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The Therapeutic Effect of Group Therapy Sessions upon the Ward Society on a Male Admission Ward of a Mental Hospital

David Joseph Reid

Loyola University Chicago

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THE THERAPEUTIC EFFECT OF GROUP THERAPY SESSIONS UPON THE WARD SOCIETY ON A MALE ADMISSION WARD OF A MENTAL HOSPITAL

by
David Joseph Reid

A Thesis Submitted to the Faculty of the Graduate School of Loyola University in Partial Fulfillment of the Requirements for the Degree of Master of Arts

February 1964
David Joseph Reid was born in Chicago, Illinois, August 26, 1914.

He was graduated from Culver Military Academy, Culver, Indiana, June, 1932, and from Loyola University, Chicago, June, 1940, with the degree of Bachelor of Philosophy.

From 1940 to 1945 the author took graduate courses in philosophy at Loyola University. He was ordained to the priesthood in the Episcopal Church in 1943. He served as vicar of St. Francis Church, Chicago and of Trinity Church, Skokie from 1943 to 1947. From 1947 to 1950 he was chaplain director of Bishop McLaren Foundation, Sycamore, Illinois and vicar of St. Paul's Church, DeKalb, Illinois. In 1951, he became rector of Trinity Church, Michigan City, Indiana where he remained as pastor until 1963.

In 1956, while serving as volunteer chaplain for Beatty Memorial Hospital, Westville, Indiana, he began his graduate studies in clinical psychology at Loyola University. He joined the staff of Beatty Memorial Hospital as part time psychologist in 1962. The following year, the author resigned his cure in Michigan City to become a staff psychologist at Chicago State Hospital.
ACKNOWLEDGMENTS

The writer wishes to express his thanks to Manuel J. Vargas, Ph.D., director of the psychology department of Beatty Memorial Hospital, for his inestimable help in planning this project, in frequent consultations during the time it was in progress, and for arranging the group therapy program which is an integral part of this project. He is indebted also to Mrs. Sally Haney, R.N., assistant director of nursing at Beatty Memorial Hospital, and to her staff for conducting the sociological studies, the results of which are a part of this study. Acknowledgment is also made of the willing service given by the nurses and aides of the admission ward of the hospital who helped to arrange for the group therapy sessions and rated the patients on the Hospital Adjustment Scale, an additional task added to their already heavy schedule. Appreciation is extended also to David P. Morton, M.D., superintendent of Beatty Memorial Hospital, without whose approval, cooperation, and desire for assisting in any research which may benefit patients this project would not have been possible. The writer is indebted especially to his adviser, the Reverend Vincent V. Herr, S.J., Chairman, Psychology Department, Loyola University, for his wise counsel and patience throughout the preparation of this thesis.

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CHAPTER I

INTRODUCTION

The use of group psychotherapy in state mental hospitals has been increasing in the last few years. With the development of drug therapy, fewer agitated patients are seen on the wards and an increased number of patients are able to participate in psychotherapy of one sort or another. Perhaps because of the short duration of a patient's residence on an admission ward, there appears to be little effort made to use group psychotherapy to assist in the patient's recovery while on the admission ward. This report is a result of a study made to try to determine what therapeutic effect, if any, group psychotherapy might have upon the ward society of an admission ward.

In 1958, the chief psychologist of the Dr. Norman M. Beatty Memorial Hospital which is the State mental hospital serving the northernmost counties of Indiana, began a program of group psychotherapy on the female admission ward. An article describing this project has since been published. In this article, Dr. Manuel J. Vargas (1960) described the ward and the techniques he used, concluding with an evaluation of the results. These results were based on the subjective reports of the employed personnel including the nurse, the charge aide, the ward physicians, and the ther-
apist himself. No study was made of changes which took place nor were reported results based on anything other than the observations of hospital staff members, all of whom were in some way involved in the whole procedure. To what extent may we rely upon the opinions of staff members assigned to the ward or of the therapist himself? The therapist expects his work to result in changes for the better or he would not begin the project in the first place. Other staff persons are hopeful and, unless there is a decided change for the worse, might be inclined to give a more favorable report on the results than is warranted by the conditions. This might be especially so if the report is made to the therapist himself who has been working with both patients and staff members on the ward.

In an attempt to obtain a more objective evaluation of the results of group psychotherapy, the project which is the subject of this report, was carried out on the male admission ward of Dr. Norman M. Beatty Memorial Hospital. The study was made from October 1, 1959 to June 30, 1960. Prior to this study, group psychotherapy had never been used on this ward.
CHAPTER II

REVIEW OF RELATED LITERATURE

The changes observed on a female admission ward of a state mental hospital were reported by Vargas (1960). The results reported were based exclusively on the subjective opinions of the therapist and other hospital staff members. According to this report, there was a marked change in the ward atmosphere as a result of adding group psychotherapy sessions to the regular program of activities and therapies. No control group was used nor was any attempt made to obtain any objective evidence as a measure of change. It was the opinion of the staff members that group psychotherapy tended to result in a more "therapeutic" atmosphere.

The present study was an attempt to determine by use of the MMPI and the HAS if such a change in the atmosphere of a ward could be objectively measured to substantiate the objective opinions of staff members. The same therapist, using the same methods of group psychotherapy, provided the therapy for the present study, but the male admission ward where there had been no group therapy before was used in lieu of the female ward.

The MMPI has been used in a number of studies to try to objectively measure changing psychopathology. Rashis and Shaskin (1946) employed this instrument to measure the change resulting
from group psychotherapy in twenty-two cases. West (1953) found
the MMPI useful for measuring changing psychopathology used it
as aid in analyzing clinical progress and the results of treat­
ment. As a measure of improvement of fifty-one students receiv­
ing conference therapy, Kaufman (1950) made use of test and re­
test with the MMPI. Changes in the MMPI scores between pre- and
post-therapy testing were reported by Gallagher (1953) who con­
sidered this inventory a useful measure of changes resulting from
client-centered therapy. Barron (1953) found a significant rela­
tionship between pre- and post-therapy MMPI scores which he con­
sidered an indication of improvement resulting from psychother­
apy.

The use of the MMPI in the present project rather closely
approximates the design employed by Schofield (1953) in a study
comparing the effects of hospitalization alone to hospitalization
combined with electro-convulsive therapy. In the study reported
here, group psychotherapy is substituted for electro-convulsive
therapy.

Tucker, et al., (1957) employed the Hospital Adjustment
Scale to measure improvement of patients on the ward of a mental
hospital when closed-circuit television was used as a medium for
therapy in the treatment of the mentally ill.

While there are reports of studies in which the MMPI is used
to measure changes in the scores as a result of various types of
therapy and such changes considered indicative of changes in psy-
chopathology, only those subjects who participated in the therapy have been considered. But the project here is to try to determine if the existence of group psychotherapy on the ward tends to make the ward a more therapeutic society so that patients who do not participate in group therapy could benefit from a changed atmosphere. No studies have been found which have attempted to evaluate changes in a total ward population nor which are concerned with changes resulting from group therapy on an admission ward.
CHAPTER III

PROCEDURE

In order to effectively evaluate changes as a result of adding group psychotherapy to the ward program, it was first necessary to evaluate changes which take place in a ward population over a similar length of time before the addition of group psychotherapy. Since there is only one male admission ward in the hospital, it was not possible to evaluate a control group and a therapy group at the same time on different wards. Furthermore, because it was desired to evaluate a total admission ward, it was not possible to use half the ward for controls and half for the therapy group. If all conditions were to remain substantially the same with the exception of the addition of group psychotherapy, it should be possible to evaluate the ward over a period of time before beginning group psychotherapy and to compare these results with those obtained from an evaluation of the ward at a different time during which group psychotherapy sessions were being conducted. One month was allowed between the end of the control period and the beginning of the therapy period during which time the therapist established group psychotherapy on the ward. Because a patient's stay on the ward had been in the past approximately five weeks, all new admissions for a two month period were tested and
evaluated within one week of admission and again thirty days later. A comparison was then made of the changes taking place during the control period and the changes taking place during the therapy period.

The Minnesota Multiphasic Personality Inventory was used in an attempt to obtain objective evidence of changes taking place on the ward during both the control and therapy periods. The scores on the MMPI describe the patterns of adjustment and it was assumed that changes would take place in patients' scores over a period on one month merely as a result of hospitalization. It was also assumed that if there were a greater depression of scores during the therapy period than during the control period this difference would be due to the addition of group therapy on the ward. The booklet form of the MMPI was used. The Inventory was administered to all patients capable of taking it within a week of admission and again thirty days later. During the control period approximately half of the patients were able to take the tests the first time but only twenty-eight per cent of the total admissions remained on the ward long enough for a second administration of the Inventory. During the therapy period approximately half of the patients were able to complete the Inventory the first time with forty-three per cent of total admissions remaining long enough to complete it for the second time.

The Hospital Adjustment Scale was used as a way to obtain a systematic subjective report of changes in the patients from the
members of the hospital staff assigned to this ward. The HAS was developed to measure the hospital adjustment of a patient without regard for diagnosis or pathology. In scoring the HAS, raw scores are converted to percentile scores to show where a given patient stands with respect to the patients used in the normative sample. Thus a score of fifty implies an average for hospitalized psychiatric patients. A high score indicates good hospital adjustment and a low score indicates poor hospital adjustment but is not a measure of the severity of the pathology. In addition to the total score indicating total hospital adjustment, three subscores are also found. Sub-score I refers to adjustment in the area of "communication and inter-personal relations." Sub-score II is concerned with the measure of adjustment in reference "care of self and social responsibility." Sub-score III attempts to measure adjustment with regard to "work, activities, and recreation." It was thought that a comparison of the scores for the first evaluation using the Hospital Adjustment Scale of patients admitted during the control period with the scores of the first evaluation of patients admitted during the therapy period would be an indication of the similarity or difference between the two groups. It was assumed that as a result of hospitalization there would be a change in the adjustment scores after a thirty day period. If the increase in adjustment scores during the therapy period was greater than during the control period it would be assumed that the difference was due to having a therapy group on the ward.
All patients were evaluated as soon as possible after admission, but transfers from the ward in less than thirty days from the date of the first evaluation made comparative evaluations possible for only forty-seven per cent of the control group and fifty-nine per cent of the therapy group. The nurses, aides, and student nurses were instructed in the use of the Hospital Adjustment Scale but the printed instructions were changed and the staff members asked to evaluate the patients on the basis of their observations of a day or two instead of two weeks to three months. A study made by Cortz, et al., (1959) concluded that, "a one day observation period yields results as reliable as longer periods of observation."

With the exception of those few patients who were transferred within a day or two of admission and were, as a result, not considered a part of this study, all patients received on the male admission ward were evaluated by the ward staff using the Hospital Adjustment Scale. This made possible a comparison of all patients received on the ward during the control period with those admitted during the therapy period. Because a number of patients were transferred from the ward in less than thirty days after the initial NAS evaluation, the two groups available for comparing changes over a thirty day period are somewhat smaller than the total admissions and were considered samples of the total ward population during the control and therapy periods. A number of patients were unable to read well enough to attempt the MMPI and a
few turned in protocols which were invalidated because the "cannot say" score was above fifty raw score points. Thus the number in the groups available for comparison of thirty day changes was even fewer than those for whom a comparison could be made on the HAS. These also were considered subgroups of the total ward population for the period under consideration. Table 1 contains the descriptive data of the patients comprising these various groups.

At the end of the study one of the nurses and several of the aides were interviewed and asked to comment on how they thought the ward had changed as a result of group therapy. Their interviews were recorded and a summary of their responses made a part of this study.

Personnel of the Nursing Education Department of the hospital conducted a sociological study of the ward at the end of the control period and again at the end of the therapy period in an attempt to evaluate the ward society and determine whether any changes took place during the interim period. A summary of the results of this study is also incorporated in this report.

All male patients admitted to the hospital were taken to the male admission ward and remained on this ward until staffed when, normally, they were transferred to a continuous treatment ward. As shown in Table 1, average residence on the ward was approximately five weeks during the control period for the patients admitted between October 1st and November 30th and six weeks during the therapy period for the patients admitted from February 1st to
### Table 1

**Gross Descriptive Data of Patients Involved in this Project**

<table>
<thead>
<tr>
<th></th>
<th>All Admissions</th>
<th></th>
<th></th>
<th></th>
</tr>
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<tbody>
<tr>
<td></td>
<td>N</td>
<td>76</td>
<td>68</td>
<td>36</td>
</tr>
<tr>
<td>Age in Years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>12-88</td>
<td>16-80</td>
<td>13-75</td>
<td>16-78</td>
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<tr>
<td>Mean</td>
<td>45.6</td>
<td>43.2</td>
<td>42.7</td>
<td>41.3</td>
</tr>
<tr>
<td>Education in Years</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Range</td>
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<td>0-19</td>
<td>0-14</td>
<td>0-19</td>
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<tr>
<td>Mean</td>
<td>8.6</td>
<td>9.6</td>
<td>8.8</td>
<td>9.8</td>
</tr>
<tr>
<td>Diagnosis</td>
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<td></td>
<td></td>
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<tr>
<td>Acute Brain Disorders</td>
<td>5.3%</td>
<td>1.5%</td>
<td>2.8%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Chronic Brain Disorders</td>
<td>32.9%</td>
<td>22.1%</td>
<td>27.8%</td>
<td>15.0%</td>
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<td>Psychotic Disorders</td>
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<td>45.6%</td>
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<td>40.0%</td>
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<tr>
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<td>5.9%</td>
<td>2.8%</td>
<td>7.5%</td>
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<td>Personality Disorders</td>
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<td>22.1%</td>
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<td>30.0%</td>
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<td>Transient Situational</td>
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<tr>
<td>Personality Disorders</td>
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<td>1.5%</td>
<td>5.6%</td>
<td>2.5%</td>
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<tr>
<td>Mental Deficiency</td>
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<td>1.5%</td>
<td>2.8%</td>
<td>2.5%</td>
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<td>Total Days on the Ward</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>3-97</td>
<td>6-133</td>
<td>34-97</td>
<td>34-133</td>
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<tr>
<td>Mean</td>
<td>34.9</td>
<td>42.7</td>
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<td>62.1</td>
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<tr>
<td>Interval from Admission</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>to First Test (in days)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
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<td>3-13</td>
<td>1-17</td>
<td>4-12</td>
</tr>
<tr>
<td>Mean</td>
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<td>6.5</td>
<td>6.6</td>
<td>7.0</td>
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<tr>
<td>Interval between Tests</td>
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<td></td>
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<tr>
<td>(in days)</td>
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<td>Range</td>
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<td>26-33</td>
<td>28-35</td>
<td>28-36</td>
</tr>
<tr>
<td>Mean</td>
<td>30.9</td>
<td>29.7</td>
<td>30.4</td>
<td>31.0</td>
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March 31st. The length of stay for some patients of both groups was considerably shortened due to physical illness for which reason they were transferred to the infirmary. A few patients who were quite agitated or disturbing to the other patients on admission were transferred to a disturbed ward the day they were admitted to the hospital or one or two days thereafter. Patients thus transferred before a first evaluation using the Hospital Adjustment Scale could be made were omitted from this study.

During the first seven days of residence on the ward, the patient was dressed in hospital clothing and not permitted to have visitors or to leave the ward for any of the activities. During this first week, and as soon after admission as possible, he was given a physical examination and other tests if requested by the ward physician. He was allowed to participate in any of the activities which took place on the ward if he so desired. During this week he was given the MMPI and evaluated by the staff using the Hospital Adjustment Scale.

During the control period, two physicians were responsible for the ward. One served as ward physician giving the physical examinations and handling any physical illness. The other physician served as psychiatrist and conducted the patient staffs. During the therapy period, there was less stability in the medical staff. During the first twenty days of the therapy period, the regular ward physician who gave the physical examinations and prescribed for the patients' ills was away from the hospital and an-
other physician substituted for him. The psychiatrist who had served during the control period was assigned to this ward for the first five weeks of the therapy period at which time he left the staff of the hospital. Replacing him was the assistant superintendent who, of necessity, had to divide his time between other duties and attending to the patients on this ward. As a consequence, patients were not staffed as quickly during the therapy period as during the control period which is reflected in the longer residence on the ward during the therapy period.

The same two nurses served the ward throughout both the control and therapy periods. Eleven aides divided between three shifts were assigned to the ward at all times. Although there was occasionally some slight shifting of personnel, the majority of the aides on each shift were the same persons during the entire time this study was in progress. Both nurses were registered nurses and were assigned during the 8:00 a.m. to 4:30 p.m. shift. There were no registered nurses on the ward from 4:30 p.m. to 8:00 a.m.

During the control period, two groups of student nurses were assigned to this ward. The first group of fifteen student nurses was on the ward from October 19th to November 15th and the second group of fourteen nurses was on the ward from November 16th to December 8th. During the therapy period a group of student nurses was assigned to the ward from February 15th to March 7th. Each student nurse had assigned to her two or three patients with whom
she was expected to spend at least one hour each day talking. The student nurses accompanied the patients to all the off-ward activities. They spent about four and one-half hours a day with the patients and when not occupied in private conversations or in hospital ward activities, played cards and danced with the patients.

Activities available to the patients were many and varied and participation in the activities by the patients varied considerably. On the ward, the television set was on most of the day and ping pong, jigsaw puzzles, and card playing were generally available and used. Occasionally the band from the Music Therapy department played on the ward and when the student nurses were present the patients danced to the band music. At other times, dancing was to the record player on the ward.

Patients who were able participated in basketball and bowling once a week and attended the weekly movie. Other off-the-ward activities available to patients and conducted by the Occupational Therapy, Recreational Therapy, and Music Therapy staff employees included minor crafts, gym classes, roller skating, social dancing, use of the library and a general socialization period. There were no observable differences in the activity program for the duration of this project.

The external impression conveyed to the visitor on the ward did not differ appreciably during the therapy period from that of the control period. Relative order and quiet prevailed. Normal-
ly, two or three patients were walking up and down the halls, and these were usually men in "greens" indicating that this was their first week in the hospital. Ordinarily, two to four men were playing ping pong, a group of six or eight were sitting around playing cards or checkers, a number were watching television, and some just sitting or reading magazines. The two nurses explained that they believed the reason for the lack of confusion and only an occasional disturbance was due to the fact that there were few restrictions imposed upon the patients beyond the restriction of remaining on the ward. Badly disturbed patients who would have created more serious problems were transferred to a disturbed ward.

During the weeks when student nurses were present on the ward, there seemed to be somewhat more confusion than usual. The ward nurses thought that when the students first came on the ward this was somewhat disturbing to the patients because of the extra attention they received. They felt, however, that after the first week the patients came to look forward to these visits and found them interesting and helpful.

The varied program of activities kept the patients busy most of the time during the day resulting in fewer problems of behavior on the ward than might otherwise be expected. Except for patients who had been on the ward for less than a week, the majority attended activity therapies on Monday, Wednesday and Friday mornings. Approximately half the patients participated in bowling on
Monday, Tuesday and Thursday. Approximately half of the ward went to the recreation open house in the gym on Sunday afternoon, and most of the patients attended the social dance in the gym on Monday evening and the movie on Thursday evening. On Monday and Friday afternoons there was music therapy on the ward in which participation varied from a few patients to approximately half of them. When an orchestra was playing, a larger number of patients was interested, but when the music was from the phonograph, fewer became involved. On Thursday afternoons a majority of the patients, accompanied by an aide, went to the canteen.

During the control period, patients were transferred quite routinely to other wards within four or five weeks of admission. Senile patients remained on the ward a relatively short time being transferred as soon as possible to another building. Consequently, during the control period there were few patients on the ward at any time who could complain very seriously about the long length of time they had been detained on the admission ward. The fact that badly disturbed and senile patients were transferred rather promptly meant that there were very few badly disoriented patients or patients out of contact on the admission ward during the control period.

During the therapy period, staffing of patients was slower, a period of six weeks elapsing on the average before a patient was transferred. Senile patients remained on the ward a longer period of time before being sent to the geriatrics ward.
Drug therapy was prescribed for all patients requiring it during all the time this investigation was being conducted. There was no major change in the drug therapy program at any time.

For this project, every effort was made to let the ward function in its accustomed manner. No attempt was made to either shorten or prolong the stay of a patient on the ward, though in many cases a patient was transferred a day or two before he was scheduled for a second evaluation or personality inventory. Although the members of the hospital staff were aware that a project was being conducted on the ward, they did not know the exact nature of the project. They knew only that they were requested to evaluate the patients' behavior on the ward using the Hospital Adjustment Scale, that the patients were being given some psychological testing, and that group psychotherapy was being initiated on the ward. These precautions were taken in order to avoid an artificial situation.

The independent variable to be introduced in this project was group psychotherapy sessions conducted on the ward. The meetings were held twice a week for one hour each time from February 1st through April 30th. All patients resident on the ward were invited to attend the meetings though none were forced to do so. No attendance record was kept nor any attempt made to distinguish between patients who did or did not participate in the group meetings. No other activity was scheduled for the ward.
during these periods, though individual patients were sometimes
occupied being interviewed by a physician or social worker.

The therapy itself is not a part of this study, the purpose
of which is to attempt to describe and evaluate how a total ward
may change as a result of group therapy. The group psychotherapy
meetings were conducted by Dr. Manuel J. Vargas, chief psycholo-
gist for Dr. Norman N. Beatty Memorial Hospital. His philosophy,
technique, and goals for the therapy are described in a special
article written for this study and included in Appendix I.
CHAPTER IV

RESULTS AND DISCUSSION

A. Changes After One Month's Hospitalization

In reporting the results of this project, it has been necessary to delineate six different groups. The descriptive data of patients in each group are given in Table 1 above.

All Admissions Control. This group includes all patients admitted to the ward from October 1, 1959 to November 30, 1959 with the exception of a very few who were transferred from the ward almost immediately. All patients included in this group were evaluated a first time using the Hospital Adjustment Scale. During this period, there was no group therapy on the ward.

All Admissions Therapy. Included in this group are all patients admitted to the ward between February 1st and March 31st of 1960 with the exception of a very few patients who were transferred almost immediately to another ward. All patients in this group were evaluated a first time using the Hospital Adjustment Scale. During this time, group therapy was being used on the ward.

HAS Control Group. This group includes those patients admitted to the hospital between October 1st and November 30th, 1959 who remained on the ward for a minimum of one month and who
were evaluated using the Hospital Adjustment Scale both on admission and thirty days later.

**HAS Therapy Group.** Included in this group are those patients admitted to the ward between February 1st and March 31st, 1960 who remained on the ward for at least one month and were evaluated using the HAS on admission and again thirty days later.

**MMPI Control Group.** This group includes those patients admitted to the ward between October 1st and November 30th, 1959 who were able to take the MMPI within one week of admission and again thirty days later.

**MMPI Therapy Group.** Included in this group are all patients admitted to the ward between February 1st and March 31st, 1960 who were able to take the MMPI within one week of admission and again one month later.

In that which follows, the term "pre-evaluation" refers to the first evaluation of patients using the HAS and "post-evaluation" means the second evaluation using the HAS whether during the control period or during the therapy period. "Pre-test" refers to the first administration of the MMPI and "post-test" refers to the second administration of the MMPI whether during the control period or during the therapy period.

1. Hospital Adjustment Scale

In order to determine if the patients admitted during the control period were drawn from the same population as those admitted during the therapy period, F ratios between variances on
the HAS were figured for all admissions during the control and therapy periods. There was no significant difference as shown in Table 2. Nor was there a significant difference in F ratios between variances on the first evaluation of the HAS therapy group and HAS control groups as indicated in Table 3.

Table 4 reveals that there was no significant difference between the HAS percentile score means for all admissions during the control period and all admissions during the therapy period. On the basis of these results, it is possible to conclude that the hospital adjustment of patients as measured by the Hospital Adjustment Scale did not differ significantly upon admission between the patients admitted during the control period and those admitted during the therapy period. Table 5 indicates that the HAS percentile score means of patients comprising the HAS control group were consistently higher than the means of all patients admitted during the control period, the difference being significant at the .05 level of confidence. This meant that the control group to which the therapy group would be compared showed a better adjustment to the hospital at the outset than the total of all patients admitted during this period.

Table 6 reveals that during the therapy period, the HAS percentile score means of the HAS therapy group showed a significant difference at the .05 level from all admissions on only Scale II of the HAS, indicating that the HAS therapy group showed a significantly better adjustment to the hospital at the outset than the
Table 2
HAS F Ratios Between Variances of All Admissions During Control
Period and All Admissions During Therapy Period
on Pre-evaluations

<table>
<thead>
<tr>
<th>HAS Scale</th>
<th>F Ratio</th>
<th>Required F</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>P = .10</td>
</tr>
<tr>
<td>I (Communication and inter- 1.23&lt;sup&gt;a&lt;/sup&gt; 1.47 1.74</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>personal relations)</td>
<td></td>
</tr>
<tr>
<td>II (Care of self and social 1.04&lt;sup&gt;a&lt;/sup&gt; 1.47 1.74</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>responsibility)</td>
<td></td>
</tr>
<tr>
<td>III (Work, activities and re- 1.26&lt;sup&gt;a&lt;/sup&gt; 1.47 1.74</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>creation)</td>
<td></td>
</tr>
<tr>
<td>TOTAL (Hospital adjustment) 1.19&lt;sup&gt;a&lt;/sup&gt; 1.47 1.74</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup> Based on 75/67 df.
Table 3
HAS F Ratios Between Variances of Control and Therapy Groups on Pre-evaluations

<table>
<thead>
<tr>
<th>HAS Scale</th>
<th>F Ratio</th>
<th>Required F</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>P = .10</td>
</tr>
<tr>
<td>I</td>
<td>1.19&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.736</td>
</tr>
<tr>
<td>II</td>
<td>1.09&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.736</td>
</tr>
<tr>
<td>III</td>
<td>1.29&lt;sup&gt;b&lt;/sup&gt;</td>
<td>1.725</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1.36&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.736</td>
</tr>
</tbody>
</table>

<sup>a</sup> Based on 39/35 df.

<sup>b</sup> Based on 35/39 df.
Table 4
HAS Percentile Score Means and Standard Deviations of Pre-evaluations of All Admissions in Therapy and Control Periods

<table>
<thead>
<tr>
<th>Control Period</th>
<th>Therapy Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>57.96</td>
<td>31.82</td>
</tr>
<tr>
<td>58.91</td>
<td>33.49</td>
</tr>
<tr>
<td>53.86</td>
<td>38.91</td>
</tr>
<tr>
<td>TOTAL</td>
<td>57.64</td>
</tr>
</tbody>
</table>

\text{a} All t values are based on 142 df.
Table 5

<table>
<thead>
<tr>
<th>All Admissions</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>57.96</td>
<td>31.82</td>
</tr>
<tr>
<td>58.91</td>
<td>33.49</td>
</tr>
<tr>
<td>53.86</td>
<td>38.91</td>
</tr>
<tr>
<td>TOTAL..57.64</td>
<td>34.74</td>
</tr>
</tbody>
</table>

* Significant at or beyond the .05 level of confidence.
<table>
<thead>
<tr>
<th></th>
<th>All Admissions</th>
<th>Therapy Group</th>
<th>Mean</th>
<th>SD</th>
<th>Mean</th>
<th>SD</th>
<th>Mdiff</th>
<th>SE mean of sample</th>
<th>C. R.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>62.46</td>
<td>28.64</td>
<td>65.98</td>
<td>29.37</td>
<td>3.52</td>
<td>2.94</td>
<td>1.20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>65.32</td>
<td>32.76</td>
<td>72.30</td>
<td>32.08</td>
<td>6.98</td>
<td>3.37</td>
<td>2.07*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>65.13</td>
<td>34.60</td>
<td>68.13</td>
<td>33.62</td>
<td>3.00</td>
<td>3.56</td>
<td>.84</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>63.51</td>
<td>31.80</td>
<td>68.43</td>
<td>31.09</td>
<td>4.92</td>
<td>3.27</td>
<td>1.50</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Significant at or beyond the .05 level of confidence.
total of all patients admitted during this period in that area only which is measured by the Scale II items of the HAS. For the other two scales, as well as for the Total Score, the mean in each case was higher for the Therapy Group than for All Admissions, but the difference did not reach the .05 level of confidence. The tendency was for the level of adjustment of both the control and therapy groups to be higher than for all admissions during the corresponding period.

The mean differences in the HAS percentile score means between the pre-evaluations and the post-evaluations of the control group are given in Table 7 and of the therapy group in Table 8. The mean for the post-evaluation is higher than the mean for the pre-evaluation for each of the scales, as well as the total score, for both control and therapy groups. Only in Scale III for the control group, however, was the change for better adjustment significant at or beyond the .05 level of confidence. This scale is based on items judged to refer to work, activities, and recreation. The highest mean difference for the therapy group was on this same scale but the difference failed to reach the .05 level of confidence. For both the control and therapy groups, the least change was noticed on Scale II which is based on items which have to do with care of self and social responsibility.

Since our concern in this study was to attempt to determine what changes took place as a result of adding group therapy to the ward, we were interested primarily in the change between the
Table 7
HAS Percentile Score Means and Standard Deviations of Pre-evaluations and Post-evaluations of Control Group

<table>
<thead>
<tr>
<th>Pre-evaluation</th>
<th>Post-evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
</tr>
<tr>
<td>I...67.42</td>
<td>26.99</td>
</tr>
<tr>
<td>II...68.33</td>
<td>30.76</td>
</tr>
<tr>
<td>III...63.47</td>
<td>38.17</td>
</tr>
<tr>
<td>TOTAL...68.08</td>
<td>26.62</td>
</tr>
</tbody>
</table>

^{a} All t values based on 35 df.

* Significant at or beyond the .05 level of confidence.
Table 8
HAS Percentile Score Means and Standard Deviations of Pre-evaluations and Post-evaluations of Therapy Group

<table>
<thead>
<tr>
<th></th>
<th>Pre-evaluation</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
<td>Md_diff</td>
<td>SE_diff</td>
</tr>
<tr>
<td>I</td>
<td>65.98</td>
<td>29.37</td>
<td>70.08</td>
<td>22.58</td>
<td>4.10</td>
<td>3.62</td>
</tr>
<tr>
<td>II</td>
<td>72.30</td>
<td>32.08</td>
<td>73.25</td>
<td>25.53</td>
<td>.95</td>
<td>3.78</td>
</tr>
<tr>
<td>III</td>
<td>68.13</td>
<td>33.62</td>
<td>76.98</td>
<td>26.72</td>
<td>8.85</td>
<td>4.54</td>
</tr>
<tr>
<td>TOTAL</td>
<td>68.43</td>
<td>31.09</td>
<td>73.28</td>
<td>24.30</td>
<td>4.85</td>
<td>3.39</td>
</tr>
</tbody>
</table>

\(a\) All t values based on 39 df.
pre-evaluation and post-evaluation difference. In Table 9, we have compared the differences between the means of the therapy and control groups on the changes between the pre- and the post-evaluations, as well as the differences between the means of the therapy and the control groups on the pre-evaluations and post-evaluations. It will be seen from this table that there was no significant difference between the means of the therapy and control groups on the pre-evaluation, the post-evaluation, or the change between pre- and post-evaluations. In every instance, the $t$-value is quite small.

Inasmuch as the Hospital Adjustment Scale is scored on a 100 point scale, each of the mean group scores is a mean group percentage of the total possible score. Hence, the differences in mean scores are really differences in percentage of the total possible score and may be read as percentage figures in Tables 7, 8, and 9.

Comparing the pre-evaluation and post-evaluation scores of individual patients, we asked how many in each group showed improved adjustment, how many showed poorer adjustment, and how many did not change as evaluated by the Hospital Adjustment Scale. The results are tabulated in percentage figures in Table 10. The results are similar to those obtained when we compared the change between the differences of the two groups.

A product-moment coefficient of correlation between the pre- and post-evaluation scores was figured for both the control and
Table 9
Significance of Differences Between Means of Therapy and Control Groups on HAS Pre-evaluation, Post-evaluation, and Changes Between Pre- and Post-evaluations

<table>
<thead>
<tr>
<th></th>
<th>Pre-evaluation</th>
<th></th>
<th>Post-evaluation</th>
<th></th>
<th>Change between Pre-evaluation and Post-evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Difference</td>
<td>t&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Difference</td>
<td>t&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Difference</td>
</tr>
<tr>
<td>I</td>
<td>1.44</td>
<td>.22</td>
<td>3.78</td>
<td>.72</td>
<td>-2.54</td>
</tr>
<tr>
<td></td>
<td>.43</td>
<td></td>
<td>.54</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>-3.97</td>
<td>.55</td>
<td>-4.56</td>
<td>.72</td>
<td>.59</td>
</tr>
<tr>
<td></td>
<td>.10</td>
<td></td>
<td>.39</td>
<td></td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>-4.66</td>
<td>.57</td>
<td>-1.90</td>
<td>.29</td>
<td>-2.76</td>
</tr>
<tr>
<td></td>
<td>.39</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>- .35</td>
<td>.05</td>
<td>.19</td>
<td>.03</td>
<td>-.54</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.10</td>
</tr>
</tbody>
</table>

<sup>a</sup> All t values are based on 74 df.
Table 10

Percentages of Patients in Control and Therapy Groups Showing Changes in Hospital Adjustment as Evaluated According to the Hospital Adjustment Scale After One Month of Hospitalization

<table>
<thead>
<tr>
<th></th>
<th>Improved Adjustment</th>
<th>Poorer Adjustment</th>
<th>No Change in Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SCALE I</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control Group</td>
<td>61%</td>
<td>31%</td>
<td>8%</td>
</tr>
<tr>
<td>Therapy Group</td>
<td>50%</td>
<td>45%</td>
<td>5%</td>
</tr>
<tr>
<td><strong>SCALE II</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control Group</td>
<td>36%</td>
<td>36%</td>
<td>28%</td>
</tr>
<tr>
<td>Therapy Group</td>
<td>37.5%</td>
<td>32.5%</td>
<td>30%</td>
</tr>
<tr>
<td><strong>SCALE III</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control Group</td>
<td>53%</td>
<td>33%</td>
<td>14%</td>
</tr>
<tr>
<td>Therapy Group</td>
<td>42.5%</td>
<td>30%</td>
<td>27.5%</td>
</tr>
<tr>
<td><strong>TOTAL SCORE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control Group</td>
<td>56%</td>
<td>36%</td>
<td>8%</td>
</tr>
<tr>
<td>Therapy Group</td>
<td>50%</td>
<td>40%</td>
<td>10%</td>
</tr>
</tbody>
</table>
therapy groups for each HAS scale and the total HAS score and the results given in Table 11. In every instance, the $r$ was found to be significantly different from zero at or beyond the .01 level of confidence. Comparing the coefficient of correlation for the control group with that obtained for the therapy group for each of the HAS scales and for the total scores resulted in a nonsignificant difference between the two groups for all three scales and the total score.

From the data collected as a result of this study, whatever other effects may result from group therapy, the ward did not change in such a manner that its patients became better adjusted to the hospital as measured by the Hospital Adjustment Scale. If anything, the tendency was in the opposite direction but the differences were so slight that it is necessary to conclude that there was no change.

2. Minnesota Multiphasic Personality Inventory

During both the control and therapy periods, fewer patients were able to complete the MMPI two times than were evaluated using the Hospital Adjustment Scale. This was due chiefly to lack of ability to read, inability to comprehend the statements on the inventory, and faulty eyesight. Because most of the patients admitted to the ward could not successfully complete the MMPI, it is not possible to compare the pre-tests of the MMPI control and therapy groups with all admissions during the corresponding period as it was possible to do with the Hospital Adjustment Scale. Our
Table 11
Pre- and Post-evaluation Correlation Coefficients of the Control Group and the Therapy Group on Each HAS Scale and the Significance of the Difference Between the Correlation Coefficients of the Two Groups

<table>
<thead>
<tr>
<th>HAS Scale</th>
<th>Control Group r</th>
<th>Therapy Group r</th>
<th>Control Group z'</th>
<th>Therapy Group z'</th>
<th>SE diff</th>
<th>z</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(N=36)</td>
<td>(N=40)</td>
<td>(df 33)</td>
<td>(df 37)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>.54&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.64&lt;sup&gt;b&lt;/sup&gt;</td>
<td>.60</td>
<td>.76</td>
<td>.23941</td>
<td>.668 NS</td>
</tr>
<tr>
<td>II</td>
<td>.60&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.68&lt;sup&gt;b&lt;/sup&gt;</td>
<td>.69</td>
<td>.83</td>
<td>.23941</td>
<td>.585 NS</td>
</tr>
<tr>
<td>III</td>
<td>.56&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.57&lt;sup&gt;b&lt;/sup&gt;</td>
<td>.63</td>
<td>.85</td>
<td>.23941</td>
<td>.084 NS</td>
</tr>
<tr>
<td>TOTAL</td>
<td>.63&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.73&lt;sup&gt;b&lt;/sup&gt;</td>
<td>.74</td>
<td>.93</td>
<td>.23941</td>
<td>.794 NS</td>
</tr>
</tbody>
</table>

<sup>a</sup> Significantly different from zero at or beyond the .01 level of confidence using the Wallace-Snedecor tables and based on 34 df.

<sup>b</sup> Significantly different from zero at or beyond the .01 level of confidence using the Wallace-Snedecor tables and based on 38 df.
next concern is to know whether the MMPI control and therapy groups could both have come from the same population. The MMPI F ratios between variances of control and therapy groups on pre-tests is given in Table 12. With the exception of the "Cannot Say" scale, the two samples could have come from the same population. The F ratio for the "Cannot Say" scale was significant beyond the .05 level of confidence. But this is a validating scale, whereas the MMPI is primarily a measure of the severity of psychopathology. In view of the fact that this is the only F ratio which is significant at or beyond the .05 level of confidence, it seems safe to assume that these two groups could have come from the same population.

In recording the MMPI scores, raw scores were used for the "Cannot Say" scale and profiles with an excess of sixty cannot say items were discarded and these patients considered unable to complete the inventory. On all the other scales, the raw scores were changed to T scores using the K-Correction factor. On the basis of these T scores, fifty would be considered a normally elevated score. The pre- and post-test mean scores for the MMPI control group are shown in Table 13 and Figure 1. With the exception of the K, Pd, Ma and Si scales, there was a lowering of the mean scores in the direction of a normally elevated score of fifty. Those scores which tended in the opposite direction increased very slightly. The Pt scale score decrease was significant at or beyond the .01 level and the decrease in the ? and D scale scores
<table>
<thead>
<tr>
<th>Scale</th>
<th>F Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>?</td>
<td>2.31&lt;sup&gt;b&lt;/sup&gt; *</td>
</tr>
<tr>
<td>L</td>
<td>1.34&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>F</td>
<td>1.59&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>K</td>
<td>1.39&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Hs</td>
<td>1.27&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>D</td>
<td>2.22&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Hy</td>
<td>1.11&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Pd</td>
<td>1.14&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Mf</td>
<td>2.05&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Pa</td>
<td>1.37&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Pt</td>
<td>1.09&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Sc</td>
<td>1.07&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Ma</td>
<td>1.15&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Si</td>
<td>1.33&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

* Significant at or beyond the .05 level of confidence.

<sup>a</sup> Based on 20 df.

<sup>b</sup> Based on 28 df.
Table 13
T-Score Means, Standard Deviations, and Codes of Pre-tests and Post-tests of Control Group

<table>
<thead>
<tr>
<th>Pre-test</th>
<th>Post-test</th>
<th>M\text{diff}</th>
<th>SE\text{diff}</th>
<th>t value$^a$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
<td></td>
</tr>
<tr>
<td>?</td>
<td>13.76</td>
<td>6.67</td>
<td>10.19</td>
<td>-7.09</td>
</tr>
<tr>
<td>L</td>
<td>53.48</td>
<td>52.71</td>
<td>11.42</td>
<td>- .77</td>
</tr>
<tr>
<td>F</td>
<td>61.76</td>
<td>60.00</td>
<td>19.67</td>
<td>-1.76</td>
</tr>
<tr>
<td>K</td>
<td>52.57</td>
<td>53.90</td>
<td>9.13</td>
<td>1.33</td>
</tr>
<tr>
<td>Hs</td>
<td>55.10</td>
<td>51.14</td>
<td>10.94</td>
<td>-3.96</td>
</tr>
<tr>
<td>D</td>
<td>64.67</td>
<td>56.57</td>
<td>14.61</td>
<td>-8.10</td>
</tr>
<tr>
<td>Hy</td>
<td>57.19</td>
<td>55.10</td>
<td>12.19</td>
<td>-2.09</td>
</tr>
<tr>
<td>Pd</td>
<td>67.10</td>
<td>67.67</td>
<td>14.35</td>
<td>.57</td>
</tr>
<tr>
<td>Mf</td>
<td>59.52</td>
<td>57.33</td>
<td>10.30</td>
<td>-2.19</td>
</tr>
<tr>
<td>Pa</td>
<td>59.76</td>
<td>58.67</td>
<td>14.93</td>
<td>-1.09</td>
</tr>
<tr>
<td>Pt</td>
<td>62.67</td>
<td>55.43</td>
<td>13.59</td>
<td>-7.24</td>
</tr>
<tr>
<td>Sc</td>
<td>63.38</td>
<td>61.24</td>
<td>22.83</td>
<td>-2.14</td>
</tr>
<tr>
<td>Ma</td>
<td>56.62</td>
<td>57.81</td>
<td>13.17</td>
<td>1.19</td>
</tr>
<tr>
<td>Si</td>
<td>54.38</td>
<td>54.76</td>
<td>10.81</td>
<td>.38</td>
</tr>
</tbody>
</table>

$^a$All t values based on 20 df.

$^b$Raw scores.

*Significant at or beyond the .05 level of confidence.

**Significant at or beyond the .01 level of confidence.

Pre-test code: 42 37 - 65 39 10  F - LK/?.
Post-test code: 48 - 69 52 730 1  F - KL/?.

Pre-test code: 42 37 - 65 39 10  F - LK/?.
Post-test code: 48 - 69 52 730 1  F - KL/?.
Fig. 1. Pre-test (solid line) and post-test (broken line) profiles for control group.
significant at or beyond the .05 level.

The pre- and post-test mean scores for the MMPI therapy group are given in Table 14 and Figure 2. On only the validating scales, L and K were there increases in the mean scores. Of these, the change in the K scale score was significant at or beyond the .05 level. All other scale scores decreased in the direction of a normally elevated scale of fifty. The change was not significant, however, on the ?, L, or Mf scales. It was significant at or beyond the .05 level on the Pa scale and the .01 level on all other scales. Thus, there was a quite marked change as measured by the inventory between admission and one month later for the therapy group.

Table 15 shows the comparisons between therapy patients and controls on their respective pre-tests. Except for the ? and F scales, the differences between the two groups is in the direction of higher T scores for the therapy group. The greatest differences were on the Hy scale which reached the .01 level of confidence and the Hs scale which reached the .05 level of confidence.

Table 15 also shows the comparisons between the therapy and control groups on their respective post-tests. In this comparison, no scale shows a significant difference. The two scales which showed the greatest difference on the pre-tests, Hy and Hs, still show the greatest difference. However, scores for the therapy group, higher than those for the control group on the
<table>
<thead>
<tr>
<th>Pre-test</th>
<th>Post-test</th>
<th>M_{diff}</th>
<th>S_{E_{diff}}</th>
<th>t \text{ value}^a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
<td></td>
</tr>
<tr>
<td>?</td>
<td>6.00</td>
<td>10.32</td>
<td>5.97</td>
<td>11.16</td>
</tr>
<tr>
<td>L</td>
<td>53.76</td>
<td>8.65</td>
<td>55.10</td>
<td>8.12</td>
</tr>
<tr>
<td>F</td>
<td>60.38</td>
<td>13.69</td>
<td>55.45</td>
<td>10.31</td>
</tr>
<tr>
<td>K</td>
<td>54.79</td>
<td>7.33</td>
<td>57.48</td>
<td>7.88</td>
</tr>
<tr>
<td>Hs.</td>
<td>65.90</td>
<td>16.58</td>
<td>58.34</td>
<td>13.98</td>
</tr>
<tr>
<td>D</td>
<td>68.83</td>
<td>12.72</td>
<td>62.00</td>
<td>12.48</td>
</tr>
<tr>
<td>Hy.</td>
<td>66.14</td>
<td>10.82</td>
<td>61.10</td>
<td>10.51</td>
</tr>
<tr>
<td>Pd.</td>
<td>72.10</td>
<td>11.66</td>
<td>66.00</td>
<td>11.73</td>
</tr>
<tr>
<td>Mf.</td>
<td>60.83</td>
<td>6.95</td>
<td>58.69</td>
<td>10.16</td>
</tr>
<tr>
<td>Pa.</td>
<td>64.86</td>
<td>12.77</td>
<td>59.69</td>
<td>9.95</td>
</tr>
<tr>
<td>Pt.</td>
<td>66.48</td>
<td>14.43</td>
<td>56.93</td>
<td>11.17</td>
</tr>
<tr>
<td>Sc.</td>
<td>65.86</td>
<td>18.35</td>
<td>58.21</td>
<td>14.01</td>
</tr>
<tr>
<td>Ma.</td>
<td>60.69</td>
<td>11.70</td>
<td>54.07</td>
<td>12.20</td>
</tr>
<tr>
<td>Si.</td>
<td>56.76</td>
<td>9.35</td>
<td>53.24</td>
<td>9.90</td>
</tr>
</tbody>
</table>

^a All t values based on 28 df.
^b Raw scores.

*Significant at or beyond the .05 level of confidence.
**Significant at or beyond the .01 level of confidence.

Pre-test code: 4 ' 2 73186 59 - 0 F - KL/?.
Post-test code: 4 23 - 6518 7 90 K FL/?.
Fig. 2. Pre-test (solid line) and post-test (broken line) profiles for therapy group.
Table 15

Significance of Differences Between Means of Therapy and Control Groups on Pre-test, Post-test and Changes Between Pre- and Post-tests

<table>
<thead>
<tr>
<th>Pre-test Difference</th>
<th>Post-test Difference</th>
<th>Change between pre-test and post-test Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>t</td>
<td></td>
</tr>
<tr>
<td>L</td>
<td>-2.28</td>
<td>.106</td>
</tr>
<tr>
<td>F</td>
<td>1.38</td>
<td>.315</td>
</tr>
<tr>
<td>K</td>
<td>-2.22</td>
<td>.980</td>
</tr>
<tr>
<td>Hs</td>
<td>-10.80</td>
<td>2.599</td>
</tr>
<tr>
<td>D</td>
<td>-4.16</td>
<td>.929</td>
</tr>
<tr>
<td>Hy</td>
<td>-8.95</td>
<td>2.821</td>
</tr>
<tr>
<td>Pd</td>
<td>-5.00</td>
<td>1.455</td>
</tr>
<tr>
<td>Mf</td>
<td>-1.31</td>
<td>.548</td>
</tr>
<tr>
<td>Pa</td>
<td>-5.10</td>
<td>1.480</td>
</tr>
<tr>
<td>Pt</td>
<td>-3.81</td>
<td>.904</td>
</tr>
<tr>
<td>Sc</td>
<td>-2.48</td>
<td>.478</td>
</tr>
<tr>
<td>Ma</td>
<td>-4.07</td>
<td>1.195</td>
</tr>
<tr>
<td>Si</td>
<td>-2.33</td>
<td>.834</td>
</tr>
</tbody>
</table>

^aAll t values are based on 48 df.

*Significant at or beyond the .05 level of confidence.

**Significant at or beyond the .01 level of confidence.
pre-test, are now lower for the therapy group on the Pd, Sc, Ma, and Si scales, as well as on the ? and F scales.

Table 15 also presents the comparisons of differences in change from pre-test to post-test between the therapy and control groups. The results show a greater change toward a normally elevated score for the therapy group on all scales except ?, L, K, D, and Mf, than for the control group. There was practically no difference for the Mf scale, both groups having changed almost the same in the same direction. The difference was significant at or beyond the .01 level of confidence for the Ma scale and at or beyond the .05 level of confidence for the Pd and Si scales indicating a greater change for the therapy group. The only scale for which the difference reached the .05 level on which the change was in the direction of a lower score for the control group was the ? scale.

For the therapy group, all correlation coefficients between pre-test and post-test scores are significantly different from zero at the .01 level of confidence, as shown in Table 16. But for the control group, although most correlation coefficients are significantly different from zero at or beyond the .01 level of confidence, that for the Pd scale is significant at the .02 level and those for the ?, Hy and Pa are significant at only the .05 level. The coefficients for the control group are lower than for the therapy group on the following scales: ?, Hs, Hy, Pd and Pa.

3. Interviews With Staff Members
Table 16
Test-Retest Correlations of Each Group on Each MMPI Scale

<table>
<thead>
<tr>
<th>Scale</th>
<th>Control Group (N=21)</th>
<th>Therapy Group (N=29)</th>
</tr>
</thead>
<tbody>
<tr>
<td>?</td>
<td>.456*</td>
<td>.591***</td>
</tr>
<tr>
<td>L</td>
<td>.784***</td>
<td>.539***</td>
</tr>
<tr>
<td>F</td>
<td>.921***</td>
<td>.848***</td>
</tr>
<tr>
<td>K</td>
<td>.737***</td>
<td>.599***</td>
</tr>
<tr>
<td>Hs</td>
<td>.706***</td>
<td>.764***</td>
</tr>
<tr>
<td>D</td>
<td>.716***</td>
<td>.676***</td>
</tr>
<tr>
<td>Hy</td>
<td>.445*</td>
<td>.747***</td>
</tr>
<tr>
<td>Pd</td>
<td>.524**</td>
<td>.670***</td>
</tr>
<tr>
<td>Mf</td>
<td>.744***</td>
<td>.633***</td>
</tr>
<tr>
<td>Pa</td>
<td>.499*</td>
<td>.608***</td>
</tr>
<tr>
<td>Pt</td>
<td>.707***</td>
<td>.621***</td>
</tr>
<tr>
<td>Sc</td>
<td>.851***</td>
<td>.796***</td>
</tr>
<tr>
<td>Ma</td>
<td>.805***</td>
<td>.597***</td>
</tr>
<tr>
<td>Si</td>
<td>.871***</td>
<td>.825***</td>
</tr>
</tbody>
</table>

* Significantly different from zero at the .05 level of confidence.

** Significantly different from zero at the .02 level of confidence.

*** Significantly different from zero at the .01 level of confidence.
At the conclusion of the study, the head nurse and four psychiatric aides were interviewed and the interviews recorded. A transcript of these is found in Appendix II. Although the ratings assigned the patients by the aides using the Hospital Adjustment Scale show no significant difference, these staff members did report a changed ward atmosphere based on their own subjective appraisal. They found it difficult to express in precisely what ways there had been improvement, but all were in agreement that the ward was better off for having group therapy. They reported less fear, less tension among the patients and a willingness if not a desire to discuss their problems with each other and with the attendants than before the group meetings were held. They seemed to think the patients related better to one another, the more capable helped the more handicapped, and in general there was a higher degree of participation in the activity program.

4. Sociological Study by the Nursing Education Department

Before beginning the group therapy program and again at the conclusion of this study, student nurses, under the guidance and direction of the Nursing Education Department of the hospital, conducted a sociological study of the ward. The reports of these studies are included in Appendix III.

The patients were asked a standardized set of thirty questions and the answers to these analyzed by nursing education instructors. The report at the conclusion of the study emphasizes two situations which were definitely "non-therapeutic" and possi-
bly are reflected in the results of our study. 1. Patients were kept on the ward too long before being staffed, and 2. geriatric patients were retained too long on the ward resulting in a larger than usual number of older men who needed special care and were unable to participate in ward activities to the extent younger men did. Both situations came about because of the shortage of physicians necessitating a longer wait before the diagnostic staff could be held.

In spite of this unavoidable variable, the final report of the sociological study is summarized as follows: "It was felt by the group doing the study that some changes had taken place since the last study. The fear and tension present at the time of the last study is not apparent now. The patients seem more willing to express themselves and were able to verbalize that they needed to talk with someone. It is our feeling that this is a step forward but that the aides need to be encouraged to spend more time with patients and allow them to express their feelings when the need is there."

B. Evaluation of Change of the Ward Society

The Hospital Adjustment Scale is designed to be a means for measuring how well a patient adjusts to the hospital, but makes no claim that better adjustment is a measure of a reduction of pathological symptoms. A greater percentage of the patients in the control group receiving no group psychotherapy experience showed improved adjustment to the hospital than those in the ther-
apy group. This could be due in part to the greater resentment which built up during the therapy period when patients were retained a longer time on the admission ward. But it could also be an indication of a desire to leave the hospital, a dissatisfaction which could appear as poor adjustment to the hospital situation. Whatever good hospital adjustment may signify, however, need not concern us in this study, for as measured by the HAS, both groups showed some improvement, but any change in one group when compared to the change in the other group proved to be so slight that it was negligible. Hence, hospital adjustment does not appear to have been modified as a result of group therapy. While the nurse, aides, and the sociological study all reported a less tense, less fearful atmosphere, the individual behavior of the patients as a whole was rated as changing no more during the therapy period than during the control period. In fact, the tendency was in the opposite direction.

Turning to the results of the MMPI, the most convenient way to evaluate the changes would seem to be in terms of the meaning of each of the scales.

The Cannot Say Scale. The difference between the control and therapy pre-tests, while rather large, does not reach the .05 level of confidence and the difference for the post-tests is minimal. However, the change for the control group was sufficiently greater than for the therapy group that the difference between the mean scores for pre- and post-tests is significant at the .05
level. This was accomplished purely as a result of a lowering of the mean score for the control group, which was especially high on the pre-test but close to both the pre- and post-test mean scores for the therapy group. The only significance which can be attached to this is that pre-test mean scores for the other scales for the control group could be somewhat lower than they might otherwise be, since the "Cannot Say" items appear in other scales.

The L, F, and K Scales. There being no significant differences on these scales in any of the comparisons, they do not contribute to an understanding of any changes with which this study is concerned.

The Hs Scale. The therapy group scored significantly higher than the control group in the pre-test. This difference does not appear in the post-tests. While there was a marked lowering of the mean score for the therapy group in the post-test, the mean score for the control group was lowered also to such an extent that the difference between the pre- and post-tests does not reach the .05 level of confidence. That the significant lowering of the therapy group's score can be attributed to group therapy cannot be asserted with confidence, for apparently hospitalization alone or undetermined factors can result in a lowering of this scale score.

The D Scale. There were no significant differences on this scale in the comparisons of the pre-tests, the post-tests, or the difference. The control and therapy groups each showed a significant lowering of the mean scores between pre- and post-tests, but
these were in the same direction suggesting that hospitalization alone was sufficient to result in some reduction on this scale.

The Hy Scale. On the pre-test, the therapy group scored significantly higher than the control group, but the difference disappears in the post-test. The mean scores for both groups were lower for the post-test, but the difference between the pre- and post-tests is not of significant magnitude to attribute the change to group therapy.

The Pd Scale. The change in the mean score for the therapy group was sufficiently great that although the control group's score changed in the same direction, the difference was enough to be significant at the .05 level of confidence. Personality disorders was the diagnosis for 42.9% of the control group and 41.3% of the therapy group. More control group patients were placed in this diagnostic category than in any other and of the therapy group, only psychotic disorders had a higher percentage (44.8%) of patients thus diagnosed at the time of the psychiatric evaluation. Because of the interpretation often attributed to a combination of high Pd and Ma scale scores, the Ma is considered next.

The Ma Scale. There is no significant difference between the mean scores in the pre-tests or post-tests for the control and therapy groups, but the mean score for the control group increased slightly between pre-test and post-test while that for the therapy group was reduced enough to be significant at the .01 level of confidence. The change between the pre-test and post-test differ-
ence is significant at or beyond the .01 level of confidence, making this scale most sensitive of all to the changes resulting from group therapy in this study.

Throughout the literature on the MMPI, persons scoring high on the Pd and Ma scales are considered to be tense, overactive, and inclined to engage in acting-out behavior. They are restless and talkative. Marital and family problems are common and often there is considerable anxious distress.

The Pd scale consists of items concerned with social maladjustment and a lack of strongly pleasant experiences. These items include complaints against family, feelings that the person has been victimized when a child, of general boredom, and of being isolated from the group. The Ma scale is made up of items dealing with expansiveness and inflation of the ego plus a number of items revolving around irritability.

**The Mf Scale.** There were no significant differences between the pre- or post-tests and virtually no change in the difference between pre- and post-tests. This scale proved to be the least discriminating of change as a result of therapy of all the scales.

**The Pa Scale.** The change between pre- and post-tests for the control group was negligible and for the therapy group significant at the .05 level of confidence. The pre-test and post-test differences between the two groups were, however, not significantly different nor was the change between the differences sufficiently great to be able to attribute any change in the therapy group to
The Pt Scale. Both control and therapy groups showed a lowering of these scores in the direction of a normal score and both to the extent that the changes were significant at the .01 level of confidence. But there was no significant difference between the groups on either the pre-tests or post-tests. Both groups changed in the same direction, the therapy group somewhat more than the control group, but not enough to be able to predicate a change as a result of therapy.

The Sc Scale. There was no significant difference between the pre- or post-tests and no significant change between the pre- and post-test difference. While the therapy group did change enough between pre-test and post-test to be significant at the .01 level and the difference for the control group was relatively small, there was insufficient difference between these changes to make for a significant difference to make it possible to credit group therapy for the change.

The Si Scale. The difference between pre-tests and post-tests was insignificant. The control group's mean score was lowered slightly between the pre-test and post-test whereas the therapy group's score was reduced enough to make the difference between the changes significant at the .05 level of confidence.

Retest Correlations: The significance of the difference between pre- and post-tests for each group indicates systematic differences. Because of the size of the groups, testing the signif-
Sicance of the difference between the coefficients for each scale is not possible. A high correlation coefficient would not be expected in a hospitalized group such as the two considered in this study. Hospitalization alone seems likely to modify the person's responses to the inventory, unless the personality and character traits measured are themselves rather stable. Furthermore, a change in the group will be indicated by a rather lower coefficient. Rather high coefficients were obtained for the F, Hs, Sc, and Si scales for both groups. It would seem that the dimensions of personality measured by these scales are relatively stable.

In spite of this, the change resulting from therapy as measured by the Si scale was significant at the .05 level, though the coefficient for the control group was .871 and for the therapy group .825. This can possibly be explained by the fact there was a very wide range of scores for this scale.

The scale showing the greatest change (<.01) was the Na scale for the therapy group. Here, we find a high coefficient for the control group where the mean score increases only slightly, whereas the coefficient for the therapy group was one of the lowest of all the scales. This tends to support the conclusion reached above that the personality traits measured by this scale changed most as a result of therapy.

The remaining clinical scale which showed a significantly greater change for the therapy than for the control group was the Pd, for which is found a correlation coefficient of .524 for the
control group but a higher coefficient of .670 for the therapy group. From the coefficient alone, we might expect a greater change for the control group, but actually the change was very slight in the direction away from a normally elevated score. For the control group, there were many individual changes in both directions, rather than a group change in the direction of lower scores as shown by the therapy group. But the range of scores was not great.

During the control period, this group of patients showed little change in MMPI mean scores. Except for the K, Pd, Ma, and Si, the general tendency was in the direction of lower mean scores for the post-test than for the pre-test. All changes, however, were quite small, with the exception of Pt, which difference was significant at the .01 level of confidence, and the "Cannot Say" and D scales, on which the difference was significant at the .05 level. The case is quite different, however, for the therapy group. Except for the L and K scales, all mean scores displayed a tendency to be lower in the direction of a normally elevated score. The difference for the L scale between pre- and post-tests was not significant and the K scale difference significant at the .05 level of confidence. Of the remainder of the scales, the "Cannot Say" and Mf did not change significantly, the mean score differences being very small between the two tests. But the mean scores for all other scales changed from pre- to post-test in the direction of a normally elevated score to an extent that the differ-
ences were significant at the .01 level of confidence.

Considering these two groups in this way, there is a strong suggestion that therapy was undoubtedly helpful. But before drawing such a conclusion, it is necessary to compare the changes on each scale for each group. When this is done, it is found that a change resulting from group therapy alone can be attributed to only those traits, personality characteristics, or attitudes which are measured by the Ma, Pd, and Si scales.

If we consider these scales apart from those on which the change did not reach a significant difference, we should expect to find the ward less hypomanic or less vigorously active, better adjusted socially, with more interaction among patients. There would be less tendency to act out, less tenseness, fear, and apprehension. Patients could be expected to be somewhat less irritable and, though they may talk about family problems and their complaints, we might expect the talking to be somewhat more constructive. That the ward did seem to change in this way is supported by the interviews with the ward personnel and by the sociological study made by the nursing education department. The latter knew nothing about the study made on this ward, so this report might be considered truly objective. The ward personnel described the patients in general, after group therapy had been established on the ward, as less fearful, less tense, and more willing to discuss their problems with the aides, nurses, and other patients. They were more sociable and interested in one another. The socio-
logical study resulted in the conclusion that a change had taken place in the ward atmosphere, with less fear and tension and a willingness to express themselves.
CHAPTER V

SUMMARY AND CONCLUSIONS

A male admission ward of a state mental hospital was studied to try to determine in what ways, if any, a ward itself changes if group psychotherapy is employed in addition to the normal therapies regularly used. A group therapy population was compared to a ward population lacking group therapy. All other conditions remained the same for both groups. All patients admitted to the ward during a two month period were rated using the Hospital Adjustment Scale and those capable of taking it were given the Minnesota Multiphasic Personality Inventory. These were repeated for the same patients one month later and the difference in mean scores reported. One month after the completion of this procedure, to allow time for these patients to be transferred from the ward, group psychotherapy was started on the ward. Once the group therapy program was established, all newly admitted patients were rated on the Hospital Adjustment Scale and given the Minnesota Multiphasic Personality Inventory if able to complete it. These were repeated one month later and the difference in mean scores reported. The head nurse and four aides assigned to this ward during the entire period of the study were interviewed to determine their own opinion of any changes which had taken place. The
nursing education department conducted a sociological survey of the ward before group therapy began and another survey after the completion of the study of the ward. Those participating in the sociological survey were unaware of the nature of the study reported in this paper.

The following results were obtained:

1. The difference between the differences of the mean scores of the two groups were not significant for the total score or any of the subscores on the Hospital Adjustment Scale.

2. The difference between the differences of the mean scores of the MMPI for the two groups were significant at the .01 level of confidence for the Ma scale and at the .05 level of confidence for the Pd and Si scales, the change being in the direction of a more normally elevated score for the therapy group. The difference for the ? scale was significant at the .05 level of confidence in the direction of a more normally elevated score for the control group.

3. The observations of the nurse and aides were in agreement and also agreed with changes which could be expected from the changes noted on the MMPI scales.

4. The sociological survey revealed changes in the ward society in keeping with the results expected from the measured MMPI changes and with the observations of the nurse and aides.

The Hospital Adjustment Scale seems to be insensitive to changes which could be accomplished on an admission ward, in all
probability because of the large number of items which would be applicable on an intensive treatment ward or even a chronic ward, but had to be scored, "Doesn't Apply," because inapplicable to patients on the admission ward. Hospital policy and ward limitations prevented an improved score on such items as those referring to behavior on home visits.

On the basis of the MMPI scales which showed a significant difference as a result of group therapy, the observations of nurse and aides, and the report of the sociological survey, the conclusion can be drawn that on this admission ward, group psychotherapy did produce a more therapeutic society in which the patients were less fearful and tense; there was less acting-out behavior; there was improved cooperation between patients; and patients were more willing to discuss their personal problems with one another and with ward personnel.
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I. PRELIMINARY CONSIDERATIONS

What has been the ingredient or ingredients that have been brought into the ward community by this group psychotherapy project? What is the central factor or factors which are unique to this effort? Essentially the ingredients or factors have been the person of the therapist. He has operated with certain ideas, on the basis of certain attitudes, expressing himself through particular techniques. It would be well to get an overview into this person of the therapist so as to appreciate what ingredients or forces he has brought to bear in this ward therapy project. Here the therapist will have to describe his philosophy, his attitudes as he can best know them, his observations of techniques and interactions; in general, we must get at the mind of the therapist and he must reveal himself to us as subjectively as possible. His statements, therefore, must necessarily include a great deal of subjective self-description.

I know that the best I can bring to the patient is myself. I cannot be any better than what I am at best, but I can be worse than my best. I must therefore keep in mind my purpose: To express the essence of what I see good in me or that which I see good in others and I must continuously keep looking to find that which is worthy in the others. Another aspect of the purpose can be expressed in the following manner: Be open with the patients to the best of my ability. I will try to be direct, forthright, sincere as best I can. I will make mistakes and hope that I will be corrected and I will look for such corrections. With this knowledge that I will be in error and that I will seek correction,
I am willing to state my opinions as honestly, clearly, and directly as possible so as to test them against the thinking and evaluations and reactions of the patients. I will not know how right or wrong I am unless I can state the opinions and act upon them in some manner, observe the consequences, then learn from the results.

We find much which is dreadful, frightening, confusing and numbing in the experience of the patients. Much of this has not been possible of denial, nor has it been explained away. Some of it remains quite realistically present to be endured at first, then perhaps overcome by a change in one's inner philosophy and reactions.

In this process of facing and overcoming there have been occasions when the patients and I, in a somewhat joking fashion or lighthearted mood, have gone into very deep and disturbing problems. In this "light" way we were able to talk about experiences that otherwise would be too disturbing to bring about. This has appeared to be a helpful use of "good humor." I have not "tried" to spare the feeling of patients - when a patient asked me a direct question I answered it directly. I have been willing to state my disagreements with patients or my agreement with them. Sometimes this disagreement has been stated deliberately with the purpose of provoking anxiety or of unsettling a person from a defensive position in which he had settled. For example: When a patient said that there was nothing wrong with him, that he should be discharged immediately or very soon, I replied to the effect that I thought there were several things wrong with his thinking, that one major thing I saw was that his thinking was very self-centered - furthermore, since he had been in institutions for eight years he was likely to remain eight years longer and eighteen years after that unless there were some changes in his mind or in his inner makeup. At other times I have been willing to state an opinion not so much to provoke anxiety but rather to introduce an idea which might start a trend of thought, that is, point out an avenue which a person might find interesting to explore within himself.

Knowing that I am presenting "that which I am" for the patients to observe and respond to, I hoped to elicit some of their own correct perceptions, sound judgment, intelligence, nobleness, purposiveness, strength, self-determination, as well as interest in their own mistakes. I feel these reactions were obtained.

This inner self which I am includes my attitudes, my understanding and the technique by which these were expressed. All this is reflected in part in the previous statements, and in an earlier paper written about the female ward. Since the same atti-
tudes, understanding and techniques apply to the project on the male ward, it will be instructive to repeat what I stated in that paper.

I noticed that the admission patients were the ones that were usually in the greatest turmoil. After some observation I concluded that this was because the admission patients were, on the whole, filled with anxieties, not being as yet adjusted to the hospital, nor sufficiently adjusted to the stresses that led up to their hospitalization. The admission patients have as yet not made clarification and resolution of their inner problems, experience much turmoil and the greatest fluidity in their mental structure and have an acute desire to integrate their inner experience. This desire can be worked with to help them integrate themselves, (1) in a more healthy manner than they have before their hospitalization or, (2) in a more healthy manner than they might, if left to do it alone. It might be, I thought, that some of these might make an adjustment on their own, at least a hospital adjustment, yet one which would not be sufficiently helpful to them to cope with the problems with their families and the society at large.

I concluded that these patients having a need for help because of their acute anxieties would respond better than others to a limited effort from me. Furthermore, I felt some confidence in their constructive interactions for I observed these patients searching for help from each other, and some of them appeared capable of giving and receiving help if and when their constructive emotions and realistic perceptions were elicited. The following points seemed to fit these patients.

A. I regard the individual patient on the admission ward.
   1. As I look into his sources of anxiety, I note these to be outstanding:
      a. The events just prior to and leading up to the patient's hospitalization, especially the final ones involving the relatives, police, parents, children, friends, even strangers - that is, events with people - are fraught with pain.
      b. The disruption of and separation from long range desires and goals, activities, the disruption of his ties, not only to persons, but to his work, his interests, his habits - these are cut off with a sense of loss.
      c. His emerging concept of himself as "crazy" and having or feeling his symptoms, his sensing that "part of me is out of control," or that something in himself is not part of himself, the awareness of this and the reactions of others to these symptoms is
frightening.
d. His reactions to other patients, "who are those others?" especially to see that he is classified with some others whom he can plainly see to be "crazy"; the external or superficial interest, sometimes the indifference, of the staff as experienced by the new patient (for the nurses, the aides, the doctors and other hospital personnel usually appear to the new patient as being impersonal and generally insensitive and indifferent to him with his own unique problems); "the hospital" has an impersonal and cold feeling. All this gives him the feeling that no one could really care for him.
e. The hospital routines impose restrictions, medications, clothing, etc. This may also have a de-personalizing, constraining and inhuman influence.

2. The admission patient, however, has reality contacts and is able to appreciate many aspects of reality. For example:
   a. He may appreciate another patient's distortions and recognize them as distortions.
   b. He may appreciate another patient's pains and fears and perhaps the true basis of the pain and fear.
   c. He may appreciate another patient's talents, his goodness, hostility and other real motivations behind the patient's expressions.
   d. He may appreciate the limitations of the hospital due to impersonal circumstances such as lack of staff time, lack of information in a staff member who may answer a question with "I don't know," may appreciate problems around plumbing, food, linen, his physical ailments, lack of privacy, etc.
   e. He may give understanding and companionship to a degree wanted by another.
   f. He may correctly describe his own or another's problems, the situations on the ward or at home, and may go on to look at his own contribution to the problems.

3. The new patient asks himself "What am I?"
   a. What are my problems?
   b. What are my abilities, what are my strengths, what can I do?
   c. Can I trust myself? When? With whom? What do I really know?

4. And when we study him:
   a. We may look to observe what he does accept and what he does reject in himself. We may look to see what are his plans, his desires, his frustrations, his purposes; what is his past and his future, as he sees
it and as we think it possible.

b. We may wonder and look into whether he thinks of himself and feels as an object or whether he thinks of himself as a person within himself.

c. We may wonder and look for information on whether he feels responsible for himself, for his problems, for his treatment, for his recovery, for other patients, for ward problems and for staff matters.

B. Let us also see and note a few features of the ward to which he comes.

1. There are the formal lines of authority which the patient must know, the channels through which he must go in order to get his needs attended to. What can he expect from each of the various staff people? The personal aspects of these staff people are important.

2. Then there are the lines of influence within the patient groupings; that is, which are the most respected patients, the ones that would protect you, the ones who might be able to speak for you, the ones whom you should fear, the ones to whom you could go when you have a problem on your mind, the ones whom you can trust.

3. Then there are the ward routines. The sequences of the getting up, the dressing, the breakfasting, the cleaning, the activity programs, the staffings, etc., and how does one react to these routines—obediently, passively, rebelliously, with understanding and cooperation, or in some other fashion.

4. Then there are the important ward programs, the student nurses, the activity therapies, the visits from home, the orientation group.

C. With all this, I felt that the ward milieu was too impersonal. There were not enough personal contacts built into the administration of the ward. I suspected that perhaps the staff and I were allowing the clear, formalized demands on our time push us away from the unclear, the novel, the vague reachings out of the patients for personal contact. I also felt that because we might be somewhat unskilled and unfamiliar with some of the problems in the patients, we might find it easy to stay away from them and become engrossed in the familiar and known duties and treatment programs. In addition, I noticed that it is easy to allow oneself to be caught up in a rush of "necessary" business and then to remain caught up in this business such that the important, personal matters were left to be done later and often not at all. I decided to attempt to make the ward society more therapeutic.
II. IMPLEMENTATION OF THE THEORY

How could I implement this concern and theorizing about the admission ward patients? By getting better acquainted with the patients on the ward and build up the establishment of "group therapy" sessions on the ward if I were asked.

A. There had to be a process in which I would choose certain patients as being of value to me; they would choose me as important to them. I did this in the following way:

1. I visited the ward informally, greeting the patients, chatting here and there, asking questions and listening to as much as they were willing to tell me, never staying with any one patient very long.

2. After a time, certain individuals went into their problems a little more deeply and occasionally two or three would gather around me and talk rather intimately about their problems. It seemed that at this point there was beginning a group that was spontaneously choosing to be open together. At one point, as I was talking to one man, several others, I believe it was five others, gathered around. Several of these others made comments showing that they had a similar problem as the one that was opening up. After about twenty or twenty-five minutes of this we felt we had achieved a feeling of mutual trust and understanding. They asked whether we could meet again. I agreed to meet with those patients and asked whether they would mind if we had a general meeting to which all the patients who were interested could come. They accepted this idea.

Then I asked whether we could meet regularly on a scheduled basis. They enthusiastically took this up.

3. When I thought about this group meeting later, alone, I decided to put an announcement of the meeting on the ward bulletin board, inviting anyone who was interested in discussing their problems - their feelings about the hospital, their families, and themselves - and anyone who was interested in hearing others discuss their problems, and anyone who wanted to ask questions about such a group, would all these sign their names to the paper bearing the announcement of the first meeting. At the time of the meeting, there were fifteen signatures affixed to the announcement.

4. At this first meeting, there was a discussion of the tentative purposes and the schedule for the meetings was made up. We were to meet twice a week for one hour each time. Then we went on to questions about personal problems and hospital procedures.
B. From that first meeting we have continued to the present.

1. At first there were anywhere from fifteen to twenty pa­tients in the group and very few of these took an active part. These few were usually those who were quite hos­tile or the few who had great anxieties and had to talk about their problems. There was not so much a careful search of how they felt but a pouring out of pent-up feelings.

2. At first the people attending this meeting were mainly the physically mature persons, excluding for the most part, senile patients and the teenagers. Teenagers, at first, attended irregularly, but gradually they have attended more and more frequently.

3. The attendance has increased to the point where now almost everybody attends every meeting. Very few stay away and when they do so it is for compelling reasons, such as that they may be at a staff meeting, they may be ill, they may be off the ward for some special reason. The number of people present varies from between thirty to fifty pa­tients, according to the ward census and the number on home visits, sick, etc.

4. Now it seems that the total patient population is partici­pating to a greater or lesser degree in the meetings; but not only the patients, also the nurses, aides and the stu­dent nurses attend whenever possible - so that it does seem as though the total ward is participating.

III. THE TYPE OF INTER-ACTION WHICH OCCURS

A. My original ideas have determined this, in part.

1. I had proposed to try actively to draw out the groups' re­sponse to any given patient. I ask for problems similar to the one stated; I ask for reaction to the stated feel­ings of a given patient; I ask for advice from the pa­tients when a given patient asks for advice; when a pa­tient seems to need sympathy and I notice some of the group responding sympathetically, I sometimes encourage such patients to express their sympathy as openly and clearly as possible. Occasionally when one patient has broken down and cried, I have sent that patient with one or two others who are able to appreciate this one, to one side where they tried to listen and comfort the crying one while I continue with the rest of the group discussing some other problems.

2. Another idea I began with, which I am carrying out, is that I direct the patients to express as much as they can in a group meeting, and if ever an additional problem
comes to them which they cannot express publicly then they should think as far along as they can, up to the point where they feel frightened and hurt in their thinking. I advise them not to stop there, but to continue in their thinking through the pain, and then to find some one patient or staff member to whom they feel they might be able to communicate privately some or all of this line of thought. I persist in the response that my time for individual sessions with them is very limited and though I am willing to see them, it will be infrequently. Perhaps it might be two or three weeks before a person who asks to see me privately would be able to meet with me.

3. Another idea I have is that I try to protect any one patient who is not being protected by any other and who is being singled out for hostility by some of the patients.

4. I also proposed to myself that I would not search deeply into any one patient's problem. I am willing to go only as far as the patient is willing to disclose publicly. Furthermore, I may have to relinquish working with a patient even though he wanted to go more deeply if the group is uninterested or unable to go along with this patient in his deeper search.

B. The inclusion of the ward personnel is needed to make the ward people more understanding and helpful of one another.

1. I asked the ward personnel present to make comments and answer those questions asked that were within their scope of information or personal reaction.

2. I urge the patients to go to the ward attendants and nurses with problems of a personal or ward nature. For this to occur under the best conditions, I think it important that the ward personnel should attend the group meetings. I encourage them in this and they attend whenever possible.

C. There have been some progressions in the type of meetings.

1. We began with questions and answers but we are now at the point where individuals can sometimes bring up very deep problems and group members can help in the participation and discussion. Quite often the therapist remains silent while several patients carry on around a given issue.

2. Whereas the problems began pretty much on a superficial basis, we now sometimes get to the point where some proceed to bring up a great deal of anxiety. This often arouses much involvement in the other patients.

3. Whereas we began with a great deal of hostility towards the hospital, criticism of policies, personnel, routines, etc., this has dropped out completely. We have gotten to the point where there has been occasional criticism of
the therapist for his lack of time or his lack of sympathy with some of the patients who want to receive more understanding and time from him.

4. There has been an increasing willingness on the part of the patients to accept responsibility for their own symptoms and their problems and look at their contribution to their difficulties.

5. Since patients are rarely kept on the ward longer than three months, there have been many changes in the population. I have seen many improve and leave; others improve only mildly, a few do not get any better. These last two types are usually transferred to other wards. As some patients calm down and find some understanding and a better order, newer patients begin their expression of distortions and chaos. There is a continuous beginning and ending.

**IV. TECHNIQUES**

Some of the techniques I have used have already been indicated, but a few more can be noted.

A. At times dreams have been brought up for group interpretation. 

B. Hypnosis has been used, on one or several patients at one time. They have been hypnotized and asked to think about whatever questions they have in mind and penetrate whatever block they have about it. Sometimes there have been stated problems which are investigated through hypnosis. Occasionally there have been questions which a person had in mind but would not state to the group. However, even these were investigated so that the person would be able to discover the answer to the questions and see through certain blocks. At various times, some of the patients so helped have stated that they have not wanted to remember what they have found out because it was too frightening. At such points, the hypnotist then suggested to them that they would forget what they had discovered.

C. Psychodramatic techniques have been used. Patients have taken various roles with respect to each other, often the roles of family members, and they have had practice in expressing their attitudes towards these. Occasionally the therapist has deliberately taken on the role of a family member with respect to a given patient and has stated the words of the family member which the patient had described, in this way seeking to get direct responses to the therapist and to handle in a vivid, present way the relationship which is held with an absent family member.
APPENDIX II

TRANSCRIPT OF INTERVIEWS

An Aide

Interviewer: Now, Mrs. B., you were on the ward last fall, weren't you?

Aide: Yes.

Interviewer: And then, during the winter and on through this spring. So, you were here at the time that Dr. Vargas began his therapy on the ward. Now, what we are interested in knowing, is your own opinion, your own reaction to group therapy, and what it's done on the ward, how it may have changed the ward, if it has changed the ward. Now, not just each individual patient, but you know, a ward seems to have an atmosphere to it and sometimes you go on one ward and it has one kind of atmosphere, and you go onto another ward and it seems to be somewhat different. There would be a difference, for instance, if you went on P-2 than if you went on 0-1, wouldn't there. You would feel it as you went on there. Now, do you think that the atmosphere of the ward society here has changed between last fall and this spring, since Dr. Vargas began his group therapy. Do you see any difference, and if so, how could you describe this difference. Just put it in your own words, any way at all.

Aide: Well, now, the one thing that I see that the patients that we have now... Well, first, I want to say that we have such a big turnover until it is actually hard to tell how much change there is, but for the patients that we have for a month or two months I can see that there is some change. They seem to enjoy and look forward to the meetings and to Dr. Vargas' coming, and they talk, they sort of tell their troubles and share their troubles with the other patients. And, now the group that we have, they remember the days that he is coming and they get all the chairs together in the room and they get the tables out and they sort of clean the ward - the room, up for him. So, I think that this group is showing more improvement, and seems to enjoy having him up here, more than any group we've had so far.

Interviewer: Do you see any difference in the ward when he is not
here having therapy? In other words, he's here only one hour Monday and one hour on Thursday. How about all of the rest of the time? Do you think that the ward is any different than it used to be, or is it just the same?

Aide: Well, they seem to go about their business about the same, I suppose. Their daily routine. Some of them don't go to the meetings anyway, but the majority of them do go to the meetings and they go about their work, they help clean the ward and well, I say again that when they know he is coming they do look forward to it.

Interviewer: Do they do a better job of cleaning the ward than they used to do? In other words, now that they have group meetings, do they, is the ward quieter, or is it more noisy, so the patients participate in the activities better or with more enthusiasm, or with less enthusiasm, or what? Have you any other observations?

Aide: I think that they participate in the activities more better, because we had one particular patient, he'd lose when he came here he was sort of afraid, and he didn't know what was going to happen. So, the aides really didn't have time to talk to the patient and spend as much time with him as they should, so that this meeting has really helped him because this way he found out that he would be able to go to the activities and to church, and all, and I think that he participated better in the activities once that the fear left him.

Interviewer: In other words, you mean that even if you can't see any other change, at least the patients, now, get to know more what's going on, because of being able to talk at the meetings, so that they can participate a little more freely.

Aide: Yes, I would say so.

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An Aide

Interviewer: Miss P., you were on the ward since January with group therapy. Now what we are interested in knowing is how the ward has changed, if there has been a change on the ward since group therapy started. In other words you remember how the ward was last fall and then group therapy started. Has there been a change in the ward. We are not interested in each individual patient, as such, but you know you kind of have a feeling that the ward is better or the ward is worse - just like some days the ward is better and some days the ward is worse. Has there been a real
change in the ward atmosphere, maybe we can call it, since group therapy started. And, if there has been a change, how do you think it has changed. Can you describe how it has changed, either for better or for worse?

Aide: In a way, a lot of the patients like to go into meetings to express theirself. And, others, feel that it harms them if they express theirself in these meetings, so therefore, they don't go down there. They learn a lot of policies in the hospital that the aides don't have time to tell them and they can adjust better through these meetings. In these meetings the patients get better acquainted with one another, they learn to talk easier with one another and they talk their problems over with one another, instead of keeping it inside of them.

Interviewer: Well, how does this tend to change the atmosphere of the ward, at times when there is no meeting in progress. In other words, in between meetings, how does it seem to change the whole atmosphere.

Aide: They talk to one another everyday instead of waiting for the meeting, they talk their problems over with one another. No other changes, except that the patients, like I say, get better acquainted and there is no arguing or bickering between the patients.

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An Aide

Interviewer: What we want to know is if you've seen any change in the ward since the middle of January. You know, Dr. Vargas has been conducting his group therapy since about the middle of January. Now, do you see any changes in the ward since the groups began. We're interested in the ward as a whole, not the individual patients, one by one, but the whole ward. Do you see any change in the ward, does it seem different to you in any way, and if so, how does it seem different?

Aide: Well, in one respect, the patients seem to be more together, and then they talk together quite a bit, and then they look forward to having these group meetings every Thursday. And, as a whole I think it's good for the patients.

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An Aide

Interviewer: Now, you've been here on the ward since last fall,
haven't you?

Aide: That's right.

Interviewer: And, in January, you remember, Dr. Vargas started his group therapy. Now, what we are interested in knowing is whether you see any changes on the ward since Dr. Vargas has been conducting his group therapy. We're interested in the ward society as a whole, not just each individual patient. We want to know if you feel that there has been any change in the ward - if the ward seems different since the first of January or the middle of January when the group started, from the way it was before that time, and if so, how.

Aide: With the group motivation, group discussion, I think it has helped the patients quite a bit, inasmuch as they seem to discuss more problems with the employees on the ward, and there seems to be a much less tensified atmosphere among the patients on the ward. And with the test that you have been running, I think I have not seen any much improvement with the patients themselves, but possibly this could have benefited in some type of way.

(This aide returned a few days later saying he had something to add.)

Interviewer: Now, Mr. S., you said you had some more things to say that you didn't think of the other day because you weren't forewarned at all, and some other things had occurred to you. We'd be real happy to have all of your ideas about what you think has happened on the ward, how the atmosphere on the ward, or the general feeling on the ward may have changed since the beginning of group therapy. If you see any changes, whether for better or for worse, we're interested in knowing.

Aide: I think that the group therapy meetings have benefited the patients quite a bit. I think it gives the patients...a...well...it...lets patients know more about the different procedures that you have to go through here in the hospital, and also, I think it also causes a less tensified atmosphere here on the ward.

Interviewer: You say the atmosphere is less tense on the ward. Just what do you mean by that? How can you - how is it shown? How do the patients show a less tense feeling, can you tell us that?

Aide: Well, I think if the patients know more about the different things that are happening on the ward, and the different things that they have to go through, well, this, in a way, in a sense, would lessen the tensified atmosphere.
Head Nurse

Interviewer: You were on the ward last fall, and have been on the ward right straight through, haven't you?

Nurse: Yes.

Interviewer: So, you were here when Dr. Vargas started his group therapy in the middle of January. Now, what we're interested in knowing is your own opinion of this, we want a truthful opinion. How you feel about it. Whether you see any difference in the ward as a society, as a ward, during this last three months since there has been group therapy on the ward, from the way it was before that. Does the ward seem different in any way - maybe better, or maybe worse. And if you see it as different, in what way do you see the difference? How do you think it is different? Now just put it in your own words.

Nurse: Can I express anything? I have noticed one change in that I think this is something that Dr. Vargas was trying to do in starting this group. That the patients - some of the patients who are better able to get around and who are in better contact have been helping some of the patients who have, for instance, physical defects, or, well, they have been helping them with their personal hygiene and I think they are also a little more tolerant of patients who may seem rather odd to them. It also seems to have good psychological effect on the patients, in that we have been rather low on staff, as far as doctors are concerned and, and the patients don't see their social workers. But, here at least, they see some other professional person, twice a week for two hours, or for one hour each time, and this makes them think at least that someone cares about them, and they are getting some therapy. One thing I did notice that patients usually, immediately after therapy, within the next ten minutes or thereafter, they seem to be anxious to talk to the individuals, and they will come and approach us and it seems that these group meetings stimulate them to talk about themselves, even if they haven't said a word in the group meeting. They just seem very anxious to tell someone about their problems. I noticed this change.

Interviewer: Now, you've been on the ward through this whole period, and you've seen changes perhaps as a result of the group therapy being conducted. Has there been anything happen on the ward in the way of personnel that you think may have adversely affected the ward. Do you think that maybe something has happened in the way of staff, or anything like this which may have made the ward not improve as much as it might have otherwise.

Nurse: No. There have been very little changes in personnel
since we began the group.

Interviewer: Well, do you think staffing has affected the ward?

Nurse: What do you mean?

Interviewer: Well, are they staffed later now?

Nurse: Yes, they are. There is a period of restlessness that we noticed. However, it doesn't seem so noticeable because, as I say, they do have this contact with some type of professional person, even though they don't see a psychiatrist.

Interviewer: Do you mean that the staffings now are not as soon as they used to be.

Nurse: No, they are not, however, there is - seems to be some type of a substitution.

Interviewer: So, in spite of the fact that staffing was what - about four weeks after admission before.

Nurse: It's now from six to seven weeks following admission.

Interviewer: And, in spite of this, the patients don't seem to be more restless because of having the groups.

Nurse: I think that the groups do help a lot in keeping them from being so restless about it.

Interviewer: If Dr. Vargas were to say, well, he was busy and is going to have to stop having his group, how would you feel about it?

Nurse: I would be very disappointed because I think it has been a very valuable thing and if patients can get accustomed to having group therapy here, perhaps they would be able to adjust better on some of the wards that they go to, or, maybe they could make a good adjustment at home. Although we don't have any patient government or any actual group in our male continuous treatment area.

Interviewer: How would the patients feel if we were to have to discontinue the groups, do you think?

Nurse: I think they also would be very disappointed, although some patients don't attend every group meeting, I'm sure there's many of them would miss them if we were to discontinue them.
Interviewer: What part have you taken in the groups? Have you attended most of the group meetings and participated, or have you missed most of the group meetings, or have you been to the group meetings and just attended and said nothing, or what?

Nurse: I have been able to attend almost all of the group sessions. Sometimes, I am interrupted. I've usually been - not participated, unless there was some question come up that Dr. Vargas was unable to answer as far as ward routine, staffing, and, I don't know - routine practices. Very often some of the things that the patients say in this group meeting are very - very helpful in giving us clues as to how we can have our personal relationships with our patients. And, also, sometimes it is very helpful in our staffings - some of these things that are brought up. Although maybe I should be careful not to mention that.

Interviewer: What you are really saying then is that you can help that - by having groups on the ward, the patients reveal things which members of the staff such as the nurse and the aides then use to better minister to the needs of the patient and also give the doctor a better picture. Is that right?

Nurse: Yes. I mean the individual needs of the patient sometimes these are not brought out except when the patient speaks up in group therapy. It seems strange that there should be....When group therapy first began on the ward it seemed that some of us were, us professional people, were a little bit discouraged, but as time went on, even though we have such a turnover of patients, it seems that we have developed better attitudes toward the groups and the patients pass on the word that there is group therapy and thus it seems that there is more interest among the patients and the aide group, really, in the program.
APPENDIX III

SOCIOLOGICAL STUDY OF THE MALE ADMISSION WARD BY
THE NURSING EDUCATION DEPARTMENT

Summary of Questions Asked

1. Who is the most important person in this hospital?
2. On this ward who would you go to if you needed help?
3. Do the employees tell you where they are going when they leave the ward?
4. What is the bath routine on this ward?
5. How do you get a message to the doctor when you want to see him/her? Psychologist? Social Worker? Chaplain?
6. Who gets snacks between meals other than canteen supplies? Why?
7. Do you have a rest period in the afternoon or can you rest anytime?
8. Who selects T.V. programs and how often is T.V. played?
9. For what reasons do you have shake downs on this ward? Who does it?
10. What is the most important factor in patients getting well?
11. What is the procedure for writing and sending letters?
12. Who is the "stool pigeon"?
13. What is the least desirable ward job? Who gets it?
14. Who gets meals served first? Who decides?
15. Is there anyone who can make refreshments in certain areas on
16. Are there any cliques on this ward?
17. Who spends most time with employees? Doing what?
18. How long are patients kept on ward? Why do some get transferred and others stay?
19. What patients accompany personnel on errands and assist with special tasks?
20. Who is the ward bully?
21. Who initiates ward group activities such as housekeeping and recreation?
22. What is the best ward job? Who gets it?
23. Whom do you confide in?
24. Who opposes ward activities?
25. Who shows you "the way around" when you are new on the ward?
26. Do patients ever congregate together? For what reason?
27. Who gets the blame when something goes wrong?
28. Who is the most trustworthy?
29. How do you feel about the care you get in the evening?
30. How do you feel about the care you get at night?
I. Purpose of the Study: To give students an orientation to sociological methods for sampling and collecting data regarding interaction of groups of patients and personnel on a ward.

II. Desired Outcomes:
   A. To determine
      1. Who runs the ward.
      2. The quality of patient care given.
      3. Whether or not favoritism is shown, if so, to whom and by whom.
      4. The ward atmosphere.
      5. If any stalemates exist in personnel-patient relationships.
      6. The dominate themes of the ward.

III. Method Used:
   Each student asked several standardized questions of many patients and one or two of the ward personnel. The time allotted for this event is approximately one-half hour after which the students and their clinical supervisor have a Seminar to analyze these samples and recommended ways of intervention to bring about desirable changes.

In reference to the desired outcomes listed above; the following conclusions were reached as a result of this study:

1. A patient runs the ward in a firm and quiet manner. Another patient, his "assistant" handles many of the ward routines such as managing the clothing room but his decisions are made in accordance with the wishes of the patient who runs the ward. One of the staff aides answered the question "Whom do you confide in?" with this patient's name.

2. Good custodial care is given the patients. Their physical needs are tended to readily. Many of the stronger patients assist in caring for the older less able patients. A very minimum amount of therapy is given by the nurses, probably due to their frequent absence from the ward setting. The aides are present but there wasn't any evidence of them giving therapy.
3. Favoritism was observed as being directed mainly toward two patients. Such comments were made as "Mr. __ does a very good job in the clothing room, he is one of our most dependable patients." Also when other patients were asked if favoritism was shown these two names were mentioned frequently. The amount of off-ward privileges generally given to patients depended upon how helpful these men were with ward duties.

4. Superficially the ward was very pleasant and quiet. It seemed very clean and orderly. However, there seemed to be a subtle atmosphere of tension and fear. Patients hesitated to complain or criticize even though they apparently had some negative feelings.

5. One of the obvious stalemates existing was role-reversal. Some of the patients directed routine activities on the ward and handled the tasks of housekeeping. Some of the aides accepted this quite passively seemingly unaware of how the ward was run.

Another stalemate was discovered in that patients were kept on the ward because of the usefulness to the personnel.

Goals are not defined on the ward. The patients generally speaking, have very little awareness of "how to get well" or "how to be transferred". Such answers as "help with the ward work" or "keep the ward clean" were standard.

6. The dominant themes on the ward were dependency, resignation and helplessness. The older and sicker patients on the ward were quite dependent on the younger and stronger patients who cared for them, thus they were pretty eager to please them.

The theme of resignation was picked up on the part of the aides who seemed pretty much resigned to what was going on around them. They did not seem consciously aware of or concerned about what was happening. Some of the patients were resigned insofar as having an attitude of "Oh, well, I will go along with this and soon get off the ward."

The feeling of helplessness was picked up from some of the patients who seemed aware of the situation but unable to change it. Several of them felt their cooperation with the leaders would determine whether or not they would be able to leave this ward.

The feeling of the group doing the study was that the ward setting presently is not very therapeutic. Perhaps more teaching to the aides and a clarification of their role in patient care would lead to a more therapeutic ward atmosphere.
I. Purpose of the Study: To give students an orientation to sociological methods for sampling and collecting data regarding interaction of groups of patients and personnel on a ward. This study was requested by Psychology in conjunction with a research project to evaluate the ward society and determine whether any changes have taken place during the past six months.

II. Desired Outcomes:
   A. To determine
      1. Who runs the ward.
      2. The quality of patient care given.
      3. Whether or not favoritism is shown, if so, to whom and by whom.
      4. The ward atmosphere.
      5. If any stalemates exist in personnel-patient relationships.
      6. The dominate themes of the ward.

III. Method Used:
    Each student asked several standardized questions of many patients and one or two of the ward personnel. The time allotted for this event is approximately one-half hour after which the students and their clinical supervisor have a Seminar to analyze these samples and recommend ways of intervention to bring about desirable changes.

1. It is pretty difficult to determine who runs the ward as the ward work seems to be pretty well divided. However, there seems to be some hesitancy to assume the leadership as well as some doubt about who the leader is. Several patients assume this role to various degrees to suit their own purposes, but no one person seems to have complete authority.

2. The quality of care given is mostly custodial. There is little interaction between patients and personnel. The general feeling seems to be that when the aides need to talk with the patients they are called to the "Treatment Room." Also when the patients want something they go to the "Treatment Room" to ask the aides for it.
   It was also mentioned several times that the aides spend much
more time with each other than with the patients. There were
two exceptions to this however, two aides, Mr. ____ and Mr.
____, were mentioned as being willing to listen to the pa-
tients and talk with them.
It was also mentioned by two patients that they have a chance
to talk with a psychologist once a week.
3. It is felt that favoritism is shown to the more aggressive pa-
tients. It could not be pin-pointed to specific patients,
however, as it does not seem to be deliberate on the part of
the aides, but rather that the aides in their passiveness re-
spond to the more demanding patients.
Several of the patients expressed the feeling that Mr. ___,
a patient working in the clothing room, is shown a great deal
of favoritism. This is shown by his spending a great deal of
time with the aides and leaving the ward with them frequently.
4. The physical atmosphere is fairly clean but quite "crowded" in
appearance. Several of the dayroom areas seemed cluttered.
The ward atmosphere seems quite free from tension and fear.
Many of the patients seemed troubled and expressed a wish to
sit down and talk with someone. It was felt that because of
the lack of opportunity to express themselves, there was some
unrest among the patients.
5. There were three obvious stalemates in the ward situation
which we felt had an important affect on the ward society.
The first is the "backlog" of patients who have been on the
ward quite a while and are awaiting transfer. Almost without
exception the patients expressed resentment at having to stay
so long on the ward because they had not yet been staffed.
They seemed to feel that staffing was the most important ex-
perience in their hospitalization and that this one incident
would determine to what other ward they would be transferred
or if they could "ever" go home.
Secondly and very closely related, it was felt that the large
number of geriatric patients who are left on this ward has had
its effect on the other patients in the situation. This great
number of patients needing more physical care and closer super-
vision has lessened the time and personnel available to provide
more therapeutic care for those with functional disorders.
The last stalemate and probably the most detrimental, accord-
ing to the group, was the obvious lack of interaction between
patients and personnel.
The patients expressed repeatedly that the aides, with the ex-
ception of the two mentioned before, didn't have time to spend
with them. The only time they spend together is at off-ward
activities.
6. There were two main themes observed by the group in the ward
situation. The first theme seemed to be waiting; for staff-
ing - for transfer - to see the doctor; many things were men-
tioned, but almost without exception there was waiting. There
seemed to be no ideas of what could be done to shorten this waiting period. It is apparently felt by most patients that it is inevitable. The most important factor in getting well according to several of the patients was to wait for staffing, "it" would be decided there. The second theme was helplessness, this was brought up in relation to waiting. The patients were unable to do anything but wait. They expressed helplessness through their inability to do anything else. They expressed very little overt hostility about their situation but rather a feeling of "that's the way it is, there's nothing we can do".

It was felt by the group doing the study that some change had taken place since the last study.

The fear and tension present at the time of the last study is not apparent now. The patients seem more willing to express themselves and were able to verbalize that they needed to talk with someone. It is our feeling that this is a step forward but that the aides need to be encouraged to spend more time with patients and allow them to express their feelings when the need is there. This interaction should be initiated by the aides and nurses regularly rather than only on special occasions. We feel that the ward personnel are on the ward the majority of the time and their relationships with the patients are important determining factors in whether or not patients get well.
APPROVAL SHEET

This thesis submitted by Reverend David J. Reid has been read and approved by three members of the Department of Psychology.

The final copies have been examined by the director of the thesis, and the signature which appears below verifies the fact that any necessary changes have been incorporated, and that the thesis is now given final approval with reference to content, form and mechanical accuracy.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

May 14, 1964

Date

Signature of Advisor