deutsch,[34] as a result of extensive controlled experimental research, supports Williams' results and goes much further to suggest that competitive situations tend to lead to an increase in tension and conflict and to a decrease in human effectiveness. Levy and Freedman confirm Deutsch's observations and go further to relate competition to psychoneurosis.[35]

Unity of Direction. If the tasks of everyone in a unit are specialized, then it follows that the objective or purpose of the unit must be specialized. The principle of unity of direction states that administrative and organizational efficiency increases if each unit has a single (or homogeneous set of) activity (activities) that is planned and directed by the leader.*

This means that the work goal toward which the employees are working, the path toward the goal, and the strength of the barriers they must overcome to achieve the goal are defined and controlled by the leader. Assuming that the work goals do not ego-involve the employees (i.e., they are related to peripheral skin-surface needs), then ideal conditions for psychological failure

* The sacredness of these principles is questioned by a recent study. Herckscher[36] concludes that the principles of unity of command and unity of direction are *formally* violated in Sweden. "A fundamental principle of public administration in Sweden is the duty of all public agencies to cooperate directly without necessarily passing through a common superior. This principle is even embodied in the constitution itself, and in actual fact it is being employed daily. It is traditionally one of the most important characteristics of Swedish administration that especially central agencies, but also central and local agencies of different levels, cooperate freely and that this is being regarded as a perfectly normal procedure."

have been created. The reader may recall that a basic "given" of a healthy personality is the aspiration for psychological success. Psychological success is achieved when each individual is able to define his own goals, in relation to his inner needs and the strength of the barriers to be overcome in order to reach these goals. Repetitive as it may sound, it is nevertheless true that the principle of unity of direction also violates a basic "given" of personality.

Span of Control. The principle of span of control* states that administrative efficiency is increased by limiting the span of control of a leader to no more than five or six subordinates whose work interlocks.[38]

It is interesting to note that Dale,[39] in an extensive study of the organizational principles and practices in 100 large organizations, concludes that the actual limits of the executive span of control are more often violated than not. Worthy [40] reports that it is formal policy in his organization to extend the span of control of the top management much further than is theoretically suggested. Finally, Suojanen,[41] in a review of the current literature on the concept of span of control, concludes that it is no longer valid, particularly as applied to the larger governmental agencies and business corporations. Healey's findings contradict Suojanen's. He reports that the concept of span of control currently used closely adheres to that advocated in theory.[42]

In a recent article, however, Urwick [43] criticizes the critics of the span of control principle. For example, he notes than in the case of Worthy, the superior has a large span of control over subordinates whose jobs do not interlock. The buyers in Worthy's organization purchase a clearly defined range of articles; therefore, find no reason to interlock with others.

Simon criticizes the span of control principle on the grounds that it increases the "administrative distance" between individuals. An increase in administrative distance violates, in turn, another formal organizational principle that "administrative efficiency is enhanced by keeping at a minimum the number of organizational levels through which a matter must pass before it is acted on." [44] Span of control, continues Simon, inevitably increases red tape since each contact between agents must be carried upward until a common superior is found. Needless waste of time and energy results. Also, since the solution of the problem depends on the superior, the subordinate is in a position of having

* First defined by V. A. Graicunas.[37]

less control over his own work situation. This places the subordinate in a work situation which is less mature.

Although the distance between individuals in different units increases (because they have to find a common superior), the administrative distance between superior and subordinate within a given unit decreases. As Whyte[45] correctly points out, the principle of span of control, by keeping the number of subordinates at a minimum, places great emphasis on close supervision. Close supervision leads the subordinates to become dependent on, passive toward, and subordinate to the leader. Close supervision also tends to place the control in the superior. Thus we must conclude that span of control, if used correctly, will tend to increase the subordinate's feelings of dependence, submissiveness, passivity, etc. In short, it will tend to create a work situation which requires immature, rather than mature, participants.

A Basic Incongruency Between the Needs of a Mature Personality and the Requirements of Formal Organization

Bringing together the evidence regarding the impact of the formal organizational principles on the individual, it is concluded that there are some basic incongruencies between the growth trends of a healthy personality and the requirements of the formal organization. If the principles of formal organization are used as ideally defined, then the employees will tend to work in an environment where (1) they are provided control over their workaday world; (2) they are expected to be passive, dependent, subordinate; (3) they are expected to have a short time perspective; (4) they are induced to perfect and value the frequent use of few skin-surface, shallow abilities; and (5) they are expected to produce under conditions leading to psychological failure.

All of these characteristics are incongruent to the ones healthy human beings are postulated to desire. They are much more congruent with the needs of infants in our culture. In effect, therefore, formal organizations are willing to pay high wages and provide adequate seniority if mature adults will, for 8 hours a day, behave in a less mature manner! *If the analysis is correct, this inevitable incongruency increases as (1) the employees are of increasing maturity; (2) as the formal structure, based on the above principles, is made more clear-cut and logically tight for maximum formal organizational effectiveness; (3) as one goes down the line of command; and (4) as the jobs become more and more mechanized, i.e., take on assembly-line characteristics.*

As in the case of the personality developmental trends, this picture of formal organization is also a model. Clearly, no company actually uses the formal principles of organization exactly as stated by their creators. There is ample evidence to suggest that they are being modified constantly in actual situations. However, those who expound these principles would probably be willing to defend their position that this is the reason why human relations problems exist; the principles are not followed as they should be.

In the model of the personality and the formal organization, we are assuming the extreme of each in order that the analysis and its results can be highlighted. Speaking in terms of extremes helps us to make the position sharper. In doing this, no assumption is made that all situations in real life are extreme, i.e., that the individuals will always want to be more mature and that the formal organization will always tend to make people more dependent, passive, and so forth, all the time. The model ought to be useful, however, to plot the degree to which each component tends toward extremes and then to predict the problems that will tend to arise.

Stating the basic findings up to this point, in terms of propositions, one could state:

Proposition I. *There is a lack of congruency between the needs of healthy individuals and the demands of the formal organization.*

If one uses the traditional formal principles of organization (i.e., traditional chain of command, task specialization, etc.) to create a social organization, and if one uses as an input, agents who tend toward a mature state of psychological development (i.e., they are predisposed toward relative independence, activeness, use of important abilities, etc.), then one creates a disturbance, because the needs of healthy individuals listed above are not congruent with the requirements of formal organization, which tends to require the agents to work in situations in which they are dependent, passive, use few and unimportant abilities, etc.

The disturbance will vary in proportion to the degree of incongruency between the needs of the individuals and the requirements of the formal organization. An administrator is, therefore, always faced with an inherent tendency toward continual disturbance.*

* In the full analysis, specific conditions are derived, under which the basic incongruency increases or decreases.

Drawing on the existing knowledge of the human personality, a second proposition can be stated:

Proposition II. *The resultants of this disturbance are frustration, failure, short-time perspective and conflict.*

If the agents are predisposed to a healthy, more mature self-actualization:

1. They will tend to experience frustration because their self-actualization will be blocked.[46] [47]

2. They will tend to experience failure because they will not be permitted to define their own goals in relation to central needs, the paths of these goals, etc.[48] [49]

3. They will tend to experience short time perspective because they have no control over the clarity and stability of their future.[50]

4. They will tend to experience conflict because, as healthy agents, they will dislike frustration, failure and short-time perspective which are charactertistic of the present job. However, if they leave, they may not find a new job easily; and/or even if a new job is found, it may not be much different.[51]

Based on the analysis of the nature of formal organization, one may state a third proposition:

Proposition III. *Under certain conditions the degree of frustration, failure, short-time perspective and conflict will tend to increase.*

The resultants of the disturbance in the organization will tend to increase in degree: (1) as the individual agents increase in degree of maturity (as operationally defined in the personality model); and /or (2) as the degree of dependence, subordination, passivity, etc., increases, ((a) as one goes down the chain of command, (b) as directive leadership increases, (c) as management controls are increased, (d) as human relations programs are undertaken but improperly implemented); and /or (3) as the jobs become more specialized; and/or (4) as the exactness with which the traditional formal principles are used increases.

Proposition IV. *The nature of the formal principles of organization causes the subordinate, at any given level, to experience competition, rivarly, intersubordinate hostility, and to develop a focus toward the parts rather than the whole.*

1. Because of the degree of dependence, subordination, etc., of the subordinates on the leader and because the number of posi-

tions above any given level always tend to decrease, the subordinates aspiring to perform effectively* and to advance will tend to find themselves in competition with, and receiving hostility from, each other.

2. Because, according to the formal principles, the subordinates are directed toward and rewarded for performing their own task well, the subordinates tend to develop an orientation toward their own particular part rather than toward the whole.

3. This part-orientation increases the need for the leader to coordinate the activity among the parts in order to maintain the whole. This need for the leader, in turn, increases the subordinates' degree of dependence, subordination, etc. This creates a circular process whose impact is to maintain and/or increase the degree of dependence, subordination, etc., plus the rivalry and competition for the leader's favor.

Up to this point, a few of the resultants of the relationship between the initial components of organization, the human personality and the formal organization have been analyzed in some detail. Clearly, I have not begun to describe the complexity one usually finds when observing social organizations. Although time and space do not permit a continuation of this analysis to demonstrate how much more of the commonly observed organizational behavior can be derived in detail as a natural extension of the framework stated up to this point, it might be useful, at least, to indicate some of the results.

Continuing from Proposition II, it can be shown that under conflict, frustration, failure and short-time perspective, the employees will tend to maintain self-integration by creating specific adaptive (informal) behavior such as:**

1. Leaving the organization.
2. Climbing the organizational ladder.
3. Manifesting defense reactions such as daydreaming, aggression, ambivalence, regression, projection, etc.
4. Becoming apathetic and disinterested toward the organization, its make-up and goals. This leads to such phenomena as:
    a. Employees reduce the number and potency of the needs they expect to fulfill while at work.

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* These problems may not arise for the subordinate who decides to become apathetic, disinterested, etc.

**Adaptive activities Nos. 1–9 became major categories under which much empirical research can be included.

b. Employees "goldbrick," set rates, restrict quotas, make errors, cheat, slow down, etc.

5. Creating informal groups to sanction the defense reactions and the apathy, disinterest and lack of self-involvement.
6. Formalizing the informal groups.
7. Evolving group norms that perpetuate the behavior outlined in items 3, 4, 5, and 6 above.
8. Evolving a psychological set that human or nonmaterial factors are becoming increasingly unimportant while material factors become increasingly important.
9. Acculturating the youth to accept the norms discussed in items 7 and 8.

Comparing the informal behavior with that prescribed by the formal organization, we may state:

Proposition V. *The employee adaptive behavior maintains individual self-integration and simultaneously impedes adaptation with the formal organization.*

Proposition VI. *The adaptive behavior of the employees has a cumulative effect, feeds back into the organization, and reinforces itself.*

1. All these adaptive reactions reinforce each other so that they not only have their individual impact on the system, but they also have a cumulative impact. Their total impact is to increase the degree of dependence, submissiveness, etc., and to increase the resulting turnover, apathy, disinterest, etc. Thus a feedback process exists in which the adaptive mechanisms become self-maintaining.

2. The continual existence of these adaptive mechanisms tends to make them norms or codes which, in turn, act to maintain the adaptive behavior and to make it the proper behavior for the system.

3. If paragraph 2 is valid, then employees who may desire to behave differently will tend to feel deviant, different, not part of the work community (e.g., rate busters).

The individual and cumulative impact of the defense mechanisms is to influence the output-input ratio in such a way that a greater input (energy, money, machines) will be required to maintain a constant output.

Proposition VII. *Certain management reactions tend to increase the antagonisms underlying the adaptive behavior.*

1. Those managements that base their judgment on the logics of the formal organization and their self-concept will tend to dislike the employee adaptive behavior. They also will tend to diagnose the problem behavior of the employee to be the fault of the employee. It follows, therefore, for these managements, that they should tend to take those "corrective" actions that are congruent with their self-concept and the logics of formal organization. These actions tend to be:

a. Increasing the degree of directive leadership.

b. Increasing the degree of management controls.

c. Increasing the number of pseudohuman relations programs.

The first two modes of reaction tend to compound, reinforce and help to maintain the basic disturbance outlined in Proposition I. It follows, therefore, that the behavior included in Propositions IV, V and VI will also be reinforced. (This is the behavior which management desires to change in the first place.) The third mode of reaction tends to increase the distance and mistrust between employee and management because it does not jibe with the realities of the system within which the employee works.

2. The present employees influence the attitudes of future employees. They will tend to behave according to their self-concept, thus acculturating the future employees (future input) to the nature of the internal system and the adaptive behavior.

3. One must conclude that the management behavior described in Proposition VII primarily acts to influence the output-input ratio so that a much greater input is required to obtain the same constant output or that a disproportionately higher input will be necessary for a given increment of output.

Is there a way out of this circular process? The basic problem is to decrease the degree of dependency, subordination, submissiveness, etc. It can be shown that job enlargement, employee-centered (or democratic or participative) leadership are a few factors which, if used correctly, can go a long way toward ameliorating the situation. However, these are limited because their success depends on having employees who are ego-involved: highly interested in the organization. The adaptive behavior listed above predisposes the employee to disinterest, non-ego-involvement and apathy. The existence of such states of affairs, in turn, acts to require the more directive leadership pattern to "motivate" and control the disinterested employee. The directive leadership pattern, in turn, requires strong management controls if it is to succeed. But, as we have seen, directive leadership and

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management controls actually create the human problems that one is trying to solve.

This dilemma between the needs of the individuals and the demands of the organization is a basic, continual dilemma, posing an eternal challenge to the leader. How is it possible to create an organization in which it is possible for the individuals to obtain optimum expression and, simultaneously, for the organization to obtain optimum satisfaction of its demands?

Although a few suggestions may be found in the literature, they are, by and large, untested and wanting in systematic rigor. Here lies a fertile field for future research in organizational behavior.

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DISCUSSION

Dr. Saul Sells, The School of Aviation Medicine, Randolph AFB, Texas: The question I would like to raise for your comment, possibly anyone else's, is about one element. *Healthy* people live in a culture where they are first sensitized in a private family situation, then they go to schools where they are taught to give the teacher the answers that the teacher wants. I always liked that story in the "Caine Mutiny" about the range of the submarine. We train on this basis. When we get into industry we are already "checked" out on this kind of behavior, so the question is: What do we mean by *"healthy"?*

Dr. Argyris: Though I am not saying that this is true, the assumption of the model is that, as you are predisposed to be more relatively independent, active, and so on, you are "healthier." Now there is another very important question: Isn't it healthier to be apathetic and indifferent and so on in the context in which you have to live and work? Well, my answer is, "That is a value question." I don't know. I would like to tell a story I believe Dr. Plant once told which sort of captures this incongruency. It concerns a girl who had very low intelligence so that he was afraid she was really going to be hurt when she took a complicated job. He saw her 6 months later expecting she would have been injured, but she wasn't. She said to him, "Doc, you thought my fingers would be cut off, didn't you?" He said "Yes, I did." "Well," she said, "let me tell you something that I learned in business. It's only them that can think that gets hurt."

Question: I am sure that we all enjoyed Dr. Argyris' paper. I would like to ask him about the medical department in industry. In certain places, psychiatrists are being hired to function in large industrial corporations, and one gets the feeling that at times a psychiatrist is being used as the axe-man by industry. As a reaction to this, I know that certain unions, I think, for example, the Teamsters Union, have now insisted upon having their own psychiatric service. The question of the communication between these two psychiatrists, those hired by management and those hired by industry, will certainly lead to some kind of an impasse. I wonder if he would tell us about the relationship between the medical department, management and the worker?

Dr. Argyris: Well, there isn't much research in the actual study of what does exist. I have a lot of informal evidence which is congruent to yours. I would like to make these two comments, however. One is that management tends to hire a staff in order to rationalize out its own problems. In effect, management says, "You solve it and let me not have to face it." When you get to

human problems, this becomes quite crucial because if you are a competent psychiatrist or any other kind of therapist this person has to be helped to face the fact that this is his problem. He feels in a tremendous failure situation if he suddenly finds that he hired you to help him become more aware of himself. He wants no part of this, and I can say as a researcher I have felt the insecurity. I have really felt, "Boy, if I were hired by this fellow I think I would be scared for fear he might throw me out of a job."

The second comment is that I have a feeling, and I bet that Dr. Butler's paper will add to this, that there is going to be a new function some day in the field of organization. It is going to be an "organizational doctor" who has a medical background or a psychological background but who really knows the psychological impact of the industrial organization. That man will be hired and can be fired only under the condition that he tries covert manipulation. He will get into a pay scale that goes quite high so that he doesn't have to worry about his next raise. He then can be free from the power politics in the company, let's say, to be used by the people as they see fit.

I think this organizational diagnostician is coming. I can tell you that there are three very large consulting firms in New York who already are looking for people today. Their definition of the job is: "We want a social psychiatrist or a social scientist who can come into our organization and never become identified with us in the sense of accepting our values. He must continually take a look at us and help us see ourselves." It would be sort of an organizational therapy, if you will. He will be paid by management. If anybody feels this is bad, I would ask him to take a look then at his own motives, because I don't feel this should have any impact whatsoever. If anybody questions this I think he is questioning his own anxieties rather than the other individuals'.

Dr. Sells: Just a brief comment about this medical department problem. The airlines have this in a very acute form and the competing expert has become a problem. Several airlines, in agreement with the Airline Pilots Association, which is a union, have worked out an agreement whereby a third party, who is also a physician and agreeable to the opposing parties, is brought in in any case in which disagreement between the two experts was originally experienced. This has worked out very successfully as a means of mutual arbitration.

Dr. Argyris: Now I have no experience, so I speak strictly from ignorance and a feeling for a situation, which usually means I don't know what I'm talking about but I feel strongly about it.

I wouldn't like that kind of an approach. I don't think it's healthy in the sense that it maintains the problem. You now have an arbitrator because you really can't communicate with each other. I think that I would fire that man under this sort of ideal system. I feel that some day, the kind of "organizational therapist" I described will have to have the freedom to help management and unions take a look at the fact that, if they can't trust each other, this is the problem they ought to face. They should not have to hire a third party.

THE EFFECT OF CHANGING INDUSTRIAL METHODS AND AUTOMATION ON PERSONNEL

EUGENE H. JACOBSON, PH.D.

Introduction

This is a good era for social psychologists interested in studying industrial process. It is a time of rapid industrial change. It is a time of great differences in work situation from plant to plant and even within plants. When equipment and methods are compared, some offices and plants can be said to be operating in the 1980's, and others, perhaps in the same block, are using technologies of the 1920's or earlier. In some instances, plants are moving from a very advanced technology to one even more highly developed, and the change can be said to be evolutionary. In others, the changes are so far-reaching and radical as to make the new work situation almost totally different from the old.

In such times, industrial process is laid bare. It is not necessary for the social scientist to make so many assumptions about how things get to be the way they are. They can be observed in the process of becoming. But, more importantly, the change process itself becomes an appropriate object of research. And, in studying change, it is possible to study the mechanisms of industrial process as they shape the work situation for the employee.

Old research problems can be approached with new data and changed methods, and new research problems suggest themselves when change itself is taken as the focus for study. Industrial psychology, although a relatively new discipline, has a history that parallels the development of industrial technology. There is an abundant literature on the man-machine relationship and the management of work situations. But the rapid acceleration in the development of technologies during the past 20 years presents an opportunity for moving from studies of relatively static situations to study of industrial change.

In the remarks that follow, I will attempt to establish this position, first, by outlining an approach to the study of industrial change; second, by reviewing some social psychological studies done during the recent past that illustrate useful theories and

methods; third, by describing a research program on industrial change that is reflecting this altered emphasis; and, finally, by suggesting ways in which this approach can be incorporated into thinking about criteria for evaluating the health of an organization and the health of the relationship between the employee and his work environment.

A Definition of the Research Problem

In studying employee response to industrial change, there are two important phenomena to investigate. One is the relationship between the employee and the advanced technology as such. How does the employee respond and adapt to new technic, machinery, work pacing, hours and periods of work, tasks, etc.? The other is the relationship between variations in the change process itself and employee response to change.

Industrial psychology is making real contributions in studying the first of these phenomena. In a paper delivered to the Institution of Production Engineers in England in February 1956, N. H. Mackworth summarized approximately 40 publications that have appeared since 1950, about half of them since 1954, in the area of human engineering, that deal with response to advanced technologies.[1] They are concerned with decision-making under stress, tracking moving objects, pacing, inspection for sporadic defects, continuous and consecutive inspection methods, effects of repetitive tasks, training employees for work with advanced electronic equipment, and similar subjects. Much of the current research is being conducted in the military establishment.

When any studies of the effect of technological change on employees are undertaken, they must be concerned with this aspect of employee response. If the employee is moving from a task with self-pacing to one in which there is machine-pacing, it is important to be able to anticipate characteristic worker adaptation to machine-pacing.

But these studies are not directly concerned with technological change. They can be, and often are, conducted in static situations. Furthermore, a work process that is assessed to be at an advanced stage of technology may include tasks for the worker that make greater, equivalent, or lesser demands on him as an individual than his former tasks. It is as important to study the effects of the employee's moving to less demanding situations as it is to study his response to situations of maximum demand.

If we accept this alternative research problem—the investigation of employee response to any change, whether it involves his

doing a more or less demanding task—we then become interested in what can be described as the phenomenology of change and with the individual and organizational determinants of the phenomenology of change.

The phenomenology of change includes the worker's perceptions, expectations, attitudes and beliefs about his performance, his role, and his relationship to himself. As the change occurs, the worker will be concerned with his performance, the differences that the change makes in his task, his physical working conditions, his hours of work, and his work pace. He will have and will develop attitudes that will influence his performance in the new task.

A technological change quite frequently includes a change in role for the employee. He will have new relationships with his peers, his subordinates and supervisors, and with the entire work organization. Interpersonal contacts may become more or less frequent, his status may be increased or diminished, his dependency on his superiors may be more or less pronounced, his opportunities for influencing the performance of his peers may be reduced or enhanced.

And certainly the technological change will be the occasion for increased concern with the worker's relationship to himself. He will have and will develop attitudes about his adequacy to perform in the new situation, his career plans, the significance of his own contribution to the work process, the meaning of his task, the expression of his abilities or talents or interests in the new task, and his preference for certain kinds of activities.

These are the ingredients of research design if we focus on the phenomenology of change.

As possible individual determinants of differences of perception, expectation, attitudes, and beliefs about the meaning of the change, we can look to personality theories and to individual work histories. In the field of personality theory, the current work on mental rigidity and flexibility offers promise.[2]

But another class of variables offers more promise to the researcher who wants, ultimately, to be able to describe ways in which response to change can be affected. If it were shown that personality differences are related to differences in adaptation to change, it is unlikely that any large-scale effort to adjust personalities would be in prospect. Only selection and placement practices might be influenced. But the other class of variables, the social psychological variables of organization, offer the promise of providing understanding that can lead to improved management practices that are always subject to revision.

These organizational variables can be grouped roughly into six classes corresponding to recognizably separate theoretical developments in industrial social psychology. They originate in attempts to understand: (1) hierarchical control, (2) role, (3) communication, (4) supervisory climate and leadership, (5) small groups, and (6) organization.

I am not suggesting that there is coherent theory in each of these areas or that the variables that authors use in each are unambiguously defined. Rather, I am presenting them as a useful oversimplification of what seems to be reflected in current writings of many industrial social psychologists.[3]

Nor are they mutually exclusive in theoretical development. Development of role theory necessarily involves concern with communication, leadership, and small group processes. And, if it is applied to complex structures, it leads to concern with hierarchical control and organization. Rather than spell out how these theories are developed, in the next section I will illustrate their usefulness in aiding understanding of technological change by reviewing some recent empirical studies.

In stressing the study of the phenomenology of change, I did not intend to propose that the theory and methods available cannot be used in studying employee behavior as well as his attitudes, perceptions, beliefs and expectations. On the contrary, phenomenology is studied as a basis for understanding employee performance and adjustment in the work situation. Independent measures of productivity, absenteeism, quality, and a variety of objective indexes can be correlated with phenomenological data.

In brief, the approach outlined can be stated in this way: Employee response to technological change, as reflected both in performance and in attitudes, expectations, beliefs and perceptions, can be studied, fruitfully, as a possible product of variations in individual personality and as a possible product of variations in six classes of organizational variables derived from developing theory about hierarchical control, role, communication, supervisory climate and leadership, small group process, and organization process.

If this proves to be the case, such studies could lead to prescriptions for the more systematic management of organizations undergoing technological change.

Selected Studies of Industrial Change

In the limited number of published reports on empirical studies of employee response to technological change, or even the some-

what larger group of discussions not based on empirical data, much of the emphasis has been on understanding resistance to change. This approach is best illustrated in the reports of a series of studies done by students of the late Kurt Lewin.[4] In the 1940's, Alex Bavelas, J. R. P. French, Jr., Lester Coch and Alfred Marrow, among others, took advantage of an opportunity to study a typical problem of technological change.[5 6] In a clothing factory that worked on relatively short manufacturing cycles in which different garments were processed, there was a characteristic lag in individual worker productivity after each production change. It was the assumption of the researchers that this lag could be reduced.

Alternative methods of introducing changes were tried, systematically, and the authors report that in those experimental groups in which the actual change operations were jointly devised by workers and management, production lag was less than in groups in which the workers were told what the changes would be, or were involved only in discussions of the proposed changes. Not only was production lag overcome, but ultimate level group productivity was reported to be higher in the experimental group as compared with the controls.

The authors analyze the data in terms of the resolution of a complex of forces toward and against change. Effectively, these forces are operating within the individual worker and expressed in his ultimate response to the change. The studies assume forces against change and a pervasive resistance to change. No evidence about the phenomenology of change is included in the study reports.

This work is perhaps the most provocative and stimulating among the current technological change studies. It maintains continuity with the pioneer work of the Harvard group under Elton Mayo, who demonstrated the feasibility of designing experimental studies of worker performance within the industrial setting and pointed to the importance of group processes in establishing, maintaining and altering individual worker standards of performance.[7] It goes beyond the Western Electric research in proposing a theoretical scheme for understanding the response to change and in setting up an initial classification of kinds of relationships between workers and management that might be expected to result in different responses to change.

In its emphasis on resistance to change, it suggests the possibility of a complementary construct of readiness to change, but the study reports do not deal with this kind of construct. Nor is

there any evidence of objective measures of worker expectation, perception, belief or attitude about change. The data are all at the level of descriptions of what management did in introducing change and objective records of worker performance. Referring to the theoretical schemes proposed in the introduction to this paper, this research reflects a concern with theory about group process and leadership styles or supervisory climate.

Studies reported by Fleishman, as part of the investigations of leadership under the direction of Carroll Shartle at Ohio State University, also focus on the factors in the group situation that tend to reduce the likelihood of change taking place.[8] Parallel studies are reported by Hariton, under the direction of Mann, working in Rensis Likert's Institute for Social Research at the University of Michigan.[9] In the Fleishman-Hariton investigations, typical foreman-training programs were studied. Worker and foreman attitudes were studied before, during and at periods after foremen had left their work situations to take part in foreman-training schools. In both sets of studies, it was assumed that the training program was intended to change foremen's attitudes and behavior. The data show that there is change of verbal expressions of attitude during and immediately after the program, but that both foremen and workers report that there is much reversion to initial foreman performance and attitudes when the foremen return to the work situation.

The interpretation of these findings is that forces in the work situation do not allow the foreman to practice the behaviors nor to reinforce the attitudes he has learned in the school situation. As a student, he is free to change. As a foreman, he is less free because of work pressures and supervisor and worker expectations.

Again, as in the Lewin studies, the emphasis is on resistance to change. There is no analysis of readiness and no extended discussion of successful change. Referring again to the theoretical scheme proposed in the introduction, these studies introduce a concern with theories about hierarchical control, role, group process and leadership.

Lieberman's study of role change and attitude change, done in the Likert program, provided some of the first data from an industrial setting about the relationship between roles and attitudes.[10] As in Newcomb's study of changes over time in students' attitudes as they moved into and through a college environment,[11] Lieberman studied worker attitudes over time as changes oc-

curred. He first questioned a cross-section of employees about their attitudes toward union and management. Then, a year later, when some had been promoted to foremen and some had been elected as stewards, he administered questionnaires again. And, six months later, when some of the recently created foremen and stewards had been returned to rank-and-file status, he administered questionnaires a third time. His findings were that attitudes of prospective foremen and stewards were not markedly different prior to the role change. When they had been in their new roles for a time, they expressed significantly different attitudes. And those who returned to worker status tended to express attitudes like those of other workers and like those they originally expressed before their role change. Lieberman found no statistically significant relationship between expressed interest in making the role change and subsequent attitude changes, largely because so few persons indicated an interest in making the change.

In terms of our theoretical emphases, Lieberman has made a contribution to role theory as a basis for understanding employee response to change.

Morse and Reimer moved directly to the study of hierarchical control in their experimental analysis of the determinants of employee performance and adjustment in complex organizations.[12] Working in the Likert program, they attempted an experimental test of the Lewin-type hypotheses about worker involvement in decision making. In a large organization with a number of parallel and equivalent work departments, they systematically introduced two types of change. In one set of departments, they created the conditions for greater concentration of control in the staff functions at the top of the organization. This meant introduction of more detailed accounting and control procedures related to individual worker productivity. In another set of departments, they created conditions for more and more control being vested in the lower levels of the organization, culminating in first-level work groups making decisions they had not previously made. These changes took place over a period of 2 years. In that time, there was a series of attitude-measurement studies, and continuous records of individual worker productivity were kept. As a gross summary of findings, the authors reported that productivity increased in both sets of departments, but not at the same rate, and that worker satisfaction decreased in the more tightly controlled departments and increased in those in which workers had more voice in decision making.

In addition to the variables of group process and leadership style used in the Lewin studies, the Morse and Reimer research made explicit use of theory about hierarchical control in understanding employee response. Their study design did not include an emphasis on the study of change, as such, but their interpretations and findings were directly related to a change analysis. Working with them, Tannenbaum produced data about the relationship between personality factors and productivity and attitudes that would allow a response-to-change interpretation.[13]

Quantitative experimental studies of response to change in the industrial setting that illustrate the use of theory about communication and theory about organization are not to be found in the literature I have examined. However, there are four sets of research reports that suggest the components of such studies.

The first is the report of a method for analyzing the communication structure of a complex organization, by Weiss and Jacobson.[14] They approached the problem of describing the communication network in a governmental agency through the use of a modified sociometric technic. This work represents an attempt to set a basis for classifying kinds of communication patterns in large organizations and for obtaining evidence about them. The communication data are then related to employee attitudes and organization function. Mellinger has applied this method of analysis to investigate the relationship between communication and employee attitudes in another governmental agency setting.[15] Both of these studies were single-measurement operations. If such investigations were repeated, over time, they could furnish some of the data necessary for a study of the relationship between communication and employee response to change.

Three groups of investigators are providing valuable case materials that illustrate the organizational theory approach.

Scanlon, and Krulee reporting on Scanlon's work, have accumulated case-study material on a method for introducing wage systems that involve the entire work organization.[16] [17] The method consists of establishing work committees at the operating level that take an active part in establishing, maintaining and changing wage systems. They do this through a group of committees above them that ultimately involve the entire organization. Scanlon and Krulee develop theory for understanding how this process facilitates the change to new wage systems. Although this material does not give quantitative estimates of employee response, it does provide objective reports of work-process observation, and offers

provocative hypotheses about the relationship between styles of work organization and employee response to change.

Jacques' study of organizational change in an English factory is an interpretation of group processes in a plant undergoing change.[18] Jacques reports on the relationships among groups and among roles as the plant moves toward a new system of management. Here, again, although there is only evidence of instructed observation, classes of variables are suggested that would allow quantitative studies of the relationship between processes of organization and employee response to change.

Walker and Guest observed steel mill crews over a period of 3 years as their part of the factory installed and learned to use more highly automated equipment.[19 20] Through systematic interviews and controlled observation, they accumulated a body of data that allow interpretation in terms of time-correlated patterns of employee adjustment to technological change. They describe initial responses to change itself and to newness, ways in which different individuals adjust, ways in which first-level supervision attempts to cope with problems brought about by the changes, and the ultimate establishment of new standards and values. In the analysis, they develop a hypothesis about characteristic responses over time. This material is to be published by Walker and Guest.

Mann and Hoffman have conducted a study of two electric power plants, one more highly automated than the other, to assess differences in employee attitudes.[21 22] They related differences in worker satisfaction in the two plants to differences in size of work force, training programs, shift arrangements, job definition, supervisory climate, management philosophy and other factors associated with changes in technology.

In terms of our theoretical scheme, Mann and Hoffman make a major contribution in establishing operations for measuring the dependent variable, employee response to change. They refer to the set of factors sketched in the paragraph above as including possible determinants of these employee responses.

I have not spent any more time in talking of these studies than the bare minimum necessary to indicate the kinds of variables that are being measured and the kinds of research problems that are being posed. This was purposeful. The quantitative experimental study of technological change has only begun. There are no classical studies that have firmly established productive lines of investigation. Nor are these studies that have given definitive answers

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to the applied change problems. But I think that this handful of studies, all conducted within the very recent past, demonstrate that there is beginning to be a collection of methods and variables and research designs which together will lead to important understanding of the phenomena of change within complex organizations.

A Program of Research on Technological Change

With this theoretical and methodological orientation, a program of research on technological change has begun at Michigan State University. Working within the Labor and Industrial Relations Center, staff from the psychology and economics departments gathered their first data 6 weeks ago. The two principal investigators are a social psychologist and an economist. The economist intends to study the changes in jobs and in job opportunities that occur during technological change. The psychologist is to study employee response to the change and the relationship between that response and some of the variables suggested by the theoretical approaches outlined in the preceding paragraphs.

In the first study, conducted in the home office of a medium-sized insurance company that has just installed an IBM 650 Computer, all levels of employees—approximately 240 nonsupervisory and 30 supervisory—below the board of directors filled out questionnaires. Data about perceived effect of the installation of the new equipment, expectations about the future, job satisfaction, and general attitudes toward change were obtained as components of the dependent variable. Measures of tendency toward rigidity as a personality trait are included as an intervening variable, and measures of leadership practices of supervisors and communication practices of the company are obtained as possible determinants of differential response to change.

The questions about supervision focus on possible differences in style of leadership that might be hypothesized to result in different employee readiness for change. It could be expected that some styles of supervision would result in employee apathy about company policy, others would result in hostility toward company-initiated change, others would result in readiness to accept change.

The analysis of this first study has only begun. It is intended that succeeding studies in this series will be conducted in some sites that replicate the design above, and that others will be done in heavy industry and will include additional variables.

Conditions for Organizational Health

In the preceding sections, I have attempted to demonstrate the feasibility of conducting quantitative experimental studies of technological change in functioning complex organizations. Now, perhaps, it is in order to talk about a point that might have been raised earlier: What are some implications of this kind of research for those interested in the mental health of employees and the functional health of organizations?

It must be clear that this approach conceives of the work situation as embodying continuous change, made more dramatic during periods of rapidly advancing technologies but always present in the complex organization. People are moving into and out of the work situation and moving laterally and vertically within it. Jobs and roles are being created, altered or eliminated. Supervisory styles are changing and new generations of supervisors emerge or incumbents are replaced. Communication networks are being established, used, or abandoned or altered. Work processes are in flux.

Correspondingly, changes within the individual alter his relationship to the organization. The relatively new, relatively young employee just learning to perform is different from the mature, fully contributing employee who, in turn, is different from the employee approaching retirement age. An industrial psychology based on assumptions of unchanging organizations and unchanging individuals is less likely to provide understanding of the conditions for a healthy relationship between the individual and organization than a psychology concerned with change.

In the traditional approaches, a healthy organization is said to be one in which the organization is capable of performing its functions efficiently in terms of maintaining quantity and quality of output, and is capable of maintaining its organizational integrity—that is, it can attract and retain the appropriate personnel and keep them reasonably contented. But in addition to those criteria, if it is granted that change rather than non-change is the characteristic organizational state, the criterion of the organization's ability to meet internal and external demands for change must be added.

But even with this addition, it could be conceived that the desirable condition of an organization is static equilibrium. And that, correspondingly, the healthy relationship between the organization and the individual is one of equilibrium. Rather than that, a fourth criterion for a healthy organization could be that it is capable of development and that it is capable of providing a work

environment in which the individual has an opportunity for expressing his potential for development while working toward organizational goals.

It is in the context of these criteria that a healthy organization can be seen as one that understands its change processes, is capable of assessing and accepting need for change and, most importantly, is capable of facilitating change when it is appropriate and of anticipating what effects the change will have on the people in the organization. It is the purpose of the research discussed in this paper to disclose to what extent the meeting of these criteria depends on systematic differences in hierarchical control, role relationships, supervisory climate, communication structure, subgroup organizations and total organization process.

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DISCUSSION

Captain Hilmar, Office of The Surgeon General, Department of the Army: I have a question which I think can be directed to both Dr. Argyris and Dr. Jacobson. Dr. Jacobson spoke of organizational health and Dr. Argyris' comments were somewhat along the same line. I have the feeling that organizational health, the epitome of which is reflected in Dun and Bradstreet ratings, may in many cases come in conflict with the welfare of the individual involved. In the past we have had safety legislation regarding conditions in mines, in factories, shorter hours for women, and so forth. I have the feeling that, in order to achieve the ends that psychiatrists and psychologists seem to seek, an outside influence in the form, perhaps of legislation, is required, pretty much in the same way as was required for the implementation of satisfactory safety precautions. This is probably the only way we can hope to preserve the individual's health, not simply against catastrophic psychosis but in terms of full enjoyment of life.

Some means probably will have to be provided to protect workers against the expedients to which management may in some cases be forced in order to preserve what Dr. Jacobson calls organizational health. I think in this respect that management is not capable of using psychiatrists freely for the welfare of the individuals concerned. Although this might be possible in good times, in general, there might be a very real conflict between so-called organizational health and the health of the individual workers involved. This is, I think, the crucial question to which we must direct ourselves. The same thing of course occurs within the Armed Forces. There are needs that the Armed Forces must meet and we certainly consider individuals important aspects and important implements in accomplishing this mission. However, in any large formal organization, the Armed Forces included, the individual becomes an instrument and not an end in himself. I don't think you can assume that organizational health will automatically subsume individual health and I would appreciate any comments either of you gentlemen care to make.

Dr. Jacobson: Of course, this is the central question. That is, is there a fundamental paradox, a fundamental dilemma between meeting the needs of the organization and meeting the needs of the individual? I think that you can best approach this question by asking yourself: Is there any situation in which a socialized individual is not in fact a part of some sort of organized behavior? That is, isn't the essence of socialization some sort of integrated relationship with other people? Your formal organization is an easy object to observe. You can describe it adequately, you can

observe it intact, you can say to yourself, "All right, here is something that is capable of being questioned." I think that the same sort of question can be directed to all individual activity. Every action of the socialized individual is to some extent restricted by the needs of the larger organizations of which he is a part, whether it be the family, the community, any one of the appendages of society that has caused this individual to be socialized.

The answer then apparently lies in this direction. It is not a question of whether the goals of the organization are going to be paramount or whether the goals of the individual are going to be paramount. The question is: What kind of relationship between the individual and the organization is going to be one that allows the individual most adequately to express himself while at the same time being a socialized individual? I think that that is the basic question, and I believe that through a study of organization it is possible to describe those conditions under which the socialized individual is perhaps not only conforming but also becoming more a person through the process of socialization. That is, an individual doesn't exist really outside of the social context—if he does he's pathological. Right then, your individual within the social context becomes potentially more of an individual in the process of being a part of a socialized milieu.

Dr. Argyris: I would like to make one comment there. I was going to say "Amen," I agree with Dr. Jacobson, up to a point. I would like to at least emphasize, I think, a different point of view, namely, I do think there are some fundamental conflicts. There are also some differences in that in an organization, as Dr. Jacobson's data have provided, the people do not have control over their lives. It's in someone else's control and it becomes a very important function for management or for any administrator to take a look at this. I think there are times in which the individual's health will be opposed to the organization's health. We have to find out what are these times. Individuals will always try to maximize their health and I don't think they can in an organizational situation. We have to find out what is optimum and this is to me a very thorny question. The Dun and Bradstreet indexes of health are certainly not what I call organizational health, because I think I could make a case for absenteeism and so on as not necessarily being bad things. That is, accidents may very well be good things. For example, I'm not against resistance to change. It is possible that resistance to change may be a very healthy thing and under certain conditions we may want to help administrators become as creative in resistance to change as workers

have become for many years. So, I think there is this basic problem. I don't have a solution to it.

I'd like to say that one other sign of health is the executive's willingness to take a look at himself. There are 58 schools of executive development in the United States. Quite apart from whether they teach anything or not, executives are going to them and paying money. They are willing to take a look at themselves. They are willing to take a look at their biases. Find me one school for professorial development in the United States. I'm not worried about the executive.

Dr. Jacobson: In addition to the executives' willingness to examine themselves there must be the organizational willingness to examine itself, to review its own work processes continuously and its own relationship to the people in the organization.

Dr. Guze, Washington University, St. Louis: I would like to ask both Dr. Argyris and Dr. Jacobson whether they know of similar studies or analyses which might pertain to organizations other than industrial. I'm thinking in particular of educational systems, and in particular of universities.

Dr. Jacobson: Well, Dr. Argyris has recently done a review of the literature so he is thoroughly familiar with this work. Let me simply say that the unions are beginning to do this kind of study, that recently there have been some studies of four locals of the rubber workers' and the automobile workers' unions designed to determine how styles of leadership within the union are reflected in the individual union member's relationship to his larger organization. There have been relatively few studies in educational institutions. There have been some studies in social work groups and there have been other studies that Dr. Argyris will be more familiar with.

Dr. Argyris: There are studies going on in hospitals, also. There are a few studies going on in the educational institutions but if you mean in terms of this problem of the organization versus the individual, I don't know of any. Dr. Butler, I hear, does and he'll mention one. The Military, I hear, is beginning to get interested in this.

Dr. Butler: In the April 1956 copy of *Mental Hygiene* there's a report of a school district in California that finally came to the point at which they had the money to hire a mental hygiene team, a psychiatrist, a psychologist and a social worker. They were delighted, all the teachers immediately lined up all of their problem cases for referral to the clinic team. The clinic team said, "Wait a minute, we want to do a few things. We want to look at the

structure of the schoolrooms. We want to help you examine the milieu in which you are teaching." They said, " Fine, let's set up a seminar for some week-end and hurry and get that over with so that we can get on with the job of referring these people on to you." The team insisted that they carry them along for one year with workshops continuing throughout the total year with school administrators, principals and teachers together, and looking at organizational structure and function. At the end of the year they had one case referred to them just for consultation.

Dr. Guze: Based upon the effect on the teachers? That's what I had in mind.

Dr. Butler: This was based upon the effect upon the teacher, the school organization and administration, and it did have this effect that we are talking about.

Dr. Argyris: I forgot to mention, about 2 months ago I was at the National Institutes of Health. They are starting a very long-range program exactly in this area.

Question: I think it's very important for us to include consideration of one other aspect of this problem. That is, when we think of the health of the organization and the health of the individual, to some extent we may be expressing value judgments to which we're all becoming very sensitized in this meeting. I think that the goal or the mission of the organization is a very important problem, particularly to military organizations. There are times when the mission will take precedence over all other considerations even to the great disadvantage of all members of the unit. Now, we should be concerned with the nature of the relationships which exist and what it costs an organization in terms of a burden upon its members to accomplish certain tasks rather than simply to say that the object of our study is to have the healthiest organization and the healthiest members and so forth.

Dr. Jacobson: Yes, it certainly is true that this problem of the optimum relationship between the individual and the organization is only a meaningful problem when you conceive of the organization as being ultimately engaged in something that is potentially healthy. If the organization is engaged in something that is, in terms of values, not healthy, then there's no possible healthy relationship between the individual and the organization. There's no way of arguing against that.

PROFESSIONAL PERSONS IN BUREAUCRATIC ORGANIZATIONS

DAVID N. SOLOMON, PH.D.

Our social life is to an increasing extent dominated by bureaucratic institutions. While bureaucracy was formerly reserved as an epithet for governmental bureaus; today, schools, churches, universities, hospitals, industry, recreation, in fact almost all institutions except the family, are organized in the bureaucratic pattern. The rapid increase in scientific knowledge and its technological applications has been no less spectacular. As a result, the specialized professional expert is essential to society in general and to bureaucratically organized institutions in particular. Increasing size and complexity make both professional specialization and bureaucratic organization indispensable.

By definition, professionals and bureaucracies are incompatible. In principle, professional codes and bureaucratic organizational codes are mutually exclusive. They cannot coexist. Nevertheless, professionals perform a variety of roles in bureaucratic organizations. The incompatibility in principle, in practice results in a number of strains or dysfunctions. The task of this paper is to review the dysfunctions that have been reported and the institutional and social psychological adaptations which are appearing as bureaucratic organizations attempt to improve their operations by employing professional persons, while professionals on their side learn to adapt their careers to the bureaucratic situation.

The paper is in three parts: (1) the incompatibility of professional and bureaucratic ideologies, (2) the strains arising from incompatibility, and (3) the processes of accommodation and adaptation.

INCOMPATIBILITY OF PROFESSIONAL AND BUREAUCRATIC IDEOLOGIES

Professions and bureaucracies are institutions in the sense that they consist of sets of rules of behavior which guide the conduct of members in all relevant situations. If we focus our attention on the idealized norms rather than on actual behavior, a

number of inconsistencies between the two normative orientations become apparent.

The Legitimation of Authority

In bureaucratic organizations, authority is legitimated by the positions held by the various parties, rather than in terms of personal qualities, such as, for example, technical competence or affability. Every superior has the right to expect that subordinates will obey him, and the obligation to obey his superiors.

The subordinate "holds in abeyance his own critical faculties for choosing between alternatives and uses the formal criterion of the receipt of a command or signal as his basis for choice." [1]

The notion of authority is not central to professional ideologies. The professional expects to defer only to superior professional knowledge and competence. While in the bureaucracy the superior has the "right to the last word" [2] because he *is* the superior, in professional matters the last word goes to the one who has greater knowledge or experiences, more convincing logic or experiments, and the like. In particular, professionals justify their reluctance to take orders from laymen on the grounds that they are ignorant within the area of professional competence.

Thus in the one case the notion of authority is central and is legitimated in terms of the relative positions of the individuals concerned, while in the other it is not a central concern and is legitimated in terms of professional competence.

Organizational Loyalty and Loyalty to Clients

The central and distinguishing norms of professional behavior define the obligation of professionals always to serve the best interests of their clients. The professional is expected not to attempt to get the better of his clients, as is the case in other relationships, but rather to give the best possible service to all clients, wherever and whenever they require it, regardless of any other considerations.[3]

In the case of bureaucracies, the expectation, of course, is that the bureaucrats will choose courses of action which further the interests of the organization and will refrain from behavior which is inconsistent with organizational goals.

The Requirement for Disciplined Behavior

There are two aspects to the achievement of the highly disciplined behavior required by the normative orientations of

professions and bureaucracies. First, there must be a system of rewards and punishments which are applied (a) through formal, official acts, such as when an organization grants or withholds promotion, or when a professional association accords honors, or reprimands or disbars members; and (b) informally, during the daily interaction of small groups of bureaucratic or professional colleagues.

Second, sanctions are necessary but not sufficient. Disciplined behavior also rests on individual self-discipline, that is, on the internalization of the appropriate norms. Professionals and bureaucrats must develop conceptions of themselves as persons who are obligated to behave in certain ways.

> Discipline can be effective only if the ideal patterns are buttressed by strong sentiments which entail devotion to one's duties, a keen sense of the limitation of one's authority and competence, and methodical performance of routine activities. The efficacy of social structure depends ultimately upon infusing group participants with appropriate attitudes and sentiments. . . . there are definite arrangements in the bueaucracy (and in professions) for inculcating and reinforcing these sentiments.[4]

Competing Reference Groups

If we think of individuals as referring for guidance in behavior to groups towards which they feel some sentiments of attachment, then it is clear that a professional in a bureaucracy is confronted by two such groups, each of which demands that when there is some conflict, its own peculiar norms shall be given precedence.

TENSIONS OF PROFESSIONAL ROLES IN BUREAUCRACIES

In principle, then, professionals and bureaucracies are incompatible, and the professional in a bureaucratic situation is at best an anomaly.[5] In practice, however, professionals perform a variety of roles in and around large organizations, but the essential incompatibility between the two results in a variety of tensions, some of which are discussed in the pages which follow.

Relations with Clients

The independent professional determines the fee to be charged for his services, serves many clients, and can always afford to lose a few. The employed professional may serve numerous clients, but even if he does, his employer sets the fee for services, and the professional receives a salary which is determined by the operation of the labor market in which he offers himself. This

is by no means the whole story, but it suggests a crucial aspect: The employer is a powerful intermediary between the professional and his clients, and the professional may frequently have to choose between the interests of employer and client. It must be the rare battalion medical officer who, in a doubtful case, has not pondered whether to declare a man unfit for duty and risk the ire of his commanding officer, or to satisfy the commander and take the risk with the man. Similarly, scientists think they ought to make all findings freely available to the public. Their employers, industry or government, frequently insist on secrecy.[6] "The school teacher, for instance, can be devoted to his pupils. But he is limited in what he can do for them, since he must follow his employer's views on the matter or lose his post." [7] In short, the presence of an employer creates the possibility of conflict between the demands of the organization and of professional ethics with respect to clients.

Relations with Colleagues

Just as the employer tends to become an intermediary between the professional and his client, so also he tends to stand between the professional and his profession. Sometimes because of the insistence on secrecy, but frequently for other reasons as well, there is little publication or other outside contact, and the profession loses the ability to appraise professional competence. Many employed professionals must in fact be unknown to their colleagues on the outside and therefore have no real professional standing whatever.

The employer thus becomes the sole authority in appraising competence, and since he also controls the system of rewards and punishments, he is in a much better position than the professional group to indicate what kinds of performance are preferred and which are undesirable. Moreover, the daily informal associations of employed professionals are often mainly with nonprofessionals or with other isolated professionals; and consequently, professional norms and the professional self-conception lack the support of both formal and informal interaction with colleagues.

Power Struggles

Professionals in large organizations are often engaged in power struggles with managers, other professionals, and sometimes even with clients. Clients have little power vis-à-vis the

independent professional except, of course, that they may look elsewhere for service. However, when the professional is part of an organization, clients may discover ways of bringing pressure to bear. Schoolteachers are sometimes threatened by parents, particularly upper-class parents who are likely to be persons of power and who may complain to higher authorities about the teacher. The teacher has to rely on her own ingenuity as well as on the support of the principal, which sometimes may not be forthcoming.[8] Patients in veterans' hospitals sometimes appeal to the Legion when they consider that their rights are being infringed. The Legion then brings pressure to bear through politicians who can appeal directly to the governmental department concerned or, worse still, raise the question on the floor of the legislature.[9] In still other situations there is the possibility that dissatisfied clients will complain to management. The employed professional thus loses a good deal of the independent professional's immunity to pressures from clients.

Professionals, like others, frequently have mobility aspirations, but since they are isolated from professional channels of advancement and also may find it difficult to shift from one organization to another, their whole stake may be invested in the promotion opportunities of a single organization. This brings them into competition for scarce positions, both with managers and with other professionals who wish to demonstrate that their specialties are the most important to the organization. The conflict is aggravated by personal differences between the professionals and others. Professionals are likely to be younger,[10] and although they have more education than the managers, their origins may be in lower social classes.[11] Mobility aspirations, personal differences, and the generally weak power position of the professionals may lead them to strive more anxiously for promotion than even the managers.

Partly for reasons of this sort, and also because they wish to preserve their autonomy, professionals may seek to occupy positions of power in the organization, sometimes at the expense of other professionals. Those who are most anxious for power may be the more willing to accept management orientations and consequently the more likely to be appointed to positions of power. This drives out others who may be resistant to management or more committed to professional ideology, and thus changes the character of the organization, usually from "basic" research to a more applied program.[12]

Since professionals ordinarily are by definition not part of the

"line" of authority, they can only advise managers who are not obliged to accept advice. Management frequently seems reluctant to accept what appears to the professionals as good advice. But the professionals have a trump card to play in this struggle. Managers are frequently unavoidably ignorant in the area of the professional's competence but are by definition responsible for everything. This places the manager in the position of a "Jack-of-all-trades and master of mone." [13] Specialists were in the first instance introduced to overcome this deficiency, to be an extension of the skills and knowledge of managers.[14] But some unanticipated consequences occur. Professionals sometimes use this ignorance to buttress their own power and privilege.[15] The managers thus feel threatened by the new men of knowledge they have introduced [16] and, at the same time, guilty about their own deficiencies,[17] and consequently sometimes wish they had let well enough alone and not sought expert members of their teams.[18]

The result of these power struggles is that professionals generally have lower prestige than "line" authorities and sometimes even are viewed with suspicion. The specialist's loyality is impugned. He does not have "the sound judgment, the broadened view" [19] and is suspected of using the company as his laboratory or, worse still, his guinea pig.[20] The expert is not regarded as a "company man" until he is willing to hide his Ph.D. and protest his loyalty by making only managerial noises.[21] Gouldner's reference to professionals who have moved into management as being "renegade experts" [22] suggests the conflict of loyalties that is involved.

The professional is thus very much in the position of Simmel's stranger. He is valued because he is detached, but he is suspect because he does not fully belong.[23]

Bureaucratization and Professional Careers

From the point of view of the professionals, the most serious changes are those which involve the professional career itself. Like many others in a bureaucratized society, professionals are no longer free enterprisers in the sense that they operate their own businesses, build clientele by their own efforts, or establish reputation among colleagues by demonstrating competence. The professional has been transformed from a free entrepreneur into the incumbent of a bureaucatic office.[24] Success thus becomes a matter of climbing the steps of a bureaucratic hierarchy. One has to get on at the bottom of the escalator and stay on long enough to be carried as high as one cares to go. Frequently there

is a ceiling on success unless the individual is willing to abandon his profession and become a manager. In this context, ultimate success depends not on professional competence but rather on managerial "human relations" skills, that is, on behaving in ways that are effective or acceptable to subordinates and superiors.[25]

The premium on managerial skills applies to other types of personnel as well, but although they lack the initial advantages which specialized competence gives to the professional, they are not handicapped by the professional ideology which emphasizes professional competence rather than managerial skill as the proper criterion of success. The professional has somehow or other to reconcile professional and managerial notions of success.

The Professional Self-Conception and Professional Roles

The preceding sections indicate that there are a good many possibilities of conflict between professional and organizational codes. To the extent that the professional code tends to be internalized, the conflict is one between the professional's self-conception and the actual roles he is obliged to play. A good deal of what is involved can be summarized under the heading of "autonomy."

Since the turn of the century, if not earlier, only a minority, one-quarter to one-third, of professional persons have in fact been self-employed, independent practitioners.[26] Nevertheless, many think of themselves as having the right to be autonomous, at least within the sphere of their competence. They conceive of themselves as self-determining persons who choose their own problems, work on them in their own way, set their own hours of work, and need competence and knowledge.[27] They are willing to accept superior knowledge or "logic" but are reluctant to subordinate themselves to institutional authority.

However, in most organizations their actual status is inconsistent with this self-conception, and they are in fact subordinate to incumbents of superior offices who frequently are laymen and thus by definition incompetent in professional matters. The dilemma can be simply stated: Professionals see themselves as persons who are, or ought to be, guided by professional considerations, while in fact they are guided or threatened by superior organizational loyalty.[28]

Summary

These considerations suggest that life in a bureaucracy is likely to put great strains on the professional self-conception. The

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indoctrination of the professional during his training seems inconsistent with the roles he is likely in the future to play in large organizations. While managerial ideology has taken account of bureaucratization, professional ideology has not. On the other hand, there seems to be no real place in managerial ideology for the ideal type of professional. Consequently, there is likely to be an uneasy tension between managerial authorities and professional specialists. The professional is driven or tempted to abandon his professional identity; but whether he does so or not, he threatens to usurp some of the power of those who invited him into the house in the first place.

THE RESOLUTION OF STRAINS

Large numbers of professionals, the precise number depending on how rigorous a definition is applied, are performing various roles in bureaucracies. The increasing need for specialists and the trend toward bureaucratization of almost all activities will undoubtedly continue. In view of the incompatibility in principle and the tensions which arise in practice when professionals are introduced into bureaucracies, what indications are there of the ways in which these tensions are likely to be resolved or reduced? Two major lines of development are indicated: (1) In some cases there have been massive changes in the structure of organizations; and (2) many professionals are developing roles and role conceptions which are at least not incompatible with the demands of bureaucratic organizations.

New Organizational Structures

While hospitals are perhaps to some extent atypical, they do give some indication of one possible line of accommodation. The maneuvering of physicians to keep from coming under the authority of the laymen who constitute the administration of the hospital has resulted in

> the emergence of two competing chains of command. One of these proceeds from the superintendent of the hospital down through supervisors of nursing, of the kitchen, of the housekeeping staff, of accounts, and so forth, and provides a system of orders, and of accountability, from the top to the bottom of the organization. On the other hand, the hierarchy of the doctors stands completely outside this structure. The doctors have their own hierarchy. . . . No person in the administrative hierarchy gives commands to medical staff members. And though doctors do give commands to those in the administrative hierarchy, they do it in an almost unique way.[29]

The doctors thus preserve their professional self-conception and status intact, although others, nurses for example, are not so successful. The need for members of one hierarchy to give orders to members of others remains a source of tension, indicating that further emergence of new patterns is to be expected. The place to look for further adjustments may well be, as Hall intimates, the pattern of relationships in the small "teams" responsible for patient care on the wards and elsewhere. There are some indications, for example, that the modern operating room is not to the same extent as formerly a situation dominated by one great figure of authority and skill, but more one in which the diverse skills of a number of near-equal specialists are coordinated.

In some mental hospitals, changes justified in terms of "new values in psychiatry" appear to be having similar effects on authority systems. It is reported that ward physicians are being relieved of administrative duties, given more autonomy, and encouraged to "give greater attention to the making of integrated teams of workers," including nurses, social workers, psychologists, and the like.[30] While these various workers are not of course equals, and one frequently hears of divisive tensions, nevertheless, the concept of the *working team* is different from the notion of integration around a central authority figure, or domination from the top of a pyramid. It remains to be seen how effectively these new concepts will be worked out.

Something similar appears to be occurring in certain military and industrial organizations. In some cases, research has been organized *as a function* in a separate hierarchy under a vice-president, who has equal status, at least on paper, with vice-presidents in charge of other functions such as sales, production, and the like. While the scientists are of course oriented to the demands of the organizational "users" of scientific productivity, they by no means accept all the problems offered to them; they preserve a degree of freedom to originate research, to publish, to attend scientific meetings, and generally to participate in the life of their professions. In theory at any rate, they report not directly to "users" but rather up through the scientific hierarchy. Since this is a hierarchy of scientists, the basic conditions of life are established at least to some degree by the professional organization operating as part of the larger institution.

These scientific organizations sometimes include the administrative specialists necessary to conduct their own affairs: personnel, pay, purchasing, and the like. Alternatively these func-

tions are performed for them by the existing branches of the organization. In either case, these administrators are likely to be subject to company rules governing terms of employment, the ways money can be spent, the purposes for which money can be spent, and the like. In government organizations, the administration of research organizations must of necessity come under much the same rules as govern all hiring, promotions and, in particular, spending. Moreover, many of the scientists in the hierarchy are scientific administrators; their skills are administrative rather than professional, and administrative positions bring more pay, prestige and power. The scientific administrators therefore frequently tend to become oriented more towards the administrative criteria of their organizations than to the interests and standards of their professions.

Whether by intention or not, the independent hierarchy works to preserve the autonomy and prefessional character of the scientists. But the control of administration in terms of outside standards may result in a loss of some of the gains arising from the new structure. While a parallel hierarchy relieves some of the important tensions, clearly its evolution is not final.

New Roles and Role Conceptions

Regardless of whether or not organizations are massively restructured, there is evidence that professionals are working out for themselves roles and role conceptions which enable them to perform adequately in bureaucracies. Leonard Reissman, describing professionals in a midwestern State governmental bureau, reveals four types of role conception.[31] The *functional bureaucrat* is a professional who maintains his professional role and identity intact. He is oriented towards his professional group and away from the bureaucracy, is concerned with the "professional quality" of his work, and "may be portrayed as a professional who 'just happens to be working for the government.'" The *specialist bureaucrat* has similar professional orientations, but he does seek "his recognition from the department and the people with whom he works rather than from like professionals who are privately employed." The *service bureaucrat* is oriented more in terms of the bureaucratic structure, but seeks recognition for his services to some group outside the bureaucracy—handicapped children, for example. Finally, the "*job bureaucrat* . . . is immersed entirely within the structure. Professional skills only provide the necessary entrance qualifica-

tions and determine the work to be done." Otherwise, he differs little from any other bureaucrat.

Marvick reaches similar conclusions in a study of career perspectives of personnel of a Federal agency carrying on a research-coordinating and research-subsidizing program for the national defense establishment.[32] Three career types are described: *institutionalists,* almost all of whom were not professionals in the first place, and whose entire orientation is that of the organization; *specialists,* slightly more than half of whom are professionals to the extent that they have higher degrees, and most of whom tend to maintain their professional orientations more or less intact; and finally, *hybrids,* less than half of whom have higher degrees, and who seem to have neither a professional nor an organizational orientation, but whose behavior is governed mainly by consideration of what courses of action will be most beneficial to their own individual careers.

A small number of exploratory interviews from a preliminary study of young Ph.D. chemists employed in pharmaceutical research laboratories suggest similar findings. Some are oriented one hand in industry, and the professional people on the other, aspire to be "group leaders," that is, to direct or lead the work of several younger Ph.D.'s, much as a professor might lead a group of colleagues or students. Still others, although they would like to escape from the "bench," have more modest aspirations and want only to continue to be involved in research. The first type have a relatively high level of aspiration and face with equanimity the prospect of abandoning their profession if it will bring promotion, prestige and pay. The second type have a more moderate level aspiration and are concerned mainly with achievement in their field of competence and also of course with the intrinsic interest of the work. The third type has similar aspirations with respect to pay and promotion, that is to say, quite modest ones by comparison with the first type; but rather than scientific achievement, they tend to give the major stress to the intrinsic interest of the work, and are content as long as they feel that pay will be moderately good and that they will be able to continue to do interesting work. Our interviews have not as yet included any who started at the "bench" and are now in management.

In none of these three studies is it clear to what extent persons with formal professional qualifications start out with a professional orientation which is modified during the course of organizational experience or to what extent those with different types

of role conceptions were different types of persons initially. The visible and formal marks of professional status may conceal quite different orientations. Presumably, both types of thing are involved: People enter with different orientations and change in different ways.

This leaves a number of unsolved problems for both professions and organizations. To what extent are the role conceptions, inculcated during professional training, inconsistent with the available roles? If organizations value all the types, if not equally at least to some extent, will it be necessary for them to have several different organizational systems of control, incentive and motivation, in order to retain them in the organization and maximize their usefulness? [33]

Professional persons and bureaucratic organizations are thus becoming adapted to each other in two ways, and perhaps also in others as yet unreported. Bureaucracies, like other institutions, although they have apparently rigid and persistent features, are always changing. This is largely because the problems they face in maintaining themselves as going concerns are also shifting, particularly in a society characterized by fairly rapid social change. New ways of meeting problems are continuously being devised, and one of these is the incorporation of new types of personnel and the discovery of workable roles for them within the institution. These processes of change are presumably the mechanisms whereby institutions become better adapted to the environments in which they exist.

FOOTNOTES

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19. Mills, C. W.: *The Power Elite,* pp. 140 *et pass.* Oxford University Press, New York, 1956.
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26. For U.S. and U.K. figures see Mills: *White Collar,* p. 113, and Carr-Saunders: *op. cit.*, p. 283, respectively. See also Canada, Dominion Bureau of Statistics, Ninth Census of Canada, 1951, Vol. IV, Table 11. Queen's Printer and Comptroller of Stationery, Ottawa, 1953. Of the rather heterogeneous set of persons classified as professionals, only about 15 percent were either employers or working on their own account.
27. See, for example, *Human Relations in a Research Organization: A Study of the National Institutes of Health, General Summary.* University of Michigan, Survey Research Center, Ann Arbor, Mich., n.d.
28. Hall, *op. cit.*, p. 462, makes a similar comment with reference to hospital nurses.
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DISCUSSION

Dr. Duhl, National Institute of Mental Health: I wonder whether you would talk a little about what happens to the professional who raises up in the bureaucratic structure in his relationship with his other professional colleagues, and some of the tensions that exist there?

Dr. Solomon: Well, in the institutions with which I am familiar, these people are called scientific administrators. This is an effort to indicate that they preserve a dual self-conception. I think in actual fact, the longer they stay at it, the more difficult this becomes. I believe hat the emphasis is really on the administrator because of the fact that in making their decisions they must defer to the administrators of the organizations, in the case of a government organization to the treasury board, for example, so that they progressively get an administrative orientation. Furthermore, they bye and bye lose their professional competence, because they can't keep up, so they don't know the score. I think they are involved in a position of strain, and they are thought of as renegade experts or renegade professionals. They have to work these things out for themselves, however they can, as far as their subordinates are concerned. It seems to me that they just keep active in the power struggle, and try to get the things done they want to do.

Dr. Frank Tallman: Medical School of UCLA: I would like to ask Dr. Solomon if there isn't a possibility of another level of power struggle, the struggle between the bureaucrats on the one hand in industry, and the professional people on the other, and if this level doesn't have to do with the frame of reference. You often find a professional person going into an industrial situation with the insistence that his competence and his frame of reference and his opinions be accepted because he is a trained man in a given field and therefore has something to maintain and sustain. The bureaucratic organization, on the other hand, has to protect itself from an onslaught that its lack of communication makes it impossible for it to understand. It seems to me that this very often leads to complications and to an ideological power struggle.

One of the problems I think that psychiatrists have in industry is that they can't communicate in an understanding way with the executives. They get frustrated and they feel rather combative, because their knowledge of human behavior is not exactly dealt with in the frame of reference that the psychiatrists expected it to be. Very often, tensions arise because of this. I would appreciate some comments about how you see the problem of the pro-

fessional counselor organizations that work within industry, and their relationship on the one hand to the industry which employs them, and on the other hand to the labor unions which fear them. Here is another power struggle in which the professional person finds himself.

Dr. Solomon: There is a very insightful article by Lyman Bryson in the *Reader in Bureaucracy* edited by Robert Merton, which discusses these problems in a very interesting fashion. The thing that happens here is, as suggested, that when the professional person comes into one of these organizations they want to use him for their own purpose. The purpose that is involved may be one of interest to a particular executive. I suppose we have all had this kind of experience in consultation work: If you make a recommendation which buttresses some reorganization or other that some executive wanted to get in all along, then he says, "That is a wonderful report—that is the best report anybody has done up to now." He takes your recommendations and gets the thing done.

On the other hand, if your recommendations go against the empire-building interests and activities of somebody, then they viciously and bitterly attack your report and shelve it. (We have had both kinds of experiences in our work.) Now, I don't mean to suggest that there is anything wrong with people being involved in the power struggle. That is what you have to do, that's the way the world is and that is what life is like. I think what the professional person has to recognize is that that is what is going to happen. People are going to try to use him. What he has to do is to make his own kinds of decisions, which may be moral kinds of decisions, as to whether he wants to be a part of it or not. But if he is shocked, surprised, hurt and frustrated, which many of us are when this happens to us first, then he just finds out what he has to learn. This framework of the organization, whether it is a union or a company which wants to use the professional one way or another, I think is inevitably the framework with which we have to work. We have to recognize that and accept it. I can's see any way of altering it.

Dr. Argyris: May I just add to the other side that we as professionals also need to use people and manipulate them. I want to talk at least of myself. I have even written a book which I thought was scientific and so on, and as I became more aware of what I was doing to "the person" in the name of science, well —I didn't like it.

Dr. Solomon: This reminds me of some of the studies of

criminals and the like that have been done, in which the sociologists doing the studies have paid their informants. The criminal believes that everybody has an angle. Although these sociologists said they didn't have any angle, their subjects, who were well paid for their autobiographies in some cases, didn't believe this. Well, as Dr. Argyris is pointing out, the criminal, the con man, and other people who were involved were quite right. The sociologists did have an angle—they did have a racket—they were going to publish books. We always do have an angle, and I don't think we should ever feel "simon-pure" *vis à vis* the other guys. We are getting something out of it, too.

Dr. Stanton, McLean Hospital, Waverley, Mass.: I have one question only. In view of the experience of most of the professions, it is suggested that holding one of these double positions, either teacher and researcher, or hospital physician and private physician, or combinations of this sort, may not only lead to strife and tension which has handicapping results, but may at times have creative or very beneficial effects upon the person taking part in this. Is this in accord with Dr. Solomon's views?

Dr. Solomon: Well, it is my notion—and I was going to make this comment earlier when one of the previous questions came up—I don't think this idea that conflict or stress or strain is unhealthy is a valid one. I think we ought to get over that notion that a conflict-free world is what is wanted. Now, conflict can be dysfunctional from the point of view of people who are studying an organization or of those who are studying individuals. On the other hand, it can be functional. One of the things it does is to function to stir up creativity. If you are in a conflict kind of situation, it seems to me that unless you just get out of it, you struggle to find a new way of solving it. Out of these conflicts, it seems to me, what has to happen is that the bureaucrats and the professionals are going to have to work out some uneasy equilibrium. Now it may be one that is full of tension and keeps threatening to fall apart all the time, but then people are going to keep working at it to keep it going. I quite agree with Dr. Stanton.

STUDIES ON EXECUTIVES

PERRIN STRYKER

I am very glad to be here on behalf of *Fortune* to tell you what we have discovered over the years about executives, but I don't stand here as any kind of expert. Journalists are not experts in anything except possibly observation. That, however, can be very useful. It is flattering that this Symposium, at any rate, wants to hear about *Fortune's* findings. Yet as I consider the title of my assignment, "Studies on Executives," I have more or less concluded that it might better have been worded, "Can Executives be Studied?" Seriously, the real studies of executives—what they do, what they think, and what their attitudes are—have scarcely been started.

This morning I will attempt only a brief rundown of some of the areas that *Fortune* has explored in the last 8 to 10 years or so during which we have concentrated rather heavily on the phenomenon known as the executive. We have, as many of you know, tried to identify them. There was a study of about 900 executives *Fortune* made some years ago in which their background, educational training, and company experience was tabulated. The average, typical executive seemed to be a man who was well educated (three-fourths had college degrees) and he was a son of a businessman in the Middle West or East. He had been with his company about 30 years, was between 50 and 60 years old, and earned anywhere from $70,000 to 110,000. This is a very misleading picture, but it is typical of the kind of picture you arrive at when you make an over-all study.

Functions of Executives

A year or so ago we undertook to find out what it is that executives really *do*. In this we employed an on-the-spot survey technic. We went to the town of Charleston, West Virginia, where there are operating divisions of several large companies, and talked to the managers there and also to leading businessmen in the town. We interviewed directly or by questionnaire over 100 high-ranking executives to find out what work it is that an execu-

tive performs. By their own definition, these executives established that their work is complex and really involves five different functions: (1) helping to set the company's objectives and policies; (2) making or approving decisions that can significantly affect profits; (3) coordinating at least several major departments or divisions; (4) maintaining and developing an organization of trained subordinates; and (5) delegating authority and responsibility and controlling performance.

These five functions seem to identify the real executive. It was a combination of all five, not one or two or three of them, that qualified as executive work. This was, we believe, a useful contribution to the understanding of what the executive is. So many people now use that term loosely that the staff man, for example a treasurer, is widely thought of as an executive. But our finding from executives themselves shows that staff men very often do not qualify under this definition. We found also that well-known fact that only the executive in a company can tell who an executive is.

The number of executives in the United States is probably relatively small. By statistical maneuvering we can arrive at a series of estimates, anywhere from 75,000 to over 400,000, depending on how we manage the figures. In any case, in our experience the real executive is an extraordinary man who has been maligned by the portrait of him drawn by Hollywood and by novelists like Marquand and others. Perhaps he is not maligned so much as just misunderstood and badly painted.

The various management problems that *Fortune* has explored include a great many in the field of executive development. There the problems of the *"crown prince"* alone are many. Some executives seem to think that many of the young men going into management today have the wrong attitude. They are considered too impatient for advancement, among other things. But one of the things we discovered, and I am sure it is not new to any of you, was the emphasis they placed on the dseirability of "getting along with people." This was widely held to be the high road to executive success. The great executive trick today is not to drive subordinates but to "motivate" them, "persuade" them. Some of you may have seen at General Electric's big new management school at Croton-on-Hudson the chart that describes in five sections, I believe, the functions of the executive. Down at the bottom of the chart, dropped from the word "persuade," is a small footnote to the effect that "Now and then direct orders are necessary." In our observation, direct orders are not only neces-

sary in management; they are continuous. The executive may have to know how to make orders palatable, but the real job is learning how to make it seem as though the subordinate manager himself is making the decisions.

Delegation of Authority and Responsibility

This led us into studies of delegation of authority and responsibility where we certainly verified the fact that delegation is the most difficult of all executive functions, and the least understood. Delegation has become a catchword primarily because of the recent emphasis on decentralization. In industry today the assumption generally is that the more you decentralize authority and responsibility, the more readily men learn how to manage. The fact, however, seems to be that the more you decentralize, the more you must centralize controls of the organization. Controls must remain in one man or a few men at the top. By a process of continual, subtle, indirect coaching, the top men are able to shape the decision-making powers of those under them so that these men will arrive at decisions that top management can approve. Thus a sort of shorthand description of top management's function would be the preshaping of decision-making in line with the organization's policies and objectives, which are very often not openly stated.

These points also turn up in *Fortune's* studies of line and staff squabbles, certain elements of which were cited by my predecessor at this podium. The line and staff conflict has been sharpened by the growth and expansion of industry. The need for more managers has brought into management a horde of staff men who shortly begin to yearn for the line authority of direct command. By their superior knowledge they very often have an authority that the line man has not, and they exercise it. For example, engineering vice presidents, who are usually staff men, can often tell manufacturing vice presidents what to do, though actually the line men are the ones who are issuing the orders, or should be. Thus you have an almost inevitable conflict between the man who knows better and the man whose job it is to get the job done.

Problems of Psychological Testing

The problems of psychological testing have been covered by *Fortune* from time to time. My colleague, Mr. Whyte, made a very interesting study of personality tests, in which he took them

heavily to task. He showed that the zeal for scientific nethodology had in fact obscured the immeasurable quality of the judgments that are involved by any psychologist, psychiatrist or any other person who attempts to gauge executive or managerial ability. We think that the emphasis on psychological tests in management is overdone, though only about a fourth of some of the corporations *Fortune* looked at seem to use tests as a check on management competence. The inadequacies of these tests have been exposed by using them to test some of the men who have gotten there, who are successful; for instance, I think less than half of one group of presidents was able to pass the test on "how to supervise." That sounds funny, and it is; it just shows how wide of the mark a test of such a management ability can be.

Executives, I need scarcely say, are themselves highly suspicious of tests, and one of the facts that we keep running across is that the executive is not a man whose potential can readily be spotted in advance; it takes a lot of judgments of his intangible characteristics. Certainly he has intelligence, but he also has to have a lot of other things. Dr. Argyris, on my right here, has done much work in this area and can give you an impressive list of the characteristics of the successful executive.

Problems of Status and Communication

We have explored various areas of the status problem, and rather specifically the vice president problem. This seems to be an occupational disease in some industries, banks and advertising agencies in particular. Now in many companies the vice presidential title is used primarily as a sop to executive ego, and I do not think that this is such a waste of title as some consider it. The fact is, when a man gets to a certain point in his executive career it becomes evident to him that he is not going to go any further, that his retirement actually has begun with the first passing over for promotion that he suffers.

The areas of industrial communication we have explored have been many—from the office grapevine to the use of status symbols in the office, and the anxieties that these can develop in managers. One of the obvious facts we reported was that symbols, such as carpets in an office, mahogany desks versus oak or steel, and so forth, are extremely important to many executives—though I would prefer to use the term managers in this case, since later I tend to reserve the term executive for a more developed person. But symbols certainly are important to the executive ego.

The problems of management in attempting to communicate with employees and subordinate managers are manifold. One of the basic points, as *Fortune* pointed out, is that management really cannot communicate, because of the great divergence in background between most managers and employees. Their goals are different, their psychological attitudes toward their jobs are different. The man who rises in management, for example, soon forgets how he felt about communicating with his own boss in the past. Enormous attention has been spent in industry on exploring the technics for getting information and data down the line. Very little attention has been devoted to the problem of getting information up the line, particularly within the echelons of management. And it is here, of course, that communication is probably most critical.

Executive "Qualities"

The aspects of human relations in management that have been pointed out by many are, we have discovered, the cause of many of the problems in organization today. The emphasis on getting along with people, the demand for a well rounded individual—for a man, therefore, who has no corners, who has no sharp points that can irritate—is, I believe, in many cases rather more theoretical than real. In this connection, I should like to say something about a more recent study that we have been undertaking for the last year or so on that great problem of executive "qualities." We have avoided this enormously difficult task for a long time for obvious reasons. And the more we have explored the subject, the more we have become convinced that it is not going to be possible to identify executives in terms of any series of specific qualities, any yardstick. The difficulties are clearly increased by the fact that almost every executive job is different, every hierarchy, every milieu is different, and executives themselves differ extraordinarily from man to man.

These differences showed up in the definitions of qualities that we have explored. We tried the experiment of asking over 100 top men what they thought a dozen or so qualities were, i.e., what *they* meant by them. Most of these men took the time and thought to write out their definitions, and we spent many absorbing hours wih 40 or 50 others who expounded their semantics on such common terms as loyalty, integrity, judgment, foresight, and so forth. The differences in meanings were in some cases very revealing. For example, to many of these men "initiative" is the trait of being a self-starter. It is one of the prime man-

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agerial qualities uncovered by a recent study within the ranks of 25 corporations; indeed, initiative appears to be the one quality that most readily differentiates the successful managers from the unsuccessful in these companies. But to one man in *Fortune's* survey who heads one of the largest steel companies, initiative is not a trait of "self-starting" or "self-reliance"; it is the ability to plan ahead, to think about changing policies and procedures.

Another sample of the radical difference in meaning to be found among men of the highest rank is supplied by the word "dependability." This is considered an essential characteristic by many executives, but to many of these men it does not mean the kind of complete operating reliability that is ordinarily associated with this word. It means the kind of frankness that inspires the boss's confidence. A "dependable" man is a man the boss can count on to say what he really thinks about things, and this, of course, is what top management often values more than a great many of the other qualities in men. Presidents get so much "soft soap," so many yes answers, that they may prize a man who will speak out, especially since, as you know, the pressures of any hierarchy work against a man who speaks out when he knows that the boss might not like to hear what he has to say.

In our observations, one trait of the executive seems to be more discriminating than perhaps any other. This is the shift that occurs in a manager's attitude toward himself and the organization. At some point in his development, there appears a willingness to do the best job for the organization, and do it impersonally. The desire for personal reward fades, as it were, and an attitude of dedication or loyalty, but more usually the satisfaction of getting a job done, becomes the dominant motivation. In all of the really top executives that I have observed, this shift of attitude away from the self seems to be the basic difference between them and those who are not so outstandingly successful. The executive drives himself hard until he finally realizes that he is not going to be able to stop driving himself hard. He realizes that there is so much work to be done that he is going to have to drive almost all the time, and can only rest, or try to relax, in order to get more strength to go back and hit the job. I suppose some psychologists might call this compulsive, but in my observation it is a sign of a kind of maturity. That is, it indicates a maturing to the point where the man receives more satisfaction out of doing a good job than out of the personal material rewards that he may get from the job.

This is a shift of attitude that becomes marked in really top

men, in our observation, more and more marked. But emphasis on non-personal management is still pretty rare. One study we made of a large electric company in the Middle West where a sort of "Executive Suite" situation had developed, illustrated the power of this kind of management. A lawyer was installed as president over about 20 vice presidents who had been ruled for years by a very dominant president, an old rugged-individualist type. This lawyer was anything but that; and yet, by concentrating on the job, by convincing all those under him that he wasn't out for his own reward, or interested in flaunting his own position, but was interested only in the job and in helping them do it, he has gained for himself, and even more for the company, a loyalty that his predecessor, who was extremely paternalistic, never achieved.

There are not yet many of these men in industry who can manage effectively without putting emphasis on personal characteristics. This man, for instance, will step on toes as readily as he will praise, but he has been able to convince those under him that there is nothing personal about his stepping on toes. This is not so simple an achievement as it sounds, but it *is* possible, and in my opinion the most able executives develop this ability. In fact, I think this may be the kind of top manager who is going to evolve increasingly in the future. He is not a man torn with ulcers and worrying about security; he is a man who is primarily concentrating on the job, and he gets enormous satisfaction and enjoyment out of it. Although he may even gripe continually, by his very concentration, by his impersonal method, he greatly reduces any need he may have had for many of the technics of "human relations" that have been so widely advertised.

I want to emphasize this point because it is one that I have found scarcely anywhere in the literature of management. Many of the studies of executives have revealed their psychological limitations; and some of the frustrations of executives have been explored. But the ability of a man to grow to the point where he can manage nonpersonally is still rarely recognized as an executive characteristic. If I am right, it is the really important trait of the mature executive.

There is much more that I could say, but I think that my time has run out. I want to thank you again for letting me come here today.

DISCUSSION

Dr. Monroe, Tulane University: I'd like to ask Mr. Stryker whether a superficial impression of mine is right or not, that is, that corporations are turning more and more to younger men to appoint to top executive posts. It seems to me that this has vast implications sociologically and I should think would have a great effect on morale within the corporation.

Mr. Stryker: There have been a good many young presidents appointed but I think statistics would show that presidents holding office today are actually two or three years older than those who held the position back in 1929. The tendency of a corporation to appoint a young man is perhaps more marked for that very reason. That a 63-year-old president appoints a 39- or 42-year-old man only sharpens the apparent fact. I think there may be, here and there, cases of extremely young presidents appointed but the fact is that the executive functions demand a maturity that a man in his late 30's or early 40's usually has not attained.

Dr. Hans Lowenbach, Department of Psychiatry, Duke University: I have two questions which are really two aspects of one question. Have you had the opportunity to investigate the relationship of your top executives to their wives and their families, or, formulated as a second question, have you had an opportunity to interview the wives of these top executives and their evaluation of their husbands?

Mr. Stryker: My colleague, Mr. Whyte, did the study of corporation wives, not concentrating on the wives of the very top men necessarily but mostly on wives of middle management men. The wives of top executives that I have talked with had certainly, in most cases, arrived at an adjustment to the fact of their husband's absorption in business. They have either adopted outside interests or, shall I say, cracked up, but the woman who marries a man who does go to the top must have some sense that the job, for him, is first. I don't know exactly what else was behind your question, but we have not specifically explored top executives' wives as a group, so I'm only speaking from a rather limited sample.

Dr. Argyris: Last month I was with the Young Presidents Organization and their wives. Three hundred of them met and discussed for 2 hours how to prepare yourself to be a widow even if your husband is alive.

Dr. Fiedler, Department of Psychology, University of Illinois: I have been struck by the preoccupation of executives and of people in business with accounts of democracy in industry and business. I think many of the papers today and yesterday have

reflected this. I have also been struck by the amount of guilt feelings which executives have developed about giving direct orders. Mr. Stryker has pointed to one of these by his remark about the footnote on the chart saying that sometimes direct orders are necessary. I wonder if you would like to comment on this?

Mr. Stryker: Well, I think that's certainly true. A good many of the public pronouncements of top executives stress the democratic ideal of business and try to give the impression that businesses are democratic. Group management is very popular, participation in management—there's a whole school following that now. Young presidents, I may add in reference to the former question, are, many of them, extremely interested in this participation experiment. The fact is that a corporation that is really running, in my observation, is inevitably autocratic and this parliamentary delegation, which we spoke of earlier, points it up very clearly.

The teachings about democratic ideals and so forth have unquestionably affected people's outer opinions of what should go on in a company, but to get the work done the men at the top know they must guide, direct and control all the decisions down the line as far as they can. That's why Mr. Curtice at General Motors will be found popping into the studio to change a mudguard a few days before the car is ready to go into production. This is a very expensive change, but, since he had followed the car for weeks, he saw at the last minute something four or five echelons below him that had to be done and he did it. This could have meant millions of dollars of loss had he not done it. I point this out as an example of what some consultants call "meddling" by top management but it is the necessary fingering that goes on throughout an organization by the man at the top to be sure to check and control the decisions being made under him. When an executive arrives at the point where he has been coached or his coaching about decision-making has taken effect, the man at the top can probably trust him, but you will still find this incessant checking going on, which is not, shall we say, in the democratic tradition.

Committee management is another aspect of this effort to be democratic but, in our observation, committee management is more honored by lip service than otherwise. Actually a decision is made in a committee, usually by one or two men, most frequently by one, and the other men learn how to adjust their opinions accordingly. But, at least, the information about the

company gets spread out in a committee, which in itself can be valuable. Therefore, the judgments of the other men—and it is judgment in executives that is the most important thing—become better educated.

Dr. Solomon: I want to add a footnote for Mr. Stryker. Those of you who have read Mr. Churchill's memoirs will no doubt have been tremendously impressed by the incessant concern for detail that is exhibited there. If I remember correctly, he once asked the appropriate Chief of Staff to tell him how many hobnails there were in an inch of the men's boot.

INDUSTRIAL PSYCHIATRY—THEORY AND PRACTICE

Industrial Psychiatry and Social Psychiatry

JOHN L. BUTLER, M.D.

The field of social psychiatry has gradually become definable in terms of an organized discipline to examine the whole social framework of contemporary living. Within this broad field, industrial psychiatry has centered an inquiry on the social structure and function of the human organization in business and industry. Industrial psychiatry seeks to determine significant facts which affect personal adjustment and social adaptation of the individual in the industrial situation.

Since World War II, business and industry have afforded somewhat of a laboratory for social psychiatry. Intensive and extensive studies in the area of human relations in industry have yielded a body of data of importance to the general mental health field. Community mental health workers, military leaders and leaders of any human organization are looking to industry as pioneers in the arena of applied action. Industrial psychiatry must evaluate these experiences and the data from them. As we pursue our inquiry, we see our body of knowledge grow and merge with a number of disciplines.

We psychiatrists are physicians with responsibilities to heal the sick and injured, and to prevent sickness and injury. We have taken a bold step away from medical tradition in our attempts to diagnose and treat a whole organization as an organism, rather than a collectivity of individuals. This holistic approach to matters of health and illness does not reduce the need for skillful individual diagnosis and treatment. It adds other dimensions to the intrapersonal and interpersonal focus of intensive analysis. These are the small group; the formal and informal organization; and the industrial setting as a community. We also seek to understand the impact of social institutions and culture on the patterns of organization. As physicians, therefore, we regard anything that precipitates illness or injury, or that creates the precursors to the failures of health as a public health

problem. This is a problem upon which the hard-won knowledge and intelligence from a number of disciplines must bear. For this reason, psychiatrists, psychologists and social scientists in related disciplines are combining their various approaches to view, as a unit, the "individual-in-his-situation"—his situation being the natural work setting.

The purpose of our inquiry is to define, within a particular organization, the nature, extent and effect of noxious and therapeutic social forces. We look into the indices of organization health. These include the incidence of absenteeism, accidents, inefficiency, labor turnover and disciplinary offenses. We also examine employee morale and the incidence of alcoholism, emotional disorders, psychosomatic illness and other reactions which suggest an impairment of personal adjustment. We try to relate these various indices to the social forces that operate in the interpersonal field within the organization. We not only ask what makes people ill—or maladjusted; but also, what makes and keeps people healthy in their particular setting. We do not claim that the "cause" of either healthy or ill conditions is to be found only in the social functioning of human organization. We grant that there is a wide diversity of causal factors with no one pathogenesis. However, among these causal factors are some which are currently operative in the life of the individual. Our inquiries have been rewarded by finding certain patterns of interpersonal relations and social forces which precipitate and/or perpetuate an unduly high incidence of problems of personal adjustment. The people most predisposed to stress reactions become the casualties. One objective is to reduce the incidence of casualties.

To realize our objective, we have the alternatives of increasing individual resistance to the stress; of reducing the stress; or both. Some "psychiatrists in industry" have chosen to emphasize the first alternative. They have, of course, had some success in reducing the various indices of poor organizational health. Individual and group psychotherapy with patients referred from the medical department will help keep many people on the job. However, as an "industrial psychiatrist," I have chosen to emphasize the second alternative; i.e., to reduce the stress, thereby decreasing the noxious precipitants. With this choice, I still find it necessary to use the knowledge and skills of intensive psychotherapy. However, except for emotional first aid, the source of referral is rarely from the medical department.

Points of Reference

We have a conceptual basis for our methods and procedures of applied action. We reluctantly refer to it as a "theoretical framework." Despite its loose organization and obvious gaps, we recognize a growing fund of knowledge which will enrich it. We start out with the following points of reference.

1. The structure and function of the organism depends upon the nature of its component parts and the structural and functional relationships between these parts.

2. The segment with the most vital effect on the total organism is the management-administrative-executive group. These people are the "architects of the social structure." They influence structure and function by creating the philosophy, the policies, principles and practices which shape the social climate. We can call this the *nuclear group* because it is the most essential and vital part of the organism.

3. The nuclear group serves its members as an extended, or substitutive family context.[1] The cultural, social and psychological factors impinging upon the group provoke a family-like response. Thus, when referring to these features of the group, I use the term *nuclear family.* The term *nuclear person* refers to an individual member.

4. A social milieu in the work-setting is the interpersonal field in which systems of belief and values form; in which they are communicated and translated into activity. The resultant behavior of one segment has an impact upon other segments of the organization. Beliefs, values, activities and behavior blend, thus forming social forces which may precipitate or perpetuate mental health or mental illness. These social forces evolve and operate in a more or less predictable pattern within the organization. The control or modification of these forces is the responsibility of the nuclear group.

5. A human organization is only as strong or effective as its emotional components. These components are the essence of the binding or repellent forces between people.[2] The nature of these forces in a nuclear group is decisive for the function of that group. Conflict and axiety caused by interpersonal problems within the nuclear group *must* be kept below a certain threshold. Othewise, the welfare of the group and the total organism is endangered.

6. Certain persons may produce stress (called *stress producers*) in the organism, but may themselves have a high

tolerance for stress. Others are highly predisposed to react to stress (called *stress reactors*) with some degree of psychiatric disorder. A stress reactor often produces more stress for the organism and can begin a snowball reaction through the organization.

7. As interpersonal and intrapersonal strivings interact, anxiety is mobilized. When this conflict is near or above a certain threshold, and more or less continuous, there may be consequences which precipitate psychiatric disorder as described by Leighton.[3] Whether or not such a disorder is precipitated in the person central to the conflict, certain consequences will surely permeate the nuclear family and the extended organization. Thus, social forces may be unleashed into the organization with no serious psychiatric consequence to those central in the conflict. However, the stress may be enough to precipitate a psychiatric disorder in a highly predisposed person some distance from the actual center of conflict. Such a person is a candidate for emotional first aid.

8. Within the context of the nuclear family, there is the possibility of substitution for parental or authority figures.[4] Whenever one nuclear person places another as a surrogate, certain problems accrue to the nuclear family.

9. Psychosexual problems must be dealt with in some manner by the nuclear family. Many persons bring psychosexual immaturity or deviations into this family context.

10. The degree of success or failure of the nuclear family in coping with (a) substitution for parental figures, and (b) psychosexual problems, will determine the degree of "health" of the group.

11. If the nucleus is "healthy" the organism should survive and fulfill its purposes. If it is not, there will be evidence of this fact reflected, in part, by the indices mentioned earlier. These have an impact upon the mental health of all members of the organization.

12. In order to maintain and perpetuate itself, the organism must fulfill certain purposes. One essential purpose is to create the necessary and sufficient conditions under which all of the members of the organization can maintain an optimal level of health; i.e., mental, physical, social and economic well-being.

13. Certain organizational, small group and individual prerequisites must be within the nuclear group before it can create and maintain the above-mentioned conditions. The therapeutic goal is to help establish these prerequisites.

14. Any significant, constructive and enduring modification of the social milieu must be effected by modifications within the nuclear group. The focus for "therapeutic intervention" by a sociological-psychological-psychiatric team is, therefore, the nuclear group.

The Nuclear Person in His Work Setting

Further theoretical elaboration leads us to more specific consideration of the basic unit of observation, which is the nuclear person in his work setting. Consider the following common situation.

Let us assume that a work setting of a particular nuclear person serves significantly as an extended family context. Such a person turns to the nuclear family for certain need satisfactions, supports, etc. This has a number of consequences, one of which is that one's own family relationships are impaired. Of course, "company loyalty" is rewarded in most organizations and this strengthens the nuclear family. The tendencies to either lean on others, or take initiative for responsibility have roots in parent-child relationships. The first tendency is seen when there is still a predominant orientation toward the mother-figure. The latter reflects an orientation toward the father.[5]

Assume that more than one person in this nuclear family has made the "boss" a substitute father without yet having resolved the mother ties. This makes the soil ready for "sibling rivalry." In the work setting, it is called "professional jealousy" and "power struggles." Assume further, that several nuclear group members have a problem with repressed latent homosexuality (and they do more commonly than we may wish to think)! This yields an interpersonal field highly disposed to precipitous amounts of anxiety, hostility and interpersonal conflict. In such a situation, anxiety is continuously mobilized and must be dealt with by the total group.

The Nuclear Group

The group has two general recourses for dealing with the anxieties that permeate it. First, the members may resort to some discharge mechanism—the most common of which is the use of humor. "Horse-play," or practical joking are others. Whenever the problems of repressed latent homosexuality are combined with a fair amount of sibling rivalry, the "horse-play" may be quite sadistic, or the humor may be merciless and often at the

expense of a scapegoat. If the anxiety is not effectively reduced by these discharge mechanisms, more serious defenses come into play. This, the second recourse for the group, is commonly seen in paranoid and/or depressive defenses.[6] Such defense mechanisms often have serious consequences for individual members of the group as well as the total nuclear group.

When paranoid defenses are predominant within a group, the following consequences often accrue. The perceptive faculties become impaired; interpersonal communications become emotionally colored, inaccurate and otherwise inadequate; silent power struggles may break into open conflict and the binding forces between the group members become threatened. All of this perpetuates anxiety which may require the use of scapegoats, or other release mechanisms outside the work setting. Oral narcissistic needs are often stimulated and may be reflected in overeating, excessive drinking, chain smoking, telling dirty stories, incessant circumlocution, etc.

In such a situation, the nuclear group may respond as a unit with a collective defense. Even though sub-groupings may carry out joint activities, the purposes are generally for the total group. There may be a party—with eating, drinking and esoteric talk to meet the oral needs. There may be serious discussion that may or may not bear directly upon the problems at hand. There may be a field trip, which often culminates in joint sexual escapades (or at least discussions of them), drinking bouts, and "weighty" discussions. (I have called this "mutual psychological masturbation" because of the symbolic latent homosexual components so often woven into the content.) One serious consequence to this later reaction is that there may be an excessive mutual exposure of matters which have been well repressed in the work setting. The mutual exposure while away from the work setting often yields anxieties that intensify the very problems the participants had intended to resolve.

When depressive defenses are used, the consequences will be quite different. Decision-making processes, as well as other vital functions, are slowed down. The communicative interactions become fewer and less meaningful. Social distance enlarges and thereby threatens the binding forces between the nuclear persons. Subordinate members of the group capitulate to the demands of the situation or escape from the stress by some means. Alcoholic excesses, psychosomatic illness, or other escape mechanisms may come into play. The affected member may look outside the nuclear family for supports. If he turns to his own family, or another

group, his shift of loyalties may provoke troublesome guilt feelings. Again, the nuclear group may respond as a unit with a collective defense. The parties, the field trips and the serious discussions may all combine in an effort to reduce the permeating anxiety. As in the previously described situation, these defenses sometimes intensify the problem.

When both the paranoid and depressive defenses operate within a nuclear group, the patterns of adaptation are exceedingly complex. However, in my experience this is the usual state of affairs in organizations under stress. We see two common individual modes of reaction to stress. The first combines the mobilization of psychosexual problems (usually repressed latent homosexuality), paranoid defenses and oral narcissism. A person with such a reaction is capable of extreme hostility and may find outlets in aggressive actions. His tolerance for slowness and lack of push is very low. The second combines problems about authority (usually a feeling of rejection from a parent substitute), depressive defenses and various escape devices. Such a person internalizes guilt, and may have some psychosomatic illness, resort to alcoholic excesses, fly into reverie, etc. His tolerance for aggression and hostility is very low. Despite this state of affairs, we find that most nuclear groups will experience both reactions during periods of stress. Each reaction grows by means of mutual provocation. In this context, "sides" of an argument or issue are usually taken, thereby creating cleavages within the organization.

Practice of the Industrial Psychiatrist

In light of our theoretical orientation, we see that the interdisciplinary approach is essential. The practice of industrial psychiatry is facilitated in a team relationship which at least adds industrial psychology and sociology. Psychiatry, as the main therapeutic discipline, is largely responsible for leadership in the applied activities of the team. Psychiatry must provide certain important incentives to those explorations that may yield practical and useful tools for applied social action. It is, of course, necessary that each discipline continues to develop its own concepts and technics from the standpoint of its own orientation. The following discussion, however, focuses upon the practice of the industrial psychiatrist.

The nuclear person, his work setting (including other people in the situation) and the tasks he performs, influence each other in a truly dynamic fashion. The industrial psychiatrist intervenes

as a participant-observer in this work setting.[7] The psychiatrist begins by inquiring into *the facts* regarding the structure and function of the total human organization. The beginning is with the top nuclear person, or nuclear persons. Each fact[8] the psychiatrist gets from, or passes on to another, activates communication and refines perception. This reciprocal interaction between observer, observed and situation, provides time for the modification of perception of the facts. Through time, the focus of inquiry is gradually shifted from the periphery of the organization to the structure and function of the nuclear group itself. Throughout this entire process, the patterns of interpersonal relations and the environment will undergo dynamic modifications. These serve as a continuous irritant to many people in the setting who felt secure in a more static situation, and who poorly tolerate the ambiguities that come with change. Such people, whether in or out of the nuclear group, need emotional first aid.

The industrial psychiatrist is especially well equipped to give emotional first aid. This is not only by virtue of therapeutic skill; but also because he knows *the facts* as they bear upon the changing situation. The emotional first aid may consist merely in helping an anxious person or group of persons to perceive and restructure the situation more accurately. In actual practice, the methods for emotional first aid can be simple and brief by combining the restructuring with technics to facilitate repression and suppression. The uncovering procedures are rarely indicated. As a matter of fact, they are usually contraindicated.

The industrial psychiatrist identifies with the needs of the organization in general and of the nuclear group specifically. He should try to avoid, as much as possible, the view that he is only management-oriented. He should definitely avoid being overidentified with any particular individual. This allows the essential freedom to gather data and glean *the facts* from the entire organization. Such activities are facilitated by the team members who should have enough interactions throughout the entire organization to develop and maintain the view that the total organization is being observed as a unit by the total team. *Facts,* mixed with nonfactual material regarding the total organization, filter into the nuclear group via three channels. The first is through the "grapevine," which always becomes activated when an organization is so observed. The second is through the formal channels of communication which react as *facts* are sought. Both the strengths and weaknesses of the communications process tend to stand out in bold relief as the study continues. Finally, the

industrial psychiatrist and/or the team bring information to the nuclear group. All of this communicative activity yields material which may be data, information or facts for the nuclear group. The fate of the material and whether or not it is used to the benefit of the organization depends upon the fact-shifting and decision-making skills of the nuclear group.

The industrial psychiatrist who serves as a participant-observer in staff conferences can help the nuclear group evaluate and re-evaluate its effectiveness in its essential functions. The method used must help them filter out the emotionally distorted perceptions. The decision-making processes are facilitated with group technics for the repression or suppression of significant interpersonal issues. Emphasis is continuously placed upon task-oriented communications. Intimate acquaintance with the facts gives rise to skill in decision making, program planning, policy making, and in taking action.[9] Uncovering procedures within this group are definitely contraindicated. However, if an individual group member is observed to interfere significantly with effective group function, certain out-of-group activities with him and/or other members may reduce this interference.

There are certainly no rules for how or when to effect out-of-group contacts with nuclear persons. They may range from formal to informal. The purposes depend upon whether the contact is one who primarily interferes with or facilitates group function. If the contact is one who interferes significantly with group function, a certain amount of introspective analysis may be indicated. Unfortunately this is fraught with dangers and is often impossible because of undue resistance. It is often dangerous because it may precipitate explosive issues which had been well controlled, and fairly well adapted to by the entire group. Therefore, the most one can usually hope to accomplish with such a contact is some education, help in fact interpretation and gradual persuasion to be more adaptive to the modification within the nuclear group.

If the out-of-group contact is one whose actions usually facilitate improved group function, he often has little resistance to detailed discussions with the psychiatrist. Such a person may be led gradually into an awareness of some essential interpersonal and intrapersonal issues that operate within the group. However, it is important, at the same time, to help him learn to strengthen group defenses against anxiety and to facilitate the repression and suppression of certain issues. He should never be provoked to "throw" his interpretation to the group and be looked upon as

the "know-it-all," who has become cozy with the psychiatrist. His increased awareness of group functions can be used to help the group work through its problems. He can facilitate the development of a group climate in which modification will be accepted by the more resistive, and in which those who interfere with group function will either modify their own role within the group or will leave the group. Very often, this is done by becoming ill.

As the nuclear group becomes more effective in sifting facts and decision making, it also develops skills for self-evaluation. At this point, there are usually concurrent changes in the organization. The "grapevine" is less active. There is an improvement of morale. There are fewer indices of poor organizational health, and the formal channels of communication are strengthened. The company will probably have undergone a thorough reorganization. The team may further serve the organization in a continuing consultive relationship; or having come to this point, may terminate the case. Just as in any psychotherapy, the patient may get well and no longer need the therapist.

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SUMMARY AND DISCUSSION OF PAPERS ON INDUSTRIAL PSYCHOLOGY AND PSYCHIATRY

Dr. Closson, USPHS, Baltimore: There has been a good deal said this morning and during our meetings about the executive and his opportunities for understanding and improving himself. There has been very little said about the worker, except how to keep him on the job without getting into management's hair. Actually the worker is just as important as the executive is. We have just completed a small experiment in preventive mental hygiene in which we went to a company that manufactures portable electric tools and hires about 3,000 people. The company selected 12 of their supervisors about half way in their structure, men from about 25 to 40 years old, and who supervised from 25 to 150 people. I met with these men around a small table for an hour and a half for 10 sessions, about half on the men's time and half on the company's time. I presented to them the development, the structure, the function and the possibilities of the personality. I talked for 15 to 20 minutes and the men would take over in free discussion.

It really was a wonderful experience for me and I am sure it was for the men too. Our aim was to give these people some understanding of themselves so that they in turn could perhaps understand those around them better, both above and below them. It seems to me that, if we are going to get at preventive mental hygiene, that is the level where we can get started. It's nice to treat sick and disturbed people, but if we can prevent them from getting sick or disturbed we have accomplished a good deal more.

Dr. Butler: May I respond to that with a very quick observation? I, of course, agree with the comments that have been made in general, but let me introduce a bit of warning. What I have presented has been focused upon the nuclear group, the central nuclear group. This is an essential place to start lest we get into the difficulties that the Caterpillar Tractor Company got into when they started a training course with these kinds of free discussion groups on down the line without first giving upper and middle management the opportunity of being exposed to the same material. Of course, they learned how to get along better amongst

themselves and with their immediate subordinates. They tried to use some of this knowledge they had about better organization with some of their superiors but their superiors, who had not been exposed to this thing, kind of resisted the whole idea and pretty soon Caterpillar Tractor was locked in a pretty deadly strike. That is, this training must start from the top.

This kind of an orientation about a number of factors, social, psychological, the individual human problems and other things, I think, can only operate in a milieu. This I think we will hear more about when we hear about the therapeutic milieu in hospitals where you must start right at the top, where the climate has to be created by the architects of the social structure. This is what basically I am pointing toward. I have also observed that once such a climate is created, then the individuals on down the line have more facility in communicating, in getting facts about the problems that are involved in their interpersonal relationships and in doing something about these facts.

Dr. Closson: May I say one thing more? That was exactly the opinion of these supervisors, that the ones above them are the ones that needed it.

Dr. Butler: I have always found this.

Dr. John Mabry, College of Medicine, Syracuse, N. Y.: This question is directed to Dr. Butler and Dr. Argyris, and I think perhaps to Mr. Stryker. It has to do first with the observation that one of the things that has emerged out of most of these papers has been the idea that you need to give some attention to how people solve their problems in industrial settings as well as otherwise, by using sources of strength around them, that is, before they get the psychiatrist or the psychologist. One of the well known observations is that with companies like General Electric and perhaps the military there is frequent movement and that this frequently breaks up nuclear groups of the kind that you were describing and of others. This is still a part of the life history of becoming an executive, perhaps—this is part of the question that I am asking. I would like to ask you to comment upon this idea further, namely, on the differences in sources of ego strength among those who are moving within the same industrial organization every two or three years—or joining different organizations, for that matter. In the past, as I understand it, teachers and ministers have been the mobile ones, in addition to the military. I would like to have your comment on that.

Dr. Butler: The mobility of the executive individual may certainly be other than just upward within his own organization. I

am of the opinion that the binding forces, or the repellent forces that I have talked about, which I think it would be very well for you to get a more elaborate view of, are important in maintaining or augmenting the development of an individual's own resources, his growth and his maturity in his own situation. If he does not feel that his immediate situation allows that, then he becomes a candidate for moving into another setting. Very often he does look for those situations in which he can feel not only satisfaction of the need for going up vertically relative to pay and position, but also gratification of the need for a relationship to a small human group. He seeks a relationship which gives satisfactions that will make him feel that what he puts into his work is worth a lot more than just what he gets in terms of personal recognition or financial reward.

There must be also the plain down-to-earth human satisfactions of working in a setting in which there is mutual support and mutual understanding and those kinds of things. Once an individual finds such a nuclear group he is very prone not only to stay in it but there is a mutual reciprocal stimulation of things that facilitate growth, maturity and development and give richer meaning to life. When an individual finds such circumstances he is very prone to stick. These kinds of circumstances are rarely found in professions where the individual is liable to be an isolate, such as the ministry, in school systems, or in the military where the policy is one of rotation. At least, this is true in the case of persons I have known about.

Dr. Tallman, University of California: Inasmuch as we still live in a dollar economy where we need money to buy those things that give us gratification, I would like to ask Mr. Stryker if the use of profit sharing has in any way brought the objective of the executives and management closer to those of the laborers and if this has proven to be good for industrial mental health.

Mr. Stryker: The technic of profit sharing we know is very old. There was a congress of profit sharing back in 1889 which set up the definition of it. It is used today and has increased considerably among small companies. It has been taken by some executives as the ideal that, if management will share the profits with the workers, industrial harmony will prevail. The results do not support this conclusion to any great extent.

The pitfalls of profit sharing which we explored some time ago are many. Top management *must* have good relations first. It is a question of attitude again. Profit sharing is simply a manifesta-

tion of this attitude, and will not work as a technic in itself. It is simply a technic that abets a cooperative attitude by top management. A specific fact about it is that the profit sharing must be large enough to be considered worthwhile by the workers. Many profit-sharing schemes have failed because the actual money involved was ridiculous. I believe General Electric abandoned theirs when their profit-sharing scheme got down to $17.56 a year, which was not a fair trial of the system. In many small companies, however, profit sharing has been quite effective in bringing both management and workers together on one objective.

Dr. Argyris: I would like to support Mr. Stryker by saying that the research that I looked at supports this conclusion convincingly. There is no conclusive evidence whatsoever that "better human relations" are better in plants that do have profit sharing than in those that do not.

Dr. Moore, University of Mississippi: I hold no brief for this unnamed company of Dr. Butler's. I would like to hold some stock in it, however. There are certain things, it seems to me, that should be clarified. It was mentioned that there was a large psychiatric unit. At about the time that the article was written in *Collier's* there were two people working in it. The unnamed company, however, is a very large organization. Further, when somebody makes an explicit formulation of their rationale for something, the formulation need not be correct for the results to be good. Though they may say that *this* is the reason they do so and so, their *explanation* may be looked upon as being all wrong and what they are *doing* is indeed something else. There are certain principles in what they were trying to do that I think are quite good. For one thing you mentioned yourself that they were accepting conflict, that they were teaching acceptance of conflict.

The article's title was written, of course, by the magazine to sell magazines, not to be true. "Mental Breakdowns Are Good for You" meant an entirely different thing, and I think it is quite unfair to impugn the people in terms of this particular title. What they were saying again was that one should express one's self, that it is good to "get it out," to have emotions and to make them known.

Also, you talked about individuals and spoke of individuals as a group, not as just individuals. Yet, the terms "latent homosexuality" and others are terms in the frame of reference of the individual. Changing this frame of reference to go to groups leads to such possible distortions as speaking of the psychosexual develop-

ment of an organization and I think of other examples which could be mentioned.

You spoke of changing the stress. You also said that we didn't know what these stresses are and that this was the sort of research that we need to do. We need to find out what causes these breakdowns, what these stresses are. How can we change something if we don't know what it is? Then, too, stress has been a very misleading concept, I think, in psychiatry and in neurophysiology, since it implies thresholds and quantitative values of the factors involved. Actually so much and so much often add up to something *else*. Much of the time one deals with qualitative factors and changes. Thus, when we speak of stress, immediately there is a connotation of threshold and of quantity, which is, in a way, really a very dangerous kind of thinking.

Dr. Butler: I appreciate your comments. There are a lot of things here which I think we could get together on with more time. The basic approach that I have tried to elaborate is, I think, going to be developed further when we get into the concept of the milieu's being therapeutic. I tried to telescope too much into too little. However, it seems to me that we have, as I say, two major alternatives.

One is that of trying to deduce whatever it is that is operating in our everyday life situations which serves to precipitate disturbances of adjustment or to facilitate adaptation. This is virtually what we are looking for: an applied technic that can provide a broader impact than what we would be able to accomplish with individual psychotherapy alone.

Second, I was trying to make the point that there is something other than just helping individuals at the time they begin to fail in their adjustment. There is something else that psychiatry itself can contribute. It is an understanding of individual psychodynamics as they operate in the work setting. I certainly had not intended at all to convey that I was thinking of psychosexual development of groups. That is an individual matter.

It is a fact that there are individuals in groups in industry who do have psychosexual immaturity and deviations of various kinds. It has been my observation, certainly, that these do create difficulties. Now, I didn't get into a discussion of therapeutic technics. One of them is to avoid circumstances in which the deviant tendency, which is well controlled within the group itself, is artificially brought out into the open. You get into dangerous territories if you try to do this. However, if you gain an awareness, through individual contacts with the members of the group, about the

particular problems that they have, you may help them find some way of coping with the anxieties that may be near breaking out occasionally, or which may be psychodynamically involved in some type of psychosomatic illness, or which may be contributing to excessive alcohol intake or some such thing. These problems are related to the relationships within the group as well as to the individual too.

Question: I would like to address this to Mr. Stryker on the statement he made earlier, that executives could not be selected or that you could not predict whether a man would be an executive. I think, first, it is necessary to make a distinction between executives as members of a class and "executiveship," if you will, or "performing executive duties." Now if you attempt to group a large number of people into a class and say these are all executives and then look for some distinguishing characteristic, you may not find any homogeneity among any particular list of characteristics that you use.

If on the basis of this you conclude that you couldn't predict who would be an executive, I think you might be making an error, because the problem is one of predicting how an individual will behave in a group situation where the performance must be specified and where the criteria should be known at the time that we are attempting to predict. Then the predictors selected would have some relationship to the behavior to be predicted. I think that there is a good deal of loose talk going around about the use of personality tests, the use of selection technics, etc., which is really an indictment of the ignorance of people who *misuse* them and has very little to do with their inherent validity or their limitations.

Mr. Stryker: I would agree with the latter part of the statement very wholeheartedly. The use of tests can be contributive in an original selection or weeding out. What I was saying about our observations was that the use of tests can never predict who is going to be an executive in a particular group or who will be a good one—if only because the job itself, by the time the man has matured in it, would probably have changed enormously. Also, every man who gets into a job does it differently, the fact being that executives who succeed each other are very often opposites. To take simply the criteria of the job and ask, "Can this man perform it?" and then say, "He therefore is a potential executive," is, I believe, misleading.

The use of tests as a broad screening technic is certainly valid, I believe. I would have hoped, however, that psychologists in the

field would devote more time to validating—primary validation, I believe it is called—some of the tests that have been used. Tests have been compared with each other but practically none that I have heard of has been validated against the performance on the job. I believe one set of Rorschachs is now to be tested by Standard Oil but I have not seen the results.

TUESDAY AFTERNOON SESSION

16 April 1957

PANEL ON THE SIGNIFICANCE OF LEADERSHIP FOR THE MENTAL HEALTH OF GROUPS

MODERATOR

Fillmore H. Sanford, Ph.D.

COMBAT LEADERSHIP

BRIG. GEN. S. L. A. MARSHALL (RESERVE)

It would be more surprising to me than to you if in the course of this paper I developed any ideas which are truly new. Rather it is because I am here reviewing thoughts which are old with me and almost traditional with military leadership that my contribution may possibly be worth statement. There is a modern tendency, marked in the Armed Forces, to hope or believe that science may find a new and secret key to the strengthening of moral forces within military organization which may have eluded the most gifted captains in times past who found the right way through instinct. Even to mention it suggests the necessity of holding to the best of what we already know. It does no good to hitch your wagon to a star if you forget to lock the tailgate. And there is nothing to be said for the Australian bushman who, on being given a new boomerang, went crazy trying to throw the old one away.

Just 4 years ago now I was with Dr. Rioch at Pork Chop Hill. The purpose there was to dertermine how our troops had behaved. The job was one of determining in detail all that had happened, what had motivated success or what basically had caused failure. It was a tactical review of the meaning, method and manner of leadership under the most exasperating of field conditions. The men were green; the young leaders hardly knew the character of their following, and many of the men, newly arrived replacements, were total strangers. Certainly here was an inviting laboratory. Yet when the 7 weeks' work was concluded, I had found nothing new under the sun.

More recently I was in the Middle East, with the Israeli Army in Sinai, studying the 100-hour war of last November. Never before in human history have troops been pushed as hard and moved as concertedly and recklessly to a dramatic and decisive goal in war. My job was to get at the nature of that Army by examining in detail its movements, motives and moral forces under the stress of battle. I think I got it done; there are 40,000 words in my notebook and the full story will be written in time.

But again I found nothing new under the sun. Every rule of action, every precept and example set for and by leadership toward the end that an immediate following would be stimulated and the Army as a whole would respond as if inspired, must have been old at the time of Gideon. At the high tide of danger, leaders invariably went first. They counseled their men to audacity by being themselves audacious. Amid dilemma, they resolved their courses by taking the line of greatest daring, which they reckoned to be the line of main chance. Exercising tight control amid crisis, they still bubbled with good humor. Yet one other command attitude was ever more conspicuous. While these young men—company, battalion or brigade leaders—demanded an utmost performance from their troops and pushed them many times toward the fringe of exhaustion, they did not go beyond it. Right on the battlefield, with an attack pending, they would halt everything to order a rest or a sleep if they felt that the condition of troops demanded it. For this alone, the Sinai campaign warrants rapt attention on our part. Too often we tend to an opposite course, and we waste men and opportunity because of it.

Since returning to the United States, I have heard it many times said in explanation of the dynamism of Israel's Army that: "Of course, these troops are highly motivated. They are pioneers. They have a new country. They feel great ardor for it. And besides, their land is ever in danger and surrounded by enemies." No one in his right mind would deny that these are factors which simplify Israel's basic training situation and enable Government to make a stern requirement of the individual. But for my own part, I reject finally the idea that the extraordinary elan of that Army in combat comes from self-identification of the individual with the goals of his nation in the hour when his life is in danger. That is not the nature of man under battle stress; his thoughts are as local as is his view of the nearest ground cover, and unless he feels a solidarity with the people immediately around him and is carried forward by their momentum, neither thoughts about the ideals of his country nor reflections on his love for his wife will keep him from diving toward the nearest protection.

When fire sweeps the field, be it in Sinai, Pork Chop Hill or along the Normandy coast, nothing keeps a man from running except a sense of honor, of bound obligation to people right around him, of fear of failure in their sight which might eternally disgrace him. Of late, the importance of high motivation and the spirit of dedication have received more than their just due. Generate them if you can, but don't overevaluate them as the

begin-and-end-all of combat efficiency. Even an utterly unselfish patriotism (if there be such a motivation) will not of itself make inspired leading or generate its prerequisite—that personal magnetism which produces group unity.

Just before leaving Sinai, I talked with General Dayan on this subject. I recall his words. "A leader should be moral. He shouldn't drink heavily, play around with women, be careless in his private affairs, neglect his work, fail to know his men intimately as individuals. And you may have a moral paragon who observes all the rules, and he is still not a leader. In fact, if he is that perfect, combat leading may be the one thing at which he will certainly fail." To that, amen!

But there is a magic touchstone. It lies in the word "success." Here I would avoid confusing cause and effect. There is no point in repeating the platitude: "Nothing succeeds like success." But there is every reason to state again and again the almost disregarded corollary that within military organization, faith in ultimate success is the broad highway to success itself. I have been fortunate. Four times in my military service I have had the experience of taking over a demoralized, rundown unit in wartime, with the charge that I would get it up and going again. Were that to happen to me a fifth time, I would want nothing better than that, at the earliest moment, those under me would get the idea, right or wrong: "This man is born under a lucky star. He may be cantankerous, demanding, hard to live with, and idiosyncratic. Maybe his sense of right and wrong wobbles a bit. But if we stay with him, this unit is coming out of the woods, and I personally will have a firmer hold on the future." Yes, that is what I would like them to say. In this business of rebuilding I have never known any better therapy than to talk again and again about the importance of group success as a foundation for the personal life while taking actions which indicated new direction. In writing Combined Services doctrine on this subject in *The Armed Forces Officer,* I had nothing better to offer than what I empirically had learned, which is certainly no new discovery.

I used the word therapy. I think it fits. In combat or out of it, once organization gets the conviction that it is moving to higher ground and some distinction will come of it, then all marginal problems begin to contract. Discipline and standards of courtesy tighten of themselves because pride has been restored. Malingering in the form of too many men on sick call, a.w.o.l.'s, and failure to maintain proper inspection standards becomes minimal through a renewed confidence and an upgrading of interpersonal

relationships at the lower levels. When the group gets the feeling of new motion it centrifugally influences anyone who tries to stand still. It can even make good soldiers out of potential bad actors. I remember a dying boy at the battle of Carentan. He had been an "eight ball" in the paratroop company. In the crisis of action, he had to be used as a runner. He was fatally hit on the mission. He died in the arms of his commander, Cecil Simmons. Just before death took him, he said: "Tell me at last, Captain, that I wasn't completely a foul-up." So saying, he expressed the natural longing in all of mankind.

There is this further note on therapy, that just as motion and sense of direction rehabilitate the unit, so they tonic the leader by cutting pressure from higher command. What a wonderful thing is freedom of motion and how little you can get it with someone "riding your neck!" So I long ago learned that when your scoresheet reads no VD, no court martials, no a.w.o.l.'s out of a mistaken impression up there in heaven that these things connote operational efficiency, you can win the right to be left alone, sans inspection, sans interference; and what a blessed state it is, all present well understand.

Concerning leadership radiance, within the terms of reference already here defined, my last thought is that there is one radical difference between training and combat conditions.

In training, the commander may be arbitrary, demanding and a hard disciplinarian, working and sweating his troops more than any company along the line. But so long as his sense of fair play in his handling of his own men becomes evident to them, and provided they become aware that what he is doing is making them more efficient than their competition, and better prepared for the rigor of combat, they will approve him, if grudgingly, stay loyal to him, and even possibly come to believe in his lucky star. They are more likely to do it if he also takes a fatherly interest in their personal welfare. But that feeling doesn't have to come naturally to a man for him to win the respect of troops. If he knows the business, they're on his team.

Come to combat, something new is added. Even if they have previously looked on him as a father and believed absolutely that being with him was their best assurance of successful survival, should he then develop a dugout habit, show himself as fearful and too careful of his own safety, he will lose his hold on them no less absolutely. His lieutenant, who up till then under training conditions has been regarded as a mean S.O.B. or a sniveler, but on the field suddenly reveals himself as a man of high courage,

can take moral leading of the company away from him, and do it in one day. I witnessed these battlefield transformations in France in 1918. In the wars since then, all I have observed of our forces and others has served but to confirm that first powerful impression. On the field there is no substitute for courage, no other bonding influence toward unity of action. Even men of little nerve must regard with contempt the man who has assumed a responsibility requiring that he set the brave example, if in the decisive hour his flesh proves unequal to it. Troops will excuse almost any stupidity; excessive timidity is simply unforgivable. This was the epitome of Captain Queeg's failure in "The Caine Mutiny." Screwball that he was, and an oppressor of men, his other vices would have become tolerable had he, under fire, maintained himself like a man.

So I come to the end of my time on this panel well aware that I have said nothing novel, nothing which distinguishes military leading in any real degree from the problems in other fields. Being a fundamentalist, I see man as a creature under daily challenge to prove to himself, by one means or another, the quality and character of his own manhood. And I am quite sure that in his working relations with all other men, as to whether he is to attain to firm ascendancy over them in a common activity, the hallmark of acknowledged superiority finally is the tested and proved masculine elements in his character. That implies the readiness to accept risk instead of putting ever uppermost the quest for security—and of this we hear too little in our time. It implies also a capacity for completing assigned or chosen work, without which no man may truly lead. Around two such fundamentals may be developed the aura, the manner, of leadership. If they be missing, there is no hope and the article must be exposed as counterfeit in time. All of this is to be found in Ecclesiastes, along with the phrase: "There is no new thing under the sun."

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LEADERSHIP IN THE SURVIVAL OF SMALL ISOLATED GROUPS *

E. Paul Torrance, Ph.D.

INTRODUCTION

Most of the research conducted by the Survival Methods Branch of the Air Force Personnel and Training Research Center on leadership in the survival of small isolated groups has been concerned with aircrews. Generally, these are formally structured groups and the leader is designated by the larger organization, the Air Force. For most purposes, I shall use the term "leader" to apply to the person to whom authority is designated. I shall use "survival" to refer to "staying alive in emergencies and extreme conditions in which others might have died."

To survey what we have learned about leadership in the surival of small isolated groups, let us consider the following five fundamental questions:

1. Is there a *need* for a leader in small isolated groups in emergencies and extreme conditions?
2. Who should be the leader under such conditions?
3. What do men *expect* of a leader in emergencies and extreme conditions?
4. How *do* leaders behave under such conditions?
5. How *should* leaders behave under such conditions?

Each of these is considered a fundamental question because upon its answer hang important decisions about the training and behavior of small isolated groups exposed to emergencies and extreme conditions. Each affects the mental health of groups subjected to these stresses.

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* This report is based on work done under ARDC Project No. 7723, Task No. 77460, in support of the research and development program of the Air Force Personnel and Training Research Center, Lackland Air Force Base, Texas. Permission is granted for reproduction, translation, publication, and use or disposal in whole or in part by or for the United States Government.

In our search for answers to these basic questions, we have relied upon three sources:

1. Accounts of the experiences of survivors of a great variety of emergency and extreme conditions.
2. Field observations and experiments in the realistically simulated survival situation of the USAF Survival Training School.
3. Controlled laboratory-type experiments simulating specific elements of survival situations.

In this paper, results from a large number of different studies will be reviewed, making it impossible to describe in detail the method, theoretical rationale, and implications. This has been done in documentary reports. Further, since whatever promoted continued adaptation, sustained performance under stress, relief of uncertainty and insecurity, canalization of energy, will to survive, and even survival itself may be regarded as promoting good mental health, I shall not belabor the specific mental health implications.

1. Is There a Need for a Leader in Small Isolated Groups in Emergencies and Extreme Conditions?

Some have argued that there is no need for a leader in a small group under stress. They say that such groups will respond as a unit or each man will be busy doing his special job. Everyone will feel a responsibility for the group and the group will find better solutions because they will not be overdependent upon a leader. Some argue that when one's life is at stake, he will not be willing to accept anyone else as a leader. In actual emergencies and extreme conditions, in simulated situations, and in laboratory experiments, we have found groups of all sizes up to 30 operating without a leader and without anyone fulfilling the functions of a leader. In one of our studies, Ziller* found that this was most common in groups of less than six. The performance of groups of four and five appeared to suffer most from the resultant lack of organization. Apparently, groups of less than six tend not to recognize the need for organization.

Although there may be instances when the strategy of the leaderless group is effective, as in a case described by Philip

* Ziller, R. C.: Group Size: A Determinant of the Accuracy of Group Decisions. Unpublished manuscript. Survival Methods Branch, Air Force Personnel and Training Research Center, Stead Air Force Base, Reno, Nev., 1954.

Deane[3] in a POW camp in Korea, evidence from many actual experiences, realistic field tests and laboratory experiments [7 9-13] strongly supports having a definite leader in small isolated groups. In a study of the survival experiences of 200 groups,[9] I tried to determine what forces hold groups together under stress. It was concluded that one of the most important forces is the power exercised by the leader. In bomber crews, the aircraft commander is the member with greatest power. In our analysis of the data, it became obvious that when this power was not exercised, panic, disorganization, loss of life, and other unfavorable conditions ensued. Reasons for this became clearer in a later intensive study of a group caught in a blizzard.[13] We developed the theory that failure on the part of the official leader to exercise power and organize things results in dangerously long periods of shock or lag in overcompensation and adaptation. Ultimately, someone will emerge as leader, but it may be too late. Further, it was found that the presence of official outside leaders serves as a deterrent to the emergence of indigenous leaders.

Using a projective technic with multiple-choice responses,* I studied the ideology of aircrewmen on this issue. Five pictures, each representing a different type of isloated, stressful situation, were projected on a screen. The groups included an AG & W team, a DEW Line team, a missile launching team, a scientific team in the Antarctic, and a rescue team trying to find a downed aircrew on a snow-covered mountain. I obtained reactions from 181 aircrewmen concerning the following statement: "In a group of highly trained technicians like this, there is no need for a specially designated leader. Each man should make the decisions which his particular job calls for and these decisions should be prescribed by SOP." Results are shown in table 1.

Although the ideology is not universally held by aircrewmen, there is an overwhelming belief that there should be a specially designated leader in small isolated groups under stress, at least in the five types of groups represented by the pictures.

In summary it might be concluded that there is a definite need for a leader in small isolated groups in emergencies and extreme conditions and that this concept needs to be taught widely to crews, teams, and other small groups exposed to danger.

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* Torrance, E. P.: The Structuring of Leadership in Stressful Situations. Unpublished manuscript. Survival Methods Branch, Air Force Personnel and Training Research Center, Stead Air Force Base, Reno, Nev., 1957.

Table 1. Reactions of Aircrewmen Concerning the Statement, "In a group of highly trained technicians like this, there is no need for a specially designated leader," for Each of Five Stressful Situations (N = 181)

Degree of agreement	Percent				
	AC & W team	DEW line team	Missile team	Scientific team	Rescue team
Strongly agree	6	10	10	5	5
Agree somewhat	12	7	5	16	11
Undecided	2	0	1	3	4
Disagree somewhat	21	18	14	24	16
Strongly disagree	59	65	70	52	64

2. Who Should be the Leader of Small Isolated Groups Under Stress?

Some staunchly maintain that the senior officer of a group or whoever is ordinarily the leader should continue to be the leader. Others argue that the leader should be the man who is best qualified to "save" the group, regardless of his rank or usual leadership position.

On this issue, our evidence indicates that the leader of a small isolated group under stress should be a regular member of the group and should be the same as the official leader under normal operating conditions. Smith* showed that flying personnel are extremely reluctant to accept superior technical leadership in a survival situation in favor of their aircraft commander. Only 13 percent would accept a highly skilled survival instructor as leader in a survival situation in preference to their aircraft commander. LaForge, Mason, and I,[13] found that failure of an outside leader to recognize and use the power of the indigenous leader may have disastrous consequences in emergencies and extreme conditions.

Using the structured projective technic already mentioned, I explored several issues concerning leadership in small, isolated groups under stress. Data concerning the basic question are pre-

* Smith, E. E.: The Willingness of Flying Personnel to Accept Technical Leadership in a Survival Situation. Unpublished manuscript. Survival Methods Branch, Air Force Personnel and Training Research Center, Stead Air Force Base, Reno, Nev., 1957.

Table 2. Preferences of Aircrewmen for Leader in Five Types of Stressful Situations (N = 181)

Leadership category	Percent				
	AC & W team	DEW line team	Missile team	Scientific team	Rescue team
Highest ranking officer regardless of specialty.	37	58	52	37	23
Specially trained officer regardless of relative rank in group.	49	32	38	25	63
Highly skilled and experienced civilian.	2	1	3	35	10
Rated field grade officer with special short course on specific operation.	8	6	7	2	0
High ranking outsider—not a regular member of group.	4	3	0	1	4

sented in table 2. It will be noted that the subjects predominantly favor either the highest ranking officer of the group, regardless of specialty, or an officer especially trained for the job, regardless of his rank. In no situation is there much support for high ranking officers with little training or for an officer who is not a regular member of the group. Only in the case of the scientific team is there much support for a highly trained civilian, although there is fair support in the rescue group. Noteworthy is the strong emphasis on skill in favor of rank in the rescue team.

Evidence in favor of the official leader under normal conditions as the leader under survival conditions is found in a combat follow-up study by Levi, Pletts, and me.[7] We found that the extent to which the aircraft commander was chosen at the end of survival training as the "best survival leader" of his crew was a consistent and effective predictor of combat effectiveness. Aircraft commanders of crews which were dissolved and not assigned to combat as crews received fewer such choices than those of combat crews. Further, aircraft commanders of the less effective combat crews received fewer choices than the more effective ones. Choices made at the beginning of training, however, did not predict combat effectiveness successfully.

The problem of leader replacement was also examined. As shown in table 3, general preference is for a replacing officer or for the next highest ranking officer of the group, symbolizing the controversy concerning promotion from within versus replace-

Table 3. Preferences of Aircrewmen for Replacing Leader in Five Types of Stressful Situations (N = 181)

Leadership category	Percent				
	AC & W team	DEW line team	Missile team	Scientific team	Rescue team
Next highest ranking officer, regardless of specialty.	26	29	29	23	16
Next highest rated officer	16	11	8	5	5
Most skilled and experienced member of group.	18	12	16	43	53
Replacing officer	48	47	45	28	22
Field grade officer—not a regular member of group.	2	1	2	1	4

ment from without. Notable exceptions are found in the rescue and scientific teams where there is a strong emphasis on superior skill and experience. Also notable is the small emphasis on whether or not an officer is "rated."

A special case from a mental health standpoint is the leadership of a group of enlisted men, airmen, or technicians below the professional level. To me, one of the more fascinating stories of World War II is that of a group of enlisted men assigned to an isolated Arctic outpost under the command of a staff sergeant.[4] It was argued that if an officer had been placed in command, he would have tried to keep things G. I. and the detachment would have gotten so sore at him that before the winter was over either they would have driven him "nuts" or gone "nuts" themselves. Data concerning this issue are presented in table 4. Only mild support is shown for placing another enlisted man in command. They feel, however, that the officer who is assigned should be thoroughly trained. It was also found that enlisted men are no more favorable than officers to the proposition of placing another enlisted man in charge.

Table 4. Preferences of Aircrewmen for Leader of a Group of Airmen (Enlisted Men) in Five Types of Stressful Situations (N = 180)

Leadership category	Percent				
	AC & W team	DEW line team	Missile team	Scientific team	Rescue team
Rated officer thoroughly trained for the special situation.	55	44	38	33	37
Rated officer with introductory training for special situation.	3	0	0	1	1
Nonrated officer thoroughly trained and experienced for special situation.	22	33	36	42	34
Civilian thoroughly trained and experienced for special situation.	1	0	2	9	4
NCO of superior rank and thoroughly trained and experienced for special situation.	19	23	24	15	24

3. What do Men Expect of a Leader in Emergencies and Extreme Conditions?

Much dissatisfaction and disorganization even in everyday human affairs results from discrepancies between leader and member expectations. In emergencies and extreme conditions such discrepancies can be calamitous. If the leader knows what his men expect of him he can then conform to their expectations, change their expectations, or evolve some compromise.

Some of the more interesting information on this question comes from the same structured projective technic discussed already. One of the most important issues concerns the way the leader should modify his behavior and his relationships when the emergency or extreme condition occurs. The data presented in table 5 depict the ideology of aircrewmen concerning decision-making behavior under stress. A clear majority believe that the only modification in leadership behavior desirable under stress is to check more closely to see that everyone is carrying out his responsibility. Checking up more closely appears to be regarded as less crucial in the scientific and rescue teams. Although the number is relatively small, it should be noted that there are some

Table 5. Ideology of Aircrewmen Concerning Changes in Leadership Behavior Under Five Stressful Conditions (N = 181)

Kind of change	Percent				
	AC & W team	DEW line team	Missile team	Scientific team	Rescue team
Make all decisions, process all information.	5	5	6	4	9
Delegate more responsibility than usual.	3	7	3	7	12
Make all except routine decisions	2	7	10	5	5
Make no changes in behavior	14	10	11	26	27
Just check more closely to see that everyone is carrying out his responsibility.	76	71	70	58	47

who advocate the extremes of "taking all responsibility" and "taking little or no responsibility," both phenomena commonly observed in field experiments and actual survival situations.

A second issue concerns changes in relationships between leader and men. As will be noted from table 6, about three-fourths be-

Table 6. Ideology of Aircrewmen Concerning Changes in Relationships of Leader to Men in Five Stressful Conditions (N = 181)

Kind of change	Percent				
	AC & W team	DEW line team	Missile team	Scientific team	Rescue team
Become much more formal and distant.	1	0	0	0	3
Become somewhat more formal and distant.	13	13	13	11	7
Make no changes	77	72	76	72	79
Become somewhat closer and friendlier.	8	11	10	15	10
Become much closer and friendlier.	1	4	1	2	1

lieve that stress does not warrant a change in this relationship, regardless of the situation; 10 to 14 percent believe that stress calls for a more formal and distant relationship, while 9 to 17 percent prefer a closer and friendlier relationship.

A third issue concerns unquestioning acceptance of commands in emergencies and extreme conditions. Does stress warrant more or less questioning and evaluation of the orders of the leader? As shown in table 7, aircrewmen generally disfavor evaluating or

Table 7. Reactions of Aircrewmen Concerning the Statement, "When an emergency occurs, the other members of the team should evaluate the orders of the commander and question them even more carefully than they usually do," Under Five Stressful Conditions (N = 181)

Degree of agreement	Percent				
	AC & W team	DEW line team	Missile team	Scientific team	Rescue team
Strongly agree	6	7	9	3	3
Agree somewhat	8	9	7	13	13
Undecided	3	1	1	6	5
Disagree somewhat	21	14	14	30	28
Strongly disagree	60	69	69	48	51

questioning the orders of commanders, with no real differences observed from situation to situation. From 14 to 17 percent, however, do favor evaluating more carefully than usual the orders of commanders.

Boag,[1] Homans[6] and others have commented upon the detrimental effects of a leader's associating closely with his men and living under the same hardship conditions. Although agreement is far from perfect, it will be observed from table 8 that aircrewmen generally approve of their leader's associating closely with the men and living under the same hardship conditions. They are stronger in this opinion when it concerns scientific and rescue teams. Apparently, however, this does not give the leader license to be "just one of the boys," as will be seen from table 9.

In the three situations, for which data are available, however, from 21 to 46 percent agree to at least some extent that the leader should be "just one of the boys."

Table 8. Reactions of Aircrewmen to the Statement, "In a group like this, the leader should associate very closely with his men, living under the same conditions and hardships as they do," Under Five Stressful Conditions (N = 181)

Degree of agreement	Percent				
	AC & W team	DEW line team	Missile team	Scientific team	Rescue team
Strongly agree	33	40	35	68	70
Agree somewhat	38	40	41	28	21
Undecided	7	6	6	0	1
Disagree somewhat	15	10	11	3	7
Strongly disagree	7	4	7	1	1

Table 9. Reactions of Aircrewmen to the Statement, "In situations such as this, the leader should be 'just one of the boys,'" Under Three Stressful Conditions (N = 105)

Degree of agreement	Percent		
	AC & W team	Scientific team	Rescue team
Strongly agree	2	7	2
Agree somewhat	19	39	37
Undecided	3	5	3
Disagree somewhat	42	27	28
Strongly disagree	34	22	30

4. How do Leaders Behave in Emergencies and Extreme Conditions?

In order to make more useful our knowledge about the expectations members have of their leaders under stress, we need to know what leaders actually do in emergencies and extreme conditions. Although many of our studies have dealt with the problem of what leaders do in emergencies and extreme conditions, results are rather difficult to summarize in brief form. For this reason, I shall limit myself to three specific studies.

First, I shall present some of the results from a study employing what I have termed a "Slanted" Thematic Apperception Test approach.* Pictures of three stressful situations involving varying degrees of perceived stress and uncertainty were each projected on a screen for 40 seconds. Subjects were then given 6 minutes in which to write a story about each picture. In addition to the usual Thematic Apperception Test instructions, subjects were asked to include in their stories information about how power was exercised, how the leader's relationship to the group changed, and how the relationships among members changed. Situation A depicted an AC & W team during an emergency; Situation B, a combat Marine team; and Situation C, a group of prisoners marching around in a compound.

Although the data are projective, on the basis of my knowledge of what has happened in many survival situations, I believe that the tabulation shown in table 10 provides an excellent picture of the ways leaders successfully exercise power in small isolated groups under stress. The two most frequently mentioned categories are making decisions and structuring the situation. It will be noted that the frequency of these two categories decreases as the degree of stress increases and the structuredness of the situation decreases. This is not true of the third category, reliance upon rank and military custom.

Of special interest from a mental health standpoint is the frequency with which various sources of breakdown or potential breakdown are described. This tabulation is shown in table 11. Here it is observed that the most frequently mentioned sources—isolation, depression, overwhelming stress, and need deprivation—vary directly in frequency with the degree of perceived stress. Shock, however, tends to follow the reverse pattern.

A second approach is represented by an intensive case study of a group of 26 men caught in a blizzard.[13] Numerous leadership failures were identified in the blizzard situation, the outcome of which was almost disastrous. The first failure came when the emergency first occurred and official subgroupings were replaced by subgroupings of the most able with the most able and the least able with the least able. Sociometric analysis revealed that 90 percent of the members' leadership choices and 85 percent of choices as "best able to take care of self" were concentrated into

* Torrance, E. P.: Power and Group Cohesiveness Under Three Types of Stress and Group Structure. Unpublished manuscript. Survival Methods Branch, Air Force Personnel and Training Research Center, Stead Air Force Base, Reno, Nev., 1957.

Table 10. Frequency of Mention of Ways of Exercising Power in Stories About Three Stress Situations (N = 144)

Way of exercising power	Situation A (AC & W team)	Situation B (Marine team)	Situation C (POW group)	Total
Makes decisions, gives orders, etc	52	33	9	94
Directs, organizes, structures	42	31	20	93
Uses rank, military custom, etc	26	30	25	81
Inspires faith and confidence through personal example of courage and calmness.	9	27	27	65
Job description, everyone knowing what to do.	52	7	1	60
Automatic cooperation as a team, confer with one another.	17	26	5	48
Expertness, superior experience or training.	14	24	4	41
Obtains information and controls its release, relation to higher authority.	22	8	5	35
Recognizes seriousness of situation, sizes up situation, etc.	17	15	2	34
Some symbol of authority or difference (helmet, weapon, etc.).	31	1	1	33
Briefs, orients, explains importance of task.	3	20	3	26
Exerts pressures, force, threat, prods, shouts.	6	6	10	22
Long association, knowing men and being known by them.	1	10	0	11
Totals	292	238	112	643

two of seven subgroups. No over-all leadership emerged and most of the subgroups failed to recognize the seriousness of the situation. Official power figures failed to recognize and utilize a strong indigenous leader of the group. On the one hand, designated leaders abdicated their power roles almost entirely by failing to perform necessary leadership functions. On the other hand, they reduced the power of the members of the group by denying them their usual decision-making functions.

Still another approach is represented by a study of Hites and his associates,[5] using the simulated survival situation under winter conditions as the stress experience. Members of 58 eleven-man

Table 11. Frequency of Mention of Sources of Breakdown or Potential Breakdown in Stories about Three Stress Situations (N = 144)

Source of breakdown	Situation A	Situation B	Situation C	Total
Isolation, each man engrossed in own thoughts and concern for self, no communication.	2	14	57	73
Depression, hopelessness, fear	1	4	35	40
External power or stress too great	0	2	36	38
Fatigue, deprivation of basic needs, prolonged tension.	8	12	16	36
Shock, slow recovery, failure to recognize seriousness.	13	7	7	27
Strangeness of situation, unfamiliarity with one another, temporariness of situation.	1	1	18	20
Overdependence upon leader, no jobs or responsibility for some.	4	8	5	17
Untrained, inexperienced men	3	5	1	9
Uncertainty, indecisiveness	0	3	6	9
Personality defects of leader, lack of confidence in leader.	1	6	2	9
Relaxation, concessions to comfort	1	5	2	8
Cliques, some not "in on" plans	0	1	6	7
Totals	34	68	191	293

bomber crews were administered the Leader Description Questionnaire and the Crew Description Questionnaire immediately before and immediately after the 9-day field exercise. The Leader Behavior Questionnaire yielded two dimensions: Consideration and Initiating Structure.

Leader behavior as measured by the questionnaire was not found to change consistently during the stress experience, but the variation among leaders in behavior was significantly greater when measured after the experience than when measured before the experience. Apparently, some leaders under stress exercised tighter control than usual while others "let things go" and did less to initiate structure than ordinarily. Similarly, some showed greater consideration while others were less considerate than usual. Thus, it appears that the behavior of leaders under stress *does* change but not in any consistent direction.

5. How Should Leaders Behave in Emergencies and Extreme Conditions?

Determining how leaders *should* behave in emergencies and extreme conditions is a somewhat laborious and complicated procedure. Although we have made only a small dent on this problem, we have accumulated so many data that I can only select a few examples within the limits of this paper.

Three major strategies have been used. First, we have compared the behavior of leaders who have led all or almost all of the members of their groups to safety with that of leaders of groups suffering unusually high casualty rates. A second approach has been to identify important common human characteristics which lead to disastrous results and to try to discover ways of successfully managing them. A third approach has been to look at basic but rather specific outcomes necessary for survival and to determine how to achieve them most effectively.

Perhaps our best example of the first approach is my analysis of the survival experiences of 200 groups.[9] In this study, I concluded that the effective leader differs from the ineffective leader in the following ways:

1. He exercises power.
2. He maintains the communications linkages of the group.
3. He rapidly restructures the situation.
4. He maintains the group's goal-orientation.

All four of these emphasize the importance of structuring. The importance of structure in reducing threat and its consequent effect on productivity and defensiveness has also been demonstrated in a laboratory experiment by Ewart Smith.[8]

Hundreds of our survival accounts, as well as many of our field observations, have indicated that a common source of disaster is an almost complete absorption in one's personal fight for survival and an accompanying failure to sacrifice for the common welfare. POW's in the Korean conflict labeled it the "to hell with you, Joe; I've got mine" attitude. We do not, of course, have to look far to find examples of this phenomenon in daily life. What then can a leader do to manage more successfully this common threat to group survival? A number of hypotheses have been developed through our own "survival" experiences and are being tested by Ewart Smith in a series of exciting laboratory and field experi-

ments. For example, in one laboratory experiment,* he employed a modification of Crutchfield's group squares test[2] to investigate the hypothesis that group procedures which permit members to conceal their unwillingness to sacrific for the welfare of the group intensify this common human weakness. Four experimental conditions, each employing five six-man groups, were used.

As will be seen from table 12, the covert-overt variable is a very powerful one, even more powerful than threat itself. (Threat in the experimental situation consisted of posing a conflict be-

Table 12. Percentage of Subjects Sacrificing for the Group ("Breaking" Completed Squares) Under Various Conditions of Threat and Secretiveness

Condition	Percent sacrificing
Threat-overt (N = 30)	73.33
Threat-covert (N = 30)	26.67
No threat-overt (N = 30)	90.00
No threat-covert (N = 30)	60.00
All overt conditions (N = 60)	82.00
All covert conditions (N = 60)	43,00
All threat conditions (N = 60)	50.00
All no-threat conditions (N = 60)	75.00

tween individual and group performance and telling subjects that an analysis of individual results will be sent to their commanding officer. This was described as just one in a battery of tasks. In the overt condition, noncooperation was made known to the group; in the covert condition, noncooperation was concealed from the rest of the group.) On the basis of this and other evidence, Smith concluded that chances of survival can be enhanced by leadership procedures which bring into the open the cooperativeness or uncooperativeness of members.

Another basic human weakness which threatens chances of survival is the loss of will to survive. Man is subject to lack of faith, lack of self-confidence, and fear. Control of these sets the

*Smith, E. E.: Conflicting Self-Group Goals: Overt and Covert Self-sacrifice Under Threat. Unpublished manuscript. Survival Methods Branch, Air Force Personnel and Training Research Center, Stead Air Force Base, Reno, Nev., 1957.

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stage for man's will to live and this will to live is the path that leads to survival. Zander [14] has just completed a series of laboratory and field experiments which demonstrate that ego strength and a variety of goal structure variables are related to the continued adaptation involved in will to survive. A needed next step is to test the efficacy of various leadership and group procedures in developing and maintaining these factors. A similar series of studies on panic control has been under development by Mason who has demonstrated the importance of good communication procedures in controlling panic in aircraft emergencies.*

Finally, I would like to select a few results derived from looking first at rather specific outcomes necessary for survival and trying to determine how these can be achieved most effectively.

Obviously, the members of a group need to respect and be willing to comply with the commands of the leader. In one study,** I asked survival trainees at the end of their simulated survival experience to describe some behavior of their leader which caused an increase or decrease in respect during the experience. The following six factors were found to be involved most frequently:

1. *Expertness:* being able to "get the crew out of trouble" when lost, displaying adequacy in living off the land, etc.
2. *Willingness to share danger and discomfort:* sharing unpleasant tasks; being able "take it" in spite of handicaps, etc.
3. *Willingness to take risks:* trying new skills, trying new foods, etc.
4. *Willingness to make decisions and take action:* making firm decisions, taking consequences of decisions, distributing responsibilty, etc.
5. *Actng outside his authority:* taking care of his men, taking emergency actions not anticipated by SOP, etc.
6. *Willingness to take police action:* making men keep clean, refrain from drinking excessively and becoming abusive; getting men to accept the situation, etc.

A simple projective type of experiment conducted by Hawkins

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* Mason, R.: Avoiding Cockpit Confusion. Accepted for publication in *Flying Safety.*

**Torrance, E. P.: Problems Faced by Officers in Maintaining the Respect of the Airmen on Their Crews During Survival Training. Unpublished manuscript. Detachment No. 3, Human Factors Operations Research Laboratories, Stead Air Force Base, Reno, Nev , 1953.

and me* deals with the problem of compliance with the commands of the leader in stressful situations. Subjects were required to respond to three frustrating situations similar to the well-known Rosenzweig situations. The three situations represented three different degrees of structuredness of command. As seen from table 13, compliance is directly related to the degree of structuredness of the command. (All differences are significant at better than the 0.001 level.)

Table 13. Distribution of Ratings of Compliance for Three Situations Varying in Degree of Structuredness of Command (N = 265)

Degree of compliance	High No.	Structure percent	Moderate No.	Structure percent	Loose No.	Structure percent
Unqualified obedience	139	52.4	23	8.7	34	12.8
Voiced or unvoiced resistance.	111	41.9	165	62.3	70	26.4
Refusal, direct or implied	15	5.7	77	29.0	161	60.8

Another specific outcome required in survival is the making of accurate decisions, willingness of members to accept decisions, and member satisfaction with them. Many facets of this problem have been explored by Ziller and me[12] with the general conclusion that the "best" group decisions are made when the leader permits members to contribute information, ideas and opinions and have them evaluated. The leader must, however, express his own opinions, assume responsibility for making decisions, and when required, assume responsibility for making decisions without consulting the group. We also concluded that the leader should not become too dependent upon the group; neither should the group become too dependent upon the leader. They should support one another rather than "lean upon" one another.

* Torrance, E. P., and Hawkins, C. E.: Structuredness of Commands and Compliance in Frustrating Situations. Unpublished manuscript. Survival Methods Branch, Air Force Personnel and Training Research Center, Stead Air Force Base, Reno, Nev., 1957.

SUMMARY

In this paper, an attempt has been made to summarize some of the findings accumulated by my associates and me concerning five fundamental questions about leadership in the survival of small isolated groups. Evidence was cited to support the conclusion that there is a definite need for a leader in small isolated groups under threat and that this concept needs to be taught widely to crews, teams and other small groups exposed to danger. The best evidence available also indicated that the leader of a group under stress should be a regular member of the group and should be the same person who is the official leader under normal operating conditions. In general, men expect their leaders to behave under stress in much the same way as they usually behave, with the exception that they will check more closely to see that everyone is carrying out his responsibilities. In general, they believe that the leader's judgment should not be questioned under stress, that the leader should associate closely with his men and live under the same hardship conditions, but that he should avoid trying to be "just one of the boys."

A variety of successful and unsuccessful types of leadership behavior were identified. In terms of initiating structure and consideration, leadership behavior changes under stress but not in a consistent direction. Evidence supports conclusions that leaders must exercise power; maintain communications linkages; rapidly restructure the situation; maintain goal-orientation; keep in the open cooperativeness and uncooperativeness of group members; develop procedures for maintaining ego strength and desirable goal structure; share the dangers and discomforts of the group; be willing to take risks, make decisions, act outside their authority, and take police action; give adequate structure to commands; and develop patterns of mutual support between leader and followers.

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PROBLEMS OF LEADERSHIP: IN THE DISASTER SITUATION AND IN THE CLINICAL TEAM

JAMES S. TYHURST, M.D.

THE DISASTER SITUATION

I am going to speak about leadership in two kinds of situations: first, disaster; and second, the clinical team.

First of all, with respect to disaster, the importance of leadership in crisis is well recognized and has been discussed already here this afternoon. If you will remember the outline that I gave you before of the various phases in the disaster experience, it appears that the management of the period of impact and of the individual and social disorganization that follows a disaster provides an acute need for leadership. Although we have always observed this, there is still a great deal we have to learn about this important factor. Therefore, despite the long-standing recognition of its importance we still appear to be quite unable to pick leaders or train them with complete confidence that they will be able to perform effectively when the time comes.

There are a number of points concerning leadership that might be noted. One is that it appears that the kinds of personalities required during succeeding phases of a disaster are quite different. For example, whereas leadership following a disaster may require the ability to be decisive, authoritative and directive and to provide an example with which identification may occur, in later periods leadership must be characterized by different qualities—such as, the ability to work with others, to minimize differences wherever possible, to organize, or to preserve. One of the outstanding differences between people who have led at successive phases has been the ability of the individual in later phases to persevere and the inability of the person during the earlier phases to do so.

It may be suggested, too, that the leadership required to promote interest and planning before any crisis has still different qualities. I will make some remarks in a moment about emergent leaders in disaster. Firstly, however, I think it is of importance

to recognize that the changing requirements of leadership should always be met by flexible planning and sufficient social understanding before an event so that this previous planning and organization is not so rigid that it cannot be discarded as necessary.

Secondly, there are different kinds of leadership and I think this is an extremely important concept in that many of the articles we see describe leadership under very different circumstances. This is not a single problem. Also, there are different levels of leadership. This is well recognized by the military, but we have been impressed by the fact that there was the greatest danger of carrying this analogy too far and in applying military patterns of leadership to civil society. One cannot impose leadership on civil society from outside or from above downward, save during the most acute period of crisis when public dependency upon authority is maximal. Instead it is much more desirable to find out what leaders there are at various levels of society, to encourage them and to work with them.

Failure to do this can be one of the more serious blunders of central planning for disaster, or of military or quasi-military outfits moving into a disaster area from the outside. We have repeatedly seen Army units moving into a disaster area and setting up types of staff leadership based upon the recognition of the leadership roles in society, which, in fact, have often disappeared. A ludicrous situation developed in one disaster in which the leaders in the community would meet with the brigadier and his staff. They would plan, they would issue directives, and would also issue daily reports for control at headquarters, but at the same time the civil society was doing something quite different.

A third point is that a number of social roles in society have in normal times built-in potentials for leadership which become terribly important during a disaster. This is obvious in the case of any uniformed group such as the military or the police, and it is particularly true also for other members such as the doctor and the nurse. We have been struck by the sudden importance that these institutional symbols take as aspects of leadership in disaster. For example, the physician's role has tremendously important elements of leadership and many doctors fail to recognize this when the difficulties arise. Another interesting thing is the way in which the context and the different timing or phases of the disaster change the relevance of any particular leader. For example, during the earlier phases of a disaster, during the

period of impact, there is a tremendous dependency upon uniformed groups. This can rapidly change, however, to hostility and scapegoating as soon as the acute crisis is over.

The Emergent Leader

One idea that we have been much impressed by is the notion of the emergent leader. We have seen this in every crisis situation that we have observed. Under these circumstances, the civil leaders of normal times may be replaced by leaders who emerge during and following a catastrophe. Such individuals play an important and vital role in recovery later, and interestingly enough, usually disappear completely when things have returned to normal. Their appearance is certainly not based upon personal characteristics entirely but is particularly a function of their background and qualifications in relation to the particular needs of the situation.

There have been many different examples of this but I will give you only a few. In the Winnipeg flood there were at least five or six emergent leaders in different parts of the city who were crucially important in the management of the disaster situation but have subsequently disappeared almost completely and have had no particular civic responsibility since. One of them literally took over behind the scenes, directing the activity in the central part of the city and in fact had administratively displaced the mayor. In all municipalities that made up this city there was only one mayor acting in that capacity, that is, as the leader of his community following the bursting of the dykes. St. Boniface, which is a sort of suburb of Winnipeg, was in great danger and the Norwood Community Club, which is a community club in that area, had been working rather ineffectively, but with tremendous energy, in attempting to put up a dyke around St. Boniface, which sat like a sort of saucer in the middle of the river.

This activity started at about 4 o'clock in the afternoon and at about 11 o'clock things were not progressing very fast until a hypomanic contractor appeared on the scene. This man took over and started ordering heavy earth-moving equipment from all over Manitoba. He took the responsibility that no one else was ready to take. He just didn't bother about who was going to pay for this, who was going to return the equipment and so on. And by about 4 o'clock the next morning St. Boniface was surrounded by a dyke. It is still there. He disappeared and has not appeared again.

Another emergent leader, an Army officer who had been quite restless in civilian life, appeared in another part of Winnipeg and organized convoys taking workers to the dykes in a sort of regular fashion with out-riders and orders snapping in all directions. A most interesting thing was that the population was ready to put up with it just so long as they felt this kind of organization was desirable. As soon as things started to settle down again, he returned to his job in the grain exchange, as a clerk.

Another example was a boy in the case of a severe department store fire in Halifax which killed about 13 people. The fire occurred at about 5 o'clock in the afternoon and started on the ground floor. This lad was on the third floor and he saved about two dozen people who were milling around by taking them out through a skylight in the roof. He was extremely cool, quite calm and collected, and was very effective for this group of people whom he collected and took away. He was their emergent leader.

The interesting thing about him was that he had not been particularly outstanding in the store before. He was a messenger in the store. He had been in the habit of climbing to the roof and, at the time of the fire, he simply went in the direction to which he was accustomed and took a large number of people along with him. But the fact is that he functioned as a leader and this seems to be not just a matter of familiarity with the setting but also something beyond this, because we have had other people who have been able to get themselves out quite well but have not concerned themselves with others.

I think, then, that this concept of the emergent leader is crucial. And it is something that seems extremely difficult to anticipate in advance, as are some of the other phenomena that I described in respect to these same kinds of settings. However, I think that more work should be done specifically on these people. As I say, after the disaster every single one of them, except the city engineer who took over in central Winnipeg, has had no civic responsibility since.

THE CLINICAL TEAM

The next thing I want to mention briefly is the question of the clinical team. We have been studying this problem for about 3 or 4 years now. By the clinical team I mean the psychiatrist, say three or four interns and residents, a psychologist, a social worker, three or four nurses and an occupational therapist. Now,

this is a team function, a group of people who are there for a purpose, to diagnose and to treat patients and also to train people. And this group has to function as some kind of a team. We have been much concerned with two aspects of it, the problems of leadership in this kind of situation and also the kinds of integration in this sort of group. These two factors are very closely related.

Leadership

The first problem that comes up is the problem of professional relations in this kind of a team and the question: Who is really to take the leadership? The first problem, then, has been the matter of responsibility and this has been the major reason why the psychiatrist is designated as the leader of such a team—that is, that he has the medical responsibility and if something goes wrong he is held accountable. So, the staff psychiatrist is designated as the leader primarily on the basis of responsibility.

The second problem that always arises is that of status. This problem is particularly acute with the psychologist and the social worker. The nurse is not so much concerned with status as she is with control in her own private empire. As long as this control is left untouched, she relates herself to the leader very well. The social worker and the psychologist, however, have real status problems in the team and real problems in relating themselves to the leader.

Integration

We have been concerned with the problems of the kinds of integration that exist in these kinds of teams and the ways in which these affect the leadership. I would like to name three kinds of integration: the chain-of-command type, the affective type, and the functional or theoretical type.

Most of the clinical teams that we have looked at have had primarily a chain-of-command integration in which the leader is designated on the basis of responsibility. He takes this responsibility quite overtly, he listens to what other people have to say and then he may or may not pay any attention to it. He says, then, "All right, this is a schizophrenic and we are going to do the following things." This is the chain-of-command and, interestingly enough, when the other forms of integration break down this is usually the form that takes over. Parenthetically, we may note that this contradicts the notion that the professionals are not arranged in any kind of hierarchy.

The second type of integration that we have been concerned with is the affective-type integration. This is the kind of integration that occurs in the team through having been together for a long time or having come together on the basis of long association. That is, they are not together because of any hierarchical situation, they are not there because of a chain-of-command arrangement, they are there together and they are held together by affective ties. This is characteristic, for example, of many of the kinds of groups that you see working in society or the kinds of teams that you often meet in welfare councils and so on. Of course, their affective integration may also be characterized by *lack* of integration, but where the team is cohesive, affective factors are characteristic of it.

The third type is the type that we have been concerned with most and this is an attempt to define the kind of integration that proceeds from theoretical integration—that is, from an attempt to solve the interdisciplinary problems and to reach types of formulation that include the points of view of all participating members. We have come to conclude that in any functioning team and particularly in respect to the leadership, all three types of integration must be present—chain-of-command based upon responsibility for solving the problems and setting the objectives of the group, affective integration and, finally, theoretical integration in which the leader functions as a person who integrates the material into a theoretical statement and a diagnostic statement. Without any of these the integration is inadequate and particularly the leadership suffers.

Multiplicity of Leaders' Roles

The last point I would like to make is the multiplicity of roles filled by leaders, which is extremely important in the clinical team. This is in contrast, incidentally, to the more limited functions of leaders in other settings, particularly the ones we have been describing here in crisis. We have tried at various times informally to list the various roles that the leader in a clinical team seems to be filling at any one time, and they are innumerable. At one moment he is a scapegoat, at another moment he is handing out rewards or punishments, at another point he seems to be a psychotherapist, at another moment he is the receiver of confidence, he is a stimulator, and so on. One of the major characteristics seems to be his ability to fill these roles and at the same time to keep the objectives of the group function in mind.

I have attempted to describe briefly a few primary clinical observations that we have made and are in the process of studying at the present time. The more precise information we obtain the clearer it becomes that much which is taken for granted in the field and in the clinic needs further study and definition.

NON-FRATERNIZATION BETWEEN LEADERS AND FOLLOWERS AND ITS EFFECTS ON GROUP PRODUCTIVITY AND PSYCHOLOGICAL ADJUSTMENT

FRED E. FIEDLER, PH.D.

The problem to which this paper will address itself suggests the presence of an implicit contradiction in two major types of demands we make of the leaders of small task groups. First and foremost, we obviously demand that our leaders be effective, that is, we want them to make their groups maximally productive. Second, we also want the leader to be responsible for the psychological well-being of his men. We want him to be a kindly father confessor to whom his men can bring their personal problems. We want him to listen sympathetically to his men, to give them help and advice, and to allay their anxieties and insecurities.

This paper will attempt to show that these may well be basically incompatible demands. The function of increasing the productivity of the group, and the quasi-therapeutic one of helping men to adjust, seem to require different attitudes and different roles which only the exceptional leader can successfully combine. Moreover, the organization of the formal task group is, in effect, designed to curtail, if not to inhibit, quasi-therapeutic behavior on the part of the leader towards his men. By quasi-therapeutic attitudes, we mean here basically understanding, empathetic, accepting attitudes which are non-threatening to the other person. A number of studies have shown these attitudes to be characteristic of good therapeutic relationship,[3 10] and we have evidence that similar attitudes are therapeutic in situations outside the therapist's office.

However, the organizational structure and its formal and implicit rules do not facilitate the development of such accepting, non-threatening relationships. On the contrary, they effectively discourage them in favor of the leader's task-oriented functions. One aspect of this can be seen in the operation of military organizations where we have a clearly defined system of social classes. The rules of this system encourage, if they do not, in fact,

demand, the isolation of the officer from the enlisted man, and the senior noncommissioned officers from the men in lower grades. This is exemplified by the existence of separate dining rooms, separate sleeping quarters, club rooms and wash rooms which are provided for officers and enlisted men, and in large installations for NCO's as well. All of these facilities, it will be noted, are places where men generally interact irrespective of rank, where the basis of interaction does not depend on the roles imposed by their military duties.[12]

Isolation of Leaders

Even though it may be less apparent in other organizations, the isolation of leaders is by no means limited to the military services. Social interaction between executives and lower ranking employees is discouraged to no less an extent in business and industry. Many corporations operate separate dining rooms for their executives and cafeterias for their non-managerial employees. Similarly, hospitals rarely, if indeed ever, have the medical staff eating with service and maintenance personnel.

The long history, as well as the widespread usage of these customs, leads us to believe that the isolation of leaders from their followers must have survival value, that it may indeed serve a vital function. It seems important, therefore, that we examine these customs in light of the interpersonal relations between leaders and followers which they engender. This seems particularly appropriate in view of the recent public concern with the problem of officer-enlisted man relations in the military services.[12]

Specifically, then, we shall ask, what purposes does this system serve, and how does it affect the leader's ability to function on the one hand, as the quasi-therapeutic resource person for his subordinates, and on the other, as the expediter of the group's tasks?

One very simple explanation is that separate facilities for leaders are generally better, and that they, therefore, serve as a reward. This explanation is not fully satisfactory, however. It does not account, for example, for the rules which forbid officers and enlisted men to play cards with one another, or to drink together, nor does it explain why military tradition frowns on association of officers and enlisted men in off-duty hours.

A number of other, more realistic explanations have been advanced to justify the presence of social barriers between leaders and followers. The most important of these is expressed by the well worn adage that "familiarity breeds contempt." Presumably,

permitting a subordinate to become too familiar with his leader might permit him to find out that the leader has certain unsuspected weaknesses. This discovery would then lead the subordinate to be contemptuous of his leader, and he would be less inclined to idealize him. This, in turn, would make the subordinate less willing to follow his leader blindly through thick and thin, thus lowering the potential efficiency of the group.

There are a number of flaws in this argument. First of all, the idea that lack of social contacts will prevent the subordinate from learning about the superior's faults and foibles is surely a delusion. Discussion of the superior's shortcomings ranks only slightly behind the topics of sex and women in backroom popularity. Nor is it likely that the lack of social contacts with their leaders has ever kept some men from feeling contempt for them. While we must grant that the "familiarity-breeds-contempt" notion has some merit, it does not appear to account adequately for the elaborate class systems to be found in large organizations. Most importantly, the hypothesis derived from it cannot be supported by empirical research.

Summary of Studies

I would like to summarize, very briefly, some of the studies which bear on this question.* These studies have been generally concerned with the determinants of leader-group relations on the effectiveness of small task groups. We have worked with interpersonal perception measures, the so-called Assumed Similarity Scores, which are interpreted as indicating an attitude of psychological closeness and acceptance, versus psychological distance and a readiness to regard others more critically and analytically.[4 8] Thus we have found that good therapists tend to assume more similarity between themselves and their parents than do reputedly poorer therapists.[3] Our subjects report that they like and feel more familiar with people whom they perceive as more similar than with those whom they perceive as different.[2] People with low Assumed Similarity tend to be more reserved and distant. Support of the familiarity-breeds-contempt hypothesis would then require that the groups in which members feel relatively distant towards their leaders would be more effective than those in which the members would tend to feel relatively close to their leaders.

* These studies were conducted under Contract N6–ori–07135, between the Office of Naval Research and the University of Illinois.

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We have conducted a number of studies in which this question could be tested. Thus, we investigated the differences in high school basketball teams which won a high proportion of games, and those which lost more games than they won. However, members of good teams do not see their leaders as less similar (or as more similar) than members of poor teams.[5] The same results were obtained when we compared the group members' attitudes toward their leaders in bomber crews, tank crews and sales cooperatives. Also implicit, as we suggested before, is the hypothesis that men who idealize their leader will perform better than those who do not. One way of measuring the men's idealization of the leader can be through the use of sociometric indices. It can be shown that men who idealize their leader will also rate him more highly on a range of sociometric questions than will men who do not idealize him. Hence, in line with our hypothesis, we expect the better teams to idealize their leader more than would the poorer teams. However, here again, our data do not show any systematic trends. While some investigators (e.g.,[11 13]) have reported low positive correlations, we do not find these consistently in our own studies, nor are they reported in studies of various other workers in this area who use objective group performance scores as criteria of effectiveness.[19]

There is then no empirical evidence in our studies that a feeling of familiarity on the part of group members for their leader will affect the productivity of the group. Nor is there any evidence that lack of idealization of the leader, which might be a consequence of too much familiarity, is related to group effectiveness.

Let us then examine an alternative hypothesis. Could it not be that the group's effectiveness will suffer because the leader becomes too familiar with his men, rather than because the men become too familiar with their leader? May these elaborate rules not be designed to prevent the leader from getting too close to his men, rather than keeping the men from overly close relations with their leader?

A considerable body of anecdotal evidence supports this hypothesis. Leaders often report that they experience acute conflicts in sending close personal friends on dangerous missions; many leaders would rather not know about a man's family or about his problems because they fear that this might influence their decisions. Similarly, we are more inclined to find excuses for a breach of rules which has been committed by our friends than for one committed by a complete stranger.

What is the empirical evidence to support the hypothesis that leaders who are less familiar with their co-workers have better performing teams than leaders who have close relations with their men?

Here we find that informal leaders of game-winning basketball teams perceive greater distance between themselves and their co-workers than do leaders of relatively poor teams. Informal leaders of accurate surveying parties perceive greater psychological distance between themselves and their co-workers than do leaders of less accurate teams.[5] And similar results have been obtained in studies of open hearth steel production and consumer cooperative management.

In the very shortlived military crews we can see perhaps even more clearly, the influence of psychological distance between leader and keyman on the effectiveness of the team. The teams here were bomber and tank crews. Our results show that leaders with generally close relations to co-workers have good teams provided they *do not* sociometrically endorse their keyman (that is, the person who is most directly concerned with the criterion relevant operation, for instance, the gunner in a tank crew where the criterion is gunnery performance). It is probable that this distance, which is expressed here by low Assumed Similarity scores, or else in low sociometric preference ratings, can also be obtained by limiting the informal contacts between leaders and followers.[6] The psychological distance which the effective leader maintains between himself and his co-workers basically seems to provide emotional isolation from his co-workers.

The Leader's Dilemma

How is this set of findings related to the original dilemma which we posed at the beginning of this paper? The leader who becomes emotionally involved with his men is less able to perform his job because considerations of personal nature may enter into his decisions. These considerations may be experienced by other members of his group as favoritism or discrimination. Above all, the man who is emotionally involved with his subordinates, who experiences deeply the pain of having to punish or fire one of his subordinates, will be considerably more hesitant to discipline his men. We have found the effective leader to be emotionally distant and reserved, ready to reject, if necessary, his own grandmother, if she cannot play basketball or sell farm equipment. The effective leader is, therefore, judgmental, critical and non-accepting of poor co-workers. These attitudes are exactly the

opposite from those we would expect of the therapeutic individual who should be accepting, non-judgmental and non-critical.

The dilemma arises because we expect the good leader to be a good therapist as well. If we interpret our data correctly, these seem to be two mutually incompatible functions; incompatible because of the contradictory attitudes which are involved, and because the social structure of the formal organization is designed to inhibit accepting close personal relationships between leaders and followers. True, there will always be some people who can wear the therapist's hat one hour and the judge's robe the next, but these individuals are surely rare among platoon sergeants, company commanders, or first-line industrial supervisors.

In fact, recent research conducted under the auspices of the Army's Surgeon General's Office has not produced any evidence that the leader performs quasi-therapeutic functions. This, despite the fact that other informal relations among men in small military units definitely can affect adjustment under the same conditions.*

In light of our findings, it would seem wise to consider limiting the leader's job to increasing his group's effectiveness. The task of aiding men to adjust may perhaps better be left to others in the group whose job does not preclude the performance of quasi-therapeutic functions.

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* This work was conducted under Contract DA–49–007–MD–569, between the Office of The Surgeon General, Department of the Army, and the University of Illinois.

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PROBLEMS OF LEADERSHIP IN THE OVERT AND COVERT SOCIAL STRUCTURE OF PSYCHIATRIC HOSPITALS

WILLIAM A. CAUDILL, PH.D.

The questions on leadership that are opened for discussion in these remarks revolve around such matters as the division of responsibility between administration and therapy which is made in some psychiatric hospitals, and the existence of both an overt (formal and informal) social structure or organization for work in the hospital and a covert emotional structure that underlies the more easily identified overt structure. The division between administration and therapy is a question of much current interest in efforts to arrive at a "therapeutic milieu," and this division of responsibility can be thought of in terms of the "leadership" required in carrying out administrative and therapeutic tasks. The covert emotional structure is most readily seen as distinct from the overt social structure at times when the latter is disorganized as during collective disturbances.[1–3]

Within the limits of this paper all that can be done is to suggest a number of questions in the following remarks without going into a very detailed discussion of any of them. It is hoped that some of these questions may receive more extended discussion in this Symposium during the presentation by the panel on leadership.

Remarks on Leadership

The problems of leadership in the psychiatric hospital would seem to be directly related to the material contained in Dr. Fiedler's paper for this Symposium. He is concerned with the possible basic incompatibility in the demands on leaders in small groups to strive to make their groups maximally productive and at the same time to be responsible for the psychological well-being of the men. Fiedler thinks that "the function of increasing the productivity of the group, and the quasi-therapeutic one of helping men to adjust, seem to require different attitudes and different roles which only the exceptional leader

can successfully combine." An indication of just how exceptional such leaders are comes from Bales' work (in a verbal communication to me) with experimental small groups where he finds such versatile individuals occurring about 5 percent of the time, or 1 person among 20. This being the case, it aids in our understanding of the attempt to place administrative and therapeutic responsibilities in the hands of different people in the psychiatric hospital. This separation of functions, however, creates its own problems as will be indicated later.

Much of Bales' experimental work with small groups supports the position taken by Fiedler. For example, Bales [4] says,". . . There is some kind of almost inevitable contrary or interfering relation between the strength and elaboration of the technical division of labor and the strength and elaboration of the network of solidary affective ties within a given group." In much of Bales' previous work,[5,6] two types of "leaders" tended to appear in the course of interaction in any single small experimental group. These two leaders, within any one group, embodied the task functions of the group on the one hand, and the social-emotional functions on the other. One was the "task specialist" and the other was the "sociometric star." Originally, Bales felt that these two tasks tended to be mutually exclusive. In later work, he came to feel that while the abilities to carry out these two tasks did not very often occur in a single leader, there was no necessary incompatibility between them. As he says,[4] ". . . (they) are not opposites which *preclude* each other, but are rather approximately *orthogonal* to each other. That is, the traits to which the factors refer are . . . uncorrelated; at least they are not linearly correlated." After a review of a number of studies by other people, Bales[4] goes on to say:

> But the important thing to note is that these three factors which I shall call, "activity," "task ability," and "likeability," are, in the studies mentioned, . . . not mutually exclusive, so that a high standing of one precludes or interferes with a high standing on the other, but, rather, they are in general uncorrelated.
>
> Now, this in itself may be regarded as anomalous. Indeed when I first set out to examine data from my own experimental groups, I made the working assumption that they might be some such thing as a "simply organized group," that is, one in which the rank order of members on activity, task ability, and likeability would coincide, and that these groups would in some sense or other be the most successful or best satisfied. It turned out that for the groups examined there was some positive correlation between the three, especially activity and task ability, but the top man in activity, in particular, was unaccountably low on the average as to likeability.

> . . . Some of us were loath to believe, as I hypothesized, that there was something about arriving in a top status position, owing to technical contribution to the task problems of the group, that tended to "lose friends and alienate people."

In seeking further for an answer to this problem Bales found the work of Thibaut and Coules [7] interesting in that they reported that receivers who are permitted to communicate back to a person who has sent them an act of hostility show more post-experimental friendliness to the sender than those not permitted to communicate. This study provides additional evidence to support the current cry for more and more communication in the social systems of psychiatric hospitals, combat groups, and so on. Such additional communication can, of course, be carried too far so that channels become clogged with information. Be this as it may, from such studies Bales and his group arrived at the hypothesis that the ratio of interaction received to that initiated might help to distinguish between those top interactors who were proportionately well liked and those who were not. They then went on to investigate this problem in 60 sessions of five-man experimental groups using Harvard Freshmen as subjects. One of the first things they found was that actual gross activity was highly correlated with the post-interaction ratings by the subjects as to which persons were assertive and tried hardest to lead.

This relationship between the person who speaks most and the person who is evaluated as having the most leadership is in line with the results which I obtained in the analysis (using Bales' interaction categories) of a series of 63 daily administrative conferences in a small psychiatric hospital. In these conferences those residents who spoke most were most highly evaluated by the senior staff a year later. These results are indicated in more detail later.

Further work with his groups led Bales to set up a typology on the basis of the way in which subjects were ranked by their fellows. Five types of people emerged from this analysis: (1) The "great man" who was high on all three factors of activity, task ability, and likeability. (2) The "task specialist" who was high on activity and task ability, but somewhat low on likeability. (3) The "social specialist" who was high on likeability, but somewhat lower on activity and task ability. (4) The "deviant" who was high on activity and task ability, but somewhat low on likeability. Finally, (5) the "residual member" who was ranked from medium to low on all three factors. Needless to say, the "great men" were not very common. Far more common were the "task

specialist" and the "social specialist." Within the total population of the groups there was a tendency toward a curvilinear correlation in which the top-ranking man on activity was lower on liking received, on the average, than the second or third man. Bales then went on to examine three subpopulations which were built into the design of the study but with which we cannot concern ourselves here.

At this point we are back to the feeling expressed earlier that there is a tendency (though not a necessity) for adaptive and expressive functions to be taken over by separate members in a group. Parsons and Bales [8] have explored this tendency in the behavior found in small groups with reference to the structure of the family in which the roles of father and mother are often differentiated along these dimensions. There is not space here to go into the complicated problem of the social structure and dynamics of the family. It may, however, be useful to point here to some of our results from an interview study carried out in a small psychiatric hospital, during which the analogy of the hospital to a family seemed to be particularly appropriate. These results, as well as others cited later, have received more extended publication elsewhere,[3 9 10] but it seems pertinent here to mention them briefly within the context of a discussion on leadership.

In our interviewing program we worked with four role groups: senior staff, residents, nurses and patients. It became apparent upon analysis of the interviews that the senior staff and the patients shared many similar patterns of perception about life in the hospital. Both groups were optimistic over the outcome of interaction in the areas of therapy, administration and general human relations. This was in contrast to the residents who were optimistic about therapy and human relations but pessimistic about administrative matters. The nurses had yet another pattern, being optimistic where therapy was concerned but pessimistic about both administration and human relations.

With regard to the intriguing similarity in pattern between the seniors and patients, it is interesting that neither group had day-to-day responsibility for the operation of the hospital; both groups could more easily be optimistic as they were less in touch with these problems. In addition, it is likely that this pattern is a specific instance of a general phenomenon in human relations: the tendency for alternate levels (or extremes) in a hierarchical structure to show certain similarities in attitudes and feelings, whether in a hospital, a factory, or a kinship system. In most societies there are patterns of mutual indulgence and affection

between alternate generations, such as those between grandparents and grandchildren. In this latter case, neither generation usually has direct responsibility for the other, and the two groups are united in having experienced frustration with the intermediate generation. In an analogous way, the residents and nurses might be thought of as the slightly harassed parents living between the grandparental seniors and the patient children. It is not clear to me as yet which groups, among the residents and nurses, respectively took the roles of father and mother. However, it did seem, from these and other data, that there was a tendency in the hospital for role groups to separate themselves along the lines of adaptive and expressive functions.

It is perhaps useful to pursue this matter of the interviews a bit further. Taken all together, there was a good deal more optimism than pessimism expressed by the various role groups in the picture interviews. Yet the daily observations indicated the existence of much tension and many minor, constant problems which now and then coalesced into major issues.

A clue to the meaning of this seeming discrepancy may be gained from the opinions about interactions given by the particular role groups who were actually engaged in these interactions each day. If we consider the material from what we called the area of therapy, then the majority of both residents and patients were optimistic about their therapeutic interaction. In contrast to this, while nurses were on the whole optimistic about their own therapeutic efforts with patients, the patients were pessimistic in speaking of therapeutic contacts with nurses. On the other hand, the patients saw their administrative interaction with nurses optimistically, while the nurses were pessimistic about administrative work with patients. The point here is that when an analysis was made of the congruence of opinion between role groups as to the emotional tone of the interactions in which they were involved, there was underlying disagreement in the great majority of cases. Moreover, the nature of the hierarchical structure of the hospital and the formality of relations across status lines served to impede people in differing roles from becoming aware of the discrepancy in the emotional evaluations of their interaction. It seems likely that such a condition served to accentuate the difficulties in working through the minor issues that inevitably occurred in the day-to-day operation of the hospital.

The main exception to these difficulties in communication was in the specific area of psychotherapy where, at least by definition,

such difficulties must be ironed out. Given such a situation, one might anticipate greater problems of "leadership" in administrative than in therapeutic tasks in the hospital, and such indeed was the case. If, however, administrative and therapeutic functions are combined in one person, then frustration is likely to occur; if these functions are separated and handled by different persons, then communication is likely to break down between the parties where it is most necessary.

I cannot myself suggest any immediate answers to the questions raised by the above dilemma. Perhaps some of the answers lie in the type of procedures devised by Lt. Colonel Artiss and his group in their work with schizophrenics which is reported in this Symposium. From here on I wish to consider a bit further two problems: (1) some of the effects on leadership of the fairly typical kind of psychiatric hospital social structure, and (2) some aspects of attempts to date to make such a structure more workable.

Overt and Covert Social Structure of Psychiatric Hospital in Relation to Leadership

One of the most important, and often cited, facts about the social structure of a hospital is that it includes a sharply defined hierarchy of statuses which are, as Harvey Smith [11 12] has put it, "mobility blocked." That is, under ordinary circumstances personnel can only advance within their own level—an attendant cannot become a nurse, nor can a nurse become a doctor. Movement from one level to another can only be achieved by leaving the system, acquiring further training and returning in a different status. Under such conditions interpersonal relations between people on various levels come to be, at least overtly, highly formalized. Furthermore, as we have seen in the picture interview material, such a social structure makes for the development on each level of somewhat separate values and attitudes toward everyday events of hospital life, and these differences in attitudes are incompletely known across levels.

One of the effects of this "blocked mobility" is the lack of job satisfaction that is a chronic problem in hospital administration at all levels but particularly among nurses and aides. In this regard, Schoenfeld's questionnaire survey [13] is interesting as to "why people work in hospitals." The main reason for taking the job was that it was the only job available; the main reason for keeping the job was that it was close to home; and the main

reason for leaving the job concerned the poor attitudes of supervisors and co-workers. While these may be similar to the attitudes toward work in some industrial situations, they do not, at the very least, indicate a strong motivation for employment in hospitals. There are few studies of turnover and its costs, but one was made by Hamilton[14] in a general hospital which had an average work force of 507 employees. In this hospital the annual turnover rate was just over 63 percent. The nursing service accounted for well over half of the turnover costs. This was a study of a general hospital, and the greater difficulties in holding psychiatric nursing personnel are well known.

Given the present structure of most psychiatric hospitals, if one finds a low rate of turnover in an occupation, one can assume that this occupation has developed, probably *within its own role boundaries,* a set of primary group ties and values that hold its members to it. Often, as indicated in the picture interview material, these values are at variance with those of other role groups in the hospital.

Such a situation was described by Rubington[15] in his study of psychiatric aides in a large Veterans Administration hospital. Among the aides in this hospital occupational stability was the rule rather than the exception. The average length of service for the total complement of 464 aides was 5 years, and approximately three-fourths of the aides had served more than 1 year. The question is, why should there be such an occupational stability in this group? During the study it became clear that the aides were fully aware of their low rank in the hospital and in the community. A certain minimum of self-esteem is necessary in any occupation, and in the hospital under discussion such an image of self-esteem was not provided by the patients, the doctors or the nurses, but came rather from the other aides as a group. That is, an aide's sense of personal worth and dignity came from the esteem in which he was held by his fellows.

As pointed up by Rubington, some of the aspects of this self-image held by the aides are quite understandable, but also are disturbing to those of us who like to speak of a "therapeutic community." Rubington found that the core values of the aide culture were all variations on the theme of masculinity. One of the highest honors an aide could confer upon another was to say, "He is a man." To earn this title, an aide had to demonstrate competence in handling mental patients. The demonstration of competence many times required the illegitimate use of force.

The cultural tradition among the aides required a "hard" personality if patients were to be controlled. This tradition alienated the aides, in their own minds, from the "soft" personality configuration of such professionals as doctors and nurses. Thus, very often when the aide's job was well done, it had to be done in a clandestine manner and the accomplishment only shared with other aides. This made for a spirit of secrecy. Other personnel, and the community at large, may have been ambivalent about the process through which social order was maintained in the hospital, but the aides were not. They could not, however, communicate their values or technics to other levels in the hospital. In some senses, Rubington's analysis of the "hard" culture of the aides with its theme of masculinity reminds me of the remarks on a similar state of affairs among military police as noted by Lt. Colonel Harris and Captain Little in their paper for this Symposium.

It seems useful to give some further indication of the effects of the status system in the psychiatric hospital on participation and leadership. Such effects were apparent in the analysis mentioned earlier of the administrative conferences in a small psychiatric hospital.[10] The data consisted of the essentially verbatim written record of interaction at 63 consecutive daily administrative conferences. These were held each morning, lasted for about half an hour, and were attended by several senior staff members, five residents, three or four nurses, and other personnel such as the social worker, occupational therapist and group worker. Discussion centered around routine administrative matters, progress of patients in therapy and on the wards, and questions of policy. The written records of these conferences were first analyzed through the use of Bales' interaction categories.

I only want to mention here some of the findings concerned with the sheer amounts of talking done by the various role groups. It is perhaps not surprising that, when corrected for differential numbers of persons present in a role group, the senior staff talked most, the residents next, and the nurses and other personnel least (as these latter groups had roughly equal amounts of participation). Pursuing this matter further, within the senior staff role group the psychiatrist-in-chief talked more than the other senior doctors, while among the nurses the supervisor of nurses talked more than the charge nurses, who, in turn, talked more than staff nurses. The effect of status on the amount of participation, both between and within a role group, can be seen clearly from these results.

The data on the residents can be used to illustrate a somewhat different phenomenon. When the 63 conferences were divided into three consecutive 21-conference periods, the five residents consistently maintained the same rank order from most to least talking resident. The effect of personality within a role group is evident here in that Dr. A, who talked the most, was an assertive, mature man who was much involved in his work, while Dr. E, who talked the least, was a passive woman who tended to withdraw from many situations. Nevertheless, over the three 21-conference periods, Dr. E always talked more than the supervisor of nurses *despite* the fact that the supervisor was, like Dr. A, a forceful and outspoken individual. This latter finding brings out rather sharply the interplay of personality and social role in leadership in administrative interaction. Dr. E's role as resident served to increase her participation over what it might have been, but for the supervisor of nurses, her role acted as a brake on the amount of participation she was motivated to engage in because of her personality.

The remarkable consistency over time in the rank ordering of most to least talking resident was not anticipated, and only became apparent after the data were analyzed. After analysis of the data I was struck with the correspondence between the rank order of most to least talking resident and what I thought would probably be the senior staff's estimate as to the general clinical competence of a particular resident during the year. I therefore predicted that the rank order of most to least talking resident would correspond with the rank order that would be assigned to the residents by the senior physicians. To test this I wrote to each of the six senior physicians who had taken part in the training of the five residents, giving the names in alphabetical order, and asking the senior men to rank the residents as to their general competence. The seniors were requested not to have any ties, and to make the ranking independent of consultation with other physicians. These rankings were made after the residents had completed their year on the in-patient service.

The results showed that the six seniors agreed among themselves closely as to the rank order for residents. Equally, there was a remarkable degree of consistency between the rank order of most to least talking resident and the degree of competence of a resident in the minds of the six senior physicians. There was only one exception to the agreement between these two rank orders in that the residents who were ranked fourth and fifth as most to least talking were reversed as to evaluation of competence.

It is difficult to know exactly what these results may mean. It is not thought that in any simple sense the most talking person was necessarily favorably evaluated because he spoke more during the administrative conferences. In any case, this criterion could not enter directly into the judgment of three of the six senior staff physicians because they never attended the daily administrative conferences and only saw the resident physicians in supervisory sessions concerning psychotherapeutic work. Perhaps one answer, which would be operative in both the daily conferences and the supervisory hours, is that the most talking residents tended to be qualitatively different in their interaction when compared with the least talking residents. For example, Dr. A, in the administrative conference, would not only consistently transmit the requests of his patients for approval but would also state his opinion as to the advisability of these requests. Thus, Dr. A would say, "Mr. Edwards wishes to go to the library this afternoon to return some books and I feel this is a reasonable request." Dr. D, on the other hand, would simply say, "Mr. Oliver asked me to bring up the request that he wants to go shopping today." Inherent in such examples is the likelihood that Dr. A was more personally involved in the problems of his patients than was Dr. D.

This brings up the further point that in the administrative conferences the residents who talked at greater length (Drs. A, B and C) were engaged in more heated discussion with the senior staff than were the least talking residents (Drs. D and E). That is, the sparks flew more frequently between Drs. A, B and C, and members of the senior staff. Clinically speaking, this meant that at any one time in the work of the hospital there would be a stronger opinion—either positive or negative—held by the senior staff members about Drs. A, B and C.

At the close of the year, when asked to evaluate the residents, the seniors most favorably evaluated those residents that they had had the most interchange with, whether their relationships with the residents had been positive or negative. In this connection, it is interesting that by far the most heated disagreement occurred between the seniors and Dr. A, and yet Dr. A was the most favorably evaluated at the end of the year, and he became the chief resident during the following year. These results from a real life situation would seem to be in line with the experimental work of Bales and others on the effect of the amount of participation in the evaluation of leadership.

The administrative conference data were further divided into 12 one-week periods in order to follow certain questions over time. After developing a type of content analysis, 10 indexes were constructed which it was hoped would measure various aspects of the on-going administrative process such as the extent of control exercised by the senior staff, the level of confusion in discussion, and the degree of withdrawal from active participation with each other on the part of the several role groups. When these 10 indexes were plotted, it was found that five of them reached a peak in the ninth week, and the other five in the tenth week. A collective disturbance on the wards took place during the eleventh week. This disturbance started with the majority of the patients on the open ward becoming upset on the same day, and this acute unsettled state persisted for a period of about a week.

Such an analysis by means of the indexes was, of course, after the fact. I did not know myself at the time I was gathering these data, nor were the staff aware, that such changes were taking place at the administrative staff level prior to the time that similar changes took place among the patients on the ward. However, such an analysis holds out the possibility that certain aspects of the covert emotional structure of the hospital are identifiable and, indeed, measurable in quantitative terms. It might be hoped that in the future such indexes could be further refined for use at the administrative level, and additional indexes developed for measuring changes on the ward level. The clinical usefulness of such procedures is, I think, obvious. However, there are some questions which arise as to the way in which such information should be introduced (the current popular term is "fed back") into the hospital system, and who should take the responsibility for doing this. It might be that ward personnel (nurses and aides) could, after further training, assume such responsibility, or that a new category of person, the clinical anthropologist or sociologist, might take over such a function.

It may seem from the above rather "dry" account that the collective disturbance was a matter of about a week. Such an impression would be incorrect. The disturbance occurred over a 3-month period, and it is necessary at least to indicate some of the background of it in a clinical sense. A fuller account of the disturbance has been published elsewhere.[3]

The collective disurbance, as it was seen by the staff at the time it took place, is fairly representative of the way such situations often seem to develop. Without explicit prior recognition

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or discussion on the part of the staff, certain dramatic events simply occurred which resulted in both the open and closed wards becoming disturbed, and a special staff meeting was then called to discuss the matter. Specifically, all those patients from the open wards who had privileges to go into town left the hospital one evening singly or in pairs, whereas previously they had gone out in groups of four or five. Each pair of patients who left the hospital had a disagreement among themselves, and the two individuals returned separately to the hospital. All persons who went out had an unpleasant evening and, depending upon the form taken by their personal problems, returned in an excited, depressed, or drunken condition. The upset state of these patients spread to others on both the open and closed wards, and this acute phase continued for a week.

In order to see the wider social context of the collective disturbance it is necessary to take account of the state of transition in the hospital from a diagnostic to a psychodynamic treatment center, and to look at events occurring during the 2 months prior to, and 1 month following, the acute phase of the disturbance. The events during these months must be seen with reference to what was happening at all levels in the hospital—among senior staff, residents, ward personnel, other workers and patients. We felt we could divide these 3 months into a sequence of four types of "balance of forces" between the role groups in the hospital, and this sequence is outlined below.

In the months preceding the collective disturbance, the senior staff members were engaged in trying to define their own roles, in determining therapeutic policy, and in finding ways to formalize the routine of the hospital. The residents tended to see therapeutic problems in terms of their individual patients, and were opposed to formalized routine. Such disagreement placed the nurses in confusion as to their responsibilities, and as to just what were the rules that were to be followed. In line with the effort at transition, a new activities program headed by a professional group worker was started on the wards. This new program was felt as a threat by the occupational therapist and as yet another area of confusion in routine by the nurses.

This unsettled state among the staff was reflected among the patients in a lack of certainty as to what were correct and permitted actions. These areas of disagreement among role groups tended to remain covert and were not openly discussed at such expected points as the daily administrative conference. Such disagreements were, however, often implicit in the discussion of

plans for individual patients who then became the vehicle through which differences of opinion were expressed. Some two months before the collective disturbance, the observational data clearly indicate that the various role groups had attempted to ease the difficulty of the situation by a process of mutual withdrawal in which each role group concentrated on the tasks which it felt were most sharply defined for its members, and limited in its interaction with other role groups to "neutral" activities.

This state of *mutual withdrawal* was still in effect during the week preceding the collective disturbance, and is the first of the sequence of types of balances between the various role groups, while the shift which took place during the *collective disturbance* itself was the second. Both of these periods were reflected in changes in the indexes subsequently developed from the interaction at the daily administrative conferences, but during the actual occurrence of these events the processes which were going on went unnoticed (or at least were not given open recognition) by the staff, and equally were not apparent to me as research anthropologist.

Just prior to the acute phase of the collective disturbance two key members of the patients' group were discharged, and this resulted in a fragmentation of the group structure on the ward. The patients could not, at this point, reform adequate companionable groups and, in various ways, appealed to the staff for a greater control over their activities. Because of the state of mutual withdrawal, the patients' attempts at communication did not get through in a meaningful way to the staff, and the collective disturbance ensued.

The various staff groups were at first bewildered, and then were divided, in their efforts to help the patients. The nurses and senior physicians, as one pair of role groups, tended to work together to help the patients through a greater formalization of routine and a sharpening of the boundaries of the hospital. On the other hand, the residents tried to help the patients by granting greater freedom to individual patients and suppressing information about these additional privileges during the daily administrative conferences. In so doing, the residents and patients formed another pair of role groups. Each staff role group was, in its own way, attempting to act positively, but since the disagreements between staff role groups remained covert, there was considerable confusion among both staff and patients. A situation was created in which the residents identified (in the

technical psychodynamic meaning of this term) themselves with the patients, and the nurses identified with the senior staff.

This period formed the third in the sequence of types of balances, and may be called a *paired role group response* in a "disorganized" social field. In some senses, the term "regressed" social field conveys my meaning more accurately, but I balk at the anthropomorphic quality this attributes to the social structure of the hospital. In any case, such an unstable balance of forces could not persist and, after several weeks, the discrepancy between the procedures followed by the residents in granting privileges to patients, and the policy of the hospital on this matter as defined by the senior staff, was "discovered."

This led to several conferences in which differences between the various staff role groups were openly discussed, and with this the operation of the hospital returned to a more stable equilibrum. This process of *restitution* comprised the fourth in the sequence of types of balance.

During all four phases of the process that has just been outlined, *affective communication* between the various role groups was maintained, but the lines of *cognitive communication* were at first broken, then reformed rather strangely in the period of the paired role group response, and only finally re-established during the period of restitution. Thus the covert emotional structure of the hospital was operative throughout the 3-month cycle that included the acute period of the collective disturbance, but was not supported by the operation of the overt social structure which was fractured and twisted in many ways before it returned to normalcy.

Once cognitive communication had been restored during the period of restitution, an appropriate outlet was opened for the tensions felt by the various staff role groups. Such tensions had very little to do with the patients *per se*, but had much more to do with difficulties at the staff level. For example, the residents finally came to express their concern over such matters as: (1) the problems they had in presenting their cases to the senior staff at conferences; (2) their criticism of the supervision of psychotherapy; (3) the adverse effects they felt the administrative policies of the hospital had on the therapeutic progress of patients; and (4) their own practical and emotional needs they felt had to be satisfied (e.g., as to adequacy of salary and hospital care in case of illness) in order for them to function effectively in the hospital. Such matters of job satisfaction as were raised by the residents bring us back again to the nature of the

social structure of the hospital, and to a brief consideration of recent suggestions for changes in the organization of psychiatric hospitals.

Suggested Changes in Organization of Psychiatric Hospitals

First of all, in answer to the question as to what might have been done to avert the collective disturbance, perhaps the answer is that one would not wish to do so. The phenomena referred to here as a collective disturbance are not necessarily bad and, in fact, much good can come of them. A hospital (or any other organization for work) which did not have some rhythm in its activities would not be a good hospital, it would be a dead one. The opposite is also obviously true—the ups and downs in everyday life can reach too great proportions for adequate functioning. In between a state of extreme oscillation and one of dead calm there is much to be learned from such phenomena.

Rapoport [2] has expressed the same point of view in his discussion of similar phenomena at Belmont Hospital in England. He indicates that "these tension states need not be seen as antitherapeutic and therefore categorically to be avoided. On the contrary, they may have therapeutic value." He proposes the term "sociotherapy" for the activities associated with the didactic, beneficial resolution of these tension states. Concerning this he says (Ref. 2, p. 358):

> The resolution of a hidden staff conflict might alleviate a patient's disturbance and thus be beneficial, but it would only become sociotherapeutic if it were done to the accompaniment of an analysis of the patterned personal significance of the development and alleviation of discordant relationships for those concerned. The criterion of *didactic* accompaniment to tension-reduction is conceived of as important in enhancing the possibility that persisting change in capacity to sustain harmonious relations will occur.

In his article, Rapoport develops this point of view at some length, and this is all to the good because, as he says, there has been too much enthusiasm and to date too little real understanding of what goes into the concept of "therapeutic community." Rather than attempting to do away with the phenomena that make up a collective disturbance, what is needed is the development of methods for studying the covert emotional structure in its relationship to the overt social structure with the goal of first understanding and then perhaps bringing about changes in both.

One sort of change which has been made a good deal of in the past few years in an effort to avoid some of these problems in the psychiatric hospital is the separation between administrative responsibility and therapeutic responsibility. This is usually done

by placing the administrative care for all patients on a ward in the hands of one physician, while the other physicians doing psychotherapy are supposed to look upon the ward as a reality in somewhat the same way that a therapist outside the hospital would view the setting of his patient's daily activities. Such a separation between administration and therapy was not the case in the example of a collective disturbance cited above, and this lack of separation, among other things, contributed to the process of identification of the residents with their patients in the paired role group response.

At the same time, the very process of separation of administration and therapy creates its own problems as in the well-known Stanton and Schwartz [1] phenomenon of the participation of the patient by increased excitement in disagreements between two persons who exercise authority over the patient. One reason that such disagreements arise is, of course, that the administrator has less prestige than does the therapist and moreover, that the therapist in the name of "emergency" often overrides the decisions and plans of the administrator. As Smith [12] points out very well, this is not just a problem for the psychiatric hospital or the general hospital, but is inherent in a situation whenever there are dual lines of authority—professional and administrative. Such a situation can arise in military organizations between line and staff control, or it can occur in universities between the faculty members who do the teaching and the administrators who care for the physical upkeep and financial condition of the institution. As such, this is a broad and general problem in leadership which does not admit of any easy or facile solution.

A further type of change that has been emphasized recently concerns the attemps to bring about shifts in the hospital from an authoritarian to a democratic structure, and from a custodial to a humanistic ideology.[16] Such changes, if serious and realistic, are very much to the good. Often, however, these terms (as also with the idea of a "therapeutic community") are invoked with more enthusiasm than knowledge, and are used in the more popular sense they have in American culture rather than in a technical manner. It sometimes seems as if such desires for change are a specific example of what Riesman[17] has called the "other directedness" of Americans. This can lead to such extremes as the attitude being held by psychiatrists in the hospital that "we are all patients here together" (cited in Rapoport and Sofer[18]). Such an attitude can be a useful one, but it can also be an abrogation of the responsibility to assume authoritative control and leadership when these are needed. These most certainly were needed in the

week preceding the collective disturbance described above when the patients made many attempts to communicate to the staff their desire for greater control over their activities, but the staff did not respond. Inherent in all this is, of course, more a concept of flexibility in leadership rather than an all-or-none idea of being loose or tight in matters of control.

Cross-cultural evidence provides a much needed perspective in these matters, and in my own work in Japan I was struck, as have been other observers, with the lesser degree of disturbance or, more importantly, tension to be found on Japanese psychiatric wards when compared with American wards. Control was very hierarchical and authoritarian in Japanese hospitals by our standards, and yet the life of patients on the wards seemed to be reasonably happy and tolerable. As I have noted briefly elsewhere,[9] these differences between the structure and atmosphere of hospitals in the United States and Japan might well be related to different expectations about interpersonal relationships in the two cultures. In this respect, it is quite possible that a certain tacit cultural premise concerning interpersonal relations underlies the Stanton and Schwartz phenomenon referred to earlier. In terms of American culture, it may be that both staff member and patient are in unspoken agreement that people can be moved quite a distance (consciously or unconsciously influenced in their actions on behalf of another) in human relations. The boundaries of most relationships in American culture are rather fuzzy—to a greater extent than in other cultures it is left up to the individuals concerned how wide a range of action and degree of emotional depth are to be included in a relationship.

By contrast, in Japan the boundaries of relationships are very sharp and well known beforehand by participants. The potentialities of a relationship are much more circumscribed, and what one person can do for another is almost rigidly determined by their relative positions in a tight web of status and obligation. Thus, when a patient and staff member interact in a Japanese hospital, they are probably much clearer as to the limits surrounding their relationship and hence feel freer to act spontaneously within these limits than in a comparable situation in America, but at the same time they are less free to develop the relationship in other directions. One would not expect then, other things being equal, to find the kind of phenomenon noted by Stanton and Schwartz as evident in Japanese psychiatric hospitals. I believe this is one factor, among several, that helps to account for the apparent lesser degree of tension in Japanese wards.

In any case, whether in America or Japan, it is probably most

unrealistic to attempt to avoid the hierarchical and "mobility blocked" characteristics that are basic features of the structure of most psychiatric hospitals. These are too deeply embedded in the already existing institutional system and in medical practice. This being so, we are then faced with the problem discussed earlier of job dissatisfaction, particularly among personnel below the level of the physician. One way out of this problem which seemed to make sense was suggested to me in a recent discussion with Dr. George Gardner of the Judge Baker Guidance Center. Dr. Gardner introduced the concept of "lateral echeloning" into our discussion. Essentialy this is an attempt to work within the tight vertical structure of the hospital by providing lateral opportunities at all staff levels for people to develop and become engrossed in activities in which they are interested. Simultaneously it is the job of the chief to see that such people are provided with the funds, opportunity, authority and responsibility to carry out their interests, and also to see that such special interests become part of the on-going and always changing activities of the hospital.

An example of this would be the case of a psychologist who could not advance within the hospital structure, so efforts were made to find him a university appointment and to allow him to expand his research in order that he would have an opportunity for real growth which would, at the same time, allow the hospital to retain the benefits of his service. Such "lateral development" could apply at any of the levels in the hospital, and certainly also includes the patients. The hospital system, of course, has to be flexible enough to encompass such changes, and has to have a chief who is seriously committed to the development of such a program.

More than flexibility and commitment are needed in these matters. As is well known, almost any innovation will give rise to a "creative release" of energy in which the interest of the staff is enhanced and the condition of the patients is bettered. The problem is how to develop ways of keeping up the potential for such a creative release of energy. At least part of the answer to this problem lies in the need to identify and study the group structure of emotional processes that has been referred to throughout this discussion. A further matter is how best to utilize such a potential in the clinical work of the hospital. The report of recent research along these lines during this Symposium should help us to learn more about these questions; in addition, cross-cultural research into such matters as the processes of "thought reform" as presented by Dr. Lifton should be of aid in coming to a further understanding of the relations between human beings and how effective leadership might be developed.

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LEADERSHIP UNDER STRESS

The Group "Re-education" of Six Westerners in a Chinese Communist Prison

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Leadership, like gold, is where you find it. We know well that its two main elements are on the one hand the special talent, the emotional and mystical appeal, the "charisma" of the leader—and on the other, the special demands of the particular social setting at the moment when he emerges. The first element, the leader himself, has been much studied; the second, the milieu which both produces and sustains him, is less understood. The Chinese Communists, in their development of the "thought reform" or "brainwashing" process, have produced a milieu (or a set of milieux) of unique character from which some rather unusual patterns of leadership have emerged. I would like to describe one such situation—the vicissitudes of a group of six Europeans undergoing their "re-education" together in a Chinese Communist prison—focusing upon the relationship between a specific type of milieu and the kind of leadership which arises in it. In carrying through this study I have found it necessary to view leadership patterns as active and changing processes A particular stress demands a leader with special equipment to meet it, and to help others to meet it; in a matter of days, or hours, when manipulations from above alter the nature of the stress, a different leader may be produced.

Most Westerners, when arrested in Communist China, undergo the greatest portion of their "thought reform" within a 6- to 10-man group all the other members of which are Chinese. During the 17 months which I spent in Hong Kong interviewing 25 such former prisoners, I came across just one example of the formation of an all-Western group, or subgroup, permitted to reform itself together, using the English language. The group functioned for more than 2½ years. There were several manipulations and changes in personnel, such that four additional Westerners spent short periods of time in the group, but the men whom I will discuss averaged close to 2 years of this form of re-education, and

each spent at least 1 year with all five of the others. I would emphasize that the group never constituted an entire cell in itself, but was always a subgroup within a larger cell which also contained eight Chinese prisoners. The "cell chief" was always in over-all charge of the 14 men in both subgroups.

The Western and Chinese prisoners were both completely occupied with "re-education"—the last and longest general phase of the thought reform process. This meant that each had been through, in varying dosages, the three previous stages: "the emotional assaults," "leniency," and "confession." In other words, each had already spent at least a few months in prison during which he had been subjected to prolonged, accusatory interrogation and "struggles" (group denunciations and demand for confession). Each had been subjected to physical stresses—sleep deprivation, painful application of handcuffs and chains, crowded conditions and poor food; and all had experienced the opposite side of the coin, the shift to "lenient treatment" on the part of their captors as a further maneuver in the confession-extraction process. In response to these physical and emotional pressures, each had made some concession to the government's insistence upon infallibility and demand for criminal guilt; each had made an incriminating confession containing exaggeration and distortions of past behavior.

The Europeans were brought into the cell one by one, for the apparent purpose of "helping" each other with their confessions. This early pattern (taking place at a point where we cannot yet speak of a true group structure) was essentially as follows: One European who had achieved some degree of adaptation to his environment through a certain amount of self-surrender (in confession and possibly in criticizing others) would be joined by a second Westerner who was still in acute conflict over how much to submit. The influence of the "adjusted" person upon the conflicted one would inevitably be in the direction of confession and reform, but his motivations for this "progressive" influence were complex and uncertain. Always present, in combinations only partially understood by himself, were a genuine desire to help a fellow Westerner to accept the inevitable, an attempt to demonstrate one's "progressiveness" to the authorities in order to gain merits towards release, and the need to justify one's own surrender through bringing a person similar to oneself into the sphere of those who have "surrendered" (or confessed)—a form of sharing guilt, shame and "weakness." Thus, all of this pre-group formation experience served as a preparation for the group process itself, a "softening up" prior to the re-education. More-

over, it set much of the pattern for the complications in personal relationships which were later to become more explicit within the group.

Additional sources of friction within the group become apparent when we identify the six people involved. The group included a German physician of ardent Nazi sympathies, a highly trained French Jesuit philosopher, a Dutch Lazarist priest from lowly origins, a successful North German exporter, an adventurous South German businessman, and a French Jesuit teacher of chemistry. Among such a group, the personal, cultural, intellectual, national, political and religious conflicts were formidable, always potentially disruptive, and emerging particularly at times when things were not going well. These included the German versus the Frenchmen, the Nazi versus the anti-Nazi, the priest versus the layman, the Catholic versus the Protestant, the Jesuit priest versus the non-Jesuit priest, the "crude peasant" versus the middle class "gentleman," the North German versus the Bavarian, the university graduate versus the man of limited education, the "professional man" versus the merchant.

In addition, there were conflicts which had existed in relationships among some of them prior to imprisonment: Some of these were on a personal and social level, but some on an even more highly-charged ideological level—such as disagreements among priests themselves about whether to stoutly resist all Communist pressure, or to flexibly adapt to it and accept, for instance, the Communist-sponsored "independent church" movement in China. All of these influenced attitudes and behavior in the group, still further complicated by personality clashes which in a few cases became so extreme that the mildest statement or action on the part of one became automatically the cause for overwhelming resentment on the part of another.

Could any leadership at all develop among such contending and unwilling guests at this Mad Hatter's Tea Party? Knowing just this much I would certainly have doubted the possibility. Yet somehow leaders did emerge. We may distinguish three periods of leadership, each identified by a particular atmosphere in the group and dominated by one personality. In briefly examining each of these, I will try to show the relationship among the demands of the environment, the emerging leader, and the resulting group process. It is well to keep in mind that what is described as occurring during a particular period was most characteristic for that phase, but each type of transaction occurred to greater or lesser degree during all three periods.

1. The Period of Informal Study

We may speak of the group process as beginning to exist from the time of the arrival of the fourth European in the cell. After his receiving some "help" from both European and Chinese prisoners, all of the cell inhabitants were instructed to concentrate upon the re-education process. But since none of the four Europeans present had an adequate grasp of the Chinese language (the Dutch priest and the Jesuit philosopher, who had not yet arrived, were the only ones among the group with an extensive knowledge of spoken and written Chinese), it was decided that the four Westerns could study as a group apart. They were to follow the usual procedure, one reading from a Communist document, each of the others then expressing his opinions and criticisms of others' attitudes, with a continuing emphasis upon self-criticism, self-analysis and confession.

The four foreigners realized they were under the scrutiny of the Chinese cell chief—who understood English, the language which they were supposed to use in their re-education process. However, for a period of 3 months, there was relatively little of the strong re-education pressure which they were later to encounter. The officials had apparently not fully worked out a system for the foreigners to follow as a group, and the cell chief, in his direction of all activities in the cell, was notably easy-going and almost friendly. In his daily meetings with prison officials, he was apparently not receiving much in the way of specific pressure concerning the foreigners. Thus, he demanded of them only that they maintain a continuous attitude of study, without particularly caring what it was they were studying.

The small group of Westerners took advantage of the situation by going through the motions of reading and discussing some Communist material for just a few minutes at the initiation of each study period, then digressing into many other subjects, while keeping up a more or less "academic" atmosphere. Thus, after a brief period of time, the group would find itself discussing not only the principles of Communism, but also those of philosophy in general, of the various sciences, of chemistry, anthropology, or of business practice.

No one among them had any official status as leader at that time, but the newest arrival (the German physician) soon assumed unofficial hegemony. He was able to do so for several reasons. He was by far the most knowledgeable of the group, well educated, with a great fund of knowledge which transcended his medical training and included the natural and social sciences and phil-

osophy; he had an extraordinary memory and an unusual didactic skill when enabled him to assume a professorial role with his Western cellmates and conduct interesting discussions in all of these areas. Further, he was happiest when dominating and teaching others, and had many psychological characteristics which suited him for leadership—firm convictions, the ability to articulate them with great persuasive force, and a hard core of inner identity and psychological integration. Finally, and perhaps most important, he had been of all of these Westerners the least "broken," and consequently was the least fearful among them. The few interrogations to which he had been subjected, and his intact psychological state, contrasted sharply with the brutal treatment some of the others had received, to the degree that two of them had attempted suicide. As might be expected under the circumstances, he had (although producing an exaggerated confession) made the least compromise and surrender to the process. His physical and emotional state was highly impressive to the other Westerners. As one of them later expressed it to me, "He arrived like a breath of fresh air. He still had guts."

Although he did follow advice of his Western cellmates in further developing his confession, it was largely around his influence that most of the group practices developed. This influence was overwhelmingly in the direction of resistance. At this point and throughout the group's existence, he was considered the most "reactionary" of the Western prisoners. The belief which he repeatedly expressed in the group was that their arrest was essentially a police action, and that they should therefore pay no attention to the repeated and seemingly convincing Communist statements that they would be released only when they had proven themselves fully reformed. He agreed with the others that it was necessary only to make statements acceptable to the Communists when on display, but always to maintain a check on this through open discussion of beliefs and tactical maneuvers within the small group of trusted Westerners.

The group was on the whole able to follow this program successfully for a 3-month period. The others did exert some pressure upon him towards a more cautious attitude concerning what was said even in the small group; they considered him to be a bit careless, and they feared that the group might be broken up at some time in the future, and one of them forced to confess matters which had been discussed within it. But they found him to be what they considered a "good comrade"—a man who could be trusted to help others when in physical or emotional difficulty, and

to behave with strength and dignity under stress. They at times resented his overbearing manner, his insistence that his view was always the correct one, and other egocentric traits. They did not know that the cardiac symptoms of which he occasionally complained were feigned for the purpose of gaining small extra privileges which helped to preserve his strength.

This was the most happy and cohesive of the three periods; the group was under no great pressure, all recognized the importance of making small concessions in order to maintain their group structure which they came to treasure as a source of strength, and there was little friction present. Later, among various resentments which arose, was that caused by Dr. T's racist and Fascist views. Yet this emotional attachment to the alternative mystique of Nazism was one of the sources of his strength; he was a strong leader if not always for the "right" reasons.

2. Intensive "Reform" and Conflict

Three changes brought about an abrupt end to the first phase and ushered in a much more disturbing period for the group. The "lenient" cell chief was replaced, a new foreigner was brought into the cell and appointed "study leader" for the other Westerners, and the pressures from above demanding a more genuine re-education effort were greatly magnified. The dramatic entrance of a newcomer (Father S, the Jesuit philosopher) both symbolized and created the new atmosphere. The switch was a demotion for him as he had been the "chief" in his former cell. But he was now under fire, partly for having violated disciplinary rules, but primarily because of more serious offense: He had been asked by a Chinese Catholic prisoner (through a form of trickery) to listen to a Catholic confession, and was then denounced for having done so (an extremely serious crime in this setting) by the man whose confession he had heard. Thus, immediately after coming into the cell, he was subjected to a severe "struggle" at the hands of both its Chinese and European inhabitants. Led by the cell chief, the Chinese prisoners not only denounced him verbally and slapped and pinched him, but also demanded that he do what for a Catholic priest is unthinkable—reveal the details of the Catholic confession which he had heard.

A way out was finally found when, at Father S's insistence, he first obtained a "release" from the Chinese prisoner before doing so. But Father S continued to be placed under great pressure for many weeks, as a part of a new and more thoroughly repressive atmosphere in the cell. Possessing a fluent knowledge of written

and spoken Chinese, he was made "study leader" of the small Western group, but now the activities of the foreigners were placed under much closer observation and control. The new cell chief, working shrewdly and vindictively for his own release, kept a close eye on everything done within the small group of foreigners; sessions frequently included all 14 prisoners (Chinese and European) together, Father S interpreting into English for those who did not speak Chinese.

In his roles of "study leader" and interpreter, Father S thus assumed responsibility for his foreign comrades. Father S's leadership seemed to be shaped by two powerful influences (and here we must rely upon the impressions of the others in the group, as Father S was the only one among them whom I did not have the opportunity to interview): his fear and sense of guilt, which had been engendered through the harsh treatment he had received, as well as his firm conviction that the only means of adjusting to the prison situation and earning one's release was to throw oneself energetically into the reform process. When under pressure himself, he set an impressive example for other Westerners with histrionic gestures of guilt, repentance and self-deprecation. He went to extremes in confessing details of personal immorality, such as sexual affairs with women. Nor did he stop with simply revealing everything he said or did, but fabricated stories of personal misbehavior, and intentionally expressed "incorrect" opinions in the cell in order to have more material for his demonstrative confessions.

He expected similar behavior from the other foreigners who were under his direction, about whom he was required to make reports to the cell chief. He felt that as a priest, although forbidden to conduct religious procedures in the prison, it was still his duty to do everything possible to help the others in the cell; and there was thus created the ironic situation in which a Catholic priest saw as his professional duty the need to "help" others along the path to Communism. To be sure, he had first presented this approach as a means of preserving one's values—religious and otherwise—by doing everything possible to convince the Communists of one's personal reform. But at the same time, he insisted that the members of the group maintain this extreme in their "progressive" enthusiasms and pro-Communist sentiments among themselves, as well as when with other prisoners and officials. Because of this, and of the extreme nature of Father S's behavior, this distinction between "acting" and feeling was quickly lost—to the other Westerners in the group, and apparently to Father S

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himself. This was no longer clearly a game; when criticized by a fellow Westerner, no one could be sure how the other fellow *really* felt, whether he was doing this because he felt he *had* to, or whether he was expressing genuinely "progressive" convictions.

At the same time, the cell chief and the Chinese cellmates constantly accused Father S of "shielding" his fellow Westerners, and subjected him to humiliating "struggles" on this accord. And most of the other Westerners did feel that he exhibited a great deal of courage in absorbing punishment upon himself rather than fully expose them. But after being subjected to this form of pressure, he invariably increased his demands upon the other Europeans. Other characteristics of his leadership also disturbed his fellow Westerners. He seemed to take too much pleasure in vehement denunciations of fellow prisoners; and he had the need to display his intellectual brilliance (his extensive knowledge of Communism and of Chinese culture) by intentionally bringing up complicated discussions of controversial issues—what was known in this milieu as "skating on thin ice." Further, some of the other Westerners felt that Father S was not always precise in his translations and tended to distort them in the direction of his own point of view.

In response to all of these forces, the group inevitably moved in a "progressive" direction. It studied Communist legal codes and policy documents regarding punishment of "reactionaries" and counter-revolutionaries," the requirements of fully confessing all misdeeds, denouncing others' misdeeds as well, and always accepting the re-education process—specifying "leniency" for those who fulfilled these conditions and serve punishments for those who did not. All these principles were embellished with detailed examples of "big criminals," who had been re-educated and accepted into Communist society, contrasted with relatively minor offenders whose unwillingness to confess and become re-educated resulted in their being shot. And in special "movements," one cell chief would challenge another to "out-confess" his group; to meet the constant demand for more "materials," everyone, including the Westerners, found himself digging into his past for real, exaggerated, or imagined evils. Through these activities, the Europeans were considered to have "raised" their political level.

But this "progress" was at the expense of the group solidarity. Much confusion developed concerning when and whether the "game" was in effect. Personal animosities mounted, fed by the criticism process and by differences of opinion about how best to proceed; the potential sources of friction which I previously men-

tioned now began to make themselves felt. The Western prisoners inwardly differed in their feelings toward Father S. Some felt that he had done much to protect them, emphasizing the strong pressure he had faced; most experienced varying degrees of resentment towards him and were highly critical of his approach and of his temperament. All thought that he was too egotistical and too unstable (some had learned that these qualities had been characteristic of his previous work for the Church), that he was highly susceptible to fear, that he was unduly influenced by his desire to be released and to be permitted to continue to live and work in China under the Communist regime. Their final and unanimous view was that he had gone "too far" in his actions.

When his influence was at its zenith, Father S flashed what his colleagues described as "a strongly French personality—flexible, elastic, extremely 'intellectual' in a formal way. . . . like Voltaire. . . . very vain. . . . and like to command." But his prestige within the small group declined very rapidly. His willingness, even joy, in self-humiliation, particularly at the level of personal sexuality, caused the other Westerners to lose respect for him. Further, his extremism led to distrust, both among the Westerners and the Chinese; it was felt that he was "too convincing" (in other words, insincere) in his "conversion" and Chinese prisoners called him "The Fox." As the Westerners considered him more and more unreliable, they turned away from him and looked for their leadership to Father M, the Dutch priest, who had arrived shortly after Father S.

The authorities also noted Father S's declining influence, and the cell chief began to bypass him and work through Father M (also fluent in Chinese). Father S, through implicit but unanimous consent, began to "study" less and less with the other Westerners, and became increasingly a part of the "Chinese" subgroup. Although technically "study leader" for more than a year, his period of leadership may be said to have lasted for less than 6 months, after which Father M had become the real leader. When he was finally transferred from the cell 1½ years after his arrival, he appeared to be little more than a "beaten down," highly subservient prisoner.

3. The Period of Adaptation

The transition from the second to the third stage was gradual, epitomized by Father M's increasing assumption of translation duties and of the real leadership in the group. It was partially the result of the group's preference for him as a person and as a

guide. The other Westerners valued and benefited from his more moderate and reliable approach, and their willingness to be influenced by him undoubtedly was a consideration in the authorities' recognition and appointment of him as study leader.

Another highly important, although somewhat nebulous, factor was the changing atmosphere produced by the slight diminution of pressure from above. The group had passed through the initial "breaking in" stage; the acute pressures required to "raise" its political level gave way to long-term, still powerful, but on the whole less extreme demands—to consolidate whatever had been accomplished, and to grind out further "progress" in the day-to-day thought reform ordeal. During the early months of Father M's 1½-year period of guidance, the diabolically vindictive Chinese cell chief was replaced by a man of somewhat less zealous character. And during this period, there was a nationwide change in Chinese prison policy, in the direction of elimination of physical abuse, less sharing of confession material among the prisoners, and less encouragement of patently false material.

What qualities did Father M bring to his leadership? He was in many ways the antithesis of Father S; he possessed a steady intelligence without brilliance, was circumspect and cautious, set a high example of courage and self-sacrifice, and had the ability to instill a profound trust in others. His abilities and his determination had gained him much respect in his missionary work prior to imprisonment, and he had frequently assumed positions of responsibility and leadership. He had a special talent for bringing men together, for arbitrating among extremes, for pursuing a steady and moderate approach—which was precisely his forte in his prison leadership. Yet it is interesting to note that he had all of his life, especially during childhood, been subject to overwhelming and uncontrolled episodes of hostility, expressed as temper tantrums as a youngster and later through headaches. He had painfully conquered this tendency, largely through his strong emotional bonds with the Church; and his skills as a "moderator" were in part a reflection of his highly developed, personal mechanisms of control.

These controls did at times, however, weaken. For instance, soon after his arrival, he was opposed by the entire cell group, and attacked for his "backwardness" with particular vehemence by the cell chief and the Chinese prisoners. At this point he had an uncontrolled crying spell which rather shocked some of his Western fellow prisoners. He was then much less willing to make concessions in the direction of reform than were the other Euro-

peans; they proceeded to "help" him to go as far as they did, arguing that it was necessary to do this to obtain one's release, that it was also required to hold the group together, and that he was not by doing so violating his religious convictions. Interestingly enough, it was Dr. T whose "good fellowship," despite definite points of conflict between the two men, influenced Father M in this direction. Thus, he experienced an initial "breaking in" which served to bring him in step with the group; but once this was accomplished, his own personal leadership began to emerge.

Father M, together with Dr. T who exerted a continuous influence upon him, evolved the group approach which was to characterize this phase. It consisted of a form of acting or "window dressing": making "big self-accusations" backed up by "small facts." Thus, one would accuse himself of being "reactionary" and "backward," because of taking too much time in going to the bathroom.

More important, it involved a continuous emphasis upon "playing the game" rather than losing oneself completely in the process. Thus, when Father M would harshly criticize another Westerner, he would attempt to soften the blow by getting across to him some indication that he was merely going through necessary motions. One could usually not say this outright, but certain semantic tricks were exploited to create a communication system for the Westerners which their Chinese cellmates could not penetrate. For instance, in order to distinguish the general meaning of the word "people" from the Communist mystique of "The People" (synonymous with the Communist Party and The Government), they would say "people" with an ordinary English pronunciation for the former, and "Peepul," a mock French pronunciation, to indicate the latter. The emphasis was always upon flexibility and concession in attempting to convince their captors that they were making an effort towards reform—but at the same time making every possible effort to preserve individual values and beliefs, and particularly personal dignity. The approach was largely successful, as conveyed by Father M both by guidance and by personal example. As one European fellow prisoner phrased it, "He taught us how to do the necessary and still keep our own."

Father M also had to deal with great pressures from above, and resistances to his approach and differences of opinion from below. He had a few lapses—outbursts of temper—and at one point he was sympathetically warned by another Western that the sides of his mouth were beginning to turn downwards, indicating that he was becoming too angry and impatient with the other Euro-

peans; but on the whole, he kept his own fears sufficiently in check to maintain what the other judged to be courageous and balanced leadership. His influence increased steadily, and his period of leadership was ended only by the breakup of the group by sentencing and release of the Western prisoners. He was the only person in the group who was lavishly and unreservedly praised by those among his former Western cellmates whom I interviwed; to a man, they felt that it was his influence, more than anything else, which kept the "corps spirit" of the group intact, and that this in turn preserved the values and stability of each of them.

SUMMARY AND CONCLUSIONS

What characterized each of these three stages of leadership? The first might be termed *intellectual leadership and avoidance of participation.* It was dominated by the most pedantically gifted person present, and made possible by the unstructured and temporarily lax nature of the milieu. Reality testing (or conceptual validation) was almost completely intact, and group cooperation was strong. Dr. T's talents were highly suitable for the situation, his more questionable characteristics (which would have interfered with his leadership in a more stressful period) did not at this point interfere.

The second stage might be viewed as *histrionic exhortation and demand for a splitting of identity.* Here Father S's leadership reflected his own dilemma: Was he really identified with his captors with their demand for confession and reform, or with the small group of Westerners with its pull in the opposite direction, towards preservation of values and group cohesion? He was undoubtedly more allied to the latter, but his all-out response and demands left the issue in doubt. He pushed the others in the direction of a sense of guilt (whether or not this was his intention) and towards disintegration of identity. His leadership period was characterized, at all levels, by maximum stress, transmitted to him from above, then confusingly passed on to the small group under him. Reality testing for the Westerners was lost, and group integration was at its lowest ebb.

The third period can be labeled *leadership through flexible adaptation and preservation of identity.* Father M brought about a return to the group as a solid unit, and a source of reality-testing and strength. His crucial gifts—which a milieu slightly leveled off from its former extreme permitted him to make use of—were his outstanding personal integrity and his unusual capacity for

moderating among men. The cohesive group could now serve to maintain the autonomy of each of its members.

What lessons can we derive from this rather harrowing but far from discouraging tale?

First, one cannot help being struck by the immense resiliency and ingenuity which human beings can call forth when under overwhelming stress, *if* they can maintain a cohesive group structure. Or to phrase it differently, men fortified by group support and identification are capable of impressive biological and psychological accomplishments, which for most, surpass those of which they are capable as isolated individuals.

Second, leadership is a highly complex phenomenon, which must be viewed in the light of *multiple causation.* For instance, it would be wrong to say that the type of leadership which occurred in phase 3 was a sole product of Father M's character traits; it would be equally erroneous to say that it was entirely caused by the slightly diminished pressures from above. Rather, it was the product of both of these vital factors as well as of Father S's loss of prestige, Father M's developing relationships with his Western cellmates, the particular stage of "reform" in which the group found itself at that time, and the presence of another strong influence in the person of Dr. T. It would probably be correct to say that Father M, because of his outstanding qualities, would have become a leader of most groups in most situations; but he was a particularly appropriate leader of this group at this time. It may well be that Dr. T's intellectual attainments would have kept him the leader even if Father M had been present at the beginning, and that Father S's "progressive" interpretations of Communist demands made him the most likely leader during the time when political levels had to be "raised." It is only through an understanding of the complicated and constantly-changing transactions of individual people with environmental themes and pressures that we can find the sources of leadership.

Finally, this experience suggests that we re-examine and expand our concepts (and stereotypes) of "the leader." Father M's impressive performance demonstrates the leadership potential of the man who can mediate with integrity, who can set an example which helps men to retain their identity and adapt with dignity. It may be that in this age of ideological excess, it is he, rather than his more flamboyant and charismatic counterpart, who is needed.

LEADERSHIP TRAINING

FRANCIS H. PALMER, PH.D.

The subject of this panel, "The Significance of Leadership for the Mental Health of Groups," implies that in some manner the leader's practices and characteristics influence the mental health of those under him. This seems to be a reasonable hypothesis, convinced as most of us are that any sustained social atmosphere modifies the attitudes and activities of the persons exposed. However, I know of few systematic data which indicate that the leader influences enough of the total life space of the individuals under him so that he affects the mental health of the group, and even less data which might indicate what kinds of leadership practices are related to good or poor mental health. This is not to say that relationships do not exist; it is to say that well-controlled studies are needed before we make too many assumptions.

On two occasions my work has included an attempt to gain information on this subject. While the results of those investigations (one hardly more than an observation, and the other a more systematic study) are not in any way definitive, they may be interesting as a point of departure.

A years or so ago, there was a regimental commander at Fort Ord who was the prototype of what many people think of as the authoritarian personality. He was obsessed with rigid discipline and so-called spit and polish. His subordinate commanders were directed to maintain the same atmosphere throughout the command channel. He drove his men, basic trainees, to the point that he was the constant subject of criticism among his fellow commanders, and it is said that eventually he was reprimanded for his actions by the division commander. However, he had sustained his program for approximately a year before he was stopped, so that there was time for his procedure to influence the regiment.

The other two regiments on the Post were commanded by men whom I would describe as typical in that they appeared neither more nor less concerned with discipline than is ordinarily thought necessary in the Infantry. The apparent difference between the social atmosphere of the one regiment and of the other two was

so great that my colleagues and I became interested in possible effects on individual performance among the men of the three regiments: performance in the sense of what the basic trainee learned during his 8 weeks, and performance in terms of the incidence of sick call, cases in the mental hygiene clinic, and the AWOL rate. Since all basic trainees at Fort Ord take a standard set of performance tests at the end of 8 weeks, and since we had developed those tests and knew them to be reliable, the act of comparing the one regiment against the other two on variables such as the use of weapons, first aid, map reading, etc., was relatively simple. Our results showed no differences between the average scores of the three regiments on these measures. The Chief of the Mental Hygiene Clinic was asked for information about differences between regiments for sick call incidence and clinic attendance. He reported no differences in terms of frequency or seriousness of the cases which appeared. There were no significant differences in the AWOL rate.

Evidence from a study [1] using somewhat better controls also yielded information which did not confirm the position that the personality of the leader and his organizational practices influence indices of organizational health. While the primary purpose of that study was to identify those characteristics of antiaircraft units which related to their productivity, criteria of performance included such measures as AWOL rate, accident rate and court-martial frequency.

Individual measures were obtained from the battery populations for such variables as sociometric position, personality, attitudes and morale, leadership, group structure and background characteristics. These data were related to unit performance on the criteria by categories of personnel to include key leadership roles, the various subgroups in the battery, and the battery as a whole. Consequently, results were available in the form of correlations between individual or group scores on the many variables measured and the several criteria.

Some of the results are relevant, if we assume that AWOL is a valid measure of unit health. There *were* characteristics of the leaders which were significantly and consistently related to the unit AWOL rate. In units where AWOL incidence was *high*, the NCO's as a group were younger and the first sergeant and the privates were older; the first three graders in the unit had been on their job in the battery longer; the battery commander tended to have fewer years of education. Furthermore, when the battery commander was rated low by the battery, when the first

three graders rated their commanders low, when the NCO's expressed a relatively greater disinclination for re-enlisting, and when the privates indicated a relatively greater desire to transfer to another unit, the AWOL rate was significantly higher.

But 10 personality scales, a measure of leader behavior, a measure of organizational structure and procedure, and the California F-scale failed to show a single significant correlation with AWOL rate when the battery commander, the first sergeant and the first three graders were related to AWOL. In other words, our attempts to relate psychological factors in the leadership structure to absenteeism failed. Perhaps we measured the wrong factors, or perhaps we tried the right factors with insensitive instruments. But the fact remains that we did not find any relationship between such variables and the criteria, and that many descriptive and attitudinal variables associated with subordinates did relate.

One other result of this study makes me more cautious of assumptions about organizational climate and how it is influenced by leadership. Most human groups are engaged in several activities, and performance of those activities may or may not be correlated. Our antiaircraft study demonstrates this. For example, those units who tended to perform particularly well when identifying and locking on aerial targets with their radar were no more likely to excel in maintenance activities than a unit poor in radar operation. AWOL was related —.11 with radar operatention, —.09 with radar maintenance, and .14 with artillery maintenance—none of which even approaches statistical significance. Furthermore, characteristics of specific leaders were sometimes (I grant rarely) related significantly to a desirable and an undesirable goal. (The more years of Army experience the first sergeants had was significantly related to *both* a high standard of maintenance *and* a high AWOL rate.) We must consider the possibility that specific variables will sometimes relate inconsistently to desirable ends.

The antiaircraft study was designed as a productivity study, and the AWOL findings that are relevant here are really peripheral to the purpose of the study. But it is the only kind of study I can contribute which bears on the question of the relationship between leadership and mental health. However, even in the absence of data which confirm such a relationship, we at the United States Army Leadership Human Research Unit proceed in our leadership and leadership training research with the assumption that, all other things being equal, the leader who

understands himself, who understands the consequences of his acts in dealing with others, and who understands other men particularly as they work in groups, will be more effective.

In my opinion, there are two major problem areas in the development of leadership training for the military. The first is one perhaps peculiar to the military, the second appears to apply to all leadership research.

I would hypothesize that the greatest single obstacle to effective leadership in the Army is the perceptual difference between the group which is involuntarily in the system—usually as a subordinate—and the leader group which is for the most part voluntary.

Regardless of the situational or personality factors which lead to voluntary participation in the military, some need has been fulfilled and the individual has committed himself to the system. We might predict that the individual so committed will embrace the mores of the military culture, he will minimize the significance of the restrictions. In this manner I believe many military leaders become unable to comprehend the reluctance of a draftee-subordinate, not similarly committed, to accept certain aspects of the military system. Conversely, the draftee-subordinate, who is a unique person in history because of the relative latitude that our national culture affords him in fulfilling certain needs, can understand neither the reason for certain restrictions upon his freedom nor his leaders who submit to those restrictions so readily. One element of leadership training must attend this problem by placing the burden of understanding himself and his subordinate upon the leader, and encouraging him to minimize this perceptual difference wherever possible as long as it is consistent with attainment of the military goal.

One approach which has been demonstrably effective in broadening the leader's perspective has used sound motion pictures in conjunction with group discussion technics.[2] Two of my colleagues, Carl Lange and Carl Rittenhouse, after a suggestion by Launor F. Carter, produced 10 films depicting officer problems. The films were based on descriptions of leadership situations collected from junior officers and NCO's. Each film ran a few minutes and was cut off at the point where a decision was to be made; each presented the story in a manner which offered alternative courses of action and which demanded consideration of the several possible actions. The instructor then served as a monitor of class discussion about the various aspects of the problem which should be considered. No official solutions existed for any problem. We have shown that this technic improved the quality of solutions to leadership problems as compared to solu-

tions by control groups given more traditional leadership training. The experimental group was also more accurate in the identification of those persons in their group who eventually finished the course at the top of their class.

We believe that this approach broadens the perceptual field of the leader—makes him more cognizant of his role with respect to the several persons usually involved in a leadership situation—and we hope to expand its use in experimental training programs we are planning. This technic is being used presently at West Point and other major schools with reported success.

At the Army Leadership Human Research Unit we have two other programs of immediate relevance to altering the perceptual difference I have mentioned. One study is designed to identify those behaviors of junior officers which are consistently related to how the officer is rated by his superiors and his subordinates. We hope from this to be able to communicate to the leader how his actions are usually perceived by those above and below him. The second program has to do with the early identification of potential leaders—during their first 8 weeks of basic training—and devising a specific program for that group which would train them in NCO officership during their second 8 weeks, and give them the necessary military skills at the same time.

A second problem is conceptual and probably applies to all leadership research.

We know of characteristics which are often correlated with the man successful in influencing other men in a given direction, and to some extent we know of situations where these variables are more or less important. We are now more alert to measuring leadership in terms of organizational effectiveness. Practically, we are somewhat skilled at selecting leaders for at least some situations, and we have studies which affirm our selection in terms of greater group goal achievement. But we don't know much about *how* the leaders we select actuate groups in a manner which results in greater productivity. We need to become more ingenious in designing studies to that end, and we need more support in executing them. The question of what difference it makes how a leader actuates a group to produce as long as we can select those who do, is one frequently raised when research money is allotted. I believe that only when we understand more of the intervening group process between leader act and performance change can we develop really effective leadership training programs. We hope to design studies which will yield such information, and I suspect that they may also teach us more about the significance of leadership for mental health.

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SUMMARY AND DISCUSSION OF PAPERS IN PANEL ON THE SIGNIFICANCE OF LEADERSHIP FOR THE MENTAL HEALTH OF GROUPS

Dr. Ruesch, University of California School of Medicine: I would like, if I may, to ask the panel here for a word about the process of the emergence of the leader. In what way has this a bearing on the expectations of the crowd or what bearing have the expectations upon the emergence of the leader and, too, what bearing have the natural circumstances such as needing a particular man with a particular knowledge or skill? Secondly, how is the process of selection achieved? I ask this because, essentially, people don't get around and vote. They often don't talk to each other but apparently there comes a moment when there is agreement reached that this is the leader. Now this is, of course, not momentary, but it takes sometimes very little time.

Dr. Tyhurst: I just don't know. I can only describe again. One of the leaders that we observed, for example, emerged under the following circumstances. He had arrived in Winnipeg about 3 years before the disaster. He had had a career in the Army marked not so much by promotion as by sort of off-beat activities such as being in control of fire weapons when nobody was interested in this kind of thing. He had gotten up to the field rank and had hoped to stay in the Army but didn't because he was over-age.

Upon his discharge he, through a Veterans' organization, got a job in a grain exchange and had been transferred to Perry City. He joined a community club in the western part of the city. There he was made chairman of the club's entertainment committee. He had been reading a newspaper and decided that the river was rising, which few people apparently had decided. He proceeded, about 3 or 4 days before things got really serious, to begin monitoring the two radio stations, and to correct the statements which the radio stations were making. What he did was to get together some teen-age children of club members and sit them down in the basement of the club to check the reports coming over the radio.

As things got tighter and tighter, he then started to act as chairman of the entertainment committee. That is, he proceeded to organize the people in the club by getting them together in convoys and what not. He finally got these convoys going down to the dikes and organized them completely. Eventually, he climbed back into uniform, which apparently he had only set aside in the cupboard, and in the last several days of the emergency was finally recognized by the Brigadier and given status within the military organization.

Now, I spent quite a bit of time with this man at all hours of the day and night and was most impressed by the ideas that he had about the way in which people should be organized and handled and so on. He arose like this: He responded to need, he had qualities of his own, he was in the right kind of situation, and his activities were required. Now, I have tried again and again to conceptualize this, to raise it to a slightly higher level of abstraction and every time I try I have to go back to description again. That's about as far as I get every time. I can go through each one of them again and describe just this type of natural history in which the thing emerges simply out of a complex series of circumstances, but when that context disappears then the man and his leadership qualities disappear also.

Dr. Sanford: Dr. Torrance, do you have a point you would like to make?

Dr. Torrance: Yes, we have been concerned with the small organized structured group which has a definite, designated leadership, of course. This serves as a deterrent to the emergence of a leader but we have observed two sets of conditions in which we do have these emergent leaders. One, of course, is when the designated leader doesn't recognize the seriousness of the situation and doesn't take over. Then it is either someone who does recognize the seriousness of the situation and for that reason steps into the breach or someone who has a special talent or special experience that sets him up for that. The other is when the leader recognizes his deficiencies for handling this particular situation or recognizes that someone else has special training which enables him to take over the leadership more effectively. In that way he designates the leader and you have something that is a little bit different from the emergent leader but someone other than the regular leader.

Dr. Sanford: Dr. Tyhurst, do you have any data on emergent leaders who asserted themselves but didn't function successfully that you could compare with the successful cases?

Dr. Tyhurst: The only other thing that we are interested in trying to see is the appearance of the paranoid leader and we have had no occasion to observe any of these either, although we have heard about them. I have never seen either the paranoid leader or the individual who attempts to assert leadership unsuccessfully.

Dr. Fiedler: It would also be interesting to look at the people who think they see an emergency and go around trying to assert leadership when in fact there is no emergency.

Lt. Colonel Bushard, Mental Hygiene Consultation Service, Fort Dix, New Jersey: In connection with Dr. Fiedler's paper I have been familiar with his work for some time and I think this particular paper sort of crystallizes out some things he has said before. I would like to comment that this sort of finding should register with all of us. In this particular area we are having a phenomenal impact upon large organizations such as, for example, the Army. Sociologically-minded behavioral scientists are imposing some of their rather ill-thought-through ideas upon an organization which has been functioning. I think particularly of the fact that company commanders are now being required to function more and more in the position of a therapist. If they fail to do so they become very much criticized.

Now what we are getting into is that probably from time immemorial commanding generals have been saying, "If you don't like it around here, come see me." Needless to say, not very many people do try and if they do try they usually end up in my clinic. But the company commander is in no position to have four or five large and prepossessing officers between him and those about him. He is being forced to deal directly with the anxieties concerned with becoming part of the organization rather than being able to restrict his activities to helping the individual become a member of a team, toward the accomplishment of a given goal. I think that we sometimes underestimate how much impact we have on these organizations and may very well be producing effects that we don't want to produce.

Dr. Lifton: I would like to ask Dr. Fiedler about this concept in which he distinguishes the therapeutic type of leader from the man who gets the results. I wonder if there isn't room for some further development which distinguishes perhaps a third person who partially combines these two and yet is something quite distinct, a sort of integrating person. It seems to me that somebody down among the men, not somewhere up in the mystical hierarchy or with the usual aura or charisma about him, has to

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have this integrating aspect in any effective group. I don't think this is pure pushing for effectiveness, nor is it being a father confessor who knows about everybody's past—their childhood and their sex life—but rather somebody who in some way by his own example and guidance and many other things that we talked about, pulls the group together.

Dr. Fiedler: Yes, I am sure that what you say is true. There are some leaders, either emergent leaders or formal leaders, who are able to do this. These are very rare individuals, however, and when we do find them they usually stand out. What you usually find is an individual who is willing to subordinate his concern for the individual man to the concern for the productivity of the group. I am not passing a value judgment here on the desirability of this. I think that this is a cost accounting problem in the psychiatric or social psychological sense. Whether this is good or bad I think has to be evaluated by empirical research. But the fact that this does exist, that some people are able to get the group to perform while others are able to be very therapeutic but are unable to get the group to perform, I think has to be brought out. This does not preclude the possibility that there might be some people who can combine these.

Dr. Tyhurst: I think that this discussion and the last two comments illustrate very well a point that I was trying to make before. That is, I think that the concepts that are developed concerning the incompatibility between therapy and effective leadership are simply due to the context that is being studied. I quite agree, that, for example, in disaster during the period of impact or immediately after that, to be therapeutic is just silly. However, in the clinical team or much later in a disaster, during the period of recovery and rehabilitation, the ability to persevere, to work with people, and minimize differences becomes extremely important. I don't know whether you call it therapy or not, but it is very much like the psychotherapy that we all do and contains many of the same ingredients. I feel that I would like to re-emphasize again that one of the main difficulties I think that we have in discussing leadership is that we fail to define what the leadership is for and the setting in which the leadership is required. Until we do that, we are going to be continuously talking at cross-purposes.

Dr. Fiedler: Yes, I think I can agree with you very heartily and would like to point out that my discussion was limited to small groups where there was a specific task to be performed

for long periods of time or for short periods of time, but a specific task which had a product.

General Marshall: I gave consent to what was said back here. I want to express my utter disagreement with it now. At a company commander level this is an entirely different problem and I would not like to see a company commander who did not take a fatherly interest in his men and in their welfare. I would say further that I have yet to see a good combat commander of that type, and that is from observations that come from dealing with approximately 600 infantry companies in battle in World War II and approximately 250 in Korea. It is a very interesting thing in the course of this kind of work. You can take a company commander who has had a shattered company and has been in the pivot of battle and later try to reconstruct the action with the man leading the company in discussion. As he starts talking to that company it comes almost as an electric current. You know from the relationship he has with those men as he first talks to them whether or not that company action is going to come out successfully. It follows what we used to call the law of personality, "Law, Looks, Actions, Words." You can see it in his ability to get them to spring up and get their eyes to light up when he begins talking.

I remember a very startling case of this kind in the 7th Division, the 32d Regiment, at the Battle of Kwajelein. I remember this man better than any company commander I saw during World War II. It was his company that finished the action when we knew that the battle was already won and that men were going to have to die to clinch it. He was given the hardest job of anybody on the Island and I was with that company for 3 days as we reconstructed the action. I was tremendously impressed by this man. He had been company commander for 2 years. I was impressed by this above all else—under him, no lieutenant was conspicuous. They were under the line and yet as his sergeants got up and spoke, you could see at least half a dozen that were living in his image. They talked just as he did and they had the same direct relationship with their men that he had. They spent their time trying to emulate him and I wondered how this man had this power over men to this extent, and what accounted for it.

I talked to General Arnold about it and recommended that this man be put in charge of the company commander's school within the Division because he had a quality rarely seen in men of the same degree of exeprience. On the last day of the meeting we

continued going with this chap leading in the discussion and so forth. I was through with the formation and I told him that he could dismiss the company because there was no more work to be done. He said, "Well, that's all, men, but just wait a minute. I have just gotten word that I am being transferred out of this company and I just wanted to tell you that you are the best blankety blank bunch of fellows I ever knew in my life." Suddenly he broke down and cried like a baby and you could see the explanation right there. This fellow had a wonderful love for men. Every boy in his company was to him as a son though he had had to send 17 boys of that company to their death just 3 day before this time.

It is this relationship between the leader at the company level and his men which makes possible strong companies. If science is going to intervene to say "no" to the Army then I would be one in the position that would say, "Science doesn't know what in the hell it is talking about."

Dr. Rioch: Just a couple of points. I was showing Dr. Henry Brosin, after a long conference, to one of these corner rooms, and as he came up to the room, he said, "I'm glad to see that." I asked what "that" was and "that" was a sign "Gentlemen" on the door. He said, "When I was here 6 years ago the upper rooms were for Officers, then there were Enlisted Men and in the basement there were Men. These have all been changed now to the one sign 'Gentlemen' which I think explains a good deal of our changing attitudes."

One other thing I would like to mention. I agree with General Marshall and those who disagree with him in a way. For one company officer to have two hundred children is impossible. But there is something very curious that happens. This is leaving the children out of the account when we say this. In treating schizophrenic patients, I have always told every patient that I am on call 24 hours a day 7 days a week. It may take me 3 hours to get to him if he wants to see me. Everyone of them has tried it once—always between 2 and 4 in the morning—but they have never tried it twice. You do it once and they don't have to see you again. And I think that the secret of a great deal of the leader-follower, follower-leader technic is that the man who doesn't need to see you and demands to see you is allowed to know that he didn't need to see you, but the man who does need to see you always can. Then you don't have to see him.

Dr. Sanford: I have worked on a little summary of these dis-

cussions and have been trying to revise it as content came out here. Let me quickly go back, historically.

Fifteen years ago, I think it's fairly accurate to say, the writings on leadership fell into two categories. There was the writing of an inspirational, observational nature done by successful leaders who are literate and literary. The other kind of writing consisted primarily of research articles on the traits of leaders. I think it is proper to say that 15 years ago neither kind of literature on leadership had led to the formulation of publicly testable, declarative sentences of known utility, the knowledge that has the ring of validity and wisdom. The inspirational writing on leadership somehow remains inexorably private. It does not lead to a reformed method of teaching leadership or of selecting leaders. I'm not going to underestimate the power of inspiration. But, if you want to make public statements that are testable and useful, something else is needed.

It turned out, also, it seems to me, that something else is needed besides this search for leadership traits conducted mainly by psychologists who had ways to measure traits and studied the phenomenon with the notion that the important things in life really happen within the span of the single individual and can be characterized there by well chosen adjectives quantitatively arrived at. This research just didn't amount to very much except perhaps in a negative way. Carroll Shartle's review of a very extensive literature seems to me to be characterized, or summarized in this way: There either are no general traits of leadership or if there are, we need a new set of traits to look for in leaders. As these results came out, you'd think that intelligence, for example, was a necessary trait of leaders anywhere. It just isn't. In 25 researches, for example, you'd find that in 13 the leader demonstrated more intelligence than his followers. In 10 there was no difference. The reverse held in the remainder.

In this sort of relation, however, with respect to dominance, extroversion, age and other likely traits that one would expect to characterize leaders, the only trait that seemed to hold up very widely was one already mentioned today—that of verbal facility. Apparently leaders in a wide variety of settings turned out to be more verbally facile than are their followers. But, generally speaking, there was not much nutritious matter in the search for leadership traits despite the fact that it would be very obvious that if we could discover the universal traits of leaders and use known instruments to measure them, our problems

would be on the way to solution in many practical areas of concern.

The failure of the trait approach led to scratching around in various other ways and I think we've had some illustrations today of alternative approaches to leadership. We've had very little talk, you'll notice, about the traits of leaders. We have had some, but not very much. When the adjectives lying behind the scales used by psychologists didn't turn out to have much to do with the predicting and controlling of leadership, there was some attempt to go back and look at actual behavior behind the adjectives. There has been a good deal of this showing through the research reports today. What do leaders actually do? Dr. Torrance got into this. Dr. Palmer mentioned some of it.

Then there was a tendency to get away from a focus on the individual and to look at the situation in which leadership happened. This took two kinds of forms, one of which consisted of attempting to formulate comprehensive, accurate descriptions of groups in such a way that you could define the group. If you could describe it in terms more meaningful than the phenotypical terms we use—it's a Baptist Sunday School group on a picnic, composed of boys between the ages of 6 and 10 or something—you would describe it in terms of more general parameters so that you might conceivably draw a profile of this group. The notion is that if you could *really* describe a group then you could go back to the behavior of the leader in it and make a fit between his behavior and the group's. This attempt is still going on. We might work on his mentality and other items in this general category in an attempt to understand leadership through systematic ways of describing situations in which it occurs. We've had illustrations today by Dr. Caudill and others, of another and a richer-seeming attempt to get at leadership as it relates to the total group structure and many of the references throughout these two days to small groups and their functioning. Potentially, these are relevant to the understanding of leadership as a phenomenon of group functioning having its relation imbedded in the group rather than imbedded in the characteristics of the individual.

Then there have been attempts to get at the leader-follower relation. It seems to me that this is potentially a way of thinking about leadership which helps make sense out of some of the controversies and near controversies that we've come into here. We've talked about the therapeutic role of the leader versus his functional role of doing something demonstrable and effective.

It seems to me that if we studied the follower in many leadership situations and developed an idea of his needs, we could get back to a leader-follower relationship that is analyzable and that leads to the making of maybe some interesting declarative sentences. For example, Dr. Argyris this morning had a list of the needs of people in an organizational structure. These seem to me to be persisting personal needs, not connected with a situation particularly but there in the human individual in this country, in this time, whenever he comes into a leadership situation. In a way you can say that the followers' needs set the problem for the leader and in many situations these persistent needs lead to leaders that we could describe as therapeutic. They make you feel like somebody. They accept you. They care about how you are getting along with your wife or your family. These are, in general, persistent human needs.

When you get in a situation, however, where a life is at stake, as in some of Dr. Torrance's groups, these personal needs go into the background and the needs of the followers of the situation, if you want to say it that way, become quite different. "We need to get out of here alive and we don't need a nice fellow, particularly, to get us out of here alive." The need there is for competence, toughness, authority, courage, action, and the leader who has these attributes in that situation will emerge or, if he's there by appointment, he had better demonstrate them or he will not be followed. Well, in this way of relating the needs of the follower to the demands upon the leader there seems to be some hope of getting a synthesis and a synthesizing theory of leadership.

I don't know that I've said enough about that to get the idea across. I can elaborate. We did a study of leadership in Philadelphia where we asked a thousand people or so, "What were the attributes of Franklin D. Roosevelt that made him a good leader?" We did this in 1950 after he was dead. Incidentally, 96 percent of the people in Philadelphia at that time thought he was a good leader after he was dead. Only 60 percent of our sample voted for him.

It seemed to be that the reasons people thought Roosevelt was a good leader fell into three categories. The most frequent and perhaps the most important was that he demonstrated warmth and we can say people have a need for this warmth. They are people. They want somebody who likes them. Maybe the need is for approval, warm fatherly approval from above or not particularly fatherly, maybe. The second most frequent and perhaps the most important was the need for strength. This is the reason

Roosevelt was a good leader. He demonstrated strength. The other was a need for material payoff. He did things. He got Uncle Fred a job or he saved my father's bank and this kind of business.

Now, you can talk about these needs in the population leading to the acceptance of Roosevelt as a leader. He was perceived as meeting these needs. If we were in war you'd probably find the need for dependency, the need for strength to go up and the need for warmth to go down. If there had been a real war on, MacArthur might have gotten elected president. Again this is an illustration of the thinking that the needs of the follower put demands on the leader. It is a way to get back to traits.

Incidentally, what leader can meet what kinds of needs? We've had it pointed out several times today that as the situation changes, the successful leader either drops out or changes his role and survives. We tend to think of the leader, especially in military situations, as one who can meet all kinds of needs all kinds of places and maybe there are personalities who have the abilities and the characteristics to be therapeutic on one occasion and to be domineering, strong, driving on another. If you can find people that versatile, you ought to make them officers and promote them fast, I think. Maybe what we look for in appointed leaderships are people who have no particular traits but versatility, ability to play different roles as the situation demands and maybe, as Frank Palmer points out, we train them to be sensitive to the demands of the situation of the followers. Of course, this gets complicated. You've got to go back and say the leader has demands on him because he's got to be sensitive to the demands of the job and be a middle man between the demands of the job and needs of the followers.

What is the state of our real knowledge with respect to leadership? I certainly think we have to say that our corpus of certitude is modest, that we just don't know much about leadership. This does not make me inclined to diffidence or even very much humility. However, because I have a belief in liberal education and a belief that talk about leadership, in relatively intelligent and in as precise terms as we can arrive at, can have a good effect on men of practical affairs, I trust that these concepts and partial certainty will be used to good advantage in running the practical affairs of life.

Dr. Harold Leif, Tulane University: I have a general question for the panel. Yesterday we heard something about decision making, but it was striking that today we heard very little if

anything about the ability to make decisions. I raise this question because I heard that at Annapolis with the under-classmen, particularly in the first year, there's a great deal of stress placed on their making decisions. Particular problems are posed all through the day, not only in a classroom but let's say in the dining hall, a particular situation is posed and they are asked to make a decision right or wrong. Later on in their training, the emphasis is placed, of course, on making the correct decisions. But, in the beginning they are taught to make decisions. I wonder what the panel would say about this?

Dr. Palmer: There are two ways of answering that. First, decision making as an area of research, it seems to me, along with its concomitant informational process, etc., is as important an area of research as we have. I mentioned in the latter part of my paper the difficulty in getting money for certain kinds of research. We've just had the crucifying experience of having 2 years' research on decision making pulled out from under us and we can't go on in it. But, the answer is, I absolutely agree with you. It is extremely difficult to get across to people who are good at officership or tycoonship what decision making as a research area can mean. It's a communcation problem which is beholden on us to be able to develop to the point that we can explain to people what we mean when we speak about research in decision making and information process.

Dr. Rioch: I just want to put in another anecdote of leadership which was made by a sergeant in the front lines of Korea. He said, "Up here, if a man can think 2 minutes ahead we make him a squad leader. If he can think half an hour ahead we make him a sergeant. If he can think 2 days ahead we make him battalion commander." It seemed to me that this problem of decision making is frightfully important and the main function of the leader in practical operation, apart from his personal influence on people, is to bind time, particularly future time, and in that way give direction to everybody else. Under stress, the ability to deal with temporal factors is the first ability to break down. I think it's on this basis that a group tends to separate out a leader and to protect him from the immediate needs of living so that he will have time to process the information that is required, to bind the time, and to predict something about the future. That is, I think it's organically in the structure of the organization and not just a personal characteristic.

Dr. Fiedler: I would just like to make one comment about a discourse we had earlier. That is an apparent misunderstanding

or apparent inability on my part to communicate clearly what was involved in the argument which General Marshall and I had and which was a continuation of an argument we had last night. This is that what I was talking about was the ability of involvement or familiarity and was not concerned with disinterest on the part of the leader with his men. This is something which I appear to have communicated to you and which I did not intend. It is rather the ability of the leader to disengage himself emotionally from his involvement with his men. That is the ability to disengage—well, that's about the best verb I can think of—to disentangle his own emotions with a particular man from his problem of letting the whole group move forward.

General Marshall: If he is not capable of doing this emotional detachment he soon ceases to be leader. He's going to break down. But, I'd like to re-emphasize the point that Dr. Rioch made a few minutes ago. I remember when Gen. Steward Hinson was commandant at Leavenworth and some other figure was to show up there one morning to lecture on leadership, but failed to appear. Hinson suddenly found himself in the position where he was going to have to make the address, and I remember Gen. Frank Ross remarking that this was the most noteworthy address he had heard in all his years at Leavenworth. He said that Hinson walked to the center of the platform and he said, "Gentlemen, I am supposed to talk on leadership. Well, what is it? What have I got to say about it that might add something? Well, just this, that 65 percent of leadership ability is the knack of anticipating problems which may arise and if you can begin to understand that, then you've got the power."

Now, I'd like to make one other point on this question of decision making, not from the standpoint of research but how it happens under conditions of battle stress. I remember talking to Percy Clarkson, then commanding the 33d Division in the Pacific. This was in 1943 and he raised the question about estimate of situation and said, "How do you feel about it?" I said, "I'd rather hear you talk about it for awhile." He said, "Well, I think the most of what we teach in the military schools in the United States is nonsense. We talk about this business as if it's a nice mathematical calculation and the fact of the matter is that you come to a decision almost explosively and then afterwards, when the thing is worked out, well, you come to your estimate of situation and tell yourself why it was you made this particular decision."

This re-emphasizes the point that I made in a conversation with Dr. Crawford just a couple of weeks ago when flying up from Fort Monroe. We were talking about the same problem. He wanted to know how I felt about decision making, what was the essence of it. I said, "It's just the willingness to decide, that's all." Let's face it, that if the way to solution were clear, no decision would have to be made. You'd automatically take it. So, therefore, you begin with recognizing the fact that all decision involves risk and that unless a man is willing to take risks he cannot have the power of decision. I think that this should be re-emphasized much more strongly in our school teachings than we have up till the present.

WEDNESDAY MORNING SESSION

17 April 1957

SOCIAL PSYCHIATRY IN THE COMMUNITY

MODERATOR

Colonel Albert J. Glass, MC

CURRENT DEVELOPMENTS IN SOCIAL PSYCHIATRY IN BRITAIN

G. R. HARGREAVES, M.D.

The term "social psychiatry" has so many meanings that it is well to specify at the outset that the aspect of this topic in Great Britain on which I have been requested to comment is the coordination of preventive, therapeutic and rehabilitative measures, and recent developments in that coordination which have taken place in Great Britain. Using the term "social psychiatry" in that sense, by far the most important developments in recent years have been those that stemmed from the coming into force of the National Health Act in 1948. This act has in many respects profoundly modified the previous situation of psychiatrists and the practice of medical care in the United Kingdom. In order to appreciate the changes that have arisen from it and to grasp its socio-psychiatric implications, it is necessary first to give some description of the situation which existed prior to the passing of the Act and the manner in which that Act has modified the situation.

Conditions Prior to National Health Act

Prior to the National Health Act most hospitals in Britain were independent, non-profit-making, charitable bodies, which had originally derived their income entirely from voluntary contributions and benefactions. During the present century, however, a variety of group insurance schemes arose to cover the cost of hospital medical care and the hospitals themselves began to recover from patients a proportion of the cost of treatment in accordance with the patient's means or, alternatively, by reimbursement from a hospital insurance scheme. There were, however, exceptions to this general situation in that certain types of hospitals—particularly those concerned with mental illness, infectious diseases, or tuberculosis—were provided under a legal obligation by the politically elected local government authority of the county or town. In the case of psychiatric hospitals this arrangement is one of long standing in that the local govenment

authorities' obligation to provide in-patient treatment for the mentally ill goes back about a hundred years. The cost of treatment in such hospitals, unlike that in general hospitals, fell upon local taxation, although it was to some extent recovered by the local government authority from patients or their next of kin to an extent determined by their means.

The majority of the mental hospitals in Britain were built either in the early years of this century or the latter part of the last. They were usually built remote from towns where land was cheap and they were usually much larger than would appear desirable to present-day psychiatric opinion since the per capita building and operating cost received more attention than the need for therapeutic efficiency. Not only were the mental hospitals and the doctors and nurses who worked in them geographically remote from towns, but the hospitals were also culturally remote, so to speak, from the rest of medicine. Their internal organization also differed considerably from that of a general hospital in that it was based on a strictly hierarchical structure at the top of which stood the medical superintendent who was the only physician with direct access to the health committee of the local authority responsible for running the hospital. However many thousands of patients there might be in such a hospital it was the medical superintendent who, in the eyes of the law, carried the clinical responsibility for their treatment.

The mental hospitals and the physicians who worked in them undertook, in general, little out-patient work and elsewhere there were few facilities for psychiatric treatment either for in-patients or out-patients since many general hospitals provided neither type of service. Most mental hospitals were inadequately staffed by physicians and different factors contributed to this situation in varying degree in different hospitals. In some cases the principal factor was the parsimony of a local health authority. A second factor was the general unpopularity as employers which local authorities evoked in the medical profession. A third factor was the comparative isolation of psychiatry from general medicine and its consequent low repute to which the mental hospitals', salary scales for psychiatrists contributed, since these were considerably lower than the earnings of a specialist in internal medicine or surgery.

One of the characteristics of the psychiatric scene before the National Health Act, however, was its extreme variability in different parts of the country. In one place an enthusiastic local health committee and a progressive medical superintendent might

develop services both intramural and extramural which far exceeded the local authority's legal obligations. In other areas the converse situation might lead to the provision of little more than the bare minimum of custodial care. At this period facilities for child guidance were scanty, being predominantly represented by a few clinics conducted by voluntary bodies or operated by the education department of certain progressive local education authorities.

Effects of National Health Act

The National Health Act, which came into force in 1948, produced a complete change in the position of all hospitals in the country in that with one or two minor exceptions the hospitals passed into the formal ownership of the Minister of Health, who delegated the responsibility for running the hospital service to Regional Hospital Boards. The country is divided into 14 hospital service regions each with a population of between 3 and 6 million people and it is the responsibility of the hospital board of the region to organize, develop and operate an integrated and comprehensive hospital service for the region. The board's membership is not politically elected. It is appointed by the minister after he has sought the suggestions of all interested bodies in the region. Just under half of the membership of each board is drawn from the medical and allied professions.

The boundaries, area and population of a hospital region are not identical with those of the local public health authorities since, in delineating the regions, an attempt was made to base them on a population large enough to justify a comprehensive hospital service covering all kinds of specialist as well as general hospital facilities. Many of the public health authority areas are either too small to justify such a comprehensive hospital service or too large, as in the case of London, for reasonably efficient administration. This, however, has led to the situation in which the boundaries of the public health authorities and the boundaries of the hospital regions are in no way coterminous. Indeed, parts of the areas of several public health authorities may overlap with that of a single regional hospital board. This raises difficulties which are referred to below.

In the financing of hospitals there has also been a significant change. The mental hospitals of the public health authorities before the Act were financed from local taxation. Since the Act all hospitals are financed from central national taxation from which each regional hospital board receives its funds. The medi-

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cal staffs of all hospitals are now employed by the regional hospital board and recognized specialists in all specialties now have the same basic salary scales regardless of location or specialty. In most specialties the majority of specialists have part-time contracts with the hospital boards covering nine half-days a week and spend the remainder of their time in private practice. The majority of psychiatrists, however, probably still have whole-time contracts. Their contracts, however, are now with the regional hospital board rather than a specific hospital and they do not necessarily devote the whole of their time to in-patient work within a particular psychiatric hospital as was the case with the psychiatrists who worked in the mental hospitals when they were under the management of the local health authorities.

This immediately removes one obstacle to the development of extramural work. Since the expense of running all hospitals falls on the regional hospital and since all the psychiatrists in the region are in contract with that board there can be a much greater degree of flexibility in the employment of psychiatrists in different types of work. As a result, the specialist psychiatrists on the mental hospital staffs in the region with which I am most familiar spend an average of three half-days a week working away from their hospitals on out-patient work or consultations in general hospitals. This has brought the psychiatrist into a much closer relationship with his other medical colleagues and also with the general public. This may well be one of the reasons for a considerable change in public attitude to mental hospitals, which is best exemplified by the fact that the majority of admissions to mental hospitals in Britain are now of a "voluntary" type without any question of legal commitment. In 1956, for instance, in the Leeds hospital region such voluntary admissions formed 74 percent of the total psychiatric admissions during the year.

Another important influence on public opinion was a small but highly significant change which the Health Act made in the legal processes of commitment and discharge, which gave the next of kin of a psychiatric patient committed to a hospital for compulsory treatment the power to discharge that patient from the hospital unless the superintendent gave a certificate stating that, in his opinion, the patient was dangerous to himself or to others. It seems probable that the giving of this right of discharge to the next of kin has contributed significantly to the rarity with which complaints are now heard of the illegal or unjustified detention of psychotic patients.

At this point should be mentioned a change which, although not arising directly from the National Health Act itself, took place at about the same period and has had its impact on the pattern of development of the health service. Prior to the last war there were no true whole-time departments of psychiatry in British undergraduate medical schools. Such titular chairs as there were, were associated with the superintendentship of mental hospitals and such teaching as was given in psychiatry was usually based on the type of clinical case likely to be found in a mental hospital. Since 1946, however, nine whole-time chairs of psychiatry have been established at university general teaching hospitals.

This development has had an effect, I believe, in two main directions: first, on medical education, since the teaching which the medical student now receives is not only more extensive than was formerly the case, but is now based on the orientation of a psychiatric unit in a general hospital rather than the orientation of a mental hospital. The development has also probably had its effect on the general pattern of the development of psychiatric care within the regional services since each hospital region is so planned that it includes a medical school and teaching hospital which is in some respects in a position of leadership.

Several influences have therefore been working in the same direction and have probably produced in both the teaching and practice of British psychiatry a more synoptic viewpoint than previously existed. Most of the influences of the National Health Act, therefore, and their effects have been undoubtedly beneficial in that they have brought psychiatric hospitals into a much closer relationship with general hospital services, they have encouraged psychiatrists to practice a broader conception of psychiatry, and they have led to considerable extension of extramural psychiatric services. Nevertheless there still remain some major legislative and administrative impediments to the development of an integrated practice of social psychiatry.

Impediments to Development of Integrated Practice

Apart from the hospital service two other main arms of the national health service are responsible to different administrative bodies with different geographical boundaries for different aspects of the service. Preventive medicine and public health, for instance, remains the responsibility of the local government authority from which the Act removed control of the psychiatric hospitals; yet the same Act which removed the responsibility for

hospital medical care from the local government authority nevertheless placed upon that authority the responsibility for the rehabilitation and after-care of hospital patients. Unfortunately, however, work of this type was not made a statutory obligation of the authority and therefore the extent to which local authorities have carried out this work has been exceedingly variable. Even at the best, it must be said that the development of rehabilitation, after-care and resettlement services for patients on leaving hospitals has lagged behind the development of out-patient and in-patient treatment facilities. Even if this were not so, there would still remain the problems that arise from the fact that the geographical boundaries on which the hospital services are based are completely different from those of the local health authority responsible for rehabilitation and resettlement.

The difficulties in the development of child guidance services also merit special mention in that these services exist in the borderland along the frontiers where the national health service and the education service meet. The Education Act, which antedated the Health Act by a couple of years, placed upon local education authorities the obligation to provide child guidance services. At the outset there was some tendency for child guidance services developed by local authorities to be restricted predominantly to children referred from educational sources and often to be conducted principally by educational psychologists with comparatively little contribution from child psychiatry.

The National Health Act also empowers regional hospital boards to develop services in child psychiatry. In theory, therefore, the danger exists of the parallel development within the same community of two sets of services for children with different clinical orientation and a different type of staffing responsible to different authorities and drawing their cases from different sources. Such an arrangement would not only be extremely inefficient but would be one liable to lead to interprofessional and inter-disciplinary difficulties.

Growing collaboration between educational authorities and regional hospital boards in the sponsoring of joint child guidance clinics has solved this problem in some areas but by no means all, and child psychiatry still remains more isolated from general medicine in some respects than does the practice of adult psychiatry. This is reflected in the extent to which the development of in-patient services for psychiatric problems of childhood has lagged behind the development of extramural services. The pattern of development of services can be illustrated by data from

the Leeds hospital region with a population of just over 3 million people. Between 1948 and 1955 the number of child guidance psychiatric sessions per week rose from 16 to 50, using the term "session" as indicating a psychiatric consultant devoting half a day to out-patient work. During the same period, however, no in-patient accommodation was developed for psychiatric disorders of childhood.

During the same period there was a comparatively small increase in the number of psychiatric beds for adult patients, whereas the number of psychiatric admissions almost doubled, i.e., from one psychiatric admission per annum per thousand of the population to 1.8. It is evident from these data that, although the number of psychiatric beds is little increased, the beds have been much more actively used and, as previously mentioned, 74 percent of the admissions to these beds are now voluntary without formal certification and commitment. One factor that has certainly contributed to the possibility of this more active use of beds has been a considerable increase in the medical staff of psychiatric hospitals, particularly at the specialist levels.

The increase in the development of out-patient facilities, however, has been even more marked, in that it has trebled between 1948 and 1956. In the former year there was one weekly half-day out-patient session for every 140,000 of the population. By 1956 this provision had increased to one weekly half-day out-patient session per 50,000 of the population. During the same period the number of new out-patients seen annually had increased from 5.5 per 10,000 of the population to 10 per 10,000 of the population, and the number of times each new patient was seen as an out-patient again had almost doubled from 2.9 in 1948 to 5.5 in 1955.

There is no doubt, therefore, that the National Health Act has had a beneficial effect insofar as it has led to the increasingly active use of mental hospital beds, to the threefold development of out-patient services, and the increased amount of treatment given to each new out-patient. It has certainly had a beneficial effect on the viewpoint of the psychiatrist as well as on his relationship with other branches of medicine. Initially, however, it has probably made deeper the traditional administrative cleavage between therapeutic and preventive medicine and, in the local community, has placed new obstacles in the way of continuity between treatment and rehabilitation, despite the fact that it may well have improved the possibility of developing the rehabilitation facilities themselves.

A task of the future, therefore, is the integration of those aspects of the service which are strictly therapeutic, although extramural, with those community activities concerned with resettlement and rehabilitation which are not the direct responsibility of a hospital service. Probably much of the responsibility for bridging this gap rests with the informal relationships of psychiatrists in the health service with other health workers in the community who may well be responsible to different administrative authorities. The benefits of the National Health Act and the postwar developments in psychiatric departments in universities can only be reaped to the full if these remaining obstacles to the development of an integrated social psychiatry are to be circumvented.

RECENT DEVELOPMENTS IN SOCIAL PSYCHIATRY IN THE NETHERLANDS

WILLEM L. MEIJERING, M.D.

In order to compare social psychiatry in the Netherlands and in the United States, it is necessary to demonstrate the differences between the two societies and the two cultures. Even if psychiatrists throughout the world have one psychiatric language and use the same concepts (and even this is not entirely true for different cultures), the social psychiatrist is concerned not only with psychiatric concepts but also with social systems, norms and customs. These give social psychiatry a local color and result in methods which are applicable only in the special country in which they were developed, although, if adapted, they may be useful in other surroundings. Even if American and European cultures are as alike as cultures in different parts of the world can be, they do show differences.

Psychiatry, being so intimately linked with the subtleties of the human mind (which, for not a small part, are determined by environment and society), immediately registers these differences, and a different approach of the psychiatrist is the result. We must be very much aware of this in order not to become so confused that we misunderstand each other; or worse, judge each other by our own standards and customs, and finally end by not talking to each other. There is great danger that this will happen, even if both parties are willing to converse; and in my opinion, this would be a great loss since the similarities of European and American cultures make possible a comparison of details, a comparison which could be important and which could not be executed with the totally different cultures of, for example, Pacific or Asian populations.

Therefore, I am grateful for the invitation to speak here, and I hope I can do some little thing to make possible a better understanding. But I wish to emphasize that I do not imply any criticism of American methods when I describe setups in the Netherlands which differ from those customary here; and I beg you not to judge our concepts too harshly, even though I know that they show great deficiencies.

The Dutch are, in part, a principled people, still having the same adherence to fixed principles which the Pilgrim Fathers showed when they sailed for America, and this does not make them more adaptable to new situations. Psychiatry, being a relatively new development, is not accepted readily; and in many cases, old methods, which often are confused with religiously anchored fundamentals, are adhered to even in the face of overwhelming evidence of the obsoleteness of the methods.

Complicating Factors

Social psychiatry in the Netherlands, though old (I may remind you of the development of the Belgian family care program of Geel, begun in the 14th century), has only recently been developed scientifically. It is intimately connected with the ever-growing social care program of the Netherlands government. Much more so than in the United States, the government and the individual are linked together in the Netherlands. The government assumes many cares of the individual. Many things, which in the United States are personal responsibilities, are taken over by the government, offering care which is often ridiculed as "extending from the cradle to the grave." This makes a difference in atmosphere which is important and which makes necessary a social psychiatry much more intensive than that in the United States.

The mental patient is cared for by the government, generally through private institutions most of which are connected with a religious sect, this connection between medical care, especially psychiatric care, and religion being one of the Dutch principles. This makes the situation difficult to be viewed generally.

There is a second factor which complicates matters. Much of the work which now belongs to social psychiatry was not formerly a part of psychiatry at all, not even of medicine in general. Child care, teaching, prison administration, care of asocial persons, to name but a few, all later showed psychiatric facets so that today, important parts of these regions are incorporated in social psychiatry.

The intimate connections with so many other aspects of the relations between individuals make ever more indefinite the limits of the territory called "social psychiatry," which does not make a description easier. On the other hand, this junction gives social psychiatry a vivacity which makes this task attractive.

Mental Hospitals

I want to start my description with the mental hospitals, which are from old times the centers of psychiatric treatment. One may ask whether what happens in the mental asylums belongs to social psychiatry in its stricter sense, but a discussion of the situation inside the hospital is not to be avoided if one wants to understand what happens in the outside world. The former has its repercussions on the social psychiatric provisions in society at large. The attitude of the public and, through this, the possibilities of the social psychiatrist are greatly determined by the example given by the psychiatrist and his aides. This example is explicit in the practice of living together in the closed community of the mental hospital, showing how one ought to converse with mental patients. The basis of social psychiatry is the treatment in the mental hospital.

Dutch mental hospitals are not large by American standards, the maximum being about 1,500 beds. They are mostly private institutions owned by religious nonprofit organizations, sometimes public hospitals. In general, they have a long history and are of a conservative character. Nevertheless, the last decennia show many and great ameliorations. Dutch mental hospitals first used German examples (Simon in World War I) but gradually developed their own methods. The changes started with the gradual abolition of bed-nursing in favor of a stimulation of the patient's activity by means of "work." This work-training, in its turn, changed into occupational therapy. But that was not all. It slowly became recognized that mental patients could be responsible persons. Even now, this notion is not sufficiently realized in most hospitals, but a start has been made in the direction of a "more active therapy." This therapy aims at a re-education and resocialization of the patient, and it includes, in addition to work, other important aspects of living.

Concurrently with these developments, a change occurred in attitude toward the patients. This attitude became much less aggressive, which may be evinced by the fact that aggressive problems play a lesser role in the Netherlands than in the United States (a point stressed, among others, by Querido after his recent visit to the United States). In most Dutch mental hospitals, the no-restraint method is used, which makes it possible to manage an institution without means of limiting freedom (physically, by locked doors and strait jackets; chemically, by tranquilizing drugs). This was made possible by the much less aggressive attitude of the hospital administrations.

Notwithstanding these changes, the mental hospitals must be viewed as conservative institutions, which is not astonishing when one takes into account the heavy load of tradition, the shortage of personnel, and the financial difficulties. Only gradually, timid overtures are made to introduce psychotherapy in the hospital, and a "social therapy," in the sense of a therapeutic community such as the one founded and managed by Sivadon in France, is still a long way off.

This attitude of the hospital administrations is typical of the attitude toward the position of the mentally disturbed in society. One is willing to care for them, to take good care of them (sometimes even too good), one is sometimes even willing to allow them limited responsibilities, but one is not ready to accept them as equal though temporarily or permanently disturbed persons. This paternalistic attitude is prominent in social psychiatry as well, though the contact with the patient in his surroundings often forces the social psychiatrist into a more humane pose.

Family Care Program

Starting with the mental hospitals, the first contact of the psychiatrist with society is found in the family care program. Most of the mental institutions have a department of family care. They have a regular contact with a number of families with whom they place those patients who can manage socially in some degree. This method has the advantage that these patients can be returned to society without being exposed to the burden of their former surroundings. Even if the environment is not a direct part of the causation of the psychic disturbances of the patient (as, for example, in psychoses of somatic origin), the chronic contact with the patient often has sensitized and neurotized the group at home to such a degree that an immediate return to these surroundings is a too heavy burdening of the patient. Although family care with its many difficulties is certainly not ideal (one important objection being the reduction of direct psychiatric care through this decentralization, another difficulty of finding suitable families), it is an important means toward resocializing the patient, as long as the institutions themselves cannot offer the patient an environment in which he can be treated with sufficient intensity.

After-care System

The next task is, of course, the care for the patient after his return home, and this is the territory of social psychiatric work

proper. All discharged patients come under a system of after-care. This originally was a part of the duties of the institution in which the patient was treated, but in some places, notably in Amsterdam, these after-care programs for different institutions have been combined. By this, they became an independent institute belonging to the municipal health service and intimately connected with the University of Amsterdam. This after-care treatment is, at the same time, a preventive treatment aimed at a prevention of readmission. It is directed by a psychiatrist and executed principally by nurses with special social psychiatric training. It treats, guides, and helps the patient, and prevents difficulties in and with the surroundings at home and at work. In Amsterdam, this grew into a system with a day-and-night emergency service through which oncoming difficulties can be nipped in the bud. It appears that an early treatment can give an important reduction of admissions.

The after-care programs do not give treatment, in a stricter sense, either somatic or psychotherapeutic. These services are performed by the existing out-patient clinics or the psychotherapeutic institutions, but they do provide what one might call social psychiatric treatment, treating patient and surroundings in the actual situations. For this, the need of a day hospital is certainly felt, but it has not yet been realized. This task is taken over by the sheltered workshops.

Special Problem Areas

This is a description of that part of social psychiatry which grew immediately out of the medical work. It is, at the same time, most of the care given to psychotics. But there are other parts (neurotics, children, oligophrenics) in which the psychiatrist penetrated later. This can easily be understood since, until recently, the psychotics were the only ones of the mentally disturbed who were considered "ill"—and in certain respects, indeed, they are the only ones who belong, without any doubt, to the purely medical cases. The others can be viewed as medical cases as well as nonmedical cases. The impulses for a concern for these patients often came from sources other than medical.

Next to homes for oligophrenics (who cannot keep their ground in free society and of whom many grownups at least reside in the mental hospitals), for our subject matter, of course, the social psychiatric measures taken for those mentally retarded persons who remain in society are very important. Nearly everywhere in the Netherlands it is possible to obtain special education for them

in schools where teaching is not so much directed toward the acquisition of intellectual knowledge as to the practical adaptation to society. Here the psychiatrist acts as a consultant, together with the psychologist, but the important tasks are being fulfilled by specially trained teachers. Children are admitted to these schools, mostly upon the advice of the teachers of the ordinary schools, after a psychiatric and psychological evaluation. The parents are free to continue sending their children to the ordinary public schools. Until fairly recently, the special schools had a bad name as "backward schools," but as these schools now accept, in addition to the mentally retarded, other children with difficulties in adaptation yet with a sufficient intelligence for more individually oriented training, the relation with the public ameliorates. Furthermore, the children leave the school better equipped for social life than are similar children from ordinary schools, which does not fail to have a salutary effect.

With adults, the problems of the mentally retarded change. Many of them find their way in society in simple jobs, often advised in this by special branches of the (governmental) labor exchange offices which have social workers and psychological departments, and work in close contact with psychiatrists. These special branches handle, in addition to oligophrenics, other defectives: physically handidcapped, discharged but insufficiently adapted psychotics, neurotics and psychopaths, etc. For these, an intimate collaboration with the after-care programs is the rule. In connection with the labor exchange work, governmental technical schools provide special training or retraining in the jobs wanted. These schools are used also for retraining normal persons in cases of insufficient employment facilities. During the training, the pupils receive wages as if they were already employed in their new trade, with a small deduction. This, however, leads us outside the territory of social psychiatry.

For the more severely disturbed individuals who cannot work temporarily or permanently in free society, in many places one finds sheltered workshops in which they work under expert guidance and without a special medical treatment. Although their setup somewhat resembles that of the day hospitals (the patient living at home and going to the workshop daily), they differ in that the workshops do not provide any direct therapy. As far as the mental patients are concerned, there is, of course, an intimate contact with the psychiatric services.

The training in the workshops is not a special training for a certain job but an adaptation to normal working conditions. By

using intermediate devices, it is possible to get quite debilitated persons to do fairly complicated work. Collaboration with others is stimulated and the patients are gradually brought to quicker working by assembly line procedures.

Psychiatric care for those patients who remain in society, although handicapped by neurotic symptoms or character deformations, is in many respects still lacking. Unless the neurotic is asocial and is either admitted to a mental hospital as a medical case or gets the attention of the courts as a criminal case, or unless he has much money, there are few means of treatment for him. In the larger cities, a start has been made by providing treatment at reduced rates, but for a long time to come this will be insufficient, owing to a lack of available psychotherapeutic manpower. How the enormous funds necessary to really treat the many neurotics will be found is still not clear and may even be entirely impossible.

In addition to the institutes for psychotherapy there exist clinics for more specialized disturbances such as alcoholism. In general, they do not treat but only give guidance and social help. The clinics for marriage difficulties, most often connected with some religious association, also belong to the territory of social psychiatry.

Better developed is the prevention of psychoneurotic disturbances by the treatment of neurotic children. The child guidance clinics which exist in most places are well organized and already have a long experience. Their staffs, led by a psychiatrist, include psychologists, specially trained social workers, and pediatricians. They give advice to the parents, teachers, children's courts, and other officials, and treat the children and their parents. Existing possibilities include placement in foster homes or in institutes, but this is mostly used only as a last resort. Homes for children exist in a large variety. They are more or less expertly directed, but there is a certain State supervision which, however, often supervises only hygienic conditions. The diversity in this kind of work is great, and the disadvantages of private enterprise are often apparent.

Psychiatric Care for Prisoners and for Army Personnel

There are two large groups which have not been mentioned yet and which I want to discuss now; those who come into contact with the criminal courts, and the personnel of the Army.

First, the criminals. Since World War II, the psychiatric care for prisoners and those convicted to suspended sentences has been

developed immensely by the exertions of Baan *et al.* Before passing sentence in the more serious cases, the judge has at his disposal an observation hospital in which an intensive forensic psychiatric observation is made possible in order to offer the court advice about the adequate measures to be taken. A start has been made with specially trained forensic psychiatrists who work regionally on the lesser cases.

Those who are sentenced to imprisonment are distributed by the selection institute to the different institutions which are advised as to the best treatment for the prisoner.

Most important of all, however, is the possibility of really intensive psychotherapeutic treatment for neurotics and psychopaths in the recently opened Van der Hoeven Kliniek. Following the example of Maxwell Jones, adapted to the special position of the patients and to Dutch circumstances, a community formation tries to influence their disturbances with group and individual psychotherapy. After a purely "democratic" period, which in the end did not give satisfaction, a more guided democracy has been introduced; but the right method is still in research, and the manner of approach can be adapted to ever-changing circumstances. For treatment, even seriously disturbed persons are candidates (but no psychotics), and not only prisoners but those with suspended sentences, too. Treatment is voluntary, a patient who refuses psychotherapy returns to his former state, either in prison or outside.

Time is still too short to judge results, but it is clear that one success already means an enormous financial gain.

Army psychiatry has a double task: To protect the Army against the mentally disturbed who exert a disruptive influence and, reciprocally, to protect the mental patient against the stress of the Army community. In the Netherlands, the psychiatrist is severely put to the test since the country must use every available man to fullfill its NATO obligations and to maintain a ready Army of sufficient strength. This necessitates a rejection rate which is as low as possible, and provisions to use the available manpower as advantageously as possible. A handicap is a shortage of available trained psychiatric personnel which has already led to the omission of an initial psychiatric examination of recruits, a task which has been taken over by nonspecialized doctors. This examination rejects about 8 percent of the examinees because of insufficient mental stability.

Using the same organization as the American Army (the Netherlands Army being organized after the American example), the

strength of psychiatrists is about 1 per 5,000 men, but the majority of military psychiatrists have not been fully trained. Most of them are reserves. Some of these psychiatrists are used in special selection jobs and cannot be reckoned with as far as treatment goes. For this are available four regional psychiatric services (comparable to the American mental hygiene units), two special hospital wards for psychotics mostly, and one treatment center for neurotics. Furthermore, the disciplinary center has an intensive psychiatric service. During active service, about 2 percent are ruled out because of mental disturbances, mostly neurotics and psychopaths. The Netherlands Army does not issue an administrative discharge, as is customary, if I understand right, for unmanageable psychopaths here.

The most important means for treatment are the regional psychiatric services and the military hospital for neurotics. The regional psychiatric officer has a social service which keeps in contact with the commanding officer and with the patient's family so that eventual difficulties (emotional or social) can be straightened out. Additional, shorter psychotherapies are possible. Unfortunately, most of these services are overloaded and thus their psychotherapeutic possibilities are limited.

More intensive psychotherapies are furnished by the hospital for neurotics, in which about 0.3 percent of the Army personnel annually receive treatment for 3 months. Although this small number does not have a direct influence upon Army strength, it has a certain preventive effect. And even if the number is small, it has its importance for general mental health because most of the patients would not come into psychotherapy in other circumstances. Since a selection is made of those who later will be social leaders, the influence is greater than numbers alone indicate.

Treatment, for that matter, is directed not to acquiring a sufficient adaptation for Army services only but also to furthering growth of the entire personality, regardless of social consequences.

The gathering together of neurotics is a dangerous procedure against which just objections have been made. Consequently, the resulting group formation or community has a low morale and is difficult to handle. The management of a group like this needs a special setup; nevertheless, we must not be afraid to try it out. It has been proved that the setup is possible and helpful.

The psychotherapy in the hospital takes place in an artificial community, with doctors-psychotherapists as father-images, and nurses in the mother role. A partially democratic regime offers

the patients the possibility to organize and, in doing so, to be shown the difficulties in adaptation among themselves. A continuous "talking through" of the arising problems takes place in community meetings, group sessions and individual interviews. There is a clear distinction made between administration and psychotherapy. Military regulations permit the hospital director to handle the situation in such a manner that it is most helpful in inducing those difficulties the individual patient needs for his development.

No hard and fast rule exists about how to organize such a hospital. It has to be adapted to its social background. It appears, though, that one of the demands is the creation of a continuously but slowly changing hospital atmosphere in which any rigidity in management has a deleterious effect. That the individual patient have an intimate contact, on the one hand, with the administrator in setting limits to his neurotic demands, and on the other hand, with the psychotherapist in clarifying the consequent emotions, is a second requirement. If these demands are met, a hospitalization of the neurotic patient can be helpful since acting-out and reality testing procedures are possible on a scale which society does not and can not permit. Although acting-out in out-patient therapies can be considered a drawback and can even make the gaining of insight impossible, the closed unit can make use of it, since the constant feedback by other patients and personnel always brings it into psychotherapy again. Then acting-out makes insight much more real to the patient, and it has been helpful in the achievement of maturity.

The results of this kind of treatment are still insufficiently known. We have not succeeded as yet in developing a rating scale which could give an insight in the success of this kind of psychotherapy. Many immeasurable factors play their part. According to subjective impressions, however, one may say that about three-fourths of the patients receive some advantage from this, which is far from unsatisfactory.

In the foregoing I have given a general view of the recent developments in social psychiatry in the Netherlands. To conclude, I would like to say that these developments, not withstanding many defects, show a living entity which contains the potentialities of further development. The small country with a great density of population makes a good social psychiatric service necessary; we certainly need it.

CURRENT DEVELOPMENTS IN SOCIAL PSYCHIATRY IN THE UNITED STATES

Robert W. Hyde, M.D.

The field coming to be designated as social psychiatry has been receiving increasing recognition in the past years. It is not necessary here to spell out all of the developments which led up to the existing stage, as they have been well outlined in several places. For example, Stanton and Schwartz, in their book, "The Mental Hospital"[1] survey the developments of social psychiatry within the hospital in the fields of research and its application. Greenblatt, York and Brown in "From Custodial to Therapeutic Care"[2] have an extensive bibliography in the areas of hospital organization, nursing, personnel management, social structure, public relations, volunteers, group psychotherapy, environmental treatment including rehabilitation. They add to the hospital picture some practical studies in a small intensive treatment hospital, a large State hospital, and a large veterans' hospital, showing the result of application of many of the present-day ideas in this field.

Quite recently, Kalinowsky[3] has reported on his tour of hospitals in Europe and the British Isles. This has the special value of showing that this social trend of present-day psychiatry has been a development in Europe as well as in America. In many cases more thorough use of the methods of recent psychiatry are found in certain European and English hospitals.

In the hospital field the consideration of hospital architecture has always been important, to the degree that the structure of an institution determines the way in which it functions. Here Mr. Gutersen's studies in Denmark, Holland and Norway[4] have added much to the total picture. When changed concepts are built into the structure of buildings they come to have a certain permanence.

Another area that has received constantly increasing attention has been that of social anthropology at work in collaboration with psychiatry. Here perhaps we go back to the studies of Roheim,[5] Kardiner and Linton[6]—then those of Leighton and Kluckhohn.[7]

The book by Lyle Saunders, entitled "Cultural Differences and Medical Care,"[8] shows the significance of cultural determinants

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of methods of treatments in the general hospital. Paul Barrabee made a very interesting study of psychiatric patients of different ethnic groups,[9] showing the extent to which their symptomatology was related to their cultural attitudes and, what was perhaps more important, the extent to which the nature of their closer family relationships was often determined by their cultures rather than by their psychopathology.

One area of special interest in the application of social psychiatric attitudes has been exemplified by the work of the Cummings,[10] where they were able to institute rapidly and successfully a new therapeutic program, developing psychiatric nurses in a large mental hospital, establishing demonstration wards for teaching purposes, and studying the patients' symptomatology from the point of view of how acceptable the symptoms were to the outside community. Here they were able to define deviations of behavior as more nonfrightening and more acceptable than others, and thereby successfully discharged the patients.

Present-day social psychiatry involves special attention to problems of cultural and biological groups, and to such matters as type of community, age groups, occupation, rehabilitation—all of which cut across diagnostic barriers. For example, the extensive studies of the problems of childhood and child rearing are a manifestation of this trend. Likewise, the field of geriatrics where we are becoming as much concerned with the problems of those in their later years as we are with those in their earlier years.

DIVERSE BACKGROUND

It is difficult to find the point at which to start in orienting a presentation of our present-day trends in social psychiatry. We could start with the school, the mental hygiene clinic, the church, industry, the hospital, the research center. Any one of these points of departure would, to some extent, emphasize that special area as having particular importance, being the hub of the wheel from which other developments are spokes.

One of the most significant things about social psychiatry today is that it did not appear to start from any single source. It may take years for us to get a clear historical picture that will shed light upon the actual centers in which developments started and the sequence of developments from one center to another. We all surmise that there was soil within the culture of America, the British Isles, Europe, and perhaps the whole world for growth in this area; that modern trends of legislation for social welfare

occurring in England, Canada, the United States and elsewhere, are a part of a general cultural process of which social psychiatry is but another part.

SELECTIVE SERVICE, INDUSTRY AND WAR

I am forced to look at the developments through my own eyes. The first I saw while in the Army induction stations during the Second World War. Here the psychiatric screening of selectees gave us one of our first substantial pictures of the amount of psychiatric disability of our young men. Quite suddenly everyone was aroused; the social service workers applied themselves to bringing in data upon the background of the selectees, and then to social case work on the rejected ones, both to adjust them to their new-found disability, and to arrange for appropriate care and treatment. The psychiatrist perfected his examination methods and came to many new insights into the frequency of many disturbances which he had previously considered unusual, likewise into the infrequency of other disorders he had considered common. The psychologist found that many of the usual testing methods were not appropriate to the specific needs of selection involved, and rapidly devised new methods.

A mass of miscellaneous findings accumulated so rapidly that they have never been adequately documented; for example, the large number of selectees who had been found mentally defective during their earlier childhood and now were testing quite within normal range; the degree of vocational usefulness of the mentally defective such as our finding[11] that the majority of them were substantially employed during the war years of manpower shortage, although they had been unemployed during the depression years of unemployment.

The great difference in rejection rates from one community to another led us to make determinations of the various community factors that might be responsible. The socioeconomic level,[12] population density,[13] race and nationality,[14] etc., were all considered. Here we were able to demonstrate that the social determinants of psychiatric diorders were indeed important and deserving of both further investigation and social action.

Many other situations during the war brought about a new social orientation in psychiatry. Even after the high rate of rejections at the induction stations for psychiatric disabilities there was a very high rate of psychiatric casualties. New treatment methods were developed. The psychologists did group psycho-

therapy. At the combat front the acuteness and reversibility of several psychiatric processes was seen and described. Contact between psychiatrists, psychologists, and other officers in the service brought about a great increase in psychiatric orientation. This has led to such valuable recent contributions as "Men Under Fire," and "Pork Chop Hill," by S. L. A. Marshall.

THE HOSPITAL AS A THERAPEUTIC CENTER FOR THE PATIENTS' TOTAL TREATMENT

My next experience was that in a mental hospital where it became quickly evident that the ward was a community which contributed either to the recovery or the maintenance of the disability of its patient population. We were able to start a variety of experiments in ward adjustments which led, among other things, to the present-day concept, variously called total treatment, milieu therapy, social therapy, the therapeutic community, etc. We began to see clearly that the hour-by-hour living experiences of the patient on the ward were of basic importance to his welfare.

Harry Sullivan pointed this out in his early paper (1931) "Sociopsychiatric Research."[15] The Menningers in Topeka had made strides in altering ward climate. So throughout the nation, and also in Europe, substantial developments were on the way. The significance of all aspects of the patients' lives within the hospital was studied from a research perspective, and from the therapeutic point of view there were attempts to give personnel, attendants, nurses, etc., those additional experiences which would make them most useful to contribute to the patients' community life. Patients, too, were recognized as able to help each other.

Just as we looked into the pertinence of hospital life, we were quickly led into seeking the extensions of the patient's contacts in the community; for example, what relationships with his family had brought about the final breakdown which necessitated hospitalization? Both psychiatrists and social case workers were asked to focus upon this area because, without knowing the impasse in the patient's family life, we could know little about how to remedy it. Then, too, what relationship with the family should be maintained by the patient while in the hospital? Could we arrive at any generalization as to what were the indications for maintaining close, ongoing supportive contact? Gradually, both psychiatrist and psychiatric social worker came to see the need for working with the family as well as with the patient.

Just as the ties with the family were being investigated, so were the ties with the larger community. What connections with his church groups, with friends, were maintained while the patient was in the hospital? What was their bearing on prevention and treatment? How could these ties be utilized after his return from the hospital?

The present-day trend of concern about the patient's life within the hospital extends in many directions. First, it extends back to the consideration of the patient before he comes to the hospital. What could have been done to have prevented the illness, if illness it were? What alternatives to hospitalization might have been provided? It extends forward; what can be done to insure the patient's return into a full place in society with maximum utilization of his capacities; what can be done to reduce any vulnerability he has, thereby reducing the chance of his again being hospitalized?

ALTERNATIVES TO HOSPITALIZATION

This subject of alternatives to hospitalization was perhaps an eye-opening point of view. As we looked around we were able to see that many patients were in the hospital, not because they needed the particular type of treatment that the hospital could provide, but because there was no satisfactory alternative.

The one existing alternative was the out-patient department. Throughout these same years that there had been a growing respect for the patient's living situation within the hospital there had been a great growth of out-patient service to the patient. Patients with ever increasing severity of disorder were being cared for and treated in a safe and effective manner through regular out-patient visits. The psychiatrist had become more secure and confident of his ability to treat sicker patients without feeling that they required hospitalization. Through experience he was able to see that often, if hospitalization could be avoided, the patient's positive resources and community ties could be utilized advantageously toward his recovery.

There existed, however, nothing between the out-patient department and the hospital. Either a patient must be satisfied with one or more hours of psychotherapy a week or be admitted to the hospital for 24-hour-a-day care and treatment. This rather absurd situation is slowly being remedied. One of the trends in social psychiatry today is this recognition of the need for many alternatives to hospitalization. This also includes recognition of the need for many different types of hospitalization itself—that

there are many different types of environment within a hospital, each of which may be particularly desirable with a certain group of patients.

The day-hospital or day-patient program became the name attached to the variety of alternatives between the out-patient visit and the 24-hour hospitalization. The night-hospital with the night-patient program was another alternative. It is not necessary to point out here the large number of patients who are able to do well at home during the evening and at night, but who have no constructive way in which to spend their day—also the corresponding group of patients who do well during the day, supported by their working day life, but who become distraught and panicky at night. The week-end hospital has not quite arrived, but we are seeing need for it in another group of patients who do well throughout the work week, but who have difficulty in using their week-end leisure time.

With these new alternatives, we began to scrutinize hospital waiting lists to determine if, at the point of application for admission, a patient instead of being admitted or waiting for admission, could not be included in some type of out-patient program, or if some new source of community support could be found.

Hospitalization itself is gradually becoming a less definitive condition, where the patient is not separated from his community to the extent he was heretofore. Arrangements are made for him to go into the community frequently, to spend days and week-ends at home or with friends, to do shopping; and there are ways by which a patient can be easily hospitalized for a few days and then return to the out-patient or day-patient program without any drastic alteration of his concept of himself or his manner of living. The psychiatric ward in the general hospital and the acceptance of psychiatric patients on medical wards is becoming common practice, making hospital treatment of mental illness no different than for other illnesses.

HOSPITAL TO COMMUNITY—REHABILITATION

The other end of the patient's hospitalization, that of what happens to him after he returns from the hospital to the community has, in recent years, taken on added importance. Although rehabilitation can be defined to start even as the patient enters the hospital, yet we usually think of these processes which lead to the patient's social and vocational adjustment as starting some

time during his hospitalization and being carried on to a point where he is able to take optimal advantage of his own resources.

The psychiatrist, looking around, was able to see that in many fields of medicine and surgery, rehabilitation had progressed to a point far beyond that which had occurred in mental illness. Rapid strides are now being made to concern ourselves with this important area, bringing a variety of new considerations into the whole field of social psychiatry.

Much of the problem of the immense number of so-called chronic patients in the large mental hospitals of the country appears to involve their definition as sick patients in need of psychiatric care and treatment. Not only are there insufficient psychiatric personnel to provide this treatment, but the personnel themselves often fail to see the patients' treatment needs. One of the most important reasons for this is that a great number of patients are in need, not of treatment, but of rehabilitation. Instead of suffering from active disease processes they suffer from the residuals which usually consist of gross social maladjustments, not the least of which are due to years of separation from the normal ways of life in the community. The most successful approach to this is more rehabilitation than it is therapy. Simply by redefining the needs of this vast number of patients and by providing rehabilitation services where indicated, instead of therapeutic services, one could expect to see a completely altered picture.

How to carry out this rehabilitation program is another problem; just what adjustment of the patient are we going to decide is our end goal? Which patients are of a dependent character structure, where they need to be led back into the community, as against those who need to find their own way? In no other place are personal value systems more likely to be applied than in determining what life adjustment can be seen as good for the patient. We must evaluate our own attitudes very thoroughly in this area.

PRE- AND POST-HOSPITAL FACILITIES

The post-hospital adjustment or rehabilitation occurs in many settings; for example, the sheltered workshop, the social group, the quarter-way house, and the half-way house. In one respect we are here again finding a variety of alternatives to hospitalization, where a patient can be discharged from the hospital at a much earlier time because a facility is in operation which will meet his needs more effectively than the hospital itself.

There is a direct relationship between the rehabilitation area and the prehospital preventive area. They are both alternatives to hospitalization. The patient who is not yet sick enough to require the hospital and the patient who is no longer so sick that he does require the hospital are in much the same situation, and some of the newly developed half-way houses render their services to both patients—preventing hospitalization of the one, and accelerating the return of the other to full community adjustment.

Looking into the future we might see this type of establishment as one which may grow quite rapidly and tend both to reduce our need for hospital beds, and to reduce the vast social change involved in the shift from citizen to patient status. We may see a wide variety of such facilities, each adapted to special needs, financed by different sources. The family care programs are an example of this.

SOCIAL SCIENTIST

One of the features of growth in this field of social psychiatry came about through cooperation between the psychiatrist and the social scientist. At a time when the psychiatrist had many questions in his mind about the social factors involved in psychiatric illness, its care and treatment, the social scientist was developing an interest in allied fields, he was willing to help us see our problems and help us solve them. Many of the administrative notions, theories and methods that had passed down in the nursing and medical field were now subjected to a new and fresh point of view.

This had several results: First, the social scientist, quite fascinated by the interesting life within our hospitals, moved rapidly into studying the nature of this life. This brought him into close contact with the psychiatrist, and both had a new educational experience. As both viewed the patient and the ward they saw them from quite different perspectives and backgrounds. As the psychiatrist listened to and worked with these men, he was able both to verify many of his previous hunches and to gain new insights. Both the social scientist and the psychiatrist developed favorably through the contact, so that now the point is reached where it is quite unacceptable, from a psychiatric point of view, to sit and discuss problems of hospital administration, education and patient welfare without including the social scientist as a member of the team.

Much as the social scientist was drawn into the hospital so was the psychiatrist drawn out of the hospital. He developed broader perspectives upon illness than his original concern with the inner problems of the patient. Seeing broader social implications in the

illness, he was drawn out of the hospital into the community. He became increasingly interested in the preventive aspects of psychiatry. No longer was his concern limited to the sick patient but extended to all those agencies in society which can help keep people well, and to study of the background in which illness develops. He took part in a variety of community enterprises with ministers, teachers, industrial leaders and court officers, coming to deal more and more in the area of prevention than of disease. Apparently the psychiatrist left the confines of the hospital and private office as a part of a trend in society which was reaching out for his services and to which he responded.

COMMUNITY AGENCIES

While the hospital was reaching its arms out into the community, into both the pre-hospital and post-hospital areas, the community itself was mobilizing for the social welfare of many groups. *Alcoholics Anonymous* sprang up and became one of the effective community groups for the treatment of the alcoholic. The *patients' council for the mentally retarded* made the discussion of one's retarded child acceptable. *Mental hygiene societies* developed into more effective agencies. *State mental health systems* developed clinics and received support from Federal funds. *Natural childbirth groups* were established, where prospective parents often achieved a dynamic group experience. *Golden Age groups* created new opportunities for the aging. Other age centers studied the successful adjustments of people to the aging process.

This list could go on, mentioning both the many agencies directly in the mental health field and the general health field, and many others more informal. A new desire for association with psychiatric and social case work agencies developed in many existing institutions; School, Church, Industry, Y.M.C.A., clubs, fraternities and other health agencies. They became increasingly alert in seeing the psychiatric and social problems they encountered, and reached out in many ways for help in understanding these problems.

Many trends were directly fostered by Federal funds through the Public Health Service programs in training and research. The aims of social psychiatry were being implemented both by money and by direct contact with experienced Public Health Service personnel. Others, as we have mentioned previously, grew out of the programs of either State departments of mental health, mental hygiene, or hospitals. Others were stemming from spontaneous local groups.

The growth of the private mental hospital in recent years can be regarded as an application of social psychiatry. With the advent of more treatment methods, it has been possible for people of average income to obtain hospitalization within their means without resorting to hospitalization in State institutions. These hospitals have a different relationship to the community than State hospitals. They often have programs wherein the patient utilizes the facilities of the community for recreation and social life. They are directly dependent upon the community for their support and orient their program to meet community needs. This development broadens the relationship of psychiatry to the community, making it not just another tax-supported agency, but a focus of direct community participation.

Another source of stimulation was the growth of the veterans' hospitals and clinics. Here a large, popular, well-financed organization was often located near State hospital facilities where healthy comparison and exchanges of experience could be made. In some of the newer veterans' hospitals, as in Brockton, Mass., the latest theory and practice in social psychiatry was incorporated from the start with promising results.

Perhaps one of the most interesting and valuable sources of social psychiatry growth was that of *service agencies* which developed from research. Social studies were made which had as their natural effect an alteration of the situation. The clarification of a problem through research methods was effective in resolving the problem—was, in fact, therapeutic. We had many examples of this in our mental hospital ward studies. Two further examples were the effectiveness of Lindeman's study in Wellesley in developing an important service program, and in the effectiveness of the New England Age Center.

CONCLUSION

Where is all this leading us? Developments from so many sources appear to be leading us into a position where it is difficult to think of psychiatry except as social psychiatry. With the community organizations that are asking for help, with the Federal recognition of what can be done in education, research and service, with the growth within the academic institutions of a new able group of social scientists, with medical students receiving far more orientation in social relations than heretofore, it looks as if we are progressing rapidly into an era of new methods, new concepts, new alliances, new forms of cooperation, that are increasingly challenging our psychiatric institutions of the past.

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THE U. S. ARMY'S MENTAL HYGIENE CONSULTATION SERVICE

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Introduction

Allerton and Peterson[1] have reported on the purpose of the Army's Mental Hygiene Consultation Service and on its impact on the nature of the pattern of psychiatric disease within the Army. These services have now been in operation during a period of almost 10 years. These have been years of change, evolution and development. The time appears to have arrived for attempts at formulating their manner of operation in terms of theory.

In their first days, these services were little other than struggling psychiatric out-patient clinics which were totally overwhelmed by the problem presented to them while attempting to apply usual psychiatric treatment technics in a situation in which the results were frequently discouraging. The first response to this was an attempt to handle the situation by creating a sort of psychiatric production line. Every patient referred was subjected to prolonged and intensive scrutiny by the various disciplines, through extensive social history taking and group testing, until finally all of this material was brought together in the psychiatrist's report. This resulted in remarkably complete studies and the therapeutic results unexpectedly appeared modest but substantial. The outcome was, however, not entirely all that had been hoped for and the usual conclusion was that, in view of the disparity between referral load and psychotherapeutic talent available, little could be offered. Dire predictions about the future of individuals examined were frequently offered.

After several years, a review of the situation led to several undeniable observations:

1. The work-up did not really contribute a great deal of helpful information. Insofar as the psychotherapeutic result was concerned, frequently a brief interview would have been as valuable as the remarkably thorough study conducted. A great deal of effort was seemingly being expended to little avail.

2. Psychiatric and psychological data did not reliably predict future performance. Although such examinations frequently revealed highly disturbed and distressed individuals, prognostications based on these findings were not a reliable basis for predicting either actual job performance or the future of the symptomatology. Information derived from actual observation of the patient at work and study of the actual nature of, rather than his verbalizations about, his relations with others were a far more valid basis for predicting the outcome of his problem.

3. The referral load was too great and the period of the patient's stay on the post too short to make traditional psychotherapy feasible.

4. The patient frequently went through a period of remarkably chaotic adaptive difficulties and then more or less suddenly seemed to adapt and experience few symptoms or was, in any event, able to function. Whether the initial symptoms were to resolve or to continue could not be reliably predicted from early contacts.

5. Something about the mere contact with the clinic (a contact generally regarded as a "work-up" rather than as "therapy") frequently was regarded by the patient as the crucial factor in his improvement.

6. Persons with more serious psychiatric disease, as one usually measures psychiatric disease, frequently continued to function in the field without coming to psychiatric attention.

These observations, somewhat discouraging as they were, led to a reconsideration of this process. It was finally concluded that this was a rather special situation requiring special attitudes and technics. It seemed that the work-up had values other than those intended and it was questioned whether the psychotherapeutic value could not be less expensively obtained. It also appeared that the reactions encountered were not so serious as they appeared, and that, given both understanding and time, most of the patients would recover from these immediate adaptive responses and become relatively more comfortable.

During the past 5 years, radical changes have occurred, resulting in increasing efficacy, a diminution of "work-up" and a continuous movement away from the classical methods of operation. Our experience now indicates that a rather special means of operation is effective. There is some reason to suspect that these means of operation have tended to reduce the appearance of chronic neurotic patterns because the method seems to make for the mastering of anxiety. Futhermore, the development of the sense of guilt which frequently arises when withdrawal rather

than mastery is used is avoided, as is the production of a chronic phobic phenomenon resulting from failure at this early confrontation of adult responsibilities.

The essentials of this technic are an awareness of the normal psychological and sociological mechanisms at play within the normal community, with an exploitation of these phenomena in the therapeutic interest of the patient.

The Problem

In most settings, the psychiatrist addresses himself to the eradication of psychiatric symptomatology which is personally inconvenient to an individual whose reality situation is determined by a compromise between his own desires, skills or attributes and the forces of an impersonal and uncontrollable society. The psychiatrist is frequently at a loss as to the area to which he must address himself in a military setting. He soon finds that the flood of patients makes impossible the use of the conventionally conservative and prolonged psychotherapeutic technics with which he is familiar and in which he is trained. The nature of the reactions encountered and the character of the individuals seen further complicates his problem since he soon recognizes that these technics would have little efficacy even if he had time to use them. The usual early reaction is either to withdraw to the spotty use of intensive psychotherapy where possible, abandoning the mass of the population and regarding them as treatable only if more psychotherapists were provided; or, he may find himself declaring a frightening number of men incapable of military service. He may be left without a frame of reference in which to operate.

An examination of the referral load soon leads one to recognize that there are problems here which, though not entirely exclusive to this setting, are in considerably greater evidence than in practices among the more or less chronic reactions encountered in other settings:

1. The immediate determinants of the reaction are more clearly evident.

2. The disability described is of a more global nature than one ordinarily encounters. The number of things the patient "cannot do" seems to pervade a wider segment of his function than one is accustomed to find in other practice.

3. The attitude and behavior appear to be better described as adolescent, with petulance, tears and tantrums predominating,

than as infantile. Classical depressive, compulsive and other syndromes are less common. Hysterical and conversion phenomena which have a nearly conscious component and are amenable to rather simple treatment devices are relatively common.

4. Anxiety, anger and other affective responses appear to be related more clearly to the problems involved in mastery of the immediate situation than to infantile and oedipal experiences which in other settings more clearly make mastery a problem because of individualized significance of the experience.

5. There is an almost universal and nearly magical conviction that escape from the reality situation is the answer. The reactions encountered are not so much pathological forms of impaired or imperfect mastery as they are diffuse responses to a continuing failure to attempt to master.

6. There is a frequent willingness on the part of parents and other relatives to look upon the responses as an indication that the patient should not be required to continue. If psychological symptoms are severe, rarely does one encounter the attitude that success is the desired end point. Mastery is given less value than it is in, for example, successful marriage, career, and parenthood. It is not seen as an important aspect of growing up.

7. There is a predominant use of the mechanism of rationalization. Explaining one's discomfort on the basis of intolerance of military profanity, or on rejection of the use of force in human relations, or on the basis of concern for sick parents are frequently most transparent devices. Alleging incapacity for tolerating separation from one's wife, or other universal inconveniences of military service, is likewise evident with recourse to petulant rejoinders such as, "Are you trying to tell me I shouldn't love my wife?"

8. In the absence of such rationalization, there is frequently a willingness to admit to weakness, worthlessness, unpatriotism and being simply no good as an explanation for giving up. Such persons are influenced very little by competitiveness and group spirit.

9. A certain portion of persons with psychoneurotic or tension symptoms of long standing are willing to use these symptoms as a basis for claiming disability. Although many will say that, for example, their old headache problem always flares up when they are in a new and anxiety-provoking situation so that they know it will all work out once they get accustomed to it, others make a great fuss in this very area as if the problem were new. Similar

observations can be made regarding anxiety, depression, insomnia, anorexia and any other psychologically determined symptom.

It rapidly becomes evident that psychotherapy has little impact; the psychotherapeutic interpretation, however clever, is lost; the urge of the patient toward health, if that involves staying in the Military, is minimal. To address one's efforts at the classical psychiatric syndromes is simply not feasible and has little value. If this is done, the mass of the referral load goes untreated and the reactions described are more frequently than not compounded and confused by having been abandoned either to punitive measures or conversely to uninsightful espousal by well-meaning persons whose overconcern tends to make for the continuation of the symptom. The psychiatrist finds himself in the unaccustomed position of dealing with whatever is meant by motivation.

Theoretical Considerations

Classical psychiatric theory has attempted during over 50 years to get away from the idea of free choice. It has attempted always to find a manner of accounting for behavior without recourse to such a rationalistic conception through looking upon behavior deterministically as the resultant of an interplay of lesser and greater forces in which the outcome is mathematically determined. The recent development of cybernetics and such psychoanalytic works as Colby's "Energy and Structure in Psychoanalysis" [2] are examples of this. In spite of such efforts, this ancient problem—which has beleagured philosophers into the familiar corners to which St. Thomas Aquinas and Calvin were forced—has failed to evaporate entirely. There persist the psychiatric notions of attention, of choice of neurosis, character disorder, in spite of our efforts to see human behavior as a complex resultant of complex determinants.

Deliberately created methods of making school "interesting" and "challenging" have continued to fail to interest or to challenge many. Some people will devote themselves to learning things they are *not* interested in while others fail to learn things they *are* interested in. Classical psychiatric syndromes do not successfully differentiate between these two groups.

Without appearing to deny that the future of theory and practice lies in attempting further to understand these matters through use of a "field" type of theory, the experience of working with the syndromes above described draws one toward the use of two conceptions, at least one of which involves the notion of choice. These conceptions have come to be labeled "concurrence"

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and "commitment" in our clinic. Their use seems to help one to place a meaningful interpretation upon the situation encountered and leads one to behave in a therapeutic manner with the patient —theraueutic, that is, if one regards it as therapeutic to behave in such a manner that neurotic indecisiveness leading to unstructured symptomatology is given up in the interest of more successful efforts at mastery, however impaired or distorted.

By concurrence, we mean that aspect of internal psychological operations which looks to the incoming sense data for evidence that one's behavioral negotiations with the environment are leading to goal achievement, instinctual gratification and successful social interraction. We see evidence of its need in the so-called neurotic behavior of the rat which can no longer depend upon consistency of results in the use of conditioned behavior. We see it in groups in which individuals appear to behave with standards other than their own, during riots, carnivals, etc. We see it in the anxiety of working crews whose self-confidence has been undermined by the unpredictable approval-disapproval set of an arbitrary supervisor. Such crews, if they do not quit altogether, will sometimes begin to behave in a manner which seeks approval as an end in itself with their usual standards of what is "right" or "proper" or "correct" being sacrificed to the more immediate need. We see it in the experimental situation when subjects lose confidence in their ability to make judgments, if given false information that their judgments are at marked variance with those of even one other individual.

In this setting one sees the soldier seek concurrence as he looks for the support of his chaplain, his inspector general, his family, his legislators or anyone else who might agree that the proper solution of his discomfort is a specific change such as return to his home. He has usually either abandoned his immediate colleagues, or, in any event, has failed to obtain a comfort-giving concurrence from them. He finds their behavior strange, their attitudes incomprehensible, their ability to handle the situation mysterious.

In spite of frequently impressive efforts on the group's part to bring such an individual within it, the group has failed to do so usually more out of default than for more positive reasons. Most frequently, he has been so urgent in his need to get a specific agreement from all types of agencies outside the immediate group that he has little knowledge about the nature of the people with whom he lives and works daily. When he complains that he cannot do enough push-ups, inquiry ordinarily reveals that he has

no idea how many are done by others. When he complains of being separated from his wife, he rarely knows how many others are also. He will remain in this state of social estrangement, denying the opportunity to get concurrence from those who are about him and are best able to give it, so long as he continues to seek it from more official sources. He avoids or tends to reject experiences in which there is an implication that he can and should master this situation. Whether it be a chaplain, his buddies, or a psychotherapist, he will refuse to participate in the notion that his strengths can be mobilized for remaining in the Service. Since he seeks concurrence only with his weaknesses, psychotherapy, by whatever technic, is identified by him as unfriendly from the beginning. This is the usual explanation for poor results in classical forms of treatment.

Until all agencies of escape have turned him away—i.e., have failed to concur—one can make no prediction as to what the outcome might have been, insofar as his adaptive difficulties are concerned, if he had sought his needed equanimity from the group which is immediately accessible to him. Once he does allow himself to see his sameness with those about him as opposed to his difference, one begins to sense a diminution in anxiety level, an increased capacity to function, a waning of his conception that he cannot succeed and that escape is an answer. He may continue to have his psychoneuroses, but he is at least functioning at something approaching a level of mastery.

In the concept of commitment, we are attempting to describe that emotional and behavioral set by which the individual addresses himself to the mastery of the problem at hand. It involves his maintaining his attention to it at an intensity which results in the mobilization of his physical and psychological resources in the direction of achieving this goal as opposed to or differentiated from others. It is differentiated from the more value judgmental "trying" in that it recognizes that a real try involves establishing a situation in which one's strengths might reasonably succeed. Thus, as much as he may struggle to cooperate, the inductee who has failed to make provision for the expectable needs of his parents or of his wife and children, who has not placed his business in competent hands, who does not find some source of pleasure and relaxation within the military, has failed to establish a situation which is propitious for his efforts to succeed. Having failed to commit himself through a realistic appraisal of the situation, he will be so distracted, worried and preoccupied, or will find life so dull that no one could conceive of success in any undertaking.

In the present highly differentiated Army, it is safe to say that anyone of minimal intelligence who has been able to function satisfactorily in other settings can, if he wishes to look, find a situation of success within the military. Establishing an emotional climate which makes it possible to succeed and taking a specific goal as one's own are then the common factors determining commitment. It resembles the ego mechanism of attention and recall of memories. It is absent in the college student who leaves his books at school, in the worker who does not get enough sleep, in the adolescent who quits school altogether. Persistent failure of commitment in other real life situations such as work, schools, and family responsibilities is a frequent finding in people who fail to commit themselves here. Similarly, overt or covert rejection of military service as a responsibility is seen.

Commitment closely relates to the notion of concurrence since many of the patients are asking in one way or another, "Do I really have to do this?" So long as they fail to commit, whether in combat or in a basic training camp, they will remain isolates of one sort or another, angry, discontented and frequently anxious. When the situation has reached this point, an effort to leave it is the patient's usual automatic response. The manner in which this might be attempted varies from patient to patient but usually reflects the behavioral modes with which the individual has responded to stress previously. It must be remembered that simple departure in this situation is delinquency so that this is not a technic available to all. Relatively small numbers of AWOL result from intolerable anxiety experienced by otherwise nondelinquent individuals. Instead, departure must be attempted by some means involving the achievement of social sanction through, most frequently, medical means, though there are carefully controlled administrative technics available such as proving hardship upon one's family. The therapeutic behavior in this situation involves clarifying with maximum speed whether there are legitimate bases for withdrawal. If there are not, such avenues are then shown the patient to be closed. Only at this point is it possible to measure whether the patient can master the situation.

Failure beyond this point may become more complex, and may require a variety of other therapeutic tools including restriction of physical requirements, restriction of types of training or assignment for the future, and in a small number of cases, supportive psychotherapy. None of this can be used, however, until it is determined whether the individual is capable of success—through watching him when he is really committing himself.

It will be noted that these are conceptions of value not so much in the handling of the traditional psychoneurotic in conversation psychotherapy (though perhaps one does do this when he requires the patient to go on working, keep his appointments on time, etc.), as in the mastering of what one might call physiological anxiety. One notes also, the manner in which some of these problems relate to what Freud labeled the "actual" neurosis. They make it easier to understand the results of failure to adapt rather than the peculiarities of an attempted but imperfect adjustment.

Organization and Operative Technics

The organizational structure which makes it possible to implement such ideas as this depends little on the traditional and familiar psychotherapeutic devices. The information needed, the liaisons required, the experience that is helpful are derived less from association with a hospital than with the community in which such an effort is being made. To place a meaningful value upon the symptoms, however profound, one must have more information than can be obtained simply from interviewing the patient. Fatigue, disgruntlement, anxiety in the second day of military service are of a different value than in the second week or the second month or the second year or the second decade, quite apart from the variables which can be studied by interview of the patient. One must be prepared to accede to the notion that if everyone is anxious at the beginning of an experience and less so after one month, each has had what amounts to a psychotherapeutic result.

Those who persist in anxiety may then be looked upon as therapeutic failures and may require, not a different technic of treatment, but rather an *intensification* of the technics which have so clearly been successful in the mass of the population. One must be aware of what a normal military organization normally does to alleviate anxiety and be prepared to use similar devices. It appears that we are not the most adept at treating it. Similarly, one must be prepared to recognize that military commanders have psychological problems of their own. A given unit commander will handle some situations better than others.

When the patient walks into one's office, it is frequently more important to know what his unit is, who his commander is, and how long he has been in the service than it is to know who he is, where he came from, and what his specific symptoms are. This kind of information can only be obtained by an intense familiarity with the going community.

Although structurally this service is organized into the usual psychiatry, social work and clinical psychology sections, there is a heavy emphasis upon the social work aspect. A social worker is assigned to and works within each major unit. He receives all referrals made by that unit and visits the patient in his company. There he interviews the commanding officer and the noncommissioned officer immediately in charge of the patient. This information he takes with him as he interviews the patient himself. He may actually observe the patient at training and may upon occasion interview fellow soldiers.

Upon these bases, he is then able to arrive at an evaluation of the patient's actual functional difficulties. It probably is of value that the mass of these "field social workers" are enlisted men. Their attitude and counseling are frequently of more immediate impact than would be that of an officer. The therapist serves also the function of being an agent of one of the possible avenues of escape to which the patient looks for concurrence. The manner of the therapist's behavior and the conditions of the consultation are such as to bring into particularly sharp focus the fact that the clinic's concurrence is with the patient's continued function and not with his attempts to remove himself from the situation.

Available to the social worker are opportunities to consult with a psychiatrist and, in cases with medical implication, make arrangements for the patient to be seen by a psychiatrist. Examination by the psychiatrist, depending upon the nature of the problem, may be either at the unit or at the clinic. This also tends to intensify the validity of the original therapist's attitude and counsel. Clinical psychologists serve in a similar consultative capacity in addition to their diagnostic function.

This technic is used throughout, being applied also to the prisoners. The examination in this case is done at the stockade and heavy reliance is placed upon the opinion of the custodial staff who also participate in the therapy through operation of work programs and clemency proceedings. It is frequently possible to achieve therapeutic results by working through guards and other custodial persons who are perceptive, understanding and able. By reassuring the custodial staff that a prisoner will respond, one can frequently encourage them to use their innate therapeutic talents to the patient's benefit or in connection with one's own therapeutic efforts.

This must be accomplished with dispatch and in such a way as to prevent the patient's achieving a partial departure from the situation. Every effort is made to avoid interruption of training.

Hospitalization is avoided if at all possible as is the patient's being taken for any significant period of time from actual, if impaired, participation in military routine. He is seen immediately on the day of referral. Any delay tends to add to the consolidation of the problem. Physical separation of the patient from the scene of his difficulties is accompanied most frequently by his indulging in the hope of not having to return. This usually increases his symptom in a manner which makes return to duty less possible as the distance between him and his fellow soldiers is increased either in time or space.

Physically, the Mental Hygiene Consultation Service is, for these reasons, deliberately separated from the hospital and exists as part of the military organization which is interested in the here and now of function. It is considered a part of "field" medicine. It works in and at the unit level, visiting the patient where possible in his actual work situation. The individual therapist must be prepared to expect, tolerate, and accept relatively severe symptomatology as being a nearly normal phenomenon which will only be worsened if he reacts by becoming frightened of it. His interviewing is restricted to the minimum necessary to understand the nature of the situation and most of his efforts are directed at keeping the patient in the fray where his own innate adaptive talents may come to his aid. He indicates his own confidence more nonverbally by returning the patient rapidly to duty than in any verbal manner.

Follow-up is of extreme importance and must be at the unit or working level rather than at the clinic. Here it is possible to assess the manner of the patient's effort, the degree of his success, the limitations which are insuperable.

At this point, working with the commander, duty restrictions or other changes may be recommended and assignment limitations implemented through work with personnel and assignment units. These are machinations which may, and frequently should be, carried out without the patient's knowledge.

Finally, the therapist must be prepared to recognize the fact of failure when reasonable effort has been expended. He must have a relationship with the administration which makes it possible for him to implement the discharge of the patient. This is seen as a therapeutic environmental manipulation and should be under circumstances and by means which encourage the least possible persistence of chronic symptomatology.

All of this is directed at resolving anxiety through implementing the patient's use of his own skills, the treating of it as a

normal phenomenon rather than as a pathological one, the dealing with it in such a way as to imply that success is possible. Even when failure is imminent, the effort is made to achieve separation in such a way as to impose the least implication that the patient has a chronic psychiatric disease which need impair him in other circumstances.

These ends can be accomplished through little actual, direct work with the patient himself, but do require extensive and working liaison with a variety of other agencies. Far more important than the verbal interchange with the patient is the non-verbal implication in his being seen early, listened to empathically and restored to a duty status with dispatch. Any implication that the problem stems from remote or imponderable situations, is due to "disease" or is based upon considerations which are not immediate and amenable to mastery, will frequently lead to the undermining of such defenses as may be still intact.

Summary

Ten years of experience in dealing with the psychiatric problems presented by soldiers in basic training has seen a variety of technics applied with varying success. A discussion is presented of the nature of the problems encountered and an effort is made to differentiate between these and the classical syndromes encountered in other settings. Motivation appears to be a factor of primary importance and the two conceptions of "concurrence" and "commitment" are proposed as being an aid in dealing with problems in this area. A mode of operation is described which makes a psychotherapeutic use of the normal sociological and group phenomena characterizing a military organization. A technic for maintaining the necessary close familiarity and cooperative relationship with the functioning community is described.

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SUMMARY AND DISCUSSION OF PAPERS ON SOCIAL PSYCHIATRY IN THE COMMUNITY

Dr. Closson, Baltimore: I was interested in Dr. Meijering's comment on the responsibility and the usefulness of psychotic patients. In industry we have found that to be so. When it is explained to patients with psychosis that their bizarre behavior is disturbing those around them and that if they want to continue to work, they must change, many of them are able to respond and become very satisfactory workers. Also, the supervisors in industry promote the mental health of their workers, not only the psychotic ones but normal ones, by insisting that they perform adequately on the job. Any time a supervisor shows any preference or allows any worker to perform inadequately, he's doing both the group and the individual a great disfavor.

Dr. Meijering: I quite agree with Dr. Closson in this respect and I think that it is part of the task of the mental hospital to try to establish this attitude inside the hospital as well.

Dr. Sells, School of Aviation Medicine, Randolph AFB, Texas: I would like to comment on a point made by Dr. Bushard with which I am in agreement and would like to indicate some evidence pointing out some of its implications. I refer to his comment that the preliminary work-up for a diagnosis of the patient was frequently of very limited value. It seems to me that one reason for this is that our diagnostic procedures, both psychological and psychiatric, frequently are at a fairly abstract level in that we deal with constructs and concepts which are abstract but which occur in the individual patient in a very personal and more concrete form.

We made one study, for example, in which the problem was whether or not we could match students in flying training with instructors so that they would be more compatible and so that the relationship between student and instructor would be improved. We fortunately decided not to proceed with psychological tests and try to match on the basis of traits but rather to make some preliminary studies and get some indication as to relevant variables. When we interviewed instructors we found responses like this: "What kind of student would you like to

have?" The instructor might say, "I don't want anybody over 5 feet 4 inches." Now you could express this in an abstract form but it's very personal in the case of the instructor.

To be brief, I'd like to mention one other study in which we made a long-term longitudinal follow-up by taking records of pupils in the Child Guidance Clinics of Minneapolis and St. Paul in the thirties and then following up their records through Selective Service and their military experience. We found that there was a very significant difference between those who were in problem groups and those in the control groups, in regard to the percent rejected at the Selective Service level, as well as in regard to the number discharged for psychiatric and bad conduct reasons in the military service. But the differences were not great enough to be useful for selection. When we went back and read the original files we found that the social workers' contribution to the original case file provided a better basis for prediction than the psychological testing or the psychiatric report. Going into these in detail, we now have one result which has come out with a high degree of accuracy. This is that those children who had very hostile relationships with their peers at an early age were significantly—at a practical useful, discriminating level—more prone to neurotic difficulties in the service.

Now, my conclusion is that our diagnostic workup is inadequate because we are not proceeding on the basis of knowledge which is clearly tied to criteria. Also, we need a great deal of research to make effective diagnoses. I think that it's possible, but I think we need to know more before we can do it.

Colonel Bushard: I have a couple of comments on this. In the Mental Hygiene Units we take our cue about the initial work-up essentially from Redlich and Gills' "The Initial Interview in Psychiatric Practice" and feel that the *immediate* problem needs to be the matter with which one leads. We particularly avoid the rather widespread notions that social workers take histories, psychiatrists are God, and psychologists know about tests. Whoever sees the patient deals with him.

I have one anecdote that I would like to tell about this. I had assigned with me a psychiatrist who knew nothing about the Army but was excellently trained and a fine psychotherapist, coming from a school where a very intense understanding of the patient's total life situation was regarded as the first thing to be dealt with. Fortunately, for my results and for our patients, he was also very compulsive and extremely slow. I discovered one day that he was 2½ months behind in his paper work. Finally, he came and told me that he had twice had the experience of

having soldiers come in to thank him for having helped them. The soldier had finished basic training and was on his way somewhere else, and yet lying at the bottom of a large pile of papers were the notes that had not yet been dictated, upon the basis of which that patient was going to be recommended for discharge from the service.

Dr. Duhl, National Institute of Mental Health: I wonder whether we could expand a little on the definition of social psychiatry in the community by taking into consideration some of the public health practices which are very important in the whole area of prevention. I know Dr. Hargreaves has done a lot with this when he worked with the World Health Organization. We know something about prevention in mental health in ways in which psychiatrists have not worked in the past—specific things like syphilis control, problems of general nutrition, problems of control of infection, the whole problem of dealing with pregnancy complications, RH factors, and the like. I wonder whether Dr. Hargreaves would care to comment on some of the other public health things that we can do, things in which we can manipulate our general environment in such a way that we can improve the general mental health of our population without having to deal with specific one-to-one relationships or to deal with specific clinical relationships in psychiatry?

Dr. Hargreaves: Yes, I am reminded of what Dr. Hyde said. If you're going to talk about social psychiatry you can start anywhere you like. I mean you can either start with the government or you can start with the psychiatric hospital, and I suppose I really started with the position of the psychiatrist. I really said very little about the public health service. I think this is indicative of something that's happened in Britain. The development of medical care under the Health Act has attracted all the limelight, both in professional and public circles, and I think, therefore, our public health work is rather in the doldrums and probably a little bit demoralized. That's probably why I didn't talk about it.

The other point is this. The World Health Organization report you refer to concerns the mental hygiene aspects of public health practice. We did not, I think, express a very optimistic view of the amount we knew about prevention. In fact, we've got comparatively sparse solid knowledge about prevention apart from rather specific things like syphilis and so on. For those of you who haven't read that report, when we finally tried to define what we meant by the mental hygiene aspects of public health

practice we had to express it in a very colloquial way of handling human problems in a human way. Therefore, I would think our first objective in public health work is in that direction. In many countries public health is exceedingly bureaucratic, using the definition of that word which Dr. Solomon used. Our first aim must be to get an orientation into public health whereby things about people are handled as if they were things about people rather than veterinary medicine.

Now there has been a very considerable interest in Britain particularly in those aspects of public health work which are concerned with maternal and child health, and just as I suggested that the orientation of different Regional Hospital Boards is different and their policy ideas are different, this is also true of the public health authorities. In this field I would say that the lead is taken by the health authority of the London County Council which covers Greater London. It arose out of a relationship between the London County Council and the Tavistock Clinic, and there has been quite an extensive program there of joint work by the people working at the Tavistock Clinic and the public health physicians and the public health nurses in the maternal and child health aspects of the London County Council's work.

I come from an area which is actually in the Dark Ages in this respect. In our region this hasn't happened to anything like the same extent, but to go back to what I was saying before, I think this arises from what you might call social structure. It so happens that there is in London a very large area of overlap, you see, between the Regional Hospital Board and the Municipal Health Authority. In our area, the municipal health authorities and the public health authorities form a patchwork quilt and to get this going in any integrated way throughout our region we need almost as much negotiation as signing a treaty between 45 countries. Nevertheless, in certain areas and in certain towns it's beginning to move, and our initial action has been in the same area of maternal and child health work and antenatal work.

In this respect, I would say that we sometimes find more interest and cooperation on the part of public health nurses than we do on the part of public health physicians. This raises a sort of psychological or sociopsychiatric danger in that we must, I think, take care that we don't move along faster, so to speak, with the nurses than with the physicians who are actually creating policy. So we've got to find a way of working all together. This, I think, seems to happen much more easily in this country than it does in Britain because we have, for instance, no over-all professional

organization of public health which includes all public health workers. It's very difficult to get a forum for discussion where these things can be worked through by the mental health workers and all the public health workers as a single group.

There is another difficulty that I think exists more in our country than here and that is a tendency for specialization within public health practice. For instance, in the town where I work the public health nurses who do the school health service are quite different from the people who do the antenatal service and different again from the people who do the postnatal work and the maternal-child health work. That isn't true everywhere. There are some health authorities where they have generalized public health nursing and where the public health nurse has a parish, so to speak. In that parish she does the work with the school children, maternal-child health work, and so on. That's a much more favorable situation. So even in this respect I think we do come back to macrosocial problems. I've been very impressed by the extent to which the National Health Act has revealed the immense influence of these macrosocial problems of which I think we were never aware as individual practitioners. This is why I think social psychiatry was born in the Army—and because those macrosocial factors were so much more evident. They only become evident if we realize the size of some of our difficulties in developing the side you mentioned, namely, the public health side. I think it is the development of National Health Service which, curiously enough, is what created the opportunity to tackle them and also showed other difficulties.

Question: I've a question for Colonel Bushard. I agree with most of the things that he has said. However, I realize his paper was geared to the patient or the trainee in mental hygiene or training situation. I wonder if he would comment on what is being done to orient the command to this idea of not having to have every patient that comes to a Mental Hygiene Consultation Service seen by a psychiatrist, and how are they accepting this idea?

Colonel Bushard: It's a very interesting problem which I have to admit I haven't had to deal with. We just do it and somehow or other we've managed to get along without much trouble. We've had two quite celebrated incidents arise in situations in which the patients had been dealt with by a non-physician but thus far we have had no difficulty from command on this score. I think that probably the only thing that makes real sense to the man who has carpets to sweep is an effective carpet sweeper and the

only kind of program that is going to convince a company commander is one that works. This is, I think, perhaps to some degree the charm of our program in that it has been efficacious and has helped the commander a great deal. It's terribly important as a simple matter of the dramatics of everyday life that ever so often you cure a patient dramatically. When some soldier is sent down to you kicking and screaming—virtually kicking out the windows—and he comes back tomorrow and tells the first sergeant, "I'm going to really settle down and soldier now," you may not have any idea how this came about from what you did with the patient, but it certainly gets you in solid with the company.

Dr. Hamburg, Michael Reese Hospital, Chicago: I'd like to ask Colonel Bushard a question. He mentioned, and in fact, by implication, put some emphasis on the more or less therapeutic process that takes place for a great many men through the basic training period. He also mentioned some of the therapeutic potential in people not ordinarily regarded as therapeutic personnel like the custodial people in the stockade—an unlikely place for a therapist if I ever heard of one. Now, I wonder if he could tell us if there are any systematic studies of this kind of process? Secondly, if not, what kind of impressions he has as to some of the important factors that may actually facilitate the growth of individuals through the basic training process?

Colonel Bushard: Systematic studies are somewhat difficult because we have had difficulty in finding a device that could measure reasonably well the clinically observable anxiety. We have tried, for example, the Taylor Anxiety Scale given on a mass level, which seems to indicate that the anxiety goes up instead of down. This simply doesn't fit the picture. So I'm afraid I don't have systematic studies and in spite of a couple of years now of trying to do some have not been able to develop any. When I speak of a nonpsychiatrically oriented individual's doing psychotherapeutic work, I'm talking about the individual who is sufficiently aware of the problems involved in a given situation and who has enough simple empathy that his very attitude and behavior can be meaningful to the patient.

This ties in perhaps a little bit with the question that Dr. Hargreaves answered a few minutes ago in regard to the problem of suicide. At Fort Dix our policy is to treat the surgical condition which has been created as a result of the suicidal gesture and return the patient, as quickly as his surgical condition allows it, to duty. We have been doing this for a number of years and

I've been following it carefully for over 1½ years. We have had no successful suicides at Fort Dix during this period, whereas we average from four to six suicidal gestures a month. We have gotten people convinced that this is a way to behave in the situation to the degree that they will go along with my suggestion that when the patient comes back they should do nothing. Don't chew him out, don't put a guard on him, don't lock him up in his room, and don't court-martial him. Simply send him back to duty.

Kai Erikson has an anecdote which reflects what I'm talking about, in which a man was cut down from hanging in the latrine and was taken to the company commander. The company commander looked at his watch and said, "My God, man, it's 5 minutes before you're due on guard duty. Get your weapon." Needless to say, this sort of thing takes courage and it takes the cooperation of the administration. Sometimes one can be wrong, but it does prevent the build-up of a system of communication in which this kind of behavior begins to have social value. Perhaps that's the best way I can answer your question.

Dr. Tallman, Medical School, UCLA: I'd like to ask Colonel Bushard whether or not there have been follow-up studies some months or years after this social treatment to see whether or not these men have continued to adjust or whether they have a higher breakdown rate than those that haven't shown this behavior in the induction center?

Colonel Bushard: The somewhat remarkable cost of doing such a thing has made it impossible. I can contribute this, however. Approximately 6.5 percent of all inducted soldiers arriving at Fort Dix arrive with comments on their induction physical examination, indicating that the induction physician and frequently a psychiatrist had felt that this man had psychiatric symptomatology such as to make for probable difficulty in the military service, ranging all the way from headaches to more serious or pervasive symptomatology. We examine these people as a routine in the third week and have followed them throughout their stay at Fort Dix whether that be 8 or 16 weeks.

We find on a basis of the actual job performance after the third week, and on a basis of the comments of the company commander and the first sergeant that, taking the 6.5 group as 100 percent, only approximately 0.5 percent of the group actually have manifested impaired function of a sort which requires assignment limitation. Following them up as far as referral rate to us is concerned for any reason, the rate runs considerably lower. I can't give you the figure as far as rate is concerned. Their dis-

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charge rate on any grounds is also lower than that of the normal population.

Colonel Glass: This question of follow-up is a difficult one because you have to specifically identify these people and follow them through their military service. Now we've only been able to do this with a certain series which was connected with a prediction study. In the course of that we followed 500 people through their military service and particularly noted those who were returned to duty by the mental hygiene unit. There were only a half a dozen actually in this group and all of them did well in their assignments and half of them did well in combat. We are doing a follow-up study of the military careers of 2,000 inductees and it's been our general impression that these people do as well as the others after their, shall I say, bouts with the Mental Hygiene Unit.

Dr. Nussbaum, Baltimore, Md: I would like to ask both Dr. Meijering and Colonel Bushard if they used group therapy technics in their work with their patients. I also would like to ask Dr. Meijering whether his patients are kept in uniform while in the hospital and what the attitude of their Commanding Officers and fellow soldiers was when they returned to duty.

Dr. Meijering: In the hospitals we are using quite a lot of group psychotherapy technics, varying from regular group sessions to psychodrama and sociodrama sessions and sessions of a kind of community organization, committee meetings, and so on. In the mental hygiene centers I don't think they use group sessions. They see the patients on an individual basis more or less in the way of Colonel Bushard's description. I don't know whether you use group sessions there but we do not. The Hospital for Neurotics in Holland appears as much as a normal military unit as possible. There are a few standards which have been lowered, but generally we try to keep them in the same atmosphere as in the military unit. We have had some difficulties with returning patients when they return to the unit in that commanding officers and their fellow soldiers held this hospital experience against them, but generally this is an attitude which is evoked by the patient himself. If he does well, this bout in the neurosis hospital is soon forgotten, and if he does badly the commanding officers will always bear it against him until he dies.

Colonel Bushard: We don't do group therapy in its usual sense. This has been attempted by at least one individual—Clay Barrett did it at both Camp Pickett and at Fort Sam Houston. This had problems of an administrative sort. We do, of course, do group

therapy in hospitals. We are trying at Fort Dix an alternative to group therapy which I suspect may prove to have some value. On the suggestion of Col. Gentry Harris, we are having an interview between a soldier who is having difficulty and the squad of which he's a member, attempting simply to promote some communication between them. There is sometimes a great impairment of communication. This is having some rather interesting results and I think the method may very well turn out to be a technic of value to us. It seems to take advantage of more of the usual, normal characteristics of military organization than group therapy in its classical forms would.

Dr. Hargreaves: I'd like to make an additional comment. I've been very impressed by the fact that a lot of different people who have spoken here have been using very similar theoretical models, and it seems to me that there's a common theoretical model arising out of the experience of social psychiatry which is very different from the classical psychoanalytic model. It seems to me that in the classical psychoanalytic model the patient is the puppet, manipulated by strings pulled by unconscious, internal objects of infantile origin and so forth. Now, this kind of model that apparently is being talked about here seems to me very different and it might be described as constructed out of a kind of interraction of field theoretical concepts on the one hand and sort of functional concepts on the other.

Colonel Bushard's notion of concurrence and commitment seemed to me very parallel to Dr. Tyhurst's model of crisis and resolution, which in turn seems to me very similar to the Wellesley model to which Dr. Hyde referred of predicament and crisis of Lindemann and Kaplan. The work that Dr. Tyhurst mentioned of repatriation of prisoners-of-war includes his model of disaffection and reconnection. I couldn't help reminding myself of Erik Erickson's very similar model of ego identity and crisis and the psychic search for moratorium and its resolution. I feel we are present, so to speak, at the birth pangs of a new kind of theoretical model which it seems to me arises out of social psychiatric practice as opposed to one-to-one, let's say two-group psychiatric practice. But that's the only reflection I wanted to make.

Dr. Hyde: I'd like to apply Colonel Bushard's idea of concurrence and commitment to the hospital in regard to what I said in the area of alternatives to hospitalization. The main thing that we are probably doing is refusing to concur with the patient's relatives and the patient in the notion that he should be hospitalized, that he should be removed from the combat situations of

life, and we are attempting to find ways to get him to commit himself to the ongoing living experience.

Colonel Bushard: I think I would certainly tend to agree with this idea. If one attempts to make any evaluation of a psychiatric symptom in terms of its communictaion value, in terms of its making a bid for some social achievement, then it would appear to me that the manner of our behavior in the immediate handling of that symptom is of crucial significance in its future history.

Dr. Meijering: I would like to amplify a little bit on Dr. Hargreaves' statement a few minutes ago that when we are present at the birth of a new concept of the psychiatric patient we are at the same time present at the birth of a new concept of the psychiatrist in that the social psychiatrist as such cannot be the detached, self-employed, professional person. Maybe other doctors can be. I wouldn't like to judge that. But the social psychiatrist has to be a part of the field of the patient and this field is a social field. As such, a social psychiatrist ought to be part of the organization in one way or another, whereas self-employed professionals are more or less standing outside that field, I think.

Colonel Glass: I must say from a personal standpoint all this discussion makes me feel very good. We utilize this thing that we call a peripheral or decentralized approach to work with the individual at the time things are happening in combat and in the work of mental hygiene units. We've been frequently accused by our colleagues of being rather harsh and concrete and various other terms—"superficial" is a very common term that is thrown at us. I fell very good about this because if this is the dawn of a new era in psychiatry and the dawn of a new model, it seems to us a very appropriate one.

We are faced with line officers who say to us that they are interested in having effective people and they are not interested in how we do it. As a matter of fact, for example, Dr. Hargreaves' report showing the increase of psychiatric participation in England, increase of psychiatrists, increase of hospital beds, reminds me that often, if I give line officers something like that, they immediately assail me with, "Here we go again; the more psychiatrists we get, the more patients we get, and we want you to keep down the amount of noneffectiveness." Of course, we try to do that, but as far as I know, what we do now, to a great measure, is prevent hospitalization—which is sometimes regarded as a mean thing to do. I think it's a very important thing. By preventing hospitalization I think that we also prevent many of the dangers which Dr. Goffman spoke about in the mortification of the individual.

WEDNESDAY AFTERNOON SESSION

17 April 1957

PANEL ON THE DEVELOPMENT OF A THERAPEUTIC MILIEU IN THE MENTAL HOSPITAL

MODERATOR

Robert A. Cohen, M.D.

TECHNICS OF SOCIOTHERAPY

PAUL SIVADON, M.D.

A psychiatric hospital, in order to fulfill its role as a therapeutic milieu, ought to be able to do three things:

First, to offer to the new patient, whatever the nature of his illness, living conditions suited to his present level of functioning.

Second, to obtain for him those circumstances which will permit him to establish satisfactory relationships with his physical and social environments, and to perfect progressively his ways of relating to them.

Third, to furnish at all times, to the largest possible number of patients, opportunity for, and means of, developing towards social behavior more and more approximating the normal.

All this requires certain conditions which may vary within limits from one hospital to another but which rest upon principles which are undoubtedly quite general. I should like to try now to elucidate these principles, basing my statements upon the experience of my own service at the hospital of Ville-Evrard in Paris.

THE PROBLEM OF STRUCTURE AND DIMENSIONS

If the patient is to benefit from the therapeutic milieu, it is necessary that he should participate in it and, therefore, that this milieu should be structured in such a way that it becomes a "social field." A social field exists if every modification in the behavior of an individual reverberates upon the whole and if every influence exercised upon this whole is felt by each individual.

In order to realize this goal the population must be large enough to permit certain diversification of groups and activities and yet small enough to be perceived as a whole by each patient. A population of the order of 250 to 300 patients seems to fulfill these conditions if it is not reconstituted more than once a year (which means 300 admissions per annum). If the mobility of the population is greater than this, the number should be smaller.

On the other hand, five or six hundred patients are not too many if the number of admissions per year is only one hundred. These numbers are meant, of course, only as a general indication.

It appears to be important that this total population should be divided into groups of about 30 patients and that these groups themselves, in the course of various activities, be divided into subgroups of from 3 to 12 patients. A pavilion system which allows for living units of 30 patients each, subdivided into smaller units of five to six cubicles and including small assembly rooms and workrooms as well as a large common hall, fulfills these needs perfectly.

The architectural whole ought to be sufficiently dispersed to give each pavilion its individuality, but also sufficiently concentrated to preserve the unity of the "field." A circular arrangement or, still better, an oval built around the center of interest (workshops, restaurant, party rooms, etc.) seems to be a desirable one. Any impairment of the higher nervous functions expresses itself in a difficulty in the integration of space (both physical and social space), and thus the reduction of distance as well as of social groups is one of the primary conditions for the patient's entrance into the "field."

It is desirable also that the population constituting the "therapeutic milieu" should be well balanced by the right proportions of patients of various categories and ages, and of staff of both sexes. It is in fact important that the patients should be able to find in the midst of the community small unisexual groups and larger bisexual groups (in the restaurant, at recreation, and sometimes at work.)

Certain particular arrangements do not contradict this general rule: One can provide for a club of adolescents or of elderly patients, but it is detrimental to specialize a whole service in this way and, above all, a whole hospital. The same thing holds for epileptics, who are quite well tolerated by other patients if they do not constitute more than 2 or 3 percent of the population, but who become totally unsociable if their proportion is higher.

A good therapeutic community should offer to the patient an opportunity to enter into whatever kind of group suits his condition, whether the group be large or small, homogeneous or heterogeneous. The community should also offer him an opportunity to devote himself to the kind of activity which will promote his need for expression or creation, whether this be in useful work or in play.

TECHNICS OF ADMISSION AND WELCOME

One of the critical moments in the community treatment is the admission of the new patient. Because of his emotional regression he needs to be accepted, or still better, to be desired by the new society of which henceforth he will be a part.

In my service I have had for the past 10 years a psychologist who functions as a hostess to welcome each new patient. She is the first person with whom the patient comes in contact. Instead of taking away his personal effects she gives him whatever he needs: toilet articles, cigarettes, writing paper, etc. She introduces him to his fellow patients, to his attendants, nurses and doctors. She tries immediately to make him feel that he was expected and that he is needed, and that his help is needed, perhaps with a party that is being prepared, with a game, or with some little service which no one else can render (as repairing a bell or a broken chair).

Then she shows him around the grounds and buildings, the workshops, the reception rooms, the bar and the hairdressing parlor. Very quickly, often by joining in a game, the patient makes the acquaintance of two or three comrades with whom he will soon work in the shops. The welcome is rounded out by introducing the patient at the weekly meeting of the committee of patients, of which I shall speak later.

Finally, each week there is a friendly gathering at which the medical director and the hostess meet with the patients who have been admitted in the past 7 days. We find out whether they are provided with everything they need, and we solicit their criticisms and their ideas. Then each one is given a brochure with his own name printed on it in which he finds, following some words of welcome, the principal kinds of information which are likely to relieve his anxieties. In particular, he finds there the name of his personal physician and of his social worker. He is also given some visiting cards with which he can introduce himself to his comrades and which he can place at the head of his bed or at the entrance of his cubicle.

These technics of welcome, as well as others which will occur to you, turn out to be of considerable importance in promoting the rapid participation of the new arrival in the community. In effect, the more one wishes the patient to allow himself to slip quietly into the communal life in a relaxed way, the more important it is to individualize him as much as possible and to make him feel himself to be a person. It is for this reason, namely, to counterbalance the communitarian atmosphere into which he is

plunged, that the patient is at first seen privately by his personal physician, who gives him an appointment by a written personal invitation.

THE TECHNICS OF RESOCIALIZATION

For patients at very low levels of regression (catatonic schizophrenics in particular) we use methods of progressive re-education which permit development toward modes of social contact compatible with their integration in the communal life. This is often a long-term procedure lasting 2 or 3 years, but sometimes it occurs within weeks or months. The methods used are essentially psychomotor and expressive technics. In psychomotor re-education, ball play chiefly is used. At the onset the instructor and the patient squat on the floor very close together in a confined space and toss a ball back and forth to each other. Next the distance is increased. Then a second patient and a third are introduced. Finally, the play is complicated by modifying the position and the number of patients, by introducing a second ball, and by interposing first an obstacle, later a screen, between the patient and the instructor, and so on.

Through this technic we succeed in mobilizing more and more complex functional structures by enlarging the space within which the patient can function adequately and by shifting from direct perception of an object to its representation. In short, we pass from simple, near at hand, immediate relations of the "physical" type to complex, distant, mediate relations of the "mental" type.

At the same time the patients are offered expressive activity with the help of modeling clay or paints. At first they simply knead or mold the clay directly with their hands, making small, rather uniform objects. Then the objects become increasingly large and forms begin to appear. Thus we collect series of objects in which a whole symbolism can be found, recalling that of prehistoric civilizations or mythological allegories, and which develop finally into objects with a social character, such as vases and various receptacles. In these the archaic style is often quite striking. Only later can the patients make designs which necessitate the use of an instrument such as a pencil, paintbrush, or paper. At first we observe undifferentiated forms, which become progressively more differentiated and more complicated and lead finally to abstract designs. Here too, we find at first symbolic, archaic styles and themes before we get designs of normal appearance.

From this moment on the patients are ready to participate in the life of the group, and their development is accelerated. This development, however, is not necessarily steadily progressive. It is often interrupted by stand-stills or even by transitory phases of regression.

As a general rule, it seems to us that all developmental progress is preceded by an oppositional phase, sometimes accompanied by aggressiveness.

TECHNICS OF ACTIVE SOCIOTHERAPY

It is precisely this notion of opposition and of aggressiveness which is the basis of the method which we employ. It is as if the developing energy of the patient, to the extent that it does not meet with an environment favorable to its utilization, is either repressed or externalized in the form of aggressiveness—whence the two types of morbid behavior which we must try to avoid; namely, passivity and inertia on the one hand and violence and flight on the other. Our aim is to promote the freeing and opening up of latent energy, to avoid its repression, and to permit its investment in adaptive behavior.

Further, it seems that by promoting the opposition of a group of patients to their environment we facilitate the mobilization of the energy of each and we promote the cohension of the group, thus facilitating the resumption of interpersonal relationships.

It is well known that in a group of normal but heterogeneous people who are seeking to establish good neighborly relations in an alien environment, the group's first step toward coherence consists in its opposition to its environment. People in a compartment of a railroad car become irritated together against the poor organization of the trains, against the responsible personages in authority, against the government, etc.—whatever may happen in the United States, this is what happens in France.

Our service is composed of six pavilions of about 45 patients each. The population of each pavilion meets once each week and is then invited either by certain natural protesters among the patients or upon the more or less insidious suggestions of the staff, to take cognizance of the imperfections of the service. Motives are seldom lacking—such and such an apparatus is not functioning; the meals are served too slowly; there is not enough diversion in the evening, etc. Soon almost the entire group participates in the common protest, and many patients who have up to this point been isolated in their indifference emerge from

their mutism. Now human relations have been established. It is only a question of improving upon all the inconveniences of which one is a victim. The premises, the staff, the doctors, the administration, and society in general bear the brunt of the criticism.

Immediately the group tends to organize itself. A delegate is elected who is charged with the transmission of the protests to the authorities. Thus six pavilions furnish six delegates who constitute the "Committee of Patients." This committee meets once a week with the doctor and the hostess. In the course of long discussions, which turn into real group therapy, the demands are studied and the whole art of the sociotherapists consists of channelizing the aggressive tendencies thus manifested toward useful activities. The first result obtained is that the doctors, attendants and nurses, by not seeking to suppress the opposition but by adopting an understanding attitude, find themselves included in the group, and the group is extended henceforth to include the whole of the service. An "esprit de corps," the basis for a community atmosphere, is already created; it still remains, however, founded upon common opposition to the environment.

This is a delicate task but one which, by experience, is practically always crowned with success. It promotes the maturation of the protesting attitude into an objective one which is expressed in the need for concrete actualization. For example, there is general agreement about the boredom of the long evenings. The initial attitude is one of protest against the negligence of the administration. But, finally, a decision emerges to organize discussions, lectures, movies and other diversions.

By this mechanism, the activities which are organized, whether in work or play, the expeditions, or the rules of discipline, correspond to the needs of the patients since they result from their own opposition to their situation. From this it follows that their aggressiveness is invested in the activity which they themselves have decided to undertake, and it is no longer manifested in the form of violence or the need to escape.

The more passive patients are led to participate in these common activities which are not imposed upon them by authority but which are linked to the resumption of their social relations. Very frequently the patients experience, first of all, the need for modifying their physical environment. After having torn out the iron fences which formerly surrounded the grounds and planted flower borders, they are happy to repaint and decorate their day rooms. They build new workshops and a minia-

ture golf course, and they organize parties and camping trips. All this is done in friendly collaboration with the staff and with the approval of the doctors. Of course, the ever renascent opposition expresses itself in the need to destroy what has previously been made so that something better may be constructed. It is to the extent that this real metabolism of energy is perpetuated (in opposition, aggressiveness, activity and creation) that the hospital community remains alive and maintains its active therapeutic character.

Now it does indeed occur, because of the lack of emotional differentiation in the majority of patients, that the situation of being hospitalized is often confused with the state of being sick. To the extent that the patient does not oppose the situation of being hospitalized, he has a tendency to be satisfied with his state of being sick, and his chances of recovery are thus compromised. On the other hand, if he opposes his situation and if this opposition is not utilized therapeutically, it will be expressed by his refusal of treatment or even by escape or violence.

It does not seem to us to be possible to escape from this dilemma except by accepting the opposition—or even by promoting it—and using it as a therapeutic element. It becomes thus not only the foundation of the homogeneity of the group but also the motive power of sociotherapy and the regulator of the collective energy.

Thirty years ago Professor Dumas wrote that mental patients are not capable of social organization. It appears, however, that all they need in order to become capable of it is that the possibility should be offered to them.

The criteria of success in this matter are simple: Success is evident when it is no longer necessary to lock doors and the number of elopments decreases nevertheless; when violent reactions become the exception; when inertia gives way to adaptive activities; and, above all, when the average length of stay in the hospital decreases; when the patients no longer have a tendency to "install themselves" in their sickness and in the hospital. Finally, faced with a situation which is difficult for them, they learn to adopt an objective and pragmatic attitude, to give up their inhibited reactions and to control their aggressive tendencies.

GENERAL CONSIDERATIONS

In these examples I have attempted to show that the therapeutic community, which a psychiatric hospital should be, derives its

value from the fact that it is a balanced, living whole. Each patient must find in it an opportunity for adapting himself to a mode of life suited to his capacities, and he must be challenged constantly by other modes of life which will lead him to develop toward perfecting his adaptive capacities. This development is expressed particularly by a progressive integration of space and time, by an increasing capacity for personalization in the midst of larger and more heterogeneous groups, and by a change from infantile, dependent attitudes to adult, autonomous attitudes.

Thus, the therapeutic milieu ought to offer the patient multiple possibilities. It seems difficult for the physician to foresee and to organize these. Even if it were possible, such an organization would always be experienced by the patient as coercion, to which he can respond only by passivity or aggression. It seems, then, more sure and more efficacious to allow the community to organize itself according to its needs.

In order that this may occur it is sufficient to keep in one's hands the motive power of the whole; that is to say, to maintain under therapeutic control the social organization of the group. Hospital sociotherapy ought to consist not in organizing activities, but in promoting their spontaneous appearance by mobilizing the energy of the group, channelizing it, and balancing it so that the entire group may be imbued with it. No infallible method exits to achieve this, but there are certain conditions (especially of space and of density) which cannot be neglected with impunity.

GRAPHIC WAYS OF REPRESENTING SOME ASPECTS OF A THERAPEUTIC COMMUNITY *

COMDR. HARRY A. WILMER, MC, USNR

This paper will describe some graphic technics which, it is proposed, suggest a basic method for studying the significance of the seating positions taken by patients in the group meetings of a therapeutic community. They are technics that were developed specifically in relation to a therapeutic community operated experimentally on the admission ward of the psychiatric service at the United States Naval Hospital, Oakland, Calif. But, it is believed, they can be usefully applied to similar projects elsewhere. Their purpose is to provide an objective means of analyzing the nonverbal communications implicit in the patient's choice of seating position and in his movement from one position to another in the course of a meeting or series of meetings.

Oakland Experiment—Background Facts

Accounts of various projects in which the therapeutic community concept has been employed in social psychiatry appear in the literature (key papers are listed),[1] and among these accounts the Oakland experiment has already been described in some detail.[2] But, for purposes of background, I shall here briefly review a few salient facts about its organization and operation.

For a 10-month period (July 1955 to April 1956) the 34-bed locked admission ward of the psychiatric treatment center at the Oakland hospital was operated as a therapeutic community under my direction. During this period, 939 patients were admitted to the ward from the area which the Oakland hospital serves—the West Coast Naval and Marine installations, the Pacific fleet and islands of the Pacific, and the Far East. All these patients were male, and most of them were young: Of the total number, 3.5 percent were officers, and the remainder were enlisted men (rated and nonrated) or rated chief petty

* The opinions or assertions contained herein are the private ones of the author and are not to be construed as official views of the Navy Department or the Naval service at large.

officers. The diagnostic breakdown of the group was as follows: psychotic—44.4 percent; psychoneurotic—26.6 percent; suffering from character and personality disorders—28.3 percent; suffering from acute situational maladjustment—0.7 percent.

Each of these 939 patients remained on the locked admission ward for an arbitrarily assigned period of 10 days before being transferred to other psychiatric wards for intensive therapy. For 10 days, therefore, each was a member of the therapeutic community.

With certain necessary modifications of the program to a military culture, the philosophy and technics employed in the Oakland experiment were largely those which I had learned from observing the work of Jones, Main, and Rees while on temporary Naval duty in England. The essence of the therapeutic community theory is the premise that the patients and the staff are fellow members of a community group and that this membership should be made part of the conscious and unconscious habit of all. This implies a commonly shared concern for the welfare of the group and a mutual responsibility for courteous and helpful behavior in the relations between staff member and patient and between patient and patient. In other words, the emphasis of the therapeutic community is upon a process of socialization, based upon conditions and attitudes which foster self-control, rather than upon a system of imposed controls.

In line with this philosophical view, sedatives were rarely administered during the 10-month experiment at Oakland (fig. 1),

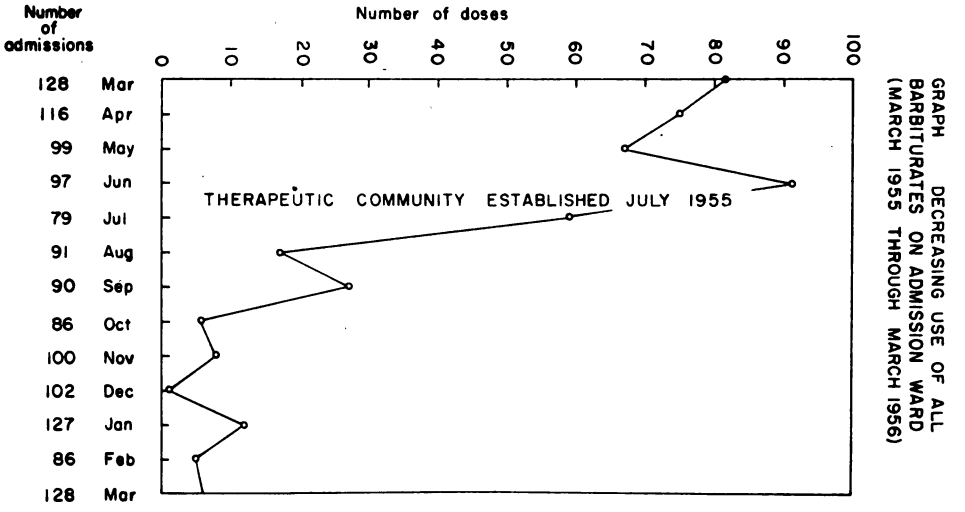

Figure 1. Decreasing use of barbiturates.

restraints were never employed, and the use of the seclusion room for isolating patients from the group was eliminated. In fact, the two "quiet rooms" on the ward went out of existence, one of them being converted into a music room and the other into an office during the course of the experiment. However, the ward operated relatively quietly for the most part, and no occasion arose that challenged the wisdom of these departures from traditional procedures.

On the positive side, I saw each patient briefly within an hour of his admission and later met him in my office for a long evaluation interview. Further interviews were always granted to all patients who signed their names on the "doctor's list" that was posted each day on the bulletin board.

In addition, the patients and staff gathered together on the ward six mornings of the week for a 45-minutes community meeting, where the patients were free to bring up for group discussion any subject they wished. This was followed immediately by a 30-minutes staff meeting. In the course of the 10 months these meetings dealt with many things. Frequently the patients struggled with their anxiety over the effect of psychiatric hospitalization upon their future, as if, like Melville's Captain Ahab, they bore a grim and ugly scar; this subject was a recurrent one in group after group. But, in general, as the weeks went by, one change became hearteningly obvious to us—a ward on which the patients had initially been almost exclusively preoccupied with questions of their disposition when they appeared before the board and with the compensation they might receive, or with complaints about the hospital itself or the military service, developed gradually into a socialized, often sophisticated community with remarkable evidence of self-control, improved morale, and the sense of being concerned in the meetings with an important task. Briefly it may be said that the discussion was permitted to take its direction very largely from the patients themselves and their immediate interests. I made a minimum number of interruptions and usually left interpretations, unless demanded by timing, to the last few minutes of the meeting.

Graphing of Seating Positions

I have described the community meetings at some length because it was from them that our technics for studying the significance of the seating positions taken by the patients developed. At these meetings, which were held immediately after sick call, each patient brought his own chair from beside his bed

and placed it in the position where he wished to sit. The choice of position was an entirely spontaneous one. There was no direction from the staff in this matter, and no interpretation of the seating arrangement was made to the group.

Early in the experiment it became clear that the position of the chairs was a form of nonverbal communication, whether considered individually or en masse. In fact, the staff were soon able to predict with a considerable degree of accuracy how a new patient would behave by the position of his chair in the community meetings. In group after group the same type of patient chose the same position so frequently that certain positions acquired a specific name in staff terminology. For example, there was a speaker of the house's chair, a preacher's chair, a sniper's chair, a guest of honor chair, a right hand of God chair, and so on. The tone of the meeting as a whole could also frequently be foretold in the same manner. When the patients were relatively free of anxiety and felt friendly toward each other and the staff, they tended to congregate toward the solarium. When there was considerable tension on the ward, the chairs were likely to be arranged in what the staff called the "fire escape maneuver," toward the door leading from the ward.

In the staff meetings which daily followed the community meetings, the seating arrangement in the community meeting that had just ended was diagrammed on the blackboard (fig. 2). From this practice we evolved the technics described here for representing graphically the positions taken and the moves made during a meeting or a series of meetings as a basis for studying their significance in terms of nonverbal communication.

I should now like to follow graphically one patient's movements through a series of meetings. The patient whom I shall select for this purpose—Patient R—was an acutely disturbed, disoriented, hallucinating 17-year-old, slight, pale, and rather immature, who had ended up on the sick list after only 6 weeks of active service. He was withdrawn and preoccupied to such a degree that he appeared to be in a dazed state, and he moved very slowly. The note which accompanied his transfer to Oakland from a previous hospital, where he had remained for 1 week, described catatonic behavior. In this previous hospital he had been treated with chlorpromazine, and this medication was continued at Oakland in the dosage of 50 mg. t.i.d.

The series of meetings through which we shall "track" Patient R are meetings of which sound-motion pictures were made, a procedure that was followed for 1 month of the experiment at Oak-

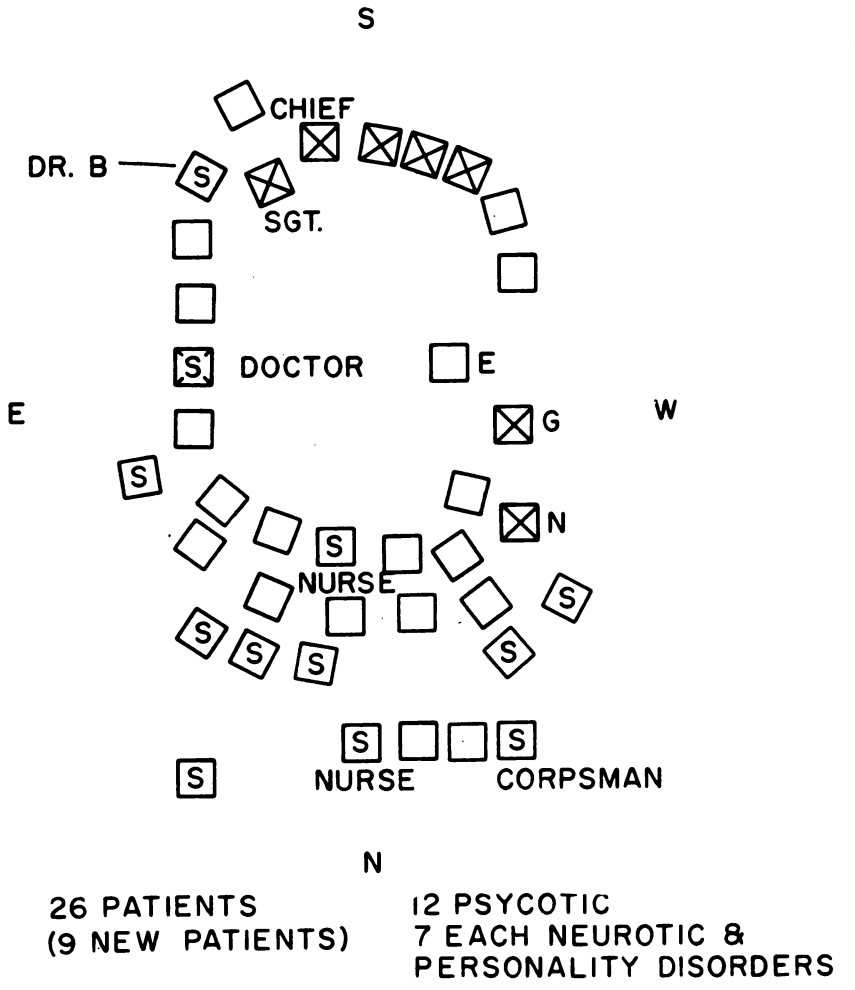

Figure 2. Seating pattern in a community meeting.

land. Thus his movements are influenced not only by the other members of the therapeutic community, but also by the presence of the motion-picture camera, the microphones, and the combat camera crew which openly photographed the meetings.

Figure 3 shows the seating pattern of the entire community on the second day of filming. Beginning here, we shall follow Patient R for 8 days, the small numbers in circles indicating his position in each of these meetings. The movements of four other patients are also charted; all others are held constant for purposes of concentration on our immediate objective—an analysis of Patient R's movements.

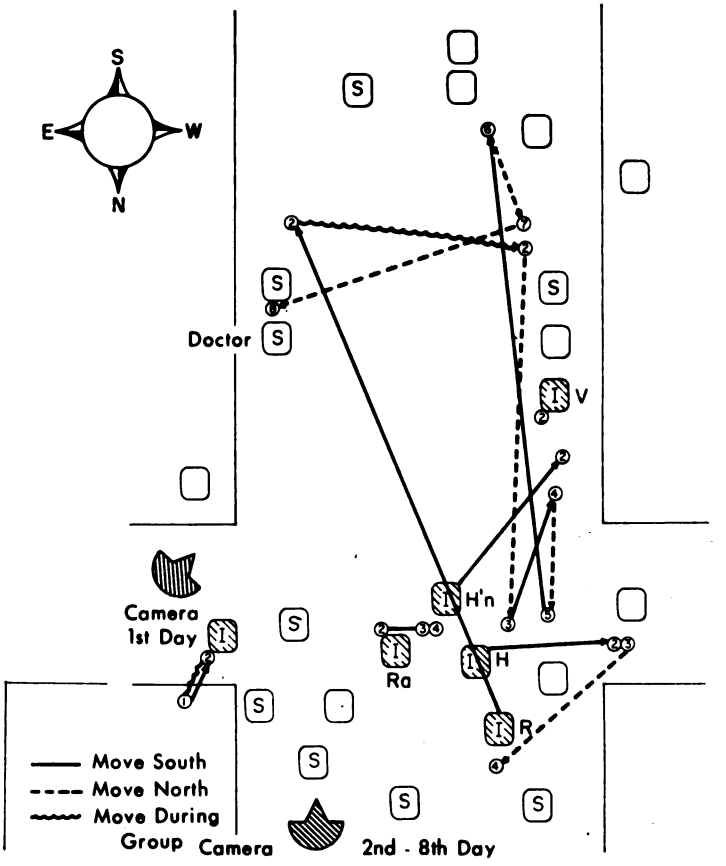

Figure 3. Movements of Patient R in second and eighth day of filming.

The pattern that emerges is as follows:

1st day.—Patient R places his chair in a cluster of patients hidden from the camera.

2d day.—He first seats himself beside me, in such a position that I "shield" him from the camera; then later in the meeting he moves to the "Guest of Honor" chair facing me. (It was from this position that he first spoke to me.)

3d day.—He takes approximately his first day's position, which seemed to be his base of orientation as he moved hesitantly about the ward.

4th day.—He seats himself slightly to the south of his original position.

5th day.—He comes back again to his "residence," so to speak.

6th day.—He places himself opposite me.
7th day.—He edges his way closer to me.
8th day.—He comes to sit beside me again, away from the camera.

While it appears that Patient R's movements are a sort of searching approach to me, or a cautious edging of his way toward me, it should be noted that he had a delusion that the camera was a lethal weapon, and for the most part he wandered away from it; his occasional movement back toward it was almost counter-phobic. We know from the content of these meetings that his phobic fear of the camera was gradually relinquished.

No specific movement pattern for any diagnostic category was discovered, but it was observed that the most mobile patients were usually, like Patient R, the hallucinating, delusional, and confused type. The more anxious and fearful patients tended to travel in small areas (See Patient H). Movements such as leaving the group and returning to the same chair are not shown.

If we now graph the relative positions of all patients in each of the first five of the eight meetings through which we have traced Patient R's movements, an interesting pattern is suggested (fig. 4, with code). The schizophrenic patients are shown here as stippled areas, the dots representing their approximate location. On these coordinate diagrams the relationships of all seating positions are shown. Using these diagrams we shall graph all patients on the three-dimensional chart. Because of the number of people being plotted, the third level is not shown as it would be confusing, being seen on end.

It is possible to show that not all schizophrenics changed their relative positions; only some did (fig. 5). In other studies it was possible to show that in a series of meetings which appeared to be marked by extensive movement, only three patients made any wide excursions. (These graphic studies have also been analyzed in terms of the content of the meetings on which they are based, the socio-environmental aspects of the therapeutic community culture, their histories and the use of ataractic drugs, to be reported elsewhere.)

The precision of the diagram is not absolute, as it appears, since the floor was not marked off in gradients and plotting is relative from staff diagrams. But it is possible to show in other diagrams and graphs that there were, in effect, fairly constant north schizophrenic and south schizophrenic neighborhoods and that Patient R moved from one to the other of these groups, seeking out their company but not speaking to them.

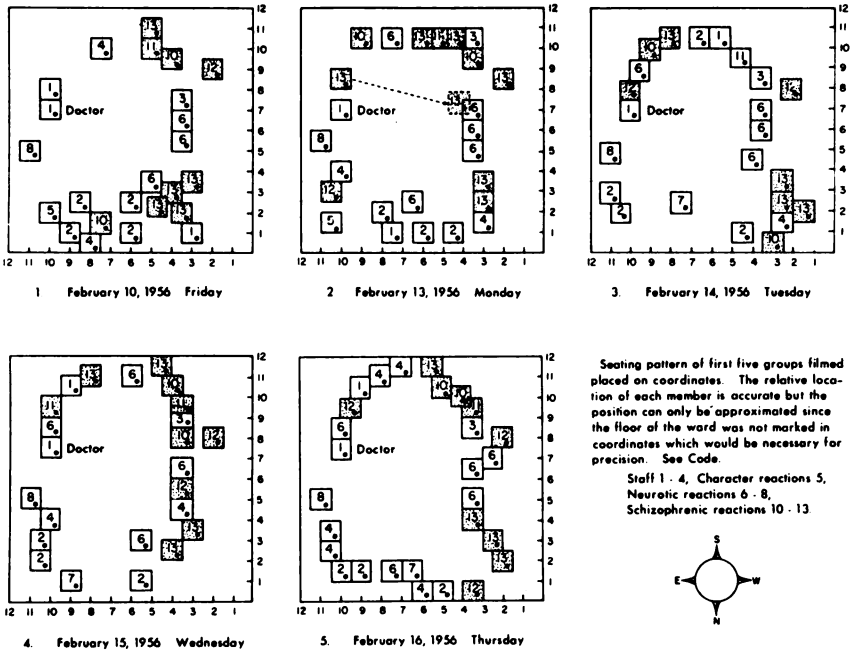

Figure 4. Coordinate graph of seating positions of all community members in first 5 filming days.

Classification Code

1. Staff	
Staff officer	1
Staff nurse officer	2
Staff civilian social worker	3
Staff enlisted corpsman	4
2. Character disorder	
Character disorder, aggressive reaction	5
3. Psychoneurotic	
Neurotic disorder, anxiety or depression, not severe	6
Neurotic disorder anxiety	7
Neurotic disorder phobic reaction	8
4. Psychotic (increasing in severity)	
Psychotic disorder, mild (schizophrenic)	10
Psychotic depressive reaction	11
Psychotic reaction, delusional, withdrawn	12
Psychotic reaction, delusional withdrawn and hallucinating	13

All motion is relative and we shall now consider the movements of Patient R as if he were the "center of the universe," holding his position constant no matter where he moves and showing the community as if it were they who moved relative to him.

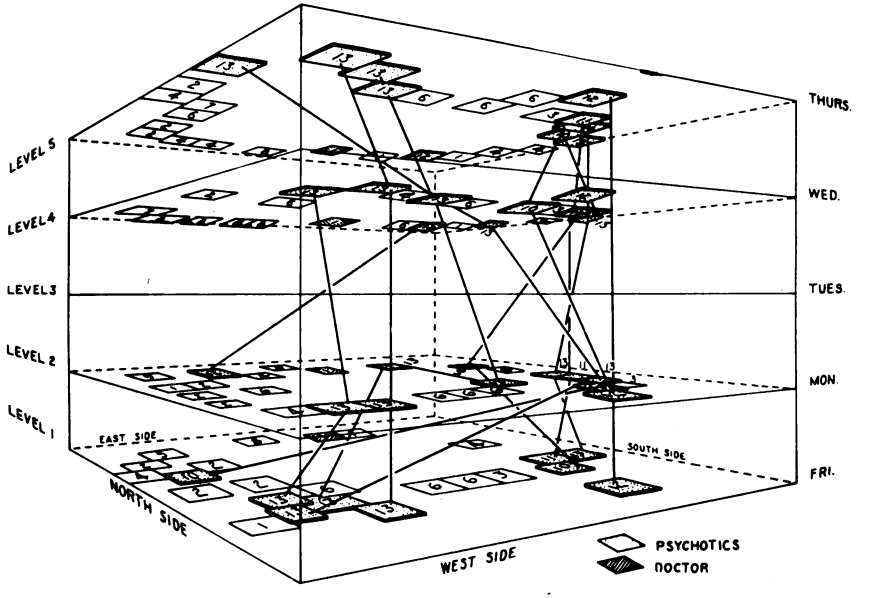

Figure 5. Three-dimensional graph showing movement of schizophrenic community members in first 5 filming days.

Movement in space now disregards conventional coordinates and is a polar coordinate (fig. 6). The position a man takes is determined not only by how he perceives the universe immediately surrounding him, but also by how he imagines that the universe perceives and reacts to him.

Analogically speaking, these areas are the universe in which Patient R moves; and, as in the infant's universe, they are represented in the diagram as an extension of himself. The four concentric rings permit us to assign to his closest neighbors a greater relative size, indicating their greater relative importance to him.

In figure 6 (a Friday meeting) we see Patient R in the center in proximity to a schizophrenic cluster (shown in shaded areas). This distance from me and from the camera turns out to be an optimum distance for him. In the following meeting on Monday (there being no Saturday meeting that week) he takes a position near me and also near a mildly psychotic patient, but as he would prefer a position nearer to the south schizophrenic cluster and farther from me he moves away during the meeting as shown in insert 3. The following Tuesday, still at his approximate optimum distance he is, for the first time, not shielded from the camera either by me or a schizophrenic patient.

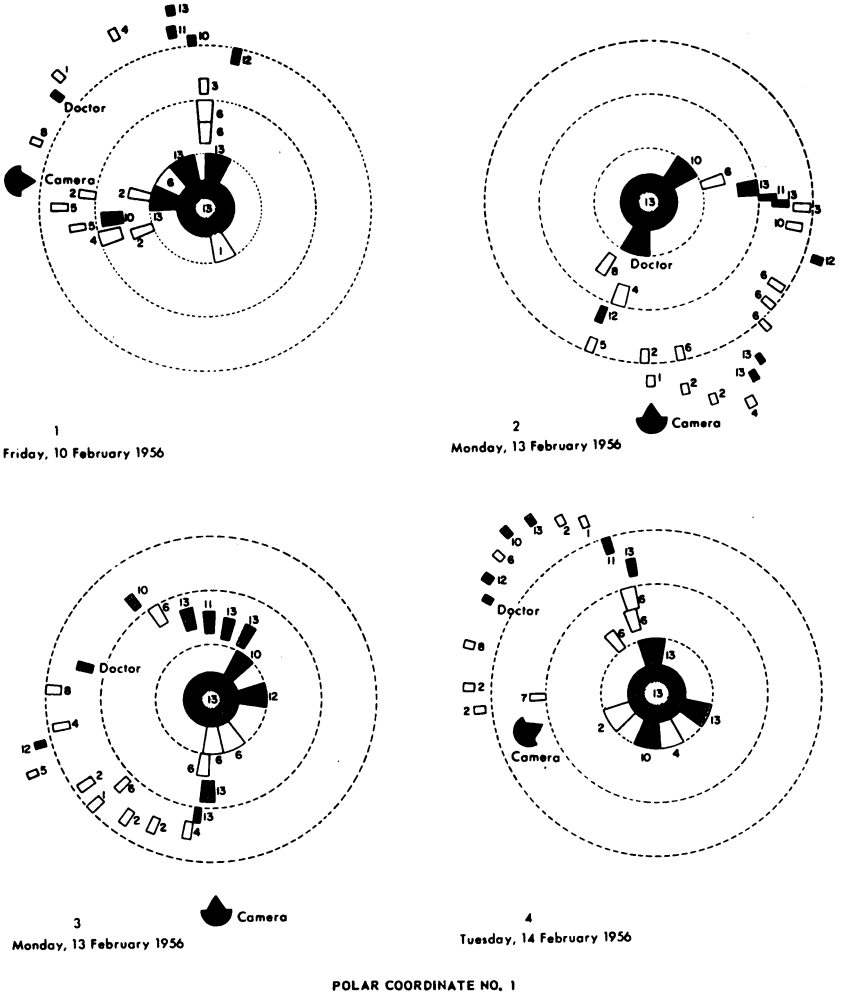

Figure 6. Polar coordinate showing position of Patient R held constant and community members moved in relation to him as a fixed point with relative size of each member proportionate to their proximity to R.

His situation is almost a graphic illustration of the dilemma of the porcupines as described by Freud—if they sit too close together, then they endanger each other with their sharp quills; and if they sit too far apart, they cannot get warmth from each other.

It is possible to carry the analogy of the universe even further for illustrative purposes (fig. 7).

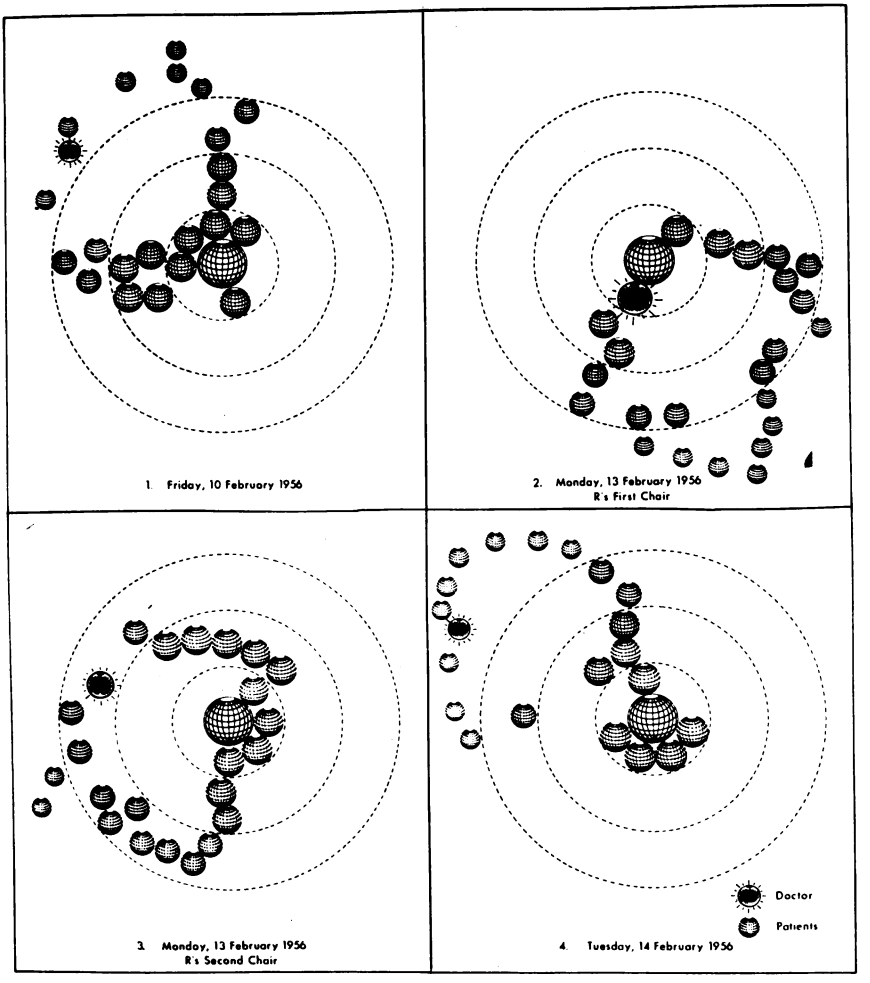

Figure 7. Same as figure 6 with "universes" substituted for blocks.

In figure 8 we see the movement of all patients in these groups showing that movement was as much in one direction as another. In the two inserts we "track" the isolated movement patterns of Patient R and his nearest schizophrenic neighbor in the first group, Patient B. While R's search and counterphobic movements have been described, the even more sick, paranoid, disoriented schizophrenic B reveals a dramatic example of a patient who always returns to his "residence" as a base of operations. It is as if he can sally out to a new place only one or at the most two

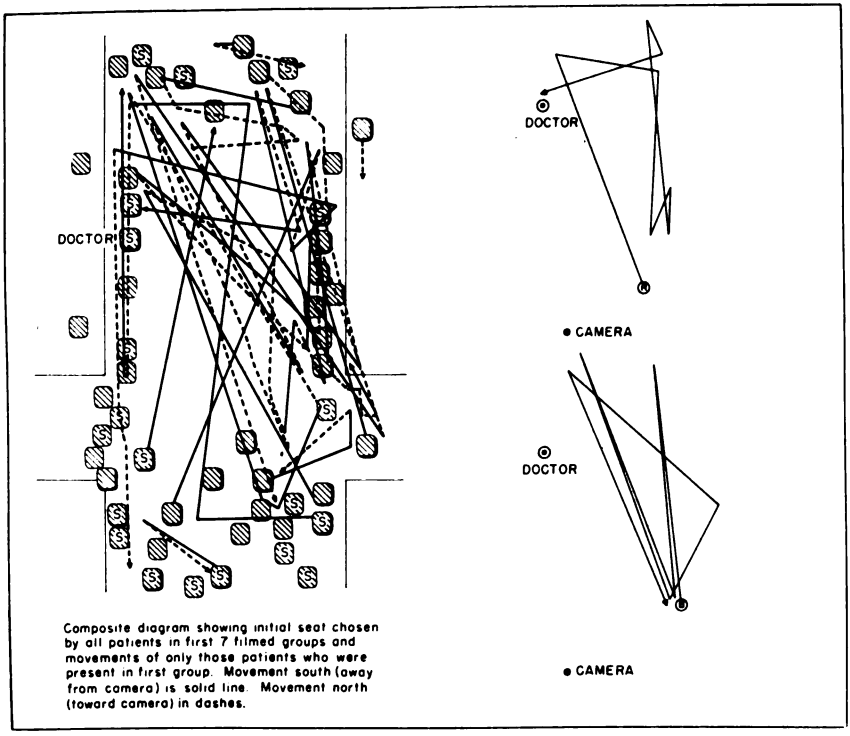

Figure 8. Diagram of movement in first 7 days of filming with movement of neighboring patients R and B tracked separately.

days at a time. While disoriented in all spheres his special orientation to his chair position is clung to as if it is a base of operations, a locus which he knows. Looking at it this way, however, we see no relatedness of the movements of R and B.

Let us now track Patient R and his schizophrenic neighbor B, whose movements were not shown in figure 1. For this we shall employ a three-dimensional graph, figure 9. Here a new phenomenon is suggested, namely, some parallel movement of these two patients. The relative center of the group is shown as a black column, and my position as a line in the East side. What occurs is a sort of movement around the vertical. Other such graphs suggest that this is not just a fortuitous picture.

The questions arise: Who sits next to whom and why? Who moves where, when and why? Who moves in relationship to whom, what, and why? Do people similar in designated ways tend to attract or repel each other? Do likes repel or do birds of a feather flock together, or is it both, and if so, when, which,

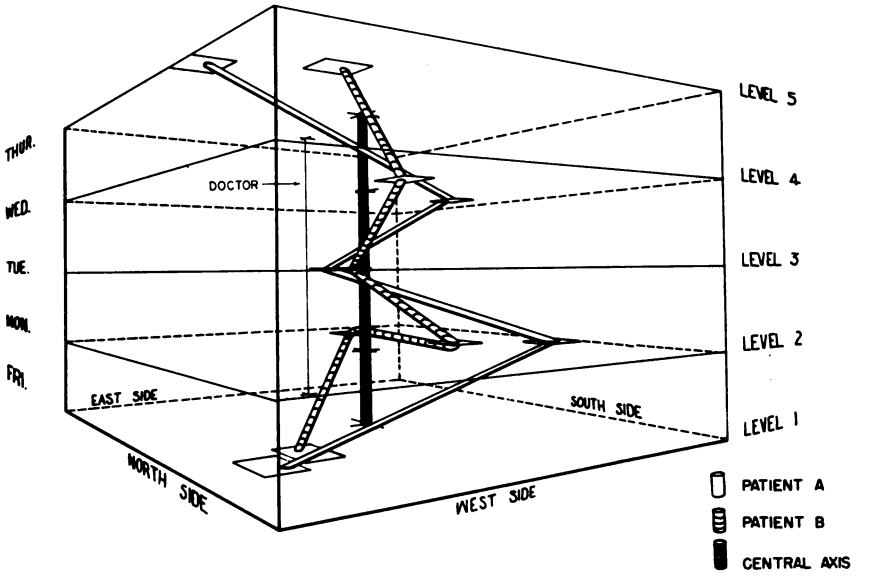

Figure 9. Three-dimensional graph of movements of patients R and B for 5 consecutive days; with only two patients being plotted it is possible to show level 3 which could not be done in figure 5.

and why? What is the nature of the nonverbal, conscious and unconscious significance of chair positions? What does this tell us about tele? Partial answers to these questions and hypotheses can be suggested from graphic technics provided they are understood in the context of the socio-environmental atmosphere of the ward and the full awareness of the current psychiatric difficulties as well as the longitudinal history and genetic development of the individual. Some suggestions are made as to these questions in this light.

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THERAPEUTIC HOSPITAL ENVIRONMENTS:

Experience in a General Hospital and Problems for Research

DAVID A. HAMBURG, M.D.

A. Problems of Therapeutic Administration in the Psychiatric Section of a General Hospital

I want to compare the experiences of Dr. Sivadon and Dr. Wilmer with those of our own group at the Michael Reese Hospital, Chicago, which is a different type of setting than any so far discussed here.

Psychiatric sections in general hospitals are now rapidly increasing in number. These units have important potentialities because: (1) They are more readily integrated into the general community than are most mental hospitals; there is greater likelihood of early admission; they may serve as a focal point for preventive psychiatric activities through their acute in-patient service and their out-patient clinic; overall, if adequately utilized they tend to bring about earlier treatment and shorter hospitalization with greater maintenance of community relationships and activities during illness. (2) The general hospital facilitates reliable continuity of treatment relationship, since the same therapist may readily work with the patient before, during and after hospitalization, for as long a time as necessary. (3) A small but significant number of general hospitals have important leadership functions for medicine generally, setting standards of practice, training therapeutic personnel, and carrying on research.

Given these potentialities, there remain formidable difficulties in attempting to make the environment of a general hospital meet the therapeutic needs of psychiatric patients.

Common complaints about the experience of being a general patient include: (a) The patient feels lost, he has a minimum of information, he knows little about the meaning of things that are done to him; (b) during much of the time he has nothing to

do—he is left to pass the time in whatever way he can with minimum activity, which promotes a kind of tense boredom; and (c) probably the most strongly felt criticism of all is that the hospital environment is cold and impersonal with a lack of consideration for each person as a human being. The upshot of all this is that patients in general hospitals often feel lonely, frightened and depressed.

From the viewpoint of social structure, general hospitals tend to be quite authoritarian. There is ordinarily a rigid hierarchy with physicians at the top. Even within the physician group, there is a hierarchy based upon rank of appointment. Nurses are in an intermediate position in the hierarchy and nurses' assistants (aides) are near the bottom. Administrative policy is made by one or two senior physicians and/or nursing administrators. The views of those lower in the hierarchy are seldom obtained even in an informal way, despite the fact that these individuals usually have the most prolonged and intimate contact with the patients. There is a tendency to make policies on a hospital-wide basis insofar as possible. Uniformity is looked upon as desirable.

All of these factors contribute to a situation in which decisions are likely to be made on the basis of inadequate information. Not only is the informational basis inadequate, but the emotional overtones of a system in which decisions are imposed from above are often quite distressing to people who value democratic processes. These are conditions under which the hospital's personnel are likely to care little about their work, to avoid participation with patients, and to displace resentment onto patients.

When a psychiatric unit is established in a general hospital, there is a strong tendency to adopt methods of policy-making that are very similar to those used previously in the hospital. Since the problems encountered with psychiatric patients are different in many ways from the problems encountered in other medical specialities, it becomes apparent with even limited experience that some policies which are suitable for other parts of the general hospital are not suitable for the psychiatric section—at least not without considerable modification to meet specific problems. If the hospital environment is to favor the recovery process, a high degree of administrative autonomy is advantageous for the psychiatric section. Such autonomy gives the freedom to make intelligent policies specifically adapted to the psychiatric setting. However, some caution must be observed so as to prevent functional isolation of the psychiatric section from the rest of the hospital.

But given autonomy, what then? Our experience strongly suggests that those who have administrative responsibilities for the psychiatric section will do well to give careful consideration to two factors which seem to be of considerable importance in developing the therapeutic potential of the hospital: (a) *facilitating communication* between the patients and staff, between disciplines within the staff, between wards, and between groups of different status; (b) *broadening participation* in the decision-making process. These two processes are intrinsically satisfying to many staff members; they tend to decrease attitudes of bitterness and non-involvement. Moreover, they usually lead to more reasonable decisions on the basis of more adequate information. This is not to say that everyone should communicate with everyone else about everything that goes on, or that everyone participates in all decisions; the *relevance* of a given person to a particular decision must be considered in deciding whether he should participate in making it. This viewpoint does not mean that people with administrative responsibility "pass the buck" to those who are in no position to make the decision, nor does it mean an endless series of conferences in which there is much communication but no effective action.

B. Description of a Program

During the last several years in the psychiatric section of Michael Reese Hospital (known as the Institute for Psychosomatic and Psychiatric Research and Training), a vigorous effort has been made to overcome the difficulties outlined above. In general, our aim has been to improve communication, to broaden participation in the decision-making process, and to work out a more rational basis for administrative policies. We have assumed that any significant movement toward these goals would facilitate the recovery of patients. This program has been described in detail elsewhere,[1 2] as well as some general observations of nurse-physician-patient relationships.[3]

The setting in which this work has been carried out is an 80-bed psychiatric section in a large general hospital with a strong teaching and research orientation. The psychiatric section is housed in a separate building on the same grounds with the rest of the hospital, and consists of five small units. Approximately four-fifths of the patients are private patients and one-fifth are service patients. The usual pattern is for the attending psychiatrist to visit his hospital patients in the morning and spend the remainder of the day treating office patients.

The theoretical orientation of staff members is mainly psychoanalytic, though a fairly large range of views is represented, not only with a psychodynamic frame of reference but also including psychiatrists who frequently utilize the somatic therapies. With respect to milieu therapy, the hospital has had three basic advantages which are often taken for granted: (a) an exceptionally comfortable, pleasant physical plant; (b) a relatively high ratio of staff-to-patients; (c) a tradition of high-caliber service, training and research. In themselves, however, these factors do not guarantee a therapeutic environment. There are great differences in the extent to which they may be utilized for therapeutic purposes.

Our basic orientation may be summarized as follows: *The problems and viewpoints of patients and of each group of personnel need to be considered: information about these various viewpoints and problems should be obtained systematically and consistently, and taken into account in making policy decisions.*

The following means have been used for bringing the various groupings within the psychiatric section into the processes of decision-making, especially in relation to administrative policy.

1. Increasing the Participation of Patients

A weekly ward meeting is held in which all patients are invited to participate. Patients are told that the purpose of the meeting is to discuss any problems arising in connection with their hospitalization.[4] Their comments and suggestions on the functions of the hospitals are actively encouraged. Emphasis is placed on the staff's willingness to take those suggestions into account and to put them into practice so far as possible.

2. Participation by Nursing Personnel

A coordinator system has been utilized. Each ward has a coordinating psychiatrist who is a member of the administrative staff. The coordinator is available at all times for consultation on problems of milieu therapy. He has considerable informal contact with people who work on each unit and often discusses with them complaints and suggestions arising from their daily work.

The main formal procedure in which the coordinator participates is the *weekly staff meeting* on each ward. This meeting may be devoted to the discussion of a patient who presents a particularly difficult problem in clinical management or to the

discussion of general ward problems (such as security measures when there are several suicidal patients on the ward). These meetings are held at the change-of-shift time so that practically all of the nursing personnel who work on the day and evening shifts can attend. The ward occupational therapist also attends. Maximum participation by all those attending is actively sought out. Special effort is made to facilitate frank communication across status barriers.[5]

Participation of nursing personnel in decision-making may be further enhanced by assignment of a resident to each ward specifically to deal with milieu therapy problems, especially in coordination of various treatment efforts. The resident is especially helpful in improving the working relationships between the private attending psychiatrist and the nursing personnel, working closely with both in resolving the day-to-day issues of patient care.

3. Participation by Residents

There is a weekly meeting of all ward residents with coordinators (administrative staff). This meeting is attended by the chief occupational therapist, nursing day supervisor, and chief dietitian (when possible). It is designed to deal mainly with three kinds of topics. First, each resident reports on the ward patient meeting which has taken place earlier in the week; any complaints or suggestions from the patient group which have not yet been acted upon are evaluated and a decision is made as to what action should be taken. Special attention is paid to arriving at a specific decision and a concrete plan of action so that the issue will not be left hanging in the air. Second, each resident reports on any important problems of his ward, whether or not these have been discussed at the patient meeting; special attention is paid to clarifying any problems that affect more than one ward or that involve the whole hospital. Third, this meeting is used to coordinate the planning of special activities that involve more than one ward, e.g., a dance given by patients of one ward in cooperation with occupational therapy, to which patients of other wards are invited.

In addition, an attempt has been made to provide more systematic instruction and stimulation concerning milieu therapy in the resident training program. As an example of this, the main clinical conference is now organized to provide an opportunity for all who have contact with the patient—psychotherapist, nurse, resident, occupational therapist, dietitian, social worker,

etc.—to discuss problems of management, as well as individual psychotherapy. The scope of the conference is thus broader than the diagnostic conference which it replaced. It seems useful both with respect to training and to treatment.

4. Participation by Private Attending Psychiatrists

In this setting it is not feasible to have a meeting of the entire ward staff with the attending psychiatrist on every patient. Such a meeting is held, however, whenever the head nurse, resident or attending psychiatrist feel that special difficulties are beginning to emerge. This includes an attempt, usually catalyzed by the coordinator, to bring out covert disagreements and resolve them.[6]

We have also periodically explored general problems of milieu therapy with the staff psychiatrist. This has been done in various ways: through the use of written material bearing on the subject, in the individual contacts and in staff meetings, and finally, through clinical research presentations.

The residents and ward head nurses function as communicative links between the attending psychiatrist and the nursing personnel (particularly aides). If they are encouraged by the administration to take an active role in contacting attending psychiatrists and clarifying doubtful or charged issues, they are able to work out many problems as they arise which otherwise might reach serious proportions.

A committee on care of private patients was established in order to get the views of attending psychiatrists on a systematic basis. It consists of attending psychiatrists of varying experience and status, who have in common a greater-than-average interest in hospital practice.

5. Coordination of All Groups: Policy Committee

This is an interdisciplinary committee in which every group of full-time staff members dealing with patients is represented: nurses, aides, resident psychiatrists, attending psychiatrists, social workers, occupational therapists, dietitians. The associate or assistant director of the psychiatric section is chairman.

This committee meets biweekly and makes most of the major policy decisions for the psychiatric section. It deals with any problem that involves more than one ward or more than one discipline. Its decisions are subject to review by the director but are rarely changed by him.

C. Evaluation of Effectiveness

A real challenge at the present time is the development of adequate means of testing the effectiveness of milieu therapy. In our setting, measures of the type outlined in this paper seem distinctly useful. To most people who work in the hospital, they seem quite reasonable and appropriate, but decisive evaluations are largely lacking in this field.

1. Decrease in Crises

One systematic check has been made on the widespread impression that crises have sharply decreased since the development of this program. The example chosen for study was physical attack on one's self or on others (patients of staff).

Since physical attacks occur most frequently and seriously on the unit which is designated for the care of the most severely disturbed patients, the daily nursing records from this unit were reviewed during a 90-day period in the first half of 1953 and a 90-day period in the first half of 1955. These are periods before and after the introduction of the program outlined above. It was found that 116 such incidents occurred in the 1953 period and 58 in the 1955 period, the ratio being exactly two to one.

In the course of reviewing the nursing records for this analysis, two incidental findings emerged. One is that the 1953 records show a great many *depreciatory statements about patients,* while these were quite rare in the 1955 records. Another observation is that the 1953 records show many warnings about *extreme suicidal danger,* while such warnings were considerably less prominent in the 1955 records.

2. Personnel Attitudes and Turnover

An important goal of milieu therapy programs is an increase in job satisfaction and an amelioration of staff attitudes of *discouragement, resentment* and *nonparticipation.* Some crude reflection of these attitudes may be gained from statistics on personnel turnover. Our data on this are encouraging though not conclusive. In brief, there was a substantial reduction in the number of resignations by graduate nurses and by nurses' assistants during comparable periods of 1953 and 1955.

3. Improvement and Transfer Statistics

In the absence of exhaustive studies of treatment results (which are generally deficient in psychiatry), some crude but perhaps

useful indices of the effectiveness of treatment may be obtained from improvement and transfer statistics. Using the conventional criteria of clinical judgment at the time of discharge, what percentage of patients show definite improvement? What percentage fail to improve?

In order to get a systematic estimate of our patients' progress during a period before and a period after the hospital-wide milieu therapy program was developed, a comparison has been made of several indices of treatment results during the first half of 1953 and the first half of 1955. The hospital census was quite similar during these two periods. All of the indices move in the same direction from 1953 to 1955, namely, toward improvement in treatment results. For example, twice as many patients were considered definitely improved at the time of discharge in 1955 as in 1953. The percent discharged as unimproved dropped almost half, and there was a slight decline in percent of transfers to another hospital.

The question arises whether these changes are attributable to the types of measures described in this paper, which may be broadly categorized as "milieu therapy." If, for example, there were significant decreases in patient load, or increase in staff, or improvement in quality of staff, or change in patient population to less severe disorders, or the use of more effective medication, then one or a combination of these factors might account for the changes. These factors are complex and difficult to evaluate. At this point it is possible only to give a judgment which is a rough estimate of the status of each of these variables. Time prevents a detailed analysis of these issues, but this has been presented elsewhere.[1]

Taking all of these factors into account, it seems likely that the milieu therapy practices account for a considerable part of the change observed, though by no means all of it.

D. Additional Conclusions

In addition, there are several conclusions reached and problems encountered by our group which deserve mention. From our total experience with the treatment of patients hospitalized at Michael Reese over the last several years, we believe that the following statements are justified.

1. Even patients with disturbances of extreme severity may be treated in a general hospital with substantial benefit if there are reasonably close working relationships within the treatment group —i.e., those who have extensive contact with the patient.

2. The relationship between the attending psychiatrist and the nursing staff is crucial in a general hospital. Patients usually do best when the doctor-nurse relationship is characterized by free communication in both directions and mutual respect. We have identified several common patterns of doctor-nurse interaction which are damaging to patients and have evolved alleviating measures. Probably the most dangerous interactions are those initiated by disrespectful attitudes on the part of physicians toward nurses.

3. The physician's traditional preoccupation with individual treatment, as well as his traditional high status, may promote a gap between him and other members of the staff who "live with the patient" in the hospital. Psychiatrists have a tendency to overlook emotionally meaningful, interpersonal influences which may help or hinder the patient's recovery during the other 23 hours.

4. Even with the most skillful psychotherapist, treatment gains from being specifically adapted to the hospital setting. It usually does not suffice to treat a hospitalized patient as if he were in outpatient psychotherapy.

5. Extreme cases test the limits of the hospital's therapeutic capacity. At the same time, they offer an excellent opportunity for learning since they highlight latent difficulties. It is valuable for the hospital to have built-in procedures which maximize the opportunity to learn from such cases.

6. Issues of control and permissiveness require further clarification. Certainly many psychiatric hospitals have been more controlling and restrictive than is helpful to most patients. The hospital cannot, however, be an all-giving mother in the sense of permitting every wish of every patient to be promptly gratified. To be therapeutic, it must be a social system in which the wishes of each patient are somehow balanced with those of other patients and this cannot usually be left entirely to the patients themselves.

7. Members of the nursing staff may enter into friendly, respectful, reliable relationships with patients that are distinctly therapeutic. The traditional notion that the nurses "should not get involved" is inadequate for psychiatric nursing. There are, however, difficult problems encountered as the nurse enters into such relationships. One of the most important is that she cannot devote herself to one at the expense of all others.

8. The treatment goals of a psychiatric hospital may generally be approached more adequately by the development of a hospital-wide program, which includes the following components: (a)

open communication channels, regularly used, between patients and staff and within the various staff groups; (b) broadening of the traditional decision-making process to include all members of the therapeutic group who are relevant to a given decision—from the day-to-day problems on each ward to the administrative policies for the whole hospital.

E. General Comments on Milieu Therapy

In closing, I would like to make a few remarks about the general state of research in the milieu therapy field.

Recent scrutiny of the hospital as a social system, and the attempts to make this system more therapeutic, are one part of a general upsurge of interest in the social aspects of psychiatry, reflected, for instance, in the present symposium. This development may, in the long run, be of utmost importance, since it adds an additional and essential frame of reference for psychiatric observation, theory and practice. Twentieth century psychiatry has been too narrowly preoccupied with physiology and/or individual psychology.

In the meantime, substantial advances have been made in social psychology, as well as other social sciences. It is high time that we make use of these advances and consider psychiatric problems from a social perspective. Yet it seems to me that social psychiatry is at present more *a point of view* than a major substantive body of knowledge. Further, there is danger of our creating sterile yet emotionally charged divisions within psychiatry. We seem to be on the verge of crystallizing three major competing ideologies: biological psychiatry (which often means simply preoccupation with somatic therapies); psychological psychiatry (which for all practical purposes means psychoanalytic psychiatry); and now social psychiatry. While distinctions between these various approaches may be useful for certain purposes, we should not lose sight of the fact that any comprehensive understanding of human behavior will require all three frames of reference, with the methods and concepts appropriate to each. Periodically, attempts must be made to integrate biological, psychological and social data as psychiatric knowledge progresses.

While the effectiveness of milieu therapy is far from definitively established, several programs (such as Dr. Sivadon's) appear sufficiently promising that it becomes worth-while to consider what might be responsible for these therapeutic effects. If we assume that beneficial changes may occur in many patients as a

result of such programs, what are the essential factors producing those changes?

First, we must consider the background against which changes in the hospital environment are often made. In many hospitals, particularly very large public mental hospitals, there has been such gross neglect and abuse of patients that almost any well-intentioned change is likely to relieve some human suffering. On the other hand, some smaller, intensive treatment hospitals had become so totally preoccupied with individual psychodynamics that each patient was considered as a separate unit, almost as if he lived in a social vacuum. In these hospitals, any reasonable attentiveness to the social environment may well be helpful to many patients. Yet to say this much is only to say that we have learned how to correct some *gross defects* in our hospitals. While this is important, one may wonder whether we go beyond the achievements of some humanitarian hospital administrators of a century ago.

A basic question in milieu therapy, as in individual therapy, is whether the desired results occur chiefly as a result of certain *specific actions* or of *attitudes and implications* conveyed through the actions. In individual therapy, is it *insight* that does the job? Or is it something about the *therapist-patient relationship* which is the hidden motor for progress? Perhaps both—i.e., insight achieved in a certain interpersonal contact has the greatest chance of facilitating personal development. Similarly, we may wonder how effective in themselves are the planned games of Dr. Sivadon's program or the insight-through-group discussion which has characterized so many milieu programs. Here again, the difficult question of the interpersonal context of these activities should be considered. Milieu therapy programs have varied considerably in the content of their activities; yet I suspect their results are not so very different from one place to another.

It is worth noting several common features which most of these programs share to some extent. These features include not only the overt, intended actions of those planning therapeutic programs, but also attitudes and implications involved in them.

Those who have become leaders in the development of milieu programs often manifest prominently several of the following characteristics: (1) an *intense interest,* approaching dedication, in understanding mental illness and/or in their patients as people; (2) *deep respect* for other human beings, pervasive in their relations with patients and usually with staff members as well; (3) thoroughgoing *optimism,* with a fundamental belief in the

likelihood of *progress* and the *perfectability* of individuals; (4) an orientation to *determined action,* amounting often to a persistent, relentless pursuit of desired goals.

The programs which such people initiate usually include several of the following general characteristics: (1) *increased interaction* between people, particularly between staff and patients—this often includes more-or-less systematic attempts to open communication channels that had previously been occluded; (2) *democratic processes,* through which those who have traditionally had a low status in the hospital are given greater voice in decision-making; (3) *emphasis on group processes,* so that aggregates of people rather than individuals become the focus of study and action; (4) *conspicuous change,* so that there is an atmosphere in the hospital of movement, excitement, reform.

In addition to these general characteristics of the people and of the programs, there are of course many detailed ideas and actions specific to each program. These too are important in each instance. The issue raised here is the importance of these *general* factors about people-and-programs in helping patients.

Is it possible, for example, that many patients will improve in any hospital in which new, determined, optimistic leadership brings about a series of striking social changes? How important is change per se in reawakening hope in our patients?

Perhaps *comparative studies* of a wide variety of therapeutic institutions and programs will give us reasonable answers to these and similar questions.

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PROBLEMS IN ANALYSIS OF THERAPEUTIC IMPLICATIONS OF THE INSTITUTIONAL MILIEU

ALFRED H. STANTON, M.D.

The years since World War II have seen a very considerable concentration of interest among social psychiatrists upon the mental hospital, not only because it poses a serious community problem, but for two other interrelated reasons: Newer awareness of social psychology having sensitized clinicians to the environmental domain, its practical clinical pertinence was immediately clear and cried aloud for study; and second, the psychiatric hospital offered a promising laboratory of human relations in that positions of authority were occupied customarily by scientifically trained and interested persons (physicians), personality data quite inaccessible in many other locations were the hospital's stock in trade, and the process of clinical improvement of psychotic and other seriously disordered patients offered an appraisive dimension to the study which was at once attractive and confusing. Much of the early work, then, crystallized about the notion of the therapeutic community, a phrase coined by Main[1] (to my knowledge) and expertly presented by Maxwell Jones.[2]

As is usual in clinical situations—where action must be taken without awaiting definitive knowledge to base the action upon—several different formulations of the most therapeutic type of community have been presented. Again, as is usual in clinical situations, these are highly empirical, preliminary formulations which are individually easy to criticize but which represent current promising trends.

By now, more or less detailed descriptions of nine psychiatric institions are available[2-10] and from these come various, often implicit rather than explicit, theories of therapy. Jones[2] seems to attribute therapy to democracy as exemplified by the radical and careful delegation of decisions to the group, with much emphasis upon group meetings with therapeutic goals. Greenblatt, York, and Brown[6] continually emphasize increased interaction (implying even that catatonic stupor is avoidable when enough interaction with others is offered) upon the diminution of re-

straints of various types, and an active and electric therapeutic intent. Henry,[11] generally silent upon therapy, focuses upon contradictions in formal structure such as divided authority as troublesome, and in personal communication speaks of the value of a very high degree of personal giving of self to patients. Dr. Schwartz and I[5] also emphasize individualization, collaboration, the active seeking out together of personnel and patients for a shared goal, and the more specific measures of individualized diagnosis and treatment. Meijering,[7] very clearly focuses attention upon the intimate counterpoint between individual psychotherapy and both formal and informal primary groups, the latter functioning indispensable as educational and disciplinary agents. He emphasizes how the social structure must be changing to exploit the small group benefits most effectively. The work programs of Sivadon and the followers of Simon* are world famous; the evolutionary rationale of Sivadon's hierarchy of tasks is the most clearly conceptualized of these.

Emphasis throughout all the studies is upon group methods in place of restrictive ones; in particular, Dr. Rees is of the opinion that locked doors during the daytime so clearly induce escape efforts, violence, and other phenomena of illness that they must be avoided where adequate staff preparation has occurred; he also relies heavily upon group psychotherapy. The granting of a much more active place to the patient in the treatment program is a quite universal common denominator.

Current Limitations of Socio-Psychiatric Analysis

It would be inaccurate, however, to leave the impression that differences of opinion have not occurred in this new area of inquiry. There are many, but of these, probably the most significant is the cleavage between those hospitals where a considerable reliance is placed upon somatic treatment methods—at times to replace locked doors—and those hospitals where such treatment programs are systematically avoided or are, at least, minimized. Attitudes toward drugs and toward shock therapy are, then, often exactly opposite among social psychiatrists, and the place of these potent influences has not yet been significantly appraised within the rest of the social structure; in informal discussions it is commonplace to hear of patients on good behavior for fear of getting

* See in this connection—G. M. Carstairs, D. H. Clark and N. O'Connor: Occupational Treatment of Chronic Psychotics (Observations in Holland, Belgium, and France). The Lancet *2*:1025–1030, 1955.

one or another form of treatment; Balcanoff and Friedman at the Boston Veterans Administration Hospital have reported upon the persistent disciplinary effect of ETC on the memory of a schizophrenic patient during 3 years of psychotherapy subsequent to the treatment while the patient was completely clear of manifest schizophrenic symptoms.[12]

I mention these issues not to try to open a complex discussion of a complex issue but simply as an illustration of certain problems in the current formulations of social psychiatry. The high degree of eclecticism which characterizes much of the writing in the field does not augur well for its development. Notions of therapy are based upon the improvement of patients without reliable or sensitive ways of estimating improvement so that predictive tests are very hard to conceive. They are almost universally without adequate follow-up. Many of our best studies are related only to such simplified goals as getting patients out of hospitals, as in the case of the Cummings' and Clancey's work at Weyburn,[13] [14] and many others which are not as clear. Such studies are indispensable in understanding how institutions can be worked with, but the relation between getting out of the hospital and therapy is surely so indirect and so variable from hospital to hospital (for instance, between a governmental and a private hospital where limits on length of stay are set by entirely different standards) that such studies are of strictly limited value in understanding or designing therapy or therapeutically organized institutions.

Again, conceptualization of the theoretical base is still in a preliminary state in that the views of good practice are couched in such a way that they are either ambiguous or greatly oversimplified. (Further, generalization from one hospital to another is handicapped by the fact that many of our findings, without our having any way of knowing it, may be based upon some relatively specific lack in one particular institution; thus, where there are very few personnel, increasing the rate of interaction between personnel and patients may have an entirely different effect than on the ward of that fortunate hospital which has a surfeit of personnel and where the need may be for more privacy. Indeed, the general deficit of psychiatric hospitals in almost everything except patients may be a significant contributing factor both to the existence of this field of study and to its present relatively inadequate state.)

The crucial lack at present in social psychiatry is an adequate theory of therapy; that is, of the ways in which the social en-

vironment intermeshes causatively with psychopathology. For until there is some guess as to the relation of the treatment to the disease, we can expect treatment methods to remain tentative, general, and relatively undiscriminating. Many of our most used concepts will be free of meaning, serving as general umbrella concepts to rationalize whatever action or view we wish to relate to them.

Psychopathology and Interpersonal Relations in the Hospital

I should like to offer here one social psychological extension of a clinical commonplace as one way in which psychopathological processes can be linked with interpersonal and social structural phenomena. Under proper circumstances, of which psychoanalysis is one, neurotic symptoms come to be expressed as directly relevant to the person important to the patient, such as the analyst. A phobic patient loses her fear only to discover that it is lost only if she can look forward to continuing contact with the physician. This is no more than a banal example of the change of a psychoneurosis into a transference neurosis; when this happens, the physicians is responded to as if he were someone else than he is. The resolution of this neurosis requires that the physician both behave differently than he would be expected to, and give continuing and effective interpretation of the phenomenon, and it requires the active efforts of the patient to see and accept the more realistic situation in spite of his own preferences to avoid recognizing it. Usually important transference misinterpretations can only be given up after long and difficult work.

A common current view of the psychopathology of schizophrenia[15] holds that, in addition to the loss of object relations and the consequent restitutional phenomena, a significant nonpsychotic part of the personality is persistently active. Transitory or lasting improvement occurs if the balance of power swings from the psychotic ego reconstructive efforts back to the residual nonpsychotic ego activity. It is a usually accepted clinical view that the degree to which this occurs is quite appreciably influenced by the degree to which the personnel who surround the patient respond to him in terms appropriate to their real role in his life rather than in terms of the role he may invite them to play in his psychotic activities.* Thus if they respond in terms of his fantasies, they encourage the developments of psychotic experience

* See for an analogous situation—John P. Spiegel: Resolution of Role Conflict Within the Family. Psychiatry *20*:1–16, 1957.

to some extent; if they respond in terms of his more realistic expectations, they support this side of his ego. This is closely analogous to the recommended activity in dealing with a transference neurosis. This is one certainly significant way in which the responses of the persons in the patient's environment affect the nature and degree of his psychotic experience.

It is also a general clinical observation that the hospitalized psychiatric patient responds with important transference-like responses to others than his therapist, and that their responses to him have therapeutic or anti-therapeutic consequences which at times may be greater than those of his therapist. The task of aiding personnel and patients in this frightfully complex problem is a considerable part of the task of the hospital psychiatrist, and it is one aspect of this task which I should like to discuss today.

We must be quite clear that the process of clarification I have just described is an ideal one approximated in practice only in the most ragged way, often worked out only with much tension, often not worked out at all, and even more often entirely overlooked. If personnel are close enough at all to patients to deal with them in an indvidualized way, quite stable relationships often spring up in which the staff member responds to the patient's unrealistic emotional overtures precisely as if they were thoroughly realistic, or he fails to notice them at all. But one very important malintegration is to strike up a stable misunderstanding with the patient in the area of the patient's difficulty, a misunderstanding that may persist indefinitely.

Stable Misunderstandings

I am, I suspect, using the term misunderstanding in a slightly different sense that it is ordinarily used. The term is usually used either as a polite euphemism, or to illustrate some unimportant cognitive error. In contrast, I am using it in the way suggested by Ichheiser,[16] whose study suggested the formulation. A misunderstanding is often subtle, serious, lasting, but difficult to uncover; I should like to emphasize that it is often difficult to uncover precisely because it offers certain values to both participants in its formation and maintenance, even if it is much more harmful in its effects than the relatively trivial but more obvious values it seems to protect.

Created and unconsciously maintained, certain misunderstandings are nearly ubiquitous, apparently institutionalized. It is this aspect which makes them important and open to study. The fact that they are reciprocally maintained suggests that they may,

with fuller understanding, be open to influence on a general scale. As a matter of fact, many of the changes in the character of hospitalized patients in recent years may be attributable to hospital procedures which avoid, or at least change, certain standard misunderstandings.

Misunderstandings spring up normally in the conduct of human relations, but we usually have fairly adequate ways of correcting them, granted both the motivation and the opportunity; needless to say, these always involve discussion. The active maintenance of a misunderstanding, therefore, is featured by avoidance either of the other person or of the topic of import. Again such avoidance often implies that both parties sense the subject matter which is misunderstood, but this seems to me rarely fully conscious. Misunderstandings would be expected to thrive generally in a situation where people talked together only rarely or on purely mechanical or innocuous topics, or subject to considerable constraint.

One characteristically mutually advantageous and institutionalized misunderstanding seems to me particularly prone to occur in wards or institutions known to have research or unusual programs, such as many of the institutions which have contributed most heavily to the literature on social psychiatry. While there are many such problems associated with charisma, I shall select the promises implicit in the admission of the patient. A usual official set of assumptions upon which both patient and doctor would be likely to proceed would be that the patient's admission represented the beginning of a somewhat promising but highly uncertain effort toward the improvement of the patient's condition, an effort into which all participants would throw themselves with considerable energy, some skill, and much good will. Nothing else would be promised overtly.

But this would, of course, be only the most superficial account of the situation, even if highly important. The very deviancy of the institution, or of the physician, if known to the patient, could not help but tacitly promise the fulfillment of all sorts of unconscious wishes, particularly if the original contact with patients was less unpleasant than other similar contacts he had experienced in the past. Few of our sicker patients, however, long entertain expectations involving the good will of persons in authority, and the siren song of the first meeting is accompanied in one way or another by the patient's precautions; one of these is to keep his hopes to himself, perhaps hinting after a time at the less important ones on a trial basis.

The physician, or other staff member, who meets the patient is usually more or less aware of the possibility of unreasonable hopes, but he has little or no idea of just what the fantasies are which the patient secretly hopes will be gratified; nor can he be quite sure how much of the patient's initial movement toward him is the result of unrealistic expectations. However, he is quite clear about how valuable it is to everyone if the patient does in fact become articulate and engaged in the task of understanding his disorder.

Again the usual contemporary psychiatrist will also be aware of the dynamic importance of any unusual or radical position held by his institution, and also of an ever present possibility or temptation to outright quackery by exploiting the patient's unrealistic hopes in treatment. Usual ways in which this temptation can be dealt with are for the psychiatrist to ignore the issue (which means to accept it tacitly for the time being), to seek to identify unrealistic expectations and " correct" them, or even to exploit them unconsciously when the patient's wishes coincide with the particular hospital program in which the physician takes the most stock. Accepting the patient's expectations, whether tacit or overt, means, however, that the psychiatrist does in fact seem to promise something of which he does not know the content. Since the interview will usually then proceed smoothly to its conclusion if no one rocks the boat, the "value" to both patient and staff member of not inquiring is obvious.

When the psychiatrist does inquire, however, he will usually find avoiding tacit unrealistic promises to be a difficult job, often an impossible one. I have seen several patients who have complained (after they had gained an ability to be clear about such matters) of the fact that upon admission to the hospital no one ever promised them anything, but often, on the contrary, hedged or qualified nearly everything. All these patients indicated that they had been forced to assume that such modesty or nihilism—they could not tell which it was—was inconsistent with the reputation of the institution and, therefore, must be simply an indication of the really great certainty the staff member had felt. Such interpretations by patients are not entirely unwarranted.

Really persistent patients may query this very diffidence and they are then likely to find themselves engaged with the therapist in the pleasant task of implying to him how good he and the hospital must really be, while he disclaims it. This highly complex situation is, I regret to say, frequently "solved" by abandoning the topic with the misapprehension rather stronger than it

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had been at the beginning. Both sides will tend to avoid bringing the topic up again spontaneously.

Other standard misunderstandings are handled in analogous ways. A few illustrations include the quite general denial of the existence and importance of the unusual power situation in the psychiatric hospital, the avoidance of recognizing the complexity of a patient's being both psychotic and competent at the same time, the shared misunderstanding that everything done at the hospital is for the benefit of the patient (when taken literally by some schizophrenic patients, this implies quite rationally that any neutral activity of hospital personnel is a sign of active hostility or, at best, culpable neglect of duty).

It is more important to my purpose, however, to emphasize that the misunderstanding about the exceptional hospital which may become a significant part of the patient's transference resistances in treatment will be unavoidably influenced for better or for worse by the customary attitudes maintained by the body of personnel toward the hospital itself. It is no secret that many hospitals, especially in these times of shortages of personnel, find it useful to concur at least passively in the view that their own institution is particularly exceptional, that it has some unusual mission, is more skillful, or that in some way both patients and personnel are fortunate to be associated with it.

Such views are not stated with such clarity that they can be seen to be true or false; they always involve an amalgam of both, mixed with a tendency to be modest or perhaps even deprecating, devices which, of course, reenforce the original charismatic impression. That such traditions may be useful in exploiting both personnel and patients is only occasionally recognized in the institution itself, but they may be and often serve this function. For our present purposes, their impact upon patients by integrating with the patients' wish to be in the hands of the best hospital in some sense at least, is important; they represent the staff's contribution to the misunderstanding we have described.

These attitudes are, however, to some extent alterable on a collective basis, in part by in-service training, by group discussions, by heightened awareness of the importance of attitudes and even by systematic self-study by the institution. In the illustration above, a general awareness of the hospital staff of its place as one hospital in the medical community, a sane refusal to idealize their hospital, would make a setting which was not conducive to such a misunderstanding. We have already suspected that these were important components of the therapeutic effectiveness of

the milieu, but it has been my additional purpose to try to sketch one theoretical bridge which would explain the therapeutic effect by linking it in a significant way with what is known of psychopathology. This sketch is only a very rudimentary one, but I have the temerity to offer it primarily because discussion of the therapeutic effect of the milieu has generally been restricted to a phenomenological level. It is my hope that we can proceed expeditiously to a more analytic and theoretical level.

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THE MEANING OF "THERAPEUTIC MILIEU"

Fritz Redl, Ph.D.

If we say "therapeutic"—just what do we mean? Danger signals on the Road to Concept Formation.

Speculations on the use of a concept are anything but popular in a new, experimentation-rich and expanding field. The people who are the first ones to try their hand at it and to unfold ideas warn us, not without justification, that a premature over-concern with narrowly defined concepts is liable to lead to precocious orthodoxy or to territorial squabbles or is simply going to hold up the conquest of the wide open spaces.

On the whole, I would agree to such a viewpoint, only I think we have worked, talked and written about this concept of "milieu" and raised the question of its "therapeutic or counter-therapeutic effect" long enough by now, so that a modest allotment of time to take stock of just what we are saying when we use these terms may not be called premature any longer.

Obviously, a few remarks on a panel discussion can't even dare to tackle the job of coming to grips with the meaning the word "milieu" has assumed in literature. The rich variety of situations it can remind us of was most colorfully and fascinatingly sketched for us in the meetings of this conference so far. I notice, however, that one of the two words which are so often used in conjunction now, namely, the adjective "therapeutic," has a peculiar tendency to swich content the moment it is attached to the milieu concept, and it does so with such rapidity that even the clinically self-conscious among us are often hardly aware of what is going on. Many times have I noticed that the term "therapeutic" loses the sharp connotation is has assumed in other contexts even by the same speaker, and allows a whole series of "submeanings" to creep in under disguise.

Obeying the demand for limitation of this short discussion, I shall try to list seven shadings of meaning which the adjective "therapeutic" often assumes when attached to "milieu," the noun. The examples I shall use are naturally taken out of my experience of working with severely disturbed children, in school and camp

settings, in a residential treatment home and, more recently, in a closed psychiatric hospital ward. While such short illustrations are, of course, wildly torn out of their rather complex context and therefore could readily be misread as evidence rather than as illustrative strokes of the brush, such risk must be taken, since I don't want to use up my time adding to the excellent description of milieu settings and designs already presented at this conference and thus lose sight of the conceptual problem to which I want to confine myself.

Level I:

"therapeutic"—meaning: *free from counter-therapeutic agents.*

Not only is the adjective therapeutic often used in such a wide way as to cover anything that is "good for a patient," it is also made to serve as a coverall for all demands to exclude damaging influences. Thus one will frequently find the idea expressed that certain injurious practices or influences on patients must certainly be absent, if a given milieu wants to make a claim of being "therapeutic" at all.

Example: Any therapeutic milieu in which children are supposed to be treated would certainly pride itself on an absence of stupid punishment, of cruel or thoughtless handling by disinterested or poorly trained employees, and would have to guarantee protection against exposure to too many "traumatic experiences"—coming either from staff or from the other children. In fact, often enough we find this negative request upon a milieu sufficient to separate one setting proudly as a "residential treatment home" from another, which is then relegated to the lowly connotation of "just a children's institution" . . .

In short—used on this level, the term "therapeutic" usually confines itself to the request of the people designing a milieu, not to do to their patients what they wouldn't do to people—any people—and to feed their patients well, without putting poison in their soup.

The question, of course, of just what is or is not good for people and patients, and how we know whether the specific impact of living arrangements, ward atmosphere or patient handling by staff, and so forth, is "therapeutic" or not in a given case, is a story in its own right and would go far beyond the scope of this discussion. May I be allowed to add at least the demand that we

become more specific about this and stop confusing our own recreational taste buds, philosophical convictions, habits of social interaction that make us feel good, with an objective assessment as to what is or is not of use in the treatment of a given patient at a given time . . .

Level II:

"therapeutic"—meaning: *basic need coverage.*

Patients in a hospital or any other form of institutional setting are a "captive" audience. They come to it, not only with the special pathological condition on which the institution's therapy hopes to focus, and for the sake of which they were sent to begin with. They bring with them all the other "basic human needs" of a given person, in a given developmental phase, with a given cultural background, and so forth, irrespective of whether such needs are always closely related to the problem for which the patient was sent, or whether they may have anything directly to do with it. Once we declare a need as basic, though, it must be well taken care of, or else some serious damage is done to the patient, no matter how well the specific therapy for which he was sent might look for the time being.

It is this fact that speakers often have in mind when they raise the question of the "therapeutic" value of special features of the institutional setting or of the ward program. In short, when we use this term on this level, we refer to the fact that it is not only important to put no poison in the patient's soup, but to see that their psychological nourishment also contains all the vitamins a healthy individual of a given age needs, not only the medication administered for a specific subgoal. Just *what,* in a hospital setting, for instance, should be considered as "basic need" is, of course, dependent on nature of pathology, age, previous life habits, developmental phase, and many other factors relating to the specific patient in question.

By the way, the *form* in which such "basic needs" must be taken care of is as important as the content, and varies strongly especially in terms of developmental phase, pathology and social background. What would be called good basic need coverage in terms of occupational therapy programs for a group of adult neurotics may have little in common with the activity program that may have to be developed for a group of hyperaggressive 12-year-olds of the borderline variety, and both programs may be unrecognizable as such by anybody who is used to catering to the

art needs and activity tastes of a normal population in a given neighborhood. It seems to me that this issue, especially, is frequently neglected in the planning of milieu designs. The expectation, in all this, is not that "basic need coverage" will in itself bring about the desired therapeutic change. It is, rather, that without its guaranteed provision the intended therapy would be counteracted, or damage in other areas of the patient's life would be produced while we are blindly busy treating the one for which he was admitted.

Example: (a) Even with 6 hours of intensive individual therapy guaranteed each child per week, one would not consider a milieu therapeutic, in which those children expected to sit on benches, waiting for their therapy hours, living in large groups with staff not trained to discover damaging influences of one patient on another, bereaved of the basic ingredients of activities, and thrown into group atmosphere heavy with hatred, fear, boredom, lethargy, or social strain.

(b) Looking at the activity program of our six boys with "borderline, acting-out type of behavior disorders" during the first few months after their admission, one would hardly have recognized much similarity between it and what customarily is considered a good "youth program" in the open community or on the school playground. Yet, it was most important to administer to these children the basic recreational vitamins which they needed in a form which, in spite of their illness, could make them "go down and stay down" . . . Thus, for instance, for a long time, organized athletic team competition had to be carefully excluded, since it would only have produced a new chain of disruptive hostility, and the essential experience of "participation in group life" had to be smuggled in through all sorts of deviously planned games, with special care to the right dosage of all ingredients all the way through . . .

Level III:

"therapeutic"—in terms of *"developmental phase appropriateness."*

This item, of course, is of special urgency in therapeutic work with children. Since most of this conference has been geared to

the adult mental patient, I will mention this one only in passing, even though in my own work it is of most focal importance. I don't feel too apologetic though, for bringing it up at all, for I do think it also has some implications for work with adults. What I am referring to here is the fact that not only must "basic needs" of the organism be guaranteed, and administered in the *form* which the patient's specific pathological condition requests, but that the specific nature of the *developmental phase* through which the patient moves during the time of his hospitalization brings before us special demands in making our milieu "therapeutic" enough.

Example: The style of adult-child relationship that is normally perceived as conveying the impression of cared-for-ness and warmth, is quite different for the 5-year-old, than for an adolescent of, say, 15 years. Thus, squeezed into a group of ten adolescents, three 5-year-olds may find themselves entirely out of focus in this important aspect. Their play therapy hours may be as frequent and well planned as those of the older groups. They still would find their milieu very strange and puzzling, indeed. To limit myself to the one issue picked out of a hundred equally important ones, here: the very adult behavior which a 5-year-old would consider most reassuring would produce spasms of hostile rebellion from the adolescent who could never tolerate such a gush of infantilizing motherly care, and the more matter of fact and "pals-y" style of the young adult with his youth group client, well suited for the older group, would badly scare the little ones, and they would be traumatized by the panic produced in them by watching the loose give-and-take between the adult and the adolescent group.

By the way, other differences, such as socio-economic and other subcultural issues, will complicate the picture further. A place that feels right for a 8-year-old from the highly educated, book reading, child-centered, protected neighborhood, may feel very strange, frightening, or quite "empty" for an 8-year-old who comes to us fresh from "open door" neighborhood survival and from play life with the "toughies" in the making.

Just what "developmental-phase appropriateness" means in different socio-economic, subcultural, racial, national strata, is in itself an issue in great need of more organized exploration.

Level IV:

"therapeutic"—in terms of *"clinical elasticity."*

Not only what facilities or program arrangements a potential milieu contains, but also how adaptable it is to the whims of clinical movement and therapeutic exigencies, makes one setting more "therapeutic" than another. I mean by "clinical elasticity" *the ability of any given milieu aspect or ingredient to yield to specific therapeutic demands, without having the overall structure get entirely lost in the shuffle.* I prefer the term "elasticity" to the more frequently used word "flexibility," for I think it somehow pays more respect to the fact that the "original structure must not get lost in the shuffle."

In so many discussions I have seen people swept away by "flexibility demands" to the point where it wasn't very clear any more just what there was to be flexible about, anyway. However, such terminological preference may be based on my chance experiences only, and may not be of real importance, as long as in our demands for either flexibility or elasticity we remain constantly aware that they are not values in their own right, and that it takes some clear-cut issue or structure, or else there is nothing left on which to use these adjectives to begin with. More specifically, the following demands by clinicians would seem to me to fall into this category:

(a) Ability of all milieu features to allow a wide leeway for "exceptions" to be made, for the partial toleration of downright "regression" even at high price in other milieu features, whenever this is indicated.

(b) Ability of milieu features to absorb the surplus of pathological behavior that a given treatment technic may require or that a given treatment policy may demand, and to provide *safe handling* of such surplus pathological behavior by the respective milieu area, out of its own domain.

Examples: The "teachers" of the children on our closed ward, during the earlier phases of their stay with us, have to be able to hold back their ambition to exploit a learning potential they may have discovered, if overall clinical policy with a given child would demand such restraint. These same teachers also must know what to expect and it means when, on certain days a child comes into their classroom straight from an exciting therapy session and hits them with "transference-spillover" far beyond what they have learned to con-

sider customary. They also must be able to "deal hygienically, but also clearly" with some of this surplus of wild behavior produced in their classroom, but coming from a different area of the therapeutic space . . .

In the same vein, the *therapist,* even while going through a phase during which an unleashing of the child's aggression is his basic main line, must retain enough sense of proportion to slow down the rate at which he works at this job, so as not to destroy other ego supportive life experiences for the child in school or on the ward, by unleashing more action-geared destruction than the rest of the outfit can cope with at the time, and more than is compatible with the ward's concept of "group psychological hygiene."

Level V:

"therapeutic"—in terms of *fringe area treatment goals.*

Over and beyond the outspoken "auxiliary" aspects of a milieu design, many speakers and writers also ascribe to certain parts of the milieu a much more direct impact on "treatment" in a much more focused use of the term. That makes it somewhere in between "real therapy" on the one end of the line, and "important, but not really therapy-focused basic need coverage" on the other end. Thus, we frequently find the idea expressed that, while the main part of the more *basic* pathological condition of the patient needs to be tackled by the psychiatrist in his own individual or group therapy session with the patient, many other things, which are also "wrong" with this same patient should be corrected somewhere else, some other time, by some other people in the institution. In short, those other areas of the patient's problem are also viewed as part of his "sickness," and what these "auxility" people are expected to do is also a "repair job" in its own right. Only, it shouldn't be confused with the therapy done on the major clinical task.

Thus, the recreational and social-living part of the design of a milieu is often emphasized far beyond its function just for "basic need coverage," and elevated to a regular job of therapy. Or, it may be a well established treatment task to open up for a patient expressional channels such as art and music, and thus afford him access to an enriched life, just as soon as the psychiatrist is through unlocking the major door. . . . On this Level V of the "therapeutic aspects" of a milieu, we expect the psychiatrist to be

busy with a frontal attack on the most "deeply rooted" phases of the patient's illness, but we also find him quite frankly relegating these *other, and also therapeutic jobs* to other people on the team, other phases of residential life, other props and ingredients than those of the individual or discussion-group-therapy room. In short, when we examine a milieu as to its "therapeutic" property on this level of the use of the term, we mainly raise the question: Who else treats other parts of the patient's disease, and how far does the setting and overall design allow such work?

Example: Even when a therapist works hard at removing the unconsicous hurdles in a child's ability to read during his work with him in the play therapy hours, there are cases where more is needed. For some of our children it is important that somebody else, not identical with the child's therapist, be loaded with the task of remedial work on the youngster's reading problems. Over and beyond this, the production of an atmosphere indulgent to curiosity during the moments of the child's ward life may be of equal importance.

Or: A therapist may work hard at establishing the proper therapeutic rapport with his patient. For the time being, everything else has to be postponed in the light of the relevance of this job. On the other hand, we also know that Johnny suffers from a specific difficulty of ever appraising realistically how the other children react to what he does to them. In many cases, we need not wait until other phases of the child's therapy are nearly finished, to tackle this one. We can assign to the group worker the task of making a repair job of this youngster's "social blindness" a judicious but clear-cut effort in its own right.

Level VI:

"therapeutic"—in terms of *"The Milieu and I."*

Some lecturers and authors go beyond this concept of "supportive milieu therapy" as a fringe job for a relevant but not focal repair job to be done, as outlined under Level V. They ascertain that there are ingredients in a good therapeutic milieu which could accomplish a specific therapeutic task *directly*—either all by itself, or at least as an indispensable and equal partner in the major therapeutic job. The claims here range all the way through from repair jobs a good therapeutic milieu alone is able

to perform, to tasks for the performance of which the "milieu" as such is claimed to be superior to other more specialized and long-winded efforts, to the more modest demands for a partnership arrangement of some sort.

In all those cases, however, whatever dynamic forces emanate from the milieu aspects mentioned are forces in their own right, well fit to be brought to bear on a "treatment" job of major proportions and no more fooling about that—enough of the pussyfooting about "auxiliary values." We are not discussing the issue of right or wrong here, we are merely outlining the conceptual intent of a term. Though the verbiage used on the various levels mentioned before may be misleading, it is quite clear that this one could not be reduced to other five—it is a claim in its own right.

Example: Among the kinds of therapeutic help the children on our ward are badly in need of, is that of at least partial "superego repair." No matter what else ails them, something went wrong in the building and development of the type of value sensitivity or conscience children normally develop over the years. It is our impression that the more serious cases of superego damage can never be tackled by any kind of individual therapy alone, unless it is also accompanied by an all-out total life-space engulfing approach, well attuned to this job, with plenty of "clinical resilience" built in so as to guarantee a long-range focus on this major task.

Over and beyond what the individual therapist can do for such a child, it is our impression that one needs to provide a living space for the child in which he can *afford* to let go of distorted defenses and *allow* himself the necessary emotional ties which need to precede any primary value identification whatsoever. It seems also clear to us that all experiences of daily life have to be geared so as to avoid guilt-flooding panic, more paranoid misinterpretation of daily events than is compatible with an already heightened sibling rivalry, and that the roles of the adult figures around whom value sensitivities are supposed to accrue or be re-arranged, are protected from overlapping and from confusion which would make a mess of the clinical scene. Over and beyond that, for some children there is a need for something like the tie to a "depersonalized group code" which alone can open the path to value incorporation, all pre-

vious personalized channels of that sort being hopelessly contaminated for a long time to come.

In those cases, the "milieu" and what it begins to mean to the individual patient, becomes as strong a force in therapy as the "therapist's relation with the patient" is customarily described to be.

Level VII:

"therapeutic"—in terms of *"re-education for life."*

Even with all the previous levels of criteria for a therapeutic milieu checked and found proper, we may want to give the term yet another twist. On this level, we are not satisfied with the appropriateness of the milieu for the present repair job to be done. We want it also to contain enough of the proper ingredients which the later, normal, open life situation will contain and to which the patient will have to adjust after his release from us.

In short, we measure our milieu in terms of its resemblance to "life for real." We find a milieu nontherapeutic which contains no challenge for the patient to grow away from his disease and from the place in which it is meant to be cured. We consider a milieu therapeutic if it openly aspires to "outlive itself" and builds into the hospital as many of the life experiences as the patient will have to meet later, hopeful that their taste may be preserved rather than obliterated by the smell of psychological detergents so importantly sourrounding him right now.

It seems to me that this level of the use of the term "therapeutic" constitutes one of the most important problems in our usual debates. In fact, aren't we somehow drifting into a paradox? Isn't this demand to contain the "normal situation and experiences of life" really contradictory to the very idea of using a "special" milieu at all? For, how is one and the same milieu supposed to manage a maximum of leeway for regression and at the same time to offer the patient all the challenges of life in the open community with its rich rewards, but even more frightening punishments? How are we to provide for Johnny a classroom experience with only two other children present, a highly trained teacher who also has time and skill to sit out five tantrums in a school hour without becoming punitive or disillusioned, and at the same time provide for him the fascinating experience of watching more well adjusted children happily at work, cheerfully succeeding and smilingly accepting criticism if they fail, and at the same time taking all the aggression and disturbance he is

liable to put out? It seems to me that on this level the term "therapeutic" needs the most careful examination of all, for the custom of making demands out of both sides of our salvation-greedy mouths, requesting opposites which cannot be delivered in one package at one time and place, is all too widespread already.

However, short of such abuse of our desire to have our clinical cake and eat it with the normal life sauce too, the demand that a really therapeutic milieu contain enough ingredients to be supportive of growth and change beyond the present level of pathology-geared design, is of great importance, indeed. In fact, if we look at most of what comes close to models of therapeutic-milieu-emphasizing hospitals or communities, we may easily find that they range all the way from those demanding protection and dependence as their prime requisite, to the most insistent emphasis on the pride in having the patients leading a nearly normal communal existence, "even though they are all schizophrenics" . . .

Fortunately, things are that bad only if we leave the facts of daily life behind us too far. For, in reality, the issues are rarely that extreme. Rather, for any given group of patients or any special therapeutic task, we can well define just which aspects of a given milieu need to be designed for the immediate therapeutic job, which of them need to be guaranteed and maintained out of the awareness that ingredients of later life need to be inserted along the path. A community that would not create special milieu conditions for the therapy of the very sick, could hardly be called a therapeutic community any more, and a hospital that found no place at all to retain and build in essential ingredients of later open life where patients need and can use such elements, would lose its claim to "treatment." Sometimes the answer is that there is a limit to what one and the same milieu design can possibly encompass, and that the patients will be better off to move from the one to the other, provided consistently in their own right but at different locations, or even under different staffs.

Example: In our children's psychiatric ward at the Clinical Center it was obvious that we had to anticipate a problem in this direction from the start. While the "closed" section constituted an advantage in the beginning of therapy, especially since it was always coupled with a rich and appropriate program design and ample staffing, it was to be expected that the children would outgrow the advantages of our "milieu" as soon as their ego functions were repaired up to a certain point. Thus

while protection in terms of the first six levels we were talking about constituted a great asset from the start, it would become important, at a certain point in their clinical advances, to substitute for it a design with much more opportunity for moving away from the highly supervised dependence we first had to lure them into. We would then have to insert the opportunity for a much more community and real life-related style of existence for them.

With this in mind, the construction of an "open cottage" in a sort of "halfway house style" was begun, and is now available as a next step in their therapy. It will be important for these children to move into a "milieu" that exposes them to a much higher degree of independent choice making in conflict situations—though exploitation of those experiences by trained staff interview and continuation of their individual therapy still needs to be provided.

Besides the seven meanings the adjective "therapeutic" seems to assume in the course of its association with the concept of "milieu," a few additional cautions need to be added to the use of the term:

Additional Cautions:

(1) When we call any milieu "therapeutic," we may still refer to either of two issues:

(a) We may think of it in terms of the effect a given milieu ingredient actually had on the treatment of a patient. In that connection it is obviously up to us to prove that a certain milieu design did or did not have "curative" effect on the patient in question.

(b) We may also make such a statement without any attempt to preclude its actual effect on a given patient. From simply knowing what ingredients we mixed into the drug to be administered, we can reasonably judge the indications as well as the contra indications for its usefulness for a given group of patients at a given time in their clincial movement. In this respect we are not really talking about the proven therapeutic effect of a milieu ingredient, but about its *anticipated effect.*

Thus it becomes obvious that, rather than talking about "the milieu that is therapeutic or not," it would become more advan-

tageous to examine specific properties of a given milieu design in terms of their indications or contraindications on the basis of a strict examination of the specific patient, disease and treatment design at hand. We might, in this way, dissolve the all too vague concept of "therapeutic milieu" into something approximating the development of a *"pharmacopeia of milieu ingredients."*

(2) In assessing the clinical value of certain milieu designs or of parts thereof, it won't do for the clinician to rely on the *extracurricular taste buds of his civilian life.* All too many statements about desirability or undesirability of certain milieu styles are still dependent on the individual therapists' personal predilections in favor or against permissivness as such, on their chance conglomeration of political and philosophical beliefs (democratic versus more authoritarian styles) or on the contemporary fashions of trust in comfort versus tension—or the other way around, as therapeutic philosophy tastes per se. No statement about the adequacy of any milieu design should ever be made without adding specifically the given setting, overall treatment goal and scope, age, social background and developmental phase of the patient, and especially the specific nature of the disease entity to be tackled in a given project.

(3) Belief in the importance of reckoning with the impact of the "milieu" in which we perform our clinical operations is nothing new. Even the most individualistic model of the classical psychoanalytic therapy with classically neurotic patients had a wide range of "milieu consideration" built into it, even though in the specific writeup of such cases those issues were often "swept under the couch" because they were so much taken for granted. Rather than creating an antithesis between individual interview therapy "versus" the impact of a therapeutic milieu, we should strain our efforts in the direction of a concrete assessment of indications as well as contraindications for the extent of the contribution of either of those modes of therapeutic endeavor in their proper clinical place.

(4) In our present studies at the Child Research Branch at the Clinical Center we think we can easily isolate at least 13 rather discrete "milieu ingredients" the assessment of which may pay off in the long run. Their description, however, would constitute a task beyond the realm of these panel-discussion remarks.

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THE ACUTE SCHIZOPHRENIC REACTION IN A THERAPEUTIC MILIEU

LT. COL. KENNETH L. ARTISS, MC

This provides me with an opportunity to briefly acquaint you with a research project under way here at Walter Reed and, at the same time, to discuss one of its problems. We are interested in the acute schizophrenic reaction in the youthful soldier. Closely integrated studies are taking place at Ft. Dix, N. J.—a basic training center. Social work field studies are also being accomplished. These facets will be reported elsewhere.

Here we have set up a special treatment, modified closed ward. It is staffed by 1 physician, 1 nurse, and 12 to 14 neuropsychiatric technicians (corpsmen) for the 24-hour care of 8 to 10 patients. A comprehensive feedback type of reporting system has been established.

Patients are housed in a made-over standard neuropsychiatric locked ward. However, the resemblance stops here. One-half (10) the usual number of beds are present, leaving adequate free space with the consequent sense of roominess. The windows are colorfully and dramatically draped. Flowers growing in pots and other greenery are in abundance.

Both ends of the ward are made into social corners. At one end, a radio is surrounded by a grouping of comfortable easy chairs. At the other end, a selection of easy chairs, small chairs and a couple of game or writing tables are grouped about the record player and record storage cabinet. Nearby, one finds a wire-recorder for patient use. Gymnasium wrestling mats are stored nearby to be rolled out in the evening for the traditional scuffles and tests of strength.

Through a door leading off the ward proper, one enters a spacious day-room, in this case more than adequately supplied with colorful furniture, a television set in one corner, a piano in another. Off the other end of the ward is the game and conference room. A ping-pong table is set up. When conferences or group therapy sessions are in order, a couple of sheets are thrown over this table, and with morning coffee it becomes a formally informal

discussion center. Staff offices, shower room, latrine and baggage room all enter on a hallway integral with the ward.

The patients are up at 6:30 a.m., shave themselves, wash, breakfast and complete their daily details (chores) in time for formal ward rounds at 8:30. The details comprise the ward housekeeping. They are managed entirely by a patient-government group. This organization elects its own officers and meets at its own will, particularly to plan its responsibilities, make recommendations to the staff, plan picnics, trips, etc., and in general, provide its own internal patient-group management.

Ward rounds are traditional, the staff accompanying the doctor, problems and plans for the day being made. The doctor asks each patient to decide on the timing of his individual psychotherapy sessions and this aspect of the day is also planned at this time.

Following rounds, the group gathers in the conference room around the table, with morning coffee and "smokes," for the group therapy session. The doctor conducts, the remainder of the staff "sitting in" as observers, to answer specific questions if needed and to gain further information concerning patient attitudes and problems.

Following this hour, the patients and technicians go to the gymnasium for an hour of almost any kind of gymnasium sport to be wished, followed by a shower and, shortly thereafter, the mid-day meal. Incidentally, all meals are taken in a large dining room with all other patients from the neuropsychiatric building.

After 15 to 20 minutes free time, the patient group goes to an occupational therapy section, well equipped and staffed for considerable individual attention. During this period, the technician staff meets with the doctor and nurse for training, to plan therapeutic maneuvers, to exchange ideas and information about their relationships with patients, and in general, to abet staff communication.

Next hour, the technicians are with the patient group again, this time at the swimming pool for games and exercise. This activity finishes at 2:30 p.m. and the afternoon relaxation period begins.

Certain patients leave the ward at this time on a grounds pass. These privileges, while ultimately approved by the doctor, are nevertheless managed by the patient-government group. Individual psychotherapy sessions are usually scheduled at this time; when more are necessary, the patient may be held back from

other activities. Another doctor-staff meeting takes place at the end of the day with the evening shift.

After the evening meal, movies and dances are available at regular intervals. During this period, the busy-scheduled day is behind and the staff concentrates upon the promotion of "bull-sessions" and opportunities to "talk things over" with the trained staff. With no formality whatsoever, many of the therapeutic relationships develop during this time.

It may be predicted that, within hours of his arrival, the new patient will begin setting up a system of relating with the staff. This system will have individual as well as general characteristics. Let us take a close look at one of the general characteristics—"the need for deception." Just as he finds it necessary to be or feel deceived by others, so does he find it necessary to provide the reciprocal, deception of others.

This schizophrenic faculty is, of course, familiar to all of you who have had opportunity to work closely with this type of patient, and may need little comment. I will confine this discussion to only those deceptions of which the patient is completely aware. A simple falsification concerning some significant history will serve as an example. As the patient does this, he will at the same time communicate to the staff that it is a deception. He may use a number of technics, verbal and nonverbal. For example, he may giggle or grin as he tells it.

In any event, he will signal what he is doing. As you well know, this has a profound effect upon the staff—and its management poses an interesting problem in technic. First of all, what is it, as a phenomenon? We find it to be general, not confined to persons or status, completely non-selective and even applied to other patients with equal force. For this and other reasons, we allow ourselves to consider it in terms of "character resistance" as defined by Reich[1] (before 1930), Alexander,[2] and numerous others since. Classical theory then suggests that this problem must be solved before effective therapy can proceed further. Our findings tend to support this hypothesis.

The Technical Problem

It soon becomes clear then that the staff finds itself faced with an openly negative transference reaction. This may be described in any convenient framework; just as adequately can it be discussed in terms of passive negativism, parataxic distortion, or hostility. In our patients, its purpose seems designed to "keep a secret" from the staff. This secret, when it becomes available, is

typically a standard psychological conflict and may be dealt with accordingly, sometimes with surprising speed. At the time, however, that the "secret" is being discussed openly—is no longer a secret—the patient behaves in a completely changed manner, in the sense that he is an active, interested participant in a therapeutic situation.

Previous to this time, however, his behavior may be likened somewhat romantically to a walled city under siege from invading enemies—the invading enemies being the therapeutic staff. Perhaps it is a somewhat romantic analogy, but it does serve the purpose of illustrating that under such circumstances, anything goes. The rules of conduct, the ethics of social intercourse, the codes of truthfulness, honesty, etc., are discarded and the enemy is fought with whatever are the tools at hand, in whatever manner may insure keeping him outside of the wall.

One Type of Solution

The therapist spends as much time with his staff as he does with patients. He assists the staff, then, in resisting the subtle challenge which is implicit in the patient's deceptiveness. By this approach, as a group we hope to show the patient that, whatever may have been his previous experience, here he will not find it easy to engage in this type of transaction. Here he will not be able to dismiss us from his world by his attempts to make us angry, and will not be dismissed himself in turn.

The unspoken message would say, in part, that we do not recognize him as a person so worthless, and so lacking in social potential, as he feels himself to be; but infer instead that he is worthy of that mutual respect which goes with realistic transactions.

It becomes vitally important, then, that he should not be deceived by staff action. Here is probably the most difficult problem. For one thing, even well trained staff members are so steeped in the traditions of convention that they find themselves again and again falling into the traps that patients so carefully set.

An example may be of interest. A patient wrote a secret letter to the Commanding General, requesting plastic surgery on his face. Although free in the afternoon to mail or deliver it himself, he chose to invite a pact with a technician to deliver it for him. The technician then, thinking it over and realizing that he had been trapped, turned in the letter to the doctor. Much discussion ensued, the patient accusing the technician of betraying him. The technician then replied, "You were free to mail that letter yourself. You gave it to me. You wanted that letter to go to the

doctor, but you couldn't take it yourself." The patient stopped arguing immediately and left the group. Later the same day, another patient sought out the technician and thanked him, saying, "He needed someone to talk to him straight like that." Both of these patients showed significant improvement following this episode.

Episodes of like nature—sometimes a playful scuffle, sometimes a joke that is in itself an interpretation—have been found to signal the beginning phase of improvement.

We find that such staff interpretations must be used sparingly and avoided until we are quite sure of our ground, roughly 60 days. A patient, for example, was habitually hesitating at doors, holding up the others, when a technician said, "Looks as if you don't want to leave here." The patient immediately went into action, picked up a chair and flung it through a window. We reason that this interpretation is both early and incomplete, sensed by the patient as a "psychiatric dirty crack."

However, patients are very understanding people, and despite our mistakes, we have found that a break-through into realistic transactions usually takes place between the third and fourth month, to be followed by rapid improvement in the succeeding 6 weeks.

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SUMMARY AND DISCUSSION OF PAPERS IN PANEL ON THE DEVELOPMENT OF A THERAPEUTIC MILIEU IN THE MENTAL HOSPITAL

Question: I should like to ask Dr. Stanton if I understood him correctly that he gave his patients a booklet telling them their rights under the commitment law. I am not satisfied with his comment that of course the results were good. I wonder if he could explore that a little more?

Dr. Stanton: I will hedge slightly by saying that the results were good as nearly as I could tell. The booklet was cribbed very largely from Dr. Sivadon's and from several others which we combined in a belief that elementary information which was unlikely to be asked for was vitally important to our patients. We knew roughly the type of question they would raise and we drew heavily upon the experience of these various other hospitals in setting up this pamphlet. We did not exclude anything that we knew they would be interested in. All I can say is it seemed to allay a great many anxieties. It made things quite clear and did not increase the number of people trying to get out. It perhaps decreased it. We did not and were not able to do a systematic survey of it. Of course, I can't separate the variables of this particular content from the many other things that were in it. At least, let us put it this way: No disaster occurred and there was certainly a sense of impending disaster that was connected with it among various people that I spoke to. I don't know if that explains it.

Dr. Sivadon (Dr. Hargreaves translating): Dr. Sivadon says that he has used this book of welcome for the last 8 years because he felt it was essential to give the patient, as soon as possible, details which first of all enabled him to understand his immediate environment and, second, which would deal with his immediate preoccupations. In this experience the major preoccupation of many of the patients is with why they are in the hospital, how long they are likely to stay there and how they leave. Therefore, he thought it was absolutely necessary to explain the various ways in which patients can be sent to a hospital and the reasons which may lead to it—either because they caused some social

disturbance or trouble or their parents or their family doctor had been worried about their health, and thought it necessary for them to go to the hospital even though they did not think it necessary, or alternatively, they themselves had chosen to accept the idea of going into the hospital because they agreed that they needed treatment.

Mr. Deutsch: I have questions of two of the panel, if I may. The first to Dr. Sivadon. I'm curious to know how, in view of the continuity of the hospital, and of your stimulation and encouragement of patient complaints and the consequent encouragement of community corrections of these complaints, you avoid building up a near perfect institution where it becomes more and more difficult to find sources of new complaints?

Dr. Sivadon (Dr. Hargreaves translating): We were also afraid at first that this would happen but experience showed that we had no reason to be afraid. There is, in fact, always something wrong in a hospital. First of all, it was because there was no recreation. Then the food was abominable. And then, finally, somebody had found a small pebble in the peas. I believe that aggression is such a fundamental propensity that the occasion that provokes it is quite secondary.

Mr. Deutsch: My second question is to Dr. Stanton. I was interested in his reference to the great number of discharges or recoveries a hundred years ago. I'm interested because a point has been made by several students that there was actually a great increase in recoveries a hundred years ago as a result of the development of "moral treatment." I think a study of the situation will show that near 100 percent recoveries were recorded in hospitals, State hospitals, where moral treatment was not used, as well as in the voluntary hospitals using supposedly moral treatment. I think the bulk of the evidence that I saw in my historical study indicates that the relative curability, as I called it, was largely a statistical phenomenon and that what actually happened was such things as that patients who were discharged 9 and even 12 times in the course of a year were on each occasion discharged recovered. Have you any evidence that there was actually a greater recovery rate and that this was stopped by the rise of the science of neurology?

Dr. Stanton: I have a certain diffidence in answering Mr. Deutsch since his work was part of what interested me in this. The authority for my statement came from a report I have read which is not yet published, and therefore, I am unfortunately not able to give the details of it. I have assumed that this was in

part a statistical matter. I would have supposed that the type of treatment in the new State hospitals—and many of them were fairly new at that time—would be very heavily influenced by the "success" of moral treatment elsewhere. The unpublished report correlates the Worcester State Hospital's falling of discharge rates with the rebuilding of the hospital into a very much larger hospital on the American notion that anything that is good ought to be twice as big. This was coincidental with medical attention moving sharply away from the humanistic areas into physiology and bacteriology. I'm glad you raised the point because I think I did make the statement too definitely but that is the sort of evidence upon which it is based.

Dr. Hamburg: I'd like to make a comment in response to Mr. Deutsch's first question because it touches on what I think may be an important issue in this kind of work. Reporting some of the impressions we have about the dangers of reaching a near-perfect state in the hospital, I would agree completely with Dr. Sivadon that this is not a very great danger. However, it does seem to me that with the type of reasonably sensitive detecting procedures that one can build into a hospital which I tried briefly to sketch, it does become more or less second nature after a while if the administration continues to take them seriously. I think there probably is considerably earlier detection of difficult matters which might have developed into much more serious proportions before these mechanisms existed. But there are plenty of relapses. New people come on the staff. New kinds of patients come in. New configurations develop. There are always relapses.

The issue of change in itself, I think, becomes important here. We were impressed that there was a period when both staff and patients, mere oldtimers, would say, when some complaint was made by newer patients, "Well, yes, but if you knew about how bad it was before you wouldn't complain." There is a certain relative contentment in comparison with what existed before. This didn't last very long and it seemed to us that this was not just related to relapses and perhaps not just related to some inner well-spring of aggression as Dr. Sivadon suggests but to a wish within the patient group and the staff group to see some kind of changes taking place which could reasonably be interpreted as constructive changes.

It's a question in my mind whether you could ever reach a plateau in this kind of program and continue to have it effective. I don't say now that any kind of willy-nilly change is a desirable

thing. I think if you make crazy changes you're liable to get crazy results, but within a very wide range I would say that probably conveying some sense of consistent attempts at constructive change within the limits defined by the culture may be an important factor in any therapeutic results that are noted with these programs.

Colonel Glass, Office of The Surgeon General, United States Army: I wonder if you'd get appropriate members of the panel to comment on this phenomenon that those of us older in psychiatry are so familiar with, that various new treatments have come along—insulin, lobotomy, drugs, electric shock, and so forth —and it's been said often of us that whenever we get enthusiastic about something or get our people enthusiastic that we get these good results that have been talked about. Now I wonder if any of the panel feel that milieu therapy is another way in which enthusiasm is communicated by the treatment personnel, and this is the crucial factor in the treatment rather than any theoretical basis that has been proposed?

Dr. Hamburg: I'll start it off by saying that what Dr. Glass has essentially done is to suggest one theoretical basis for milieu therapy. I wouldn't put it in competition with theories in general but as one theory to compete with others. Well, I think some of what I said may have implied that enthusiasm is at least effective and needs to be taken into account. It seems to me that we shouldn't run this down. If indeed a systematic study over a long period of time would show that this is a major factor in the results obtained with a wide gamut of therapies, then let's exploit it. Let's learn what the principles are governing this kind of effect and put it to use. If it should be so, maybe milieu therapy of one sort or another would turn out to be essentially a systematic exploitation of the phenomenon you're describing. I actually believe it's something more than that but I'll stop my comment with a kind of classical remark which was made in relation to the tranquilizers but could fit this kind of treatment or any kind of treatment including individual psychotherapy. When the thing first burst about Reserpine and Thorazine and so on, one distinguished psychiatrist urged all of his younger colleagues to use these drugs while they still worked.

Dr. Wilmer: Well, milieu therapy is really not new. It has a long history. I think the enthusiasm that many people have is a good thing. It has something to do with optimism, which is perhaps a commendable quality in dealing with disturbed people. I think it has more to do also with a sense of explicit

belief in the dignity of people, in the trust that you can have, whether they're psychotic patients or neurotic patients or whatnot.

I have a feeling that Dr. Redl answered your question rather well from my point of view when he said that we must come to grips in the definition of milieu in limiting traceable and discernible ingredients so that a pharmacopeia of the milieu can be put together for any particular patient population. I think that my own feeling about the therapeutic community and milieu is not that this is a panacea or that this is anything more than one type of device to help the psychiatrist. It gets back to the question that was pointed out earlier—namely, "What sort of therapeutic community for what sort of people?" so that we can compare these things. The enthusiasm, as I see it, is intrinsically a part of it and inherent in it.

Dr. Cohen: It seems to me that Colonel Glass's question is a good question and I think that no one would deny that if you do a thing enthusiastically the chances are it will be more effective or at least effective in a different way than if you go through the motions with a total lack of interest. Yet I think that Dr. Stanton, in a sense, answered your question during the course of his talk when he mentioned that when patients went from the Boston VA Hospital to the Bedford VA Hospital there was actually an improvement. We don't know that the Bedford VA, having been selected for this unusual privilege which he described, might not in some way have injected a little bit of enthusiasm into their approach to the patients. However, I think that, nevertheless, it is a common experience that when patients go from one hospital to another, perhaps from one in which they have been regarded as really quite intractable to treatment, somehow or other, a change is brought about which would indicate that enthusiasm aside, there is something in the specific milieu which may have an impact on a specific patient.

Dr. Rioch: I'd like to get into this discussion also and call attention to Elton Mayo's early work where, when the lighting was improved, production improved and went back and with 10-minute rest periods, production improved and went back. When the lighting was put back to the old form, production improved and went back. It seemed to be the effect of change.

However, there is another aspect to it. That is, there was a definite milieu factor in electric shock therapy when it came in—namely, that the staff were not to talk to the patient about his recovery. They were only to talk to him about his improvement

or about current events but not to raise difficult questions. That was part of the setting in which in many hospitals electric shock was given. Walter Freeman, writing about the handling of the post-lobotomy case, says very distinctly that it's up to the nurse to get the patient back to the community after lobotomy to make the lobotomy successful. That is, the milieu is again part of the therapy. The milieu is all-pervasive in a way and I think that the importance of the present work is not so much in the sense that this is a cure but more in the sense that we've got to learn something about people talking together in the way that makes reliable future sense rather than just getting by for the moment, which is what so much therapy has been based on in the past.

Dr. Caudill, Harvard University: This is perhaps more in the nature of a comment but I'd like to address it, I think, to Dr. Hamburg since he raised the point of change which initially made me think about this. I think that on the one hand you have the kind of situation described by Commander Wilmer where both the patients and the staff are turning over quite rapidly. I think you have another extreme type of situation, perhaps like Chestnut Lodge, but in any case some place where both staff and nursing level and patient level are there for quite a long time. You get a place like Yale that I described yesterday where you have the residents and patients turning over rather rapidly but where the senior staff and nurses were not turning over very rapidly. I think that this helped explain this parent role group response that I was talking about yesterday with the identification between the patients and residents as people who don't have really a commitment to the institution as such, whereas the nurses and senior staff did have more of a commitment to the institution.

What I'm really trying to get at here is somewhat from my own sort of anthropological notion of thinking about the therapeutic milieu with reference to the question: What kind of field of change makes up this situation? I suppose the more direct question that I have to you is that, having been engaged in this kind of study along with other people, what has been in my own mind recently is whether there might not be some job entity similar to what Chris Argyris described for industry but in this case in hospitals and with reference to a clinical anthropologist, clinical sociologist, someone whose job it was to keep track of the conditions of the whole hospital and feed this back in some way into the system?

Dr. Hamburg: I would certainly second that motion. In fact, I could be more concrete about it. We have in recent months been

trying to find just such a person to work in the psychiatric section at Michael Reese Hospital as a kind of social diagnostician, you might say. We have tried to do this in some of the ways I outlined in the paper and we have reason to believe that it would be much more effective if we had somebody who was really well trained in the social sciences, not necessarily to replace the kind of procedures I talked about but to augment them. I think it will be a very tough proposition, if and when we find somebody to do this, to determine really how this role should be shaped. It's very easy to say we should get someone and you can see his latent potentiality for the institution, but really how he should be integrated would be a difficult problem. It may be that others here have had experience with that and could say something about it—that is, the social scientist not as an investigator, as we've seen him before, so much as really a part of the treatment team.

Dr. Clausen: I just can't resist referring back to Dr. Goffman's paper of Monday because it seems to me that there is one important respect in which this matter of enthusiasm can be very necessary. That is that there are certain tendencies in what Dr. Goffman called total institutions for particular patterns to emerge and which tend to reaffirm themselves. Perhaps only where you have sustained enthusiasm, sustained analysis of aspects of such patternings which are clearly anti-therapeutic, can you hope to avoid the implications of the total institution.

Dr. Goffman: Oh no, if I could add just a point to that. It's going to be especially difficult, it seems to me, to maintain that enthusiasm because these total institutions function in some sense quite well to get certain classes of persons out of them as quickly as they can get out of there. They're not places for some of these people and it moves some of them out rapidly, so that in some ways when you look at the success of your milieu therapy attack you shouldn't aim necessarily to better the results of some of these old classical types of mental hospitals, but merely to equal them and to do it, maybe, in a nicer way. They are in many ways effective just as we've been implying milieu therapy is not going to be effective perhaps for some classes of patients who have found it a nice place. They've found a home, as we say, in the hospital. So it gets to be a more complicated kind of problem.

☆ U. S. GOVERNMENT PRINTING OFFICE: 1958—464179