UNSTRUCTURED AND STRUCTURED GROUP PSYCHOTHERAPY, GERIATRIC PATIENTS, AND DECISION TO LEAVE THE HOSPITAL

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PREFACE

State hospitals are slowly acquiring the characteristics of nursing homes for elderly citizens. Many of those who are admitted to psychiatric state hospitals quickly become institutionalized, unable to function outside of the hospital although they may not be acutely psychotic. In view of the steady increase in the number of elderly people in society today, there is an urgent need to take measures to lower the percentage of geriatric patients in state hospitals to help these institutions fulfill their obligations towards citizens who need psychiatric care. The present research was an attempt to assist institutionalized geriatric patients in making a successful readjustment to the communities from which they had come.

This work would not have materialized without the help of a number of people to whom I feel much obliged. I would like to take this opportunity to express my deep gratitude to Dr. R. Gladstone not only for his understanding attitude, patience, cooperation and constructive criticism as my thesis adviser during the preparation of my dissertation, but also for the privilege of having him as my academic adviser and the Chairman of my Graduate Committee. He has been a source of encouragement throughout my entire program.

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Finally, I would like to mention all the ladies and gentlemen from the Pontiac State Hospital geriatric program who consented to serve as subjects. Without their cooperation this study could not have been carried out. I hope they have peaceful and contented lives wherever they may be. I will always remember them with tenderness.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION

Background of the Study

As scientific advancements in medical and biochemical fields increase the life span of human beings, societies today are faced with the problems of an evergrowing percentage of an aging population. Under various types of pressures, many of these people develop socially unacceptable behavior patterns seemingly necessitating psychiatric care. However, because of the overcrowded condition of many such psychiatric centers, it becomes very difficult to meet the immediate needs of this group of elderly citizens. In order to improve the present situation, either these geriatric patients should be helped through other community resources which could meet their essential needs satisfactorily, or, if hospitalized, they should be treated and returned to the community without delay to prevent them from becoming institutionalized. In addition, careful consideration needs to be given to the problem of long-term geriatric patients who no longer need the psychiatric services of the state hospital, but having lost contact with the outside world, resent the idea of having to make a new adjustment. As one of the representatives of the designated patients expressed it: "...Hospital! What kinda crazy talk is that? This ain't no hospital. A workin' man's home - that's what it is" (Schmidt, 1965).

The present study is, basically, an attempt to move a group of institutionalized elderly patients from Pontiac State Hospital, Pontiac, Michigan, to nursing homes, preferably in the patient's home county. This experiment was designed to discover whether or not group therapy could be used to get the population in question to agree to move and whether using directive or non-directive modes made a difference. Given the experimental design for this purpose, it was inexpensive to investigate other, related questions. These questions were:

1. How does the behavior of hospitalized patients change as therapy goes on?

2. Are there relationships between given behaviors and changes in those behaviors on the one hand and the decision to leave the hospital on the other?

3. How effective are the instruments chosen to measure the behaviors in question?

4. Do the two treatment methods have a differential effect on the hospital behavior of the participating patients as measured by the rating scale?

Review of the Literature

The Hospital as a Nursing Home for the Aged

All those who are involved in mental health programs notice that the overcrowded condition of the geriatric wards in psychiatric treatment centers tend to prevent the wards from fulfilling their functions as psychiatric units and turn them to nursing homes for the aged. Attempts to find feasible solutions to this problem have stimulated research for improved methods of treating the mentally ill aged. In this

connection, the rehabilitation potential of this population has been emphasized in numerous systematic studies (Abraham, 1948; Cameron, 1947; Corcoran, 1950; Silver, 1950; Diamond, 1951; Cozin, 1953, 1955; Linden, 1953; Wayne, 1952, 1953; Lichtenberg, 1954; Goldfarb, 1953a, 1953c, 1954, 1955a, 1955b, 1956a, 1956b, 1957; Grotjahn, 1955; Meerloo, 1955; Solon, 1957, Wolff, 1957; Muller, 1963; Taubenhaus, 1964; Penchansky, 1965; Terman, 1965; Bernstein, 1965, Weil, 1966; Rippeto, 1966; and Nash, 1966.)

The basic concept of rehabilitation, here, suggests the movement of patients from a state psychiatric center to a community centered resource. This movement is extremely slow at present. According to Ross, the major interfering factors causing the delay are the following:

1. Family opposition to the return of relatives to the home
2. Patient inertia
3. Understaffing and overcrowding
4. Staff inertia
5. The matter of "good worker", patients whose release the hospital staff both consciously and unconsciously opposes (1954, p. 93).

Studies dealing with the type of behavior or needed services which necessitates the older patients' continued care in a state administered psychiatric treatment center are extremely complicated. One of the main reasons is that it is difficult to understand and scientifically explain the psychopathological processes observed in later life. This is due to the close relationship of organic and psychogenic symptoms which gradually develop non-rational and maladaptive behavior in some elderly people. It is not clear how much of the deterioration seen in

the aged is due to specific brain changes and how much to the social and psychological factors. We are reminded that even though the aging body is liable to pathological organic change, it is important to remember that psychological stresses resulting from aging in our society may also result in exactly the same symptomatology, but that the psychological stresses are believed to be more amenable to change (Braceland & Donnelly, 1954; Greenleigh, 1955). In this respect, we have no justification for assuming that all elderly psychiatric patients require long-term hospitalization.

A specially appointed research team under a mental health research project, has studied the rehabilitation potential of the above mentioned population in California. Accepting the assumption that the primary function of a state hospital was to serve as a psychiatric treatment center for acute mentally ill patients, they concluded from their investigation that the majority of the patients they had studied did not belong to this type of an institution. So long as there are no definite indications that there patients will benefit from psychiatric treatment, it follows that the essential services required by the group studied are not appropriately rendered by existing psychiatric hospital programs. The team workers felt that what such patients needed most were the type of services required as the result of long-standing physical problems and behavioral patterns. Most of these conditions had existed for years and had become chronic. However, the needed services could be given appropriately in a setting where only medical and nursing services, as well as personal supervision were available to long-term patients (Commission on Chronic Illness, 1956; Scott et al., 1962; Scott & Devereaux, 1963).

Today, institutions such as nursing homes seem to be the best alternatives for the placement of patients who are willing to leave the hospital but who do not have families to return to. These organizations, privately owned or state supported appear for the most part well qualified to take over the psychological as well as the physical care of this population. But the means of motivating these people to decide to leave the psychiatric hospital remains to be determined.

Group Psychotherapy for the Aged

When the management of elderly psychiatric patients poses a pressing social problem, the need for further research on treatment methods becomes urgent. Therapeutic approaches to the treatment of the aged is, at the present, as wide in its orientation as is the treatment of children or younger adult patients. In general, though, group situations where a number of individuals can be helped simultaneously, have proved to be most popular. It is believed to be particularly helpful for elderly patients by providing "a specific corrective experience in improvement of interpersonal relationships, resocialization in the hospital and motivation to adjust outside the hospital" (Wolff, 1965, p. 2). The same author stated that group psychotherapy was of definite usefulness to geriatric patients when the focus was placed on increasing socialization, "interpersonal relationships and group identity and encouraging self-expression while repair of the underlying personality is possible only in a limited way" (1963, p. 17).

Viewed in perspective, a crude form of group psychotherapy existed in ancient history. In the same manner, the role of the group psychotherapist can historically be traced back to the beginning of recorded

time. This author has visited the ruins of the Aesculapium which was a well-known health center in the kingdom of Pergamum, on the Western part of Turkey. Greeks and Romans have used it from the V Century B.C. until the II Century A.D. Here, patients suffering from spiritual ailments used to be gathered together in an underground sacred passage where a voice would make suggestions to them behind the wall under mysterious external effects. Likewise, the therapeutic influence of close informal groups also is well accepted today. Accordingly, any time when special beliefs, blood relationships and/or specific interests develop strong identifications between individuals and groups, the resulting spontaneous small informal groups exercise a therapeutic effect on individual members. Group researchers have repeatedly demonstrated that in more attractive or cohesive groups, members attempt to influence others more and are more willing to accept influence from others (Festinger, et al., 1950; Kelman, 1963; Kaplan & Roman, 1963). Thus, there is not anything new about the use of groups in the service of therapy except that they are artifically created by a highly trained professional person under special circumstances for specific purposes.

Research has shown that small groups offer unique opportunities for reinforcing desirable behaviors while simultaneously counteracting the secondary consequences of hospitalization, such as increased dependency and loss of self-confidence (Peck, 1963). Furthermore, as demonstrated by social science research, the motivational elements for inducing change and growth in individuals inherent in all groups are specifically strong in face-to-face groups (Hare, et al., 1955; 1963; Parloff, 1963). There is also the conviction in social psychiatry that "... in the small group we can catch simultaneous glimpses of the

societal and intrapsychic. Through such glimpses we may well begin to interrelate phenomena at the individual and community level and thus try to integrate the observations and concepts of the psychoanalyst with those of the social scientist" (Peck, 1963, p. 269).

We have reasons to believe that most old people manage to reorganize their lives by adapting themselves to the demands of their new positions, but there are many whose behavior does not conform to society's new demands. But, in general, it is assumed that their behavior is also motivated, goal-directed and problem-solving however inefficient their attempts might be with poor psychological and emotional tools (Goldfarb, 1956b). Therapeutic counseling in a group setting should help such individuals improve their adjustment reducing the need for frequent and prolonged institutionalization in many cases. In spite of the common consensus among psychotherapists about the beneficial effects of group psychotherapy for geriatric patients, there is considerable variation in the therapy methods practiced.

Group Psychotherapy with Dual Leadership: Various methods and techniques under which maximum therapeutic effects could be achieved have been widely investigated. In this respect, co-therapy methods have established a secure place in group procedures. The use of dual leadership has been looked upon as socially familiar and representing cultural authority for the aged by Linden (1954); for groups of adolescents by Boenheim (1957), Kassoff (1958), Adler & Berman (1960); and in the application of a family-oriented approach to a disturbed child by Belmont & Jasnow (1961). In working with groups of psychotic and schizophrenic patients, similar observations were made by Lundin & Aronov (1951), Orange (1955), and Cameron & Steward (1955). Co-therapy

work with clinic patients, mainly neurotics, was described by Hulse (1956). Studies on the roles, sexes and transference relations to parental figures in co-therapy groups have been reported by Demorest & Teicher (1954), Linden (1954), and Mintz (1963a, 1963b).

Many of these articles about dual leadership groups emphasize the differences they present from single-therapist groups, the special problems encountered, and consequences arising from the differing personalities of the two therapists. Most authors find more positive things to say about the advantages of such an approach as compared to the difficulties it poses to treatment. Mintz, discussing this topic said that "in combining their insights, technical abilities, and other assets, two therapists may offer more to the group than either could offer alone; that a situation close to the primary family is created, providing patients an especially good chance to work out transference reactions toward both parent figures and deal with fantasies about the parental relationship; that patients of both sexes are offered a like-sexed therapist with whom to identify; and that special difficulties in relating to either male or female authority figures can be worked through by patients who would have been unwilling to choose a therapist of the more threatening sex? (1963a, p. 127). Particularly with geriatric patients in a dual leadership group, it was believed that the members become stimulated to readopt the heterosexual interests which they had abandoned long ago and they become more outgoing, wanting to take a more active part in life (Linden, 1954).

Orientations Used in Group Psychotherapy

Before discussing the various approaches proposed for the treatment of elderly patients, we should mention the difficulty of detecting the early signs of non-rational and maladaptive behaviors which later become subject for therapy in the designated group. This is so because of the close interaction between organic and psychogenic symptoms. In this respect, the important role psychological and social factors play in converting neurotic predispositions into pathological mechanisms is well-accepted. Clow (1948), Zeman (1951), Goldfarb (1956b), Shuster (1952) among others believe that many such problems date back to personal maladjustments of long duration. Immature, compulsive, narcissistic and psychopathic personalities may often attain old age without preparing themselves to adjust to the life demands of this new phase of life. Naturally, such individuals who have had difficulties in meeting reality all their lives, have even greater difficulty adapting themselves to social expectations in their old age. Some of the principle group psychotherapy approaches used in the treatment of institutionalized elderly patients will be discussed in the following pages.

Non-Directive Group Psychotherapy: The outstanding spokesman of this supportive approach in the treatment of mentally ill aged is Goldfarb who has summarized his therapy objectives in the following quotation: "The general problem is to develop, restore or preserve a state of comfort and self-satisfaction in which there is dignity and self-esteem, at least a modicum of productivity, and also restraint from unreasonable aggression which may provoke retaliation. This includes the continuation or establishment of satisfactory personal relationships

and the alleviation of biologic tensions with a minimum of substitution and compromise" (1955, p. 495). He further observed that elderly patients, "despite gross differences in reaction type, in the extent of brain damage and physical disability....react in notably similar ways" (1956, p. 182). Other investigators have also remarked the fact that in spite of various diagnostic labels, a common characteristic which these patients share is their basic anxiety. They have an intense ambivalence of feelings which often leads directly to symptoms making them almost inaccessible for therapy purposes (Hoch & Zubin, 1950; Silver, 1950; Linden, 1953; Deaton et al., 1961; Wolff, 1962; Tauber, 1964). Once such individuals are admitted to a mental hospital, many of them become unable to function outside of the hospital although thy may not be acutely psychotic. According to Goldfarb, such old people feel their helplessness keenly and realize that their resources have diminished. Consequently, they find it increasingly difficult to master everyday problems and to satisfy everyday needs. With each new disappointment, or failure, they become less self-confident. This feeling "leads to increasing awareness of helplessness and ever-increasing fears of more failures and of damage. There follows a search for help and for protection which adds to the loss of dignity. Meanwhile the fear further decreases resources through its disorganizing effects" (1956, p. 183). Therefore, in non-directive approaches, the therapist takes over the role of a benevolent, protective parent creating a non-threatening atmosphere in which all members are given a respectful and considerate hearing. In addition, the therapist also helps the development of the type of "personal interrelationships which relieve guilt, permit free expression of emotion, decrease fear and anger, and enhance the sense

of worth" (Goldfarb, 1955d, p. 496).

The non-directive approach in group therapy which aims at the satisfaction of dependency strivings, and other emotional gratifications and socialization, has found numerous followers, among them: Gitelson, (1948); E.B. Allen, (1949); Silver, (1950); Steiglitz, (1952); Linden, (1953, 1959); Ross, (1954); Meerloo, (1955); Slavson, (1956); Goldfarb, (1953, 1954, 1955a, 1955b, 1955c, 1956a, 1956b, 1957); R. Allen, (1962). While trying to overcome their patients' sense of being unwanted, useless and unimportant, these therapists attempt to develop and strengthen a feeling of personal independence in these elderly people throughout treatment. Even if it be an illusion, they want to give their patients the impression that the latter, through their own efforts, have acquired a powerful parental figure as an ally. This maneuver is expected to encourage and reinforce the elderly patients' conviction that they are capable of mastering and manipulating social relationships. At the same time, such changes produced within the therapy situation are believed to have important bearing on the patients' behavior outside the meeting room in their everyday behavior. "Patients are thereby enabled to leave an interview with a victorious triumphant feeling, with a conviction of having a strong protector, or both. Thus strengthened their fear decreases, their anger fades, they are socially more acceptable, more self-respecting and more capable of productive behavior. Hereafter even small successes tend to breed further confidence with increasing, maintained or reinforcible gains in performance" (Goldfarb, 1956b, p. 183). Based on these dynamics, predictions are made that a "reorganization of thought, feeling and action along more productive and satisfying lines" (Goldfarb, 1956a, p. 79)

will eventually occur.

Behavioristic, Directive Group Psychotherapy: For another group of investigators, the main rationale of psychotherapy for disturbed and disabled persons rested upon the assumption that by manipulating environmental conditions, it was possible to induce changes in their behavior. They criticized current psychotherapeutic approaches for not incorporating research findings regarding the most effective means of altering an individual's behavior. They favored well-controlled experimental designs where therapy is considered an "attempt to alter human behavior and emotion in a beneficial manner according to the laws of modern learning theory" (Eysenck, 1964, p. 1). They particularly emphasize the events which are contingent on the responses made by subjects. They fully realize the importance of a functional connection between a stimulus and response. According to the principles of the operant conditioning, it is the subject who must "emit the response to the situation prior to the environmental event that becomes associated with and alters its frequency of occurence in the future either by contiguity or reinforcement" (Krasner & Ullmann, 1965, p. 16). In other words, what happens after a subject has made a response will influence the probability of that response being emitted again.

Learning theorists have already shown that rewards and punishments influence the frequency with which many responses occur in both animals and humans (Broadhurst, 1961). The response-contingent events function as reinforcers which help control or change any type of behavior. A reinforcement is the "immediate environmental consequences of a specific performance" (Ferster, 1964, p. 194). The majority of reinforcements which maintain human behavior are assumed to be of "generalized" nature.

Since most communications at the human level are carried through verbal symbols, their manipulation in therapy situations becomes of utmost importance as a powerful tool to induce changes in patient behavior. Greenspoon (1955), Taffel (1955), Krasner (1955, 1958a, 1962), Krasner & Ullmann (1965), and others have tried to find out to what extent the therapist may guide the patient's verbal behavior by "generalized" environmental reinforcements such as interest, friendliness, saying "right" or "correct" or other nonverbal cues described and utilized in verbal operant conditioning procedures. The results indicated that emissions of many classes of verbal responses can be influenced through experimental reinforcements. Behavior therapists believe maladaptive behavioral processes to be the by-product of "inadequate positively reinforced repertoires" which can be reversed by "manipulating the relevant factor within the context of the same process in which it was originally generated" (Ferster, 1964, p. 205). Thus, it is expected that undesirable behavior would "disappear as soon as alternative effective ways of dealing with some accessible environment are generated" (Ferster, 1964, p. 205).

A series of verbal conditioning studies in a group setting by Verplank (1955), Oakes (1962), Ullmann, Krasner & Collins (1961), Bachrach, et al. (1960), Dinoff, et al. (1960a, 1960b), Spielberger, et al. (1962, 1965), Isaacs (1964), & Goldstein, et al. (1966) led them to conclude that the laws of conditioning which control the behavior of a single individual, are also valid for the conditioning of verbal behavior in small group settings.

These findings encouraged many experimenters to apply the basic principles of behavior modification theory in group psychotherapy on

hospitalized mental patients. Here, the therapist's role is essentially that of a trainer. He conducts himself in such a way that his words and attitudes may influence the production rate of desirable responses. He gives direct instigations to altered behaviors. The problem of generating new behavior is to have it occur. Once it has occurred, then the therapist reinforces it with a meaningful stimulus. Depending on what the therapist thinks is a particular behavior that will help the patient most, he does everything in his power to maximize the frequency of that behavior. Ayllon & Haughton (1964), Rickard, et al. (1960), Rickard & Dinoff (1962), and others systematically manipulated the verbal behavior of mental patients. Another group of investigators (Salzinger & Pisoni, 1958, 1961; Weiss, Krasner & Ullmann, 1963; Krasner, 1958a, 1958b; Quay, 1959; Craddick & Stern, 1964; Sulzer, 1962) with studies in which they either used control groups or periods of no reinforcement (extinction), illustrated that various classes of verbal communications of hospitalized patients may be altered by reinforcements.

One of the reasons why certain therapists prefer to use this directive approach is the fact that the behavior under treatment has been found to be lawful and predictable. An additional advantage, according to Eysenck, lies in its economy of therapy time. Usually treatment is of short duration and "concentrated on a small number of sessions only" so that the alternative hypothesis of spontaneous remission can be "ruled out more sharply than would be the case if treatment had been continued for several years" (1964, p. 1).

With sound theoretical backgrounds, students of behavior modification account for the development of changed behavior in two ways. The first explanation uses the concept of discriminative stimuli. The

patient has been trained to respond to old stimuli in new ways in the therapeutic situation. It is considered likely that the patient may emit the behavior he has learned in therapy in external situations and receive further social reinforcement. Another manner in which change may occur is through extinction. "If the therapist does not make the typical or anticipated response to a patient maneuver, the maneuver has occurred without being associated with a reinforcing change of the environment" (Ullmann & Krasner, 1965, p. 36).

Comparisons Between the Two Therapy Approaches: Even though there are many differences in approaches and techniques, all types of psychotherapies use methods to change the responses of the subjects to various stimuli. Non-directive therapy may also involve a considerable amount of response-contingent reinforcement, but "such social influence procedures are neither consciously nor systematically used in the service of the patient" (Ullmann & Krasner, 1965, p. 41). In the directive approach the therapist actively selects and systematically reinforces specific behaviors.

In the non-directive approach there is the underlying assumption that "if the therapist establishes the proper atmosphere, in the very nature of the patient's disorder, certain therapeutic benefits will result" (Ullmann & Krasner, 1965, p. 11). The therapist, being "permissive", "non-judgmental" and "non-evaluative", changes the patient without influencing him. Stated differently, the non-directive therapist has as his goal the gradual alteration of his patients' attitudes and their way of life through positive suggestion, through reassurance and through helping the patients express their problems freely to an understanding professional. Thus, it appears that "...the

release of 'repressions', or the bringing into awareness of denied experiences, is not simply a matter of probing for these, either by the client or the therapist. It is not until the concept of self is sufficiently revised to accept them, that they can be openly symbolized.... In practice, it is noted that the first step toward uncovering such material is usually the perception of inconsistencies... When such discrepancies are clearly perceived, the client is unable to leave them alone. He is motivated to find out the reason for the discrepancy... Although this process of bringing experience into adequately symbolized awareness is recognized by several therapeutic orientations as being an important and basic element of therapy, there is as yet no objective investigation of it" (Rogers, 1951, pp. 147-149).

The above formulation of the non-directive approach brings out another important difference between the two schools of group psychotherapy. While the maladaptive behavior is conceptualized in the first approach as caused by underlying problems, it is believed that if the proper accepting environment is provided, the individual will continue his psychological growth once again. On the other hand, therapists, who favor the objective behavioral approach, take responses to stimuli as the focus of treatment. They assume that systematic alterations of behavioral sequences will gradually be generalized to include the entire behavior of the individual. In this procedure the therapist makes use of differential interest, sympathy, and praise to different types of behaviors to increase the production of the desirable behavior. "While it may at first appear odd, complete permissiveness or tender loving care seems to us to be a technique that bears some resemblance to extinction. Although complete acceptance and permissiveness may be

a therapist behavior that the patient expects and finds helpful in the establishment of rapport, it is eventually an inefficient technique for behavior change. If one accepts everything and reacts to all behaviors in the same way, one essentially deprives the person of an opportunity to discriminate between his adaptive and maladaptive behaviors. The person who displays complete tender loving care is acting as if what the person is doing made no difference. There is no change in the environment, and it is for this reason that we link permissiveness with extinction" (Ullmann & Krasner, 1965, p. 36).

Among all the studies that use operant conditioning principles, there appears to be a neglect in the use of geriatic mental patients as the subject population. The present project was undertaken to combine these two controversial psychotherapy approaches in a comparative design and apply them to the elderly long-term inmates of a psychiatric state hospital.

The Evaluation of Behavior

Two techniques of evaluation used in this study will be described. One of them is a sociometric technique for determining the degree of communication in the group and the place of the individual within the group. The second technique deals with a rating scale based on the direct observation of individual behavior in semi-controlled situation by trained observers. This technique is designed for the evaluation of individual conduct within the framework of various group situations.

Sociometric Techniques: Since much of clinical psychology deals with the complexities of human interaction, any technique which offers an improved method of measuring interpersonal responses is of particular interest. J. L. Moreno (1934) and associates have been

instrumental in developing methods for understanding relationships within a group based on choices of the group members for participation with one another.

According to Riley (1963), "sociometry began as the more or less personal philosophy of J.L. Moreno, who drew attention to 'tele' - the cathectic orientations or tendencies for members of a group to attract or repel one another" (pp. 173-174). It is not within the scope of the present investigation to deal extensively with the nature of group structure and dynamics.[1]

It is pertinent for our purposes to discuss how a sociometric technique can assess social relationships in groups by way of mapping the attractions and repulsions of the group members for each other. The well-known sociometric test asks the respondent to make a number of choices arranged in a preferential order with respect to certain specific criteria. Sometimes the subject is asked to name only a given number of choices and at other times he is allowed to make unlimited choices. It is possible to modify or adapt the sociometric questionnaire in various ways, but it should always retain its interpersonal focus.

So long as the answers to sociometric questions remain as lists of names of persons chosen or rejected by group members, by themselves they do not reveal the group structure, or the individual's position within that group. In an attempt to make meaningful interpretations from the data, researchers most commonly use either a statistical approach or one of the two popular sociometric devices; the sociogram and the sociometric

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[1]For further information on group dynamics and its measurement see issues of the journal, Sociometry, and Dorwin Cartwright & Alvin Zanders (Ed.s) Group Dynamics, Research and Theory (Evanston: Row, Peterson & Co., 1953).

matrix.

"The sociogram has the virtue of picturing clearly and informatively the structure of the group and the positions of the various individual roles in that structure. By raising only one or a few crucial questions about interpersonal relationships, and by organizing the data in a single diagram, the sociometrist can view the social system literally at a glance. The sociogram also shows graphically the pattern of dyadic relationships within a social system, i.e. how each individual is related to every other individual in the group" (Riley, 1963, p. 175).

The sociometric matrix is conceptually similar to the sociogram and it serves to "present formally the full information on one item, or criterion, of sociometric choice. It spreads all the data before the researcher for his scrutiny.... (However), it is not in itself equipped to handle several criteria of sociometric choice or diffuse, multidimensional information about interpersonal relationships" (Riley, 1963, p. 181).

Sociometric devices help the researcher to find out the conscious attitudes of individuals toward others in the group. Implicit in the choices of the subjects, there might be their desire to be placed with certain people in given situations. It has been observed that "as changes occur in the situation confronting the group, the group structure may shift, and a realignment of roles may take place" (Hartley & Hartley, 1952, p. 405).

Even though this type of analysis can reveal relatively reliable information concerning the feelings and the attitudes of group members toward each other, it is neither sufficient to explain the intensity of these attitudes as reflected in their behavior, nor does it suggest

effective methods of guiding these interpersonal relationships. Consequently, another behavioral measurement technique is needed to record any observed changes in an individual's behavior presumably brought about by the group psychotherapy approaches employed.

Rating Scale: Rating scales of various types have been used widely in clinical situations as a means of recording behavioral observations. Most rating scales suffer in accuracy because they largely rely on observational methods and, so long as measurement depends on the subjective judgment of the raters, some of them may be too lenient whereas others may be too critical. It is vitally important to make the traits or the specific dimensions on which people are rated as descriptive and tangible as possible to prevent wide differences among the ratings of judges. A large number of rating scales have been published but their standardizations have posed problems. Among clinical rating scales, the following are currently in use: The Adjustment Inventory, California Psychological Inventory, The California Q set, The Cassel Psychotherapy Progress Record (CPPR), Hospital Adjustment Scale, Inpatient Multidimensional Psychiatric Scale (IMPS), Progress Assessment Chart (P_A_C), The Psychotic Reaction Profile (PRP), A Social Competence Inventory for Adults, Ward Behavior Rating Scale, Clinical Behavior Rating Scale, and so on. Unfortunately, none of the above fully satisfy the theoretical requirements for a scientifically reliable and valid behavior measuring device. Some of them have used normative groups which are too small to make generalizations from, or are limited to the use of mentally retarded, psychotic or senile patients and, therefore, are far from being representative of the entire clinical population. Some have not solved the problem of construct validity, and others do not report data on

reliability. Scales have even been used where no concrete examples of patient behavior have been given that would be relevant to particular ratings.

Considering all these shortcomings, and in the absence of a particularly superior tool for the assessment of clinical behavior of patients in mental state hospitals, it was decided to use a graphic rating scale developed for this purpose by staff psychologists at Pontiac State Hospital, Pontiac, Michigan. This instrument has previously been used in connection with medical research at the above mentioned institution, but no systematic work on its validity or reliability has been reported.

CHAPTER II

PROBLEM AND HYPOTHESES

The review of the literature on elderly psychiatric patients brings out a point of general consensus among researchers. They all agree that those of them who find themselves committed to a mental hospital become institutionalized and they gradually withdraw from contacts with the outside world making the hospital ward their home. But the investigators in this area also share an optimism concerning the rehabilitation potential of institutionalized geriatric patients.

The problems which this study was basically designed to deal with were embodied in the following questions: How can we change the outlook of a group of institutionalized elderly psychiatric state hospital inmates to make them decide to leave the hospital? What type of group psychotherapy approach can be most effective in guiding the patients toward this goal? How can the presumed changes in their behavior be reliably assessed and recorded?

The proposed hypotheses were:

1. The two experimental psychotherapy atmospheres, namely, the Unstructured and Structured group therapy methods will alter the behavior of the patients regardless of the method to which they will be exposed.
2. The two therapeutic approaches will influence the subjects differentially as indicated by the rating scale scores.

3. The length of institutionalization will not significantly influence the patients' improvement in group psychotherapy.
4. There will be relationships between desirable behavioral changes and decision to leave the hospital.
5. The number of patients who decide to leave the hospital will be approximately the same in both the Unstructured and Structured psychotherapy groups.
6. There will be a significant difference between the mean improvement on the rating scale of patients who decide to leave the institution compared to the improvement shown by subjects who do not make such a decision.

CHAPTER III

METHOD

Materials

Behavior Rating Scale

The rating scale used was structured around the constructs of:

a. Anxiety

b. Affective Display

c. Socialization

d. Work Attitude

e. Appearance

Each construct was defined according to the progressive degrees of the selected dimensions. In order to simplify the use of the scale by non-professional judges, definitions for in-between categories were omitted. A copy of the rating scale appears as Appendix A.

Sociometric Questionnaire

Following the fourth week of group sessions, the participants were asked to name individuals among the ones who were included in the project with whom they would particularly like to interact in various situations. A series of interviews was conducted at the termination of the group meetings and the same questions were asked again. For a more detailed look at the questionnaire, the reader is referred to Appendix B.

Subjects, Group Leaders and Raters

Selection of Subjects

Thirty-eight subjects participated in this study, all of whom were geriatric patients at Pontiac State Hospital, Pontiac, Michigan. All but two of the subjects were 65 or older. The two exceptions were male patients, 58 and 59 years of age respectively and they had been on geriatric wards for reasons of physical handicaps.

Nineteen female and 19 male patients were chosen for the study. The following criteria had to be satisfied before individuals could be accepted as possible candidates for the selected sample:

1. They all had at least a minimum ability to communicate verbally.
2. They explicitly showed desire to remain at the hospital.
3. They openly refused to go home or consider suggestions for available alternatives, such as family care, nursing homes for elderly citizens, or the like.
4. They were in comparatively good health.
5. They were relatively alert.
6. Most were able to come independently to the location where the meetings were held. In cases where the patient had difficulty in walking, they were well enough to be wheeled.
7. Prior to their admission to the state institution, available reports indicated that they had not been either severely retarded mentally or intellectually handicapped. There was enough evidence to indicate that they had had normal adult adjustment sometime in their life.

8. They were able to control themselves in social situations.

9. They were willing to participate to the group meetings.

The diagnostic label of the patients was of minor importance. The clinical diagnoses of those selected for the group therapy sessions included schizophrenia (80%), involutional psychotic reaction (10%), chronic brain syndrome (7%), and other (3%) but they were not severe cases.

Grouping of Subjects

Individuals who had successfully met the requirements of the participation criteria were next classified according to length of hospitalization, sex and age. Average length of hospitalization was approximately 20 years and average age was 70. This resulted in the following table:

TABLE I

THE DISTRIBUTION OF THE ENTIRE GROUP OF SUBJECTS

	Hospitalization				
	Less than 20 years		More than 20 years		
	Male	Female	Male	Female	Total
Age Below 70	4	5	5	4	18
Age Above 70	6	5	4	5	20
Male	10		9		19
Female		10		9	19

Subjects from each subgroup were assigned to the two experimental groups. An attempt was made to equate the number of male and female numbers in each group. In addition, there was an attempt to equate the groups for age and length of hospitalization. One group was called

the Unstructured group, the other the Structured group for reasons which will be made clear below.

The characteristics of the two groups are described in Tables II and III.

TABLE II

THE UNSTRUCTURED GROUP

	Hospitalization				
	Less than 20 years		More than 20 years		
	Male	Female	Male	Female	Total
Age Below 70	2	2	2	2	8
Age Above 70	3	3	2	3	11
Male	5		4		9
Female		5		5	10

TABLE III

THE STRUCTURED GROUP

	Hospitalization				
	Less than 20 years		More than 20 years		
	Male	Female	Male	Female	Total
Age Below 70	2	3	3	2	10
Age Above 70	3	2	2	2	9
Male	5		5		10
Female		5		4	9

The Groups

Two experimental groups were used in the study. These were: Group A, "unstructured" group, Group B, "structured" group. There was no control group because the assignment of some of the subjects to a third group would have drastically reduced the number of patients in the experimental groups. In the absence of an additional comparable group, it was decided to regard the participating subjects as their own controls as far as their decision to leave the hospital was concerned. This was justified on the grounds that previous efforts to move them out of the hospital prior to the experiment had been resisted and no change other than the therapy was instituted. They had adjusted to the routine of the institutional life and any suggestions about changes of any type were not wlecome.

The Group Leaders

The group leaders were two professional staff members: a male psychiatrist, who was the director of the geriatric program, and the author, a female psychologist who assisted him during the group sessions and also planned and coordinated week-end activities. For purposes of conveniences, group leaders were called "therapists" and group meetings were referred to as "therapy sessions".

The Raters

Members of the nursing staff served as judges to observe and evaluate the behavior of the subjects. There were two judges from each hall, one on the morning shift (7:00 a.m. to 3:30 p.m.), the second nurse being from the afternoon shift (3:30 p.m. to 11:00 p.m.).

The Therapeutic Situations

In the Structured therapy situation, it was agreed that the therapists would enter the particular situation knowing exactly what they were going to do, what approach they were going to use, what subjects they preferred to discuss with the group, and so on. The sessions were preconceived and well ordered. The therapists made a habit of scheduling informal private conferences to discuss their mutual roles, their methods of working together and with the group to strengthen their own compatibility.

Group leaders introduced and verbally reinforced the realistic discussion by patients of significant topics at appropriate times. These topics included the medical, social, and economic problems of the aging population in general. More specifically, topics such as happy childhood memories, good friendships, carefree good old days, followed by the joys and sorrows of adult years, the difficulties and responsibilities of parenthood, satisfactions derived from having a family, past achievements, responsible jobs once held, the gradual decline of one's physical vigor in advanced age, medical complaints, financial problems, fear of death, cultural attitudes towards elderly people, and other anxieties related to their leaving the hospital were dealt with. Positive statements about such topics were reinforced by the approval and the encouragement of the group leaders. Subsequent productions of similar material were likewise received by the therapists with interest and relevant verbal reinforcements.[1]

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[1]It is recognized that verbal behavior was reinforced but it was hypothesized that the consequences would include modification of behavior in the wards and decisions to leave the hospital.

Conversely, what was considered to be an "unstructured" situation was a session where there was no specific preconceived order to the therapy situation but rather the group was permitted to proceed as they wished. The therapists here were somewhat active in that they took part in the general discussions, but they did not lead the conversations. They listened most of the time and made pertinent comments reflecting on or reacting to various points expressed by the group members to keep the flow of the conversation running. Their participation in group dynamics was minimum since they were not directive in terms of the goals mentioned above. They avoided making value judgments as much as possible.

The two groups differed in the following characteristics:

Choice of topics to discuss: The main characteristic of the structured group was the fact that the therapists manipulated and controlled the conversation, whereas everything was up to the group members in the unstructured situation. For instance, if the therapists decided to discuss a topic which was rather threatening to the patients, the structured group did not have a chance to escape it. Each individual could be asked direct questions and attempts to change the subject would fail. Thus, they developed the habit of listening to or talking about things which gave them ambivalent feelings.

In contrast to the directive approach used in the structured group situation, the unstructured group treatment was non-directive. After a visit to a nursing home, for example, the senior therapist, who did not participate in week-end trips, would ask how they enjoyed the activity, how many went, what were their impressions and similar other questions. If the group did not feel comfortable enough to develop any of these

topics and preferred to change the subject, the therapists did not pursue the topic. There were many times when the members of the group would bring the topic back and the discussion would resume. Like topics were commonly discussed in both groups, but the initiating sources were different in the two approaches; while the therapists directed the conversation in one situation, the participating members chose their own topics in the other.

Reinforcement of particular kinds of statements: The Structured group was positively reinforced with approval for positively valued statements about being independent, making one's own decisions, leaving the hospital, returning to the community, and so on, while the Unstructured group was not thus reinforced. A more or less neutral attitude was adopted in the Unstructured group, leaving the responsibility of the value judgment to the individual expressing the opinion. Statements in favor of community life, about being independent, and so forth were neither enthusiastically encouraged or deliberately discouraged.

Choice of whether or not to visit outside the hospital: The Structured group enjoyed very little freedom in terms of making decisions about participating in week-end trips. They were expected to go unless they had a serious excuse. On the other hand, the Unstructured group was free of such pressures. They could go on the trips if they wanted to. They were always welcome to join the Structured group members on such occasions, but they did not have to do so if they preferred not to.

Procedure

Measuring Criteria for Selecting Subjects

The selection of the candidates for the study was carried out through personal interviews. The author talked individually with a great number of patients in the geriatric wards and using the criteria listed on page 25, she selected the patients who qualified best. Particular emphasis was put on finding out whether the patient had ever considered leaving the hospital or if he or she would be willing to return to the community had opportunities been available at the present time.

During the interviews, patients were told that the director of the program was eager to get to know them better and was planning to set aside a couple of hours everyday to socialize with those patients who would care to join him in these gatherings and discuss with him any problems that they were particularly interested in. They were also asked if they would like to sign up for such informal groups since the number of people the Doctor could visit with at one time was relatively limited. In cases where patients showed doubt or requested time to think it over before committing themselves, they were allowed to do so. There were others who readily accepted or absolutely refused to join the groups. The ones who did not want to come to the meetings were not included in the study.

Therapy Sessions

Patients who had met the selection criteria were divided into two experimental groups as described in the previous pages. Group meetings

were scheduled for four days of the week. On Sundays they had a planned activity. Each group met for at least an hour for each group meeting. However, most sessions lasted longer than sixty minutes because discussions were not interrupted at the end of the hour letting the conversation come to a natural conclusion. Frequently, after the senior therapist would excuse himself and leave at the end of the hour, group members would express to the co-therapist feelings which they would not feel comfortable to mention in the presence of the psychiatrist. Such information provided material for the planning of future discussions. This behavior was particularly observed at the beginning of the treatment period when a number of patients, who had initially expressed a wish to join the discussion groups, changed their minds and were trying hard to find reasons not to attend the meetings. A wide range of attitudes was observed among the patients; some were compliant, obedient and willing to do anything to win the favors of the therapists, but others became suspicious, defiant and angry. It was interesting to notice changes in such extreme attitudes during the process of therapy.

Group members were either escorted to the meeting room by a ward attendant, or one of the patients was given a master key. Almost always the co-therapist walked them back to their respective wards. Conversation was very informal and rather personal at such times.

During the sessions coffee was served regularly. Refreshments were also included whenever possible. At each session a different member of the group was appointed to assist the author serve coffee. The number of volunteers increased as the time went by to the point where they started competing for the job. There were occasions when a group member would provide cookies for the group on his own account, or bring

a birthday cake to share with the rest of the group members. Many who did not take coffee at the beginning, had become good coffee drinkers towards the end of the treatment period.

Visits Outside the Hospital

Group visits were planned to various places every Sunday afternoon. All those who were in the directive group and anyone else from the non-directive group who wishes to go along were expected to be ready at a definite time. A hospital bus would pick them up from their wards and bring them back before dinner time. If the trip would take longer than two or three hours, special arrangements were made with the food services department so that dinner could be served to them when they returned after the regular dinner hours. Trips included bus rides in the city of Pontiac and to the country side around the area, to downtown Detroit, to a beautiful private university campus, visits to two nursing homes, to a farm, to a well-known recreation park where they visited the zoo and the conservatory, to shopping trips, to a concert in which the author was participating, and finally, to a big picnic for everybody who was involved in the project. On all of these occasions expenses were met by hospital and grant funds. The wishes and the suggestions of the patients were taken into consideration in the planning of these programs.

As far as individual visits in the community are concerned, the number of subjects who expressed a desire to leave the hospital increased as the participants felt more comfortable in their contacts with the outside world. However, at no time before the end of the project were they allowed to have an extended home visit or were discharged from

the hospital. These restrictive measures were taken to prevent the occurence of return cases.

Measuring the Differences Between the Treatments

In order to test whether the two approaches were different, a group of professionals from the medical, psychological and social service departments of the same institution were used. Without being observed by the group members, they followed the group discussions from the room adjoining the one where the sessions were held. The entrance to the meeting room from the hall was through this small room which had no function on its own. Upon closing the door that divided the two rooms, the small room could easily be isolated and conversational tones of voice would clearly carry if the door was not tightly shut. This was the set-up in which the judges listened to the group discussions. They were not told which group was supposed to meet. Immediately after the meeting, they were asked to name the approach they thought was being practiced with that particular group. Their judgments were recorded.

Training Judges

A number of nurses were contacted and after obtaining their consent to serve as judges and to learn the use of the rating scale, a general meeting was scheduled with all of them. At this time, information was given concerning the nature and purpose of the study including an explanation of the basic principles upon which the rating scale was structured. The role of the judges was emphasized mentioning its importance in providing a major source of data in this study. They were encouraged to ask questions and to discuss further any points which did

not seem to be clear to them. Allowing them enough time to study the scale, a practice session was scheduled next. On this occasion, judges were given opportunities to rate patients who were not participating in the study. They discussed the rationale used in assigning a level of the observed behavior on each of the five dimensions of the scale. Reasons for judgments were debated. The question of individual differences in making judgments or interpreting behavior was brought up and discussed at some length. It was explained that there would be variations among observers and the nurses were encouraged to be independent in their decisions.

Use of the Scale

Each judge used the scale on the experimental subjects in the judge's own ward only. While it would have been desirable to distribute a new form of the scale each week in order to have some control over the carry-over effect of previous ratings, practical considerations, such as personnel scheduling, made this impossible. Judges were urged not to consult one another and to make each evaluation an independent one. Their honesty was trusted.

CHAPTER IV

DISCUSSION OF RESULTS

In this chapter an analysis of the data collected in the study will be presented and the results of the tests of the hypotheses will be stated and discussed with an attempt to relate the findings to the questions asked in Chapter II. Furthermore, pertinent statistical data will be summarized in table form and references will be made to related appendices where additional information can be found.

The Effect of Therapy on the Scale Judgments

The effect of therapy on scale judgments for each group on each ward for each scale separately are given in Table IV. The characteristics of the groups are given below.

T_1H_1: Unstructured therapy, less than 20 years of hospitalization
T_1H_2: Unstructured therapy, less than 20 years of hospitalization
T_2H_1: Structured therapy, less than 20 years of hospitalization
T_2H_2: Structured therapy, more than 20 years of hospitalization

Group T_2H_2 was not represented in Ward 1 nor was Group T_1H_1 represented in Ward 4.

The values of Table IV were calculated from analyses of variance discussed later. Using appropriate values from the inverted matrices of the computer output and using the coefficients of the mathematical models (Steel & Torrie, 1960, p. 275), comparisons were made between Time 1 (at the beginning of therapy) and Time 2 (at the end of therapy)

TABLE IV

CHANGES IN GROUPS OVER TIME

Time 2 - Time 1

		T_1H_1	T_1H_2	T_2H_1	T_2H_2
Ward 1	Anxiety	-.742	2.453*	- .547	-----
	Aff. Display	-.444	.106	.299	-----
	Socialization	-.768	1.295	- .721	-----
	Work Attitude	.054	.391	- .487	-----
	Appearance	-.473	- .072	.525	-----
Ward 2	Anxiety	-.539	- .850	1.858	-1.019
	Aff. Display	.341	.718	- .568	- .538
	Socialization	.698	- .019	.698	-2.179*
	Work Attitude	-.309	.274	.217	- .197
	Appearance	-.024	- .650	.465	.116
Ward 3	Anxiety	.158	- .036	- .036	- .036
	Aff. Display	-.770	.175	.175	.175
	Socialization	-.371	.508	- .254	0
	Work Attitude	.071	- .217	.072	.072
	Appearance	-.264	1.215	- .475	- .475
Ward 4	Anxiety	---	- .130	- .140	.280
	Aff. Display	---	.532	- .916	.330
	Socialization	---	- .071	- .660	.176
	Work Attitude	---	.341	- .018	- .018
	Appearance	---	- .113	.487	- .364

* Significant at .05 level by the t-test
(+)Values indicate a positive effect of therapy over time
(-)Values indicate a negative effect of therapy over time

ratings for each treatment group on each dimension of the rating scale. A "plus" value indicated an improvement with therapy over time and a "minus" value indicated a deterioration.

Only two values were significant, a reduction in Anxiety in Ward 1, Group T_1H_2, and a deterioration in Socialization in Ward 2, Group T_2H_2. In the light of the number of calculations made, it is reasonable to assume that these significant differences arose by chance and that they could disappear upon cross validation. This lack of significant results may be due to one of the three causes or an interaction between them: the scale may lack reliability, the scale may lack validity, or the therapy may have made no difference. However, Pearson's correlation coefficients between the ratings of the judges, pooled over weeks two and three for Time 1 and weeks ten and eleven for Time 2, indicated that the lack of significant change with therapy was a function of something other than the lack of reliability. The median r for the reliability of judges' ratings obtained "before" and "after" therapy was .84. It seems most likely that substantial behavioral changes simply did not occur for the total group.

It is possible that the results of therapy might be apparent if all the groups on a given ward were combined thus testing the effects of therapy only. Such effects are indicated in the Therapy row of Tables V through VIII. These tables were derived through the use of analysis of variance. The rationale for that analysis follows.

The present research design had yielded disproportionate data with unequal number of subgroup observations. This presented difficulties in obtaining orthogonal sums of squares. However, considering each ward a block, within each block and each subgroup the judges were rating the

same patients, and the same number of patients at every evaluation. Thus, data from each ward were proportionate, therefore, orthogonal. For this reason a separate analysis was run on each ward.

The IBM 7040 electronic computer installation located in the Computer Center of the Oklahoma State University was used for the computations.

The method of fitting constants was selected to analyze the data from each ward within each pair of judges (Steel & Torrie, 1960, p. 257). The Abbreviated Doolittle procedure was used on data taken from the rating scales. The mathematical model was so structured as to make it possible to look at the main effects of the variables as well as to estimate the magnitude of the interactions for each of the five dimensions of the rating scale. Tables V through VIII show the output of the program for each ward including sources of variation, degrees of freedom, means of squares and the statistical significance level of the F test values.

In the present study the effect of therapy was a function of time. Consequently, it was possible to find the effects of therapy alone by contrasting the combined ratings of two judges for weeks two and three (Time 1) versus the combined ratings of the same two judges for weeks ten and eleven (Time 2) for all groups combined. Each ward had a different pair of judges. Under these conditions it was possible for Therapy to be significant four times for each scale, once for each ward. However, a significant difference could indicate either an improvement or a deterioration. One significant difference appeared in each of the Anxiety, Affective Display, and Appearance columns, while two appeared in the Socialization column.

TABLE V

ANALYSIS OF VARIANCE OF THE DATA

Ward 1

Sources of Variation	d.f.	Mean Squares Anxiety	Affective Display	Socialization	Work Attitude	Appearance
Total	35					
Groups	2	3.4028	31.8194**	.8403	2.8516	.8038
Judges	1	.1736	.1736	.1736	.0069	.0069
Therapy	1	1.5625	7.5625	3.0625*	3.6736	3.6736*
Gr. x J	2	.2674	.4861	.2049	.4210	.0851
Gr. x TH	2	4.1667*	.4167	.4375	.3585	.0953
J x TH	1	2.0069	.3674	1.5625	2.0069	1.1736
Gr x J x TH	2	.1007	.1944	.3437	.1085	.5017
Error	24	1.1163	3.7500	.5191	2.8550	.5104

*Significant at .05 level
**Significant at .01 level

TABLE VI

ANALYSIS OF VARIANCE OF THE DATA

Ward 2

Sources of Variation	d.f.	Mean Squares Anxiety	Affective Display	Socialization	Work Attitude	Appearance
Total	35					
Groups	3	8.8275**	5.9657*	.4942	1.5019	3.0000
Judges	1	1.0000	.5625	1.0000	.5625	.4444
Therapy	1	6.2500*	8.5069*	11.1111*	8.5069	.0000
Gr. x J	3	.0979	.3917	.2646	.1500	.4519
Gr. x TH	3	1.6312	.6435	3.5609	.3685	.2667
J x TH	1	1.7778	2.5069	.4444	1.1736	1.0000
Gr x J x TH	3	.0387	.4102	.3164	.0463	.2667
Error	20	1.3163	1.8050	2.2463	5.3900	1.5550

*Significant at .05 level
**Significant at .01 level

TABLE VII

ANALYSIS OF VARIANCE OF THE DATA

Ward 3

Sources of Variation	d.f.	Mean Squares Anxiety	Affective Display	Socialization	Work Attitude	Appearance
Total	27					
Groups	3	2.1042	1.3951	4.1667	11.0714	6.6042**
Judges	1	.0357	3.9375	.0357	6.0357	4.3214
Therapy	1	.0357	.7232	.3214	.0357	.3214
Gr. x J	3	1.8423	.9844	2.7714	6.7381	.7470
Gr. x TH	3	.0089	.1808	.6429	.0714	.2470
J x TH	1	.3214	.2232	.0357	.3214	.3214
Gr x J x TH	3	.0804	.0558	.7381	.3095	.2470
Error	12	1.0625	.9115	5.5000	9.3333	1.0625

* Significant at .05 level
** Significant at .01 level

TABLE VIII

ANALYSIS OF VARIANCE OF THE DATA

Ward 4

Sources of Variation	d.f.	Mean Squares Anxiety	Affective Display	Socialization	Work Attitude	Appearance
Total	43					
Groups	2	.8307**	10.1944*	6.6084	3.1894	16.1106**
Judges	1	.6875*	5.4602	.3636	1.6420	2.0511
Therapy	1	.0057	.6875	.0909	.0057	.0511
Gr. x J	2	.8307**	.2444	.7713	.1894	11.0551**
Gr. x TH	2	.0050	1.0182	.0743	.0076	.2010
J x TH	1	.0057	4.7784	.0000	.0057	.0551
Gr x J x TH	2	.0050	1.7228	.5781	.0076	.2010
Error	32	.1257	2.4720	4.6628	13.0052	1.5007

* Significant at .05 level
** Significant at .01 level

These results might be taken to suggest some overall change due to therapy even if Table IV showed none for given groups. However, the lack of consistency in signs either across groups within a given scale or within groups within a scale in Table IV robs such a conclusion of the appearance of truth.

The variable of judges was significant only for one scale in Ward 4, where the reliability was also lowest. This suggests that the scales are not only reasonably reliable but that the absolute level of judgment does not vary significantly.

Sex and Age

While not included in the analysis of variance, the effects of sex and age were examined through the use of graphs in a search for hypotheses which might be tested. Graphs in Appendix E seem to indicate that there was a sex difference, the men responding to therapy better than the women and better to Structured therapy than to Unstructured therapy.

Complex age and sex differences seemed to appear. There were consistent improvements in both groups of above and below seventy years old patients, but the pattern of progress differed. The Structured therapy produced more improvement on all subscales in the younger group and on Anxiety and Socialization dimensions in the older. On the other hand, the Unstructured therapy appeared to be more effective for the older group of elderly subjects particularly on dimensions such as Affective Display, Work Attitude, and Appearance.

Once more it should be emphasized that these interpretations were made following the trends which were suggested in the graphs. The

basic data were taken from the weekly evaluations of the rating scale.

We could summarize the discussion in this section by stating that we did not have enough statistical evidence to show that sex and age significantly influence the changes in the behavioral responses of the patients in each of the two psychotherapy groups, but the results suggest that these variables might be used in another study.

The Decision to Leave

Seventy-five percent of the subjects said they were willing to leave the hospital at the end of the treatment period. The confidence limits on this percentage at the .05 level lie between 61% and 89% (Garrett, 1953, p. 196) indicating that the percentage deciding to leave was not a function of chance factors. Only five times in hundred replications would such a percentage be expected to occur outside of these limits.

Tables IX and X indicate that the difference between the two therapy groups in number of subjects who decided to leave is significant at above the .10 level but does not reach the .05 level. The difference was in favor of the Structured therapy. The Yates' correction formula was used in the computation of the chi-square because of the small numbers in two of the cells of the expectancy table (See Table X). Thus,

$$\chi^2 = \Sigma \frac{(f - fc)^2}{fc}$$

becomes

$$\chi_y^2 = \Sigma \frac{(|f - fc| - \frac{1}{2})}{fc}$$

with d.f. 1 (Croxton, 1963, p. 275).

TABLE IX

EFFECT OF THERAPY ON DECISION TO LEAVE IN PERCENTAGES

Treatment Groups	Leave Hospital Yes %	No %	Total
Unstructured Group	59	41	100
Structured Group	89	11	100
Total	75	25	

TABLE X

CHI-SQUARE TEST OF SIGNIFICANCE FOR NUMBER OF DECISIONS TO LEAVE THE HOSPITAL FROM EACH THERAPY GROUP

Treatment Groups	Leave Hospital Yes	No	Total
Unstructured Group	10	7	17
Structured Group	17	2	19
Total	27	9	36

Chi-Square: 3.2

d.f.: 1

$p > .05$

TABLE XI

BISERIAL R CORRELATION COEFFICIENT BETWEEN THE MEAN IMPROVEMENT OF PATIENTS AS OBSERVED FROM THE RATING SCALE AND THEIR DECISION TO LEAVE THE HOSPITAL

Rating Scale	Unstructured Group		Structured Group	
	d.f.	Biserial r	d.f.	Biserial r
Anxiety	16	.074	18	.686**
Affective Display		.825		.954**
Socialization		.509*		.128
Work Attitude		.015		.111
Appearance		.064		.432

*Significant at .05 level
**Significant at .01 level

Biserial r's were calculated between improvement on each of the scales and decision to leave the hospital for each therapy group separately (Table XI). A significant correlation indicates that those subjects who said they would leave improved more on the given ratings than those who did not say so. The only r_{bis}'s which were significant for both groups were the ones for Affective Display. In addition, the Unstructured group had a significant biserial correlation coefficient at the .05 level on the Socialization dimension, whereas the Structured group showed a r_{bis} on the Anxiety scale which was significant at the .01 level. While all the correlation coefficients were positive, some were very low.

Table XII indicates the r_{bis}'s between initial ratings and decision to leave. The only r_{bis}'s which were significant in both therapy groups were those for Socialization. The correlation coefficients for Appearance were also high. The r_{bis}'s on this scale reached a .05 level of significance in the Unstructured group, but failed to reach the required level in the Structured group.

Similar r's between final ratings and decision to leave were also calculated. Results in Table XIII showed that Socialization was again the only dimension on which those patients from both groups who wanted to leave the institution had significantly better ratings compared to others who did not want to go. Another relative high correlation was observed in regard to the Anxiety dimension. On this scale the coefficient for the Unstructured group did not reach significance at the .05 level, but the r for the Structured group was significant.

TABLE XII

BISERIAL R CORRELATION COEFFICIENT BETWEEN THE INITIAL RATINGS OF PATIENTS AS OBSERVED FROM THE RATING SCALE AND THEIR DECISION TO LEAVE THE HOSPITAL

Rating Sacle	Unstructured Group		Structured Group	
	d.f.	Biserial r	d.f.	Biserial r
Anxiety	16	.311	18	.085
Affective Display		.198		.407
Socialization		.752**		.495*
Work Attitude		.414		.046
Appearance		.492*		.440

*Significant at .05 level
**Significant at .01 level

TABLE XIII

BISERIAL R CORRELATION COEFFICIENT BETWEEN THE FINAL RATINGS OF PATIENTS AS OBSERVED FROM THE RATING SCALE AND THEIR DECISION TO LEAVE THE HOSPITAL

Rating Scale	Unstructured Group		Structured Group	
	d.f.	Biserial r	d.f.	Biserial r
Anxiety	16	.414	18	.546*
Affective Display		.179		.074
Socialization		.680**		.469*
Work Attitude		.451		.006
Appearance		.071		.034

*Significant at .05 level
**Significant at .01 level

The Sociometric Technique

The socialization of the group as a whole was assessed by a sociometric technique (See Appendix B). The results of a t-test for significance of the difference between the mean number of names mentioned on the first application of the sociometric questionnaire and the second administration of the same instrument yielded a value significant at the .001 level (Table XIV). Therefore, the null hypothesis was rejected for the group as a whole. The two therapy groups did not differ significantly in mean increase in number of names (Table XV).

TABLE XIV

T-TEST FOR SIGNIFICANCE OF DIFFERENCE BETWEEN THE MEAN NUMBER OF NAMES MENTIONED AT THE TWO ADMINISTRATIONS OF THE SOCIOMETRIC QUESTIONNAIRE BY THE ENTIRE GROUP OF SUBJECTS

Mean of Names at Time 1	Mean of Names at Time 2	Mean of Difference Time 2 - Time 1	s.d.	t-test	d.f.	p
6.5	18.97	12.47	1.35	9.24***	35	$<.001$

TABLE XV

T-TEST FOR SIGNIFICANCE OF DIFFERENCE BETWEEN THE MEAN NUMBER OF NAMES MENTIONED AT THE TWO ADMINISTRATIONS OF THE SOCIOMETRIC QUESTIONNAIRE BY THE SUBJECTS OF EACH TREATMENT GROUP

Mean of Names in Unstr. Gr. Time 1 + Time 2	Mean of Names in Struc. Gr. Time 1 + Time 2	Mean Difference Struc. Gr. - Unstruc. Gr.	s.d.	t-test	d.f.	p
11.88	13.21	1.33	2.67	.498	34	$>.05$

CHAPTER IV

SUMMARY

The underlying assumption in this investigation was that the behavior of aged persons, regardless how inefficient it might be, had the potential to be motivated and altered. The present study was undertaken to encourage a group of institutionalized geriatric patients from Pontiac State Hospital, Pontiac, Michigan, to decide to leave the hospital wards and to move in one of the nursing homes available in their home counties. They were still going to be supported by the Michigan government. The patients uniformly refused to make the change at first.

Two group psychotherapy approaches were employed as a means of influencing the patients' behavior toward the desired goal. The Unstructured approach was a typical non-directive group therapy method, whereas the techniques used with the Structured group roughly corresponded to operant conditioning procedures. Because of its extensive work with the mentally ill aged, Goldfarb's treatment objectives were taken as the guidelines for the Unstructured group psychotherapy approach (1953c, 1954, 1955c, 1956a, 1956b). Contrasting clinical practices derived from operant conditioning principles of current learning theories advocated by Eysenck (1964), Ferster (1964), Ullmann & Krasner (1965) and related research were discussed as the major underlying theoretical bases for the Structured treatment approach.

A group of analyses were made to test changes in the patients' attitude about leaving the hospital. There was a total of 27 patients from both therapy groups who expressed a wish to leave the hospital. This number represented 75% of the entire group of subjects in the study. This percentage was significant at the .05 level indicating that results were not due to chance factors. Therapy had a beneficial effect on decision to leave the hospital.

However, there was no statistically significant effect due to the different methods involved. A chi-square test between the number of patients who expressed their willingness to move to a nursing home at the end of the treatment period in the two therapy groups did not quite reach statistical significance. What difference there was favored the Structured therapy.

As the treatment proceeded, weekly behavioral evaluations were made by two judges from the nursing department on a rating scale. Each ward had a different pair of raters. The selected evaluating instrument was developed at Pontiac State Hospital by staff psychologists. The scale consisted of five attitudinal dimensions which were behaviorally defined. The subscales were: Anxiety, Affective Display, Socialization, Work Attitude, and Appearance.

Using four groups (Unstructured, less than 20 years and Unstructured, more than 20 years of hospitalization; Structured, less than 20 years and Structured, more than 20 years of hospitalization) no changes were found in rated behavior which were considered significant.

The median r for the reliability of the judges' ratings combining weeks two and three (Time 1) and weeks ten and eleven (Time 2) on all five dimensions was .84. The ratings also did not vary significantly

between judges except for one scale in one ward.

The next question which was investigated dealt with the relationship between the rated behavioral changes of the patients and their decision to leave or not to leave the hospital. When the differences between "before" and "after" treatment ratings were taken as measures of improvement and "Yes" and "No" groups were contrasted, it was seen that the two groups showed marked differences on certain dimensions. The only consistent relationship was observed in regard to Affective Display dimension of the scale where the correlation coefficients indicated that those subjects in both therapy groups who wanted to leave the hospital had significantly better improvement records compared to other patients who did not make a similar decision. In addition, the "Yes" subjects in the Unstructured group on Socialization and the "Yes" subjects in the Structured group on Anxiety dimensions showed statistically significant improvements when their scores were compared with the average improvement scores of those patients in their respective groups who had decided to remain at the hospital.

Hypothesis number seven which stated that the ratings of patients from both experimental groups who decided to leave the hospital will not be significantly better than those who do not so decide at the termination of the treatment period was supported for the most part. With the exception of Socialization and Anxiety dimensions, there were no significant differences in the ratings of "Yes" and "No" patients at the end of the study. Socialization was the only subscale on which patients from both Unstructured and Structured groups who wanted to leave the institution had significantly better ratings compared to the ratings of those who did not want to go. However, similar analyses

using initial ratings showed that the "Yes" patients had significantly better ratings on the same dimension from the start. Even though therapeutic progress had brought the ratings of "Yes" and "No" groups much closer at the end of the experiment causing some significant differences to disappear, i.e. Appearance, on occasions it had also created significant differences between these groups, i.e. Anxiety.

It is suggested that high scores on the Socialization scale might indicate a favorable prognosis for this process.

It was possible to suggest as an hypothesis that males improve in rated behavior in Structured therapy.

Since Socialization was believed to be an important dimension which could enable institutionalized patients to make a better adjustment to the community life outside hospital grounds, it was measured separately in the third set of analyses by means of a sociometric technique. Of prime interest was to see whether social relationships among the members of the therapy groups would increase as a result of regular meetings and week-end activities. When the mean number of names given to the items of the questionnaire on two different administrations were compared, the total group showed a highly significant improvement. However, the two therapy groups did not differ significantly from one another in terms of the increase in the number of names they gave to questions dealing with social situations and activities. These analyses provided evidence to show that even though the clinical behavior of most patients did not significantly change after exposing them to certain types of group psychotherapy, their experiences in the group situation increased the number of acceptable social partners. Increased communications among the members of each therapy group and

those of between groups were reflected time and time again during the group meetings when a subject of common interest discussed in one session with one therapy group would be brought up by a member of the other treatment group in their next meeting. If nothing else, at least the regular afternoon "coffee hours" contributed to the socialization of their members.

Limitations

In interpreting the findings of this study, the readers should be reminded of certain limitations. The factors which may have influenced the findings presented in the previous pages will be discussed briefly.

One of the important factors which complicated the analysis of the data and the interpretation of the results was the unavoidably small sample size. Among all the available patients in the geriatric program no one who could meet the selection criteria was omitted. There were not enough patients to have comparable experimental and control groups. Since all the patients in the group had been in the program for quite a few years without showing any apparent progress, any changes in their behavior or attitude towards leaving the hospital could be interpreted as due to the influences of the experimental situations. Therefore, the group of subjects in this study were used as their own control.

The other related factors which were considered seriously during the planning phases of this study referred to the wards the patients were living in and to the judges who would make the evaluations. It would have been desirable to group the participating patients in such a way that all females move into one hall and all the males move into another and have two wards where the entire group of patients come from

instead of having them scattered in four different wards. This idea had to be quickly discarded because even if the hospital administration were willing to make the necessary accomodations, it was discovered that moving from one ward to another was threatening and anxiety provoking for the patients. An experience such as this, which would be perceived as an untimely imposition by many of those patients who had to make the move, could have drastically influenced their responses to the entire project. The risk involved was great enough to warrant the sacrifice of the improvement it would have introduced to the experimental design.

The consequences of the above decision affected the precision of the measurements in another way. Had we had fewer wards, the pairs of judges could have observed more patients, thus reducing the variability among judges. Also, it would have been much easier to collect their weekly evaluations and control their communication with each other. In spite of the fact that the judges were encouraged not to compare ratings, there were no specific provisions made to check their honesty.

Finally, this study dealt with a specific population. The subjects were geriatric patients in a psychiatric hospital supported by the state. They had made such a satisfying adjustment to the institution that they did not feel the need to move elsewhere. The parent population of which these subjects were a sample is uncertain.

Conclusions

In this section the conclusions derived on the bases of evidence presented by the analyses of the data will be listed in an attempt to answer each of the hypotheses stated in Chapter II.

1. Neither the Unstructured, nor the Structured group psychotherapy methods significantly altered the rated behavior of the patients.
2. The two therapeutic approaches did not significantly differ in the behavioral changes they produced as measured by the rating scales.
3. The length of hospitalization did not significantly influence the patients' improvement in group therapy.
4. In general, there were some significant positive relationships between desirable behavioral changes and decision to leave the hospital.
5. Even though there were many more subjects in the Structured group who decided to leave the institution compared to the number of the comparable patients in the Unstructured group, the null hypothesis had to be accepted because the difference came close to but did not reach the required statistical significance level.
6. In regard to certain dimensions, there were significant differences between the mean improvement on the rating scale of patients who decided to leave the hospital compared to the improvement shown by subjects who did not make such a decision. In both therapy groups on the dimension of Affective Display, those patients who were willing to leave the institution had significantly better improvement records than those patients who did not want to go. Also, significant differences in favor of the "Yes" subjects were indicated on the dimensions of Socialization in the Unstructured group and on Anxiety in

the Structured group.

7. "Yes" subjects from both Unstructured and Structured groups on Socialization, and "Yes" patients from the Structured group on Anxiety did show a statistically significant difference when their terminal ratings were compared with the terminal ratings of others who said "No" to the idea of leaving the hospital. On the rest of the variables measured by the rating scale, the ratings of patients from both experimental groups who decided to go were not significantly better than those who did not make the same decision at the termination of the treatment period.
8. When the mean number of names given to the items of the sociometric questionnaire on two different administrations were compared, the total group showed a highly significant improvement. However, the two therapy groups did not differ significantly from one another in terms of the increase in the number of names they gave to questions dealing with social situations and activities.

Recommendations

Conclusions bring out the fact that regardless of the apparent failure of both group psychotherapy methods to produce significant changes in the rated behavior of the subjects on five behavioral dimensions, many of them changed enough to decide to leave the institution. All of these individuals had lived in the hospital for years and liked their living conditions well enough to reject the mention of the possibility of finding a "home" for themselves. Such was their attitude

at the beginning of the experiment. It is suggested that future researchers make an attempt to control the experimental conditions more rigidly to eliminate at least some of the sources of error.

Sex and age were not included in the statistical analyses but there was some evidence to suggest that they may be pertinent variables. They should be controlled in a future study.

The present study was terminated at the end of the twelve week experimental treatment period. During the following weeks some of the patients who had wished to leave the hospital were placed in nursing homes. Unfortunately, it was not possible to find openings for all of those who were willing to go. Through personal correspondence with the head of the geriatric program at Pontiac State Hospital, it was learned that fourteen patients had already left the hospital and none of them had returned. Another group was expected to leave within a short time.

If the criterion of "success" was the percentage of returns from the nursing homes, we could reasonably say that whatever effects the treatment approaches had on the subjects, upon moving to a new environment, they were able to make a satisfactory adjustment. Further and more detailed longitudinal study is desirable.

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APPENDIX A

BEHAVIOR RATING SCALE

Patient's Name:
Rater:
Date:

BEHAVIOR RATING SCALE
For Evaluation of Response to Group Psychotherapy

This rating scale is designed for use for 12 evaluation periods. Ratings are to be given every week. Spaces are provided for ratings at the bottom of each page. For each week being rated write write in the number and letter (where there is a choice of A or B) of the description statement being used. For each week rated write in only one number and letter under each heading. Number without explanation refer to behavior that is in between those next to it. Ratings are given for behavior most usually describing patient's behavior for the period of observation.

I. ANXIETY

(Write in one number each week)

1. NO ANXIETY

2.

3. MILD ANXIETY. Tends to be tense and irritable or expresses mild discomfort on interview.

4.

5. FEARFUL. Definite feelings of fear in absence of external cause with real discomfort (palpitations, tremor sweating, etc.) but no loss of control.

6.

7. VERY FEARFUL. Disabling anxiety interfering with work and social functioning, possibly leading to loss of control at times.

8.

9. PANIC. Loss of control, shouting, screaming, etc.

Rating for week no.

1	2	3	4

5	6	7	8

9	10	11	12

II. AFFECTIVE DISPLAY

(Write in one number for each week; indicate A or B)

A. EXAGGERATED	(or)	B. DIMINISHED
1. NORMAL		1. NORMAL
2.		2.
3. SLIGHTLY EXAGGERATED: Somewhat sensitive and more than normal emotional responsiveness.		3. SLIGHTLY DIMINISHED
4.		4.
5. LABILE: Abnormally sensitive touchy, mild profanity but emotions do not go to extremes. May get rapid shifting from one emotion to another.		5. INADEQUATE: Tends to be unmoved or indifferent to things.
6.		6.
7. EXPLOSIVE: Sudden outbursts of weeping, anger or laughing with slight cause.		7. BLAND: Tends to deny feelings, rather detached.
8.		8.
9. INAPPROPRIATE: Extremes of feeling with little or no cause, relatively uninfluenced by external events.		9. FLAT: No evidence of any emotional feeling.

Rating for week no:

1	2	3	4

5	6	7	8

9	10	11	12

III. SOCIALIZATION

(Write in one number each week; indicate A or B)

A. WITHDRAWAL	(or)	B. OVERSOCIALIZATION
1. AVERAGE OR NORMAL		1. AVERAGE OR NORMAL
2.		2.
3. INTROVERTED: Tends to remain by self without spontaneous interest in patients or staff, but will take part in activities with a little urging.		3. EXTROVERTED: Interested in staff and other patients, but not to extent of assuming group leadership.
4.		4.
5. SHUT-IN: Tends to remain alone for long periods; will not enter into activities unless directly encouraged.		5. OUTREACHING: Actively involved and a leader in many ward activities.
6.		6.
7. ISOLATED: Completely on own; will not mix with other patients unless constantly and continually pushed.		7. MEDDLESOM: Involves self in activities of others where he is not always welcome, but is neither a leader or disruptive.
8.		8.
9. INACCESSIBLE: Does not respond to any efforts at socialization.		9. DISRUPTIVE: Attempts to push self into and break up other activity on ward.

Rating for week no.

1	2	3	4
5	6	7	8
9	10	11	12

IV. WORK ATTITUDES

(Write in one number each week).

1. EAGER WORKER: Volunteers for assignments and extra jobs.

2. WILLING WORKER: Enters voluntarily into work assignments in cheerful manner.

3. AGREEABLE WORKER: Neither reluctant or eager. Does what is required without urging.

4. RELUCTANT WORKER: Somewhat reluctant to get started, but willing to work without urging.

5. PRODDED WORKER: Willing to perform work with urging.

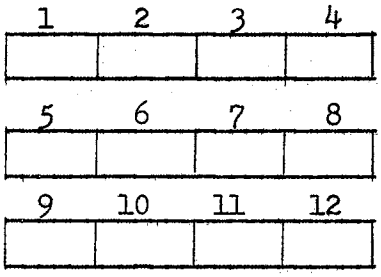
6. HESITANT WORKER: Reluctantly engages in work when urged. May only work for short periods.

7. WORK POSTPONEMENT: Gives many excuses for not working temporarily.

8. WORK AVOIDANCE: Gives many excuses for not working.

9. WORK REFUSAL: Completely unwilling to work.

Rating for week no.

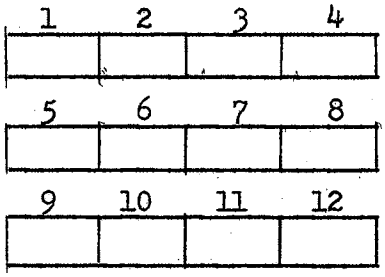


V. APPEARANCE

(Write in one number for each week; indicate A or B)

A. OVERCONCERN	(or)	B. LACK OF CONCERN
1. AVERAGE		1. AVERAGE
2.		2.
3. NEAT: Careful about dress and grooming.		3. CARELESS: Shirt or blouse not tucked in, hair uncombed.
4.		4.
5. OVER-METICULOUS: Very fussy about clothing and cleanliness.		5. UNTIDY: E.G., shoes untied, clothing wrinkled, looks poorly groomed.
6.		6.
7. DECORATIVE: Fancy and unnecessary additions to clothing and make-up.		7. SLOVENLY: Clothing soiled, torn; food spilled on clothing.
8.		8.
9. BIZARRE: Grotesque and exaggerated oddity of dress and appearance.		9. FILTHY: Soiling, wetting, smearing self with food, dirt, faces, etc.

Rating for week no.



APPENDIX B

SOCIOMETRIC QUESTIONNAIRE

If you were to choose a room-mate from the members of the group, whom would you select? (Name as many as you like according to preference.)

Whom would you like to go to the dining room with?

Whom would you like to have coffee with at the snack bar?

If we plan a bus ride, whom would you like to sit next to?

If you had a choice to go shopping with five other people, whom would you choose from the group?

If you had exciting news that you wanted to share with someone, who would you tell it to first?

If you have a personal problem, with whom would you trust your secret?

If you were appointed the chairman of a committee to plan a picnic, whom would you like to have as co-workers?

If we plan to go to a concert or to a movie theatre, whom would you like to sit next to?

Suppose you are invited to a formal dinner and you have to have a partner from the opposite sex, could you name the ones you would choose?

APPENDIX C

RAW DATA FROM THE BEHAVIOR RATING SCALE

ANXIETY

Unstructured Therapy Group													Structured Therapy Group											
	Weeks													Weeks										
Subjects	1	2	3	4	5	6	7	8	9	10	11	12	Subjects	1	2	3	4	5	6	7	8	9	10	11	12
1	4	8	13	4	4	4	4	4	4	4	4	4	18	5	5	5	5	4	4	4	4	4	4	4	4
2	4	4	4	4	4	4	3	2	2	2	2	2	19	6	6	5	9	9	8	8	8	8	8	8	8
3	4	4	4	4	8	11	11	11	11	11	11	11	20	4	4	4	4	3	3	3	2	2	2	2	2
4	7	7	5	5	5	5	5	4	4	4	4	4	21	5	5	4	5	5	4	4	4	4	4	4	4
5	7	7	7	7	6	6	6	6	6	5	5	5	22	8	8	7	6	6	6	6	6	4	4	4	4
6	14	13	12	13	14	10	10	10	10	10	10	10	23	9	7	6	5	5	6	6	6	4	4	4	4
7	5	5	5	4	4	4	4	4	4	4	4	4	24	6	6	5	5	4	4	4	3	3	3	3	3
8	6	6	5	5	6	5	4	4	4	4	4	4	25	3	3	4	5	5	4	4	4	4	4	4	4
9	4	4	4	4	4	3	3	3	3	3	3	3	26	8	7	5	5	6	5	4	4	4	4	4	4
10	4	4	4	4	4	4	4	4	4	4	4	4	27	6	6	6	5	5	5	5	5	5	5	5	5
11	6	6	6	6	6	6	6	6	5	5	5	5	28	5	5	5	5	6	6	6	6	6	6	6	6
12	5	5	6	6	6	6	6	4	4	4	6	6	29	5	5	5	5	5	5	5	5	5	5	5	5
13	2	2	2	2	2	2	2	2	2	2	2	2	30	5	5	5	5	5	5	6	6	6	6	6	6
14	6	7	7	7	7	7	7	6	6	6	6	7	31	2	2	2	2	2	2	2	2	2	2	2	2
15	6	6	6	6	6	6	6	6	6	6	6	6	32	7	6	7	7	7	7	6	6	6	6	6	6
16	6	4	4	4	6	6	6	6	6	6	6	6	33	6	6	6	6	6	6	6	6	6	6	6	6
17	2	2	2	2	2	2	2	2	2	2	2	2	34	5	6	6	6	6	6	6	6	6	6	6	6
													35	4	4	4	4	4	4	4	4	4	4	4	4
													36	6	5	5	5	5	5	5	5	5	5	5	5

AFFECTIVE DISPLAY

Unstructured Therapy Group													Structured Therapy Group											
	Weeks													Weeks										
Subjects	1	2	3	4	5	6	7	8	9	10	11	12	Subjects	1	2	3	4	5	6	7	8	9	10	11	12
1	8	8	16	6	6	6	6	6	6	6	6	6	18	4	5	5	5	5	4	4	4	4	4	4	4
2	6	6	6	6	6	6	5	5	5	5	5	5	19	6	6	6	5	5	4	4	4	4	4	3	3
3	18	18	18	17	16	16	16	17	16	16	16	16	20	5	5	5	5	4	4	4	4	4	4	4	4
4	12	12	10	10	10	10	9	9	9	9	9	9	21	11	11	11	10	9	9	8	8	8	7	7	7
5	7	7	7	6	6	6	6	6	6	6	6	6	22	10	9	8	8	8	8	8	7	7	7	5	5
6	7	7	7	7	7	8	8	8	7	7	8	8	23	7	7	7	7	6	6	4	4	4	4	4	4
7	5	5	5	4	5	5	4	4	4	4	4	4	24	3	3	3	3	2	2	2	2	2	2	2	2
8	10	10	8	8	9	8	8	9	8	8	8	8	25	2	2	4	4	4	4	4	4	3	3	3	3
9	5	5	5	4	4	4	4	4	3	3	3	3	26	10	8	7	7	6	6	6	6	6	5	5	5
10	4	4	4	4	4	4	4	4	4	4	4	4	27	8	8	8	8	8	8	8	8	8	8	8	8
11	18	8	5	5	4	2	2	2	2	2	2	2	28	5	9	6	6	6	6	6	5	5	5	5	5
12	5	6	6	6	6	6	10	10	10	10	10	10	29	10	8	8	8	8	8	8	8	8	8	8	8
13	2	2	2	2	2	2	2	2	2	2	2	2	30	4	4	4	4	4	4	4	4	4	4	4	4
14	6	6	6	6	6	6	6	6	6	6	6	6	31	2	2	2	2	2	2	2	2	2	2	2	2
15	6	6	6	6	6	6	6	6	6	6	6	6	32	7	8	8	8	8	8	8	7	7	8	8	8
16	6	4	4	4	4	4	4	4	4	4	4	4	33	6	4	4	4	6	6	8	8	8	8	8	8
17	2	2	2	2	2	2	2	2	2	2	2	2	34	4	6	6	6	6	6	8	8	8	6	6	6
													35	2	2	2	2	4	4	2	2	2	2	2	2
													36	14	14	14	18	18	18	14	14	14	14	14	14

SOCIALIZATION

Unstructured Therapy Group													Structured Therapy Group											
	Weeks													Weeks										
Subjects	1	2	3	4	5	6	7	8	9	10	11	12	Subjects	1	2	3	4	5	6	7	8	9	10	11	12
1	6	6	6	6	6	6	6	6	6	6	6	6	18	5	5	5	4	4	4	3	3	3	3	3	3
2	5	6	6	6	7	7	7	7	7	7	7	7	19	6	6	6	6	6	7	7	7	7	7	7	7
3	4	4	4	4	4	4	4	4	4	4	4	4	20	5	5	5	4	4	4	4	4	4	4	4	4
4	6	6	5	5	6	5	5	5	5	5	5	5	21	14	14	14	11	11	10	10	10	10	9	9	9
5	6	6	6	6	6	6	5	5	5	5	6	6	22	10	10	9	8	8	7	6	6	5	5	4	4
6	6	6	6	6	6	5	5	5	5	5	5	5	23	6	6	6	6	4	3	3	3	2	2	2	2
7	6	6	5	5	4	4	4	4	3	3	3	3	24	7	7	7	5	5	4	4	4	2	2	2	2
8	7	10	6	6	6	6	6	5	5	5	5	5	25	5	5	4	4	4	4	4	4	4	3	3	3
9	4	4	3	3	3	2	3	2	2	3	3	3	26	5	5	5	5	5	4	4	4	4	4	4	4
10	4	4	6	6	6	4	4	6	6	4	4	4	27	10	5	6	8	8	8	8	8	8	8	8	8
11	6	6	4	2	2	2	2	2	2	2	2	2	28	6	6	6	6	6	6	6	6	6	6	6	6
12	14	14	8	8	8	9	9	18	18	18	10	10	29	4	4	4	4	4	4	4	4	4	4	4	4
13	2	2	2	2	2	2	4	4	4	4	4	4	30	10	9	10	10	10	10	8	8	8	8	8	8
14	6	5	6	6	6	6	6	6	6	6	6	6	31	2	2	2	2	2	2	2	2	2	2	2	2
15	14	15	14	14	14	15	14	14	14	14	14	14	32	8	8	8	8	8	8	8	8	8	8	8	8
16	12	12	12	10	10	10	10	10	10	10	10	19	33	5	6	6	6	6	6	6	6	6	6	6	6
17	2	2	2	2	2	2	2	2	2	2	2	2	34	6	6	6	6	6	6	8	8	8	8	8	8
													35	4	4	6	6	6	6	4	4	4	4	4	4
													36	10	18	18	18	18	14	14	14	14	14	14	14

Unstructured Therapy Group													Structured Therapy Group											
	Weeks													Weeks										
Subjects	1	2	3	4	5	6	7	8	9	10	11	12	Subjects	1	2	3	4	5	6	7	8	9	10	11	12
1	3	2	2	2	2	2	2	2	2	2	2	2	18	6	5	5	4	4	4	4	4	4	4	4	4
2	7	7	7	5	5	4	4	4	4	4	4	4	19	5	5	5	4	4	4	4	4	4	4	4	4
3	6	6	6	6	6	6	6	6	5	5	5	5	20	6	6	6	6	6	6	6	5	5	5	5	5
4	5	5	5	5	5	5	4	4	4	4	4	4	21	9	10	10	10	10	10	10	10	10	10	10	10
5	6	6	4	4	5	5	5	5	5	5	5	5	22	18	18	17	16	14	13	12	12	11	8	8	8
6	7	7	7	7	7	6	6	6	6	6	6	6	23	3	3	3	3	2	2	2	2	2	2	2	2
7	13	13	13	12	12	12	12	12	11	11	11	11	24	2	2	2	2	2	2	2	2	2	2	2	2
8	8	8	7	6	6	6	6	6	6	6	6	6	25	5	5	4	3	3	3	2	2	2	2	2	2
9	4	3	3	2	2	2	2	2	2	2	2	2	26	6	6	5	4	4	4	4	4	4	3	3	3
10	5	5	5	5	6	6	6	6	6	6	6	6	27	15	12	12	12	12	12	12	12	12	12	12	12
11	4	4	4	4	4	4	4	4	4	4	4	4	28	2	3	3	2	2	2	3	3	3	3	3	3
12	5	4	4	5	5	5	5	4	4	4	4	4	29	3	3	3	3	3	3	3	3	3	3	3	3
13	4	4	4	4	3	3	3	3	3	3	3	3	30	4	4	4	4	4	4	4	4	4	4	4	4
14	4	4	4	4	4	4	4	4	4	4	4	5	31	5	5	5	5	5	5	5	5	5	5	5	5
15	12	16	16	16	16	16	16	16	16	16	16	16	32	14	14	16	16	16	16	16	16	16	16	16	16
16	18	17	17	17	17	17	16	16	16	16	16	16	33	15	17	17	17	17	17	17	17	17	17	17	17
17	4	4	4	4	4	4	4	4	4	4	4	4	34	4	4	4	4	4	4	4	4	3	3	3	3
													35	11	11	11	11	17	17	17	17	11	11	11	11
													36	18	18	18	18	18	18	18	18	18	18	18	18

APPEARANCE

Unstructured Therapy Group													Structured Therapy Group											
	Weeks													Weeks										
Subjects	1	2	3	4	5	6	7	8	9	10	11	12	Subjects	1	2	3	4	5	6	7	8	9	10	11	12
1	5	4	4	4	4	4	4	4	4	4	4	4	18	2	3	4	4	4	4	4	5	5	5	5	5
2	4	4	4	6	6	6	4	4	4	4	4	4	19	6	6	6	7	7	7	7	7	7	7	7	7
3	2	3	4	4	4	4	4	4	5	5	5	5	20	2	2	2	3	3	3	3	5	5	5	5	5
4	2	2	2	2	2	3	3	3	3	3	4	4	21	8	8	8	8	8	8	8	8	7	7	7	7
5	2	2	2	2	3	3	3	3	3	3	3	3	22	3	3	4	4	4	5	5	5	5	6	6	6
6	5	6	6	6	5	5	5	4	3	2	2	2	23	8	8	7	3	3	3	2	2	2	2	2	2
7	2	2	2	2	2	2	2	2	3	4	4	4	24	6	6	6	6	7	7	7	7	8	8	8	8
8	2	2	4	5	6	4	4	4	4	4	4	4	25	4	4	5	5	5	5	6	6	6	6	6	6
9	6	6	6	6	6	6	6	7	7	7	7	7	26	2	3	3	3	4	4	4	4	4	5	5	5
10	4	4	4	4	4	4	4	4	4	4	4	4	27	8	9	8	10	10	10	10	8	8	8	10	10
11	2	2	2	2	2	2	2	2	2	2	2	2	28	10	10	10	10	10	10	10	10	10	10	10	10
12	4	4	4	4	4	4	4	4	4	4	4	4	29	4	5	5	5	5	5	5	5	5	5	5	5
13	2	2	2	2	4	4	4	4	4	4	4	4	30	5	5	5	4	4	4	4	4	4	4	4	4
14	5	5	5	5	5	5	5	5	5	5	5	5	31	6	6	6	6	6	6	6	6	6	6	6	6
15	4	4	4	4	4	4	4	4	4	4	4	4	32	4	4	4	4	4	4	4	4	4	4	4	4
16	2	2	2	2	3	3	3	3	3	3	3	3	33	4	4	4	4	4	4	4	4	4	4	4	4
17	6	6	6	6	6	6	6	6	6	6	6	6	34	2	2	2	2	2	2	2	2	2	2	2	2
													35	8	8	8	8	8	8	8	8	8	8	8	8
													36	5	5	5	6	6	6	6	6	6	6	6	6

APPENDIX D

EVALUATIONS BY JUDGES ON FIVE VARIABLES IN EACH WARD "BEFORE" AND "AFTER" THERAPY FOR EACH SUBGROUP

Ward 1

Anxiety

		T_1H_1 (n=4)	T_1H_2 (n=2)	T_2H_1 (n=3)
J_1	Time 1	11.5	5	6
	Time 2	8	9	6
J_2	Time 1	13.5	6	8.5
	Time 2	7	7	6

Affective Display

		T_1H_1	T_1H_2	T_2H_1
J_1	Time 1	14	12	7.5
	Time 2	12	11	8
J_2	Time 1	17	13	8
	Time 2	9	11	4

Socialization

		T_1H_1	T_1H_2	T_2H_1
J_1	Time 1	11.5	5	6
	Time 2	10	5	6
J_2	Time 1	11.5	5	8.5
	Time 2	7	5	4

Work Attitude

		T_1H_1	T_1H_2	T_2H_1
J_1	Time 1	12	5.5	6
	Time 2	11	6	5
J_2	Time 1	13.5	5.5	9
	Time 2	10	4	4

Appearance

		T_1H_1	T_1H_2	T_2H_1
J_1	Time 1	7.5	3	7
	Time 2	9	4	7
J_2	Time 1	7.5	2.5	4
	Time 2	10	4	9

n = number of subjects in subgroup

Ward 2

Anxiety

		T_1H_1 (n=1)	T_1H_2 (n=2)	T_2H_1 (n=1)	T_2H_2 (n=5)
J_1	Time 1	1.5	8	2.5	12.5
	Time 2	1	7	4	9
J_2	Time 1	2.5	10.5	3	15.5
	Time 2	1	7	4	8

Affective Display

		T_1H_1	T_1H_2	T_2H_1	T_2H_2
J_1	Time 1	3	9	3	16
	Time 2	2	10	2	13
J_2	Time 1	3	9	3	18.5
	Time 2	3	7	1	9

Socialization

		T_1H_1	T_1H_2	T_2H_1	T_2H_2
J_1	Time 1	3	5.5	3	21.5
	Time 2	4	6	3	12
J_2	Time 1	3	6	3	20
	Time 2	3	4	4	9

Work Attitude

		T_1H_1	T_1H_2	T_2H_1	T_2H_2
J_1	Time 1	3	5	2	18.5
	Time 2	2	5	2	14
J_2	Time 1	4	7	3	20
	Time 2	2	5	2	13

Appearance

		T_1H_1	T_1H_2	T_2H_1	T_2H_2
J_1	Time 1	2	4	3	14
	Time 2	1	2	3	14
J_2	Time 1	2	4	3	13
	Time 2	3	4	4	14

n = number of subjects in subgroup

Ward 3

Anxiety

		T_1H_1 (n=4)	T_1H_2 (n=1)	T_2H_1 (n=1)	T_2H_2 (n=1)
J_1	Time 1	10	1	1	1
	Time 2	9	1	1	1
J_2	Time 1	6	1	3	1
	Time 2	8	1	3	1

Affective Display

		T_1H_1	T_1H_2	T_2H_1	T_2H_2
J_1	Time 1	11.5	1	1	1
	Time 2	8	1	1	1
J_2	Time 1	5	1	1	1
	Time 2	4	1	1	1

Socialization

		T_1H_1	T_1H_2	T_2H_1	T_2H_2
J_1	Time 1	14	1	1	1
	Time 2	10	3	1	1
J_2	Time 1	10	1	4	1
	Time 2	10	1	3	1

Work Attitude

		T_1H_1	T_1H_2	T_2H_1	T_2H_2
J_1	Time 1	16	2	8	3
	Time 2	14	2	8	3
J_2	Time 1	14	2	3	2
	Time 2	16	1	3	2

Appearance

		T_1H_1	T_1H_2	T_2H_1	T_2H_2
J_1	Time 1	6	1	3	3
	Time 2	6	1	3	3
J_2	Time 1	8	1	5	3
	Time 2	9	3	5	3

n = number of subjects in subgroups

Ward 4

Anxiety

		T_1H_2 (n=3)	T_2H_1 (n=4)	T_2H_2 (n=4)
J_1	Time 1	9	12	12
	Time 2	9	12	12
J_2	Time 1	9.5	9	11.5
	Time 2	9.5	9	12

Affective Display

		T_1H_2	T_2H_1	T_2H_2
J_1	Time 1	9	16	14
	Time 2	13	20	16
J_2	Time 1	9	21.5	8
	Time 2	9	15	10

Socialization

		T_1H_2	T_2H_1	T_2H_2
J_1	Time 1	14	18	14
	Time 2	15	16	14
J_2	Time 1	17	15.5	15.5
	Time 2	15	16	16

Work Attitude

		T_1H_2	T_2H_1	T_2H_2
J_1	Time 1	12	17	19
	Time 2	12	17	19
J_2	Time 1	12	19	21
	Time 2	12.5	19	21

Appearance

		T_1H_2	T_2H_1	T_2H_2
J_1	Time 1	9	12	10
	Time 2	9	12	10
J_2	Time 1	4	16.5	5
	Time 2	4	19	4

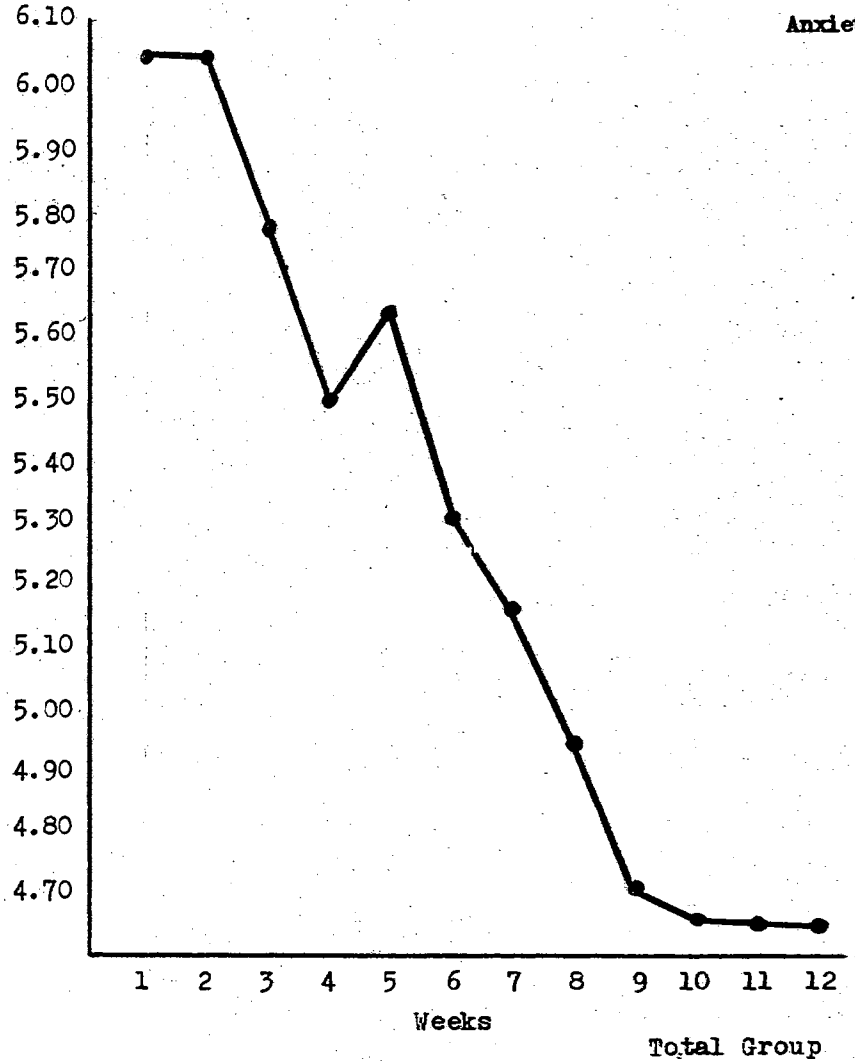
n = number of subjects in subgroups

APPENDIX E

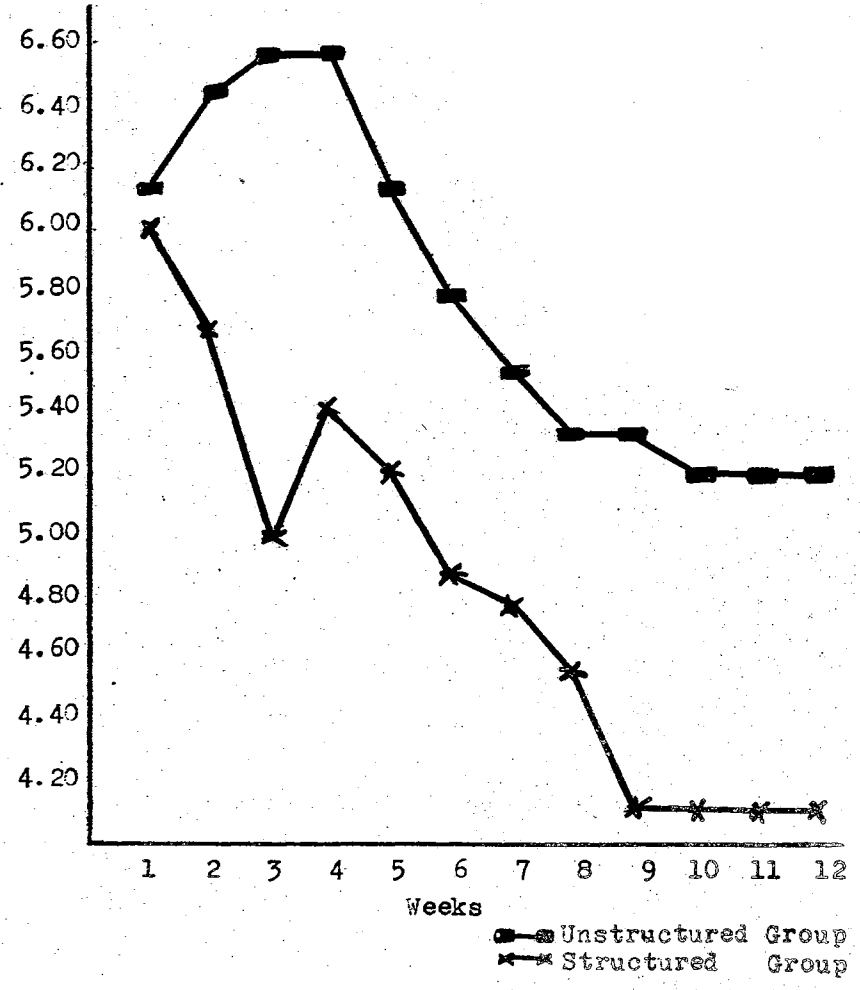
BEHAVIOR RATING CHANGES ON FIVE DIMENSIONS BY SEX AND AGE

Males

Anxiety

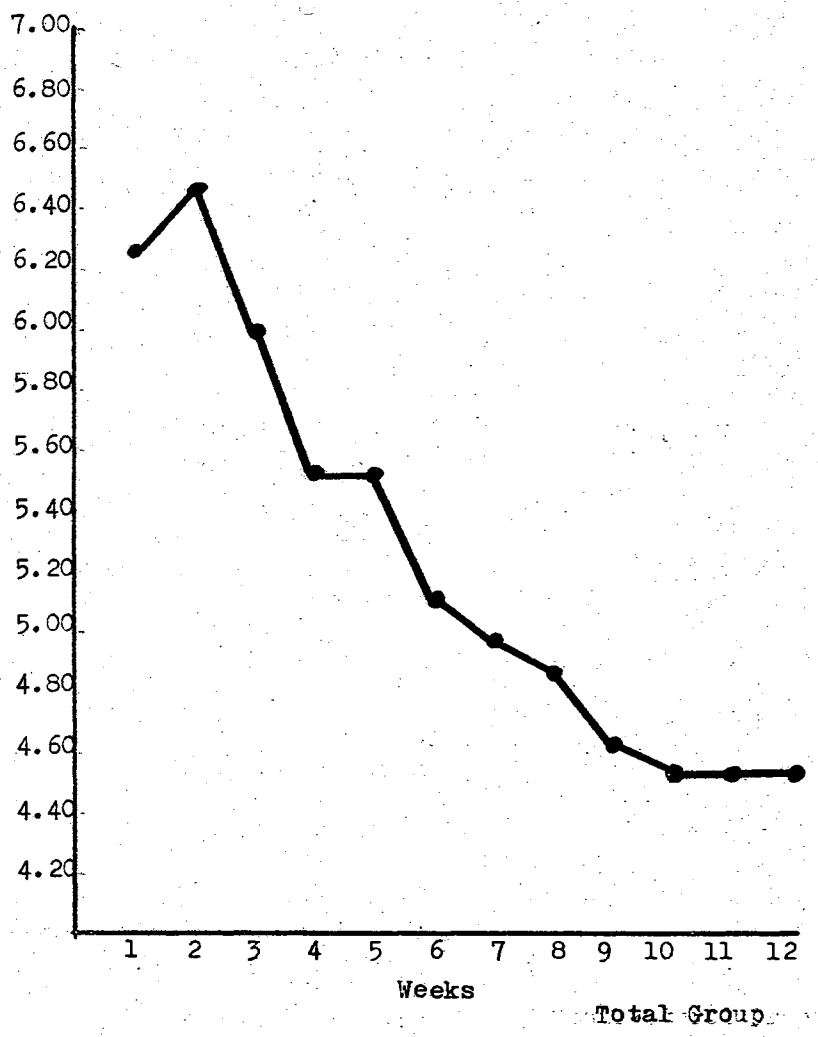


Total Group

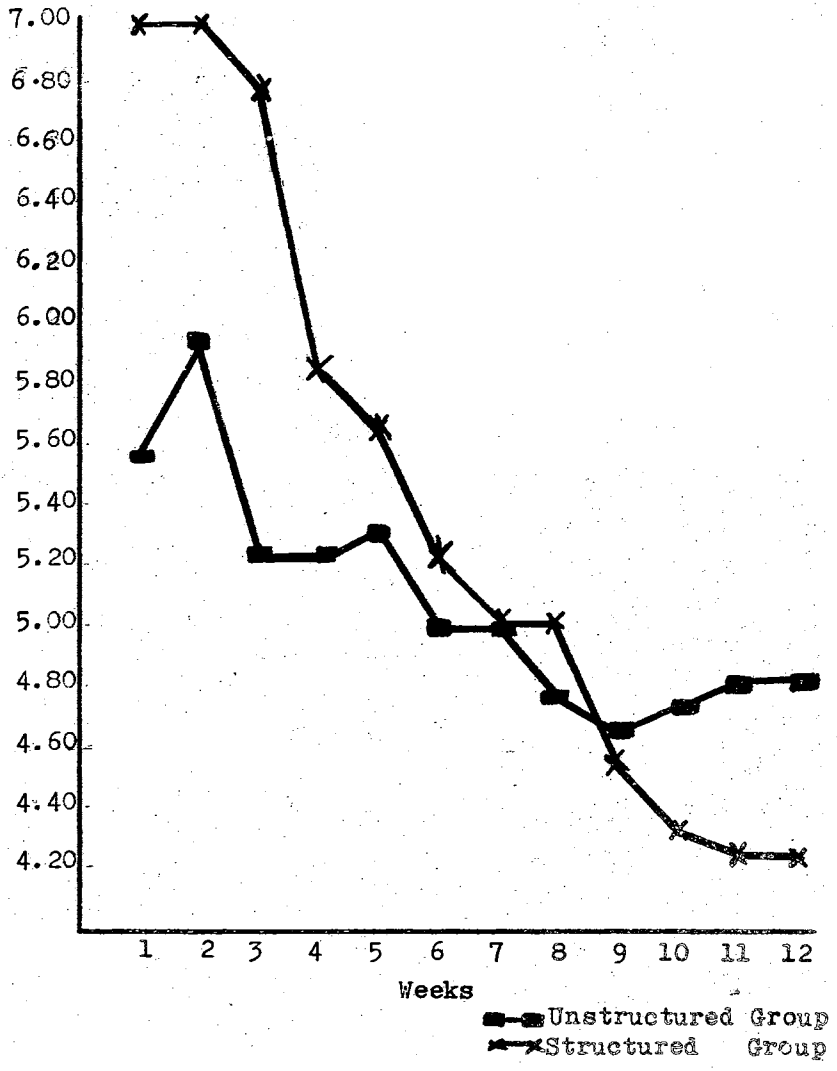


Males

Socialization

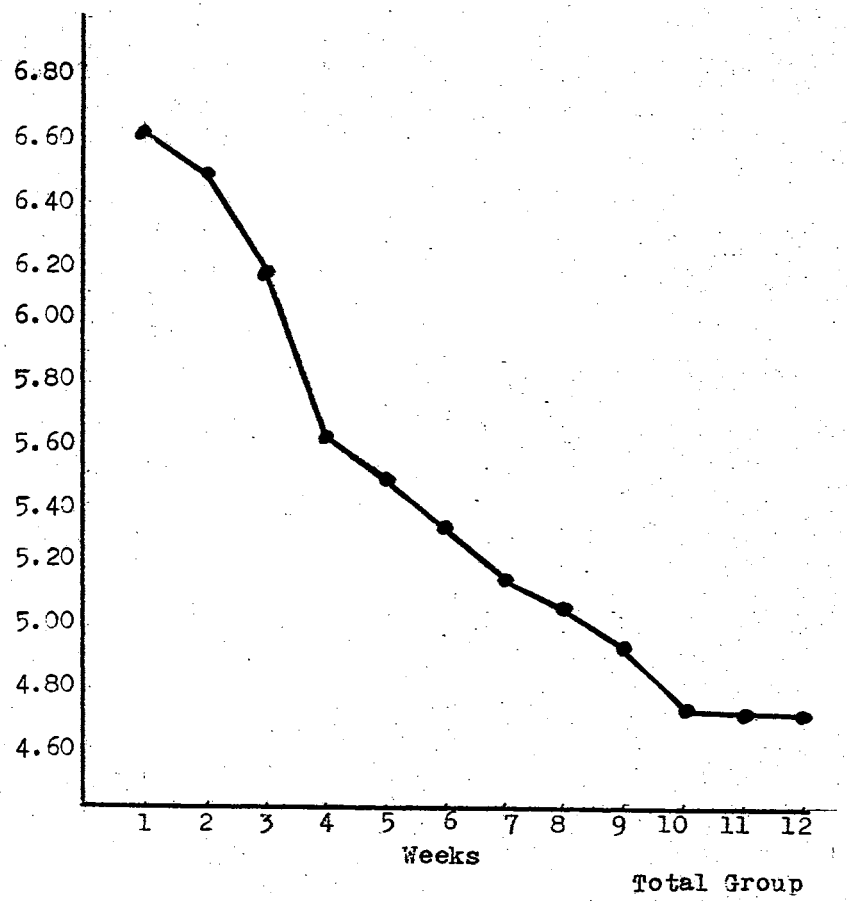


Total Group

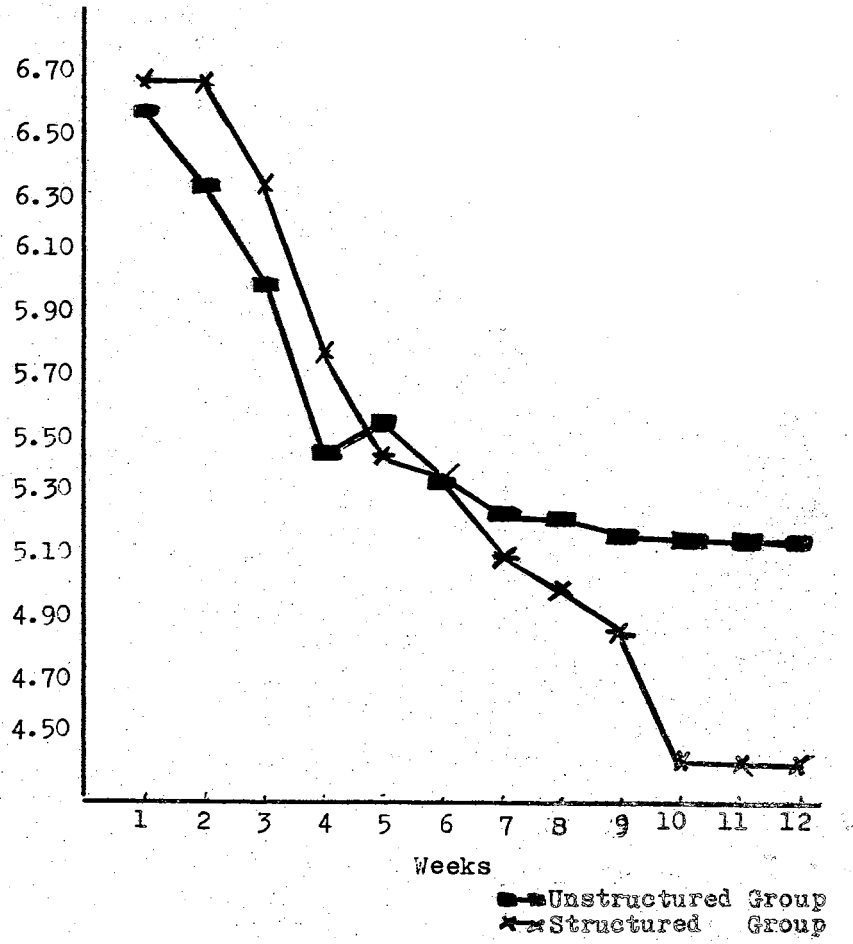


Males

Work Attitude

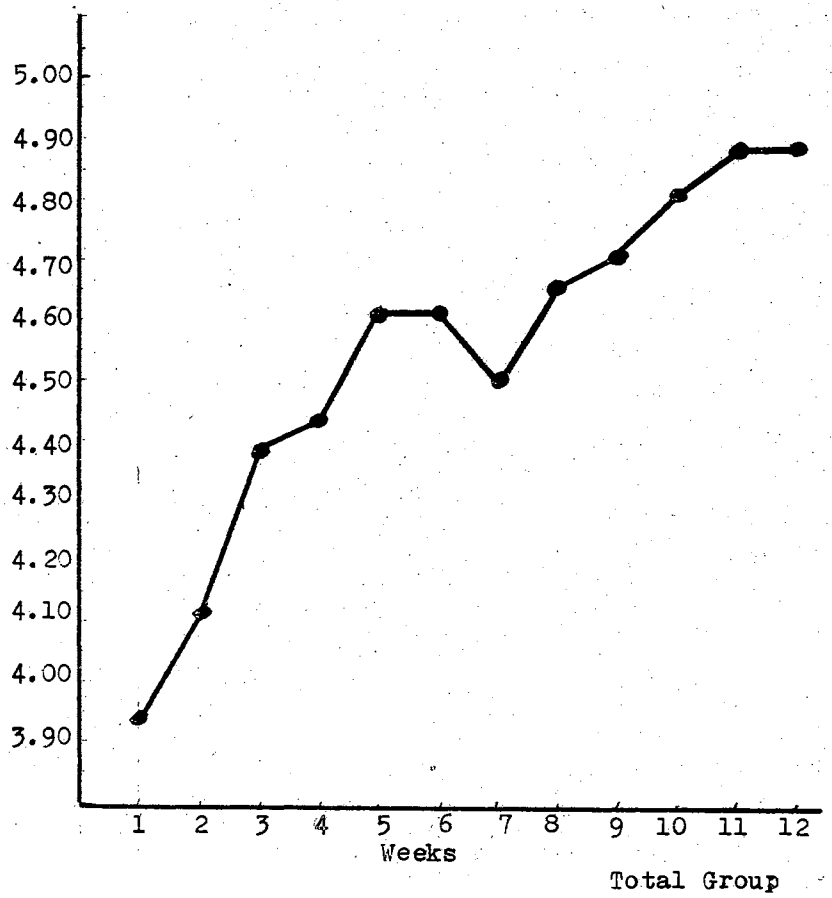


Total Group

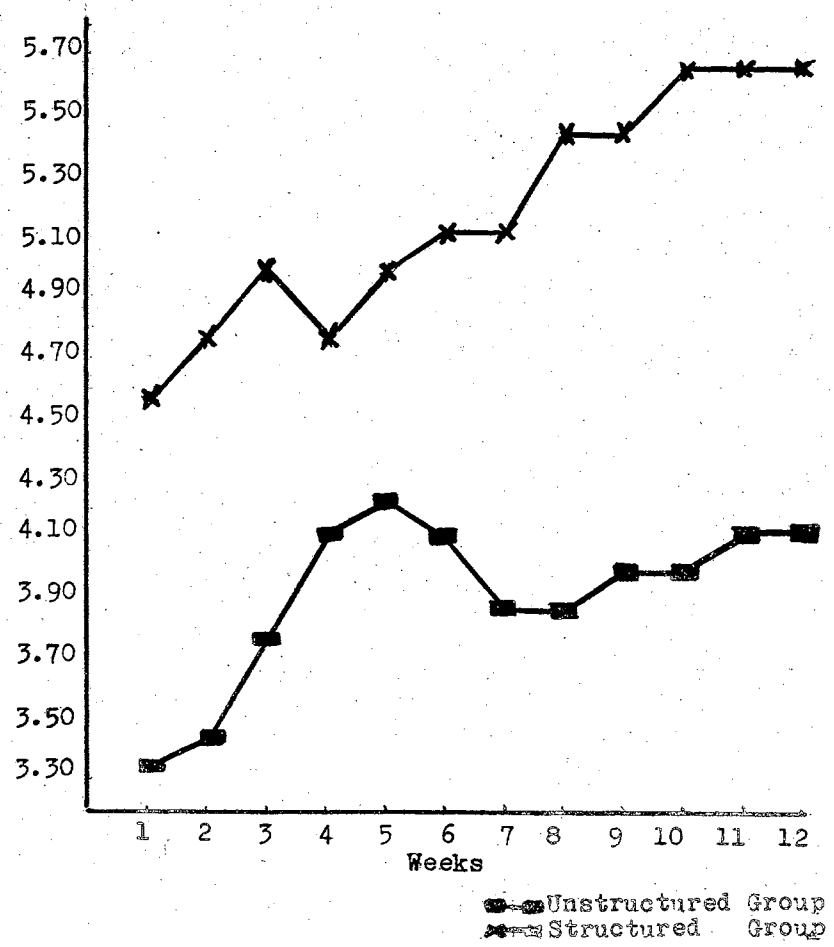


Males

Appearance

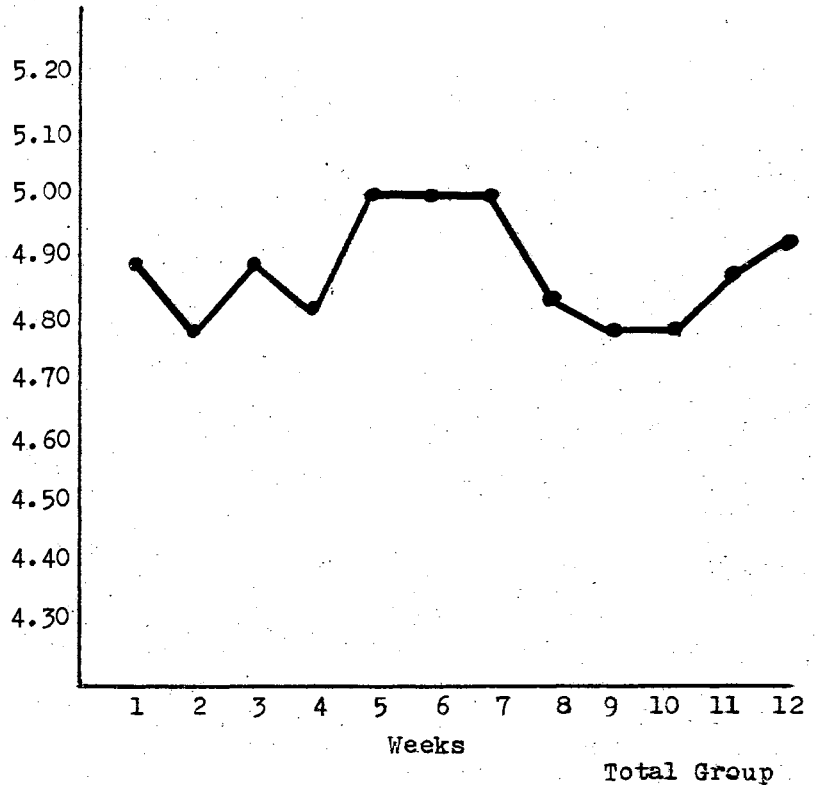


Total Group

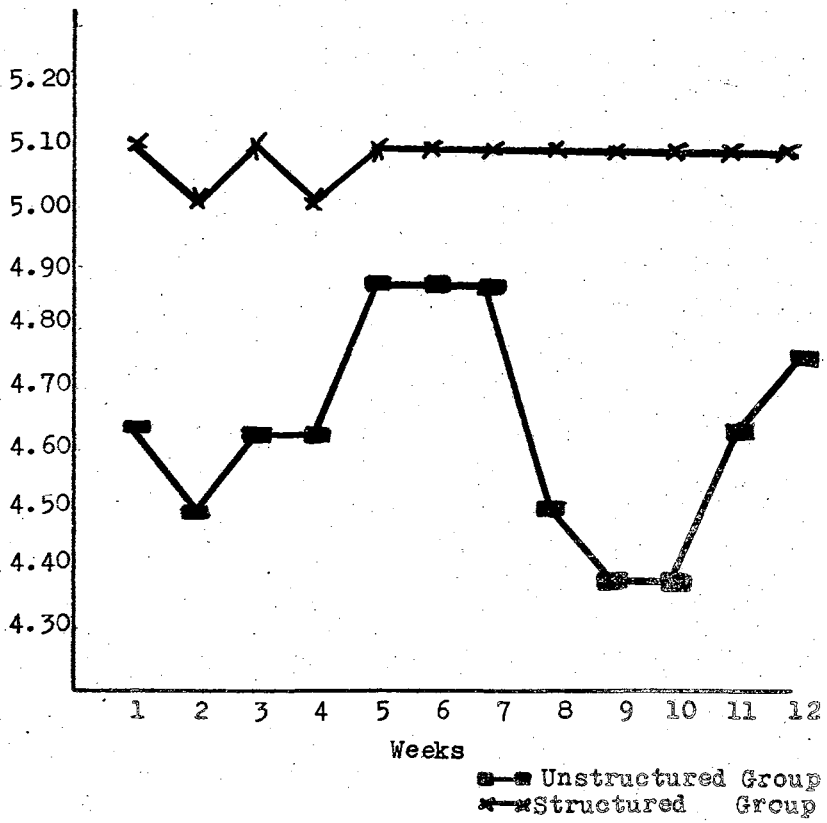


Females

Anxiety

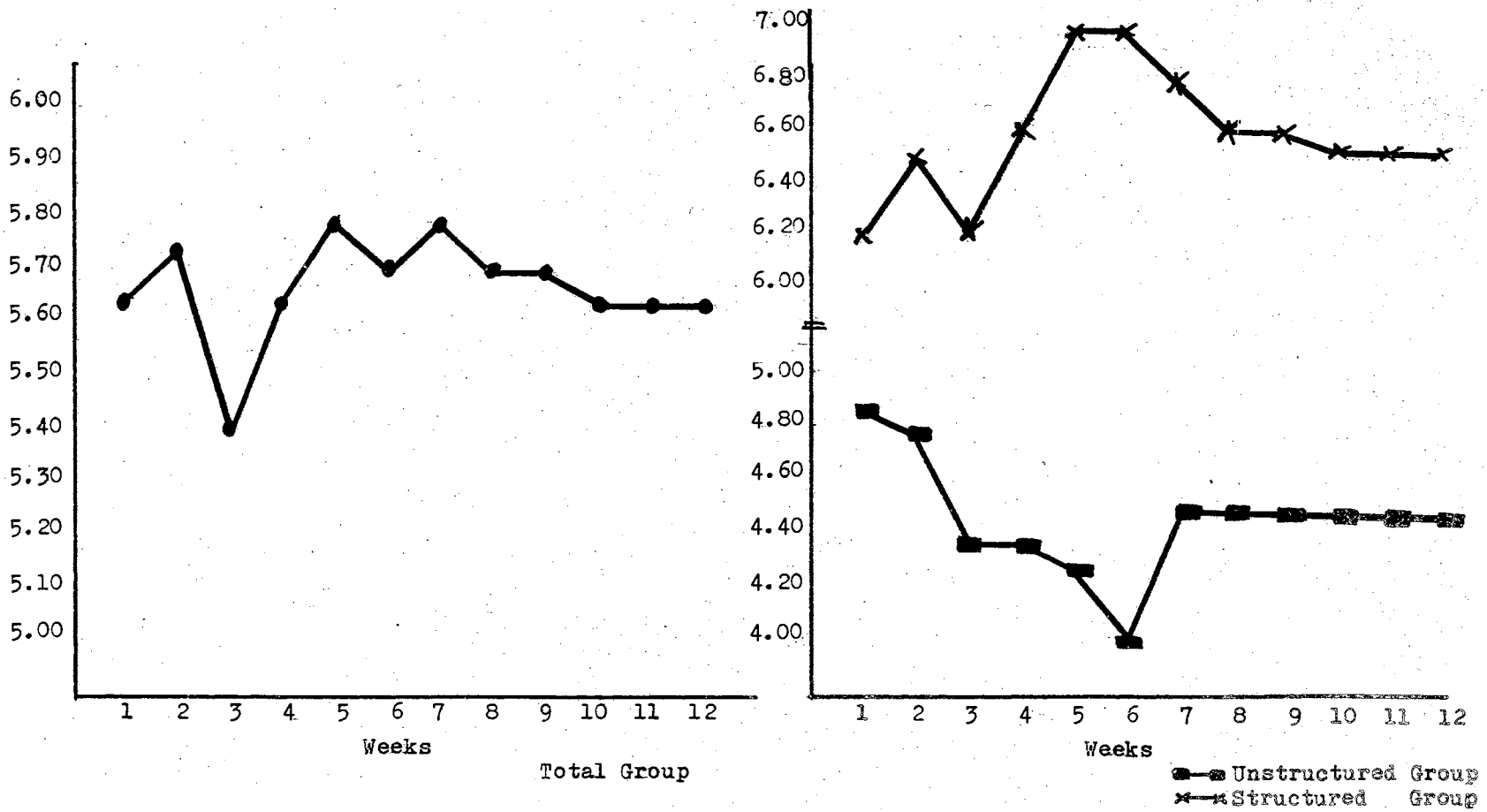


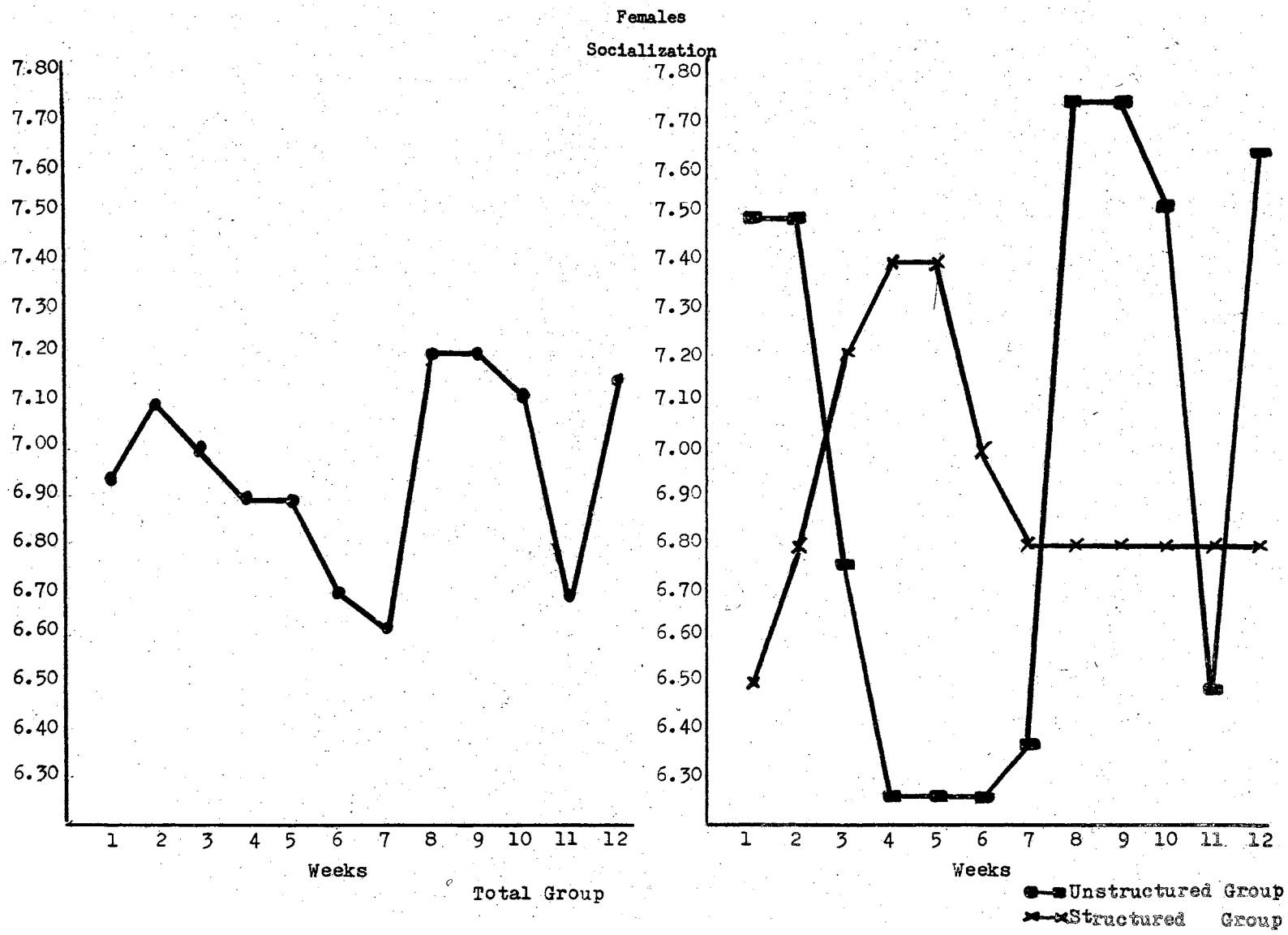
Total Group



Females

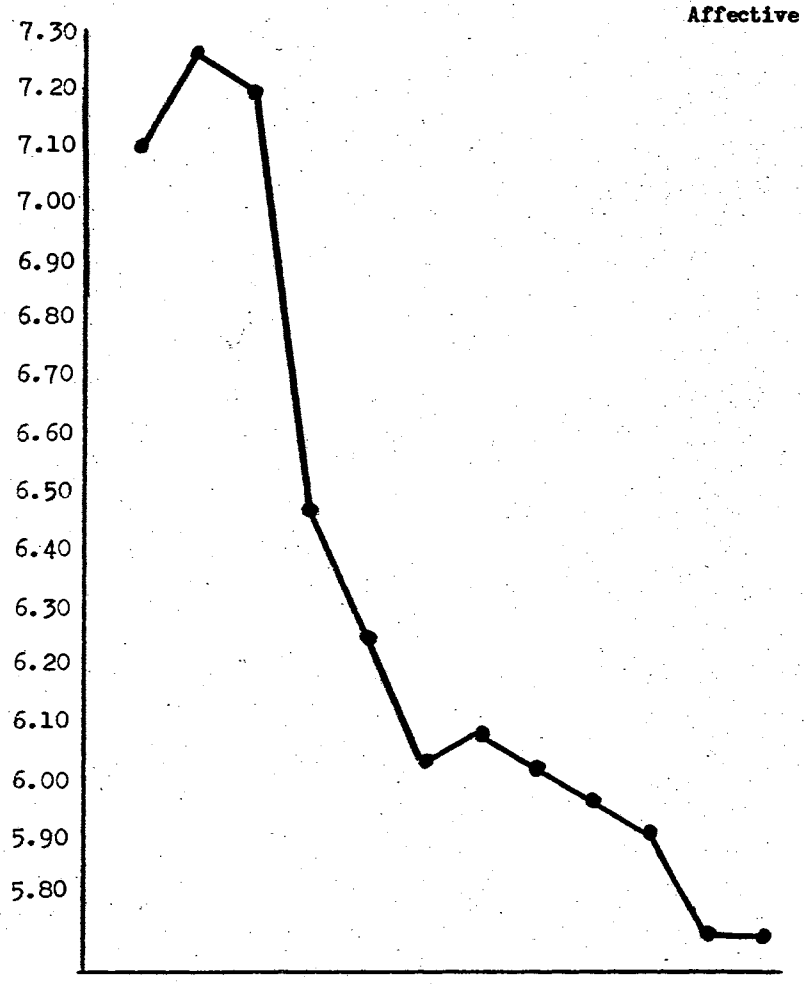
Affective Display



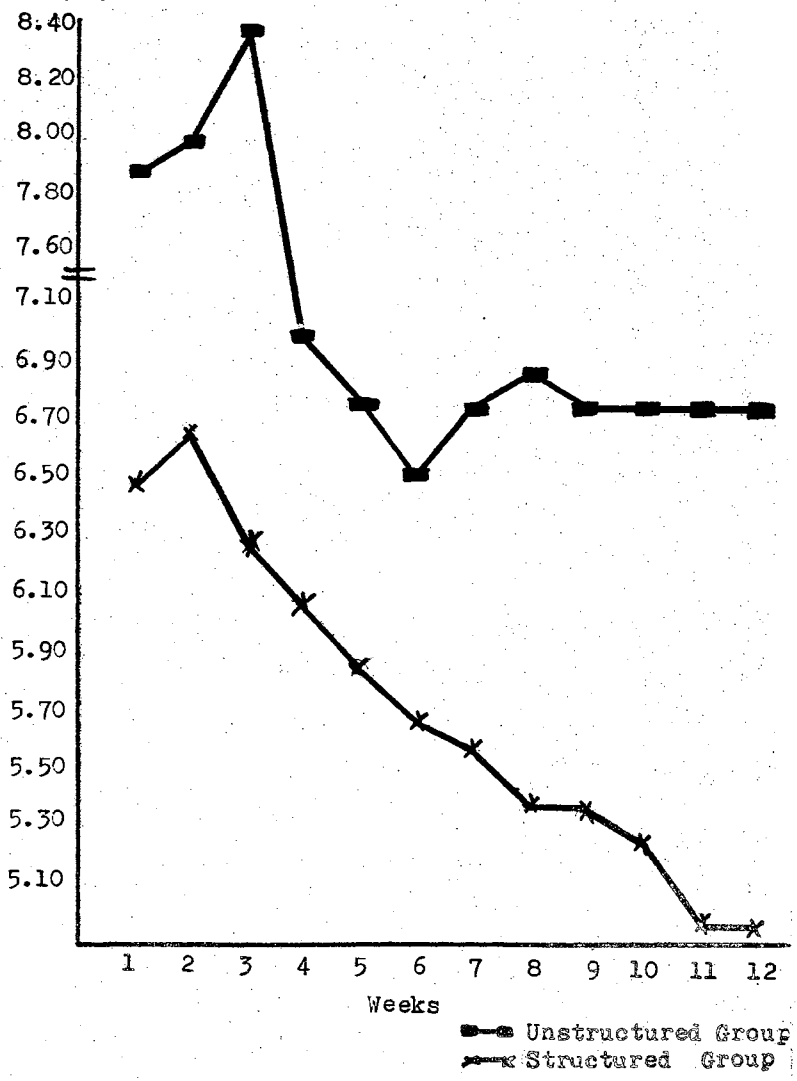

Females
Socialization
7.80
7.70
7.60
7.50
7.40
7.30
7.20
7.10
7.00
6.90
6.80
6.70
6.60
6.50
6.40
6.30
1 2 3 4 5 6 7 8 9 10 11 12
Weeks
Total Group
Weeks
Unstructured Group
Structured Group

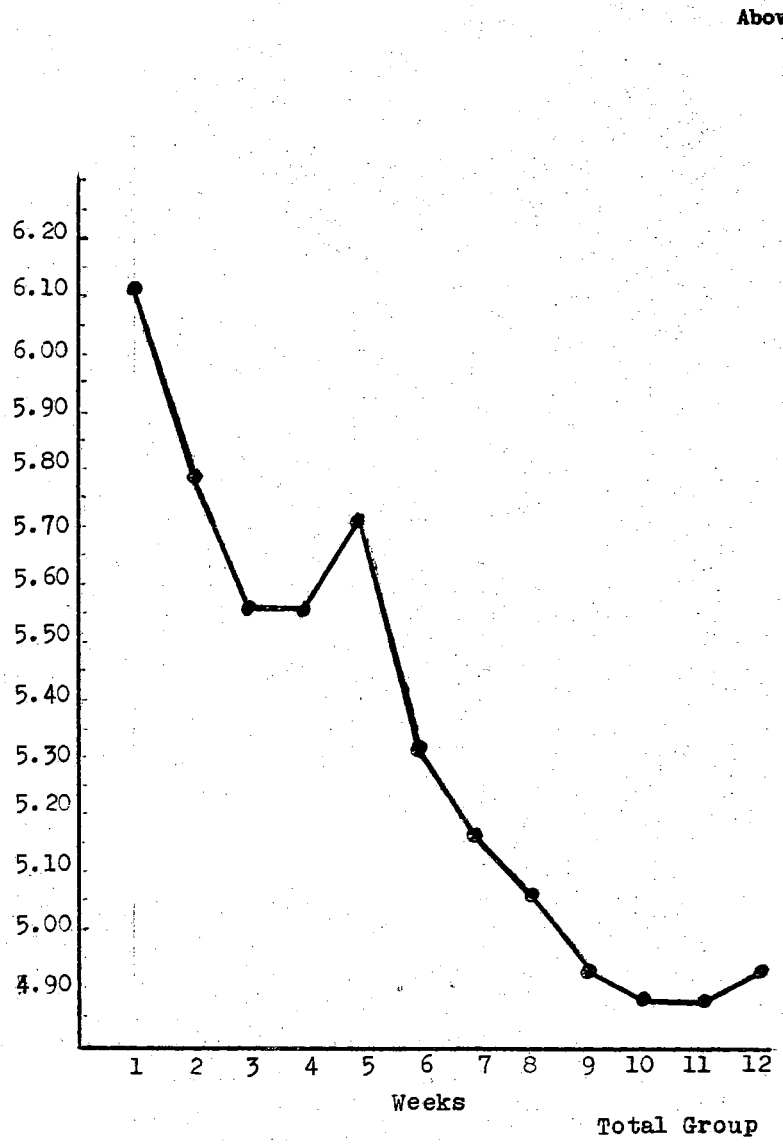
Below 70 years

Affective Display



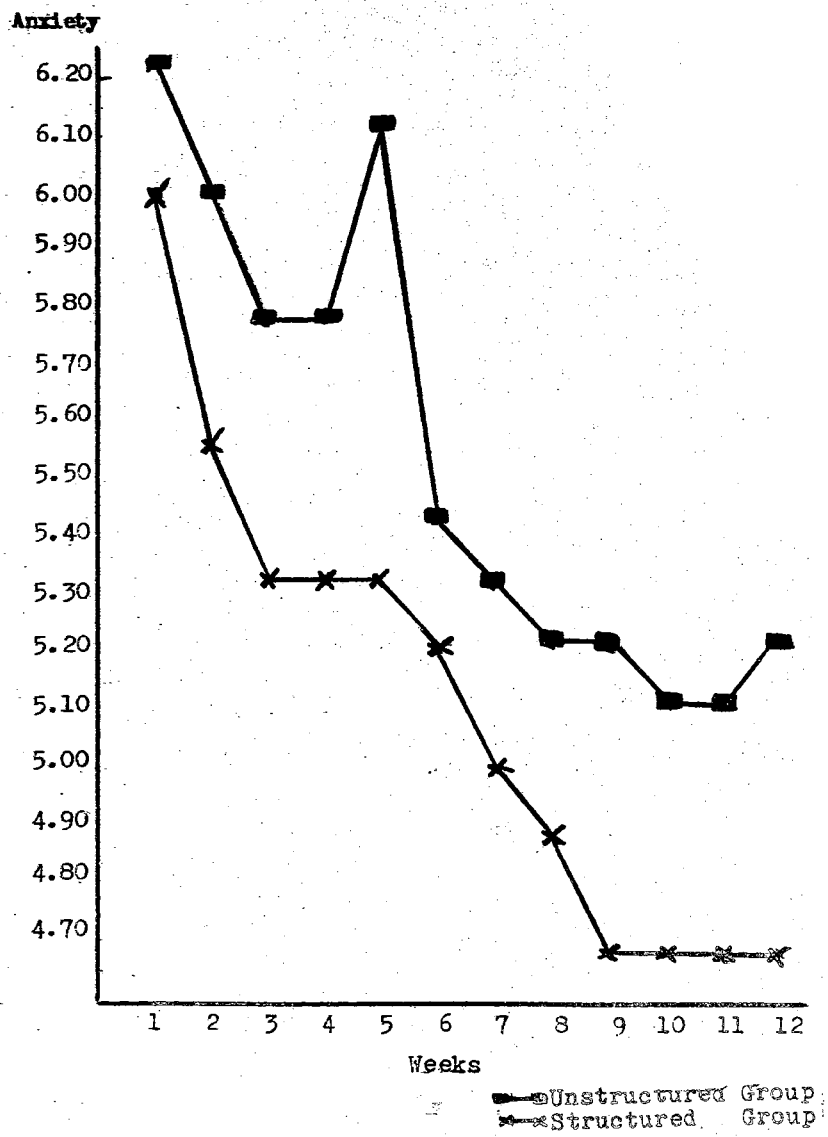
Total Group



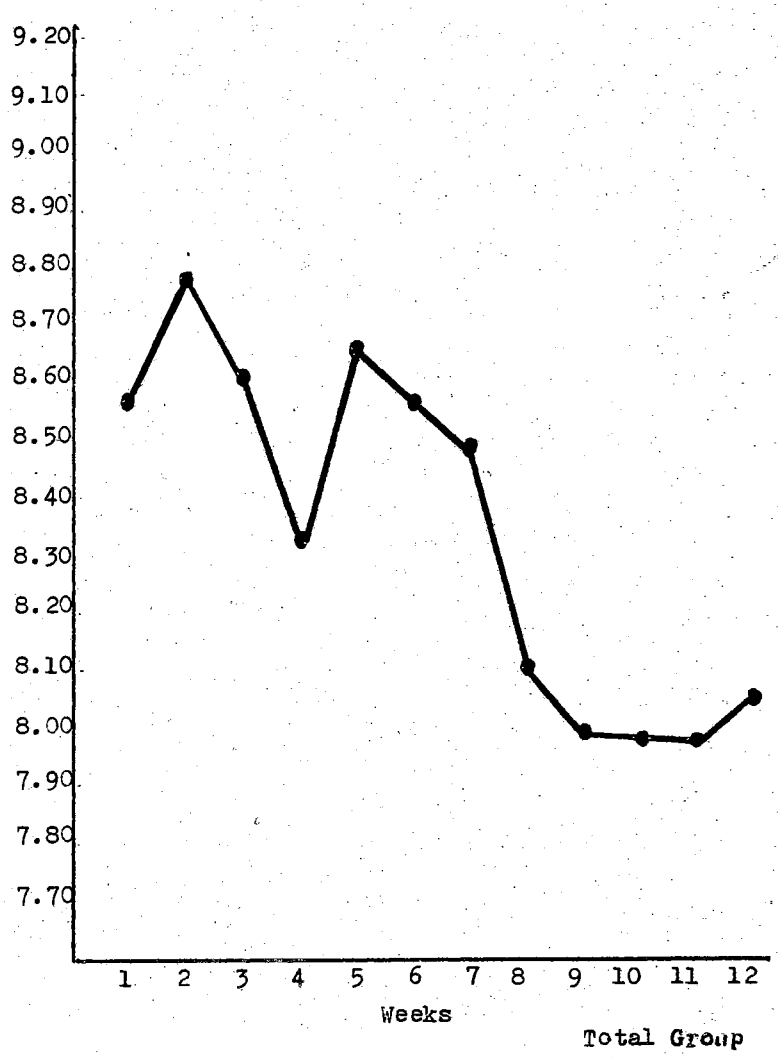


Total Group

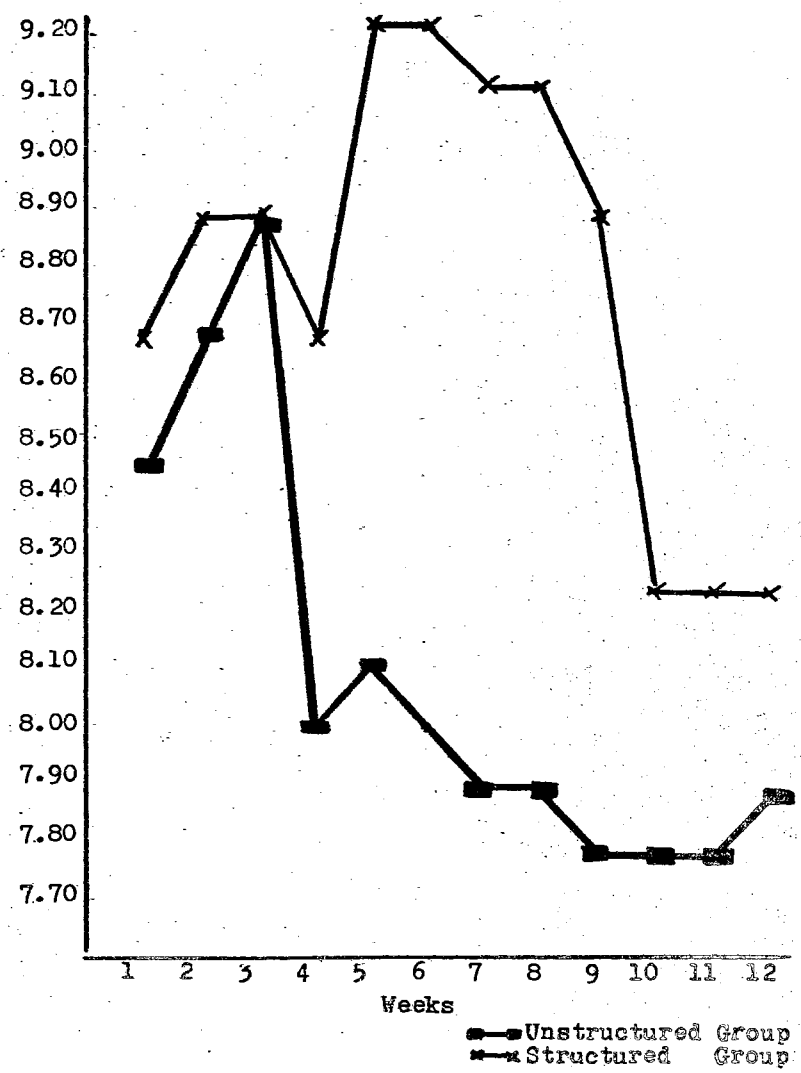
Above 70 years



Above 70 years (Work Attitude)

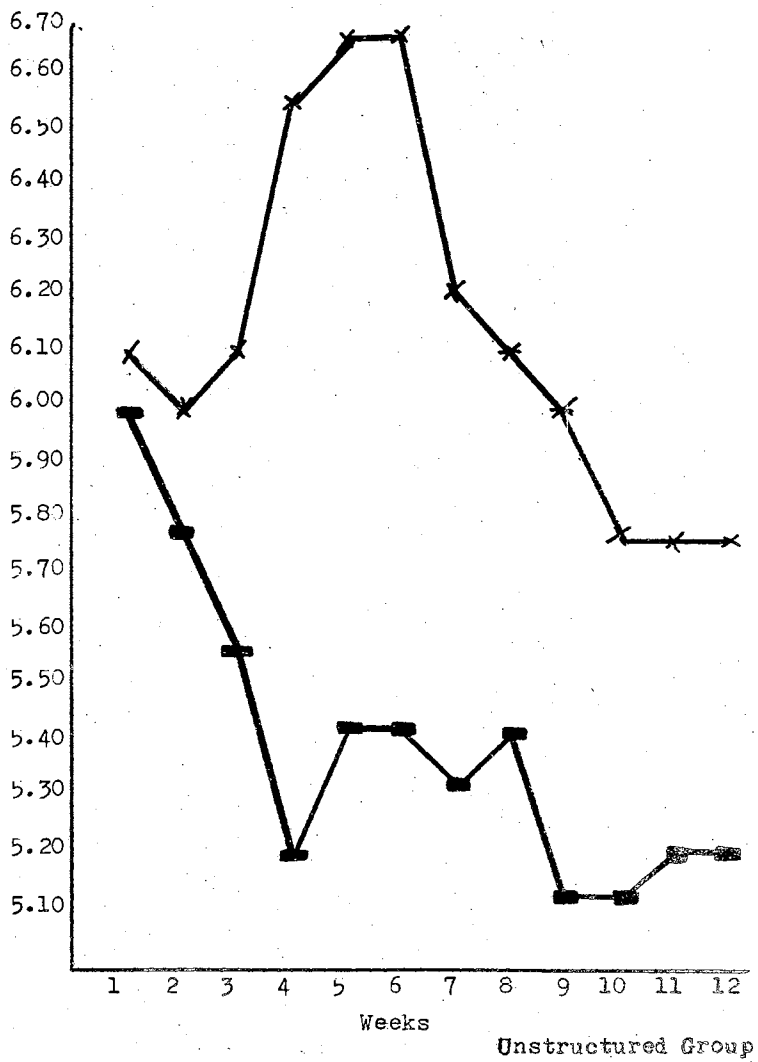


Total Group

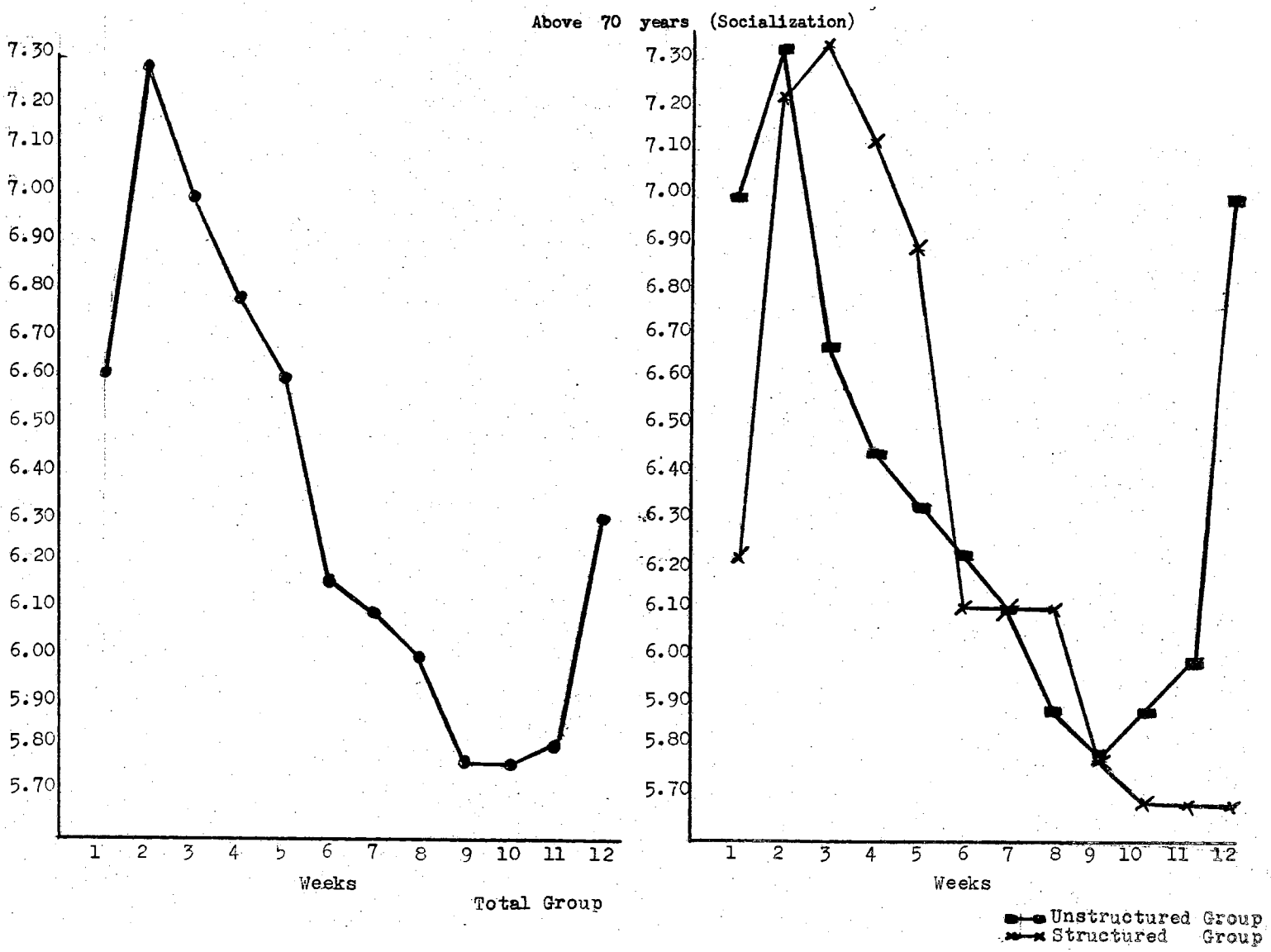


Above 70 years (Affective Display)

Total Group

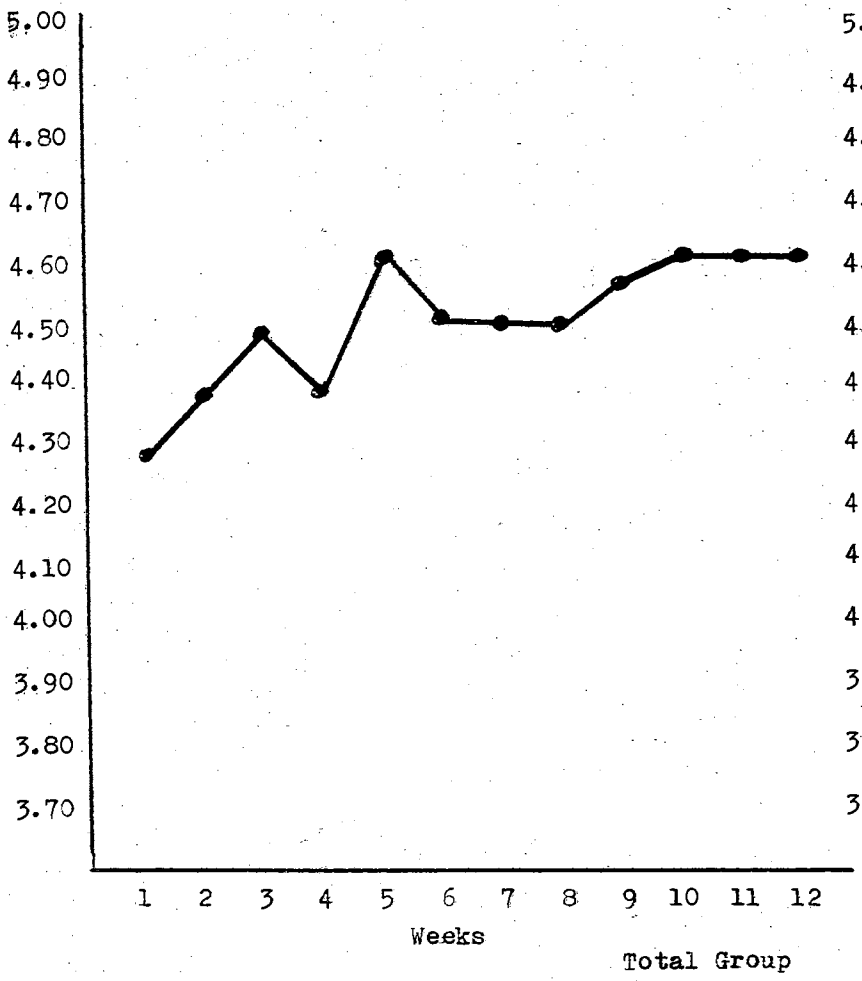


Unstructured Group
Structured Group

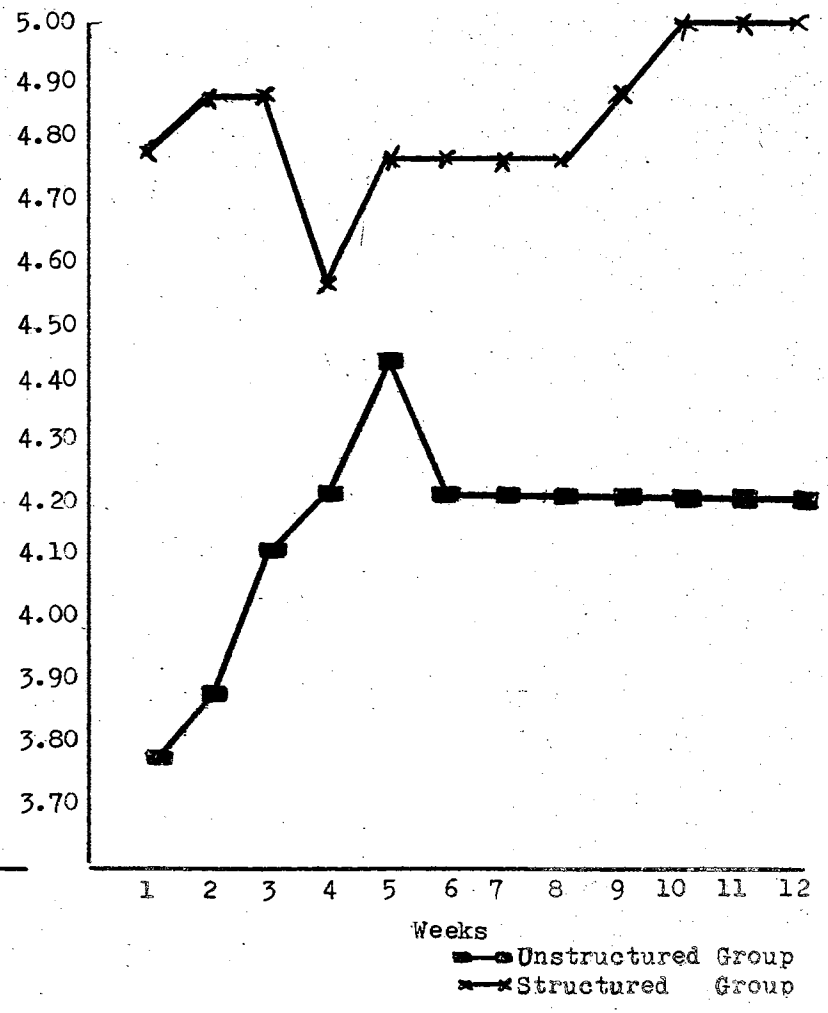

Above 70 years (Socialization)
7.30
7.20
7.10
7.00
6.90
6.80
6.70
6.60
6.50
6.40
6.30
6.20
6.10
6.00
5.90
5.80
5.70
1 2 3 4 5 6 7 8 9 10 11 12
Weeks
Total Group
Weeks
Unstructured Group
Structured Group

Above 70 years

Appearance

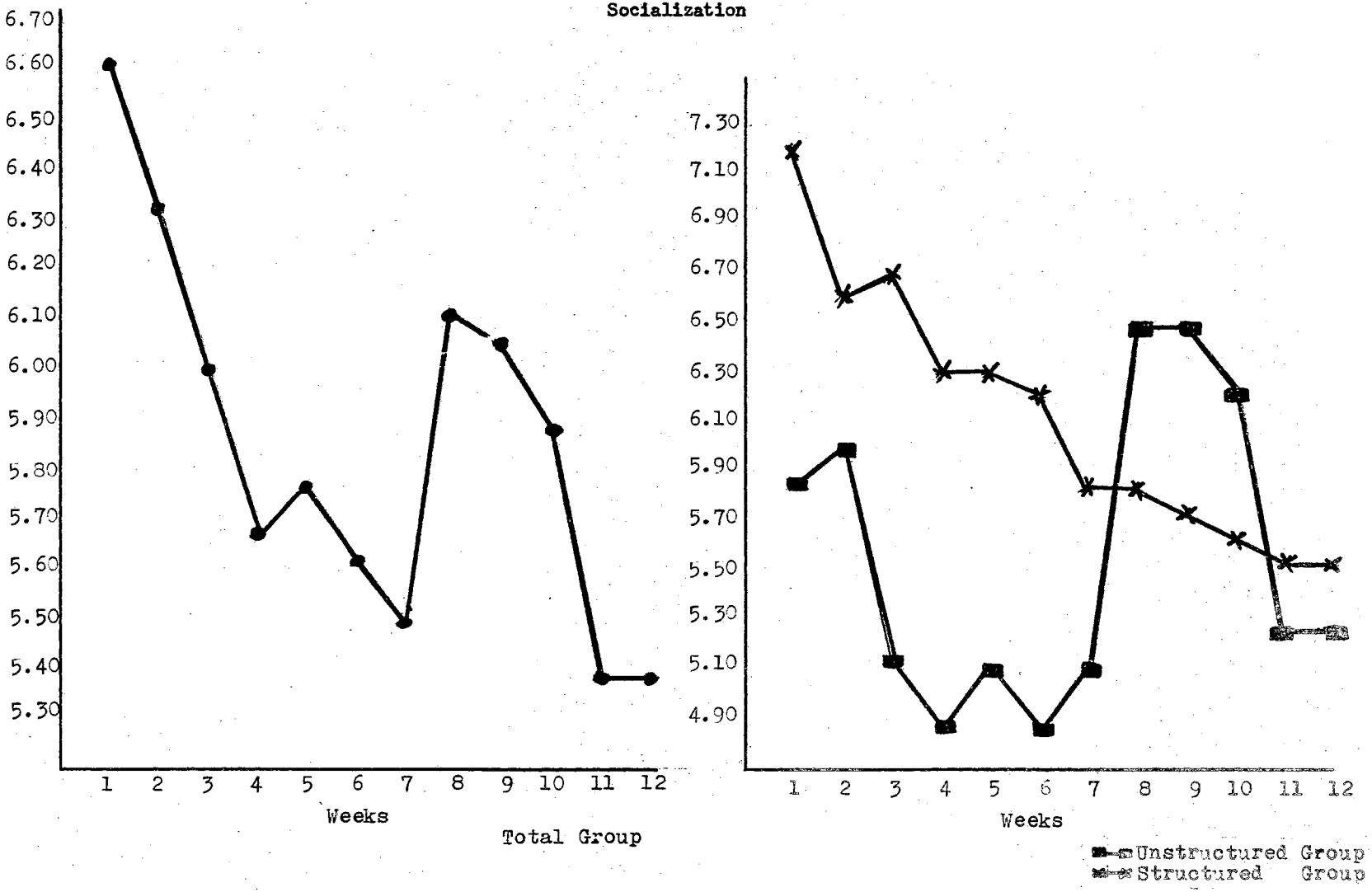


Total Group



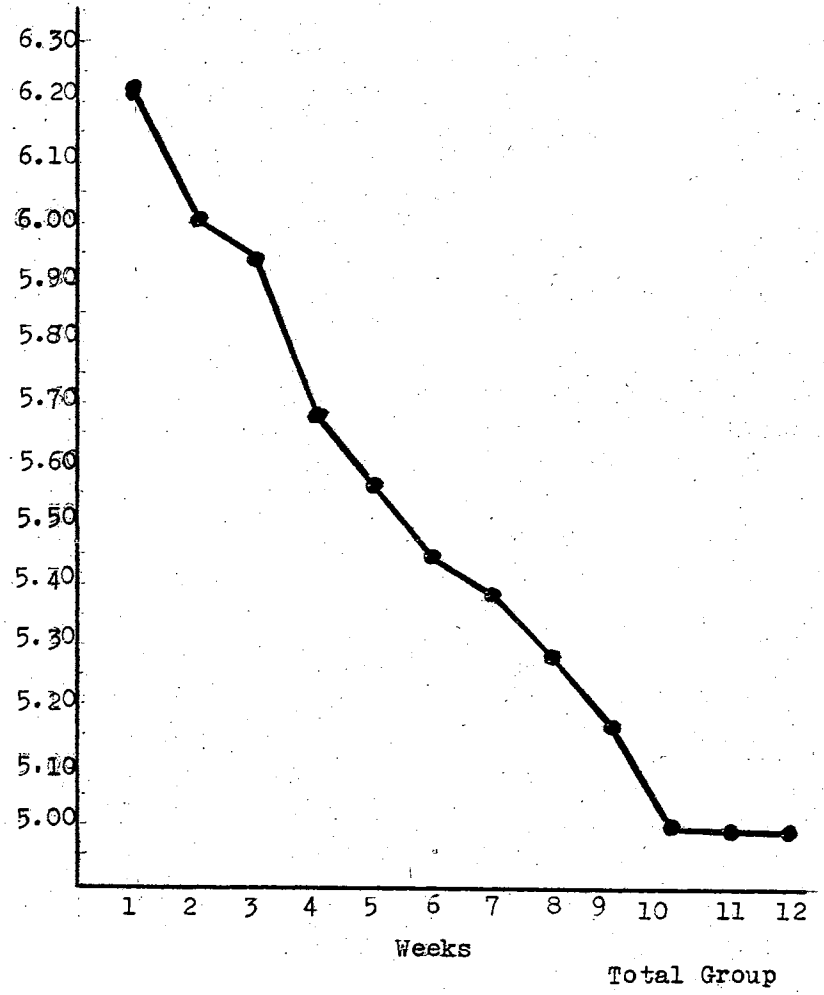
Below 70 years

Socialization

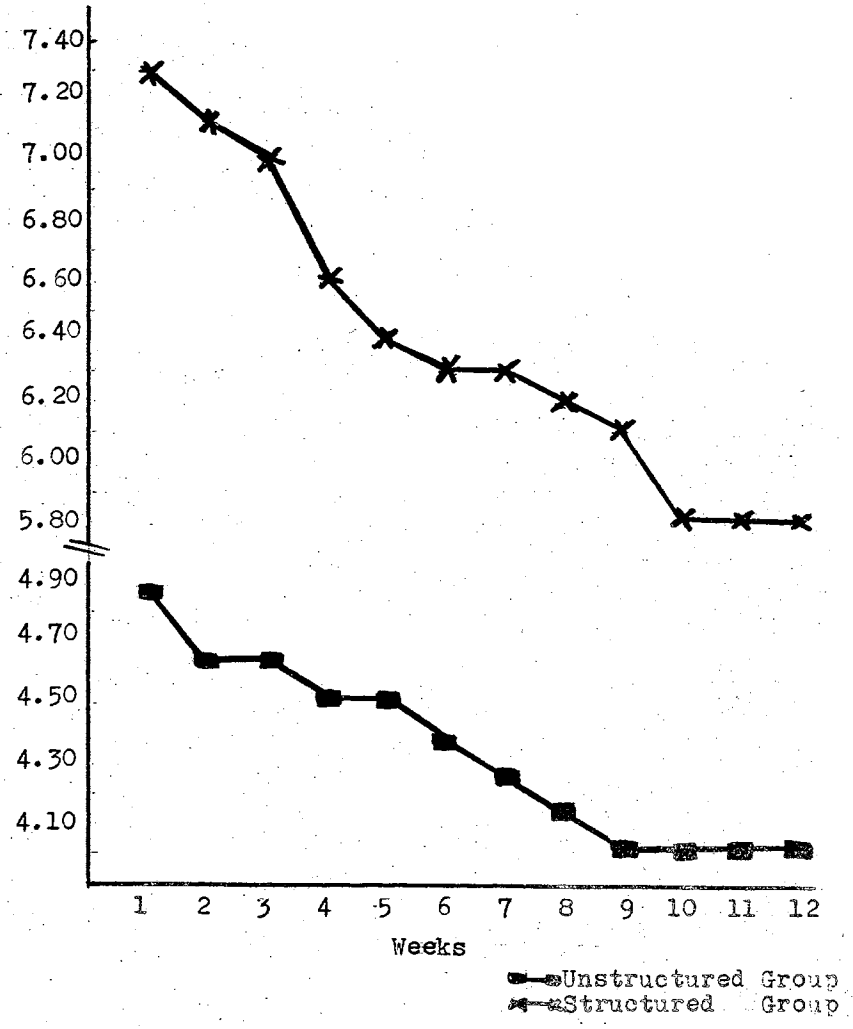


Below 70 years

Work Attitude

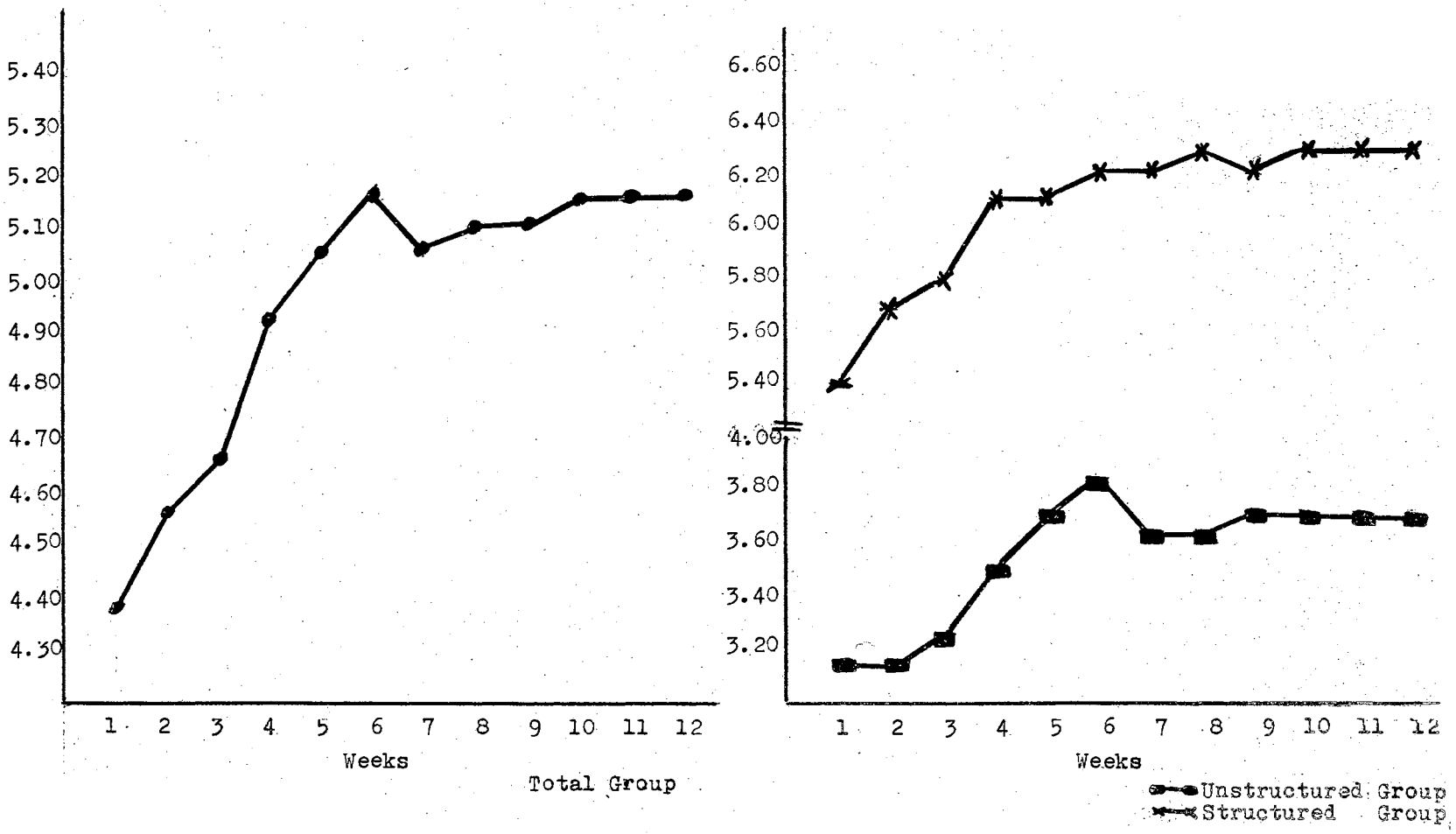


Total Group



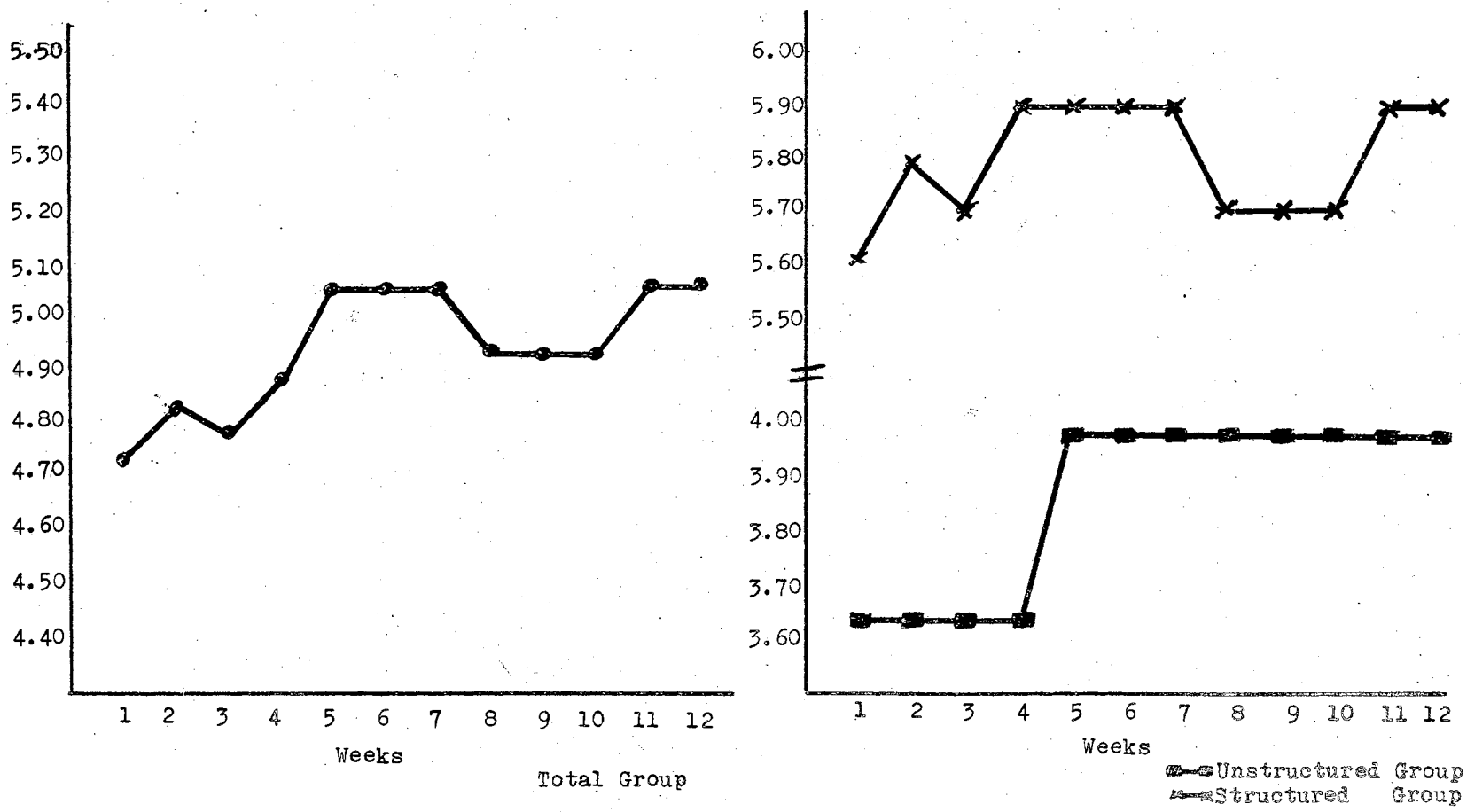
Below 70 years

Appearance



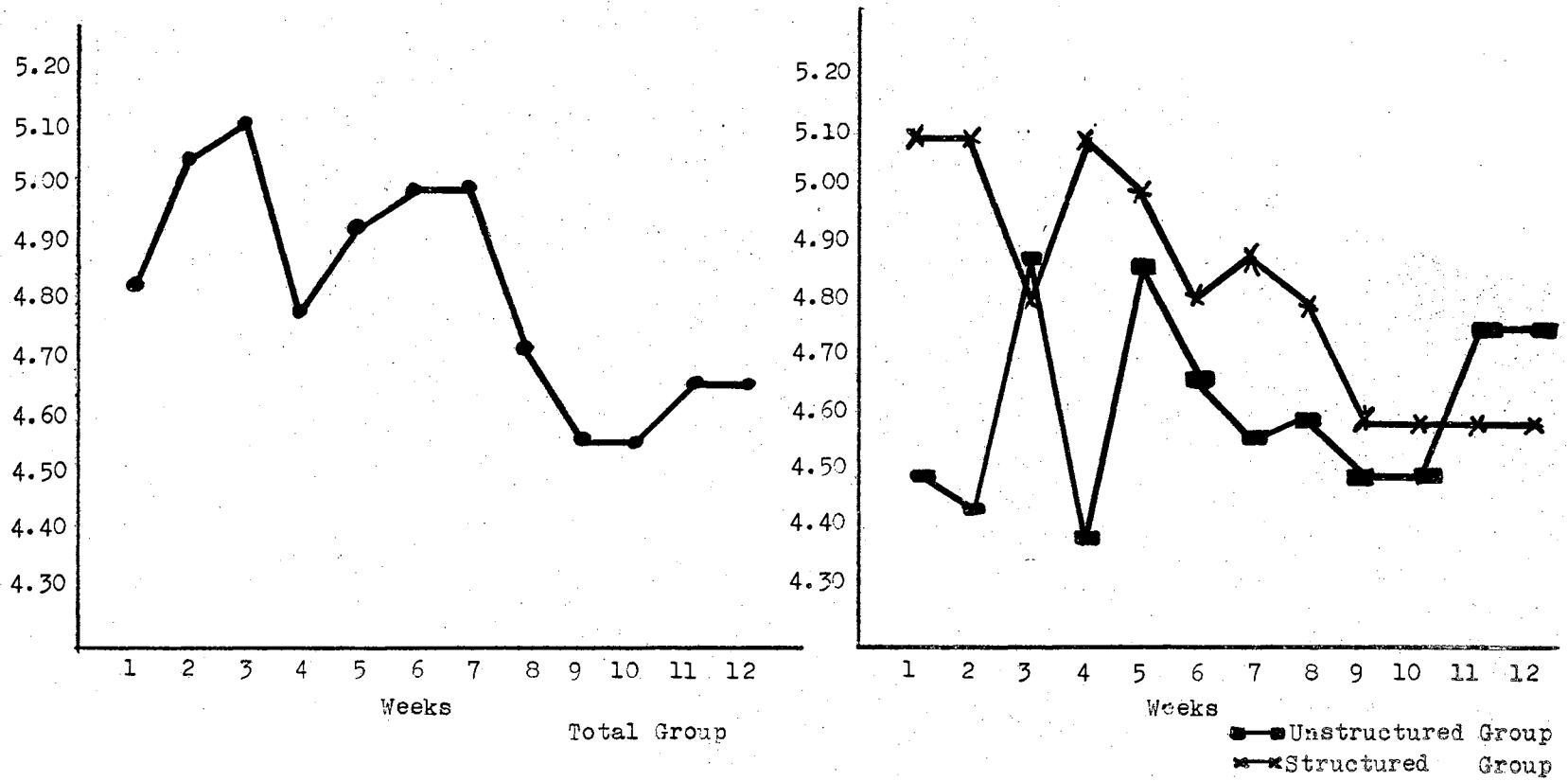
Females

Appearance



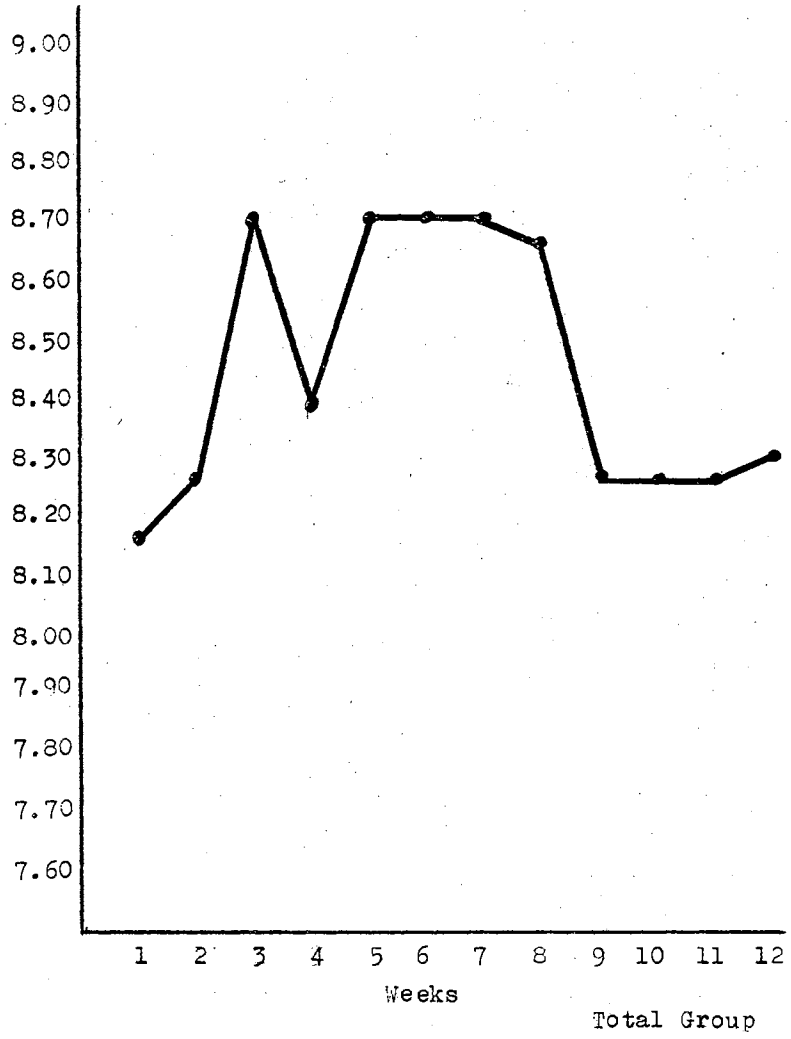
Below 70 years

Anxiety

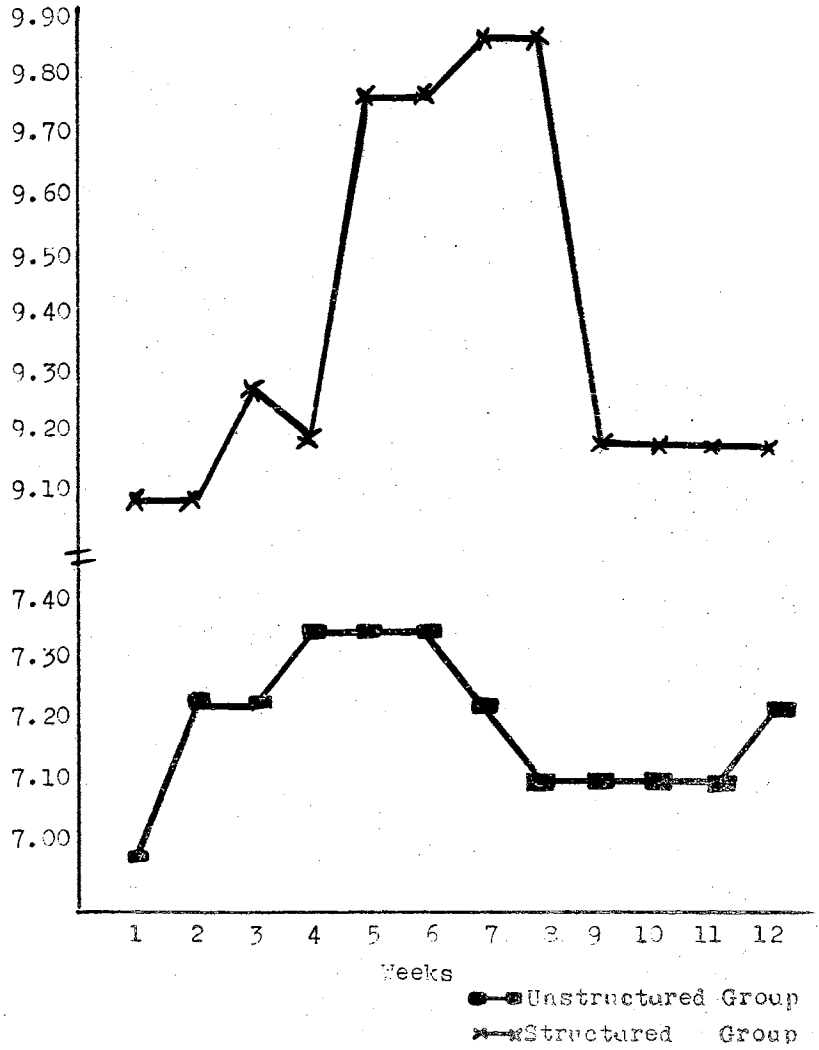


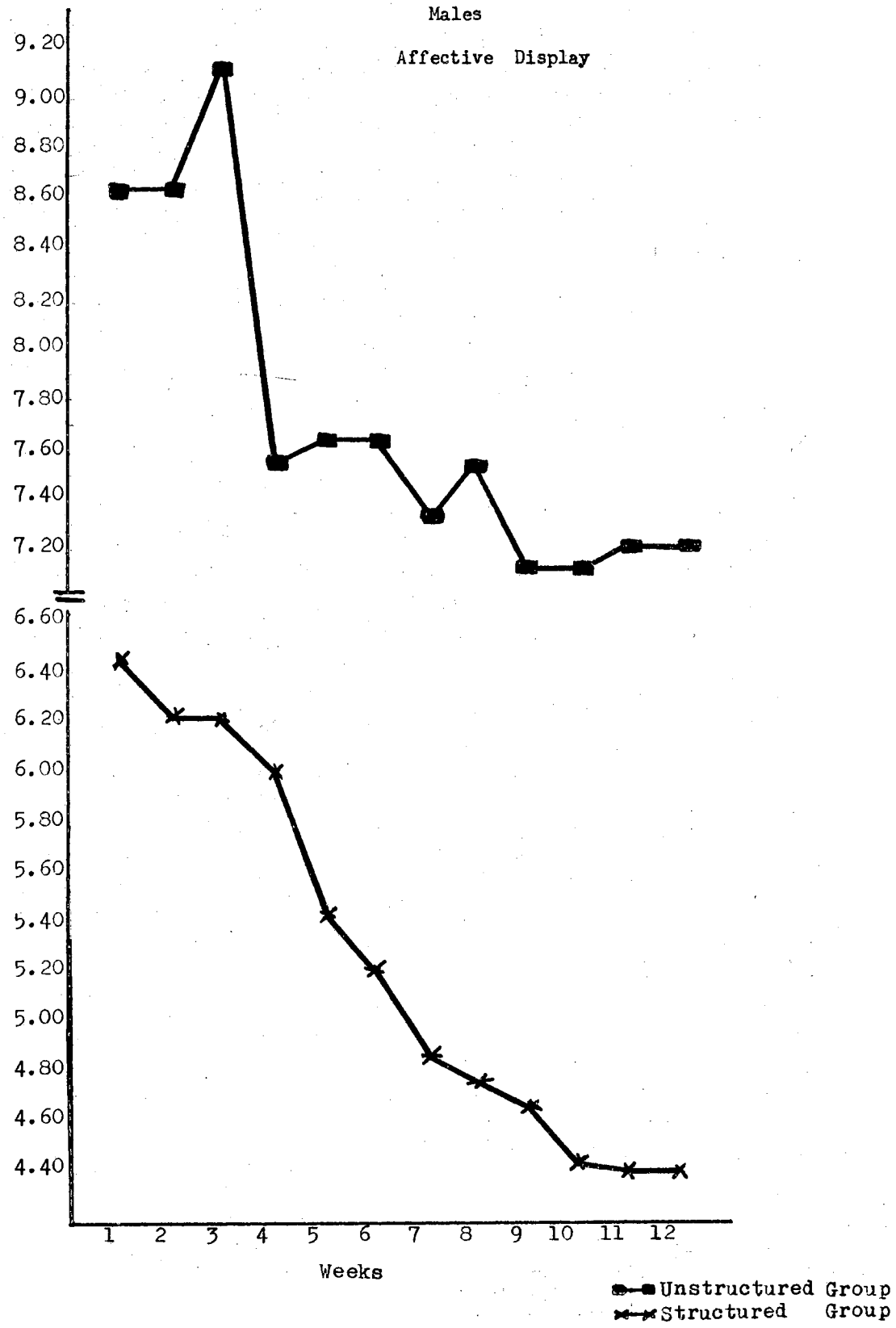
Females

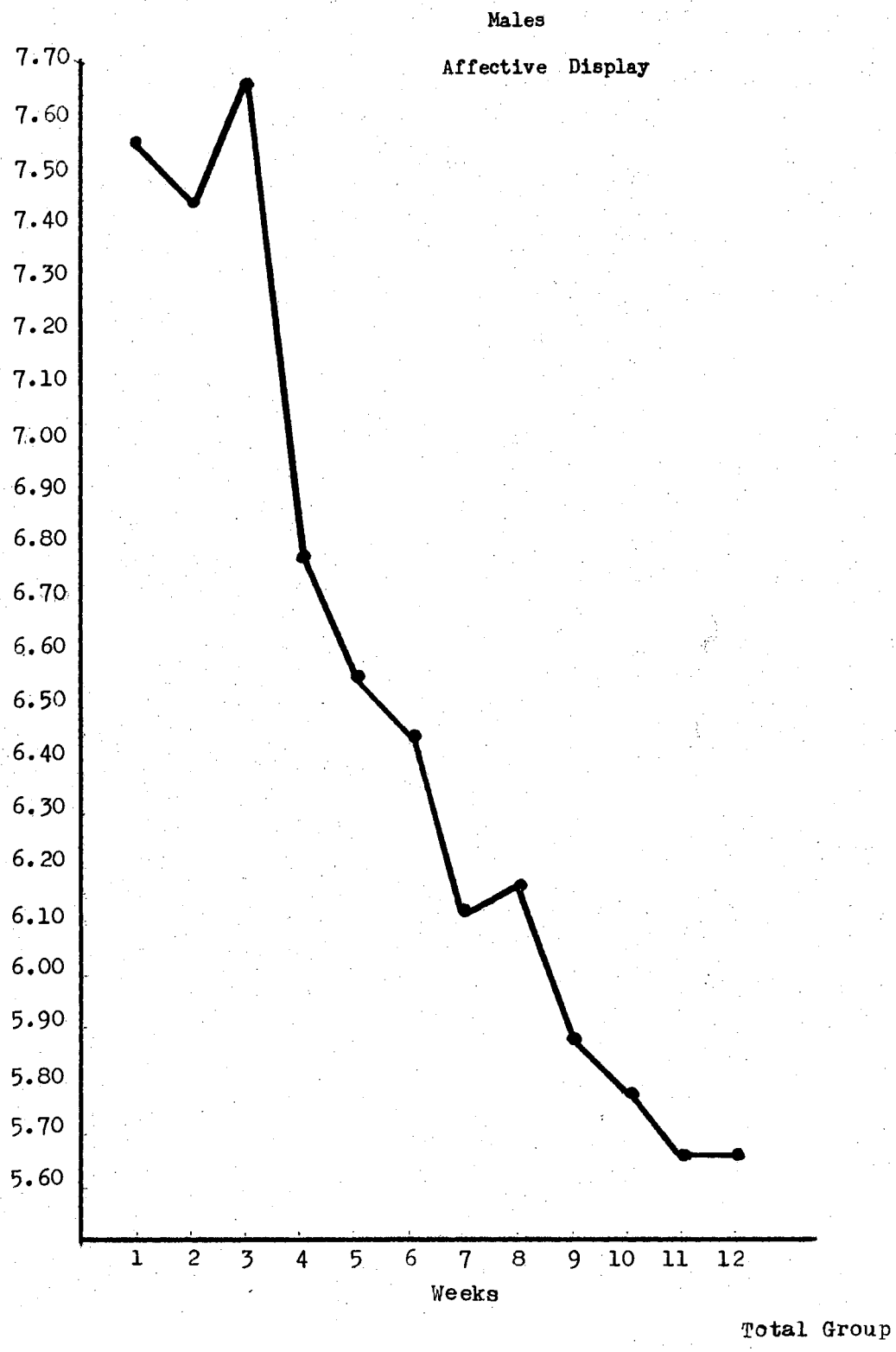
Work Attitude



Total Group




Males
Affective Display
9.20
9.00
8.80
8.60
8.40
8.20
8.00
7.80
7.60
7.40
7.20
6.60
6.40
6.20
6.00
5.80
5.60
5.40
5.20
5.00
4.80
4.60
4.40
1 2 3 4 5 6 7 8 9 10 11 12
Weeks
Unstructured Group
Structured Group


Males
Affective Display
7.70
7.60
7.50
7.40
7.30
7.20
7.10
7.00
6.90
6.80
6.70
6.60
6.50
6.40
6.30
6.20
6.10
6.00
5.90
5.80
5.70
5.60
1 2 3 4 5 6 7 8 9 10 11 12
Weeks
Total Group

APPENDIX F

CODE NUMBERS OF PATIENTS WHO WANTED AND/OR DID NOT WANT TO LEAVE THE HOSPITAL AT THE END OF THERAPY PERIOD

Unstructured Therapy Group		Structured Therapy Group	
Leave Hospital		Leave Hospital	
Yes	No	Yes	No
1	6	18	19
2	8	20	20
3	9	22	
4	12	23	
5	14	24	
7	15	25	
10	16	26	
11		27	
13		28	
17		29	
		30	
		31	
		32	
		33	
		34	
		35	
		36	

Each number is a code for patient's name

VITA

Nadya Nevruz

Candidate for the Degree of

Doctor of Education

Thesis: UNSTRUCTURED AND STRUCTURED GROUP PSYCHOTHERAPY, GERIATRIC PATIENTS, AND DECISION TO LEAVE THE HOSPITAL

Major Field: Student Personnel and Guidance

Biographical:

Personal Data: Born in Istanbul, Turkey, October 5, 1938, the daughter of Sarkis and Varsen Nevruz.

Education: Attended local primary and secondary schools: received the Bachelor of Arts degree from the American College for Girls, Istanbul, Turkey, in Liberal Arts, in June, 1956; attended the University of Istanbul and received certificates in Pedagogy and Psychiatry, in February, 1960; came to the United Stated under a Fulbright grant and received the Master of Arts degree from Wichita State University, Wichita, Kansas, with a major in General and Experimental Psychology, in May, 1964; completed the requirements for the Doctor of Education degree in May, 1967.

Professional experience: Teaching assistant at Oklahoma State University from September 1962 to June 1965; internship at Pontiac State Hospital, Pontiac, Michigan, from July 1965 to June 1966.

Professional organizations: Member of Psi Chi, National Honorary Society in Psychology.