but this is not enough. We have to know much more, *why* we are successful and *what* goes on in the individual who is a group member as well as what goes on in the group as a body with its own rights. Modern psychology has derived great insight into the psychology of the normal individual by exploring the dynamic mechanism of the neurotic. It stands to reason that the results of scientifically applied and evaluated group psychotherapy might enable us some day to understand better the great mystery of our times, namely the psychology of the masses.

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TECHNIQUES IN GROUP THERAPY*

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BOTH Mr. Slavson's and Dr. Hulse's presentations have, I think, shown quite impressively that the introduction of the group into psychotherapy has become widely accepted. Among those who have had intimate contact with this form of therapy as therapists and supervisors, there is no doubt as to its therapeutic value. While there are still many experiments going on, we are beyond the experimental stage, at least to some extent, in the area of work with children.

Mr. Slavson's presentation has shown that at the Jewish Board of Guardians four definite group-therapy methods are at this time being employed, all of which are applied with an appreciable degree of certainty and skill. The degree of certainty and skill attained here is quite comparable with those standards to which we are accustomed in individual child guidance therapy. Even in activity group therapy and play group therapy, both of which are very different from the traditional case work interviewing method, we have achieved such certainty. Continued close analysis of the group-therapeutic process in supervision and in seminars has enabled the therapist and supervisor at J.B.G. to have at any point of the therapy as exact a picture of the dynamic situation as we are able to get in individual psychotherapy.

This is really all one can demand from a new form of therapy and this degree of advance and success is entirely due to Mr. Slavson's untiring leadership against the natural inertia and the doubts of the case worker, whose resistance to acceptance of group therapy initially was considerable. Today, activity group therapy as practiced at J.B.G. is not only a workable but teachable method.

Dr. Hulse's lucid and stimulating paper, on the other hand, is very interesting because he attempts to crystallize, from quite a varied experimental experience of his own and of other workers, a number of practical general rules. I agree with much of his thinking, and yet it is extremely inviting to open a discussion on almost all of his points because, as it is with all practical rules on therapy there is none that cannot be broken, if one knows why and what for. Or, to express it differently: everything one does or everything that happens can be potentially useful in one, as it can be potentially unfavorable in another case. That explains why obviously sincere and astute observers and experimenters could arrive at apparently contradictory conclusions on technique. Dr. Hulse, himself, has not stressed this point, but I think he would agree with me. It might appear a hopeless task then to find one's orientation among all the proposed and differing suggestions on indications for group as against individual therapy, on thera-

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peutic methods to be used in the group, on group composition, leadership, etc. I believe, however, that it is much simpler on one hand, though perhaps also much more complicated on the other than it looks at the first glance. The key to this problem is exactly the subject which Dr. Hulse was kind enough not to discuss, because he wanted to leave me something to pick up, namely, the dynamics of therapy.

Any psychotherapy utilizes a personal attachment, which offers some gratifications to the patient, to facilitate and promote the resolution of mental conflicts. This occurs dynamically very much the same way as in the parent-child relationship. The child is, or better, should be, continually helped by the parent to resolve conflicts originating from the growing-up process. The parents provide and approve gratifications in one area, while they restrict in others. The child after some struggle arrives at a solution which is compatible with a good relationship to the parents and accepted by himself (or else he becomes a disturbed child). Since it is too difficult to go on living with vital conflicts, the individuals who come to us for therapy have made an adjustment to their conflicts, but an adjustment that is either unacceptable to themselves or to their environment. In both cases, the original conflict must be revived and then resolved in a more satisfactory way with the help of the therapist, as it should have been done in the original parent-child relationship.

All available group records show that this dynamic process, namely, attachment to the therapist, revival of conflicts, resolution of them, can be mobilized in the group, as well as in the individual therapeutic relationship, just as one can obviously grow up in a family among siblings. And just as it is even easier to grow up in a healthy way among siblings, a group in many respects makes therapy easier in that it facilitates and accelerates some of the important dynamic steps of therapy. For example, the relationship to the therapist is better maintained on a positive basis because of the competition with the other members of the group for the love and acceptance by the therapist. In other words, the ambivalence in the relationship to the therapist may be more easily worked out in the group. The presence of the group makes for quicker deliverance from inhibitions, as well as for less opposition to the acceptance of desirable limitations. I cannot go into this at any greater length, except to say that the presence of the group makes the members feel less exposed to the fantasied and dreaded power of the therapist, and that the members themselves on the other hand frequently impose and enforce socially desirable limitations upon the group on their own.

However, while the necessary therapeutic processes can thus be potentially mobilized in the group, the question as to whether or not a specific group will lend itself to this purpose for a specific patient is one that can only be decided individually and not by general rules. Such a decision will answer the question as to whether or not group therapy is indicated in a specific case, whether or not an existing group will do the job, of what people a group should be composed to be of help, and what group processes, group rules, activities, etc., would be helpful.

To be successful in therapy, the group must gratify and stimulate some interest in the patient. Nobody partakes in a group for any length of time without being interested and nobody gives up any gratification without getting other satisfaction in exchange. That is true of all therapy. The concrete gratification

which a group will be able to give, the interest it will stimulate and satisfy can be varied and it will depend on the chosen activity, the individual members, and to some extent on the leader. The interest a patient may take in a specific group will not necessarily be identical with the announced group purpose. Neither will the patient always be conscious of the character of his interest. For instance, a boy may accept a co-educational discussion group because he hopes consciously or unconsciously to meet girls there, to satisfy infantile sexual urges, etc. Consequently, the interest the members take in the group need not be the same for all members. The avowed purpose of joining can even be a mere excuse for joining, as in the example I just mentioned. That is not important. But it is important that the group be capable of awakening real interest, libidinal interest in the members to be placed there for therapy. Within this basic rule, one is very free in forming groups around any new or old purpose or activity. The group method, however, must lend itself to an involvement of the members in strongly affective activities, so that basic emotional conflicts will be spontaneously awakened.

As Dr. Hulse indicated, the group population must be such as to gratify and stimulate the patient through the personalities of the other members without awakening uncontrollable anxieties. To illustrate this point, I might say that too many strongly aggressive children might be a tremendous threat to one lonely, shy and anxious one, while one or two in the group might act as desirable instigators of stimulating activity. Too many withdrawn, retreating children in one group might find it difficult to overcome their inhibitions. The presence of other boys might gratify one boy's homosexual wishes and attract him to the group. In another boy, the presence of aggressive male youths might awaken, on the contrary, anxieties because of his difficulties in repressing his latent homosexuality or latent aggression, etc. The question of a mixed group composition of male and female members, which Dr. Hulse mentioned, can be answered likewise. Some children will be frightened by such a combination, others, more or less openly delighted. Of course, one must also keep in mind that the potential gratification and stimulation of undesirable wishes, through the group, may not be such as to excite them beyond control. One should also include in the group such members as will exert or support a sufficiently desirable socializing influence.

Seen this way, it is obviously correct when Dr. Hulse emphasizes that identical symptoms or diagnostic classifications are no basis for group composition. Yet they are not of necessity an obstacle. A certain range of intelligence may be desirable for a discussion group, but it is not at all required in activity groups because here physical strength, artistic talent or skill with tools or in games makes children interesting to others much more than intelligence and conversational ability, and in turn can be a way for them to derive gratification from the group. Acceptance of new group members is a question to be answered in like manner. For some children it may be disturbing, yet it can become a valuable focus for working out basic conflicts, if properly timed.

The group leader can never be passive. I can only stress here what Dr. Hulse said. No therapist can ever be passive. Therapy is never done automatically, although it sometimes runs its course with the therapist not knowing from where or whither. The therapist must always try to quite consciously control

the course but certainly at times in an unobstrusive way, while at other times he might have to take responsibility for overt control. He must stimulate or put brakes on as the situation demands. The only guide he has is his understanding of the meaning of the situation for the individual group member and its place in the dynamic process of therapy. He must therefore not only have an understanding of unconscious mental processes but also be sufficiently in control of himself so as not to respond to situations impulsively instead of knowingly.

The question as to whether group or individual therapy is indicated in a specific case thus depends on: first, the question as to whether or not a child, let us say, is interested in the group activity or his interest can be expected to awaken in and for the group, or whether the child needs gratification from an individual relationship to a man or woman in which he has not to compete with others. Secondly, it depends on the anxieties to be expected in the group or in individual relationship, respectively. In as much as anxiety can increase resistance to the point of making it unconquerable, this point is of utmost importance. More often than we recognize, an individual relationship in therapy makes therapy itself impossible, because the relationship as such is a threat, while a group could be accepted by the patient. A third factor is the question as to whether or not conflicts that need to be solved can be expected to be restimulated and resolved in either the group or individual situation directly or at least indirectly.

To give just a few illustrations: Some children may appreciate social activities; others cannot endure rivalry situations. Some may be paralyzed emotionally in a room with an adult, while the presence of other children gives them courage and so forth. Thus, one can gauge the possible effect of introduction of a child into a group or an individual relationship or into both simultaneously or into one following the other, only by an exact analysis of the dynamics of the personality and therapy in the individual case.

I am convinced for all these reasons that future work will prove that an amazing number of patients, adults and children alike, who need therapy, can never be reached successfully by individual therapy, at least, not as an exclusive approach. So that I would answer the question: "Has group therapy value for child care?" Unequivocally: Group therapy is a therapy in its own right and on the same level as individual therapy, but one which probably has even wider applicability. I, for one, am satisfied that the field of child care has in group therapy an excellent opportunity to develop for itself a most useful tool.

WHAT ARE THE SIMILARITIES AND DIFFERENCES OF CASE WORK AND GROUP WORK?

A COMMITTEE REPORT*

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GRACE Coyle in her paper, "Social Work at the Turn of the Decade",** presents the oneness of purpose in both case work and group work when she says:

"The essence of social work lies in what happens through the contact of the social worker and client whether that client be an applicant for public relief, a child in an institution, or a youth in a settlement club. Treatment and education are but aspects of the same process. When health is restored, or the family becomes self-supporting, or the dependent child is placed in a foster home, there still remains the question of whether life can be made rich, interesting, satisfying. This is often dependent on opportunities for further education, companionship, for creative expression during leisure time. Some of us work at one end of the scale, some on the other, but the common purpose is the growth and enhancement of the individual life."

There has been considerable discussion of late whether a professionally trained social worker can do both group work and case work on one job. Concretely, the question is whether a group worker with training in case work can handle the group and at the same time function as a case worker for and in behalf of individuals within the group. A similar question arises in instances where a case worker attempts to work with some of his clients in a composite unit or a group and thus takes on the function of the group worker.

These and other like questions make it essential that one examine some of the similarities and differences between case work and group work, as we see them today.

* Mr. Blanchard presented this paper for the Committee on Case Work-Group Work Relationships at the National Conference of Jewish Social Welfare, Atlantic City, May 1948. Members of this committee, organized by the Jewish Welfare Board, were: Myron B. Blanchard, Chairman, Metropolitan Section, JWB; Sarah Lederman of the Foster Home Dept. JCCA: Edith Weller of the Jewish Family Service; Fanny Houtz and Miriam Cohen, Jewish Board of Guardians; Jean Brodsky, Brooklyn Section, National Council of Jewish Women; Dora Tannenbaum, Grand Street Settlement House; Sol Rafel, Bronx House; Herbert Rosen, Pleasantville Cottage School; Saul Hofstein, Jewish Community Services of Queens-Nassau: Alexander Fishman and Benjamin Schildcrout, Youth Service Bureau; S. Pearl Tulin, formerly of the Children's Service Bureau; Syd Gale of the Bronx YM & YWHA; Emanuel Fisher, Newark YM & YWHA; Meyer Bass, Nat'l. JWB; Ruth Katz, B'nai B'rith Youth Organization.

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