

PEER GROUPS AND MEDICATION, THE BEST "THERAPY" FOR
PROFESSIONALS AND LAYMEN ALIKE*

O. HOBART MOWRER

*University of Illinois
Urbana, Illinois*

I

The Transition from Individual to Group Treatment

For many years the emphasis was exclusively on individual psychotherapy. This was unfortunate but understandable. In medicine, the Hippocratic Oath binds the physician to confidentiality, i.e., to seeing and speaking with the patient privately; and the penalty for priestly violation of the Seal of Confession is an extremely severe one. Therefore, it was tacitly assumed by psychologists that if their ethics were not to be impugned, they too would have to respect the patient's privacy and work with him on a one-to-one basis. What we failed to realize was that privacy, in the sense of guilt-laden secrets, far from being the cure, is very often the disease itself and that telling a secret of this kind to a professional with whom it will be "safe" cannot be expected to move a duplicitous, secretive, withdrawn person very far toward a clear conscience, openness, and normal social responsiveness. So clinical psychology searched feverishly for new methodologies, but such innovations as were thus developed were practiced in *the same interpersonal setting* as had traditionally prevailed both in medicine and in the church for many centuries. The results, as the Boulder Report indicates, were not conspicuously better than had been previously obtained by physicians and clergymen.

Now all of this involved two curious over-sights. Beginning in 1935, an organization known as Alcoholics Anonymous had come

into existence which, by 1949, had already helped thousands of men and women achieve sobriety where all else had failed (Anonymous, 1955); this organization was (a) characterized by the absence of professional services of any kind and (b) consisted of "a *fellowship* of men and women who *share their experience, strength, and hope* with each other that they may solve their common problem and help others to recover from alcoholism" (italics added). Here, manifestly, was *group therapy*—and it was successful! Also, under the exigencies of the psychiatric manpower shortage during World War II, it had been discovered by 1946 that, contrary to all expectations, "shell-shocked" or "battle-fatigued" patients were responding more positively to a professional therapist when treated *in groups* rather than individually.

In 1961, I published a small book in which I said:

The trail which AA has blazed is the only one down which I can at present gaze and see anything that looks like the road to the future. How AA principles can be adapted or modified to meet the needs of other kinds of confused and suffering people is not fully clear to me. But I am as sure as I can be of anything that no therapy will be radically and broadly successful which does not take the neurotic's guilt seriously and does not help him admit his errors *openly* and find ways to work in dead earnest to rectify and compensate for them (Mowrer, 1961, pp. 109-110, italics added).

1969 may appropriately be referred to as the "Year of the Group." Virtually every large-circulation magazine in this country carried at least one feature article on the phenomenon of grouping, not to mention movies and TV programs on the subject. Of numerous articles and books on this subject by professionals (Mowrer, 1971a), I would place Nathan Hurvitz's (1970) "Peer Self-Help Psychotherapy Groups and Their Implications for

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Psychotherapy" at the top of the list.¹ Why this relatively sudden explosion of both popular and professional interest in various forms of group experiences?

A perhaps too synoptic and truncated but essentially valid view of the matter is that, during the last half century, urbanization, geographic and socioeconomic mobility, and assorted technological changes have badly disrupted the traditional institutions of home, church, school, and neighborhood, with the result that great masses of people no longer are finding the sense of personality identity, emotional intimacy, and cosmic meaning which they once knew and that the small-group movement represents an attempt to create, not just a kind of "therapy," but actually a *new primary social group*, or institution, which will compensate for these basic human losses (cf. Gendlin, 1968, 1970; Gendlin & Beebe, 1968; Mowrer, 1970; 1971a).

In one of his papers Gendlin says:

For a long time we haven't had anything on the group level that corresponds even to "friendship" [cf. Schofield, 1964]. To be in a group, one had to plead sick (therapy) or one has to have (or pretend) an interest in photography, adult education, or politics. Often groups want to continue to meet, though their reason for being is over (after the election, for example) and no socially understood pattern exists for continuing a group because there is a human need to belong to a group. But such a pattern is coming. Already today we have psychotherapy groups, T groups, development groups, sensitivity groups, management skills groups, brainstorming groups, all quite similar. *Soon it will become understood that everyone needs to be in a group.*

While these groups have different names, and in some cases deal with very different contents (e.g., religious doubts, politics, *a certain vital group process occurs in all of them*: The newcomer finds himself listened to, responded to, discovers that he makes sense, can articulate feelings and reach out to others, be accepted, understood, appreciated, responded to closely (italics added).

In the future we will provide people with a quiet closed group in which they can move in depth, tell how things are, share life so to speak, perhaps say little at times, perhaps do major therapeutic work when needed, but always having the belonging, the anchoring which such a group offers. Then, in addition, those who want to, can serve a vital function in the other type of group that is open to newcomers,

where a few veterans who know how to relate intimately can swiftly bring a whole group of new people to the break-through point (Gendlin, 1970, p. 23).

This is only one of many possible sources of evidence that the Small Group is indeed emerging as a new primary social institution. How it will be related to the more traditional primary groups is still an open question, but there is at least some basis for speculation in this connection. Small Groups may help stabilize the nuclear family by providing a kind of substitute for the Extended Family. James Peterson (1960) and other writers on courtship and marriage have shown that the husband-wife relationship is likely to be or become unstable unless anchored in a larger social context. The Small Group often admirably provides such a context for engaged or married couples.

There are indications that the Small Group may largely replace the Established Church. Christianity started as a small-group movement (McNeill, 1951; Poschmann, 1964; Mowrer, 1967), with great "therapeutic" power; but it has evolved institutionally in such a way as to become increasingly "irrelevant" for many modern men and women. Integrity Groups, while non-theistic, are highly *religious* in that they are vitally concerned with human reintegration, reconciliation, or reconnection (which is what religion means—Mowrer, 1969, 1971b).² There is more than one reason for thinking that the Small Group may be the emerging "church" of the 21st Century. Already we have in one of our Integrity Groups an ordained minister, now defected from the conventional church, who says: "This is now my church." Recently I was speaking with a liberal rabbi who observed that Judaism is today fixated on certain forms of worship which consist, mainly, of "conversation," on the part of both the congregation and the rabbi, with a deity who is no longer very real to any of them. Yet they do not seem to be able to abandon these ancient and today largely meaningless liturgical forms. "What we really need," this rabbi said, "is to learn to talk to each other." This is what the Small Group provides, better than any other

¹ Perhaps the most eloquent testimony to the ubiquity of small groups is the cartoon which appeared in the July 18, 1970, issue of *Saturday Review* with the legend: "My therapy group can lick your therapy group."

² Integrity Groups are the particular facet of the Small Groups movement with which the present writer is specifically affiliated. They will be alluded to subsequently in this paper.

presently existing institution: the chance for people to talk to each other, in depth and with a view to personal change ("salvation").

It used to be that people who lived adjacent to one another constituted a neighborhood or community. Today, in rural areas and small towns there is still some sense of community; but in cities, and especially among large apartment dwellers, anonymity and personal isolation are instead the rule. There is no inherent reason why the city or even apartment houses need be so impersonal, but the fact is that, in general, they are; and we have people in our groups who say that these groups are, to all intents and purposes, also their *communities*, the people whom they know best and with whom they interact most. Perhaps small groups may prove useful in revitalizing neighborhoods and communities in the geographic sense of these terms.

The developing relationship of the Small Group movement to the schools is particularly interesting. Until a few years ago, counseling in schools and colleges was almost entirely on an individual, one-to-one basis. But schools are moving to group counseling methods, (Mahler, 1969, Ohlsen, 1969); such experience in the schools prepares or "conditions" our youth—nationwide—for participation in Small Groups in later life.

A bright undergraduate psychology student who happened to have read an earlier draft of this paper—and also a paper by Rollo May (1953) suggested the following: May is saying that when the primary institutions of a society are characterized by "disunity and disintegration" and many poorly integrated, anxious, "neurotic" individuals, then, as a result, a new profession of "trouble-shooters" come into being who first spend their time *studying* and trying to "*patch-up*" such persons. Later, what is learned in this way will be fed back into the common culture to produce institutional reform or the creation of *new*, previously non-existent institutions.

The whole point of the preceding section of this paper has been to suggest that what started out, in the latter part of the 19th century, as "individual psychotherapy" eventually led to therapy in groups, which are now dropping the term "therapy" and are becoming a new, here-to-stay, social institution in

their own right. As yet we don't have any very specific name for groups of this kind, but the important thing is that we *have the groups*. Much experimentation, refinement, and expansion are still needed, but the *core function*—Gendlin says "a certain vital group process occurs in all of them"—has been identified and more or less effectively implemented. And that is what counts!

As yet we have relatively few objective measures of the positive value and effectiveness of groups (cf. Mowrer, 1971c). How reliable an index to validity their present *popularity* is remains to be seen. In some quarters, bitter criticism as well as high enthusiasm, can be found. If a new social institution or primary group is indeed in the making here, there is going to be much trial *and error*, through which the new institution, in a generally acceptable and effective form, will eventually evolve. Because we cannot be absolutely sure, *a priori*, where we are going in this connection or what the best way of getting there is, it is probably dangerous to try to pontificate or legislate. Miss Lundberg (1970) observes, "It seems doubtful that anybody will be able to regulate or supervise a practice that anyone can indulge in" (p. 11). Witness the inability of the authorities of the whole Roman Empire to stop another small-groups movement: namely, the "House Church" of Early or so-called Primitive Christianity.

II

"Diagnostic" and Professional Implications of the Small Group Movement

The myriad theories of "neuroses" are now being dwarfed into insignificance by the diagnostic premise which flows, almost axiomatically, from group procedures. If increased group interaction is what most "neurotic" persons need (i.e., greater community), then the underlying problem is personal withdrawal, social isolation, *alienation*.

One account of this transition is by V. E. Bixenstine (1970):

About 1960, after some eight years of having plied my hand as a counselor employing in broad outline the traditional analytic model, I was forced to confront the fact that I was not very successful. This was in spite of the fact that I believed that I had usefully adopted needed corrections to analytic (Freudian) assumptions. Paradoxically, the more people I saw and

the more I began to look more closely at that brave minority who, presumably with my help, made significant and difficult changes in their lives and behavior. How in the world did they succeed? Their success was more in spite of than because of what I did. Essentially, they managed to overcome the barrier of analytic distance, impersonality, and aloofness so important to my role and establish, without my willing cooperation, a personal and significant *relationship* with me. I meant something to them. What I said and thought of them was important. Inevitably, they began to mean something to me so that whether or not they changed did not find me a detached observer (ii-iii).

This author then debated with himself, over a considerable period of time, as to whether he could, or should, try to change his style of reacting to clients so as to increase the chances of such a "relationship" developing.

The cultivation of warm gratitude and affection in order to "sell a product" seemed odious to me. I have since learned to be suspicious of my ability to find reasons for avoiding expressions of warmth. However, had I been able to shift and change my ways radically and promptly the likelihood is we would not have had the Saturday Morning Group.

As it was, I concluded that I could *not* change sufficiently to encourage a significant increase in this relationship factor I had unearthed. Having arrived at this conclusion the logic was straightforward: if the relationship factor could not be increased in one person, myself, perhaps it could be increased by integrating across a number of persons, such as a group situation. This certainly condenses my thoughts as there was a range of rationale which helped to give birth to my work with Groups. But it captures the essentials.

The Saturday Morning Group started in 1961 and was made up of the variety of persons I had been seeing or had seen who were still in the vicinity. Right from the beginning we knew we had something. . . .

The changes which took place led incrementally to the concept and inception of Community House (v).

A relationship has power, to be sure, in effecting behavioral change, but community harnesses more than the power in multiple relations, it taps as well a unity of shared judgment. Consequently, a number of associates together in a group will mount a social influence greater in force than will the same separately (vi).

Charles Dederich, after he had accidentally discovered a type of residential community that has proven remarkably successful in rehabilitating hard-core drug addicts, cannily concluded that such a community recreates a *tribal* psychology and sociology (Yablonsky, 1965). This is the very antithesis of "individual treatment" or "private therapy."

Sidney Jourard (1964) wrote: "Would it be

too arbitrary an assumption to propose that people become clients because they do not disclose themselves in some optimal degree to the people in their life. I have come to believe that it is not communication *per se* which is fouled up in the mentally ill. Rather it is a foul-up in the process of knowing others, and of becoming known by others" (p. 329).

Bixenstine continues:

It became evident that I was at best a *member of a community* whose experience, knowledge and perception earned him a not unqualified measure of respect and attention. In this community, however, I could never again rest secure behind my diploma and ward off ungentle inquiry with detached analysis of "transference" and "resistance." The result is that as a psychologist I feel, I imagine, a bit like Linus without his blanket. There is to be sure a compensatory sense of excitement and enthusiasm, but I cannot deny a certain yearning to find, if not another blanket, some clearer *modus operandi* whereby I might earn my keep.

Bixenstine's "metamorphosis", disconcerting as it was, certainly was not very traumatic. After all, he had a tenured position as a university professor which was not likely to be affected by the particular form of psychotherapy he engaged in; and this, too, was my own situation (see last section) and has been that of many other clinical psychologists. But what about the psychologist or psychiatrist who was in "private practice," i.e., dependent for his livelihood upon the fees he collected from his clients? In the first place, having to see "your doctor" in the presence of a lot of other people no doubt seemed to a lot of people a much less valuable experience than having his exclusive attention—and therefore not worth nearly so much per hour (although, in the aggregate, the therapist usually nets substantially more). Moreover, the therapist himself faced an excruciating dilemma: If he continued to do essentially "individual" therapy but with several other persons present, this was not *true* group therapy; and although the other "members" of the group had the opportunity to see and hear each other in action that was supposedly therapeutic, they never saw the therapist himself *model* this behavior, i.e., play the "patient" role. And if such a therapist did himself become anxious or otherwise disturbed, what was he to do? If he resorted to help from another therapist on an individual basis, he was showing a lack of confi-

dence in the "product" which he himself was selling; and if he turned to one or more of his own groups for help, the question might then arise as to who should be paying whom and for what. Some therapists, caught in this dilemma, have formed a special type of peer group, i.e., groups consisting of themselves and other professionals. Thus they can benefit from group therapy without having to "participate" or "be a patient" in the groups which they themselves conduct as experts, leaders, or therapists. But in the groups conducted by such therapists the only way a patient can identify with him (or her) is *qua therapist*, and what patients have traditionally wanted is not how to learn to "be a doctor" but how to "get well."

There are increasing reports of "participation" on the part of therapists in the groups which they conduct (Ruitenbeek, 1969; Psychotherapy, Fall, 1969). But if the group leaders are using their groups for their own benefit (personal change), there is a question as to whether they are justified in charging the other participants a fee when they themselves are deriving therapeutic benefit; and if they are simulating participation only as a ploy, then they are modeling a form of inauthenticity which they are presumably trying to eliminate in their patients.

For some years now, my wife (Dr. Willie Mae C. Mowrer) and I, in what we call Integrity Groups, have avoided these embarrassments by (a) not charging anyone a fee for being in these groups, (b) participating therein as co-equal members rather than as leaders or therapists, and (c) talking only when we felt we were helping others or genuinely in need of help ourselves. Special responsibilities, such as Group Chairman or Council Representative, revolves and the obligation to give as well as receive help is widely diffused. Every therapist is also a patient (if one wishes to use these terms), every student a teacher. This arrangement has many advantages, prominently including the cultivation of deep and enduring *involvement* and (much in the manner of AA and Synanon) the development of persons who (again to use a convenient but rather odious terminology) are not only "cured" but also trained. This strategy is, we believe, superior to any plan thus far proposed

for training paid "sub-professionals" (cf. Bower, 1970; Kovacs, 1970) to alleviate the much discussed mental-health manpower shortage.

As we had helped develop Integrity Groups and hoped they would remain, no one was going to make any money from them (just as no one, except a few specialists in the New York Central Office, makes any money for their activities in Alcoholics Anonymous). There is a saying in AA circles, "You can't keep it unless you *give* it away," and anyone who tried to *sell* AA would soon find himself in trouble, on many scores. Similarly it has been our feeling that anyone who charged fees for the kind of activities that go on in Integrity Groups would be prostituting himself in a way which would not only damage others but would ultimately destroy himself. The various Community Mental Health Acts—local, state, and federal, now offer a number of salaried positions which will permit a person to *give* his services to others who need and are willing to participate in Integrity Groups or similar mutual-help operations. Such salaried persons can serve as catalysts and consultants. It is not coincidental that the first person to come out of our graduate clinical training program here at the University of Illinois who also, with his wife, has had extensive I. G. experience and training is now serving as the first Director of Mental Health in a county in Illinois which said it wanted a community mental health program but not one which operated along traditional lines. This man and his wife (and an assistant who got his beginning experience in the School of Hard Knocks and then "graduated" from Gateway Houses, in Chicago) have made Integrity Groups their basic tool for personal change and have started them by *bona fide* personal participation. Now they have experienced group members who can not only keep established groups going and growing but who can also participate in the "seeding" of new groups.

This past year, for the first time, my wife and I, with the help of some of our "Thursday Night" I. G. members, have given a graduate seminar, with an associated practicum, which has been received by graduate students (and some young faculty members) in a number of departments far more enthusiastically than we

ever dared anticipate. In short, it now seems likely that there will be numerous employment opportunities for persons who are professionals in starting non-professional, mutual-help groups (instead of "doing therapy" themselves) and that universities can train and supply persons competent to perform this type of function.³

A word may be in order at this point concerning terminology. What is in essence individual therapy merely conducted in a group setting is not group therapy but might, for example, be called "demonstration therapy." And even if the leader encourages group interaction but does not himself participate, as a person with both solutions *and* problems, this is, by our standards, at best a low level group. Only in situations in which beginners may look forward to eventually possessing the same knowledge and skills as those now possessed by the more experienced members would we speak of a genuine, democratic, or "peer" group.

But this is not to imply these groups are the same as so-called "leaderless" groups. Every session of what we would regard as a peer group has a chairman, who is determined on some sort of revolving or random basis and whose responsibilities are nominal. The real work of the group is done *between* persons with problems and other group members who are able to bring the greatest skill to bear upon the constructive resolution of these problems.

This, in essence, is what is meant by a *peer* group; but a further distinction must be made here, between (1) a group of peers in the sense of persons having, for example, comparable professions, socio-economic, sex or age status, or the "same problem" and (2) a group of persons who are highly diverse in these and other characteristics but who are peers in the sense of being equals, without status or rank, except as special functions may be temporarily assigned to them—or in terms of informally recognized group experience and

competence (cf. Dreikurs, 1961). Thus, when using the term "peer group," it should be made clear whether meaning (1) or (2) is intended. Meaning (2) is the one intended in the title of the present paper, but this is not to say that type-1 peer groups (of which Alcoholics Anonymous is an example) are not legitimate and, for some purposes, especially useful.

The other source of possible ambiguity has to do with the expression "self-help." A much more appropriate term is "*mutual-help groups*," which implies give and take. Yet there is a sense in which no one can be helped by others unless he also helps himself. I have sometimes tried to capture this paradox with the statement: "You can't do it alone, but you alone can do it."

Recently I heard someone quote Heidegger's definition of man as "that creature who is a problem to himself." A rabbit's rabbitness is as given, whereas a man's manliness or a woman's womanliness has constantly to be worked at. As many writers have observed (cf. Childe, 1951, and White, 1949), *man makes himself*. And no one can do the job for him, but neither can he do it by himself because being a proper man, a proper woman, a proper *person* implies "character," i.e., special competences, skills, wisdoms, values, in relation to other people such that they will be *in community* rather than "marginal" human beings or "outcasts." A properly constituted Small Group seems to offer human beings the optimal circumstances for increasing their humanness.

Not "Sin" Alone but "Sin" AND Sickness

For many years I belonged among those who hit psychiatry (the disease model) and touted psychology (the behavior model) as hard as I could.

To date, seven studies have been carried out which compare the degree of concordance (coincidence) of cyclothymia (mood disorders) in monozygotic (genetically identical) twins and dizygotic or "fraternal" twins (who are no more alike genetically than ordinary siblings). When the findings for all seven of these investigations are combined, the Chi-square for the difference in concordance for this type of disorder between the two types of twins turns

³For information concerning two operations with very similar objectives, write to Professor John W. Drakeford, Southwestern Baptist Theological Seminary, Fort Worth, Texas 76122, and Professor V. Edwin Bixenstine, Department of Psychology, Kent State University, Kent, Ohio 44240.

out to be 82. Here a X^2 of 10 is statistically significant at the .001 level of confidence. The P-value for a X^2 of 82 is thus fantastically high (cf. Price, 1968).

Gottzman & Schields (1966) have reported the findings for 11 twin studies of a similar nature for schizophrenics; and here a composite X^2 of 928 was obtained. Sometimes an attempt has been made to dismiss this line of research on the grounds of poor methodology or other artifacts. But research designed to check on these criticisms has rather uniformly resulted in negative findings (cf. Kety, et al., 1968).

The reality of genetic influences in personality disorder compels us to speak of disease or illness. Moreover, the rapidly developing literature on psychopharmacology, which shows the possibility of successful chemotherapeutic intervention in many of the most severe and debilitating forms of personality disturbance further supports the view that we are here dealing with problems not exclusively determined by environmental factors or learning. Thanks to the psychotropic drugs, today hundreds of thousands of persons are leading essentially normal lives who would otherwise be seriously incapacitated or institutionalized (Clark & del Giudice 1970).

Now here are two manifestly valid yet seemingly incompatible points of view concerning psychopathology: the psycho-social and the bio-chemical.⁴ How, if at all, can they be reconciled?

In 1960 I published a paper entitled "‘Sin,’ the Lesser of Two Evils," and here I defined "sin," not in any metaphysical or theological sense, but as any behavior which tends to alienate a person from his reference group or community, i.e., dehumanize him. And I further took the position that the alternative concept of mental "sickness" was unsubstantiated and misleading. But in the intervening decade, both the

genetic and the pharmacological evidence has accumulated to such an extent that one can no longer, in good conscience, take an either-or position in respect to this problem. Even the most adamant advocates of the so-called "disease model" of psychopathology do not emphasize genetic and biochemical factors to the exclusion of psycho-social considerations. In fact, the most generally accepted position among psychiatrists today is what is known as the *diathesis-stress hypothesis*. "Stress" includes, among other sources, the behavioral "maladjustment" psychologists emphasize and also the anguish of social alienation.

Now "diathesis" is simply an unusual word for the familiar concept of constitutional (genetic) predisposition or variability. Thus the diathesis-stress hypothesis says that the manifestation of a particular "mental disease" or symptom syndrome is *multiply determined, interactive*. A degree of stress which will produce psychic decompensation in one person will not do so in another because of congenital differences in *stress tolerance*; and what the psychotropic drugs seem to do, in essence, is to increase stress tolerance. Similarly, of two persons with the *same* natural stress tolerance, one may become psychically disabled because of difference in experienced stress, whereas the other will not. Here is where the question of whether a person is a social isolate or "in community" is often of crucial importance; for social isolation is unquestionably more stress-inducing than is life in community, which provides many otherwise unattainable satisfactions and supports (Mowrer, 1971b).

In other words, the diathesis-stress hypothesis says that mental illness is not absolutely determined—as, for example, eye-color and sex are—by heredity but is also contingent, for its overt manifestation, upon environmental and experiential factors. An apparent exception to this general point of view is, however, found in so-called endogenous depression. In this connection, Clark & del Giudice (1970) say: "In this illness, episodes occur without any immediate life stress. These individuals often experience recurrence, a small percentage of them alternating depression with episodes of euphoria and manic excitement" (pp. 628-629). The mechanism of such "spontaneous" mood fluctuations is at present a com-

⁴ Terminological reform in this field is long over-due. Personality disturbance with a manifest or presumed bio-chemical (organic) basis is usually called a "psychosis," whereas a disturbance with a psycho-social basis is called a "neurosis." If there were a shred of rationality in all of this, a disturbance with a bio-chemical basis would be called a *neurosis* (since it involves a disorder or "osis" of the neuro-humoral system); and a disturbance with a psycho-social basis would be called a *psychosis* or—as Van den Berg (1964) has not unreasonably suggested—a *sociosis*.

plete mystery, except that it has a genetic basis of some sort. Fortunately, it is in precisely this variety of depression that the psychotropic drugs work best. "Somatic therapies, including the anti-depressant drugs and electroconvulsive therapy (ECT), are the most useful with these patients" (Clark & del Giudice, 1970, p. 629). It seems also to be true that, no matter how robust a person is genetically (constitutionally), there are forms of moral stress which may be of sufficient intensity to produce severe psychic decompensation or incapacity. But in between these two extremes, decompensations or breakdowns do seem to be a function of two factors rather than only one.

This, then, is the logic on which the title of this section is predicated. Therapists who take a rigidly monistic position are likely to find themselves ineffective in practice and inwardly confused and distressed because of their refusal to acknowledge the complexity that characterizes this area of human suffering and incapacity.

Thus, in contrast to the position we took a few years ago in our Integrity Groups, we now have a consulting psychiatrist who understands and is thoroughly sympathetic with our emphasis upon community but who also frequently provides effective bio-chemical intervention in neurophysiological states which may arise in persons whose community involvement and activities are quite satisfactory—but which will soon begin to deteriorate if the bio-chemical condition is not corrected. To refuse to take advantage of the benefits of modern psychopharmacology and to insist that all personality problems reflect what Bixenstine calls social "dislocation" is, in our opinion, as unfortunate as the practice of some psychiatrists and physicians who prescribe psychotropic drugs without any serious exploration of whether the patient is or is not suffering from social dislocation and alienation.

Toward the end of section I reference has been made to the fact that small groups or "grouping" is not axiomatically or inevitably a good thing. Groups, if predicated on the wrong principles or exploited by unprincipled "leaders," can be demonic rather than salutary. But since the evidence is not yet all in, and because it would, in any case, be legally

difficult in a Democracy to prevent people from voluntarily assembling and talking to each other in small groups, we shall have to rely on Natural Selection in this sociological sphere.

The reverse danger has been excellently delineated by Lennard, et al. (1970) in an article in *Science* entitled "Hazards Implicit in Prescribing Psychoactive Drugs." Their charge is that the pharmaceutical industry, in order to extend the use and increase the sale of "psychoactive drugs," is:

It is apparent that the pharmaceutical industry is redefining and relabeling as medical problems calling for drug intervention a wide range of human behaviors which, in the past, have been viewed as falling within the bounds of the normal trials and tribulations of human existence (p. 438).

Thus, when a physician prescribes a drug for the control or solution (or both) of personal problems of living, he does more than merely relieve the discomfort caused by the problem. He simultaneously communicates a model for an acceptable and useful way of dealing with personal and interpersonal problems. (p. 439).

These writers are concerned that both the manufacturers *and* harried physicians will not only recommend these drugs for the legitimate relief of suffering and incapacity which have a genetic or biochemical basis but will also—in fact, already pervasively have—encourage their use for the relief of psycho-social discomforts which are essential, normal *signals* that the person experiencing them ought to *change his style of life* (along lines commonly pursued in small groups).

Both peer groups *and* medication offer the two major sources of "therapy" for human beings (including professionals as well as laymen) and *both* approaches can be misapplied and over-extended. In other words, there can be and are *bad* groups, and medication can be and often *is* prescribed for problems that are far more appropriately and effectively handled on a psycho-social basis, i.e., in groups.

Someone has observed that the history of psychiatry shows that whenever the specific bio-chemical basis of any form of personal disorder has been definitely identified, the management of this problem soon passes from the field of psychiatry over into general medicine (consider, for example, pellagra psychosis, paresis, etc.). Today the new psychotropic

drugs are being increasingly administered by general practitioners; and it may soon come about that the main role of psychiatrists and clinical psychologists alike will be that of alienists, i.e., persons skilled and concerned in helping isolated, "sinful" persons return to or perhaps for the first time *find* community. In Integrity Groups our assumption is that human beings become alienated (lose community) because of the practice of *dishonesty*, *irresponsibility*, and *uninvolvement*. Consequently, our "relocating" or "reconnecting" (re-educational) thrust is upon the development of the three *opposite* positive characteristics. But we first make sure that the individual is not also suffering from bio-chemical malfunctions which no amount of grouping or community experience will correct.

It should also be recognized that personality disturbances with a strictly biochemical basis may cause a person to *withdraw*, lose community because he recognizes that he is not functioning adequately as a person, is regarded as odd or "crazy," and thus tries to avoid being so judged or rejected. Such persons, after the biochemical basis of their difficulties has been corrected by means of chemotherapy, often need group experience in re-socialization and normal personal interaction.

III

My Personal Experience

Among physicians in general, the suicide rate of 36 per 100,000 population contrasts with an over-all U. S. rate of 11 per 100,000. The suicide rate among psychiatrists is 70 per 100,000.

Although I can hardly believe that such studies do not exist, I do not personally know of any which empirically evaluate the "mental health" of "Experienced Psychotherapists" (including psychologists).⁵

On two other occasions (Mowrer, 1966, 1971e), I have written at some length about my own struggle for "mental health" and so will be highly synoptic here. During the course of my lifetime I have had eight more or less severely incapacitating depressions. Six of

these occurred between 1921 and 1944 (a period of 23 years) and only two during the ensuing 26 years: one in 1953 and one in 1966. It is a common expectation that as one gets older, depressions will become both more frequent and more severe, but the data from my own life runs counter to this dictum. Is this a coincidence or is the reversal of the common trend in some way significant. During the first period of 23 years to which I have alluded, I consulted a number of physicians (most of whom honestly said they could not help me), but one (in the early 1920's, when "focal infections" were held responsible for a wide variety of ailments) took out my tonsils, and another found a trace of albumin in my urine and prescribed bed rest and a special diet. Later, I also had some 700 hours of psychoanalysis, with three different analysts.

It now seems likely that five variables (all mentioned in the psychiatric literature) have played a role in my experiences of depression: (1) an hereditary tendency toward depression on my mother's side of the family; (2) the death of a parent (my father) when I was 13 years old; (3) "upward mobility" expectations on the part of my lower-middle class family, which I "introjected"; (4) a rather indulgent ("spoiled" in the words of Adler) upbringing, except for any display of anger or defiance; and (5) adolescent sex conflicts which caused me a great deal of guilt, shyness, and withdrawal.

So far as I can see, everything I did prior to 1945 in the way of therapeutic endeavor was ineffectual, on all counts. In that year, however, largely as a result of some contact with Harry Stack Sullivan, I began what I have called in the title of a paper (Mowrer, 1962), "The Quest for Community." Between 1945 and 1953, this involved full self-disclosure to only one Significant Other, my wife; and the depression I had in 1953, after eight "good years," suggested that although this openness had helped, it needed to be further extended; and apparently as a result of gradually becoming involved in and helping develop what we now call Integrity Groups, I subsequently had 13 depression-free years. This protracted group experience was probably salutary with respect to factors (2) through (5), listed above. But then, in the Fall of 1966, a depres-

⁵ But there is a somewhat related report edited by Wayne E. Oates (1961), entitled *The Minister's Own Mental Health*.

sion of gradual, insidious onset occurred, which seemed to be strictly endogenous, spontaneous. In the beginning my family, associates, and I tried desperately to find some "reason" for the depression but nothing very substantial emerged. We all had a strong bias at that time against the psychotropic drugs, but eventually, early in 1967, I resorted to one of the tricyclic antidepressants (Elavil), with moderately good results; and later I used another one (Pertofrane), with dramatically positive effects. Since these are the drugs which work best with endogenous depressions, the presumption is that the depression which started in the Fall of 1966 was of this nature.

It has been argued by some that all depressions, including the so-called endogenous ones, "have a purpose" (or cause) which becomes apparent only after the depression is over and has achieved its objective. It cannot be denied that the depression which started in 1966 changed my attitude toward the whole field of psychopharmacology, and as a result I now feel more honest, realistic, "cleaner," a better scientist than I did before. Paradoxically and somewhat ironically, these facts are thus congruent with what, for example, Dabrowski (1964, 1967) calls "positive disintegration," which implies a type of psychodynamics. But the results of the twin studies previously cited stand and cannot be interpreted "dynamically," i.e., they unequivocally demonstrate a genetic or constitutional predisposing factor in at least some types of depression.

On the basis of my personal experiences and the observation of others, I am today inclined to believe that probably everyone ought to be in a mutual-help or peer group (for the bearing and sharing of "one another's burdens"), not as "therapy," but as *a way of life* (cf. the earlier references to Bixenstine and to Gendlin), and that if symptoms emerge which are intractable in this context, one should seek the best advice obtainable regarding the use of appropriate medication. This is the counsel I would give to others and which I accept as the guideline for my own life. Hobbies, diversions, personal generosity, friendship, and concern with causes which transcend one's own existence are undoubtedly of some, but I would say secondary, importance here. Inveterate

commitment to life in deep community (people who, in the words of Gendlin, provide "a quiet closed group in which they can move in depth, tell how things are, share life") and, when indicated, the use of the best available new psychotropic drugs are, however, the two basic desiderata.

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