The Role of the Social Field in Psychotherapy[1]

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Contemporary psychotherapy - whether directive or nondirective, analytic or nonanalytic, administered in individual or group sessions — usually centers on the dynamics of the individual and on the creation of changes in the individual, rather than on the dynamics of the social field and on the manipulation of this field for therapeutic purposes. It may attempt to produce clarification or "inner strength" in the patient (by means of catharsis, insight, spontaneity-training, the development of frustration-tolerance, etc.), so that he is better able to understand himself and his disorders, and to adjust to (and perhaps manipulate) environmental conditions. The individual is the variable to be manipulated. The social norms and artifacts outside of the clinic or hospital are regarded more or less as constants. Such therapy may be suited for those individuals whose emotional difficulties are due to internal factors, but is it suited for those whose difficulties are brought about in the main by outer circumstances? The underlying problems were recently well formulated by CANTRIL [2].

> Since personal conflicts are so often due to conflicts in the objective situations themselves, it is obvious that unless conflicts existing in the objective groupings an individual identifies himself with can be resolved, the individual has little chance of resolving his own "inner" conflicts. . . . While it can readily be admitted that the insight gained in either a directed or "non-directed" psychotherapy may serve as a necessary prelude to show some people what has to be done in the way of rearranging the objective conditions they face if they are to regain mental health and composure, it is a cruel illusion for a layman to be allowed to entertain the thought that "insight" through psychotherapy is in itself the answer to his troubles. Indeed, this insight may often only show him that his troubles are bigger than he himself thought they were and cannot be solved until basic changes occur in the social structure. Hence, it may well be that under social conditions where objective circumstances make the resolution of many personal conflicts difficult,[2] the insight gained by psychotherapy may actually pile up visceral tensions etc., by increasing a person's sense of futility concerning an effective course of action. This is not meant as a criticism of all psychotherapy as such. Nor are we forgetting the value expert clinical help can have for those individuals whose difficulties may stem from their own unique temperamental or other personality characteristics almost irrespective of their social milieu. But we do mean to criticize any brand of psychotherapy that, in actual concrete practice, is blind to the role of conflicting, contradictory conditions that often obtain outside the individual on the stimulus side and create conflicts and dilemmas within him.[3] [2, pp. 50-51]

To be sure, it is becoming increasingly recognized, as MURPHY [10] points out, that the therapeutic session "is only one kind of situation, and it does not necessarily prevent the patient's subsequent failure when he confronts the other situations of which his life is comprised." [10, p. 885] MURPHY continues:

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[2] See, for example, [6] which indicates how community disorganization and contradictions in the nodal structure may give rise to some aspects of the phenomenon of adolescence.

[3] The author's attempt to present to and discuss with patients the role and function of some of the social factors that might give rise to mental illness are described in [6].

> For this reason psychiatry is making more and more use of situational therapy … The psychiatrist who wishes to see the whole personality must see the patient in all the situations of his life; indeed, he must place him in countless new situations to bring out new aspects of his personality. The group therapist often succeeds in shortening this almost infinite process because many of the patient's critical maladjustments appear in group situations, and it is precisely in the group situation that the diagnosis and therapy are carried on. [10, p. 835]

It has been our experience, however, that even in group therapy, one cannot begin to place the patient "in all the situations of his life," one cannot hope to duplicate the complex life-pattern of the patient, nor expect transfer of the role he plays in the group and in group-enacted situations to his existence outside of the group sessions. The very nature of these sessions, the confines of the meeting place, the artificiality of enacted situations, the varied personalities and experiences of the members, and the exigencies of the present and future, make it difficult even to approximate many of the situations which the patient has experienced or will face, particularly if he is not confined to an institution with its relatively controlled and restricted environment. To cite a case in point: We found that our group therapy program, aimed at dealing with the everyday problems and social adjustments of the members, appeared to be more effective for patients of army mental hospitals [6, 7, 8] than for patients of a Veterans Administration Mental Hygiene Clinic [9]. The hospital world offered opportunities for direct application of what was learned in the group sessions. Group therapy helped some patients to adjust to the closed ward, prepared them for the open ward, and helped them once they reached the latter ward. The goals were more apparent to the hospital patients. Adjustment in the closed ward led to transfer to the open ward; and adjustment there, to wider opportunities for freedom to indulge in various types of activities.

Unlike hospitalized patients, the clinic's patients lived at home, usually with parents and wives in crowded quarters, travelled in crowded subways, and often had to work net only for their own livelihood but for the support of their families. Daily, they faced the hurry and bustle, the competition and complexities of life in New York City. Active participation in group therapy and even apparent insight into their difficulties did not necessarily lead to adjustment in the life outside of the clinic. (True, during the Christmas season most of our patients made a vocational adjustment, since the demand for working people at that time permitted them to obtain positions, principally as postal clerks and as salesmen in department stores; but after the holiday rush, their services were no longer required, their records of mental illness again disqualifications for the securement of gainful employment.) Patients might square their shoulders as they entered the room in which the group meetings were held, and become important personages, with definite status in the group. However, when they left and shuffled their way through the crowd and the traffic, to resume their unhappy, unsatisfying existences, some again felt themselves to be, as one of our patients expressed it, "useless, unwanted, insane pensioneers." In brief, the hospital's environment was simpler, more subject to manipulation, control and prediction for therapeutic purposes than was the complex world facing the clinic's patients, so that the latter might understandably manifest less transfer from therapeutic sessions to situations outside of the clinic.

It was our impression that the least transfer usually occurred in the case of (1) those whose main cause of conflict lay in objective circumstances over which they had little control, and (2) those individuals, best described as inadequate personalities, who were unable to cope with the complexities, competition, and aggressiveness of the outside world. On the other hand, the largest carryover seemed to take place for those patients who had a number of social contacts outside of the clinic, with fairly stable, secure membership ties (in a family, church, business or social organization) which could be manipulated by the therapist for therapeutic effects. Similarly, staff members of the Veterans' Rehabilitation Clinic of Mount Zion Hospital, San Francisco, found that where "there was no stability in at least one area of the veterans' environment — his home, his job, his friends — rehabilitation became extremely difficult." [4, p. 266] Such observations

emphasize the role played in the determination of the efficacy of therapy by group-belongingness and by general social field conditions.

What can the therapist do to aid patients in the first and second categories above, and those who do not have stability in important aspects of their environment? We believe that he must be ready to take into active account the roles played by social field conditions in producing normal personalities and in creating, prolonging, and aggravating personality disturbances and also, the potentialities field conditions possess for the treatment of such disturbances. These are indeed implications that stem from the generally accepted theory that the personality is a biosocial product. If he holds this theory, the therapist ought not to regard his patient as an organism qua organism in isolation from its field, but should attempt to discover what roles social field conditions have played and *are playing* in the development of this particular personality constellation, and how he can best utilize social forces to produce changes in the personality in the direction of better mental health.[4] In order to function effectively the therapist must not only venture out into the community to study, guide and encourage a particular patient in his actual milieu, but must attempt to effect changes in the community in order to create a social atmosphere conducive to mental health for the entire community. There is a need to broaden our concept of psychotherapy to include treating the entire community. It is only then that we will be able to have the assurance, when we send a patient out into the world, that he is going out into a world in which he can function. A step in this direction can be made by the therapist engaging in action research and utilizing action techniques.

Action research and techniques, usually associated with the late Kurt LEWIN and his students, are of various types, all of which have in common their concern with problems which arise directly out of community life and community needs, and their utilization in the actual community setting, after the problems have been so formulated as to make them susceptible to investigation in this setting [3, p. 43]. They are particularly suited for the scientist "who wishes to pursue a scientific way of life and at the same time to devote his energies toward civic betterment," who is interested not only in making discoveries but in the proper application of these discoveries [3, p. 43]. Action programs have been used for various purposes, e.g., studying and attempting to change food preferences [5], studying and attempting to combat racial prejudices [cf. 3]. We propose the application of these methods to the creation of interpersonal relations conducive to mental health and for the development of group action to find places in the community for mental patients, where they can serve in a productive capacity and become integral members of the community.

A Proposed Psychotherapeutic Action Program

For a psychotherapeutic action program to be effective, it must be the joint undertaking of psychiatric, psychological, educational, and social science organizations (of clinical personnel, social psychologists, sociologists, educators, ethnologists and others who have experience in community organization and planning), and of responsible lay members of the community. We envision the program conducted on a national scale, and adapted and supplemented in individual communities in accordance with their particular conditions and requirements.

First, both in particular communities and on a broader scale, research is called for to determine (1) which social field conditions are conducive to mental health and which are conducive to the

[4] True, in contemporary psychotherapeutic theory, and even in psychoanalytic theory, the organism is seen in relation to society, but the nature of the relationship is often that of a clash or struggle of opposing tendencies in which society is regarded as a series of obstacles to man's gratification. Adherence to such a view, with its dichotomy between man and society, may cause one to neglect the positive values of social forces in permitting and enhancing the organism's development.

production and continuance of personality disturbances, and (2) what can be done to mitigate such effects or to prevent such situations from arising.

Second, it is necessary to survey possibilities of utilizing some of the mentally ill in some socially acceptable and productive capacity. As certain agents in the business world seek profitable ways of utilizing the waste products of manufacturing processes, and even create needs for them where none exists, so those engaged in a psychotherapeutic action program will be charged with the responsibility of rehabilitating our crippled personalities, will seek to find, and if need be, create places and functions for them.

Third, there must be an intensive educational program for the public. In spite of the good work done by various mental hygiene organizations, the public still maintains a host of misconceptions concerning mental illness. It is regarded as a strange, bizarre phenomenon, the resultant of an unfortunate propensity in the individual or even in the entire family. Families with a mentally ill member suffer agonies of personal and social disgrace. Employment and normal social intercourse is often impossible for one known to have been in a mental institution. While there is intense interest in the subject, it is being exploited by many moving pictures, popular publications, and radio programs - with their emphasis on violent psychoses or highly emotional neuroses, and on the dramatic, erotic aspects of psychoanalysis. It is fashionable to mouth watered-down analytic concepts, to worry about the drama of love and hate in an individual or in a family, to be concerned with sexual behavior in early childhood days, and to talk about visiting an analyst. On the whole, the public remains woefully ignorant of the frequency, nature, cause and susceptibility to treatment of various mental disorders, and, above all, of the social conditions of daily life which help to produce such disorders, of the role played, for example, by the conflicting teachings and demands of various institutions of which an individual is a member (say, family versus business versus church); by the emphasis on success and competition in our schools, business, and social organizations; by racial, national, and religious prejudices; by specific "cultural lags"; and by the general coldness and indifference frequently manifested in daily interpersonal relations.

What we propose, therefore, is a program aimed at informing the public (1) of the frequency, variety, and nature of personality disturbances, (2) of the social conditions of daily life which are conducive to such disturbances, (3) that not all of the mentally ill need be in institutions, and that both in institutions and in the regular communities there is a possibility of some of these individuals serving in productive capacities. and (4) that they, the public, can actively participate in their own communities in the prevention and treatment of mental illness.

We envision the hub of the psychotherapeutic action program as a comnunity-centered, action-orientated mental hygiene clinic, whose aims will be prevention of personality disorders, education of the public, treatment and rehabilitation of those mentally ill individuals living in, or near, the community who are not so disturbed that they require institutionalization. We have advisedly placed the action research in the clinic instead of creating another institution. The network of institutions at present dealing with the patient is so complex in organization that even a normal individual might become confused as he is sent through the maze of clerks, interviewers, testers, therapists, and personnel of allied services. The purpose of action research and action techniques is to create a simple world for these patients; to set up another institution is to add to the complexity.

It might not be out of place to mention that we believe that many of the functions at present being performed by separate and relatively independent institutions should be brought into the clinic. A community-centered clinic should incorporate, for example, such functions as educational and vocational advisement, placement service and social service. To send the patient to outside agencies may actually aggravate his problems since the various institutions, because of their

particular needs, may develop diversified administrative policies which, while expedient for them [cf. 1] are not best from the point of view of the total treatment of the patient. Moreover, to take an already confused, possibly rather rigid individual, and to send him to one place for vocational advisement, to another for educational (guidance, and to a third for some other service, may be to confront him with a confusing, overcomplex situation. Coordination of such functions within the clinic itself, under a single administrative policy, may operate against this feeling of bewilderment, and may permit better integration of the various functions in the direction of unified therapeutic aim.

Since the clinic will have some control over the outside world, the patient will be able to be placed in situations which may create in him the necessary personality structure and need for optimum functioning in the community. In short, we consider the possibility of bringing about changes in behavior by changing the patient's life situations. If the bio-social approach to personality is valid, it should be possible to structure the patient's social field to produce a desired response. It may not be out of place to add that to wait for the patient himself to manifest a desire for action because of inner growth — perhaps on the grounds that only then can it have meaning for him — may not be advisable in many cases. (In our experience, patients have often viewed the therapist's waiting for them to be ready to act as justification for remaining idle, for waiting for the day when the revelation will strike them and relieve their emotional blocks. In this connection, we might borrow a page from the history of education on the subject of readiness, and recognize the dangers involved in delaying action until the individual manifests "readiness" for it.)

As at present, staff members will study the patient's home conditions, attempt to give members of the family some understanding of the patient's problems and to secure their attendance at classes held by the clinic, or if necessary, to arrange for therapeutic treatment for some of them; and they will strive to enlist the cooperation of the family in establishing home conditions more favorable to the patient's treatment and rehabilitation. In addition, forums on topics of psychology and a group therapy program will be maintained by the clinic, not only for the patient's kin, but also for the general public. It may be advisable to open these activities to groups composed of both patients and nonpatients, especially businessmen, educators and religious leaders, in order to achieve better mutual understanding.

The clinic will attempt to enlist the cooperation of various social-planning agencies, of the community's schools, business institutions, social, recreational, and religious organizations, and to play an active role in coordinating their activities for therapeutic purpose, so that they will work along with the clinic in creating conditions favorable for mental health, and in making room for patients who will be brought to them by clinical personnel and guided and supervised by the latter while participating in the institution's activities. For example, a survey will be made of available jobs and the employers told that certain patients will be carefully selected for them on the basis of their mental and physical condition and their previous employment, that they will be given training if necessary, and that while they are on the job, daily checkups will be made by clinical personnel; moreover, they will be told that working on a job, even in a limited capacity, may help the individual to adjust and keep him out of a public institution, thus saving money for the employer and other taxpayers. Religious, social and recreational groups will be made aware of their potential importance in constructing a world for the patient, and that comparatively little danger is involved in admitting into their organizations patients carefully culled for this function by the clinic and initially supervised while in the group. Thus supported by the clinic, the patient will venture into the world and bring back to the clinic for discussion and analysis, in individual or group sessions, his problems in the world of daily life until he is ready to venture out on his own.

In brief, the clinic will study and mobilize existing forces in the community, will introduce new factors if necessary, and serve as a clearing house in which opportunities for action are matched

with the needs of the patient, in order to help ameliorate some of the sources of conflict troubling the individuals, to strengthen and produce social ties, to help create for the patient a world in which he can function at his optimum level, and to give him, in addition to verbal support, a supportive world in place of the behavioral world of his illness.

For those individuals who are not ready to reside or work in the usual community, we envision protective workshops and sheltered communities. Such institutions have been maintained in some European countries, e.g., England, and investigation is certainly called for to determine their past accomplishments and their potentialities. It seems to us that such workshops and restricted communities tend to isolate and ostracize the patient; unless they are included in a broader action program, in which they are used by the community clinic as training centers for employment and socialization of patients, and are regarded by patients and others as stepping stones for advancement to wider circles of activity and social responsibility until the patient is prepared to take his place in the regular community.

Some Critiques of Action Psychotherapy

Our ideas concerning action psychotherapy have emerged, clarified, and been altered as a result of frequent discussions with members of the Veterans Administration Clinic, and with other members of the psychiatric and psychological professions. In the course of such discussions, several criticisms of the program have been reiterated. In the main, they are the following.

Study, and manipulation of the social field is the function of social workers. Perhaps theoretically this is their task, but many social workers of our acquaintance are interested primarily in dealing with personality maladjustments of a particular patient or members of his family, usually by analytic or nondirective techniques. Moreover, they seldom can reach beyond the immediate family constellation and cannot, unaided, cope with the numerous social forces and institutions which affect, or can be made to affect, the patient. Certainly there is a decided need for social workers in action psychotherapy but the entire task of active field work in the community must not be placed on their shoulders. Psychiatrists, psychologists, and all other clinical personnel must be ready to study and work in the community at first hand, in order most effectively to help patients to function at their optimum level as socially productive members of their communities.

2. Action psychotherapy cannot replace the usual individual and group psychotherapy. Indeed, it cannot; nor was it intended to imply that it would. What we are hoping is that when confronted with a patient who requires action psychotherapy, private practitioners will utilize such therapy as a supplement to their usual procedure, or will refer the patient to the nearest clinic which can provide such supplementation. And in the clinic itself, customary individual and group psychotherapeutic procedures will be available for those individuals who can benefit from them. Moreover, if a patient's maladjustment is of such a nature that it can be treated solely by customary therapy, he will not be required to participate in the other activities of the clinic. In action psychotherapy, the pathogenic factors in the community will be treated as well as the individual patient and their particular life situations. Because of this, it may be of benefit even for those patients for whom customary individual therapy will be utilized. Action research and action techniques are not intended to supplant individual psychotherapy but to create an atmosphere in which the latter can function more effectively.

3. Action psychotherapy increases the danger of developing dependence of the patient on clinical personnel. While it is true that this therapy may in some cases continue the dependence for a greater period of time than do traditional procedures, this will be justified if in the long run the patient is better able to function in the outside world, if the guiding hand he received while walking out into the world gave him the necessary strength to walk by himself. An important aim of action

therapy is the development of conditions in which the patient can gradually acquire those habits and skills necessary for intelligent, independent action. For this reason, the support given to a patient will be decreased if and as he shows his ability to do without it. In the case of some individuals, the period of dependency on clinical personnel may even be decidedly shorter than if customary therapy were employed because of the stress that action therapy places on the creation and strengthening of varied social ties.

It is of course conceivable that some patients will permanently be dependent on clinical personnel to some extent, but there is no reason to believe that they would have fared better if no attempt had been made to help them by means of action therapy. Indeed, we believe that there is nothing inherently wrong in dependence, as such, if it permits the individual to function more capably and more productively. So much ado has been made about dependency that one is inclined to think some of the shouting is due to the reluctance of some clinical personnel to assume responsibility for the patient. Perhaps it is timely to re-evaluate this concept, not only in therapy, but in our society as a whole, since ours is a world of interdependence in which no man can really live alone.

4. The expenses involved in establishing and maintaining action clinics, protective workshops, and sheltered communities, are so prohibitive as to make these undertakings unrealistic. Compared to the huge sums of money the local governments and private citizens spend annually on clinics, sanatoriums, and mental hospitals, and the sums spent by the federal government on veterans discharged because of neuropsychiatric reasons, the constructive agencies required in action therapy may be relatively inexpensive. And by what monetary standard shall one gauge the value of the preventive and rehabilitation aspects of these agencies, the roles they may play in keeping individuals out of mental institutions, and of helping some who might otherwise be burdens on their families or governments to function in a productive capacity?

5. Until drastic reorganizations occur in our socio-economic setup, it is impossible to introduce effective action therapy. To be sure, we cannot create personal utopias for each patient. However, even under present conditions much can be done to eliminate some of the sources of objective conflicts creating emotional disturbances, to attempt to change attitudes and to teach people so that conditions more favorable for mental health are created, and to utilize action research and therapy to make some gains in the direction of more effective prevention, treatment and rehabilitation. To do so, we reiterate, calls for active cooperation among the psychiatric, psychological, and social science organizations — among clinical personnel, social psychologists, educators, ethnologists, and others who have experience in organizing a community for action.

A Note to Psychologists

We regard action psychotherapy as a particularly fertile field of exploration for clinical psychologist in which they can utilize their training in social psychology, experimental psychology, and the social sciences. Moreover, here is an opportunity to test experimentally the actual outcome of therapy in the world outside of the therapeutic chambers (the world for which we are theoretically preparing the patient), to determine the efficacy of therapeutic procedures and the amount of carryover from therapeutic sessions. Certainly social psychologists interested in action research should find stimulating and challenging the problems of organizing and conducting such research for therapeutic purposes.

What was described herein constitutes but a general sketch of our conception of what may be accomplished by action psychotherapy. Many possible aspects — for example, the organization of mental institutions in accordance with the principles of action research and techniques — have not been dealt with at all. In most cases our suggestions are not sufficiently concrete to permit their immediate application. In order that more detailed, workable plans be established, we propose as an

initial step the setting up of a committee composed of representatives of the Division of Clinical and Abnormal Psychology and of SPSSI, which will cooperate with other divisions and with representatives of the psychiatric profession. After preliminary spade work by such a committee it may be possible to obtain funds, perhaps from the United States Public Health Service, to initiate the action research, educational and therapeutic action program in an actual community.

Until this dream is realized, we shall welcome hearing from the readers what they think is the feasibility and practicability of utilizing action research in psychotherapy, and of how such a program can best be put into effect.

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