ERRATUM

Due to typographical error the text of this
Thesis begins on page xiii rather than page one.

AN INSTANCE OF GESTALT THERAPY WITH EMOTIONALLY

DISTURBED ADOLESCENTS IN A THERAPEUTIC COMMUNITY

by

Roger B. Neill

B.A., Simon Fraser University, 1971

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF

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ABSTRACT

This thesis is a case study, the object of which is
to establish the applicability or inapplicability of Gestalt
Therapy as a treatment modality for emotionally disturbed
young adolescents in an institutional therapeutic community
setting. On the basis of available data, the study attempts
to draw conclusions as to the general applicability of Gestalt
Therapy as a therapeutic tool for the treatment of young
adolescents.

Data was drawn from eighteen months of participant
observation in a Provincial Government residential treatment
centre for disturbed adolescents, and in the course of the
study, an audio-taped staff-sample interview was conducted,
content analysis of relevant unit documents took place, and a
resident sample population was drawn from clinical records.
Relevant source material on Gestalt Therapy, the social
psychology of early adolescence, and therapeutic community
was surveyed.

The design and intent of Gestalt Therapy (as out-
lined by its principal proponent, Frederick S. Perls) relative
to the range of appropriate psychiatric and behavioral dis-
orders, age group, socio-economic status, and level of educa-
tional achievement (or verbal skill) of its target population,
was compared to the design and intent of the treatment facility
under analysis and the characteristics of its treatment pop-
ulation relative to these same categories.

It was demonstrated that the original design and intent of Gestalt Therapy relative to the above variables (as described in the Gestalt literature) was not applicable to the subject-unit's treatment population, because the range of psychiatric or behavioral disorders represented at the unit was too broad, the age group was too immature, the socio-economic status of residents was too low, and the level of educational achievement or verbal skill was inadequate relative to: (a) the high level of abstraction, (b) unconventional moral stance, and (c) ego-identity development demanded by Gestalt Therapy.

Perls' own view of the applicability of Gestalt Therapy relative to psychiatric disorders, age group, socio-economic status and verbal skill, was reinforced by the assessment of staff interview respondents who held that Gestalt did not work well with psychotic, delinquent or severely acting-out adolescents who were necessarily immature, of low socio-economic status, and of poorly developed verbal skill.

It was further demonstrated that based on Gestalt Therapy's approach to therapeutic environment, patient roles, and the prerequisites of long-term co-operative, therapeutic community living, Gestalt was not applicable:

(a) as a training tool for child care staff because it makes no distinction between adolescent and adult development;

(b) as a role model for the staff employee because its demands are inconsistent with institutional role demands;

(c)   as a system of behavioral demands for the resident because its tenets are inconsistent with institutional behavioral demands; or

(d)   as a system of behavioral demands relative to co-operative, democratic-egalitarian group living because its individualistic and ventilationist qualities are demonstrably problematic in such an environment.

Participant observation, staff interviews, analysis of source material and analysis of relevant literature on adolescent treatment, all concurred to support Perls' original assessment of Gestalt Therapy as a highly successful treatment modality for mildly neurotic, middle or upper-middle class, highly verbal adults in a remote natural setting, where staff and patient roles can be obliterated in an ethos of personal responsibility and individuality and where a private "growth experience" is the primary goal.

TO KORY

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INTRODUCTION

In the late nineteen sixties, in a Western Canadian Province, a unique experiment in the treatment of adolescent psychiatric disorders began. In this experiment, a Provincial Government mental health treatment facility attempted to apply Gestalt Therapy to the treatment of young adolescents exhibiting a broad range of psychiatric disorders.

The present study is concerned with the problem of whether or not Gestalt Therapy can be used successfully in a treatment facility of this kind.

The findings of this study are relevant to current psychiatric practice in British Columbia, since at least one private adolescent psychiatrist, one private psychotherapeutic institute, one Crisis Centre, two government sponsored programs for adolescents (and multiple private practice clinical psychologists), use Gestalt theory, therapy or ideology, in their psychotherapeutic practice.

The unit was staffed at a time when "anti-psychiatry" was becoming a force to be reckoned with in the mental health field. "Line" staff and Administration of the unit tried to put into effect a new and radical treatment program, which was designed to treat the adolescent residents in a non-infantilizing, non-controlling and non-depersonalizing fashion.

At the time of the unit's inception, "Therapeutic Community" (which was to be the unit's social-structural

orientation) was still in the experimental stage and not widely accepted in the broader psychiatric community. However, not only did the unit attempt therapeutic community as a treatment modality, but it also tried to wed it to the popular Gestalt (Existential) psychotherapeutic movements of the time. The marriage was to prove tempestuous.

This treatment centre tried to address itself to the general problems of the residential treatment process. First, it attempted to break down the common distinction between "child care" (on the one hand), and "therapeutic treatment" (on the other), in order to ". . . integrate the tasks of daily living with those of direct treatment."(Schwartz and Zalba, 1971:178,182) It did so, by passing the preponderant responsibility for therapeutic work directly to the Child Care Workers. Psychiatrists, Psychologists and Social Workers were consultants for (and trainers of) the Child Care staff.

Secondly, it replaced the "Surrogate Parenthood" model of care with a more adult model, group-treatment type process. The staff purposefully refused to take on parental roles and confronted such tendencies (known as transference phenomena in psychiatric literature), as part of the therapeutic process.

Thirdly, it recognized the importance of peer culture and peer interpersonal support as a key to the therapeutic milieu. In order that the process be therapeutic, it was necessary to break down the custodial child-care role which tended to reinforce delinquent peer group activity and replace

it with a flexible and appropriate degree of resident self-
government. In these areas, the unit's efforts were particularly
creative and innovative.(Polsky and Claster, 1968)

This paper attempts to assess the appropriateness of
Gestalt Therapy and its inherent ideological implications, in
the treatment of young adolescents in such a residential setting
which subscribed to a therapeutic community approach to treat-
ment, decision making, professional role-relationships and staff
training.

The organization of this study is set so as to provide
(in Chapter One) a relatively detailed description of the unit's
physical, social and programmatic orientation. It then moves on
to a statement of the primary problems related to the application
of Gestalt Therapy within this specific setting (Chapter Two).
Chapter Three attempts to outline the design and the intent of
Gestalt Therapy as described in the specific literature of
Frederick S. Perls.

Chapter Four explores the literature on the specific
social and psychological characteristics of early adolescence
(age twelve to sixteen), while Chapter Five describes the goals
and methods appropriate to the practice of "Therapeutic Commun-
ity" as described in its source material.

Chapter Six gives data on the details of Easton's
functioning relative to the problems described in Chapter Two,
based on the literature on Gestalt Therapy, Adolescence, and
Therapeutic Community.

Chapter Seven draws conclusions as to the appropri-

ateness of: (a) Gestalt Therapy in the treatment of
Adolescents in general; (b) Gestalt Therapy in a Therapeutic
Community setting in general; (c) Gestalt Therapy in the
treatment of Easton's treatment population, specifically;
and (d) Gestalt Therapy as a tool for Easton staff training
and role-modelling, specifically.

With this introduction, we will move directly to a
detailed descriptive account of Easton's physical, social,
and program organization.

CHAPTER I.   SETTING: THE "EASTON" TREATMENT CENTRE FOR
                        EMOTIONALLY DISTURBED ADOLESCENTS.

A. Physical Description

    1. Time and Place.

        Construction of this new and attractive residential

treatment facility (which will be known as "Easton" in this

thesis) began in the Summer of 1965. One of the three resid-

ential cottages was admitting residents by August 1969 and

another residential cottage was serving as a Day Clinic by

September 1969. The second twenty-four hour residence (called

Cottage II) was opened in February 1970.

        The unit is a Provincial Government Mental Health

institution situated in a mixed, commercial-residential area

of a major Canadian city. It is located approximately within

fifteen minutes travel time from the centre of the city.

    2. Physical Plant and Facilities.

        Easton is part of a larger Mental Health Centre which

includes a Psychological Education Clinic and a Family and

Children's Clinic, so it cannot be viewed as unconspicuously

integrated into the residential aspect of the area.

        As a centre for "emotionally disturbed adolescent boys

and girls", its facilities consisted of three cottages of fifteen

beds each, two of which were twenty-four hour residences, the

third, serving as a Day Clinic. The residential part of the

complex has access to a swimming pool, gymnasium, tennis courts, an outdoor sports and play area, and has jurisdiction over its own Arts and Crafts centre, as well as schoolrooms in the School complex. There is a woodwork shop which was operational for periods of time during this study, depending on the availability of staff to supervise woodwork operations. The Administration Building for the residences is separate from the residences and School complex (see Diagram No. 1), but is integrated architecturally into Easton as a whole.

The grounds on which the unit is set are expensively landscaped and essentially fragile, with complex sprinkler systems, carefully maintained lawns, shrubbery and trees. For an urban area, it is relatively quiet, peaceful, and secluded.

The residential cottages were built prior to staff selection so that the unit Director and Staff had no formal input into the design of the cottages. They were designed essentially in the interests of indestructibility. The cottages were made of brown-biege brick with furniture built into the walls. Any moveable furniture was made of very heavy materials, veneered in arborite and supported with steel. The living room floors were carpeted and lighting was indirect and housed behind inaccessible valances.

Despite these characteristics, attempts had been made to de-emphasize the institutional qualities of the cottages, while at the same time, fulfilling institutional safety and health standards.

WOODED AREA

TENNIS COURTS

BLACK TOP PLAY AREA

COTTAGE II

COTTAGE I

DAY CLINIC

SCHOOL

POOL

GYM

EASTON ADMINISTRATIVE OFFICES

STREET

PARKING

STAFF DINING

STORES

EASTON ARTS AND CRAFTS ROOM

MENTAL HEALTH CENTRE
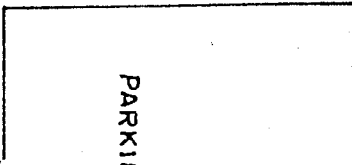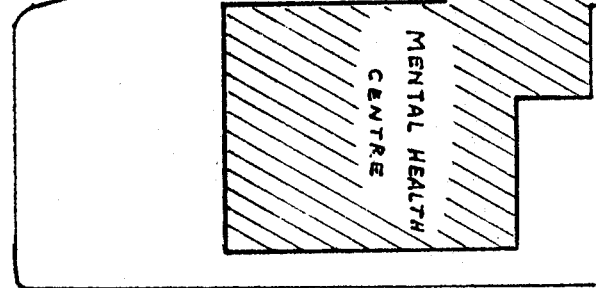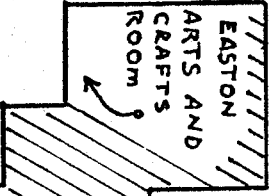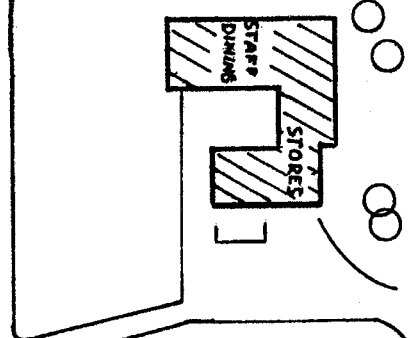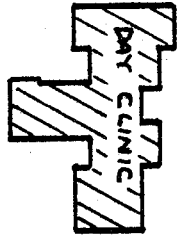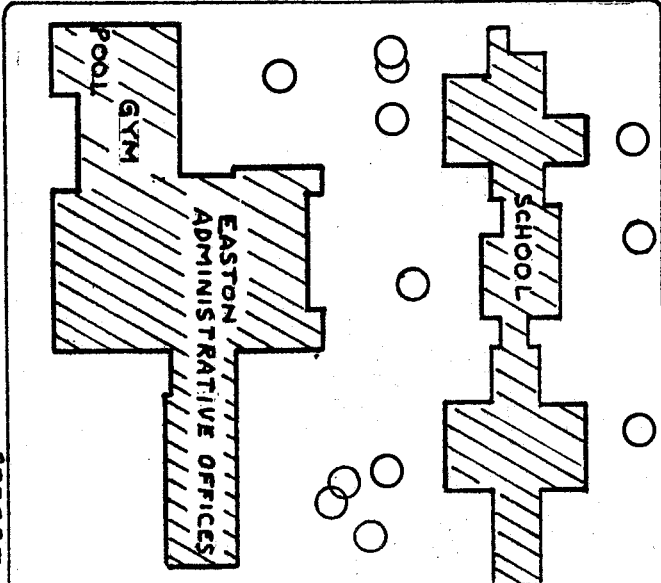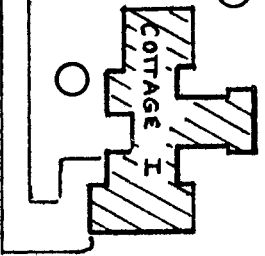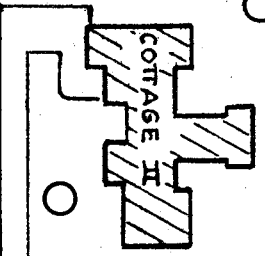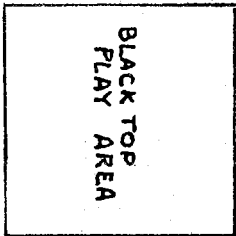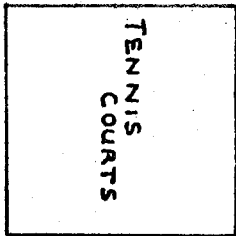
PARKING

PARKING

DIAGRAM I: EASTON COMPLEX

SCALE 1" = 100'

DOUBLE Bd Rm

SINGLE Bd Rm

DIAGRAM II
COTTAGE
FLOOR PLAN
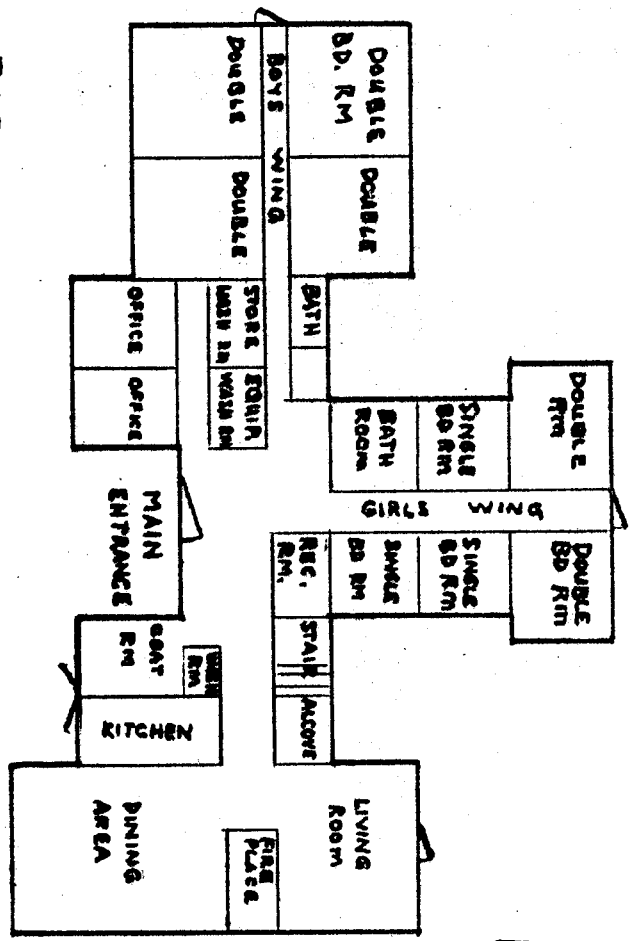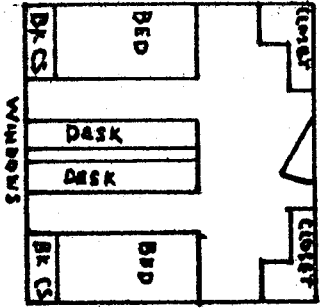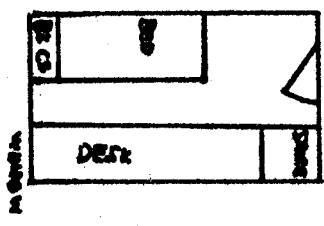
The interior was decorated in "earth" colours of browns, beiges, greens and golds. There was a great deal of grained wood, textured materials, and a fireplace in the living room. These were one-story buildings with a spacious, minimally finished basement with good lighting, and with skylights in each sector of the building.

Attempts were made by the designers to have a pleasant living environment, but the Fire Sprinkler Systems, Exit Lights, Fire Alarms, Fire Extinguishers, and the sheer immobility of the environment, had important social implications, especially in light of the unit's therapeutic orientation. The landscaping was beautiful and peaceful, yet fragile and too destructible for angry distressed adolescents.

Both residents and staff had access to library facilities in the larger Mental Health Centre. Communication in and out of the unit was relatively free, in that residents were allowed to telephone out as well as accept telephone calls from relatives and friends. An exception to this rule pertained to the initial one month period of residency, when communications were restricted, in order to encourage commitment to the unit and prevent family and friends from undermining the therapeutic effort.

B. History and Social Organization

    1. Design and Intent.

At the time of the unit's inception, the Provincial Government lacked a residential facility for emotionally dis-

turbed adolescents and was largely dependent upon its Provincial
Mental Hospital adolescent wards, or two "closed" units (one for
boys and one for girls), which were primarily designed for
severely delinquent youth. Easton was meant to fill the needs
of non-delinquent and non-psychotic adolescents, who would likely
respond negatively to a closed institution. Easton was going to
be an open-door, therapeutic unit which would bridge the gap
between the needs of severely disturbed and severely delinquent
adolescents. This meant that it could admit small numbers of
psychotic or delinquent youth or large numbers of mildly dis-
turbed youth.

A British Psychiatrist with experience in the residen-
tial treatment of children in the United Kingdom, was appointed
to set up and direct the unit. The staff orientation and train-
ing was a direct outgrowth of his own "personal orientation".[1]

2. Population.

As has been mentioned above, the unit had two fourteen
bed residential units with a third cottage used as a Day Clinic.
Fourteen residents per cottage was found to be unworkable, given
the therapeutic approach of the unit, so in fact each residence
maintained a population of between nine and twelve residents.
The Day Clinic population fluctuated within the same limits and
operated on a tri-semester system.

The age range of the residents in treatment was from
twelve to seventeen years, with eleven and eighteen year olds
included under unusual circumstances.

When the unit opened, the idea of having male and female adolescent residents under the same roof in an "open" institution was quite unusual. Nevertheless, it was accepted as policy and was an integral part of the treatment orientation.

There were ten to twelve staff members allotted to each cottage, and it was policy to make an attempt at balancing the number of male and female staff per cottage. During the period of this study, the average age of staff members was calculated at twenty-five years.[2] This staff total was spread over three shifts per day, with a two hour overlap of the day and evening shifts, to facilitate the daily group meeting. The specifics of the shift pattern will be dealt with in the section on programming.

3. Staff Organization.

a. Initial Selection Criteria - The unit began interviewing the staff for employment in February 1969 and admitted adolescents into residence, after an intensive three month orientation program for staff. This orientation exper- ience was to set the stage for unit theory and psychotherapeutic practice from that time, until 1973.

The criteria for staff selection included the Director's personal assessment of the "openness", "warmth",[3] and "enthusiasm" of the applicant, and the expected ability to relate well with adolescents. Further, the most important criteria, was how conducive to "emotional growth"[4] the applicant appeared to be. "Training has to include the present growth and

development of the individual staff member. . . ."[5], and to this end, the Director selected people who seemed "ready to grow".

The criteria of "identification to the prevalent youth culture" was applied in a rather novel fashion, where an attempt was made to equally balance the number of staff who could be intuitively classified as "hip", "liberal", or "straight".[6] The Director felt that an equitable distribution of staff who would identify with authority, could be achieved, and neither the institution's interests nor the resident's interests would predominate.

Partly by design and partly by necessity,[7] most of the staff hired were inexperienced in Child Care work, with only five members out of twenty-five having had any experience. The assumption was that ". . .an inexperienced staff. . .has the potential to be more creative as he or she is not limited by in-stitutionalized ways of thinking and doing things."(Mate, 1972:5)

A final criteria for staff selection was a University degree. The intent of this stipulation was to eventually acquire formal professional recognition for Child Care Worker positions. The Director was not specific in selection of discipline, but preferred varied academic backgrounds being represented in his staff, in the interests of having staff teach courses to the adolescent residents in a "free school" type of program.(Mate, 1972:6)

b. <u>Orientation Program</u> - The induction of these
new and relatively young staff members was an important event
in the history of the unit, since it provided those staff who
were to remain at the unit for some time, with a treatment
philosophy, induction program for new staff, and a training
scheme, which was to carry on in the tradition of the unit for
the next five years.

The key to the orientation program lay in the Direc-
tor's contention that in order to encourage and guide adolescents
through a "personal growth process", it is essential that staff
experience their own personal growth process. Growth in this
sense, means acquiring "maturity",[8] which is used by Frederick
S. Perls to suggest a "transcendence from environmental support
to self-support".

To facilitate staff growth and maturation, the follow-
ing immediate goals were seen as being of importance:

    (i) Acquisition of an in-group identity and sense
    of community among the staff;

    (ii) Acquisition of an atmosphere of trust, honesty,
    and empathy, conducive to "free learning, experiencing
    and exercising personal choice";

    (iii) Acquisition of an integrated mind-body conscious-
    ness in which physical activity, craft skill, and body
    contact, is acceptable and an important part of life;

    (iv) Acquisition of a democratic-egalitarian role and
    decision-making structure. This was to evolve spon-

taneously with the emergence of the group identity and an atmosphere of trust.

To accomplish these goals, the following methods were employed:

    (i)   Group Sensitivity Training;

   (ii)   Staff Encounter Groups;

  (iii) Awareness Sessions;

   (iv)   Communication Workshops;

    (v)   T-Groups;

   (vi) Group Recreational Activities, i.e., camping and sailing;

 (vii) Group Arts and Crafts, Sports, and Body-contact training sessions.

    c.   <u>Training Program</u> - From the unit's inception, the Director made it abundantly clear that "orientation" was <u>not</u> training. Orientation was designed to facilitate staff personal emotional development and an in-group identity. Training on the other hand, was the "experience" of interacting with the patients, while having to deal with their problems in a residential setting.(Mate, 1972:12) In the Director's view, the only adequate training took place in the actual process of <u>doing</u> therapy under the supervision of more experienced staff.

    Ultimately, in the interests of achieving professional recognition for Child Care Work, it became necessary to devise an In-Service training program for staff. One day, every second week, was set aside for In-Service training, and one-half of the

staff population got together on these days for supervised instruction. The program consisted of a morning theory lecture and/or discussion with the Psychiatric and Psychological consultants. The lunch period was a social hour where this mixed staff population (members from the various cottages, Day Clinic and Administration personnel), got together over lunch to discuss their particular problems and successes. Immediately after lunch, group sport and group arts and crafts skill were learned, and in the early afternoon, an intensive group therapy session took place. These were either Gestalt Groups, Awareness Sessions, Encounter Groups, or Bio-Energetic Groups.

Contact with other agencies and treatment facilities was maintained through tours and discussion groups; however, these were relatively infrequent.

Prime emphasis in the training program was given to ongoing supervisory assessment of staff work performance in the cottages. This was achieved by attempting to give almost immediate feedback to junior staff on their performance. This often took place with residents present in the community meetings, or privately, in the shift change meetings each day. As little communication as possible was to take place behind closed doors, and the residents were encouraged to confront, criticize, or support staff as they saw fit, in the presence of the entire community.

One informal expectation on those who wished to become supervisory staff, was that they undergo psychotherapy either

outside or inside the unit.[9] Many supervisory and line staff
were involved in Gestalt and Encounter groups as well as Primal
Therapy "Intensives".[10] It was chiefly the supervisory staff
who undertook the time and expense of such therapy outside the
unit's auspices. (Free groups were conducted by the Psychol-
ogical consultants to the unit.) Thus, Gestalt, Primal and
Bio-Energetic "ideologies" were transmitted by these influential
people through verbal description, informal behavioral expect-
ations on staff members, or through role-modelling by other
staff and residents.

d. Social Organization - At the beginning of the
study period, staff at the centre included the Director (who
was also the unit Psychiatrist), a Psychologist (concerned with
training, evaluation of the program and, to a degree, staff
evaluation), three Social Workers (one for each of the three
units), a Chief Child Care Counsellor who was responsible for
staff performance, and an Administrative Assistant whose job it
was to co-ordinate unit policy and provide liason with Provincial
Government officials.

Cottage supervisory structure included a Cottage
Head (or supervisor), three Shift Heads, one of which was
responsible for each eight and one-half hour shift (two daily),
and a single night staff who covered 11:30 p.m. until 8:30 a.m.

Of the twelve to fifteen regular staff members
attached to each residential cottage, three or four staff
covered each shift. The day and evening shifts overlapped from

3:00 p.m. until 5:00 p.m., when a one-half hour shift change
meeting took place, to discuss the events of the prior shift
in preparation for the coming shift. This was also the period
of the daily "Community Meeting" of all the residents and staff
of the two shifts.

Some exceedingly important structural changes took
place during the period of the study. In June of 1971, the
Director-Psychiatrist of the unit departed, and over a period
of six months, the administrative structure changed dramatically.

The Chief Child Care Counsellor of the unit became
Acting Director for the remaining one and one-half years; the
Cottage Head position was removed from the cottages, and the
three Shift Heads became a committee in charge of cottage admin-
istration and policy. The three Cottage Heads became adminis-
trative personnel serving specified areas of supervision which
included: Training, Residential Cottages, and Day Clinic. In
the absence of a formal Director, this administrative group
generated policy through weekly administrative meetings with no
preponderant authority vested in any single individual. The
Acting Director provided liason with the Provincial Government
and cottage Shift Head representatives were included in these
meetings, to voice cottage interests. This entire evolution
towards a decentralized, committee-type decision-making structure
was an important extension of the "Therapeutic Community"
principle proposed by Maxwell Jones.(1968)

Diagram III

- 11a -
Administrative Structure

August 1969 - June 1971

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                    ┌─────────────────────────┐
                    │  Director - Psychiatrist │
                    └─────────────────────────┘
                  ┌──────────────────────────────┐
                  │  Chief Child Care Counsellor  │
                  └──────────────────────────────┘
┌──────────────┐ ┌──────────────┐ ┌──────────────────┐        ┌─────────────┐
│ Cottage Head │ │ Cottage Hd.  │ │ Day Clinic Spvsr.│        │ Consultants │
│   Cott. I    │ │   Cott. II   │ │                  │        └─────────────┘
└──────────────┘ └──────────────┘ └──────────────────┘        2 - Psychologists
                                                               1 - Teacher
                                                               3 - Social Workers
┌──────────────────┐ ┌──────────────────┐ ┌──────────────┐
│3 Cott. I. Shift  │ │3 Cott. II Sft.   │ │2 Day Clinic  │
│     Heads        │ │      Hds.        │ │  Sft. Hds.   │
└──────────────────┘ └──────────────────┘ └──────────────┘

┌──────────────────┐ ┌──────────────────┐ ┌──────────────┐
│ Cott. I Child    │ │ Cott. II Child   │ │ Day Clinic   │
│ Care Staff (8-10)│ │ Care Staff (8-10)│ │ Staff (4)    │
└──────────────────┘ └──────────────────┘ └──────────────┘
```

June 1971 - October 1972

```
                    ┌──────────────────┐
                    │  Acting Director  │
                    └──────────────────┘
                                                      ┌─────────────┐
                     ┌────────────────────────────┐   │ Consultants │
                     │  Administrative Assistant   │   └─────────────┘
                     └────────────────────────────┘   1 - Psychiatrist
                                                       1 - Psychologist
                                                       1 - Teacher
                                                       3 - Social Wrkrs.

┌──────────────────────────────┐ ┌────────────────┐ ┌───────────────────┐ ┌─────────────────┐
│ Chief Child Care Counsellor  │ │Training Spvsr. │ │ Day Clinic Spvsr. │ │ Cottages Spvsr. │
└──────────────────────────────┘ └────────────────┘ └───────────────────┘ └─────────────────┘
                     ┌──────────────────┐
                     │  Program Spvsr.   │
                     └──────────────────┘
┌─────────────────────┐ ┌─────────────────────┐ ┌──────────────────────┐
│ Shift Heads Cottage I│ │Shift Heads Cottage II│ │Shift Heads Day Clinic│
│        (3)          │ │        (3)          │ │        (2)           │
└─────────────────────┘ └─────────────────────┘ └──────────────────────┘

┌──────────────────────────┐ ┌─────────────────────────┐ ┌──────────────────┐
│ Child Care Staff Cott. I.│ │ Child Care Staff Cott.II.│ │ Child Care Staff │
│                          │ │                         │ │   Day Clinic     │
└──────────────────────────┘ └─────────────────────────┘ └──────────────────┘
```

4. Patient Organization.

      a. <u>Selection Criteria</u> - A high degree of control over admissions was maintained during the period of study, and residents were not automatically accepted in waiting-list fashion, but rather were chosen on the basis of:

      (i) the degree of perceived desperation of the situation as viewed by the potential resident. . .

      (ii) the degree of desperation as perceived by the referring agency or person. . .

      (iii) alternatives available to the potential resident. . .

      (iv) how the adolescent and the nature of his or her problem would likely affect the existing group dynamics in the cottage, and

      (v) how well suited the adolescent and his behavioral problem was to an "open door", community-oriented treatment milieu.

These admission criteria allowed the unit to accept a specific (but relatively low) number of delinquent, pre-psychotic, run-away or drug-abusing children at any one time.

An attempt was also made to keep the average age of the adolescents-in-care relatively consistent, so that the cottage community was not predominantly older or younger people; it fluctuated around the fourteen to fifteen year old age range.

Admission interviews usually included the prospective resident, his parent or Social Worker, a cottage staff member,

a unit Social Worker, and the unit Psychiatrist.

b. <u>Orientation</u> - There was no formal orientation program for newly admitted residents. They were usually ushered into cottage life as it existed and were told only the most fundamental cottage rules. From that point on, they were to learn by viewing cottage life or by asking questions.

c. <u>Resident Organization and Rules</u> - No formalized resident organization existed. . .no formalized roles were assigned. However, in the instance of rules for cottage residents, the following did apply:

(i) <u>For the first month</u>, the resident was allowed no "free time" away from the cottage; he or she was allowed no telephone calls in or out of the cottage except where permission was given by the cottage community; and he or she was allowed no contact with friend or family except at the unit, and with permission of the cottage community.

(ii) No drugs or alcohol were allowed on the premises of the cottage, nor was the resident allowed (without specific sanctions), to return to the cottage after "free time", under the influence of alcohol or non-prescription drugs.

(iii) No sexual activity was to take place between residents in the cottage.

(iv) The resident was expected to complete his clean-up duties on the basis of a resident-devised

roster system, and to keep his room in an adequate
state of cleanliness and order, so as not to disturb
the other residents and staff.

(v) The resident was expected to rise by nine o'clock
in the morning and be present for breakfast, unless
the community should allow otherwise in unusual circum-
stances.

(vi) The resident was expected to involve himself or
herself in a community program of either a therapeutic,
educational or recreational nature, and to show that he
or she is involved in "helping themselves and the other
residents", where appropriate.

(vii) The resident was expected to enter family therapy
at the unit if it was possible, and his or her subse-
quent home visits were contingent upon progress made
by the whole family on these sessions.

Should a resident not comply with these rules, he was
expected to explain why, in the presence of the community.
Depending on the individual and his problem, and on some com-
munity-arranged agreement, he or she was allowed a certain number
of times to fail in these rules and, on each occasion, the
individual and his reasons were confronted in "community meetings".
The ultimate sanction was expulsion from the community. There
were no lock-up rooms on the unit premises.

Since Easton was an "open unit", perhaps the basic rule
was that the resident not run away. Understandably, many resi-

dents did run away for periods of time, for in many cases,
this was the basic behavioral problem of the adolescent. This
like all the other rules, was dealt with in community meetings,
but the leniency with which this problem could be addressed,
was to a large degree, much less than all the other rules with
the exception of alcohol and drugs.

    5.   Time of the Study.

        The period of time for which this study applies, is
from April 1971 till September 1972. . . an eighteen month
period beginning twenty months after the unit formally opened.

        Some important historical events applying to the time
of the study, include the establishment of a "Wilderness Camp"
for the initial group of male residents who were severely
delinquent in their behavior, and who proved to be unmanageable
for the inexperienced staff of this open-door institution. At
that point in the unit's history, it was possible to allow
greater resident responsibility in unit decision-making and
programming. The so-called "Democratic-Egalitarian" aspects of
the unit's initial design intentions, came to the fore in the
period under study, since the extreme control problems resulting
from dealing with a unified delinquent population, were removed
when the boys went to the Wilderness Camp.

C. Program

    1. Patient Therapeutic Program.

        The primary therapeutic agents in the unit were seen

to be the following:

(a) Residential living itself, with its duties, decision-making responsibilities, conflict resolution, problem sharing, mutual interdependence and learning to deal with both adults and peers.

(b) Community meetings, with their emphasis on interpersonal communication, problem-solving, group process, and social interaction.

(c) Daily therapy groups which were either Gestalt, Encounter, or Bio-Energetic in their orientation, making use of the specific techniques of Role Playing, Psychodrama, Audio-Visual Playback, Awareness, Dance, Sensitivity Training or Yoga.

(d) Immediate gratification of Arts and Crafts, progressing to more difficult programs, served as occupational therapy.

(e) Education of a "Free-School" variety where residents were "attracted" to learn by a non-compulsory, individualized educational program, which relied heavily on audio, visual, and manual learning devices.

(f) Family Therapy in the unit conducted by the cottage Social Worker and a Child Care Counsellor of the resident's choosing.

(g) Staff-resident one-to-one consultations, resulting from developed relationships between a staff member and a resident.

2. Daily Routine.

During the five weekdays, the residents were awakened by one of their members (chosen by roster), and came to breakfast between 9:00 a.m. and 9:15 a.m. Breakfast ended between 9:30 a.m. and 9:45 a.m. and the residents had fifteen minutes to make their beds, straighten their rooms, make themselves presentable and arrive for either group therapy, Arts and Crafts, or be at school by roughly 10:00 a.m.

Groups, school or Arts and Crafts, lasted until the hour of 11:30 a.m. and then the residents could do what they wished until Noon and the lunch hour. In the afternoon, various combinations of the above programs were made available until 2:30 p.m. when a snack was prepared in the cottage, before the "community meeting" at 3:30 p.m.

From 3:30 p.m. till 4:45 p.m., the community meeting took place and cottage decisions were made, personal problems were discussed, and interpersonal conflicts were addressed.

After the evening meal, the time was free for general relaxation, one-to-one discussions, television, games or sometimes a drive into the city. The pool and gym were available and small groups used these facilities at their discretion.

On one evening a week, the entire cottage had the option of going to a movie as a group. Special plays and community entertainments were made available to the residents from time to time. On occasion, a Y.M.C.A. youth group would come for the evening to play volleyball or swim, or come to the cottage for

guitar, cake and coffee.

The weekends were flexible and the residents were allowed to sleep in late; often, the entire group would go to the beach or go skiing, or to a park, or else the cottage residents and staff would split into smaller groups and go their separate ways for activities.

On Sunday night, a special meal was prepared by staff and residents and, often by candlelight, it was enjoyed in as much of a family atmosphere as could be generated.

3. Additional Therapeutic Services.

Complementing the resident therapeutic program des-cribed above, were the following services:

a. Parent's Group - This weekly group was made available to the parents of the adolescents in residence. They were conducted exclusively for those parents who wished to discuss family interpersonal problems with other parents and the counsellors who were dealing with their children. Parents had the opportunity to share their feelings of confusion and despair surrounding family problems, and to take part in group psychotherapeutic exercises. "Couples Therapy" was often con-ducted in these groups.

b. Alumni Groups - This weekly group was held for those residents who had been discharged and who desired help with problems of coping with their lives in the larger society. Adolescents in residence who were nearing discharge were encouraged to attend these groups in order that they might

discuss the difficulties encountered by their peers who had
left the unit.

      c. <u>Wilderness Camp</u> - This facet of the program became
an integral part of unit functioning during the period of this
study, and residents who could not adapt to the "open door"
urban Easton facilities, were moved to the Camp, where the
restraints on their behavior were not from the authority of
adults but rather from the authority of nature. This Camp was
situated in a Provincial park, approximately twenty-five miles
from the city. It, too, was open-door, and there were regular
trips into a small local community, but generally ten miles of
wilderness separated the residents from civilization. Residents
who for a multitude of reasons, were not benefiting from cottage
life, were given the option of the camp, and many adolescents
exhibiting a wide range of behavioral problems benefited tremen-
dously from this program. The staff who manned the Wilderness
Camp were subject to Easton's orientation and In-Service training
programs.

      In conclusion, it must be stated that the unit (at the
time of study) was totally opposed to locking-up the adolescents
in its care, and depended completely on internal restraints and
group pressure to keep the adolescents in residence. Further,
at the beginning of the study, the unit was strongly opposed to
using psycho-pharmacological methods for influencing resident
behavior. By the end of the study, medication was being used
to a greater extent, but generally it can be said that psycho-
pharmacology was not a primary therapeutic device.

FOOTNOTES - CHAPTER I

1. The Director's "personal orientation" was based on a series
    of postulates: first, that a Counsellor's ability to
    deal therapeutically with an adolescent was directly
    related to his own personal development through psycho-
    therapy; second, that in a treatment centre, the
    cultural milieu is determined by the nature of staff
    interaction, staff personal development, and the level
    of staff interpersonal communication and personal self-
    disclosure; third, that personal freedom within a
    therapeutic community is the key to learning, exper-
    iencing and personality development. More specific
    aspects of his orientation will be addressed where the
    need arises.

2. Unit Psychologist's Report. "A Brief Report on the
    Residential Treatment Unit for Emotionally Disturbed
    Adolescents", 1972. Unpublished.

3. "Openness" within the context of the unit jargon, is
    defined as the capacity to give and receive emotional
    messages; the readiness to share one's immediate
    emotional responses in a given situation; the ability
    to reveal one's emotional difficulties and to share
    personal histories. "Warmth" implies the ability to
    share positive affectionate emotions with people, and
    to reveal empathy combined with the ability to express
    both physically and verbally, those positive emotions
    one has toward other people. These terms are part of
    current, popular, psychotherapeutic jargon, and formal
    definitions do not exist.

4. In the writing of Frederick S. Perls, "emotional growth"
    or development, is synonymous with maturation. For
    Perls, ". . . maturing is the transcendence from
    environmental support to self-support".(Perls, 1969:28)
    Manipulating the social environment by playing roles,
    is the "characteristic of our remaining immature",
    so for Perls, growth or maturity is represented in
    shedding our roles and putting our energy into creative
    personal development.(Perls, 1969:35)

5. J.J. Mate. ". . . The Evolution of a Therapeutic Community:
    A Case Study." Master of Arts Thesis, Department of
    Political Science, Sociology, and Anthropology, Simon
    Fraser University, March 1972, pp. 11-12. See also
    Unit Psychologist's Report, "A Brief Report . . ."
    where the same theme is pursued.

FOOTNOTES (Cont'd.)

6.   In this period of the late nineteen sixties, "hip"
       generally applied to long-haired, jean-clad,
       politically radical, anti-authoritarian youth.
       "Straight" applied to short-haired, task-oriented,
       morally and politically conventional professionally-
       conscious people. "Liberal" generally applied to
       the various shades of cultural and political orien-
       tations between these two extremes. All three are
       stereotypes and are not particularly useful terms.
       (Mate, op. cit., p. 4)

7.   Mate, op. cit., p. 5. It appears from the interviews
       and from Government recruitment policies for the
       unit, that the Province had a severe shortage of
       experienced Child Care Workers at the time. The
       unit had been intended to eventually serve as a
       Province-wide training facility.

8.   See Footnote 4.

9.   Quote from Staff Interviewee #5: "I was supportive of
       Child Care Counsellors and insistent that they have
       time for their own growth and that they take it
       seriously. It was agreed at the first interview
       that this was a growth opportunity and the demand
       was there. If somebody wasn't moving or getting on
       with self-growth, there were two alternatives:
       I would call them in and recall the commitment of
       the first interview and should they not respond,
       then the possibility of leaving was brought up.
       There were Gestalt groups provided free, or else
       they could go on their own time at their own expense
       to groups outside the unit."

10.   Out of a total staff of approximately forty persons,
       thirteen (32%) were involved in Gestalt or Primal
       groups outside the unit. Of these, one-half held
       supervisory, administrative or consultative positions.
       These people held nearly three-fourths of the exist-
       ing supervisory, administrative and consultative
       positions during the first half of the period under
       analysis.

CHAPTER II.   GESTALT THERAPY WITH EMOTIONALLY DISTURBED
               ADOLESCENTS IN A THERAPEUTIC COMMUNITY.

A. Statement of the Problem

        Given this descriptive account of the physical,

social and programmatic orientation of Easton, it is now neces-

sary to state observeable problems which relate to the applica-

tion of Gestalt Therapy to Easton's treatment population,

physical environment, and institutional system of behavioral

expectations for staff and patients alike.

        The fundamental question which this study attempts

to answer can be stated thus: Was the design and intent of

Gestalt Therapy applicable to the design and intent of the

Easton treatment facility?

        As we will see in the survey of Perls' Gestalt Therapy

literature, his brand of therapy was applied largely in the

treatment of university-educated adults who were (for a variety

of reasons), finding life in North America's advanced industrial

society, both vacant and frustrating. Gestalt Therapy provided

a radical philosophical and psychotherapeutic prescription for

problems related to this type of alienation, and used a specific

physical, social and therapeutic environment as a remedy.[1]

        At Easton (as we have seen), we are dealing with an

institutionalized treatment population, institutional physical

environment, social structure and therapeutic ethos.

Easton's treatment facility operated (during the period under analysis) on a very high resident per diem rate, and represented the only Mental Health In-Patient facility designed specifically for adolescents in the Province. It was thus under considerable pressure from the various referral sources (Social Welfare, Correctional, Mental Health and Private Psychiatric), to take only the most seriously disturbed adolescents into care.

Since, in fact, we are dealing essentially with a high-cost, high-priority, Provincial Government Mental Health institution, the question must be asked:

1. Was the design and intent of Gestalt Therapy applicable to the types of psychiatric and behavioral disorders treated at the Easton facility?

Since the in-treatment population of Easton is age-specific (early adolescence), it is necessary to explore the specific cognitive, social and ego-identity characteristics of early adolescence as it applies to the therapeutic-performance demands of Gestalt Therapy in these three areas.[2]

Further, since studies on the social epidemiology of mental disorder suggest that patients-in-treatment are disproportionately representative of lower socio-economic status groups, then it is necessary to explore the socio-economic status of Easton's treatment population as it relates to the socio-economic status of Perls' treatment population.

It is also necessary to explore the general level of educational or verbal skill achievement manifest in Easton residents, as it relates to the level of educational achievement or verbal skill demanded in Gestalt Therapy. To state the problem, we must ask:

2. Was the design and intent of Gestalt Therapy applicable to:

(a)   the age group of patients treated at Easton?

(b)   the socio-economic status of patients treated at Easton?

(c)   the education level or verbal skills of patients treated at Easton?

"Setting" was a primary concern to Perls' Gestalt orientation, as was the expected therapeutic effect of the social-structural milieu in which the therapy took place.

The obliteration of "staff roles" and "patient roles" was (formally at least) a goal for Perls, and the training of his therapists entailed re-education into a highly individualized, intuitive and creative, personally-responsible framework for identity development, behavior and role-modelling. Its theory and practice was applied in an intensive, short term therapeutic contact for both adult patients and staff.

Easton represented an institutional physical milieu, with institutional demands on staff and staff-patient roles, in a long-term therapeutic contact for adolescent patients and adult staff.

Under these circumstances the question must be asked:

3. Was the design and intent of Gestalt Therapy applicable to:

(a) the physical characteristics of the Easton facility?

(b) the social-structural characteristics of the Easton facility, which has two major areas of concern?

Staff Roles

(i) Was the theory, therapy and ideology of Gestalt Therapy applicable as a training tool for the assumption of staff roles at Easton?

(ii) Were the role demands of a Gestalt Therapist consistent with the role demands of a staff member at the Easton facility?

Patient Roles

(i) Were Gestalt therapeutic behavioral demands applicable in the context of Easton's institutional demands?

(ii) Were Gestalt therapeutic behavioral demands applicable in the context of the behavioral demands of extended-term, therapeutic-community living?

B. Methodology

The data for this study was drawn primarily from six sources:

(a) Participant Observation as an Easton Child Care Counsellor for two and one-half years, of which time the final eighteen months constitute the subject period of this study.

(b) Personal journal data from the eighteen months of Participant Observation.

(c) Content analysis of the relevant documents made available by Easton for this study, including statistic sheets from a sample of resident files.

(d) Data drawn from an audio-taped interview sample of twenty-five staff members.

(e) Clinical data on residential treatment facilities for adolescents, as well as psychiatric literature on adolescent treatment.

(f) Source Material:--

(i) the writings of Frederick S. Perls on Gestalt Therapy;

(ii) relevant literature on the Social Psychology of adolescence;

(iii) relevant literature on the goals and methods appropriate to the "Therapeutic Community" treatment approach.

1. Participant Observation

In accordance with the criteria of the Symbolic Interactionist approach to Participant Observation (as manifest in the work of Erving Goffman, Howard S. Becker, Norman Denzin and Raymond Gold), this data was gathered from the observational role of a "Complete Participant".(Gold, 1970:370)

> Participant Observation represents the avowed commitment on the part of the investigator to participate as intimately as possible in the experiences of those he studies. . .
> The observer must, to the extent of his abilities, learn to view the world of his subjects from their perspective.
> (Denzin, 1970:365)

Because of the extent of involvement as an employee and the "total immersion" in the unit's functioning, there was no problem of "mastering a hitherto strange. . . universe of discourse". Likewise, there was no problem of having to develop "artificial" relationships or of having to mediate the contradictory demands of self expression and self integrity. Because of the observer's total involvement (as an Easton employee), there was no problem of "role pretence" to contend with, or other problems which often inhibit the effectiveness of the Participant Observer as an interactor.(Gold, 1970:371)

Systematic observation of the type employed by Polsky and Claster (1968) was not possible in this instance, because (a) the unit had no mandate to conduct its own research during the period under analysis; (b) unit therapeutic ideology maintained the primacy of therapeutic service over any empirical

research or outside intervention; (c) it would interrupt any intensive psychotherapeutic effort as well as, (d) impinge upon the resident's right to privacy and confidentiality.

Given the powerful influence of in-group identification (i.e., "this is our home") and the careful development of a "ward culture", it was only through long-term and devoted involvement that one could enter and be accepted in the unit and thereby capture the experience that many residents and staff found so enriching.

2. Personal Journal

This 295 page document was kept in unsystematic fashion with entries being made on a weekly or bi-weekly basis.

The journal was analyzed for material directly related to the eight facets of unit functioning under analysis here. All directly relevant information from the journal is included, whether or not it supports the hypothesis of this study.

3. Analysis of Relevant Documents

Easton made the following documents available for analysis:

(a) Unit Psychologist Report - "A Brief Report on the Residential Treatment Unit for Emotionally Disturbed Adolescents", 1972. Unpublished.

(b) Shift Head Report - "Cottage II General Program Capsule", 1971. Unpublished.

(c) "Training Program Committee Meeting", March 29, 1972.

(d)   Unit Psychologist Report - "Education as a Part of a Residential Treatment Centre for Emotionally Disturbed Adolescents", 1972. Unpublished.

(e)   Descriptive Pamphlets available to the public and agencies.

(f)   Cottage II Monthly Staff Schedules, April 1971 - Sept. 1972.

(g)   Cottage II Monthly Reports, April 1971 - Sept. 1972.

The two Unit Psychologist Reports and the Program Capsule are among the most important descriptive documents produced by the unit during the period under analysis. These specific reports were circulated to staff and revised before they were approved.

The remaining documents provide basic information on unit programming and staff population.

4.   Interview Sample

The interview program was conducted in "non-scheduled, standardized" fashion as described by Benny and Hughes.(1970:186) The list of questions was fixed, but there was a degree of flexibility in the delivery of the questions designed to meet the needs of the individual respondents.[3] The interviews were audio-taped and conducted at a time and place chosen by the respondent. Audio-taping of the interview facilitated the pursuit of specific areas of interest for the respondents, and

also provided a chance to explore contradictions in answers to various questions.[4]

This interview program was conducted in accordance with the "Naturalistic" approach to research and information gathering (Schatzman and Straus, 1973), where the interview is considered to be a variation of everyday social interaction.

The Sample - Since the basic premise of this study was likely to be antithetical to the official view of the administrative group, the interview sample was "weighted" in favour of the official pro-Gestalt view. The interview sample was therefore weighted against the substantiation of this paper's premise.

Of the twenty-seven interviews conducted, approximately 48% were administrative or supervisory personnel interviewed at the time of their work at Easton. In actual fact, their numbers constituted less than 30% of the total staff population.

Out of the twenty-seven interviews, an initial test sample of four were taken in order to judge the clarity of the questions. After the first two interviews of the test sample, the questions were not significantly revised, so calculations will be made on the basis of an interview sample of twenty-five. All percentages will be rounded off to the nearest full percentage place.

Out of a total of forty full time staff members (encountered directly during the period of the study), twenty

(or 50%) were interviewed. The remaining five staff interviewees were people who had arrived after the period of study had ended, or had not been directly encountered during the study.

Since the study was longitudinal and there was a gap in time between the end of the Participant Observation and the beginning of the interviews, changes in policy had to be taken into account. The questionnaire attempted to take this fact into account. Approximately 20% of the sample were new staff to the unit, (and at the time of interview had been there less than six months) which gave the opportunity of viewing what had been retained over a period of time in unit ideology and clinical practice.

An important factor influencing attitude toward the unit, was whether or not the interviewees were currently employed or whether they had terminated employment. Sixty-eight percent of the sample were employed at the unit at the time of the interview. The preponderance of currently employed interviewees again gave the official view of the unit a "good hearing". Generally, it was observed that the terminated employees were more critical of unit ideology than those currently employed.

Of the staff interviewed, 32% had been hired in the first six months of unit development and operation, therefore a sense of unit tradition and historical continuity was represented in the sample.

Forty percent of the sample respondents were female and sixty percent were male - a relationship roughly appropriate

to the sexual proportions in the unit. Easton tried to maintain a 50-50 male/female staff ratio but most frequently, the scales tipped in favour of males.

In terms of length of stay at the unit, the interview sample breaks down as follows:

8% - less than six months

4% - greater than six months, less than twelve months

12% - greater than twelve months, less than eighteen months

8% - greater than eighteen months, less than twenty-four months

68% - twenty-four months or more.

On the basis of these figures it is felt that the sample is representative of the many stages of inclusion, experience and authority in the unit, and that significant attitude differences related to length of stay, degree of authority, current or past employment at the unit, and prior experience, are all taken into account.(For content of the Questionnaire, see Appendix "A".)

5. Adolescent Population Sample

In the Provincial Government Mental Health institution reports for the year 1971 and for 1972 (which include descriptions of the Easton facility), the total number of residents treated ranged from thirty-five to forty-five (35-45) in 1971 and to fifty-one (51) in 1972. The resident sample of thirty-

nine (39) is therefore numerically typical for the average
in-patient population during the period of the study.

The sample of residents-in-treatment included
adolescents from the two residential cottages and those
adolescents who had (for therapeutic reasons) been moved from
the Day Care program into residential care.

Thirty-four of the sample thirty-nine residents
represent approximately 80% of the total patient flow through
a single residential cottage, during the eighteen month period
of the study. Since there was no significant difference in
the intake criteria of the two residences, this represents a
significant "random" sample of residents for the unit as a
whole. The remaining 20% of patient flow was excluded from
the sample, because they either were discharged immediately
after the study began, or came into the cottage immediately
prior to the study's termination. One of the criteria of
selection in the sample was that the observer have direct
therapeutic contact with the resident, in order that well
documented Participant Observation material apply to each of
the sample residents.

The remaining five sample residents were adolescents
directly treated during a one month period in the second resi-
dential cottage.

In terms of sexual balance, 38% of the resident
sample was female and 62% were male, but during the period of
the study, the male/female ratio fluctuated near one percent

but usually favoured the male residents.

The resident sample does not comply with rigid sampling techniques but does provide a representative sample of the Easton treatment population.

6. Gestalt Source Material

This material came from the writings of Frederick S. Perls who proved to be the primary theoretical and clinical influence in the unit. This is empirically verified in the Staff Interview sample.(88% of staff respondents maintained that Perls' Gestalt Therapy was a primary theoretical and practical influence.)

Although staff were encouraged to read the major writings of Perls, in fact, the major facilitators for the dissemination of his ideas were:

(a) Senior staff undergoing direct therapy with Perls and his immediate disciples.

(b) A unit Psychological consultant who trained with Perls, was primarily responsible for one-third of daytime training during the period under analysis.

(c) Outside consultants who were responsible for In-Service training sessions, displayed Gestalt orientations.

(d) The Director's organizational, therapeutic, and ideological input which was powerfully influenced by Perls, personally.

As will become clear in the detailed delineation of

Gestalt Therapy and ideology, the major emphasis is on learning
by "experiencing" (as opposed to studying and analyzing). Thus
the training sessions at Easton consisted largely of Gestalt,
Sensitivity, Awareness and Encounter sessions, which used
techniques directly drawn from the pages of the principal writ-
ten works of Perls. However, since the major medium for the
dissemination of his methods was through "experiencing" those
techniques in staff group, theoretical distinctions or internal
contradictions in Gestalt itself, or problems in the application
of its methods to Easton's specific population, were seldom
considered and more often ignored.

     As will be seen, this therapy has the tendency to be
highly abstract and philosophical. Hence, the theoretical and
practical implications of its proper application deserve special
attention. The result of this purely "experiential" education
in In-Service training, using a therapy that is abstract and
essentially anti-intellectual, led to a very confusing blend of
therapeutic slogan (see Appendix "B"), ideology, and clinical
technique. The consequence of this process is a primary
consideration of this paper.

FOOTNOTES - CHAPTER II

1. As will be seen in the analysis of the source material,
   this therapy carries with it an implicit lifestyle.
   This lifestyle has a system of attitudes towards
   political activity, the nature of so-called "healthy"
   human interaction, and a theory relating to current
   human historical problems. It has a philosophy of
   history and a ready-set system of social behavioral
   expectations. It has a pattern of moral beliefs
   about man and society. Gestalt Therapy fits Edward
   Shils' definition of ideology as ". . . one variant
   form of those comprehensive patterns of cognitive
   and moral beliefs about man, society, and the
   universe. . .which flourish in human societies."
   (Shils, 1968:66) The term "ideology" is also used
   in this study since it is primarily interested in
   the application of this "pattern of cognitive and
   moral beliefs" to a specific physical and social
   setting.

2. Ego-Identity is the term used to refer to the "successful
   outcome of a stage of ego development hypothesized to
   occur during adolescence".(Marcia, 1973) ". . . the
   process of identity formation emerges as an evolving
   configuration - a configuration which is gradually
   established by successive ego syntheses and resyntheses
   throughout childhood; it is a configuration gradually
   integrating constitutional givens, idiosyncratic
   libidinal needs, favoured capacities, significant
   identifications, effective defences, successful sub-
   limations, and consistent roles".(Erikson, 1956:71)

3. Since few respondents share the same perspective, a few
   words, terms or concepts, elicit the same range of
   responses. Hence, where a question's wording elicits
   little or no response, there is the freedom to
   rephrase it, in the interests of clarity and gaining
   material from various respondents.(Denzin, 1970:186)

4. In keeping with Howard S. Becker's contention (1970:199)
   that the interviewer must actively enter the interview
   encounter and experiment with the respondent as the
   interview progresses, I have allowed myself the same
   luxury of pursuing key areas which seem important to
   the interviewee. Contradictions or aberrations in
   the continuity of the responses were probed. This
   method of the active pursuit of information combined
   with respondent "freedom of expression", has proven
   itself much more satisfying for respondents and,
   therefore, much more rich in information.(Schatzman
   and Straus, 1973)

CHAPTER III.   DESIGN AND INTENT OF PERLS' GESTALT THERAPY.

Frederick S. Perls and Gestalt Therapy: Source Material

In clearly delineating the design and intent of
Gestalt Therapy, our primary sources are understandably the
works of Frederick S. Perls. However, since Perls is represen-
tative of a whole wave of existential psychotherapeutic theory,
therapy and ideology, the views of his immediate circle of
colleagues and supporters are also useful. Hence, the section
of this chapter which deals with "situating" Perls in the
movement of existential psychology, uses some important secon-
dary sources.

For the purpose of our study, it is necessary to seek
in the work of Perls, clear statements of:

(a) Perls' target population relative to types of
mental/emotional disorder;

(b) Perls' target population relative to age, socio-
economic status and intelligence as manifest in educational
level and verbal performance;

(c) Perls' concept of therapeutic setting as it
relates to physical environment, social-structural character-
istics (particularly staff and "patient" roles), in generating
a "therapeutic milieu". Keeping these points in mind, we will
move on to Perls' place in modern psychology and psychotherapy.

Overview

Frederick Perls and Gestalt Therapy have been prominent features in the wave of existential psychology and psychotherapy that swelled in North America during the late 1950's and early 1960's. The book, Gestalt Therapy (1951) gave impetus to the theory and practice associated with the move to "Humanistic Psychology" and what came to be known as the "Human Potential Movement".

This movement within psychology attempted to integrate the clinical procedural innovations of Freudians such as Ferenczi, Rank, Jung, Adler, and Reich, with newer philosophical perspectives represented in the existential and phenomenological work of Kierkegaard, Heidegger, Husserl and Nietzsche. The most fundamental themes in existential psychology include the goal of bringing physical action into rhythm with the introspective psychoanalytic methods; the focus on total characterological manifestations of distress in muscular, behavioural and psychological traits; and focus on the broadening of professional psychotherapeutic practice beyond the limits of the psychoanalytic and psychiatric fraternities.(Polster, 1968:5-7)

Polster speaks of existential psychology as addressing the ". . . social need for new religious experience. . .which requires emphasis on the 'human need' for self experience, coherence, unity and direction in life."

In speaking of Gestalt Therapy in general, it must be said that there is a mystical element in it which supposedly

defies the analysis, evaluation or operationalization of its
tenets: ". . . only the experience of Gestalt Therapy could
provide you with a means for saying what it is."(Pursglove,
1968:vii)

Other tenets of Gestalt Therapy include the freedom
of the therapist to experiment, formulate and develop his own
personal therapeutic style and repertoire of procedures.[1]
Psychotherapy becomes an art which invites virtually any
creative, intuitive, or innovative technique which the thera-
pist might feel is appropriate to the situation.(Polster, 1968)
However, the basic or primary therapeutic devices fall into
three categories: (1) Encounter (2) Awareness and,
(3) Experimentation. (Polster, 1968:13-18)

Perls' version of Gestalt theory and therapy was
highly sophisticated and yet his "Americanized" version of
Gestalt, cleared away much of the turgid, mystifying language
that was the legacy of the European academic Gestaltists. In
keeping with the American version of existential psychology,
Perls displays a theoretical stance which integrates the frame-
work of William James, John Dewey and Alfred North Whitehead.
His focus on total organismic functioning, his stress on the
interplay of organism and environment in an interactional field,
his understanding of the devastating conceptual (and psycholo-
gical) implications of the mind/body split in Western philosophic
history, and his grasp of the central importance of the socio-
cultural dimension of the human environment . . . all represent

important departures from Freud's mentalism, mechanism and reductionism.(Becker, 1970:5)

A. The Theory

Perls' goal was to devise a theory and method that would extend the applicability of psychotherapy to both normal and abnormal psychology.(Perls et al., 1951:vii) The theory was to encompass Freudian and post-Freudian psychology, including Reichian "armour theory", semantics (the meaning of meaning), and philosophical "Holism", and to incorporate it all into a new "Gestalt" . . . a comprehensive theory of man in his natural and social environment.(Perls, 1969a:7)

Gestalt Therapy was meant to shift psychiatry's emphasis away from the "adoration of the unconscious" toward the problems of the phenomenology of awareness. This phenomenology of awareness is characterized by four interdependent categories of experience: contact, sensing, excitement, and Gestalt formation. Gestalt formation accompanies awareness, and the formation of complete Gestalten is the condition of mental health and growth.

The completed Gestalt represents the organization of an automatically functioning, flexible reflex unit, encompassing the total organism. Within this context, neurosis is defined as the condition wherein incomplete Gestalten limits the area of contact, sensation and excitement for the organism, and the "unfinished situations" prevent the formation of new experiential configurations or "wholes". In neurosis, organismic elasticity

needed in the completion of environmental contacts and inter-
action, is replaced by rigidity, repression, and the loss of
awareness in the form of contact, sensation and excitation.
(Perls et al., 1951:vii-ix)

Gestalt theory breaks with all structural or mechanistic
views of the world, by maintaining that understanding the organism/
environment as a "totality" is the only useful format for psychol-
ogy and, therefore, psychotherapy. It further maintains that the
understanding of organismic behaviour as a purely reactive phenom-
enon is inadequate, since it takes no account of the creative,
outgoing, searching nature of organismic sensing and movement in
a world of novel situations.(Perls et al., 1951:Intro.)

For Perls, the interaction of organism and environment
is the starting point of all psychological investigation. Such
interaction takes place in a "field" and, for the human organism,
the field is predominantly socio-cultural. For the Gestaltist,
the subject matter of psychology is "the operation of the contact-
boundary in the organism/environment field".[2]

Since all contact is creative adjustment of the organism
and environment, "psychology becomes the study of human 'creative
adjustments'. Within this framework, abnormal psychology becomes
the study of the interruption, inhibition, or other accidents in
the course of creative adjustment.(1951:227-231)

1. The Self:

The "self" for Perls is the totality of the acting
human organism (aware of its contact with the world through

sensation and excitation). The self is not a static construct but rather a process of experimental mobilization for greater effectiveness as a bio-social being.

In contrast with the naive, pristine characterization of a "natural self" representing pure instinctual motivation (as seen in Janov and other neo-Reichians), Perls does not separate the "self" from social roles or social interaction. For him, there is no <u>true</u> personality which represents the "self" . . . rather it is a part of each person which is vested in (and finds expression in) each of his or her prescribed roles. "The problem is to integrate them so that all of a person's self comes together and lives life continuously."(Perls, et al., 1951: p. 172)

The self is a temporal entity - "a system of contacts at any moment" varying with the dominant organic needs and environmental stimuli. It is neither totally a system of the organism (as Reich thought) nor of interpersonal relations (as Sullivan thought), because it is the contact-boundary <u>at work</u>, synthesizing and integrating meaning. . .forming "figures and grounds". (Perls, et al., 1951:235)

This self is different from the classical "ego" of psychoanalytic theory because it encompasses total organismic striving. The integrated self assimilates social roles and expectations (hitherto known as the functions of the Super-ego), spontaneous, impulsive organismic reactions (hitherto associated with the <u>id</u>), as well as conscious, active, and reality-testing

functions usually associated with ego function.

The self is the totality of which the ego is a contact function providing awareness of the self as a totality (Perls, 1969a:138-139), but because of its contact function it is the centre of the system of "identifications and alienations" of the self.(Perls, 1951:235) The system of identifications and alienations, is the foundation of the Gestalt description of psychological order or disorder.

> If a man _identifies_ with his forming self, does not inhibit his own creative excitement and reaching toward the coming solution. . .then he is psychologically healthy. . . But on the contrary, if he _alienates_ himself and because of false identifications tries to conquer his own spontaneity, then he creates his life dull, confused and painful.   (Perls, 1951:235)

The phenomenological aspect of this theory of the self as an ongoing, developmental process, is that it demands that the individual discover, discriminate, mature, and "grow" through _his own_ motivation and understanding. He or she must not discover his world, his body or his life, through the interpretations of his analyst, nor indeed through the forcedmanipulations of any group.

Through creative identification and alienation, the goal of Gestalt Therapy was organismic self-regulation. The quest was to provide a major impetus to freedom and democracy in psychotherapy (specifically), and in human development in general. The hope was that aware, sensitive, active individuals would find the "robot life" of technological or totalitarian states intolerable.

The second most important theoretical conception in Perls' system which bears upon the questions at hand, is his conception of "time". Perls' conception of time was similar to that of James and Dewey. As Perls states in Ego, Hunger and Aggression, "everything has extension and duration" and therefore must be considered as time-space "events". The human organismic event is no exception. Understanding "things" as time-space events, enters human life and psychology insofar as tension is generated through the time-concept disparity between a wish and its fulfillment. In Perls' view, "The time centre of ourselves as conscious, human, time-space events is the present. There is no other reality than the present." This, in no way, tends to deny the importance of origins and trends in human development, but rather to state emphatically that "past and future take their bearings continuously from the present and have to be related to it".(Perls, 1969a:90-93)

The importance of this view as it relates to the classical psychoanalytic stress on genetic reconstruction, is that it undermines the idea of the utter dependability of genetic "scripts", and states that they will necessarily be a function of present emotional and social conditions.

In terms of Gestalt theory, both retrospection and anticipatory thinking represent "lack of contact with the present" and a "lack of the actual feel of ourselves". "Escape" into the past or future is often an avoidance of current anxieties and their context.

In <u>Revolution in Psychiatry</u>, Ernest Becker points to
the loss of a conception of time in the Schizophrenic, and Perls
(understanding the significance of the time factor), forged
important therapeutic techniques for contacting the "here-and-now"
reality.

In terms of "growth" and "actualization", the self is
viewed as the power that forms the Gestalt in "contact" situations.
It is the formative process, the dynamic relation of the "figure
and ground", and exists not as a fixed institution but as a
creative adjustment to intense situations.(Perls, 1951:375)

In Perls' view, the self is a potentially creative and
active, yet temporal and situational process of contact and assim-
ilation in the interest of development and growth in a social
environment. This conception attempted to overcome all fragmented
and elemental or mechanical views of human activity. It attempted
to integrate all the creative descriptive aspects of id, ego and
Super-ego concepts and to mediate all mind/body/environmental
splits. This provided the basis for Perls' innovative therapeutic
techniques.

2. <u>Self and Society</u>:

The personality is one aspect of the total self which
is artificially isolated (in orthodox psychoanalysis), for
analytical convenience. It is a dimension of organismic contact
whose "ground" or field is interpersonal relationships. Person-
ality involves a system of attitudes assumed in interpersonal
contacts, and the rationalizations as to why that attitudinal or

behavioral system is assumed.

As a "structure", it is quite understandably created
out of childhood interpersonal relations, and represents an
assimilation of social behaviour and norms facilitated through
the medium of language. Personality thus becomes a structure of
speech habits. . .a verbal replica of the self.(Perls, 1951:320-
321)

The process takes place through a sequence beginning
with the pre-verbal social relations of the organism, moving
toward the formation of a verbal personality in the organism/
environment field (early childhood), and finally to interpersonal
relations between developed personalities.(Perls, 1951:321)
When the fluid development of this process is hindered by inflex-
ible, restricted speech and behaviour patterns which tend to
narrow the field of discourse and "contact", the personality
becomes restricted, rigid and unadaptable.[3] One often sees in
(so-called) neurotics, a speech that is insensitive, monotonous,
affectless and stereotyped in content.

The other dimension of personality (i.e., the "verbal
replica of the self") is restricted, as it comes to consist of
mistaken and inappropriate concepts of oneself (i.e., introjects,
ego ideals, masks and delusions).[4] At the other end of the
spectrum, is the personality that is accurately aware of itself
and flexible enough to encompass a broad range of responses in a
social situation. In this instance, the personality functions
in every kind of interpersonal context because the language and

concept of the self is accurate enough to provide a reference
point and system of predictable responses in others. Where
social expectations delimit the range of possibilities in such
a restrictive fashion that a high state of anxiety and tension
is generated, the sensitive and aware individual must (in his
own interests), resist or remove himself. "Resistance" is the
creative, healthy function of aggression in Perls' view, and is
of tremendous socio-historical import. This is the central
conceptual concern of his work, Ego, Hunger and Aggression.

The tendency to aggressively demolish or otherwise
overcome restrictions to personal development (or self-actualiza-
tion), is an important part of organismic-biological, as well as
social activity. Repression of these activity-potentials makes
the idea of acting upon them a very severe psychological threat.
The limited intent of the activity becomes obscured, as social
expectations (and consequences) paint it in the "lurid colours
of the forbidden". Repression then becomes an aggression against
the self (Perls, 1951:334), and the outcome is loss of "feeling"
- loss of "contact".

Aggressive confrontation and angry destruction of a
block to contact with the environment, is what emotional health
is all about, in Perls' view. The cathartic release of aggres-
sive energy in the interests of environmental awareness was of
tremendous importance in overcoming the self-destructive effects
of repression. Angry interpersonal confrontation between friends,
can liberate energy that is otherwise devoted to a forced and

artificial "confluence" between them.[5]   The active liberation

of this aggression in a mutual exchange, creates the ground for

otherwise unattainable compatibility. "Aggression is the 'step

toward' the object of appetite or hostility. The passing of

the impulse into the step is initiative; accepting the impulse

as one's own and accepting the motor executing as one's own."

(Perls, 1951:342) This is the fundamental Gestalt to be made

in human emotional growth.

3. Unconscious:

Perls' view of the unconscious is similar in many ways

to that of Harry Stack Sullivan. Rather than the orthodox Freud-

ian version of the unconscious as the mysterious, deep, sometimes

inaccessible object of the therapeutic act, Perls saw it more as

a system of instances of "selective inattention" or a "blind spot"

in awareness. The function of therapy then, is to use the peri-

pheral awareness (of events, behaviours, and emotions) that do

exist . . . and through bodily awareness techniques, discover how

the person makes himself blind to them.(1951:117)

4. Defence Mechanisms:

For Perls, defences are defined as "temporary functions

that often healthily meet the emergency of excessive danger and

frustration, with the function of protecting sensitive (contact)

surface." The boundary is protected by temporarily desensitizing

or motorically paralyzing it, waiting for the emergency to pass.

(1951:261) Every defence requires a tremendous amount of energy

and takes place on two levels: the internal and the external.
(Perls, 1969a:48-49)

The defences which protect us from environmental
hazard include: sudden reactive flight, fainting, amnesia,
shock, as well as the kind of interpersonal and physical
"muscular armour" of which Reich spoke.(Reich, 1972) But the
internal (proprioceptor) type of defences bear more of a
"straight-jacket" analogy, in that they physically defend our
personality from socially inappropriate or threatening thoughts
and behaviours.[6] This type of defence is "muscular armour" and
tends to desensitize and motorically paralyze.

5. Transference:

Because of its sophisticated understanding of
"relationship", Gestalt theory and therapy do not fall into the
orthodox psychoanalytic trap of viewing transference as totally
a manifestation of Oedipal experiences and unresolved conflicts
projected by the patient onto the therapist . . . as a resistance
to psychotherapeutic "progress".(Freud, 1962:82-83)(Freud, 1953:
450-451)

In much the same vein as the "Interpersonal Theorists",
Perls felt that transference and counter-transference were
characteristic of interpersonal contacts of which the therapist/
patient contact was one variation. For Perls, transference is
part of a context and, more importantly, it is situated in an
experimental situation in the psychotherapeutic context. It is
an immediate, actual, here-and-now "contact" in which needs,

aims, feelings and anxieties might potentially be brought into awareness.

Such a view of transference removes the "interpretative" and judgmental dimensions of orthodox transference analysis, which often inhibits therapist insights into the nature of the patient's everyday interpersonal relationships.

6. Neurosis:

In the study of his case material, it becomes clear that Perls dealt primarily with patients displaying what are in the psychiatric literature termed as psychoneuroses or mild personality disorders.[7] For this reason, he does not delve into the issues surrounding the diagnosis and treatment of (so-called) Schizophrenics or people displaying thought disorders. Thus, neurosis, its definition and treatment, is what is important in the analysis of Perls' work.

Neurosis is defined by Perls as the condition of behavioral inflexibility and ensuing anxiety generated by an interruption or inhibition in the course of creative adjustment to one's environment. It is described as a process beginning in childhood, whereby we inhibit the overt muscular expression of impulses which are inappropriate in our social environment. The deliberate inhibition of expression gives way to unaware inhibition . . . suppression is transformed into repression. ". . .Since constriction of muscular action tends to constrict the senses and make them inefficient, we begin to lose our orientation. . ." and thereby we lose our contact with our environment and the flexibility to behave effectively in it.(Perls, 1951:117)

7. <u>Emotion</u>:

Emotion is defined as "the integrative awareness of a relation between the organism and the environment. (It is the 'foreground' figure of various combinations of proprioceptions and perceptions.) As such, it is a function of the field." (Perls, 1951:407-408) In this sense, emotions are a "means of cognitions" . . ."unique deliveries of the state of the organism/ environment field."

Perls stresses the fallibility of emotion - a point often overlooked in other neo-Reichian theories. This has important consequences for the often religious character which Gestalt and neo-Reichian groups take on, when emotional or intuitive insight is taken to be inherently truthful.

B. <u>The Gestalt View of Man and the Place of Gestalt Therapy</u>

The Gestalt perspective of Frederick S. Perls, views man's basic dilemma as one of being "dispossessed of his own centre. . .fragmented within himself by the mechanisms of defence, cut off from his best interests and best functioning, from a full and expansive relationship to the world."(Becker, 1970:1)

Because of the child's fundamentally helpless condition, he is subject to the anxieties of the significant adults in his life, (for instance, sexual anxieties) and is usually blocked from pursuing pleasure, spontaneity, and assimilation of experience in a fashion which is appropriate to him. He is thus

virtually forced to internalize "anxieties that are foreign to him". He takes pieces of adult behaviour and tension and introjects them in order to please those adults. He develops a style of character that defeats his own integrative, assimilative self powers.(Becker, 1970:2)

The outcome of this process is blocking of awareness of himself-in-the-world.[8] He loses contact through what often becomes inefficient and self-defeating self-regulation. This is the condition of neurosis.

Within this framework . . .

> The goal of therapy is to make awareness possible by recentering the person on himself, by giving him back his integrative powers, by finding out why and how he blocks his own perceptions and his own desires and satifications, by letting him discover and practise his own activity in the world.   (Becker, 1970:3)

Perls' theory and therapy was based upon a very sound and sophisticated theory of human nature . . . one which drew the best from Freud, Reich, Adler, Rank, the Gestaltists, and the Interpersonal Theorists. He moved away from Freud's mentalism and moved toward the "organismic", the "present", and the "interpersonal". Man was no longer to be seen as the "passive plaything of unconscious forces" but rather as a physically and emotionally restricted organism in its social environment.

The goal of therapy was to accent total organismic experience, and to reunite self and body through proprioceptic awareness in the interests of self-governance rather than mere relexive response to the world. Since organismic awareness is

necessarily in the present, so too, is the focus of the therapy. Perls concentrated on the "here-and-now".

In reading Perls, one becomes aware of the fact that he is bound to the Freudian vocabulary and (in Becker's view), this conceptual atomism was retained at the expense of the inter-personal aspect of his theory.(Becker, 1970:21) This deficit in the interpersonal aspects of the theory becomes problematic in its therapeutic application . . . especially a "socio-therapeutic" application.[9]

Towards the end of his life, an anti-intellectualism came to pervade the Gestalt scene, and his descriptions of Gestalt theory and practice became more simplistic and less clear. He began making distinctions between physiological and psychological functions and spoke of "splits" between social and biological being.(Perls, 1972)

His earlier "field" view of the relationship between action and meaning became simplified and an almost "Cartesian" dualism of mind and body became evident.(Perls, 1972:9) His approach to the social "game" became more simplistic (as compared to his earlier view of roles and the self), and converged with Eric Berne's conception which he previously had vigorously disputed.[10] The possessive individualist and isolationist implications of the "Gestalt Prayer" came to the fore in state-ments such as:

> There is no bridge from man to man. I guess,
> imagine, empathize whatever this may mean.
> For strangers we are, and strangers we stay
> Except for some identities where you and I
> In sameness blend together. (Perls, 1972:12)

Perls' eventual "loss of the interpersonal" becomes
very clear in . . . Garbage Pail (1972), when he oversimplifies
the necessarily "projective" quality of the mental activity of
human beings in interpersonal encounters.(Mead, 1972:25-26)
Perls characterizes this rehearsing as a mere restriction on
spontaneity:

> Freud also saw the greatest thing. That
> thinking is rehearsing, trying out. But what
> are we rehearsing for? A play, an action?
> What performance? Without rehearsing we take
> risks. We are spontaneous. (Perls, 1972:16)

Acting upon the predicted response of others is a
basic characteristic of human social behaviour; only the context
connected with the response changes, as Erving Goffman has shown.
(Goffman, 1959) Perls' own groups and workshops do not exhibit
an absence of rehearsed responses, but rather an alternate
repertoire of expected responses.

In his later life, Perls was prone to a utopianism not
unlike his mentor and analyst, Wilhelm Reich. Perls had a con-
cept of Gestalt communities which, if set up, would provide an
"efficient means of producing real people".(Perls, 1972:24)
This concept of "real people" is a dramatic departure from his
concept of the self portrayed in his 1951 work. The "Gestalt
Kibbutz" idea combined with his movement toward a Reichian belief
in a real, natural person who "trusts his senses rather than his
concepts. . .", is a significant move from the fundamental pre-
cepts of Gestalt theory.

It appears that a Reichian version of Freudianism won

Perls over and the "commune" plans and goals bear a striking resemblance to the utopian projects of a later Reichian therapist named Arthur Janov.[11]

In the introduction to Gestalt Therapy Verbatim (Perls, 1969b), Perls warns against the anti-intellectual and utopian trends that he saw developing in Gestalt. He regretted the era of the "therapeutic guru" and the therapeutic gimmicks, yet the Gestalt Kibbutz and the following concept (which in his view could eventually encompass nearly all people), and his own acceptance of himself as a "guru", suggest that he was falling into his own trap.(Perls, 1972:290) (Perls, 1972:99)

The objection might be raised that In and Out the Garbage Pail (1972) was not a serious statement of his position, but it must be mentioned that he described the work as the "testament" to his accomplishments. However, the most potent of the statements establishing his anti-intellectualism comes from Gestalt Therapy Verbatim, where he writes:

> Intuition is the intelligence of the organism.
> Intelligence is the whole, and intellect is
> the whore of intelligence--the computer, the
> fitting game: If this is so, then this is so--
> all this figuring out by which many people
> replace seeing and hearing what's going on.
> Because if you are busy with your computer,
> your energy goes into your thinking, and you
> don't see and hear any more.   (1969b:22)

Gestalt Therapy is, in fact, an attempt at the practical application of Existential Philosophy to the problems of relatively mild emotional disturbances. Perls makes this clear by his use of the terms "Gestalt Therapy" and "Gestalt

Philosophy" as almost interchangeable.(Perls, 1969b:66; Perls, 1972:148) As a philosophy-in-practice, one of its most important aspects is its system of behavioral expectations. In the case of Gestalt Therapy, behaviour has been largely influenced by the role-modelling of Perls' own behaviour, plus his strong emphasis on the therapeutic value of the discipline of the Eastern Religions (Zen Buddhism, especially).(Perls, 1972:102-112) The next step then, in the delineation of the Gestalt view of man, is to describe the implicit Ideal-Type "Gestalt Man".

The Gestalt Man is the "whole" man, aware of his component parts but who has integrated them into a unified functional whole. He is the man who knows and accepts himself and is aware of all aspects of himself; he is cognizant of his potentialities and is seeking to develop them to the fullest. (1969b:26-27) Translated into concrete behavioral terms (the behaviour displayed and promoted by Perls), this means a person whose behaviour is in no way systematized or rigid but is (on the contrary), spontaneous, unpredictable, impulsive, creative (meaning able to express the products of his personal and environmental awareness), and communicative with other people.(1969b:7) Gestalt Man obeys the "wisdom of the organism" and is free of the self-manipulative restraints imposed by morals and conscience. (1969b:17) Perfectionism of any kind is an anathema to the Gestalt view of the healthy man. Self-improvement schemes are seen as doomed to failure. Ideally, the only controlling factor in our existence is the organism's automatic self-regulation to

"the situation". The situation (in the case of the aware person) defines its own controls; moral or social dictates do not enter thereupon. "The organism knows all. We know very little." (Perls, 1969b:19,22)

By implication and word, efforts toward thinking, planning, scheduling and computing, in the interests of predicting life events, are all pathological.(1969b:24) The impulsive, here-and-now, curious and innocent spontaneity of the child is idolized by Perls.(1969b:27) It is juxtaposed to the "role-playing" of the adult which is viewed as "environmental manipulation", and which is the antithesis of "self-support" and maturity. Role-playing (for Perls) is a manifestation of dependence upon others, and as he states it: ". . .the aim of therapy is to make the patient not depend upon others, but to make the patient discover from the very first moment that he can do many things, much more than he thinks he can do."(1969b:29)

Quite obviously, this is not a conventional morality; indeed, Gestalt makes the clear claim that it will not help "adjust" an individual to society (a society which it views as largely insane), but rather make him or her "healthy" at the risk of being crucified.(1969b:30)

In terms of "role-playing", Gestalt Therapy implies that behaving in any prescribed manner or in accordance with any social dictates apart from organismic spontaneity, is unhealthy . . . and is therefore a "game". The games include:

(a) the "good boy" - or co-operative patient, seen

as using compliance to prevent his own insight;

(b) "playing helpless" - or looking to the therapist or group for cues and answers as to what he or she should do;

(c) "playing stupid or inadequate" - as a way of avoiding the implications of one's full independence and responsibility for one's behaviour; or,

(d) "the flattering role" - where veneration for the therapist and the group supposedly covers the fear of having personal insights or of letting the therapist see one "as they are".(Perls, 1969b:36-37)

Perls' Gestalt system denigrates those who try to take control or who seek interpersonal power in the group. It denigrates those who ask "Why?", or seek reasons. "Why and because are dirty words in Gestalt Therapy." "These are the two legs upon which Gestalt Therapy walks: now and how. . .Now covers all that exists. The past is no more, the future is not yet. . . How covers everything that is structure, behavior, all that is actually going on - the ongoing process. All the rest is irrelevant - computing, apprehending, and so on."(Perls, 1969b:44)

Gestalt idealizes the person who lives and expresses himself in the present tense - "the here-and-now". "Awareness is the only basis of knowledge, communication, and so on."(1969b:44) This means that the healthy person speaks in statements of the present, which are expressive of "feelings" at the present time. (Perls, 1969b:48) The most important feeling to express is resentment, since the consequence of not expressing it is guilt.

Therefore, the healthy person is able to <u>immediately</u> ventilate

his or her resentment and anger. Once this is complete (and the

unfinished situation is finished and the Gestalt completed), then

the expression of "appreciation" is forthcoming.

Another significant behavioral aspect of Gestalt comes

from the severe distrust of the verbal aspect of communication.

"Verbal communication is usually a lie. The real communication

is beyond words."(Perls, 1969b:53) Many of the therapeutic

devices stress the non-verbal level of communication as well, but

in behavioral terms, this tends to put the verbose individual in

a bad light and the quiet, non-verbal person "in power". Despite

the fact that Gestalt Therapy and interaction demand a high level

of verbal skill and verbal interaction, it is the non-verbal

level of communication that is idealized.

Throughout his work, Perls speaks of "authentic" and

"real" people who represent his ideal of the healthy individual.[12]

Emotional expression is one of his criteria for authenticity.

Perls categorizes four kinds of emotional "explosions":

   (a) <u>grief</u> (when a patient works through a loss or a

   death);

   (b) <u>orgasm</u> (in the instance of sexually repressed

   individuals);

   (c) <u>anger</u> (in the case of liberated resentment); and

   (d) <u>joy</u> (in the case of laughter and the release of

   positive emotion, and <u>joie de vivre</u>).

These explosions of emotional catharsis represent the completion

of a Gestalt - the connection with the authentic personality, the "true" self.(Perls, 1969b:56)

Perls further idealizes the person who is able to display a propensity for active fantasy in the "here-and-now". Many of his techniques require flights of fantasy, and their success depends upon the ability to easily drift into reflection and fantasy.(1969b:50)

In terms of a role model, Perls best displays himself in the work, In and Out the Garbage Pail. The work is very open, revealing, and a tribute to his own devotion for living in accordance with the criteria he tended to set for other people. He speaks of his guiding philosophical principle as being one akin to S. Friedlander's "Creative Indifference", which he again relates to an Eastern Religion, Lao-tze.(Perls, 1972:76) His own approach to this thesis is that in one's life it is necessary to find the centre of conflicting poles . . . to commit oneself to the zero point in order to remain in balance. Perls displays a powerful commitment to non-commitment, and this is the foundation of his "creative indifference".(1972:222)

Openness, self-expression, self-revelation, and personal responsibility for one's behaviour, are the cornerstones of Perls' system of behavioral expectations. In and Out the Garbage Pail is a tribute to his belief in open sexual expression and self-revelation. He is free with the nature of his own sexual life and fantasies, and makes it clear that sexual repression (in his view) is the embodiment of all other incompleted Gestalten. He makes it

clear that within his groups there was a good deal of sexual
activity, and that he was in no way outside this activity.
Interpersonal "warmth", physical contact, hugging and kissing,
were all part of the open expression of feelings. It could be
no other way, if the "wisdom of the organism" is to be trusted
as opposed to social norms, and if any unexpressed or unaccepted
impulse could conceivably form an "unfinished situation".

Perls also speaks of experimentation with Psychedelic
drugs as part of his awareness-expanding quests.(Perls, 1972:83)
From his description of the Esalen milieu, it is clear that it
was powerfully influenced by the "hip" counter-culture of the
mid-sixties. He identified with the so-called "anti-establishment"
youth, and his stereotypes of "Toxic" and "Nourishing" people,
display his own life-style and personality preferences. The
"N" person uses social roles only to bring his or her "true essence"
across. This is done through a show of genuine feeling and sensi-
tivity.(1972:138) It is very telling that in the caricature of the
"N" and "T" personality types, the "T" is neatly dressed, short
haired and smiling, whereas the "N" type is long-haired, scruffy
and frowning. The "T" type is described as the person that leaves
you feeling irritated and exhausted; they are poisonous question-
askers and advice-givers - shrill and somniferous.(1972:137) In
this section of the book, it becomes clear that to be labelled "T"
or to possess the above characteristics, would be the Gestalt
equivalent of the "kiss of death".

Despite its facade of unqualified behavioral freedom

and potential for individual development, it must be understood that Perls, as a role model and his writings as a system of implicit behavioral expectations, represents an ideology. The ideology has a code of "healthy" behaviour and a system for the interpretation of the meaning of specific behaviours. Certain behaviours have a high level of status attached (i.e., crying), and other behaviours are anathema to Gestalt group behavioral expectations.(Perls, 1972:229-232) It is the functional and dysfunctional aspects of this behavioral code within a specific context (therapeutic community of adolescents), that concerns us here.

C. The Therapy

1. Milieu:

During the phase of his life when he was most influential (specifically, most influential on the Easton Staff), Perls conducted his work at Esalen in California, and at Lake Cowichan on Vancouver Island, British Columbia. These "institutes" became the models for what the Gestalt therapeutic milieu should be.

The Esalen Institute stood high on the cliffs above California's Big Sur, where ocean waves rolled in and the nearby slopes were carpeted with shrubs and flowers in a beautiful uncontrolled wilderness. The facilities included large sulphur baths for group bathing and modern architectural designs for accommodations with balconies, large plate glass windows overlooking cliff, sea and mountains.(1972:95,151) The workshop rooms

were decorated with works of modern art as were the grounds.
(Perls, 1972:227) Lake Cowichan was similar in its natural
beauty, solitude and relaxed atmosphere, where the primary sen-
sory input was conducive to a calm and meditative state of mind.
There was always considerable physical distance between these
institutes and the conventional urban or suburban sprawl. The
Centres were a retreat from the sensory flooding and pollution
of North American cities. Sensory awareness and introspection
were easily facilitated in these milieus where everyday social
demands were systematically excluded. Given the behavioral
expectation for a normally serene demeanour in the Gestalt system,
this physical milieu was quite necessary.

As Perls himself has stated, Gestalt Therapy is:
". . .a kind of individual therapy in a group setting. . ."(1969b:
p. 73) His workshops took place in a casually decorated, quiet
room with the "seminarians" and therapists (no distinction was to
be made), sitting in a circle or ellipse around a centre open area
with three chairs: one seating Perls, and the other closely facing
him seating the "patient".(1972:289) The third chair was made
available for "chairwork" routines, where the patient would address
aspects of himself in an attempt to effect "closure".

The essence of Perls' therapeutic method lay in having
the patient explore and become aware of his own world, by using
the intuitive (non-interpretative) eyes of the therapist to point
out events which appeared to be "blind-spots" in the patient's way
of experiencing himself and the world. There was to be nothing

judgmental or evaluative in the therapist's activity. Rather,
he was to facilitate the patient's discovery of those feelings,
thoughts and behaviours which had heretofore remained "unassimi-
lated". At this point, the patient himself could choose which of
those feelings, thoughts and behaviours he wished to integrate
and which he intended to alienate.

The therapeutic context was a face-to-face contact
between the patient and Perls, and it might well begin with Perls
asking how the person felt at that very moment. The person was
asked to be explicit about this - aware of the details of bodily
sensations and such. Perls would then point out bodily orienta-
tions and movements which did not come up in the person's des-
cription of his own state of feeling. The meaning of his postural
gestures (such as an unconscious but rapid tapping of the foot, or
the "cradling" of the ribcage with the arms), would be explored by
the patient himself. The therapist does express openly, the
message he or she intuitively receives from the gesture: (i.e.,
the person says that he is calm yet his foot is tapping wildly;
the therapist might suggest that it seems as though he has a
desire to run away.) This focus on bodily attitude included:

(a) the quality of the voice (i.e. monotone, rasping
or choked);

(b) physical attitude in the chair (i.e. rigid,
rounded-over, cross-legged);

(c) eye-movement (i.e. avoidance of eye-contact with
the therapist);

(d)   dress, and in general, nearly all visible physical and behavioral characteristics.

As the person explored the nature of these gestures, both genetic and current "therapeutic material" would emerge and be dealt with. However, Perls' predominant emphasis was on the here-and-now. Should the person stress future or past material, the present context of the "escape" into past or future, would be explored as a key to the person's anxiety.

It is assumed in this method of therapy that no part of the patient's world is meaningless, and that all dimensions must come into awareness and be explored for subjective meaning. For Perls, subjective meaning was the key to the patient's "dasein" - his "being-in-the-world".

As the patient progressed through various levels of emotional intensity, he was encouraged to "go with" or "get into" the feeling; (i.e., to bring impulsive bodily activity into rhythm with the memories or emotions to which they were attached). The main function of therapy was to experience and express the full intensity of the emotion.

2.   <u>Aggression and Anger</u>:

What is normally called "Negative Transference" in psychoanalytic literature, was invariably manifest in Perls' sessions, since this "prying little man" kept demanding that each gesture and expression be explored in minute detail. Perls often laughed facetiously at the efforts of his patients, called them derogatory names or labelled them in such a way that they would

become angry.(Perls, 1969b:58) Since aggression played such a
large part in his theory, he translated it into therapeutic
practice by encouraging the patient's forceful verbal or physical
expression of anger toward him.(Perls, 1972:97-99) Intense anger
is not an emotion which most people in our culture accept in them-
selves or others, and for Perls, the integration of this "alienated"
aspect of each person's self, was fundamental to the therapeutic
act.

The active physical expression of anger toward role-
played figures in one's life was meant to form a Gestalt with that
dimension of one's self - (i.e., the angry, physically destructive,
hateful dimension). "Closure" usually meant that positive feelings
such as love, could be afterward expressed towards the hated object
(often parents), once the hostility was released.

3. Integration:

"Chair-work" was fundamental to Perls' technique, in
that each dimension of the self which came into awareness, was
addressed verbally and personified in an empty chair opposite the
person. What one liked, disliked, accepted, or rejected about
himself or herself was addressed, and usually intense emotion was
released. The phenomenon of the flood of awareness of repressed
emotion towards alienated parts of the self, was considered to be
therapeutic, and once a person had "owned" those previously reject-
ed aspects of himself and the accompanying feelings, a Gestalt was
formed.

4. <u>Dreams</u>:

Perls facilitated a patient's exploration of his dream material by having him play-act all aspects (events, figures, objects, persons) of the dream, in order to bring its subjective meaning into awareness. At no time did he interpret any aspect of the dream material but rather has the patient explore the emotions associated with all facets of the dream.

It is perhaps his work with dreams that is best known and respected in Perls. The various films of his work are a tribute to the powerful impact which he has made on the analysis of dreams as a therapeutic device.[13]

5. <u>The Group</u>:

Perls applied the fruits of his awareness techniques to interpersonal relations as well as through role-playing, video-techniques, psychodrama and general exploration of gestures, words and non-verbal communication associated with interpersonal encounters. He attempted to ask non-leading questions about how each individual felt and encouraged open expression of the full range and intensity of emotion on an interpersonal level. He, as the therapist, was to be the catalyst to personal explorations of meaning and emotion, and extrapolation of those methods into interaction was assumed.

In chair-work and hotseat sessions, members of the larger group were present but not included. However, he often did "Couples" work, using the same basic techniques and premises to improve interpersonal communication and awareness of situational

"roles" and "games" which individuals get into and become selec-
tively blind to.

The group's presence during the individual or Couple's
therapy, was primarily educational. Self-awareness, emotional
expression, integration, and development of potential as technique
and goal, were learned by observation. More importantly, a norm-
ative and behavioral code was established and perpetuated. At the
interpersonal level, this meant:--(a) expression of anger,
despair (tears), and love (touching) . . . (b) self-disclosure,
(c) individualism, (d) serenity and self-knowledge . . .
(e) skill in intuitively discovering the moods and needs of
others, and (f) Gestalt analytic ability . . . were all held in
high esteem. On the other hand:--(a) reluctance to express anger
or tears or warmth (physical or verbal), (b) non-disclosure,
(c) consciousness of the "social", (d) display of tension or
hyperactivity, (e) lack of self-knowledge . . . (f) lack of
intuitive sensitivity to the needs of others, (g) over-verbal
behaviour, (h) organizational mentality and behaviour, or power-
consciousness . . . were all considered to be vestiges of conven-
tional social behaviour, and therefore necessarily "unhealthy".

Based on these behavioral criteria, a far more intense
level of interpersonal communication and contact was to be reached
amongst group members.

6. Private Self-Awareness Techniques:

The pillars upon which all of Perls' work rested, were
the sensitivity and awareness techniques outlined in Vol. I of

Perls et al., <u>Gestalt Therapy</u> (1951). This work generated the

<u>language</u> of sensitivity, awareness and feelings, which was an

integral part of personal "exploration". These techniques can

be categorized as follows:

    a. Environmental Contact.

      (i)   Experiencing in the present
     (ii)   Experiencing personal and environmental
            dialectical opposites
   (iii)   Experiencing foreground/background
            relationship
    (iv)   Differentiation and unity in self
            and environment

    b. Technique of Awareness.

      (i)   Remembering
     (ii)   Body-Sensing
   (iii)   Feeling (Emotion)
    (iv)   Verbalizing
     (v)   Integrating the above

    c. Focus on Blocks to Awareness (Directed Awareness).

      (i)   Changing automatic response to active
            response (contact)
     (ii)   Changing anxiety into excitement

    d. Focus on Self-Manipulation: Goal, Spontaneity
                              and Contact.

      (i)   Retroflection - Discovery, muscle mobiliza-
            tion, re-reversal
     (ii)   Introjection - Discovery, Eating, Regurgi-
            tation, Digesting
   (iii)   Projection - Discovery, Assimilation.

                         (Perls et al., 1951:Vol. I)

7. <u>Treatment of the Seriously Mentally and Emotionally
    Disturbed</u>:

       Perls was well aware of the limitations of Gestalt

Therapy when it came to the treatment of very serious mental

disorders. He excluded severely acting-out individuals from his

workshops, especially those representing a suicidal risk.(Perls,

1972:215)

> I tell them that if they want to go crazy or
> commit suicide, that if this is their "thing",
> then I would prefer it if they leave the group.
>
> I also learned to be very sensitive to severe
> pathology. If somebody brings a dream of
> desolation with no people, no vegetation, or if
> he shows signs of bizarre behavior, I refuse to
> work with him.
>
> (Perls, 1972:215)

It is predictable that Perls should respond this way

to the treatment of serious mental and emotional disorders,

since his therapy represents more of a radical philosophical

change of life . . . a religious conversion . . . than a pro-

phylaxis for serious disturbances. Since increased awareness

is his goal in therapy, he is powerfully anti-medication, which

(in combination with other treatment modalities) is the only

proven high-success method in the treatment of Schizophreniform

Psychoses, or Schizophrenia.[14] (1972:94) He admits the "inefficiency" of

his method, in terms of time expended, yet always held a fascin-

ation for unbinding the "Gordian Knot" of Schizophrenia.(1972:113)

It never happened in his lifetime even though he invited research

into Gestalt's applicability in this area. To some extent this

paper addresses this issue.

D. Summary

In summary, it is important to note that Perls' version

of Gestalt Therapy is exceedingly abstract and complex in its

theory and the linking of the theory to the therapeutic method.

It was researched primarily on voluntary subjects, most of whom were powerfully motivated to seek personal life changes. His patients (or seminarians) were largely middle class, university educated, neurotic adults. In terms of its stated behavioral expectations, norms and values, it is unconventional especially in the areas of sexuality, emotional expression and general life-style. It is highly individualistic and functionally introspective; its language is highly complex.

Gestalt Therapy as conducted by Perls, was highly authoritarian in social organization and structure. Its therapeutic setting requires solitude, natural beauty and physical distance from the trappings of conventional urban or suburban life. Its behavioral code suggests that one's primary responsibility in life is to oneself, and that accountability is a block to personal freedom and responsibility. Since it is largely experiential, Gestalt Therapy is difficult to operationalize and teach. It allows its therapists almost total freedom in devising personal approaches to personal patient problems, and relies heavily on a well-developed intuitive skill on the therapist's part. Gestalt purposefully obscures the distinction between therapist and "patient", and therapy is the mutual "discovery" of personal and environmental characteristics.

Gestalt idealizes an immediate and "appropriate" emotional response to a situation which precludes any socially expected pragmatic response.(i.e., In a crisis situation, if one feels like crying and withdrawing rather than acting "strong",

then that is what they are to do.)

Gestalt Therapy encourages intense emotional contact between patients as well as between patient and therapist. Gestalt Therapy, in its available source material, does not address itself to adolescence at a specific stage or era in human development. There is a highly developed and implicit anti-intellectualism in Perls' Gestalt Therapy, and formal or controlled research was not in his repertoire of priority projects.

As a group-living ideology, Gestalt encourages the ventilation of emotion, self-revelation, sexual expression, and a high degree of interpersonal honesty. The language of Gestalt is a language of "feelings" and less a language of task, goal, organization or control. It is an education in feeling, and considers education to be primarily the process of discovering oneself and his or her environment, from the perspective of subjective meaning. Education in this view represents neither analysis, manipulation, conceptualization or control. A high level of formal educational achievement is assumed and the attending everyday practical skills of living come into question, only when they are to be "therapeutically" adjusted.

Goal-orientation, task-orientation, conceptualization and analysis, or focus on power or control, are all unhealthy but often unavoidable aspects of everyday life. They are to be avoided whenever possible.

In attempting to place Gestalt Therapy in the context

of the more conventional psychiatric approaches, it can be said
that it relies largely on:

    (1)   Insight as cure - of an existential nature;

    (2)   Psychodynamics - of a revised type (retroflection,
introjection, alienation, assimilation, project-
ion);

    (3)   Ego Psychology - of a revised type, but focusing
primarily on the Defence Mechanisms and Resistances
in order to break them down;

    (4)   Bio-Energetics - Ida Rolf's version, as the means
to breaking down bodily armour and bringing the
body into awareness;

    (5)   Some Spontaneous Abreaction - of the birth trauma
type;

    (6)   Role-Playing and Psychodrama - often with the aid
of video equipment;

    (7)   Hypnosis - both meditative (self-induced) and
formal.

FOOTNOTES - CHAPTER III

1. Twenty-five percent of the interview respondents mentioned
    (spontaneously), the freedom to innovate in therapeutic
    technique as a unique characteristic of the Easton
    facility (in response to Question 11 of the Question-
    naire).

2. Examples of "contact-boundary" include such varying
    structures as: skin, (tactile stimulation required
    or, in the case of infants, death will result), and
    language, (which for Perls was a key contact feature
    of social functioning).

3. For example, the German word for "genitals" ("beschlecht-
    steil") is translated as "the parts of shame".

4. "Introject"(noun) is defined by Perls et al., as material
    (a way of acting, feeling, evaluating) which an indi-
    vidual has taken into his system of behaviour, but
    which has not been assimilated in such a fashion as to
    make it a genuine part of one's organism.(1951:189)

    "Ego Ideal" is defined by Freud as the socially constructed
    standard of how we ought to behave.(Vol.XIV. pp.93-94)

    "masks and delusions" are respectively the social face
    that we present (based on an ego ideal), as distinct
    from our actual feelings at any time, and delusions
    are the pictures we present to ourselves (consistent
    with the ego ideal), which often bear little resem-
    blance to the mask we show.

5. In Gestalt terms, two people are "confluent" when "there
    is no appreciation of a boundary between them, when
    there is no discrimination of the points of difference
    or otherness that distinguish them."(Perls et al.,
    1951:118)

6. "Proprioceptor" is defined by Perls et al., as the sensors
    which inform one of their internal response to a
    situation, i.e., the sensor which makes you aware of
    heart palpitations or nauseated stomach at times of
    anxiety.(1951)

7. "Psychoneuroses" are defined as those symptoms "which
    comprise a group of non-organic mental disorders
    which .... do not possess the qualities of severe
    affective change or thought disturbance which are

FOOTNOTES (Cont'd.)

associated with the psychoses." There are six
general reactions included in this category:
(1) Anxiety (2) Dissociative (3) Conversion
(4) Phobic (5) Obsessive Compulsive, and
(6) Depressive. Myre Sim & E. Gordon, Basic
Psychiatry. Churchill Livingstone: London, 1972,
p. 171.

8.   This is the subject matter of a Swiss Existential
       Psychiatrist, Ludwig Binswanger, which is called
       "Dasein Analysis". Existence: A New Dimension in
       Psychiatry and Psychology (1958).

9.   "Socio-therapy is a method of treatment the focus of
       whose operations is the situation - particularly
       the social system . . . in which the individual is
       treated."(Edelson, 1970:22-24)

10.   Social "Game" has been defined by Eric Berne as: an
       ongoing series of complementary ulterior trans-
       actions progressing to a well-defined, predictable
       outcome. Descriptively, it is a recurring set of
       transactions, often repetitious, superficially
       plausible, with a concealed motivation . . . .
       (Berne, 1964:44)

11.   Arthur Janov, Anatomy of Mental Illness. Putnam's Sons:
       New York, 1971. Perls' utopianism is manifest in
       his belief that Gestalt Kibbutz as a therapeutic
       concept, would transcend the conditions of race,
       socio-economic class, age, etc., but his naivete
       in this regard never reached the grandiose incredu-
       lity of Janov, who states in the above work:
       "I am convinced that Primal Therapy can be likened
       to the 'Fountain of Youth' we have been searching
       for . . . ."(p. 16)

12.   In Perls' conception, "real" people were those who were
       "centred" on themselves (i.e., aware of their own,
       natural and immediate responses to situations),
       communicative of their immediate responses to things
       and people. They were undefended (in the psycho-
       analytic sense of defences), warm, emotional, spon-
       taneous, free, sensitive and aware people.(Perls, 1972)

13.   Available films on Frederick Perls and Gestalt Therapy
       (actual film of live workshops) include: "What is
       Gestalt?"; "Awareness"; "Everything is an 'Aware'
       Process"; "Gestalt Prayer"; "Madeline's Dream"; all
       of which were produced by Aquarian Productions in the
       Gestalt Series. They were released by Films Incor-
       porated in 1970.

FOOTNOTES (Cont'd.)

14.   The most recent evidence suggests that a combination of
        social manipulation, socialization, and medication,
        appear to have the greatest success rate in the
        treatment of Schizophrenia.(Meyer and Chesser, 1970:
        p. 19) (P. May, 1968).

CHAPTER IV.   THE SOCIAL PSYCHOLOGY OF ADOLESCENCE.

          Perls' target population was not adolescents specifi-

cally, and we can see that in his work no special material on

the characteristics of adolescence (as a stage of human develop-

ment) existed.

          However, for the purpose of this study, we must ask

ourselves questions such as:

          (a) Are there specific characteristics of adolescent

cognitive, moral and ego-identity development which might make

Gestalt Therapy inappropriate as a treatment method for adoles-

cents?

          (b) Do the specific characteristics of adolescent

psychiatric disorders suggest any clues as to the appropriateness

of Gestalt Therapy as a treatment method for adolescent psychiatric

disorders?

          (c) Do the characteristics of adolescent group behav-

iour or relationships with adults, give any clues as to the appro-

priateness of Gestalt Therapy as a treatment method for adolescents

in a twenty-four hour residential treatment facility where the

staff members are adults?

     1.   The Psychology of Adolescence (The Cognitive Leap).

          Adolescence is the period of human development about

which we know the least.[1] It is characterized by rapid physical,

emotional and social changes in the individual - changes which are

difficult to deal with in the best of social and historical
circumstances. The combination of tumultuous personal change
and the history, economics and politics of mid-twentieth century
North American society, makes modern day adolescence a particu-
larly crisis-prone period. The Mental Health and Hospitalization
statistics of the 1960's bear witness to this fact.[2]

Adolescence is a stage in human development character-
ized by the breaking of powerful normative, affectual and behav-
ioural bonds with the significant adults in one's life (usually
the parents). It is a restive, puzzling period in which rapid
(and often unbalanced) physical development takes place, while
social and psychic "restructuring" is in progress.

It is in "early adolescence" (age twelve to sixteen)
that the individual begins to acquire the potentiality for
abstraction . . . to move from the childhood condition of strict
adherence to the tangible and concrete, and to begin dealing in
concepts which are neither tangible or concrete.(Adelson, 1972:
p. 108) As a result, the capacity for abstraction is merely
developing in early adolescence, and is not yet an establised
cognitive faculty. Thus it is extremely difficult for the young
adolescent to adopt such concepts as a sociocentric perspective.
It is only in middle and late adolescence that abstractions such
as society, community and the place of the individual in the
social system, come to have meaning.

One other aspect of this developing cognitive capacity
for abstraction, is the adoption of a time perspective.(Adelson,
1972:110-112) In the early stages of adolescence there is little

sense of history. The past is not seen to weigh upon the present.
This situation usually changes from middle to late adolescence,
although it often remains undeveloped even to a later date. As
Adelson points out, the developmental step from early to middle
or late adolescence usually brings a more powerful sense of the
future, a developing sense of "the consequential" (in Piaget's
terminology), as part of the cognitive "leap" from concrete to
formal operations.(Adelson, 1972:111)

Early adolescence is also a period of development
toward an increased grasp of the complexities of human motivation
as well as personal and social change. These developments repre-
sent an embryonic "capacity for ideology".(Adelson, 1972:107)
It is of extreme importance to stress here that individual adol-
escents are subject to wide variations in the rate of such devel-
opment, just as their physical development varies widely.(Tanner,
1972:1-24) Hence, these changes can only be considered as trends
subject to wide variations (related to social class and status
variations) within the same society, and broader variations with
respect to different cultures and levels of socio-economic devel-
opment.

2. Ideology and Adolescence - (Social Development).

Young adolescents exhibit a very simple, black-and-
white all-pervasive authoritarian bias which seems to transcend
sex, social class and nationality. Theirs is a view of man which
is essentially Hobbesian. They show little faith in the human
capacity for self-control or conscience, and see government as

providing the necessary restraints on human impulsiveness.
(Adelson, 1972:117) Accompanying this is an "ingenuous belief
in the goodness and justice of authority". Adelson suggests
that this is most likely connected with the child's inability
to grasp the abstract concept of "Human Rights" and thus his
attitude to government and law is "trusting, uncritical and
acquiescent".

It is only in middle and late adolescence that a more
critical and pragmatic attitude emerges and with it the under-
standing of competing interests, contradictory values, and the
need to balance ends and means in the pursuit of long-range
objectives.

> . . . the young adolescent. . .has only a dim
> appreciation of democratic forms. . .he shows
> little sensitivity to individual freedom or
> minority rights; he is indifferent to the
> claims of personal freedom; he is harsh and
> punitive toward miscreants; his morality is
> externalized and absolutistic. The decline
> and fall of the authoritarian spirit is, along
> with the rapid growth in abstractness (to which
> it is related), the most dramatic developmental
> event in adolescent political thought.
>
> (Adelson, 1972:119)

". . . utopian ideals are not only uncommon in adol-
escence, the mood of most youngsters is in truth firmly anti-
utopian", and in opposition to any form of idealism it is found
that the mood is basically one of skepticism, sobriety and
caution.[3](Adelson, 1972:120) The move to a "principled" social
and political morality cannot conceivably happen until the child
has acquired the cognitive skills of "formal operations". He

must be able to manage abstractions, synthesis and generalization beyond the specific instance, and the transcending of the present in the imagination of a future.[4]

This is the most impressive potential step for the adolescent and thus is predictably, one of the most difficult. Gaining the capacity for hypothetico-deductive operations and conceptions of principles, is contingent upon the child's experiencing the unspoken assumptions about the nature of appropriate political behaviour, and upon the youngster's _investment_ in political and social matters.

Kohlberg and Gilligan (1972) allude to three levels of "Moral Stage Development" through which the adolescent passes as he moves toward adulthood, but as has been mentioned, the transitions are heavily coloured by cultural variations. In an empirical study, Kohlberg and Gilligan found that almost 50% of Americans never reach adolescence in the cognitive sense.[5] Those who do, seldom reach it before the age of fifteen or sixteen, and this is among chiefly middle-class American University students who themselves represent an elite minority.(Kohlberg and Gilligan, 1972:155)

The _Preconventional stage_ of the child is manifest in "good" and expected behaviour (in its social context); he is responsive to cultural labels of good and bad, and interprets these labels in terms of their physical consequences (punishment and reward).(Kohlberg and Gilligan, 1972:159) Principles are also decided upon the physical power of those who enunciate the

rules defining good and bad. In middle-class North American
children, this level ranges in age from four to ten years.

The Conventional level of moral stage development is
immediately pre-adolescent in middle-class North American youth.
Behavioural expectations and rules in the individual's family,
group or nation, are perceived as valuable in their own right.
The principal concern is with conforming, maintaining, support-
ing and justifying his group's social order.

The Post-conventional level is first evident in early
adolescence and is characterized by a major thrust towards
"autonomous moral principles" having authority apart from the
groups or persons who hold them.(Kohlberg and Gilligan, 1972:
159-160)

Early adolescence, then, is (in middle-class youth)
the transition from Conventional to Post-conventional morality.
Conformity to a stereotypical image of majority natural, normal
behaviour and respect for authority, rules, and order, is in the
process of changing to a principled view of "right", defined in
terms of general human rights and a relativism of personal
values and opinions.

The existence of these moral "stages" and their rela-
tionship to cognitive development, suggests that social develop-
ment has a "basic cognitive-structural-component".(Kohlberg and
Gilligan, 1972:164) But it is true also that cognitive maturity
is not necessarily accompanied by maturity in moral judgment.
Adolescents may have formal logical capacities without principled

moral judgment, and this is a source of difficulties for many.

3. The Self in Adolescence - (Ego-Identity Development).

Kohlberg and Gilligan's study represents a complex analysis of the inter-relationship between Cognitive Development(Piaget 1952), Moral Development(Kohlberg), and Ego-Identity Development(Erikson) in adolescence. An important aspect of this total process is the discovery of the subjective "self" and the subjective experience in adolescence; for Kohlberg and Gilligan, it is the core phenomenon in the advance to adulthood. Emotionality comes to be experienced as part of the self, rather than as the concomitant of objects in the environment.(Kohlberg and Gilligan, 1972:152) This discovery of the self is a tripartite phenomenon including cognitive advances, moral stage development, as well as the establishment of an ego-identity.

Erikson's Psycho-historical Stage Development schema (1964) centers around forms of "self-esteem". The key features of ego-identity development involve progressive self/other identification and differentiation through phenomena such as degrees of trust or mistrust, autonomy or shame, and finally, dependence or initiative.(Erikson, 1963) The identification aspect is manifest in the fact that children identify with those aspects of people which most immediately affect them.(Marcia, 1974) The formation of an identity requires the integration of all significant identifications, past and present, into a reasonably coherent whole. It is a process of synthesis where social

constraints, ego ideals (the internalized aspirations and behav-
ioural ideals of a given society), and personal characteristics
merge and meld into a structure of commitments, expectations,
behaviours, feelings, ideals and images by which an individual
contacts his social reality and against which he judges his own
and other's behaviour.(Marcia, 1974) It is the flowering achieve-
ment of the adolescent period . . . if it takes place.

Researchers in the field of ego-identity have estab-
lished a link between moral stage development and ego-identity
development, which suggests that to question conventional mor-
ality, demands the questioning of personal identity.

> . . . morally conventional subjects have a
> considerable likelihood of never having an
> identity crisis or an identity questioning
> at all. Erikson's picture of an adolescent
> stage of identity crisis and its resolution,
> then, is a picture dependent upon attainment
> of formal logical thought and of questioning
> of conventional morality. It fits best, then,
> the picture of adolescence in the developmen-
> tally elite and needs further elaboration for
> other adolescents.
> (Kohlberg and Gilligan,
> 1972:171)

Ego-identity development is a difficult and rare achievement
even in late adolescence. In the M.H. Podd study of male college
juniors and seniors, only two-thirds of the "post-conventional"
principled subjects had reached what he called "identity achiev-
ement" status; less than one-half (40%) of the conventional
stage subjects achieved the same status.(Kohlberg and Gilligan,
1972:170)

4.   The Peer Group.

The newly developed cognitive skills in adolescence
demand questioning of childhood assumptions about the nature
of God, Parents and Sex; newly developed sexual maturity in-
creases the power and significance of emotions, while at the
same time increasing the complexity of social relationships.
Amidst the disarray of the "old" and the increased demands of
the "new", the adolescent must somehow maintain the integrity
of his newly developing self.(Kagan, 1972:98)

The new social relationships that are to be formed
demand a balance between the exploitative urges of the egocentric
"child" (on the one hand), and the powerfully developing need for
"others" as he grows out of his old parental dependencies toward
a degree of intellectual and emotional autonomy. At the same
time, the educational "tracking system" demands that the adoles-
cent form a more or less rigid self-view so that his educational
program can be planned. The adolescent's cognitive development,
his institutional setting and his ego-identity needs, require
interactions with others (peer and adult) on a much more complex
level than those of childhood. Therefore, the preoccupying
motives come to be: sexual adequacy, interpersonal power,
autonomy of belief and action, and most importantly, the accep-
tance of his or her peers.(Kagan, 1972:98-100)

Through the complex, competitive and often hurtful
trial-and-error testing of the interpersonal power, norms and
behaviour of his peers, the adolescent finds how tough or how

fragile his "self" is. He tests his power on the toughness or fragility of others. He or she scans the equipment, skills, talents and interiors of others in order to assess (or in fact "constitute") his or her own "self". Through this process, the adolescent builds a repertoire of actions and beliefs which were not available to him in childhood. It is an intricate social interactional process, and without this interpersonal contact his repertoire of behaviours, and his fund of experience is seriously limited.(Cottle, 1972:322-323) Any exclusion or rejection on the part of the peer group, calls all areas of his or her adequacy into question. Show the adolescent a picture of himself which is interpersonally powerless, and the self which he sees in the eyes of others is pathetic, unacceptable, and virtually impossible to act upon.

Although opinion varies, it seems that intimacy and honesty are not the fundamental goals of the adolescent interactional process.(Kagan, 1972:102) Friedenberg maintains that:

> Groups of juveniles are not friendly; and strongly
> felt friendships do not commonly form among them,
> though there is often constant association between
> members of juvenile cliques. They are not there
> to be friendly; they are there to work out a crude
> social system and to learn the ropes from one
> another. To some extent they behave like the gang
> in an office, jockeying for position within a
> superficially amiable social group. . .The juven-
> ile era provides the solid earth of life; the
> security of having stood up for yourself in a
> tough and tricky situation. . .the safety of know-
> ing the exact margin by which adults are stronger,
> smarter, or trickier than you; the calm gained
> from having survived among comrades, that makes you
> ready to have friends.

(Friedenberg, 1968:18-22)

Group identification, which is so important in adolescence, tends to help the process of emancipation from adults which begins before early adolescence.(Smith and Kleine, 1971: 180-183) The conformity-demands aspect of group identification exerts the dominant behavioural influence in specific areas of the adolescent's decision-making.(Brittain, 1963) This must be taken into account when attempting to understand adolescent group behaviour. Predictably, physical setting powerfully affects group identification and behaviour. What Smith and Kleine refer to as the "Locales of Adolescent Reference Groups", affect the degree of group integration, the fluidity of its boundaries vis-a-vis other groups and the consistency or changeability of its membership. These factors in turn affect the structure of group leadership, the behavioural characteristics required of the leader, relationship to adult authority, and the nature of the roles within the group.(Smith and Kleine, 1971:186-189)

The residential treatment setting as a "locale" brings a specific set of these characteristics into relief. In the institutional setting, close and constant physical proximity to authority figures (adult staff), and their powerful effect on expectations and sanctions, influences the characteristics of the adolescent that acquires "natural" leadership. The rigidity or flexibility of staff expectations and their stress on group function (or lack of it), powerfully affect, whether or not the adolescents act in concert, or separately, and whether or not their group identification is based on resistance to staff, or

co-operation with staff (or ambivalence). Staff behaviour has
also been shown to affect the degree of exploitation of one
resident role over another, i.e., whether leadership is managed
by coercion or co-operation.(Polsky and Claster, 1968:138-148)
The professional structure within the residence also powerfully
affects peer-group functioning, as Counsellor, Aide, Social Work
and Psychiatric roles and jealousies can be exacerbated by the
adolescents in specific ways, facilitating the rise of a type of
natural adolescent leader with specific qualities.(Polsky and
Claster, 1968:142-155) A hierarchical staff structure lacking
co-operative team or egalitarian characteristics, will generate
(dependent upon a series of other variables) the same type of
resident hierarch . . . one not very different from that of the
street-corner delinquent peer-group structure.(Smith and Kleine,
1971:188-190)

Interpersonal contact, personality identity, group
identity, and social system formation, are characteristics of
and important to adolescent emotional, social and intellectual
development, and despite the popular myth, it is also true that
adolescent values do not vary dramatically from those of their
parents.(Bandura, 1971:194-199) Significant adults play a
central role in adolescent attitudes, values and behaviour,
despite the powerfully increasing impact of peer-group expecta-
tions.

Spalding cites research which shows that adolescents
tend to accept the role models of people who are similar to them

in personal (social) background.(Spalding, 1971:163) This fact
was also reinforced in the Polsky and Claster study. Further,
it has been found that role consistency in significant adults,
based on explicit standards of performance, are more important
in the longrun in influencing or changing adolescent behaviour,
than mere "nurturance". However, as Spalding points out, con-
sistency in adult behaviour and explicit behavioural expectations
on adolescents, does not imply rigidity or unreasonable demands.
As Havighurst points out, any educational program must focus on
building the self-esteem and "social fidelity" of the often un-
committed, underdeveloped and underachieving adolescents in it.
(Havighurst, 1971:174-177) This, he maintains, can be accom-
plished by the powerful role-modelling impact of adults who
exhibit confidence, high self-esteem, social fidelity and vitality.
The role-modelling goes hand-in-hand with performance demands
which are clear, constant and within the reach of the adolescents.

These conditions must be qualified, however, with the
added demand that the adults be authentic and fully aware of the
adolescent's frame of reference. The acute social sensitivity of
adolescents, makes them particularly perceptive (and critical of)
adult inauthenticity, maternalism, paternalism, or infantiliza-
tion. The crisis period of adolescence requires at least some
temporary moorings in significant, predictable, specific adults.
(De Varon, 1972:337-348)

In the case of youth who have had particularly dis-
tuptive home or family lives (or who have had no family at all),

stable adult relationships are of specific importance. But as
a complement to the predictability of adult behaviour, roles
and expectations, the adolescent needs sufficient flexibility
to test his own decision-making capabilities. The transition
requires that at times, the adolescent be recognized as an adult,
while at the same time requiring the luxury of childhood mistakes
and behaviour patterns.(Stone and Church, 1968:497-498)

5. Adolescence and Emotion.

A key problem for adolescents, seems to be finding a
balance between the interactional demands of controlled (appro-
priate) behaviour in both adult and peer cultures (on the one
hand), and the overwhelming emotional swells which grow out of
the helplessness of not being able to either situate oneself
socially or personally . . . or to resist doing so.(Gesell et al.,
1956:383) "The threat embodied by the difference between what
one is and what one wishes to be generates strong anger."(Kagan,
1972:337) De Varon explains the helplessness by describing
those situations where one is caught in the interactional "double-
bind" of wanting to express anger at one's peers for perceived
abuses, yet being terrified of the possible rejection which might
be the consequence. Adolescence demands that sense be made of
these new, powerful emotions, and that new meanings be assigned
to human social interaction.(1972:339-348) The process of making
meaning out of new and powerful experienced emotions (and defin-
ing them in terms of human interaction), demands the "taming" of
the explosive emotions. The greatest fear in adolescence is of
presenting a view of the self that is uninviting to one's peers.

To prevent this occurrence, defences against the all-consuming outburst, are necessary. The fragile defences of the adolescent include: (a) degrees of emotional isolation and withdrawal; (b) escape from thought into sensuality (usually expressed in sexuality and drug experimentation); or (c) total commitment to expertise in a skill or activity. These defences are a necessary part of testing the boundaries of emotional expression as it relates to social interactional imperatives.(Kagan, 1972:337)

Kagan points out that the orthodox (psychoanalytic) view of sexual repression is not what we are dealing with in adolescence . . . rather it is the problem of "emotions that threaten because of their obscurity". The fear of sexuality, then, is not something to be approached with cathartic release being the therapeutic goal, rather, the giving of words to puzzling and obscure emotion is what most helps alleviate the stress for the adolescent.(De Varon, 1972)

The adolescent is wrestling with the problem of understanding, communicating and behaving in a newly discovered interactional field. From the initial (childhood) position of pure egocentrism, the adolescent is learning to pick up those complex verbal and non-verbal communicative cues which make up the matrix of peer and adult social interaction. (Elkind, 1971:50) He is exploring his "self" through this process - developing an integrity which is contingent upon the forging of appropriate defences against interpersonal "hurts". The luxury of powerful, spontaneous, uncontrolled outbursts of emotion, is a childhood privilege

and in interaction with peers the adolescent is rapidly learning
that the luxury is much too costly an indulgence.

Social psychological experimentation has confirmed the
efficacy of this position, but also added evidence which is of
tremendous importance to the residential treatment of adolescents
in general, and Gestalt Therapy in particular.

Leonard Berkowitz(1973) states that social psychological
experimentation shows that the consequences of acted-out aggres-
sion in an intentionally "therapeutic" setting, can have reper-
cussions for behaviour outside the "therapeutic setting". It has
been shown that depending upon the circumstances, a person's
inhibitions can be lowered or (even further), aggressive behaviour
reinforced by the so-called "therapeutic" acting-out, which can
dramatically increase the propensity for aggression outside the
therapeutic situation.(Berkowitz, 1973:28)

In Seymour Feshbach's experiment with young boys, it
showed that free-play experiences with aggressive toys lowered
the youths' restraints and significantly increased their overt
hostility to one another and adults.

Ventilation of aggression admittedly makes a person
feel better, but because the disturbing anxieties surrounding
aggressive behaviour were extinguished as a result. In a similar
but (allegedly) better controlled study, similar results were
reproduced.(S.K. Mallick and B.R. McCandless)

Further, the ventilative therapies (of which Gestalt
is a stated example) of aggressive behaviour are rewarded by the

group and the therapist, and these rewards heighten the likeli-
hood of subsequent violence especially in the case of children,
and produced a broad range of aggressive responses.(R.H. Walters
and Murray Brown) (Berkowitz, 1973:28)

In adult behaviour, the so-called "therapeutic" encour-
agement of verbal ventilation in a group situation ". . . encour-
ages an individual to attack available targets later". The inter-
actional consequences are equally severe; there is the demonstrated
gratification experienced by the aggressor at the injury to his
intended victim. In seeing the victim's defeat and submission,
the adult is less likely to want to attack the victim further,
but experimentation shows that children are more likely to act
aggressively again. Also, the observing group's response comes
into relief as a result of this social psychological experimen-
tation. "A person who watches violence is much more apt to become
aggressive himself, whether he is angry at the time or not."
(Berkowitz, 1973:29)

A final and more important observation related to
ventilationism and its social interactional consequences, is found
in the fact that the therapist or group members are encouraged to
describe a subject's feelings for him. (i.e., "If I were you, I
would be really angry that he said that.") The descriptions of
the therapist or more experienced group therapy members are assum-
ed to be more accurate (and therefore carry more weight), than the
subject's own descriptions of his feelings. This process has a
powerfully suggestive component. As Berkowitz states, the inter-

pretation has a way of making the diagnosis come true.

Berkowitz describes Stanley Schachter's study, which
contends that an emotionally aroused person doesn't necessarily
have any "real" underlying emotion:

> He (the subject) can act in very different
> ways, showing either fight or flight, euphoria
> or anger, depending on what those around him
> are doing and how they define his arousal. If
> his group insists he is "really" angry and he
> accepts this interpretation, he may well become
> more inclined to act aggressively in conformity
> with this view.
>
> (Berkowitz, 1973:30)

6. Adolescent Emotional Disturbances.

Adolescence is a crisis period in even the most normal
of family or social situations, and it very often scars the in-
dividual for a lifetime.(Allport, 1971:394-399) It is an era of
severe disorientation and dislocation which could be interpreted
as a form of insanity, if psychiatric diagnostic categories were
to be applied.(Stone and Church, 1968:546-547) Severe social
and physical environmental conditions such as filth, noise,
over-crowding, discrimination, economic deprivation, or severely
disturbed family life, add crippling conditions to a standard
developmental crisis. A disproportionately large percentage of
our population grows up under these conditions, and the statis-
tics for the incidence of child and adolescent emotional dis-
turbance is on the increase both relatively and absolutely.[6]
(Adams et al., 1971:63)

For the purpose of this study it is necessary to
define Adolescent Emotional Disturbances in terms of the pertin-

ent literature on adolescent psychiatry. The Diagnostic and
Statistical Manual of Mental Disorders (1968) defines adolescent
behavioural disorders as: ". . . the major category devoted to
disorders occurring in childhood and adolescence. . .which are
more stable, internalized and resistant to treatment than the
transient situational disturbances, but less so than psychoses,
neuroses, and personality disorders."(Wilson, 1971:277) The seven
categories of specifically adolescent disturbance enumerated
under this general category include:

   (i)   Hyperkinetic reaction
  (ii)   Withdrawing reaction
 (iii)   Overanxious reaction
  (iv)   Runaway reaction
   (v)   Unsocialized aggressive reaction
  (vi)   Group Delinquent reaction
 (vii)   Other

The number seven category applies to specific learning distur-
bances, feeding disturbances, enuresis and encopresis.

Most of the children who were referred to Easton could
be classified by the above behavioural categories. However, a
minority of important exceptions exist. Approximately fourteen
percent of the adolescents directly dealt with during the period
of this study, represented severe psychiatric disorders. One
twelve year old girl with an alleged history of incestual rape
experienced brief but cyclical psychotic episodes with delusions,
ideas of reference, disorientation, etc., with a very low level
of social involvement. Her hypomanic periods and her generally
flat effect yielded an initial diagnosis of Schizo-Affective

Disorder. Another fifteen year old boy exhibited severe ritual-istic, obsessive-compulsive behaviour characteristic of an obses-sional neurosis. Another twelve year old boy who characterized himself (and behaved as) a robot, was hypercognitive, dys-sexual, overly-compliant in family relationships and severely deficient in peer relationships. Initially he was diagnosed as a case of Childhood Autism. In the period of the study, two adolescent residents had been diagnosed as Latent Schizophrenics or Border-line State. These cases have been raised to illustrate the extreme difficulty in diagnosing adolescent disorders. Some adolescents fit adult diagnostic categories while others are more amenable to childhood categories. Others defy diagnosis altogether.

Most of the residents of Easton showed signs of Adoles-cent Depression as manifest in sleep disorders, eating disorders (obesity or food refusal). Many children had difficulty in bladder control and had ritual compulsions surrounding bowel and bladder functioning. One fourteen year old girl was a chronic drug user (soft drugs) and a fifteen year old boy had a severe stutter. During the period of the study, three of the adoles-cent girls exhibited hypersexuality, while one fifteen year old boy was homosexual. Approximately three of the thirty-seven residents had suicidal attempts in their histories and came to the unit with suicidal ideation.

As Wilson points out, many of the seven DSM-II cate-gories are reactions to the severe crises of the adolescent tran-

sition and must not be put into strict diagnostic classifications.
(Wilson, 1971:277) Still others must be considered as quite
normal reactions of a developing adult in an intolerable social
environment (broken homes, repeated foster homes, alcoholic par-
ents, abusing parents, scapegoating, etc.). One sixteen year old
Easton resident exhibited a "Withdrawn Reaction" with severe bouts
of depression and melancholia. Her father was an alcoholic, her
mother was dying of Cancer, and her brother (who had frequently
beaten her), was in prison. One fifteen year old female, "Run-
away Reaction" refused to return to the home of an alcoholic
mother who was dying of Cirrhosis of the Liver, while the father
was away for six months (occupational necessity), and all the
other siblings had achieved self-sufficiency. An example of
"Group Delinquent Reaction" was seen in a thirteen year old girl
whose mother died unexpectedly. Her father remarried and the
girl began spending time with a small early adolescent group in
the neighbourhood, refusing to obey the stepmother whom she
overtly resented. One "Hyperkinetic" twelve year old boy had
accidentally killed his sister.

Although these are "weighted" examples, they represent
a significant number of the children who enter the doors of men-
tal health treatment institutions. The instances must be consid-
ered where these "Reactions" are almost logical behavioural
responses of a young adult to a noxious social environment in
which withdrawal, escape, aggression, delinquency and hyper-
activity have positive or protective behavioural consequences in

their specific social setting.(Laing and Esterson, 1970) In
these instances the characteristics of "normal" adolescence
largely apply, but what of the fourteen percent who might be
considered Childhood or Adolescent Schizophrenics?

Information regarding Childhood Schizophrenia is not
completely clear or unqualified, and the epidemiology of child-
hood psychosis is not established.(Goldfarb, 1969:686) Careful
and sophisticated evaluation of therapeutic methods have been
rare and/or inconclusive. As we have seen before, diagnosis is
too broad.(Goldfarb, 1969:688) Because of this, the classifi-
cation of a child as a Schizophrenic or Psychotic carries little
weight in the devising of an individualized therapeutic program.
Such a program is contingent upon the child's adaptive strengths
and weaknesses, and biological and social factors, all of which
might be manipulated to assist in the normalization of his behav-
iour.(Wilson, 1971:276-278)

The range of disorders commonly viewed in children
diagnosed as Schizophrenic, include:

(a) Gross and sustained impairment of emotional
relationships;

(b) Apparent unawareness of personal identity to a
degree inappropriate to age;

(c) Pathological preoccupation with particular
objects or certain characteristics of them, without
regard to their accepted function;

(d) Sustained resistance to change in environment;

(e) Abnormal perceptual experience in the absence
of discernible organic abnormality;

(f) Acute excessive anxiety, frequently precipitated
by change;

(g) Impaired speech and language;

(h) Distortion of mobility;

(i) Serious intellectual retardation with islets of
normal or better intellectual skill.

All these criteria are subject to a wide variation in
severity and are recognized as being elastic in character.(Gold-
farb, 1969:686-688) Accompanying these general characteristics
are specific inabilities in: (a) patterning sensory stimuli
into configurations (perception), (b) categorizing perception
on the basis of common traits (conceptualization) or, (c) in
orienting themselves with respect to time, place or person.
These children are often deficient in monitoring and organizing
of behaviour; they sometimes avoid sensory stimulus and are
highly limited in the range of pleasurable or painful responses.
Schizophrenic children or adolescents lack goal-directed behav-
iour and, indeed, see no responsibility or necessity in initiat-
ing and carrying through successful action at all. The child
can therefore not distinguish self from non-self nor attain
continuity in self-feeling or body image.(Goldfarb, 1969:688)
The deficiencies in self-awareness and the inability to give
meaning to new experiences, prevent connections between self,
behaviour and previous learning. The child is in a nearly con-

stant state of bewilderment and disorientation.

> There is a great deal of evidence that these
> children struggle to overcome the frightening
> strangeness and meaninglessness of a reality
> which does not assume the aspects of predict-
> ability and form. They also demand repeatedly
> of the therapist or the therapeutic environment
> that steps be taken to diminish the vagueness
> and uncertainty of experience.
>
> (Goldfarb, 1969:690)

Thus, the three fundamental dimensions of Schizophrenia
(lack of perceptual integration, lack of self-awareness, and lack
of communicative ability) must be addressed in any corrective
therapeutic environment. This means teaching the child to:
(a) attend visual and auditory stimuli (especially where con-
nected with another human being); (b) acquire a realistic
concept of the body and its separateness from others; (c) develop
a concept of spatial and temporal reality, and (d) develop com-
munication and interpersonal skills.(Goldfarb, 1969:690-691)

The theoretical relationship between the social psy-
chology of adolescence here discussed, and the therapeutic goals
and methods of Gestalt Therapy, will be dealt with in the final
chapter of the thesis.

FOOTNOTES - CHAPTER IV

1.   Both Coles and Kagan (eds.), <u>12-16 Early Adolescence</u>,
         Norton: New York, 1972, and Robert M. Wilson,
         "A Proposed Diagnostic Classification. . . "
         Sherman Feinstein (ed.) <u>Adolescent Psychiatry Vol. I</u>,
         Basic Books: New York, 1971, p. 276, state the
         difficulty in defining "adolescence" in general and
         "adolescent emotional disturbances" in particular.

2.   In 1965, 12.7% of the Male, and 11.7% of the Female
         Canadian population were expected to be admitted to
         a psychiatric institution on at least one occasion
         in their lives. This does not include private psy-
         chiatric care or out-patient care. In 1969, admis-
         sions to Mental hospitals were 24% higher than in
         1965 and 218% higher than in 1955. In 1970, admis-
         sions were up 8% over 1969, and in 1971, were up 6%
         over the previous year. "Mental Health Statistics",
         occasional catalogue, #83-506, Oct. 1968, p. 8,
         <u>Dominion Bureau of Statistics</u>, Ottawa, Canada;
         also, "Mental Health Statistics" (DBS) Patient
         Movement, Preliminary, 1971, Ottawa, Canada.

3.   This stance was corroborated in the G.B. Rush and
         N.J. Mansfield study, "Apprenticeship for Adulthood:
         Growing Up in Shore City", Simon Fraser University,
         1973.

4.   "Principle" in this sense, means the abstract maxim
         which underlies political catch-phrases and slogans.
         It implies the ability to move from the specific to
         the general in deductive fashion.

5.   The inevitable questions on the relevance of social
         class and cultural dimensions of the criteria for
         this "stage", are dealt with in the above mentioned
         study by a rigorous cross-cultural analysis. It
         tends to substantiate the fact that a capacity for
         such a conceptual "leap" exists in all cultures.
         Rural-Urban factors, and social class powerfully
         influence whether or not the "leap" takes place.
         (Kohlberg and Gilligan in Kagan and Coles (eds.),
         <u>op. cit</u>., p. 158)

6.   "Mental Health Statistics", Patient Movement, <u>Dominion
         Bureau of Statistics</u>, 1969: Ottawa, Canada.

CHAPTER V.   GOALS AND METHODS IN THE PRACTICE OF
               THERAPEUTIC COMMUNITY: PERTINENT LITERATURE.

Since Easton described itself as a Therapeutic

Community, it is necessary to explore the theoretical contra-

dictions and consistencies (on the theoretical level) between

the tenets of Gestalt Therapy and the tenets of Therapeutic

Community. Hence, we will explore some of the relevant lit-

erature on Therapeutic Community.

1. The Concept of Sociotherapy.

"Sociotherapy is a method of treatment the focus of

whose operations is the situation--particularly the social

system. . .in which the individual is treated." The central

focus is on the potentiality for personality and behaviour

change as a result of the influence of the milieu's social

system on the individual's personality.(Edelson, 1970:22-24)

Fundamentally, the therapeutic community version of

sociotherapy serves a wide range of functions which are dis-

tinctly different from standard psychiatric hospitalization.

While removing the patient from the terror and anxiety of

complex social situations which he found difficult to handle,

it at the same time attempts to place him in a social situation

which is simpler, though definitely not isolated or deprived.

Transactions with others not only provide reality-testing

situations, but with a degree of control, most of these con-

tacts can be non-threatening since they are made with people
in similar stages of crisis and situational difficulty.
Ideally, the environment should be quite predictable and yet
honest and as authentic as ward environment can be. The level
and complexity of social performance required should be appro-
priate to the population.

Rather than exert external physical control over a
patient's behaviour (which is often impulsive, disorganized or
self-destructive), it is hoped that the patient will hopefully
learn personal controls and appropriate social responses to
staff and other patients.

Due to the often chaotic, unpredictable nature of the
environment from which many disturbed people come, it is usually
desirable that predictable role demands and organization prevail
rather than anxiety producing, lawless expression of personal
impulses.(Edelson, 1970:12)

The anxiety-producing fantasies and misconceptions
about other people, events and relationships (often fostered in
the patient's informal groups) are ideally checked in an envir-
onment which attempts to make information available about all
aspects of the environment. Rumour and the often viewed emot-
ional contagion of impulsive behaviour, is checked by open
communication among residents and staff in the community. With-
drawal and regression are thwarted by pressures to participate
in a wide variety of community activities. All members must
take some responsibility for group living and the decisions

which are crucial to its functioning.(Edelson, 1970:13) It
must be emphasized that these are the theoretical ideals of
therapeutic community.

Ideally, this approach to therapy is designed to re-
place external coercion with a commonly developed system of
values, which will provide the foundation for developing com-
munity solidarity and a basis for judging the appropriateness
of the behaviour of its individual members. The often coercive
demands of institutional functioning can limit the achievement
of this goal.

Quite understandably there are many problems in the
application of these goals:

a. There is the problem of passive conformity to group
norms and values which in fact emerge from the wishes and inter-
personal power of the more active and articulate of the group
members.

b. There is the problem of the severe acting-out,
anti-social individual who will not commit himself to any
ideology or behavioural system. Since socialization is the goal
of this milieu, a person who actively resists it becomes a
problem for the group.

c. There is the problem of how to resolve the contra-
diction of predictable environmental and interpersonal responses
without developing artificial or inauthentic interpersonal
interaction.

d. There is the problem of predictability of response
and support for the patient's self-esteem, while at the same

time expecting honesty in an environment where open communication
is expected.

These are sociological problems, and the focus of socio-
therapy on the operation of the unit as a social system is fund-
amental. "Sociotherapy focuses upon. . .the life of a group. . .
rather than the life of a single individual; the situation or
external reality in which a person acts rather than his inner
world."(Edelson, 1970:25)

Integration into a social system is, of course, the
mainspring of this effort, but the distinction between formation
of a surrogate or ephemeral primary group bound by effect (on
the one hand) and integration based on social symbols (on the
other), is of tremendous importance. Edelson states:

> In this group it is not people primarily that
> are the objects of integrative concern but
> rather cultural objects--values and beliefs or
> ideas concerning man, nature, and society--and
> the integration or harmonization of these with
> each other.

> Members are bound not by feelings toward one
> another, but by their disciplined commitment to
> shared values and the beliefs linked with these.
>   (Edelson, 1970:49)

Now, into this integration process comes the ideal of
egalitarian organization and the difficulties of its implemen-
tation.

Mutual staff-patient decision-making tends to make
everyone involved in the process an integral part of the group
process. It generates a feeling of solidarity and serves
(ideally) the function of integration. However, in terms of

the individual therapeutic programs, it can generate difficulties
for staff because of necessarily incomplete information or know-
ledge on the part of other patients (i.e., confidential records
or techniques which require a degree of objectivity for assess-
ment of results, such as attempting to limit the power of sugges-
tion on a resident). The problem of attempting to communicate
everything to everyone is impossible even in group situations.

> . . .Groups are paralyzed, inundated with inform-
> ation they cannot process and the relevance of
> which to any differentiated task, is unspecified
> . . .Smoldering personal antagonisms disguise
> realistic conflicts between different interests
> and functions that must be carried out, because
> no one is responsible to represent a particular
> function and do battle in the service of it.
> Patients as well as other groups sabotage rational,
> adaptive problem-solving by making democratic
> decisions and taking democratic actions impul-
> sively, often primarily in the service of reliev-
> ing anxiety by getting rid of any difficulty as
> rapidly as possible.

>   (Edelson, 1970:117)

Democratic-egalitarian organization, if considered an
important part of sociotherapeutic practice, must represent an
organized system of communication to one or more members of a
group who have the responsibility and are accountable for the
consequences. Feedback mechanisms must be systematically
devised which will give group members assurance that multiple
opinions and all available information are being taken into
account in the final decision.(Edelson, 1970:117-118)

Therapeutic community is to provide a socialization
process - "a school for living" - which will facilitate improved
social life and conditions outside the institution. Interper-

sonal tensions and inter-group antagonisms are dealt with in
full view of the "community", providing (through re-education)
a larger repertoire of possible responses in social situations.
In this situation, the patient is helped to become aware of his
ways of relating to people and he or she is confronted immed-
iately by the consequences of his or her behaviour. In a
twenty-four hour residential facility, the chances of maintain-
ing a defensive facade over a long period of time are exceedingly
limited.

Staff, to be effective, must be aware of interpersonal
and interactional patterns which develop frequently around speci-
fic patients, but must also be aware of how they themselves fit
into the interaction. The patterns must not be "palmed" on the
patient, but rather an analysis of how staff members facilitate
the pattern is of prime consideration. The understanding and
analysis of transference phenomena is of primary importance even
though preventing its development is entirely impossible.(Edelson,
1970:172)

Although a predictable (rather than chaotic) community
environment is often advantageous, tension reduction and the
alleviation of conflict is not the goal either. Tension and
conflict, their exposure and resolution, is what the therapeutic
environment is all about. Neither complete stability nor com-
plete chaos must predominate.

Several very important and delicate balances must be
maintained in the realistic functioning of a therapeutic com-

munity, such as the following:

(a)   the balance between resolving interpersonal con-
flicts and developing interpersonal skills without merely
glossing over severe conflicts or developing dependency rela-
tionships;

(b)   teaching interpersonal skills which will allow
the patient to cope with his environment without "merely adjust-
ing" him or her to a society, at the expense of the integration
of his personality system;

(c)   allowing consequences for the individual patient
to condition decision-making without consideration for the group.
As Edelson emphatically states, these are all genuine dilemmas
for sociotherapeutic treatment which must be met in the specific
situation.   No general prescriptions apply.

2.   The Therapeutic Tools of Therapeutic Community.

Maxwell Jones (1968) laid the theoretical and practical
groundwork for therapeutic community, most of which have been
touched upon in the above theoretical discourse.   However, to
categorize the techniques, we will list them as follows:

(a)   The democratic-egalitarian decision-making struc-
ture as embodied in the "Community Meeting", where staff and
patients congregate to decide upon the important decisions that
affect them.   These decisions, of course, are restrained by
general bureaucratic and institutional limits.

(b)   The open flow of communication between staff and
patient, staff and staff, and patient and patient;

(c) The systematic de-emphasis of usual professional, hierarchical, duty and role relationships prevalent in hospital social organization;

(d) Permissiveness, with respect to the open expression of emotion by staff and patient alike;

(e) Stress on the development of a unique ward "culture" which generates a tradition over time;[1]

(f) Active patient involvement in their own therapy and the therapy of other residents;(Maxwell Jones, 1968:86-87)

(g) Interchangeability of formerly private professional "preserves", where Child Care Workers are involved in Group and Family Therapy, Social Workers are integrated into residence life, and Psychiatrists are working as equals in the devising of treatment plans.

(h) Involvement of as much as possible of the patients' "outside" social network (i.e., family, friends and community);

(i) Patient-contribution to the treatment process by openly criticizing staff behaviour, and forming (where possible) organized patient councils;

(j) In-Service Training and supervision combined with staff, undergoing therapy, in order to better understand the practicalities and intricacies of patient behavioural changes. (Maxwell Jones, 1968:88-94, 147)

3. Therapeutic Community and the Residential Treatment of Adolescents.

The trend away from purely custodial containment of

adolescents (for one hour per day, psychotherapeutic interviews
with a psychiatrist), began with the work of Jones (1953) and
Sivadon (1957), and the empirical work of Polsky and Claster
substantiated many of their claims. A sociotherapeutic focus
in Residential care gave an entirely new role to the Residential
Care Workers, and required new, sophisticated training programs
and decision-making structures.(Polsky and Claster, 1968:157-
163) It was these specific characteristics that powerfully
influenced Easton's development.

Jones, Sivadon, Polsky and Claster, all rationalize
these institutional and therapeutic changes on the basis of the
residence social system as a therapeutic tool. They recognize
that a sophisticated sociological understanding of social system
functioning in a "therapeutic milieu" is required.

If the social system is to provide an important thera-
peutic tool, the Child Care Worker (who has maximum contact with
the child in everyday interaction), must be trained extensively
in group process. Further, the worker's own personal and inter-
personal needs must be attended. The literature suggests that
Sensitivity Training methods and T-Group techniques might best
facilitate this. However, such self-awareness and personal
development must be accompanied by the development of a sound
theory of Residential Child Care Worker function. Goals, expec-
tations, methods of goal attainment must all be clearly delin-
eated for the worker, just as they must be socially developed
for the patients. This demands focus on the functional inter-

relationships of staff roles. A model of what Counsellors and patients want to attain in the cottage, must be developed as a departure point.(Polsky and Claster, 1968:161,175) Just as residence group autonomy in decision-making (and goal attainment) is the main focus of the therapeutic atmosphere, so too, is a degree of Residential Child Care Worker autonomy with respect to administrative dictate necessary for the Child Care staff. A model of Care Worker/Administration functional interrelationship must be arrived at, to give the staff/patient group a degree of security in the boundaries of their decision-making capabilities.(Polsky and Claster, 1968:162-163)

Development of capacities for responsibility and for initiative outside the institutional environment is the goal of sociotherapy to begin with. To do so, it requires a tremendous amount of skill and knowledge on the part of adolescent treatment staff. "To help such clients exercise autonomy in a socially adaptive way involves much more than simply handing over to them more power to control their lives in the institution." Not only would this be severely anxiety-provoking to extremely insecure or socially maladapted residents, but for highly manipulative adolescents of a delinquent bent, it is inviting them to exploit opportunities to repeat past behaviour patterns. A degree of custodialism is required in nuturing more socially adaptive[2] ways of relating and making decisions. The Cottage worker fulfills four interdependent roles in Residential care: He is monitor, guide, supporter, and integrator of a social system

which requires adaptation, goal attainment, tension management,
and integration.(Polsky and Claster, 1968:11,165) In serving
these functions, the worker attempts to use the peer group and
its norms as a vehicle for autonomous goal activity.

> Group confrontation, we feel, provides a testing
> ground for common needs and interests, goal
> formulation, and strategies for reaching goals.
>
> The skills that Counsellors have to develop,
> therefore, is mobilizing the strengths of the
> group toward constructive goals and processes
> rather than delinquency and yet not being trap-
> ped into a repressive authority role.
>
> (Polsky and Claster, 1968:
> 167)

There is no question at all whose values and goals
predominate in the residential environment; it is adult-counsel-
lor values. However, within the bounds of these adult values
and institutional requirements, the residents are allowed the
greatest degree of possible autonomy.

There are several functional requisites for the imple-
mentation of therapeutic community goals with adolescents.
They include:

(a) attempts being made at facilitating the greatest
degree of open communication within the unit between staff and
resident, and staff and staff;

(b) a group-goal perspective must be developed
accounting for needs, interests and problems on both the group
and the individual level;

(c) after the above two conditions have been met, a
group definition of the problems can be effected;

(d)   from the group definition of the problem, a shared, concrete, realizable goal can be set;

(e)   formulation of a strategy and the allocation of roles (and related tasks) is the next step after which the group attempts to . . .

(i)   Procure necessary resources

(ii)   Implement the goal, and

(iii)   Finally attempt to evaluate the outcome.

(Polsky and Claster, 1968:
168-169)

These components emphasize the instrumental activities for consummating group goals.   They provide a learning experience in the logic of approaching problematic situations, and everyone has the opportunity of viewing the actual outcome. Feelings and attitudes that are sparked in the interpersonal contact required for these efforts can be dealt with "therapeutically".   Indeed, this is the real "meat" of therapeutic intervention.   The residents will (ideally) see themselves as part of an active, decision-making group rather than the passive-aggressive (or openly aggressive) underminers of a custodially administered program.   Residents learn interpersonal skills as they attempt to function in this manner.

"Integration" in the Polsky and Claster study is demonstrated by the privately verbalized solidarity among resident members (through the answers in the questionnaire), commitment to the task and the goal, and general effect expressed during the activity.   Although this process model of goal

attainment is an ideal type, it is designed to address the
specific problems of the Residential Care of Adolescents based
upon intensive and controlled research with Adolescents in
Residence. It is designed to give a kind of methodological
security to problem resolution for a developing group.

Fundamental problems in the implementation of such a
program include:

(a) the tension between institutional rules and
regulations which tend to control the use of resources and
generally restrict activity; however, this condition (if shared
realistically with the group) can provide a source of group
cohesion. It nevertheless puts Cottage staff in a vise between
administrative dictates and resident autonomy-demands.

(b) the problem of creating a climate of trust in the
Cottage that will allow residents the security of taking the
risks involved in investing in such group activities.

Two factors of importance in addressing these problems
are:

(1) In-Service Training must teach Residential Care
Workers to deal, negotiate, and where necessary, to confront
administrative rulings which can be clearly shown to be anti-
therapeutic.(Polsky and Claster, 1968:173)

(2) Creating a climate of interpersonal trust,
demands personal "self-development" on the part of the staff
so that they are secure and confident enough to be honest,
authentic and communicative with residents. They must be very

aware of the way they relate to residents and other staff
members so that dishonest or covert interpersonal difficulties
do not develop into major unit problems. Polsky and Claster
suggest that Sensitivity Training, Group Therapy experiences,
and Awareness techniques, are the tools for such development
in Residential Care staff. Staff autonomy has a price and the
price is self-development, involvement with residents, and
commitment to the unit and its goals.

The custodial situation is much more simple and demands
less investment on the part of both resident and staff, but the
results have been far from acceptable. The sociotherapeutic
approach is designed to "structure cottage life so that indif-
ference and frustration can be worked through in social action."
(Polsky and Claster, 1968:176)

3. Important Therapeutic Considerations

Perhaps the most fundamental consideration when dealing
with adolescent behaviour in residence, is knowing that he or
she will almost invariably attempt to recreate the interpersonal
and interactional patterns of the family situation from which
he or she came.(Denber, 1964:189) Those are the patterns he
knows, and significant adults will "fit" many of those patterns.
(Holmes, 1964:252) The residential setting gives ample oppor-
tunity for viewing possibilities and attempting to reconstruct
the so-called "pathological" aspects of family interaction.
Of course, intensive Family Therapy at the same time is neces-
sary to confirm or reject speculations from the Cottage situa-

tion. Being fully aware of possible Transference patterns,
the staff must resist stepping into automatically designed roles
already patterned for them by the youngsters.(Rinsley 1971)
They must try to objectively analyze the situation, draw infer-
ences as to familial patterns, but resist ". . .the sick young-
ster's automatic efforts to recreate with them his old, familiar
patterns of interaction with people.(Holmes, 1964:252)

The staff role is to provide (as far as possible) a
reality-testing function to show that the distortions in commun-
ication method and interaction can be corrected, as well as
provide motivation to change and bear the stress of significant
behavioural change.

The physical and social environment of the unit is
tremendously important. Although it must be made clear that the
youth is in a psychiatric unit for treatment, the physical sur-
roundings should be as comfortable and appropriately designed as
possible. The inherent messages of the physical environment are
important to behavioural expectations; the symbols of personal
responsibility should be visible in the form of breakable
(standard) home items, if personal responsibility is indeed the
group behavioural expectation. A milieu which verbally requires
trust and responsibility while showing the physical trappings of
containment and restraint (locked doors, barred windows, and
immovable furniture), gives an ambivalent and untherapeutic
message to its residents.[3]

The social implications of physical facts must be
carefully considered in a residential therapeutic milieu. Two

practical physical considerations, noise and filth, come to
have particular importance in a residence for adolescents.

Personal or environmental filth have interpersonal
implications among residents as well as implications for the
larger community viewing the institution. Personal lack of
cleanliness gives indications of a definition of self, which
is either low on the social scale (cleanliness is historically
the "stamp" of the higher social echelons) and therefore learned
and accepted, or else very personally low as manifest in low
self-esteem. This is not to suggest that the distinction is
clear cut. Uncleanliness also serves as both a personal and
social group boundary-maintaining mechanism, as well as a method
of conditioning community response (i.e., exemplifying rejection
of established behavioural norms preferring isolation and boun-
daries between in-group and out-group - "hippies" and motorcycle
gangs).(Klausner, 1971)

In a mental health residence which stresses resident
autonomy, staff autonomy, and contains adolescents many of whom
come from lower socio-economic income groups, the fact of clean-
liness and filth, the duties surrounding clean-up and the general
level of hygiene, invariably become a contentious issue. All of
the above social considerations become crucial as well as the
particular problems of the individual resident. The child who
exhibits the behaviour of the obsessive-compulsive ritualistic
handwasher, becomes a particular problem when his lavatory duty
comes up on the roster. Similarly, the child who has filth as

part of his social symbolic repertoire, becomes a problem when the issue of Public Health regulations is raised. Group decisions on this issue will be conditioned by both historical social conditions of the residents as well as by the specificity of their behavioural or psychiatric disorders.

Noise (defined as the pejorative version of "sound") is an important social issue in residence, since its social implications include violation of "personal space", the expression of individual interpersonal power and, under certain circumstances, can affect individual goal-directed performance.(Felipe & Sommer, 1970)(Klausner, 1971:114-115) Research has shown that the level of annoyance to particular sounds relates more to its social appropriateness in time and place, whether or not it is displaced in time and space, whether or not it is attached to the behaviour of an out-group, and whether or not it is in appropriate sympathy with the normal social rhythm of interactional engagement and withdrawal, than to either the level of the noise or to individual personality traits. In other words, the level of annoyance and disruption that the noise causes is related to the social and personal meaning attached to the sound and to the group response, rather than to level, physical nature of the sound, or frequency of the sound (i.e., the number of times it occurs per day).(Klausner, 1971:114-123)

The observable results of noise and cleanliness factors in the residential treatment of adolescents (where individual emotional ventilation, individual autonomy and anti-task orien-

tation are the ideological bywords), will be discussed in a
subsequent chapter of this thesis.

The behavioural expectations of a residential unit
must be clear and staff-role responses, must be predictable.
Despite the seeming pettiness of the issue, rules for mutual
respect and language control (i.e., rules against profanity)
are important in a therapeutic environment, in that the perpe-
tuation of obscene language situations often enables the resi-
dent to take a generic rather than an individual view of the
adult. The indiscriminate use of profane language also gives
an ambivalent message to the adolescent with respect to role
definition of the adult staff. There are powerful interactional
consequences to linguistic norms and free-floating obscenities
that allow children who are often experiencing infantile omni-
potence, to degrade the staff member or peer (while enhancing
his own illusory sense of power). This can be quite destructive
in a social as well as a psychiatric sense.(Holmes, 1964:256)
If unit "culture" is to be considered a major therapeutic device
then the interactional consequences of language, physical struc-
ture, social structure, and norms and values must all be taken
into careful consideration.

In terms of the literature on residential treatment,
it is stressed that what must be clear is that the children or
adolescents have security in the fact that should their personal
control over their behaviour prove insufficient, predictable

consequences (and in some cases, containment) will be under-
taken by staff.(Holmes, 1964:261) Personal responsibility must
not be the punishment which the staff metes out to anxious, in-
secure adolescents, who may well have experienced the anxiety
of omnipotence in their own families. Adolescents require of
adults an intuitive knowledge of what external controls are
required.(De Varon, 1972)

Researchers maintain that adolescents in a group treat-
ment situation progress through a relatively consistent set of
stages where first, the group coalesce by resisting treatment
altogether. Secondly, the group begins to function together in
active resistance to the therapist while testing the limits of
the power situation. Thirdly, there comes a stage of ambival-
ence and peer interpersonal testing, and fourth, there are
gradual, tentative moves toward self-revelation and trust in
group as a whole (therapist included).

Several factors are of importance in movement through
these stages. First, is the factor of sexuality. Adolescent
boys and girls will relate differently to a therapist of either
the same or opposite sex. Rebelliousness, seductiveness, or
self-consciousness can be a consequence of relations with an
adolescent contingent upon the sex of the therapist. The dif-
ferential in ways of relating provides the "meat" of therapeutic
work. Because of extreme sensitivity to sexual matters (dis-
played in adolescence), it is often considered useful to begin
with the least threatening combination (i.e., therapist and

group, all of the same sex), and as social skill is developed
and anxiety reduced, movement is made up the anxiety-producing
hierarchy. But under any conditions, individual and group res-
ponse to its sexual composition, must be taken into considera-
tion.

Second, it is important to consider the relative
maturity of the various group members because children that are
too young (emotionally, socially or intellectually) to cope with
the group situation, can subvert and frustrate the efforts of
the more concerned and mature members. They can also draw a
great deal of destructive anger upon themselves for their imma-
ture behaviour.(MacLennan & Felsenfeld, 1968:157) Younger chil-
dren can benefit from the group, but content, goals and procedures
must be fitted to their needs.

Third, attention must be paid to processes such as
anti-authoritarian indigenous leadership, which can subvert any
therapeutic effort if not carefully dealt with. Perhaps even more
dangerous is the scapegoating phenomenon which can happen in child
and adolescent groups, while drawing group attention away from
interpersonal inadequacies or personal problems.

Given the extreme sensitivity to peer pressure manifest
in early adolescence, the group treatment situation is quite
threatening, and to allay the severe anxiety, the therapist must
take care in developing a level of trust, mutual identification,
the reinforcement of subtle self-revelatory gestures and inter-
personal honesty.(MacLennan & Felsenfeld, 1968:86-87)

The value of the group as an activity must be firmly established at the outset, and no adolescent's omnipotent strivings must be fed by his being able to disrupt the group. Peer influence in the character of what many therapists call "emotional contagion", must be interrupted so that a degree of security and predictability can be established in the group situation. Without this security a climate of trust cannot possibly develop.

Since interpersonal power is of such importance in early adolescence, the strong youth will inevitably try to wrest the power from the therapist's hands, but having done so, he feels insecure in his power and often experiences guilt.(MacLennan & Felsenfeld, 1968:87) The therapist's role must be firmly established and maintained without being either authoritarian or overly tolerant. Every group will define the situation differently, but the range of disruptive possibilities is quite narrow, and the therapist can develop through experience the sensitivity and skill in handling nearly all these contingencies, so long as he is aware of the social dynamic processes which predominate in adolescent groups (i.e., the above mentioned quest for power and control inherent in "omnipotent" adolescents, scapegoating as avoidance of personal anxiety, and isolation of the therapist, etc.). Individual differences and conflict among the youth, competition, member roles, individual and group resistances, monopolization, avoidance of certain areas of discourse, and physical gestures, all provide the substance for personal and interpersonal contact at the group level.(MacLennan & Felsenfeld: 1968:89-100)

In an adolescent group (as in most others), if the
therapist is to generate an atmosphere which generates genuine,
helpful, personal revelation and sharing, he must focus on
interpersonal processes and group dynamics which include the
therapist's own behaviour and feelings. If he does not focus
on the interpersonal but rather emphasizes manifestation of
personal effect, he may well be reinforcing group resistances
to learning how they function socially and interpersonally.[4]

When the group is to be genuinely used as a therapeutic
tool (rather than just as an arena for individual symptoms), its
patterns and mechanisms serve multiple functions. The group can
ideally offer the following:

(1) A secure setting for adolescents to become acquain-
ted with (and interact with) their peers and significant other
adults.

(2) It generates a visible field for identification
processes and transference phenomena.

(3) It encourages powerful emotional reactions, dis-
cussion of symptoms and investigation into the adolescent's
self and his social network.

(4) It provides models for new behaviour and the
testing of personally frightening behaviour (such as anger or
tears) in a secure setting.(Clark and Yeomans, 1969:129)

In the terms of specific experiential categories it can affect:

        (a) acceptance (by others);
        (b) altruism (for others);
        (c) universalization (realization that one is
             not unique in one's dilemma;

(d) intellectualization (acquiring knowledge and labelling experiences);

(e) reality-testing;

(f) transference;

(g) interaction;

(h) ventilation;

(i) spectator therapy (positive effect by listening and observing oneself and others).

These categories were designed in an attempt to cover the three significant and interdependent levels of human functioning: the intellectual, the emotional, and the behavioural. (Clark and Yeomans, 1969:129-130)

FOOTNOTES - CHAPTER V

1.   Therapeutic ward "culture" is used by Maxwell Jones to
      refer to the system of roles, behavioural expecta-
      tions, communication methods, language, norms,
      values, and modes of interaction which take place
      on a therapeutic ward. Analysis of ward culture
      demands the critical appraisal of all roles on
      the ward, including the Doctor and Nursing roles.
      The Therapeutic Community ward culture includes a
      democratic-egalitarian decision-making mechanism,
      and daily community meetings for the analysis of
      communication and interaction difficulties on the
      ward. This system includes the patients as a key
      factor in the decision-making process.(Jones, 1968:
      102-105)

2.   This is not meant in the sense of "normal, adaptive
      behaviour" as representing compliance with normal
      social behavioural expectations (i.e., "good"
      behaviour), but rather in terms of peer group
      relations as well as relationships with adults.
      It suggests, not perpetually abusing, terrifying
      or scapegoating weaker members of the group or not
      falling into so-called "primitive" relationship
      patterns, such as incessantly inducing the wrath
      of the whole group down upon oneself.

3..   This, of course, assumes admissions control in order
      that chronic, violent, self-destructive or run-away
      adolescents not be admitted to any therapeutic group
      in large numbers so that their behaviour predominates
      the ward culture and its norms. Such was the case
      at Easton.

4.   There are many examples. For instance, if personal
      ventilation of anger is socially reinforced and its
      interpersonal consequences not considered, then a
      scapegoating situation can be viewed as therapeutic
      for some people (grandiose or obsessional individ-
      uals). However, individual and group hostility may
      well represent group avoidance of motivating
      anxieties such as sexual tensions or group fears
      (i.e., lack of confidence in group ability to func-
      tion). This was a problem often at Easton. Another
      phenomenon is manifest where personal ventilation
      of sadness (i.e. crying), especially by staff mem-
      bers, can become extremely anxiety-provoking for
      residents. At times, this has an integrating effect

FOOTNOTES (Cont'd.)

on group functioning (i.e., group "rallying-around"
the staff member giving support), but it also can
be a way of avoiding frustration and anger at the
way the group is functioning as a process. In
this milieu, the way to appropriately express your-
self is on the emotional level. In the event that
you criticize the group from an intellectual or
"process" level, you have made yourself subject to
the group criticism of being "into your head".
Ventilation and introspection often prevent situa-
tional analysis. It can cause a group to become
"situation bound" (i.e., unable to move beyond a
particular effective level, like sadness). It tends
to drain off energy which the group would devote to
self-criticism and active social change. Ventilation
and introspection can subvert "social learning" in
the form of setting goals, completing tasks, organ-
izing activity. . .the benefits of co-operation,
organization and group effort.

CHAPTER VI.   PARAMETERS OF EASTON IN-TREATMENT POPULATION, TREATMENT FORMAT AND STAFF FUNCTIONING.

A.   In-Treatment Population

   1.   Categories of Psychiatric and Behavioural Disorders.

        At the beginning of the study, Easton's Director and staff held a high level of control over admissions and adjusted intake to the contingencies of the treatment modality. However, as the community and agency pressure grew, more severely disturbed youths were admitted but always under conditions where staff could consider the potential resident's suitability for the unit with respect to: (a) existing inter-cottage group dynamics; (b) applicant motivation; (c) severity of the applicant's disturbance; and (d) applicant's "potential for growth".

        Despite this admissions control, the resident population (during the time of the study) represented a relatively severely disturbed group of adolescents. The Diagnostic and Statistical Manual of Mental Disorders, Second Edition (APA, Washington, 1968), known as the DSM-II, has been used as the source of the Diagnostic categories provided below.

        From a sample of thirty-nine residents (see Appendix "C" for sample characteristics), nine out of thirty-nine (9/39) were diagnosed as Psychotic (not attributed to physical conditions) exhibiting a range of disorders which included Schizo-

phrenia (Paranoid type), Schizophrenia (Latent type), Schizo-
phrenia (Chronic-Undifferentiated), as well as Schizo-Affective
type and Childhood Schizophrenia.

A further six out of thirty-nine (6/39) residents
manifested symptoms diagnosed as "Personality Disorders and
Other Non-Psychotic Mental Disorders", including Hysterical
Personality, Passive-Dependent Personality, Anti-Social Person-
ality and Passive-Aggressive Personality.

Two of the sample thirty-nine residents were Non-
Prescription Drug users qualifying as "Drug Dependent" (304)
and "Group Delinquent Reaction" (308.5) as well.(The bracketed
numbers are the DSM-II identification numbers for these cate-
gories.)

Two of the sample thirty-nine residents were diagnosed
as "Adjustment Reaction of Adolescence" and related to Speech
Disturbances (306.0), which is of importance in a therapy deman-
ding a high level of verbal performance.

Only five out of thirty-nine (5/39) residents exhib-
ited a clear-cut "Transient Situational Disturbance", the most
common of which was "Adjustment Reaction of Adolescence"(307.2).
This category represents the least severe of disturbances to
this point, and has the highest statistical chance of therapeu-
tic success. Situational disturbances were essentially the
target population for the Gestalt therapeutic approach, but many
of the adolescents admitted were assessed as "transitional" upon
intake and were found to have more severe difficulties during

treatment. For instance, two of the "Adjustment-Reaction" type youth were found to have discrete learning disabilities.

The remaining fifteen residents were presented to the unit, being twelve with Behaviour Disorders of Childhood and Adolescence (308) which included Group Delinquent Reaction(8/39), Overanxious Reaction of Adolescence (308.2), Runaway Reaction (308.1), Withdrawal Reaction (308.4), and Unsocialized Aggressive Reaction of Adolescence (308.4).

Further, two of the resident sample exhibited Organic Brain Disorders. In one case, a thirteen year old boy had been diagnosed as having Hurler's Syndrome, which is often accompanied by mental deficiencies. Another resident presented with Non-Psychotic Organic Brain Syndrome with Epilepsy (309.4). One resident in the sample exhibited a clear-cut "Obsessive-Compulsive Neurosis" but was the only one of the sample to clearly fit into that category (Neuroses).

Using the fundamental DSM-II Diagnostic nomenclature to assess the above numbers of residents, we find the following percentages:

TABLE I

Percentage of Easton Sample Population Representing Particular Diagnostic Categories:--

DSM-II Diagnostic Category	Percentage of Sample Population
II-B Non-Psychotic Organic Brain Syndromes	05%
III Psychoses not attributed to physical conditions	23%
IV Neuroses	03%
V Personality Disorders	15%

DSM-II Diagnostic Category	Percentage of Sample Population
VII Special Symptoms	10%
VIII Transient Situational Disturbances	13%
IX Behaviour Disorders of Adolescence	31%

It is interesting and useful at this point to assess the staff perception of therapeutic success relative to these broad diagnostic categories.

Approximately sixty percent of staff-interview respondents maintained that Easton's treatment modality was not appropriate for delinquent or severely acting-out adolescents, while nearly one-half (fifteen out of thirty-nine - approximately 41%) of the adolescents-in-treatment fell into this category. In this 41% of the sample population, are included all the Behaviour Disorders of an "Unsocialized Aggressive Reaction" type, plus Runaway Reaction, Hyperkinetic Reaction, Group Delinquent Reaction; also included are Personality Disorders including "Hysterical Personality", Anti-Social Personality as well as Organic Disorders manifesting unpredictable explosive outbursts. All residents falling into the "Schizophrenic" category were excluded.

Further, 40% of the staff respondents maintained that Psychotic adolescents could not be successfully treated with Easton's treatment modality, while 23% of Easton's treatment population (assuming that the sample is representative) had been diagnosed as Psychotic.

In summary, we can state that 36% of the Easton staff

sample maintained that neither severely acting-out (or Delin-
quent) adolescents . . . or adolescent Schizophrenics . . .
could be successfully treated at Easton while these categories
of adolescents constituted approximately 64% of the In-Treatment
population.

2. <u>Age Range of the In-Treatment Population</u>.

Easton's target population was young adolescents, from
age Twelve to age Sixteen years. In each cottage, the average
age of residents fluctuated in accordance with age variations on
intake. However, seldom was the average age of cottage residents
older than Fifteen (15.74 was the average age in resident sample)
and for a period of four or more months of the study, in one of
the residences it fell to just over Fourteen years of age. The
number of Seventeen and Eighteen year olds was generally small
due to the unit age policy, and this suggests that the cottage
group gravitated towards the "immature" end of the "early-adol-
escent" spectrum.

With respect to the <u>cognitive development</u> aspects of
Easton's in-treatment population (relative to the intellectual
demands of Gestalt Therapy), there are only a few observable
phenomena worthy of recording.

First, there are the incidents of openly expressed
confusion with respect to: (a) the meaning of Gestalt terms,
therapeutic phrases and ideological concepts, and (b) the con-
crete behavioural expectations implied in these terms, phrases
and concepts in the context of cottage life. The following

incidents are relevant to the discussion.

Incident No. 1 - After having lived within a cottage environment and having attended two months of daily cottage meetings, a Sixteen year old working-class male stated: "I don't know what you're all talking about around here. . .I don't know what's being said most of the time in community meeting. . ."

Incident No. 2 - A Fourteen year old boy diagnosed as an Adolescent Schizophrenic ventilates anger by shouting very mechanically in a group, as the therapist instructs him. When the therapist states that it: ". . .doesn't seem real", the boy shouts in frustration and tears, ". . .what do you want of me, what do you want of me?" The therapist could only reply that it didn't "feel" right.

Incident No. 3 - A Seventeen year old boy (with a very low intelligence rating), having pounded a pillow and who shouted at his father-surrogate, states: ". . .what do I do now. . . if I ever hit my Dad, he'd kill me. . . ."

These are three characteristic incidents which manifest a recurring phenomenon at Easton:-- adolescent confusion over the abstract terms, concepts, and expectations in the Gestalt milieu. Typically, most disturbed or acting-out adolescents are not particularly verbal, therefore the confusion would not often be expressed this clearly and other indices must be sought.

There is the phenomenon of the verbal, manipulative and assertive residents adopting the slogans in automatic fashion

or using them as verbal indictments in their interpersonal relations.

Example No. 1 - Resident (Blair): "I think you're all just trying to analyze me to make me do what you want. You all get together in a group and pick on one person." Resident (Kim): "All you're doing is 'mind-fucking', Blair. You're avoiding. . . so you don't have to tell us about your problems."

Example No. 2 - Staff Member: "Vic, I think you're acting out here in this group because Joan (new female resident) is here and you want to show off." Resident (Vic) responds: ". . .projection. . . ."

Example No. 3 - Resident (Marg): Turns her face into a corner when group confronts her on not showing any motivation in group therapy activities. She has done this repeatedly. Resident (Alf) shouts at her, "Oh, here we go again, Marg, playing your stupid little game, drawing all the attention to yourself." Marg responds in outburst: ". . .game! game! that's all people talk about around here. I'm not playing any game; I don't even know what you mean by a game!"

Staff were repeatedly concerned (especially in clinical consultation meetings) that the residents were adopting the Gestalt language without grasping the meaning, and although specific Gestalt words and slogans could be removed from discourse (strategically by staff), the phrases that replaced them were quickly adopted by the verbal, assertive residents and in-

advertently reinforced as signs of "treatment success" by staff.
This language, then, became part of cottage culture. The mean-
ings, however, remained vague and unqualified (largely due to
the anti-intellectual, anti-operationalization bias in the
therapy), and were predictably far too complex for the residents.

In terms of ego-identity development, the most readily
observable index of adolescent difficulty in this area was mani-
fest in the response: ". . .I don't feel like I have a 'real'
self. . ." or, "I don't feel like I'm being 'real', even when I
do what you say. . ." and, "I'm a different person when I'm
with different people."

The expectation that one "find themselves" is a high
expectation when addressed to highly educated, competent adults
but the adolescent seldom responds in a way which can either
behaviourally or verbally express compliance with the expectation.
This is predictable, given the earlier material presented on
adolescent ego-identity development.

In terms of the moral stage development indicative of
conceptual and behavioural adaptation to a democratic-egalitarian
social organization, few of the residents expressed other than:

(a) a conventional-type adherence to the rules of
freedom and/or restraint which prevailed in the cottages, or

(b) a wish for blanket individual freedom manifest
in total manipulation of any freedom given them, or

(c) a wish for firm, punitive measures taken against
miscreants, or

(d)   a compliance based largely on situational inter-
personal or social power of staff members or other residents.

Staff could <u>enforce</u> a democratic-egalitarian ethos
only by diluting or redirecting the more authoritarian, punitive
and power-based modes of behaviour displayed by the adolescent
residents in their interpersonal relations.

In terms of the three categories of development assoc-
iated with the age group of the population, these are the chief
behavioural manifestations of their specific "stage" of adoles-
cence while in treatment at Easton.   On the basis of the above
observations, we can state that most of the adolescent residents
were indeed <u>young</u> adolescents in terms of cognitive, moral stage
and ego-identity development.

3.   Socio-Economic Status of Families
<u>of Residents-in-Treatment.</u>

a.   <u>Category by Occupation of Principal Earner</u>

Available information from the statistics sheets in
the file of each resident, provided only one consistent index
of the Socio-Economic Status (SES) of the family:-- the occupa-
tion of the principal earner.   However, as the literature on
Socio-Economic Status suggests, there is a high correlation
between the various scales for measuring SES.   Warner and Lunt's
1941 study used two methods: (1)   Evaluated Participation (EP)
and, (2)   Index of Status Characteristics (ISC).[1]   In their
particular study, the ISC correlated .97 with EP ratings, and
Kahl and Davis (1955) have "demonstrated that all measures of

SES correlate highly and that occupation is by far the most

important factor."(Kennett, 1969:5,7)

As in the Kennett study, we will use Edwards' (1943)

occupational classifications, since they best apply to the

statistical data available on resident's families.

TABLE II

Percentage of Easton Sample Population Representing Particular
Occupational (Socio-Economic Status) Categories:--

Father's Occupational Category (Edwards 1943)	Percentage of Residents' Fathers* in Category
I. Professional	(6/39) 15%
II. Proprietory and Managerial	(5/39) 13%
III. Clerical and Sales	(3/39) 08%
IV. Skilled Labour and Supervisory	(7/39) 18%
V. Semi-Skilled Labour	(7/39) 18%
VI. Unskilled Labour**	(11/39) 28%

TABLE III

Range of Occupations Represented in Families of Easton's
Treatment Population:--

Father's Occupational Category (Edwards, 1943)	Range of Occupations Represented (Easton Sample)
I. Professional	City Business Executive University Teacher Finance Executive Insurance Executive Ex In-Business Proprietor
II. Proprietory and Managerial	Engineer High-Income Sales Personnel Successful Small Business Proprietor

Father's Occupational Category (Edwards 1943)	Range of Occupations Represented (Easton Sample)
III. Clerical and Sales	Farmer/Town Official Company Timekeeper Bank Clerical
IV. Skilled Labour and Supervisory	Train Conductor Millwright Carpenter (Specialty) Shop Foreman Smelterman Sheetmetal Worker
V. Semi-Skilled Labour	Warehouseman Carpenter Service Worker Janitor Appliance Repair Parts and Service
VI. Unskilled Labour	Part-Time Sales/Clerical Unemployed Semi-Skilled Unskilled Labourer (Carpentry) Unemployed Transient Business

---

* If Mother is the principal income earner, her vocation was placed in the category.

** Note that unemployed workers and welfare recipients are included in Class VI.

If we use the traditional classifications of upper class, middle-class and lower class (which Hollingshead and Redlich, 1958 believe is still fundamentally useful), and divide the professional categories into three basic groupings, we find that nearly one-half (46%) of the resident sample is in the "lower class", one-quarter (26%) are "middle-class", and just over one-quarter (28%) are in the upper-class range. As we will

come to see, SES as a factor, powerfully influences a child's
Intelligence Scale performance and level of verbal skills.
Both intelligence and verbal skill are important factors in
improving the probability for success when applying Gestalt
Therapy.

b. Staff Perception of Treatment Success
    Relative to SES Ratings

The relationship of Social Class or Socio-Economic
Status to projected treatment success, was not dramatically
stated in the staff interview sample and indeed, five out of
twenty-five (20%) of staff interviewed stated categorically that
SES bore no relationship whatsoever to treatment success in their
estimation. Nevertheless, ten out of twenty-five (40%) of staff
interviewees maintained that Easton's therapeutic approach had
the best success with middle-class adolescents, and an additional
nine out of twenty-five (36%) felt that the chances of treatment
success were low with working-class or lower class adolescents.
One interviewee said that he could not judge any relationship,
due to lack of information.

A clearer statement of the relationship of SES to
treatment success (as perceived by staff) can be stated in this
fashion:

> (i) 40% of the staff sample maintained that of
> the total treatment population, middle and upper
> class residents were more accessible to treat-
> ment. This SES group constituted only 28% of
> Easton's sample population.

(ii) 36% of the staff interview sample maintained

that what constituted 64% of the treatment popula-

tion (working-class and lower class residents)

were less successful as treatment subjects.

(iii) 76% of the staff interview sample maintained

that Easton's treatment method had a better suc-

cess rate with middle or upper-class youth, than

with lower or working-class youth.

Therefore, a significant proportion of staff perceived a direct

relationship between level of SES and probability of treatment

success. Let us now consider information related to the probable

reason why.

4. Intelligence Quotient and Level of Verbal Skill
    of the Resident.

a. Literature on the Inter-relationship of
    SES, I.Q. and Verbal Skill.

The previous section on Socio-Economic Status bears

directly on the level of verbal skill manifest by residents-in-

treatment. There is a wealth of literature suggesting an impor-

tant connection between Socio-Economic scale levels and Intelli-

gence Test results.(See Table VI, at page 14)

All the studies from Burt (1922) through Davis (1948),

show that children of various SES groups vary in mental age and

therefore in cognitive performance and verbal skills. Research

shows consistently that children from professional families

score consistently higher on I.Q. Scales than children from

labouring families. Terman and Merril (1937) show that children

of unskilled labourers average about twenty points (on the I.Q.
Scales) lower than children of professional-occupation families.
More relevant to this study is the fact that McGehee and Lewis
(1942) found that high SES families produced more gifted and
fewer retarded children, while the reverse was the case for lower
socio-economic families. It was Milner (1951) who showed the
direct relationship which exists between SES level and language
development.

Of special importance to a highly verbal and concept-
ually abstract therapy such as Gestalt, is Terman's (1937) state-
ment, that: "Language, essentially, is the shorthand of the
higher thought process and the level at which this shorthand
functions is one of the most important determinants of the level
of the processes themselves."(Noted in Kennett, 1969:21)

Further, Kennett goes on to state that other researchers
such as Eells et al (1951) indicated that SES was the chief fac-
tor affecting scores on the intelligence tests, and pointed out
that the largest advantage gained by middle or upper-middle class
SES children was on the verbal items.(Kennett, 1969:23)

Later, correlations between I.Q. and higher SES group-
ings exist in the work of Vernon (1969) and Rosen (1961), who
suggest that higher SES groups have the verbal skills and the
motivation to perform well on such tests. Verbal skill and mot-
ivation were two of the implicit intake criteria at the Easton
facility.

B. Bernstein (1960) argues that "the predominant
language codes of the middle and lower working classes underly

their whole systems of relations to objects and people. . . ."
The middle-class uses a largely "formal" or "elaborate" code
while working and lower class groups use the "public" or "res-
tricted" code.(Vernon, 1969:49)

> The former code emphasizes precise description
> of experiences and feelings, allows for subtle
> discriminations by appropriate adjectives and
> adverbs and makes possible the analysis of
> relationships and sustained concentration on
> significant themes. In contrast, public lang-
> uage is much simpler, disconnected, "bitty";
> . . .It is inefficient for tracing causal
> relations, and incapable of providing a medium
> for Piaget's formal, operational type of
> thinking.
>
> (Vernon, 1969:49)

Formalization is precisely the linguistic demand made
by the Gestalt group encounter, the Easton language of cottage
interpersonal relations, and the "language of feelings" in
general. If Bernstein and Vernon are correct, the possibility
exists that the language of Easton's everyday cottage life, and
its therapy, was virtually inaccessible to as much as 64% of
the Easton sample treatment population.

b. Intelligence Ratings of Easton Sample
   In-Treatment Population.

Although Easton did not do any systematic I.Q. eval-
uations of residents upon intake, the individual resident files
did give general (although unstandardized) assessments of intel-
lect based upon the Wechsler Intelligence Scale for Children
(WISC), the Wechsler Adult Intelligence Scale (WAIS), the Minn-
esota Multiphasic Personality Inventory (MMPI), and the more
intuitive psychiatric and psychological assessments based upon
face-to-face interviews where verbal performance, drawing per-

formance, and play were observed.[2]

Based on these assessments the in-treatment population sample presented itself as follows:

TABLE IV

Full Scale Intelligence Assessment of Easton Sample Population:--

Full Scale I.Q. Assessment*	Percentage of Easton Sample Population
Above Average Intelligence	19%
Average Intelligence	51%
Below Average Intelligence	28%

*These I.Q. assessments include some WAIS, WISC and MMPI ratings and psychiatric and psychological evaluations of a non-measured type.

TABLE V

Verbal Intelligence Assessment of Easton Sample Population:--

Assessed Verbal Performance**	Percentage of Easton Sample Population
Above Average Verbal Performance	12%
Average Verbal Performance	12%
Below Average Verbal Intelligence Performance	20%

** This Table represents only 43% of the Easton Population Sample for which Verbal I.Q. ratings were available. There were only two test types: WISC and MMPI.

In summary, we can say that based upon the SES profile of Easton's in-treatment population sample, one would expect a

lower I.Q. Scale performance by Easton residents than if the

in-treatment population were more representative of middle and

upper SES groupings.(See Table VI) Further, since one would

expect a lower I.Q. Scale performance, one could expect a lower

level of verbal performance on the part of a significant pro-

portion of the Easton population, and this was indeed the case.

Although the I.Q. rating did not follow the SES profile as

expected, the results suggest that given the high level of ver-

bal performance demanded in therapy, 20% of the in-treatment

population were clearly assessed as being low in verbal skill,

while an additional 8% scored low in Full Scale ratings which

suggests a low level of verbal performance. This group were

most certainly at a serious disadvantage in terms of probability

for treatment success related to the expectations of Gestalt

Therapy. This fact was reinforced in the results of the Staff

Interview.

      c.   Staff Perception of Verbal Skill and Intelligence
          Relative to Probability of Treatment Success.

Fifty-six percent of staff sample respondents main-

tained that average, or above average intelligence, was a pre-

requisite for therapeutic success at Easton.

Forty percent of staff interviewed, maintained that

high level verbal skill was a prerequisite for therapeutic

success.

In terms of the Easton in-treatment population, this

suggests that at least one-half of the Child Care staff inter-

viewed, felt that (what has proved to be) twenty to twenty-eight

percent of the in-treatment population sample were less accessible to the treatment modality.

Now, the twenty to twenty-eight percent low accessibility rate is not a dramatic treatment casualty rate under any circumstances, but other variables must be taken into consideration. One must consider that verbal performance and intelligence were part of the intake criteria at Easton, since a high level of motivation and ability to articulate problems were required of the applicants. Thus, the Easton population is an artificially manipulated treatment population relative to verbal skill, intelligence and, therefore possibly, Socio-Economic Status.[3]

The most important point to stress here, is that the verbal performance demands required by an I.Q. examination bias the results in favour of higher SES groupings. The Gestalt verbal performance demands are very similar in their formal language requirements, and therefore probably bias therapeutic treatment success in favour of higher socio-economic groupings.

Even though Easton's intake procedures favoured more verbal and motivated treatment subjects, its in-treatment population was still predominantly drawn from the working and lower class SES groupings, a significant proportion of whom possessed low verbal skill.

Table VI

Scores on the Army General Classification Test for Occupational Groups
Converted to Deviation I.Q. Equivalents (from Stewart, 1947)

Civilian Occupation	N	76	84	92	100	108	116	124	132
Accountant	216								
Teacher	360								
Lawyer	164								
Stenographer	206								
Bookeeper	302								
Pharmacist	78								
Draftsman	139								
Clerk (general)	2063								
Radio Repair	198								
Cashier	168								
Salesman	895								
Store Manager	385								
Telephone Repair	62								
File Clerk	119								
Airplane Mechanic	115								
Artist	82								
Photographer	70								
Musician	161								
Toolmaker	147								
Shipping Clerk	408								
Printer	192								
Stock Clerk	791								
Machinist	617								
Policeman	172								
Sales Clerk	2362								
Electrician	435								
Meat Cutter	691								
Sheet Metal Wkr.	462								
Welder	236								
Plumber	222								
Auto Mechanic	1693								
Bricklayer	213								
Carpenter	1004								
Baker	334								
Painter	680								
Truck Driver	3473								
Tailor	74								
Cook	653								
Labourer	7805								
Barber	166								
Miner	502								
Teamster	284								
Farm Wkr.	7475								
Lumberjack	236								
Men in General									

10th Percentile Median 90th Percentile
25th Percentile 75th Percentile

(from Tyler and Thompson,
1972: 351)

B. <u>Treatment Format</u>

1. <u>Physical Milieu and Treatment Ideology</u>.

As we have seen in the descriptive chapter on
Frederick S. Perls, Gestalt stressed creativity, spontaneity,
and always used mobility in the physical environment as a
therapeutic tool. The Gestalt ethic in cottage life encouraged
individuality and impulsiveness in the construction of one's
physical environment. The staff firmly believed in these prin-
ciples and conveyed them to the residents. Hence, the residents
often placed their own tie-dyed sheets (made in Arts and Crafts)
as room dividers or as secondary doors to their rooms. This
was designed to assure their privacy and "personal space".
They likewise created a quiet meditative atmosphere in their
rooms by blacking out the windows and burning their own craft-
made candles, as an alternative to the institutional fluorescent
lighting.

In an even more creative technological vein, two of
the residents procured two discarded telephones and skillfully
devised an internal intercom system between rooms.

All these creative, innovative schemes were consistent
with Gestalt precepts, and Child Care staff tended to reinforce
these efforts. However, during the first organized Public Works
inspection, all these devices had to be removed. Fire regula-
tions prevented their installation.

The residents were understandably angry when they
found out that they, indeed, did not have control over their

physical environment, and that it was infinitely less mobile
than they had been told。 These incidents punctured holes in
cottage myths that tended to deny the institutional aspects of
the unit. It created a "double message" to residents and staff
about the nature of their environment. Also, it placed Child
Care staff in a difficult position vis-a-vis the Gestalt ideol-
ogy they adhered to as "therapeutic" versus the institutional
environment in which it was placed, and it placed the staff in a
difficult position politically between the residents that they
hoped to treat, and the institutional rules of health and safety
that they had to enforce. The fundamental difference between
Gestalt ideology and institutional ideology lay in the concept
of responsibility. In Easton, staff were <u>responsible</u> for the
adolescents. In the land of Gestalt, each individual is <u>respon-
sible</u> for himself.

2. Psychiatric Assessment, Treatment Goals
    <u>and Treatment Plans.</u>

A minimum of available diagnostic information on res-
idents was utilized by Child Care staff and material from the
Psychiatric Intake Assessment seldom became a key feature in
devising any treatment goals or a treatment plan.

The problems of the adolescents admitted, (whether
runaway behaviour, withdrawal, group-delinquent behaviour, psy-
chotic reaction, obsessive-compulsive behaviour or explosive-
ness) were largely assessed in the context of Perls' theory of
emotional disorder。

From responses to Questions No. 15 and No. 16 of the Questionnaire (see Appendix "A"), it became clear that at Easton the problems of the residents were viewed as being primarily related to difficulty in expressing emotion, or in being unaware of themselves, since they purportedly had no insight into the nature or effects of their distressing behaviour. They were assessed as being unable to give or receive warmth from other individuals, as having poor family or peer relations, and also as being generally socially isolated.

In general, the problem sources were interpreted and assessed rather than the actual observable problems. The residents were generally seen as lacking spontaneity and the "freedom to learn", and were "immature" in the sense that they found it necessary to manipulate their environment through disturbed or disturbing behaviour, rather than by achieving independence from environmental manipulation. The therapeutic goal was to have the adolescents accept personal responsibility for their behaviour and acquire awareness into the sources of their behaviour.

The lack of intensive or formal psychiatric assessment is manifest in the response of the following staff interviewees:

> .. . . how can one ask oneself what are the kinds
> of behavioural and emotional disorders that the
> kids arrive with. Our system of describing the
> kids while they are here is generally inadequate.
> It's a very kind of subjective language and based
> on how you're feeling about somebody, and that
> doesn't leave me with any sense of development of
> typologies.
>
> (Staff Interviewee No. 1)

Easton was unique because they were willing to ap-
proach it Diagnosis from a different place. . .
They were really interested in the feelings of the
child rather than saying the symptoms are simply:
"The kid has run away from home and he doesn't get
along with his parents." Easton took it one step
further. . . into, "How do you feel as a person?",
"Let's find out what that's all about." and, "Who
do you want to be?"

(Staff Interviewee No. 7)

Lacking a diagnostic system or a nomenclature for

symptomatic or behavioural patterns, most of the residents were

seen as displaying general common difficulties (characteristic

of North American society as a whole), which come under the

following general categories:

a. <u>Emotional Repression</u> - as manifest in difficulty

in expressing feelings of anger, sadness, despair or

love to either their family, other residents, peers,

or the Easton staff; also, lack of insight into the

genetic "sources" of one's emotions and lack of

awareness (insight) into how one is feeling (in the

immediate present).

b. <u>Social Isolation</u> - as manifest in difficulty in

tolerating emotional closeness and warmth with other

individuals, whether peer or adult. The manifestation

of this isolation (and supposed mechanism for protec-

ting it) was viewed as "defensiveness", or "resis-

tance" to intensive personal contact, i.e., setting

up "rejecting" behaviour; lack of verbal expression

or communication with peers, family, residents or

staff; resistance to physical contact with others,

and withdrawal or acting-out. Social isolation

took place on three significant levels:

    (i)   Peer relations

   (ii)   Family relations

  (iii)   Relationships with other significant
          adults.

c. Behavioural Inflexibility - as manifest in

"automatic"responses in particular situations; lack

of spontaneity in "experiencing" one's physical and

social environment; dependency upon environmental

manipulation rather than "self-direction" for one's

behavioural repertoire.

d. Communication Deficiencies - as manifest in

resistance to intensive verbal, physical, or emotional

interchange with other people.

e. Low Self-Esteem - as manifest in lack of motiva-

tion, poor personal hygiene, defensiveness, and resis-

tance to interpersonal contact; little sense of self

worth.

Treatment Goals

> . . . when something goes wrong in a child's devel-
> opment, it's due to their obscuring their feelings
> . . .not feeling free to be aware of what they are
> feeling or to put it out straight to other people. . .
> Mental illness is a denial of a "feeling state".
> The nature of therapy is to keep questioning the out-
> ward thing that the kid gives you, in order to dis-
> cover what caused them. . . .
>
>   (Staff Interviewee No. 16)

Since psychiatric assessment was based largely on

broad, general and common categories of emotional problems

(making no distinction between their characteristics in adolescence, adulthood, or with respect to the degree of severity), therefore the treatment goals tended to be very broad, general and common to the total group of residents.

In response to Questions No. 21(a) and No. 21(b) of the Questionnaire, it became clear that resident "improvement" while in treatment was judged according to:

a. The perceived degree to which the residents allowed themselves to ventilate their personal emotions to other members of the group or their family.

b. The perceived degree to which they shed their social isolation as manifest in:

    (i) Verbal contribution to the group;

    (ii) Commitment to "community" activities;

    (iii) Verbal, physical, and emotional interaction with other residents and staff (or family members during family therapy);

c. The perceived degree to which they displayed behavioural flexibility, spontaneity, and motivation to learn about themselves and their environment, as well as take personal responsibility for their behaviour in cottage situations.

d. Improved communication skills as manifest in verbal and physical contact with other residents and staff; contribution to group therapy sessions and personal "sharing" with individual staff members; also, improved capacity to clearly hear, listen and understand the communications of others.

e. Improved self-esteem as manifest in increased
motivation, activity and involvement in "community"
affairs; improved personal care and hygiene; and,
increased personal responsibility and assertiveness
vis-a-vis community demands and his or her own
personal needs.

The language with which these goals were transmitted
to residents and other staff members was exceedingly complex,
abstract and non-specific. The interview sample displayed many
of the key therapeutic phrases which were often both the treat-
ment goal and the therapeutic device.

Staff Interviewees described the therapeutic goals
as being to: ". . . bring him (the resident) into touch with
himself and. . .into touch with another person."(Staff Inter-
viewee No. 2) The resident was to become: ". . . perfectly
clear with his emotions. . . ." and ". . . really good at the
language of emotions."(Staff Interviewee No. 1)

The in-group expectation of progress within the unit
entailed becoming: ". . . more sophisticated emotionally" with
". . . emphasis on the child's own responsibility to the healing
of his body and his own spirit and mind. . . ."(Staff Interviewee
No. 2) The therapeutic ideal was the child who displayed:
". . . (positive) self-image and emotional strength. . . with
. . . a real sense of himself. . . who is . . . open to reaching
out and asking for help."(Staff Interviewee No. 4)

The sense of responsibility was to be shown in terms

of a "responsible attitude toward the cottage in everyday living", being able to "respond to people in an appropriate way. ° . .", and being able to sit down and talk about their problems rather than acting out their anxiety.(Staff Interviewee No. 7)

Among the other "in-residence" goals were:

(a) to be "self-motivating"(Staff Interviewee No. 9)

(b) to have "self-esteem, self-confidence, experience in relating to other kids, reality-testing capacity, self-awareness, a capacity to listen, and potential to grow".(Staff Interviewee No. 10)

The Existential-Analytic stance representative of Perls, is fundamentally one where a person is expected to "do as they feel. ° . .not as they are told", and in seeing oneself a "lot clearer", one is to learn not to "lay on oneself the 'trips' from the society or from parents. . . ."(Staff Interviewee No. 13). However, in terms of treatment goals, over one-half of the respondents included expectations such as: "doing his (the resident's) clean-up without hassle, following his program in the way he is supposed to, fulfilling his 'gym' commitment." (Staff Interviewee No. 14)

The counsellors interviewed felt that goals were always individualized and some degree of improvement was all that was required of any resident. However, clear individually planned treatment goals did not exist to monitor that degree of improvement. Speaking of goals related to the ideals for dis-

charge, one counsellor states:

> . . . a lot of the criteria were not observable
> phenomena. It was connected with ability to
> relate to staff and other kids in an open, honest
> way. . .ability to take a stand in a hassle. It
> was basically in what they were able to express,
> in feelings and their basic concerns.
>
> (Staff Interviewee No. 21)

There is quite a sharp distinction between the

character of the responses to Questions No. 21(a) and No. 21(b).

Part (b) of No. 21, which related to the discharge requirements

of the residents, brought an entirely different category of

response vis-a-vis the demands of conventional, urban, and social

behaviour.

The discharged resident was (according to the counsel-

lor respondents) supposed to be able to make concrete, realistic

decisions concerning his future. These decisions included,

whether or not to return to his or her family and whether or not

he (or she) would return to school or work.

It was expected that the discharged resident be able

to, ". . . deal with life in a more positive way", deal with

school and work and show himself to be motivated and determined.

(Staff Interviewee No. 23) They must be decisive in the immed-

iate decisions concerning their lives (i.e., placement, resid-

ence, finances, education), and capable of responsibly making

longer range plans and beginning to implement them.(Staff

Interviewee No. 25)

It was also suggested that "resolution" with the family

is a necessary treatment goal, and that the resident be "easier

to live with" than when he or she came into the unit.(Staff
Interviewee No. 27)

It is useful to point out here, that the in-treatment
goals are abstract, non-specific and general (in behavioural
terms), whereas the post-discharge expectations on the adoles-
cents are concrete, specific and pragmatic. The transition
from one set of goals to the other was seldom made gradually.

Treatment Plan

In answering Questions No. 9 and No. 10 of the Ques-
tionnaire, respondents made it quite clear how powerful the
Gestalt influence was on unit treatment concepts despite the
largely "eclectic" label which most staff placed on the unit's
therapeutic orientation.

In terms of the parameters which have been isolated
as fundamental to the psychiatric assessment and treatment
goals, the following treatment plan emerged at Easton:

a. Emotional Ventilation - facilitated by open con-
frontation between resident and resident, resident
and staff, as is characteristic of Encounter Group
techniques; other abreactive techniques applied on
the individual level (but usually with resident ob-
servers) such as:

(i) the physical beating of parental or sibling
surrogates (such as pillows, mattresses) while
ventilating angry feelings;

(ii) physical fighting between "community"

protagonists in "safe" conditions (with boxing

gloves, styrafoam swords, pillows, etc.);

(iii) physical frustration and mild sensory

deprivation of residents to provoke explosive

outbursts (i.e., through physical "Holding

Techniques", confrontation of a repetitive type,

and twenty-four hour intensive therapeutic mar-

athons in isolated and physically small rooms;

(iv) Gestalt "Chair Work" and "Dream Work".

b. Social Integration - through the following:

(i) self-revelation with respect to personal

historical material and current feelings toward

resident and staff members;

(ii) therapeutically controlled physical contact

between resident and resident, resident and

staff, with an orientation toward "self-awareness"

in a group situation. Specific techniques inclu-

ded meditation, body awareness exercises, relax-

ation exercises, self-hypnosis, Yoga, and

recreation.

(iii) interpersonal communication experiments

including "Sculpting" techniques, of the Virginia

Satir (1967) variety, open expression of emotion

toward group members, observation of "body lang-

uage", and group attempts at conflict resolution

between individual residents. These techniques

were designed to address peer and adult relation-

ships in the cottage. As pertains to Family
Therapy, a more subdued form of ventilation,
physical contact, self-awareness and interper-
sonal communication was applied.

c. <u>Behavioural Flexibility</u> - to be achieved through:

(i) insight into personal behaviour patterns,
obtained in confrontation and group encounters;

(ii) ventilation of repressed emotion supposedly
releasing unconscious physical and behavioural
defensive manoeuvres, giving alternative behav-
iours a chance;

(iii) Body and Self-Awareness techniques which
bring defensive manoeuvres and resistances into
awareness, allowing the formulation of behavioural
alternatives;

(iv) arts, crafts, and recreational skills as
alternatives to social withdrawal and restricted
physical expression.

d. <u>Improved Interpersonal Communication</u> - through:

(i) Role-Playing;

(ii) Non-Verbal communication exercises;

(iii) Audio-Visual Playback of behaviour in group
activities and workshops;

(iv) Arts, crafts and recreation as modes of
communication;

(v) Group tasks, group activities and group
decision-making.

e. <u>Improved Self-Esteem</u> - through the following:

(i) increased understanding of one's own behaviour, feelings and social interaction (as obtained through self and body awareness techniques);

(ii) viewing the product of one's own activity and powers in a group situation (Encounter Group, audio-video playback) as well as the products of one's own hands in arts and crafts, in community decision-making, and in therapy with other residents.

On each afternoon, five days per week, a specialized one and one-half hour group would be available to cottage residents and staff, conducted by either a Child Care staff member, a unit staff consultant or an external staff consultant. Audio-visual equipment and special soundproofed rooms were provided for this program. Although the groups were never formally compulsory for the residents, it was expected of a resident that he or she attend a complete "series" of these groups intermittently, to indicate his or her commitment to therapy and to personal change. These were both requisites for the resident's continued stay in the unit as well as grounds for discharge should the resident feel ready to leave.

C. Social Interactional Considerations

1. Staff Roles

    a. Staff Training: Foundation for the Role-Modelling Aspect of Therapy.

Staff learned the above therapeutic techniques from Gestalt, Encounter, and other therapeutic groups both inside and outside the unit. As has been mentioned, the expectation upon staff was that they undergo therapy. In-Service training was to provide personal experience of Gestalt Therapy in staff team functioning as well as direct experience with the residents themselves.

Out of both internal and external therapeutic experiences, an ideal-type model of the Child Care Counsellor emerged and was described by the interviewees in their responses to Question No. 20 of the Questionnaire.(See Appendix "A")

The model Child Care Counsellor was described in the interview sample as a "centered" person - remote and intense - a person who was privately "working through" his or her own personal problems in a therapeutic fashion. They could be described as sensitive, aware, open, and sharing people . . . who would reveal their own personal feelings about other people. (Staff Interviewees No. 26 and No. 27)

The ideal-type Counsellor was described as firm and yet gentle, in confronting the perceived dishonesties and the defensiveness of staff and residents, while showing support for

all earnest efforts made towards personal change. The model
staff member has to be "together" (i.e., emotionally strong,
mature and well "integrated"), having gone through an extended
period of intensive therapy himself. He or she must be able
to give newer staff a general organizational direction as well
as a role-model for staff and the residents' personal lives.
(Staff Interviewee No. 25)

The ideal Child Care Counsellor had multiple program
skills (i.e., arts and crafts, camping, athletics), and was
willing to take personal and social responsibility for the
events on his shift while openly communicating his feelings to
his team members. He or she must be a person who can facili-
tate communication between all members of the community and
have the intuitive skill, ". . . to work with people's inten-
tions rather than their overt behaviour." At the same time,
the ideal-type was to be spontaneous, non role-playing, and
experienced in the full range of his or her own emotions. He
or she was to share a great deal of love with residents and
other staff.(Staff Interviewee No. 24) Other adjectives of
description included:-- intuitive, spontaneous, uninhibited,
and less intellectual.(Staff Interviewee No. 22)

The ability to display emotional weakness as well as
strength held a high priority in response to Question No. 20,
yet the ideal-type also had to have the strength to be unpopular
and to set firm limits with residents. Other predominant char-
acteristics included the ability to pay attention to the details

of both resident and staff behaviour, the ability to display
flexibility with respect to personal needs, expectations and
rules, and the ability to "pace" themselves so that they don't
wear out emotionally on the job. Other consistent adjectives
included: (i) knowledge of the group process and adolescent
development, (ii) high self-esteem, (iii) ability and willing-
ness to learn, (iv) defencelessness (v) innovation in devising
new therapeutic techniques, (vi) conscientiousness, (vii) task
orientation, and (viii) the ability to separate their outside
life from their inside-the-unit life. The ideal-type Counsellor
was also described as a charismatic leader.

Over one-half of the respondents maintained that the
ideal-type Counsellor and the ideal-type resident were counter-
parts of one another . . . and that indeed, the behavioural model
was almost the same for staff and resident. Four staff respon-
dents maintained that the ideal-type Child Care Counsellor was
composed of contradictory expectations and characteristics (task
orientation and high-level personal individuality demanded con-
currently), and that the totality of demands was unrealistic
even in its most diluted form.

    b. Gestalt Therapy as Training in the
        Treatment of Adolescents.

Of the sample interviewed, thirty-two percent of staff
felt that the training program (centered around Gestalt and
Encounter group experience), was appropriate for their needs
as Child Care Counsellors. Forty-four percent stated ambival-
ence on the topic, related either to the supposed lack of theor-

etical teaching on adolescent development and psychiatry, or
to supposed lack of "practical method" content in training.
Eight percent of the sample were categorically dissatisfied
with the training program stating that it was inappropriate to
their needs as Child Care staff.

In either event, it is clear that Gestalt theory and
practice strongly influenced the training program, and from our
description of the source material on Gestalt Therapy, it is
also clear that no significant distinction was made between the
psychology of adulthood and the psychology of adolescence.
Further, no significant psychotherapeutic distinction was made.

Thus, when a child would not respond to treatment or
would only respond automatically as he or she was instructed,
the behaviour was often interpreted as "resistance", "avoidance",
or "game playing". Further, if a child would not respond to the
treatment modality in a period of months and appeared competent
enough to handle his or her own affairs, they were discharged on
the grounds that they were responsible for their own resistive
behaviour, and had "chosen" not to be treated.

Also, in identifying adults with adolescents, there
was less of a tendency to understand that the linguistic problem
in Gestalt might serve as a barrier to young adolescents, both
conceptually and behaviourally. The slogans were abstract,
vague and complex.

Another problem related to this characteristic, was
the tendency to expect a "principled" rejection of conventional

society based upon an already acquired competence in navigating one's way through the intricate complexities of everyday inter-actional events. An adolescent may or may not be competent in everyday interaction, but if he is not, he is less likely to possess information with which to construct a rationale for rejecting conventional norms of interaction. Further, it is unlikely that he possesses the tools with which to forge altern-ative modes of interaction.

In identifying adult neurotic disorders with adoles-cent psychiatric disorders and relating them to a concept and "experience" of the self, Gestalt Therapy tended to obscure the fact that ego-identity development depends upon a high level of cognitive development, since the "self" is an abstraction. The Gestalt ethos assumed that the adolescent residents had already constructed a self which they only had to discover, when in fact their "selves" were (cognitively and socially) in an embry-onic stage of development. There may well have been little "self" for them to discover.

The Gestalt non-distinction between adolescent and adult emotional, mental and behavioural disorders, may well have been the principal source of adolescent expressed confusion and staff frustration in the carrying-through of the therapy.

c. Role Conflict: (1) Staff Member as Employee vs. Staff Member as Gestalt Therapist.

The Public Service Commission Child Care Counsellor expectations included:

(i) the ability to justify a therapeutic approach

in the light of appropriate Psychiatric, Social Work
or Nursing criteria;

(ii) the ability to control adolescent behaviour
in either crisis or acting-out situations;

(iii) the ability to display strength and author-
ity as a role-model in a tumultuous situation;

(iv) the ability to keep sufficient personal
"distance" between oneself and the residents, so as
not to foster dependency between oneself and the
resident;

(v) the ability to apply therapy consistently,
without reference to whether or not one was "under-
going" psychotherapy.

Gestalt Therapy on the other hand, stresses creativity
and individual initiative, plus intuitive responses to situations
as opposed to justifiability or accountability. It stresses the
display of the full range of emotions (i.e., display of adult
weakness, tears, anger, grief, despair, depression, etc.), as
opposed to a "strength and control" behavioural model. Gestalt
Therapy stresses the development of love and warmth in relation-
ships (physical touching, closeness, interpersonal dependence,
sexuality), as opposed to objectivity and "distance". It stres-
ses the continuity of psychotherapy and total life style . . .
of _doing_ and _undergoing_ therapy.

The language of Gestalt is strategically a language
of individuality, personality, personal accountability, and
awareness. It does not include in its repertoire the language

of justification, explanation, accountability or administrative
responsibility. Therefore, when visitors or administrators
questioned the use of these techniques, the response was very
often: "You have to 'experience' the unit to understand it",
. . . "this unit is based on people functioning at the 'feeling'
level and its concepts cannot be operationalized. . .they have
only to be experienced."

The open ventilation of adult (staff) emotions led to
situations where staff were clearly out of control of the situa-
tion. In one instance, a child was ventilating the emotion from
a painful past scene, and became quite physically threatening.
The staff member was so swept up in the emotion and pain of the
situation, that he or she collapsed in tears and had to be vir-
tually "rescued" from potential danger by another staff member.
Also, when staff were encouraged by other staff to "go with
their feelings" and break down emotionally, very often the adol-
escent emotions related to the incident would have to go un-
attended until staff could disengage themselves. In other inci-
dents, the residents would respond dramatically with multiple
"blowups" of their own, and the cottage would go into temporary
chaos, which was considered "therapeutic" by the staff.

Understandably, the issue of open sexual expression
was a troublesome one and staff living consistently with Gestalt
ideology were compelled to express their sexual feelings towards
residents in the interests of their own "mental health" and
honesty. However, the complications were horrendous. On mul-

tiple occasions, staff/resident enfatuations became an admin-
istrative issue and Counsellors' jobs were threatened even
though no overt sexual activity was involved. On other occas-
ions, the expressed sexual feelings of staff would tend to
escalate resident grandiosity or power-controlling, and would
complicate therapeutic development.

Encouraged ventilation of staff anger was also a
contentious issue whenever it led ultimately to a resident being
handled physically. Frustrating and manipulative adolescents
would often try to provoke staff, and in a ventilationist ethos
residents would sometimes be handled. As soon as the problem
became an administrative one, then the staff member was held
accountable for not having sufficient controls or of not having
dealt with his or her anger ("therapeutically"), whereas the
Gestalt training ethos and especially its source material, sug-
gested that ventilation was personally therapeutic.

Gestalt Therapy and Public Service varies dramatically
in their expectations upon the staff members, and the indices
of the resulting stress on staff will become evident, later in
this section.

d. Role Conflict: (2) Gestalt Individualism
vs. Role of Therapist.

The extreme isolationism and individualism manifest
in the "Gestalt Prayer" based on the belief that, "There is no
bridge from man to man. . .strangers we are, and strangers we
stay", is in direct opposition to a community setting which
requires the formation of interdependent relationships between

peers and staff. Residents were often criticized in Case

Conferences, or Monthly Reports, for not having formed close

interpersonal relations with others or for not having committed

themselves to "the group". Similarly, staff were expected to

form "warm" relationships with other staff and residents as a

prerequisite for their own evaluated development. "Commitment"

demanded in-group identification, whereas Perls was demanding

"individuation". The intricate problem of encouraging individ-

uation while establishing commitment to specific therapeutic

community cultural values, was not as difficult for staff who

had a well developed social life outside the unit, but many of

the residents had poorly developed or "pathological" relation-

ships outside the unit. On the one hand, they were told to "be

themselves", while at the same time they were·expected to depend

on the group and live up to group expectations.

In this intensively demanding emotional milieu, staff

meetings would repeatedly bring up individual staff needs for

temporary emotional isolation. The Gestalt ethic demanded that

he or she "be as they felt like being, apart from the expecta-

tions or demands of the residents". But were they to do so, the

resident was left virtually "abandoned" with a developing emot-

ional attachment that had previously been demanded of him (the

resident) as therapeutic, and now that the commitment was made,

the staff member might respond by saying: "Back off for a

while, please. ．．look, this is too much for me right now. ．．

I'm not in the 'space' for closeness." The dependency issue

was especially complex in this milieu.

e. Indices of Staff Difficulties.

(1) Excessively High Staff Turnover

Of the forty-nine Counsellors, Administration person-
nel and Consultation staff that were working full time in the
unit at the beginning of the study, twenty-four were remaining
eighteen months later at the termination of the study period.
This represents a turnover rate of 51% of the original staff in
a year and a half.

This figure must be considered in the light of the
fact that the unit made itself appealing to staff by its non-
institutional ethos, its stress on staff creativity, spontaneity
and individual initiative, as well as its focus on the individ-
ual staff member's personal development apart from his or her
employment. It presented itself as a new and enlightened, non-
custodial, open-door facility, with a pay scale which was twenty
to thirty percent higher than those in other Child Care facil-
ities in the Province.

Despite these potentially appealing aspects of the
unit's policy, the staff turnover rate was 37% higher than the
Psychiatric Nursing and Psychiatric Aide staff turnover rate at
the central Provincial Mental Hospital, in the same period of
time.[4]

Another interesting fact is that of the twenty-five
out of forty-nine who terminated with the unit in the eighteen
month period of the study, 72% were (at least temporarily)
leaving the Mental Health field. Two years later, ten out of

twenty-five (40%) of those who had terminated had still not returned to the Mental Health or Social Work field.

In terms of the high cost of training new staff, a twenty percent attrition rate in eighteen months is significant and costly from an administrative point of view. In terms of days lost to the in-service training program, this represents an approximate cost of $13,000.00 in eighteen months.

(2) Low Staff Morale

In the period under analysis, multiple stages of staff group-depressions took place and were often related to multiple staff terminations, staff transfers to other cottages or to the camp, or were related to resident discharges. It was often considered to be "group therapeutic" when staff were at a low emottional ebb, but it invariably put pressure on the task-oriented staff who kept the unit functioning at a stable level.

Personal journal information shows that cottage staff were at a low emotional ebb in late August of 1971, after a long period of stabilization and control. Two staff members were in heavy personal therapeutic involvement, and severe interpersonal encounters were being "worked through" among other staff members. This was concurrent with a significant staff exodus. After an energizing September and the first half of October, the staff morale began to fall dramatically again through to November and December, as Senior staff began to involve themselves in intensive personal therapy. This depression lasted until mid-January of 1972, when residents and staff seemed to come together on an intensive emotional level after three months of group crises.

The Spring and Summer brought multiple staff terminations and also the induction of new members (March, 1972), with about one-third of staff leaving. April was also a depressing month for the residents since they began to react to staff termin-ations, and the ensuing chaos put an extra strain on staff. The month of May saw periods of individual staff crises, but the Summer months provided additional areas of programming, and resident camp trips and weekly outings took the "emotional heat" off staff and residents. By August, crises and depressions were emerging as a result of further staff resignations, and also, the time lapse was emerging for the two to three month old staff members who were just now entering their own personal therapeutic crises, at the same time that they were just beginning to under-stand their work with the residents.

Over the eighteen month period of the study, there was on the average a crisis (of proportions important to staff func-tioning), every six weeks, and during those times the fatigue of staff was visible. Much of the time, staff looked drawn and depressed, very low in energy (a sign of being "into it"), and although this was not criticized by the supervisory staff, pro-longed periods of depression would often mean that the super-visors would suggest that the staff member undergo intensive psychotherapy. This would often mean that the staff member, (should he or she choose to do so) would be a partial liability on other staff during the period of the therapy.

2. <u>Patient Roles</u>

      a.   Ventilationist Ideology as Infantilization
          of Residents.

Within the cottages (as a result of Gestalt influence) staff as role-models, were encouraged to ventilate their angry or sad feelings to other staff and residents. Residents were encouraged to ventilate, as a sign of committed therapeutic involvement. Because this type of behaviour is not accepted in everyday interaction and also because it is more characteristic of infantile behaviour than adult behaviour, it had the tendency to allow both resident and staff to regress.

Angry, tearful blowups were common and perceived as therapeutic in residence, but indeed, the implicit assumption was that the resident need not be responsible for his behaviour so long as he was being "himself". However, he must face the honest "feedback" from other residents. This position assumes that the resident (like the adult), can conceive of the intense difference between "therapeutic" behavioural expectations, and those of the society at large. There were multiple occasions when discharge plans were being made, that residents came proudly back to the unit describing how they had "told off" the interviewer because he wasn't being honest or "real" with them or was trying to lay a "trip" on them. Ventilationist outbursts are perceived as infantile, in the society at large . . . and indeed they do not take into account the consequences of the outbursts for the other person in the interaction.

Further, ventilation of verbal aggression leads to a ward "cultural language" based on profanities and obscenities, and the social-interactional consequences of this cultural characteristic remained unanalyzed.

Despite the fact that the "street language" of most adolescents is frought with sexual reference and general profanity, a primary therapeutic consideration must be:-- how the perceived role of adult and adolescent is affected by the indiscriminate linguistic "labelling" of people in ward culture.

The realistic perception of authority and adult roles (by often grandiose adolescents) is not generally enhanced by this labelling (stereotyping) process, and its social function must be considered in any "therapeutic milieu".

It can also have a deleterious effect on other residents who are in a process of sexual identification and change, and if they are subject to constant sexual epithets which undermine their self-esteem, it serves no therapeutic function but tends to enhance the power of already powerful or grandiose adolescents in the group.

At Easton, verbal aggression was necessarily a part of therapy, and the function of this linguistic aspect of ward culture went unanalyzed because the Gestalt focus was individual rather than sociotherapeutic.

b. In-Patient Role Expectations vs. Post-Discharge Role Expectations.

The discharged adolescent had to be aware that the situation at Easton was an insular situation and it couldn't possibly be a reality "out there" in the community.

(Staff Interviewee No. 11)

Forty percent of the interview sample of staff, stated that re-introduction into the community was a problem for Easton residents because the behavioural demands inside the unit were diametrically opposed from those outside the unit.

The in-treatment stress was primarily on resident ventilation of emotion, personal awareness, openness, honesty, spontaneity, independence from social conventions, improved sense of self-esteem, and ability to relate to peers and adults. The post-discharge goals, on the other hand, were:

(i) the ability to make concrete, realistic decisions concerning his or her future (i.e., whether or not to return home, go to school or go to work,etc.);

(ii) the ability to cope with a broad range of new social situations;

(iii) resolution of family conflicts;

(iv) the ability to procure professional assistance in time of difficulty;

(v) responsibility for personal hygiene; and,

(vi) the ability to deal with school or work expectations.

As an outgrowth of Gestalt concepts, there was a clear-cut separation between getting one's "emotional" house in order (on the one hand), and functioning in urban North American society (on the other hand). This separation assumed that one's ability to function socially and vocationally would automatically develop, once one's emotional difficulties had been adequately addressed.

c. Ventilationism and Concentration of
    Interpersonal Power in an In-Treatment
    Setting.

Encouraging the ventilation of aggression in a

residential setting has the effect of:

(i)   increasing the propensity for aggressive

outbursts in other (often inappropriate) circumstances;

(ii) increasing the concentration of interpersonal

power (with official reinforcement) in the hands of the

physically larger, more verbal and assertive residents;

(iii) increasing the propensity for contagious

group-acting-out or group depression, which dramati-

cally increases the general anxiety level and the in-

security of the resident population.

Since cottage life reinforced ventilationist behaviour,

it was often observed that this behaviour was exhibited in family

therapy sessions where its appropriateness was questionable.

The open expression of anger towards parents and siblings in a

physically threatening manner had serious consequences for the

family, and often for the individual resident. In one incident,

the parents refused to return for therapy for some weeks, and

in another instance, parents who had come from out of town, left

the unit in quite a serious state of personal crisis without any

professional assistance to see them through. These were only

the readily observable consequences. Some of the predictable

interactional consequences could not be viewed; (i.e., fear of

the resident being displayed by other family members, increased

grandiosity and interpersonal power on the part of the resident,
parental fear that the child was either getting worse or was
being taught how to be impudent; ostracization of the patient
within the family once the residence support was removed; and
longstanding resentment at irresponsibly ventilated verbiage).

On repeated occasions, older and physically larger
residents would form alliances in pairs. Their encouraged phys-
ically verbal outbursts in a group situation would be formally
legitimized by staff, and their threatening power over smaller,
younger residents would be systematically established. There
was very often a high element of drama in these scenes. Asser-
tive residents were often given additional privileges for their
control over the community in chaotic times, and for their verbal
prowess and assertiveness. Younger residents often privately
expressed their fear of these people to staff and other residents
wherein they were requested to verbalize it in Community Meeting.
When they expressed their fear, once again, the concentrated
power of the larger and older residents was reinforced. Outside
of individual staff support of the smaller residents, they were
left largely undefended during their private times.

In the period of the eighteen months under consider-
ation, six major cottage crises took place where staff and resi-
dent depressions were acted out and spread to the total popula-
tion of the cottage, creating a severe sense of insecurity and
anxiety in the unit, which usually coincided with major resident
unrest inside and outside the unit.

d. <u>Resident Verbal Performance and Resident Status.</u>

Stress on verbal performance in "community meeting" gives official sanction and recognition to those residents who are more assertive, articulate, and educationally advanced, and tends to handicap those residents who are withdrawn, inarticulate and educationally restricted. In other words, it tends to give greater advantage to the residents from higher SES groupings.

As the response to Question No. 21 of the Questionnaire (Appendix "A") has indicated, verbal performance in group held a high priority as: (1) a therapeutic goal, and (2) as indication of preparedness for discharge.

Residents with middle-class backgrounds and a relatively high level of educational achievement, had immediate advantage over residents who were non-verbal, withdrawn, or were exhibiting poor language skills. The response most often, was the verbal adoption of the therapeutic jargon without a conceptual understanding of what was in fact meant by the jargon. No systematic effort was made in the unit to appraise the level of "principled" understanding of Gestalt language.

Further, in terms of emotional expression (which was the primary index of therapeutic accomplishment), those residents whose verbal repertoire of emotion was more developed, could display therapeutic advancement much more easily than those residents who could not verbalize obscure emotions. Indeed, if in fact, the identification of "effect" in language is akin to the experience of the effect itself, then the more verbal resi-

dents had a broader emotional repertoire than the non-verbal,
lower-class residents.(Shands, 1960) Given that 28% of the
residents were assessed as having low verbal skill, a signifi-
cant number of residents were at a distinct therapeutic advantage.

3.   Gestalt Therapy and Social Interaction
     in a Therapeutic Community

     a.   Individual Responsibility as Gestalt Goal vs.
          Sociotherapeutic "Group Function" Upon Discharge.

The relegation of group-problem-solving and task-
addressing functions of the "community" to a secondary role in
favour of Gestalt Group "therapeutic performances", had a dele-
terious effect on the potential sociotherapeutic involvement of
residents in the pre-discharge plans, and discharge plans of
their fellow residents as a social-learning experience.

Individual discharge plans were customarily left to
the "responsibility" of the individual resident, because within
the Gestalt ethos, it was assumed that if a resident desired to
leave and had displayed favourable therapeutic performance in
treatment, that he must have reached a sufficient level of
"maturity", self-support, and personal responsibility to complete
realistic discharge plans. School or vocational plans were
worked out with individual resource counsellors. The realistic
or unrealistic elements in the individual's discharge program
were discussed in private, the result being that (apart from a
brief in-group statement, or statements, of plans), the larger
group of residents did not benefit from the practical experien-
tial element of addressing discharge plans in a group-problem-

solving fashion. Hence, resident after resident acted on
individual (and often unrealistic) plans without ever being
accountable to his group of peers, or allowing them the group-
learning experience of confronting practical life problems.
Social Work staff tried to temper resident discharge plans with
realism, but essentially, the responsibility was left to the
resident.

        b.   Gestalt Ideology and Social Interaction
            in Residence.

        Of special importance to this study is the question:
How well did Gestalt Ideology fit the needs of a "community"
whose intent was to be therapeutic for the residents and staff
living therein? It will also check the relevance of the ideo-
logical model of "healthy conduct" in Gestalt terms vis-a-vis
the goals of the sociotherapeutic enterprise as described in a
previous chapter. Again, it must be stressed that the term
"Ideology" is used here to mean, ". . . one variant form of
those comprehensive patterns of cognitive and moral beliefs
about man, society, and the universe. . .which flourish in human
societies."(Shils, 1968:66) It is to be distinguished from
Gestalt Theory and Therapy in that the theory is the conceptual
rationale (in Gestalt terms and concepts) for why the therapy
should succeed. The therapy is a compendium of specific techni-
ques applied in a "therapeutic setting", and the ideology is an
outgrowth of the theory and therapy which draws conclusions as
to how a mentally healthy life should be lived, and creates a
role-model for how the mentally healthy person behaves.

(I) The particular moral or cognitive belief around which the unit functioned, was that societal repression of spontaneous, creative "organismic" behaviour, caused people to disown parts of themselves (i.e., specific behaviours and emotions). People who were suffering emotionally needed only the opportunity to behave without restraints, to communicate freely on an interpersonal level, "discover" themselves and re-own the "split-off" parts of themselves in order to "heal". If everyone was honest, open, expressive of their emotions and able to form close emotional relationships, then the emotional difficulties were likely to disappear. To be open, honest, warm and communicative, was thought to be the only way one person could help another in emotional distress. This being the central moral and cognitive belief, there was understandably a degree of resistance to elements or variations of therapeutic techniques which stressed <u>behaviour</u> rather than <u>feelings</u>. The conceptual block to behavioural or cognitive approaches to treatment, was evidenced in the resistance a new psychiatric consultant encountered, when he stated in a lecture that: "A feeling is nothing other than an emotionally charged THOUGHT." A tremendous political battle ensued in the unit between the forces of Sullivanian Psychiatry (then identified with "medical-model"), and the forces of Gestalt and the Existential Psychology which maintained a firm conceptual and practical distinction between the act of "feeling" and the act of "thinking". The battle became sufficiently heated enough that a proposed dismissal of a staff member was imminent. In this battle, the

"psychiatric" influence lost out and the plague of "feelings as thoughts" was thoroughly exorcised from the unit. Stability was restored.

The unit was also closed to any therapeutic approach which stressed staff objectivity and "distance" from the residents rather than close interdependent contacts. The unit also repelled techniques which stressed objective analysis of interpersonal processes or the educational approach to therapy.

> . . . (Easton) operates on the philosophy that when something goes wrong in a child's development, it's due to their obscuring their feelings, not feeling free to be aware of what they are feeling or to put it out straight to other people. They find ways of avoiding feeling. . . Mental illness is a denial of a "feeling state".
>
> (Staff Interviewee No. 16)

These beliefs and the ideological (and interactional) insulation which resulted, are not unusual in in-patient units using experimental therapeutic techniques, but nevertheless it is a characteristic of the social interactional nature of Easton. However, there is another interactional problem resulting from the nature of the belief itself.

(II) This problem was manifest at termination of a resident from the unit. An ethic of closeness, warmth and contact, tended to exacerbate a standard problem in institutional settings, where many patients experience anger and hurt feelings, at being "rejected" by the unit which has nurtured them for months.(van Eck, 1972) In demanding tremendous emotional involvement by a community of adults and peers while encouraging indulgent emotional expression, the unit had a tendency to

reverse the process of growth toward autonomy, which is a
healthy characteristic of adolescence. In fact, the process
could be termed regressive. Staff were encouraged to regress
and were reinforced for angry, fearful or sad behaviour as well
as fantasy expressions, which were indicative of re-living one's
childhood. Residents were likewise encouraged.

The indices of dependency on this type of interactional
mode are manifest in: (i) the number of residents who either
repeatedly attempted to establish relationships with staff after
discharge, or who took up residence with staff after discharge;
(ii) the residents who sabotaged their own discharge plans or
repeatedly returned to the unit unannounced, and attempted to
re-establish themselves in its life pattern.

Further, the high rate of staff turnover made the mes-
sage clear that although the community was demanding warmth,
closeness, contact and commitment, that it in fact could end
quite suddenly and unpredictably. "Old staff" and "old kids"
returning to the unit, were met with a curious attitude of re-
jection mixed with an obligation to show that really the old
"warmth" had never left.

Since contact with "severed" residents and staff was
relatively frequent and the turnover high, the general effect
for staff and resident was to question the validity of the
"closeness" and "commitment" expectations. This was evidenced
in frequent staff meetings where staff who had been at the unit
for more than a year, would express feelings of futility and
despair at the "parade" of residents and staff that they had

"given their life's blood to", and who had then departed.
Residents would express the strange lack of feeling for old
staff and residents who had visited, combined with a general
feeling of rejection and resentment for having been "abandoned"
by those who had left.

For the residents and staff, a definite "double bind"
existed. If community was to be built upon close, warm, feel-
ing, touching and commitment type interpersonal relationships
(which resembled "primary" role relationships), and yet the re-
lationship could be artificially terminated at any time, upon
what foundation was this "community" based? It was based on
intense, high-investment, short-lived relationships, which are
not the best relationships upon which to build a lasting sense
of "community" or group culture.

For many of the residents who had fleeting and con-
stantly fluctuating unstable relationships with unstable parents,
this was merely a repetition of past emotional investments and
past "hurts". It in no way was a predictable and stable envir-
onmental alternative to the family situation which may have been
the eclipsing factor in the emotional crisis in the first place.
That this may have been the case, is indexed by children often
reverting (in residence) back to the same pattern they had
adopted amidst parental instability:-- to run away, withdraw
into themselves, or to act-out in residence.

(III) Similarly, the ideological imperative for staff
to "be themselves" did not provide the residents with a pre-
dictable adult role nor with consistent behavioural expectations.

Instead, the inevitable staff frustrations, anger and despair,
were acted-out, and often the resident (who was expected to
divulge past hurts and have close contact) would at another
time be expected to leave the staff member in his "own space".
In instances of staff angry outbursts, depression, tears or
despair, the residents were often subjected to instances of
instability and insecurity very similar to their own tumultuous
family backgrounds. So long as residents could discriminate
between this as a learning experience and a reality-testing
situation for them, and that indeed the staff would not be
abusing them, then the episode could be very therapeutic but
the risk of alternative interpretations was high.

(IV) The fourth ideological difficulty which was a
source of potential confusion to staff and resident alike, is
characterized in: (i) an unclear relationship of the Gestalt
rules for living as related to the rules of "therapeutic com-
munity" living, and (ii) the relationship of Gestalt "rules"
for living as related to the rules of everyday social living.

In a mental health institution where multiple resid-
ents live together in close contact, the stress on personal
hygiene, residential cleanliness and a degree of order in every-
day living is essential. With common toilet facilities, shared
sleeping accomodations and shared eating facilities, comes a
shared responsibility in the prevention of communicable diseases
and respect for the sensitivities of others. This requires reg-
ular attention to after-meal clean-ups, laundry, bedroom straigh-
tening, living room clean-up, and careful attention to toilet

hygiene.

With the Gestalt emphasis on responsibility-to-self (as opposed to social expectations), on spontaneity as opposed to organization, and also on ventilation as opposed to repression of hostility, the normal problems of getting residents and staff to "clean house" were extremely difficult.

Staff, encouraged through Gestalt to identify with anti-authoritarian and anti-organizational tendencies, would either: (i) leave it to the residents to clean up when it became intolerable to them, or (ii) do it all themselves in co-operation with the "responsible" residents, thereby reinforcing the manipulative behaviour of the more egocentric residents and staff.

Encouraging ventilation of aggression created heated flare-ups surrounding clean-up, and the "imitation" factor was much more difficult to deal with than in a less ventilationist ethos.

If the cottage went substandard in upkeep for a period of time, the staff supervisors were placed in an untenable position between the Gestalt ideology of individual freedom, and the institutional demands for cleanliness and order in group living.

The unit in its descriptions of itself, stressed that Easton was a place where adolescents could "let themselves go". This meant that residents could smoke, swear, be aggressive, be sad, and call adults in the unit derogatory names, be abusive and in general, emotionally expressive. This may or may not

have been therapeutic for the residents. The question however, is why this behaviour was not analyzed from a functional perspective and considered as a focal point prior to discharge。 The answer:-- Gestalt does not consider it an issue because Gestalt was not designed for adolescents and their <u>behaviour</u>.

The double-bind implicit in the "freedom to be yourself", is that (like society at large) your "self" will come under immediate scrutiny in the light of group norms。 The adolescent who was emotionally expressive (as he was required to be), brought himself under the analytic eye of the group。 If he (or she) was aggressive or angry, he would have to tell the group why it was so. If he (or she) was depressed and tearful, he would have to share what was "behind" the depression. Residents were required to explore what was "in it for them" to behave that way。 Self-revelation was the price of assertiveness but it was also the passkey to in-group membership. Once the adolescent learned how to express himself and then how to placate the group in therapeutic language terms, he or she was then faced with another contradiction:-- adapting those skills to a larger society that does not operate in accordance with those rules.

V. In the larger community, one does not have the mandate to express immediate emotional responses, nor to express deep-seated fears or difficulties, nor also to openly express aggression。 Nor is everyday language based on an intricate language of personal feelings。

Many of the discharged adolescents were able to discriminate what was appropriate to the "outside world" and what was not. However, many were "stuck" in the Easton jargon and the Easton pattern of interpersonal relations. The chief problem was not that the language of feelings and the modes of interpersonal intimacy were not therapeutic for the residents. The problem was that the ideology prevented staff from seeing the therapy as a form of socialization. Rather, it was seen in terms of "unstructured" social relationships where only free interpersonal communication and expression took place, and therapy was merely being "real" with other people. The ideology covered the fact that socialization (in fact, re-socialization) was taking place and that its appropriateness in everyday interpersonal interaction must be carefully accounted for long before the resident is discharged. It was assumed at Easton that, like the adults that voluntarily opt for Gestalt Therapy, upon termination from the group they can make a rational, principled decision as to which mode of interaction they would prefer. This is a very large expectation to present to emotionally disturbed young adolescents.

FOOTNOTES - CHAPTER VI

1. <u>Evaluated Participation (EP)</u> as a Status Scale is based
    on the proposition that the kinds of participation
    an individual has in both formal and informal groups,
    are known and evaluated by the people who know him.
    Evaluated Participation (EP) is rated by matched
    agreements, symbolic placement, status reputation,
    comparison and simple assignment to class and in-
    stitutional membership, by a large sample of res-
    pondents.

    <u>Index of Status Characteristics (ISC)</u> is rated
    objectively on the basis of occupation, source of
    income, home type, dwelling area, and is the sum
    of various "weighted" indices.(Kennett, 1969:5-7)

2. <u>Wechsler Adult Intelligence Scale (WAIS)</u> includes a
    verbal and performance measure of intelligence
    based on eleven (11) subtests. Verbal tests in-
    clude: Information, Comprehension, Digit Span,
    Similarities, Arithmetic and Vocabulary. Perform-
    ance tests include: Picture Arrangement and Com-
    pletion, Block Design, Object Assembly, and Digit
    Symbol. The result is a "profile" of abilities
    with computed numerical scores for Verbal, Perform-
    ance and Full-Scale I.Q. (David Wechsler, 1939, 1955,
                                                    1958)

    <u>Wechsler Intelligence Scale for Children (WISC)</u> is a
    scaled-down version of the WAIS, for ages Five (5)
    to Fifteen (15).

    <u>Minnesota Multiphasic Personality Inventory (MMPI)</u> is a
    very thoroughly studied paper-and-pencil adjustment
    inventory whose items are declarative sentences with
    which the individual agrees or disagrees. Scores
    are secured for a number of psychiatric categories
    (depression, hypochondriasis, schizophrenia, etc.),
    and interpretation and administration demand the
    most highly skilled and experienced psychological
    staff. The test has been researched and revised
    widely since its appearance in 1940. The individ-
    ual's responses are compared to those of various
    psychiatric groups. As with all the above testing
    techniques, its validity has been seriously ques-
    tioned; however, its one area of relative predictive
    validity was in the area of delinquent behaviour
    among high school students.

FOOTNOTES (Cont'd.)

3.   "Studies of Mental Disorders by occupation have
generally indicated that those in the <u>less skilled
and lower occupations</u> tend to exhibit a high rate
of major mental disorders, particularly the
psychoses."(Jaco, 1960:125)

"The schizophrenia rate was highest for the <u>service
occupations</u>, closely followed by that for the pro-
fessions; the lowest rate was for the proprietary
occupations."(Jaco, 1960:132)

Jaco has also shown that the unemployed had the
highest <u>public treatment rate</u>, followed by the
rates for service workers, the manual workers, the
professionals and semi-professionals, agricultural
workers, clerical-sales workers, and managerial,
official and proprietary workers.(Jaco, 1960:134)

(1)   A definite association exists between class
position and being a psychiatric patient.

(2)   The lower the class, the greater the proportion
of patients in the population.

(3)   The greatest difference is between classes
IV and V in that class V has a much higher
ratio of patients to population than class IV.
(Hollingshead and Redlich, 1958:216-217)

4.   The reason that both psychiatric nursing and psychiatric
aide statistics were included, was because the
Child Care Staff had responsibilities encompassing
both of these mental hospital roles. They there-
fore had job satisfaction and dissatisfaction charac-
teristics applicable to both categories, and combin-
ation of both categories into the Staff turnover rate
provided a more realistic basis for comparison.

CONCLUSIONS

It is necessary to restate first the questions raised in Chapter II. Was the design and intent of Gestalt Therapy applicable to the design and intent of the Easton treatment facility? For answering this question, the following conclusions are offered.

1. Range of Psychiatric Disorders Represented in the Easton Population.

As we have seen in Chapter III, Perls was well aware of the limitations of Gestalt Therapy when it came to the treatment of psychotic, suicidal, or severely behaviourally disoriented individuals. His theory, which was based upon an extremely abstract philosophical concept, demanded a high level of organization and well-verbalized interpretation of one's emotional experiences. This necessarily demanded a relatively well controlled, non-psychotic individual who was not in an extremely desperate frame of mind. Perls' fascination with the problem of Schizophrenia belies the fact that in his lifetime, he was unable to address it as a therapeutic problem which Gestalt Therapy could adequately deal with.

A significant proportion (23%) of Easton's in-treatment population, however, fell into this category of "the psychoses" which, in terms of Perls' design and intent for Gestalt Therapy,

were inappropriate. If we add to this category, those of Easton's population who were described as severe behavioural disorders (31%) - which Perls found unworkable - we see that approximately 54% of Easton's in-treatment population was inappropriate by virtue of Perls' own criteria.

If we add to this the 5% who represented Organic Brain Syndrome, and the 10% with learning disabilities (which would make extensive verbal interaction difficult), then we see approximately 69% of Easton's in-treatment population as virtually inaccessible to treatment due to Perls' own criteria.

None of the psychotic adolescents in treatment represented serious suicidal risk, but of those adolescents who exhibited personality disorders, three out of thirty-nine (7%) were of relatively high suicidal risk. This brings the total of potentially inappropriate adolescents to approximately three-quarters (76%) of Easton's in-treatment population.

Further, we have found in our staff interview that a disproportionately large number of staff felt that Easton's treatment method was inappropriate for the treatment of delinquent, severely acting-out or psychotic youth, which supports Perls' own assessment of the range of applicability of Gestalt Therapy.

Based on this analysis, it appears that Gestalt Therapy was not applicable (by virtue of its own criteria), as a treatment method for more than three-quarters of Easton's in-treatment population, and therefore was largely inappropriate

as a general treatment method for Easton's design and intent as
a therapeutic facility.

2. a. Age Group of Residents at Easton.

In Chapter III we have seen that Gestalt Therapy
makes no special distinction between the psychology of adult-
hood and the psychology of adolescence. Further, it is signi-
ficant that in his work Perls makes no specific reference to
knowledge of the application, success or failure of Gestalt
Therapy in the treatment of young adolescents.

It is clear from Chapter III that Gestalt Therapy is
highly abstract in its theory and ideology, and that explanation
of its fundamental philosophical precepts was felt (by Perls) to
be important, since he started most of his groups with a brief
explication of the nature of Gestalt Therapy.

The theory, slogans and therapeutic methods of Ges-
talt are verbally sophisticated. Reading and understanding the
fundamental works would require a university-level education.
The sophisticated Gestalt therapeutic language is complex because
of its high level of abstraction. In our analysis of Gestalt,
we have seen that developing "patient" insight is a major thera-
peutic goal. Psychotherapeutic insight demands the ability to
manipulate abstract psychological concepts.

In placing the Easton in-treatment population into
this context, we have found that based upon the literature of
Early Adolescence, young adolescents are not likely to have

achieved the high level of abstract thought required by Gestalt
Therapy. More specifically, we have found that in the case of
the Easton population sample, 76% were one or more years behind
their peers in educational achievement.

The specific incidents of expressed adolescent con-
fusion surrounding the meaning of Gestalt therapeutic slogans,
combined with staff assessment of an average to above-average
intelligence requirement for treatment success, suggests that
indeed a high level of ability to abstract was required in Ges-
talt Therapy at Easton, and that it posed a problem for treatment.

To conclude then, given the very immature stage of
cognitive development represented in early adolescence in general,
plus the low level of developed ability to abstract at this age,
we can state that Gestalt Therapy is not applicable for the
treatment of Early Adolescents in general, because of its demands
for a post-adolescent level of cognitive development.

Further, in the specific instance of Easton's in-
treatment population, we see that a disproportionately large
percentage of residents were generally behind their peers in
academic performance. Although this does not categorically est-
ablish that their learning ability was generally lower than their
peers, it does suggest that on some level, three-quarters of the
Easton residents were exhibiting difficulties in displaying
their skills. This does raise the possibility that the Easton
population may have been _less_ prepared to deal with the level of
abstraction in Gestalt Therapy, than so-called "normally devel-
oping" adolescents.

Therefore, given the inherent low level of formal operational ability exhibited at early adolescence and the cognitive development exhibited by the Easton population, we can state that Gestalt Therapy was not applicable as a treatment approach at the Easton facility.

      b. Socio-Economic Status of Easton In-Treatment Population.

Although Perls made no specific reference to the applicability of Gestalt Therapy relative to the Socio-Economic Status (SES) of its treatment population, the test population for his 1951 study was university students. Further, the cost factor of his sessions at the Esalen and Lake Cowichan institutes assured a relatively high-income and status group.

Information as to the presence and goals of Esalen and Lake Cowichan institutes was attainable largely through the university or psychotherapeutic community on the West Coast, and was not to be found in the Union Hall or the Welfare Offices. Therefore, Perls' test population was largely middle-class and upper-class white collar and professional, or university-educated adults. This is predictable if one considers the high level of intellectual and verbal sophistication demanded by the therapy.

Placing this in the context of Easton's in-treatment population, we find that nearly one-half of the Easton Resident Sample were in the lower SES groups. Further, three-quarters of the Staff Interview Sample felt either that treatment success was more likely with middle or upper-middle class residents, or

less likely with working or lower-class residents.

The SES of residents is important, as it relates to expected verbal skill and intelligence. This is the subject of the next subtitle of this chapter.

However, based on the SES characteristics of Perls' test population and the SES characteristics of Easton's resident population, we can state that:-- The design and intent of Gestalt Therapy was not applicable to the design and intent of Easton's treatment facility relative to the Socio-Economic Status of their respective treatment populations.

c. Educational and Verbal Level of Achievement
   Manifest in Easton's In-Treatment Population.

It was not by accident that Perls used a test population of university-educated or professional "seminarians", as we can see by the level of conceptual and verbal sophistication manifest in Gestalt literature.

Similarly, the literature which relates SES to intelligence test results, shows that children of professional families score consistently higher on I.Q. evaluations than children from working-class families, and that this is the result of more developed verbal skill. The higher one moves up the SES ladder. Lower SES groups do not emphasize precise linguistic descriptions of experiences and feelings, which is the central demand of Gestalt Therapy. Hence, lower SES groups would probably fare more poorly in Gestalt groups, just as lower SES group children fare more poorly on Intelligence Quotient ratings. Nearly one-half

of Easton's in-treatment population were representative of lower SES groupings.

The intelligence ratings of the resident population sample did not predictably follow the SES characteristics of the sample, which is probably due to the fact that the intake criteria favoured intelligent, verbal adolescents. However, a significant sector of the population (28%) were below average in-telligence, while 20% were clearly below average in verbal intelligence. This group would be totally inaccessible to the verbal aspect of Gestalt Therapy.

The Staff Interview Sample results support this con-tention in that Child Care staff (to the extent of 96%) felt that either average or above average intelligence was a prere-quisite of the therapeutic success of the resident, or that high level verbal skill was a prerequisite for therapeutic success.

Given the high level of educational achievement and verbal skill demanded by Perls in his practice of Gestalt Therapy and given the low level of educational achievement and verbal skill manifest in Easton's in-treatment population, we can state that the design and intent of Gestalt Therapy was not applicable to the design and intent of the Easton treatment facility, rela-tive to the level of educational achievement or verbal skill manifest in their respective treatment populations.

3. a. Physical Environment of Easton's Treatment Facility.

As we have seen in Chapter III, a wild, natural and

uncontrolled physical environment conducive to introspection,
emotional calm, sensuous self-indulgence and privacy, is consis-
tent with Perls' therapeutic goals of bodily awareness and sensi-
tivity, personal self-awareness, individualism, and "defence"-less
ness. Peaceful self-reflection was a necessary antidote to the
rigours of the heavy emotional confrontation and personal analysis
demanded in the therapy sessions. Perls' stress on individuality,
intuitive self-reliance, spontaneity, creativity, and an essential
"religious" experience in natural, self-indulgent physical sur-
roundings communicated to the seminarians a sense of continuity
between environment and therapeutic task. Easton proposed essen-
tially the same therapeutic tasks in a radically different physical
environment.

Easton's facility was immobile in essential physical
structure, social structure, and urban setting. A major city high-
way was situated within one hundred feet of the residences, and
the anonymity of the city centre was close for those who chose to
"run" from their personal emotional turmoil. There were "quiet
places" - open, manicured fields surrounded by trees - but the
factor of city-sound was seldom diminished, and the freedom of
movement or use of the environment was minimal.

Thus, the need for a retreat into peace and quiet
during heavy emotional encounters was not available. A place to
escape the human presence was not possible. The message of in-
stitutional, behavioural control was embodied in signs on cottages
and the firm, rectangular configuration of the buildings. Free-
dom, spontaneity, self-indulgence, peace and serenity were not

available at Easton though the need for them within the thera-
peutic and ideological context was great.

Thus, it can be stated that on the basis of the design
and intent of Gestalt Therapy relative to its requisites for a
"therapeutic" physical environment, it was not applicable to the
physical design and intent of Easton's treatment facility.

b. Social Structural Characteristics
of the Easton Facility.

As we have seen in Chapter III, Perls' goal was to
obliterate staff/patient roles and to present Gestalt Therapy as
a total co-operative "growth experience".

He further saw the fundamental mental/emotional prob-
lems of our society as coming from one source (repression, defence,
resistance and lack of environmental contact), and therefore made
no distinction between the stages of human development, and placed
early adolescence in no particular category.

His demands on therapists and patients alike were to
develop an individual personal responsibility, true to one's own
current needs and growth as separate from the demands of "the
group", society, or relatives and friends. His was a ventilation-
ist ideology based on freedom, spontaneity and awareness, and the
lack of role-distinctions or separation of age groups, fit well
into his total therapeutic system. It represented a unity of
physical environment, therapy and group-behaviour. At Easton,
staff and patient roles were inherently separate as a result of
institutional legal responsibility for the lives of its youthful
residents.

In this context, we will look at the discontinuity manifest in the application of Gestalt Therapy with adolescents at Easton.

(I) Staff Roles: Gestalt Therapy as a Training Tool.

The inherent anti-intellectualism of Gestalt, combined with its non-recognition of the specific characteristics of young adolescence, generated a rather stultifying intellectual environment. A more simplistic interpretation of Gestalt came to pervade Easton's training scene, and reading, debate, and analysis stopped on the grounds that it interfered with "experiential" (or existential) development.

The characteristics of adolescence and adolescent psychiatric disorders (as outlined in Chapter IV), never entered into the training in a serious fashion during the period under analysis. When residents did not respond, the tendency was (in a prescribed three to four month period) to diagnose them as too disturbed, too intransigent (as with delinquents), or unwilling to take the responsibility upon themselves to change their lives.

Questions as to the applicability of Gestalt Therapy for the treatment of adolescents relative to the issues raised in Chapter II, were never posed.

Staff training continued to consist largely of sensitivity, awareness, and encounter groups, with the additional expectation that the staff member continue his therapy outside the unit. Sensitivity, communicativeness and individual psychological influence on other staff and residents were the

chief criteria of staff development.

The Gestalt ideological ethos appeared to prevent staff development in areas related to:

(i)   proper assessment methods appropriate to the range of behavioural and psychiatric disorders present at Easton;

(ii)   team formulation of treatment goals and plans to be carried through and periodically evaluated;

(iii)   treatment plans appropriate to the individual (and group) level of functioning, based upon the fact that residents were adolescents and not adults; and,

(iv)   the fact that therapy should educate residents for post-discharge survival rather than Gestalt therapeutic performance alone.

Fifty-two percent of the Staff Interview Sample felt that the training program was inadequate generally, or inadequate in specific areas. Many respondents felt that it was weak in the area of analytic or intellectual pursuits related to Developmental Theory or alternative therapeutic approaches. Many respondents felt that the stress on the emotional development of staff members (as promoted by Gestalt) in no way prepared them to treat psychotic, delinquent or other severely disturbed adolescents.

In terms of Gestalt Therapy's implicit therapeutic objectives, plans and methods, it is predictable that this should be the case. Emotional ventilationism, behavioural flexibility, improved interpersonal communication and improved self-

esteem are complex goals to achieve with severely disturbed
adolescents in a supercharged residential environment. It
requires much more than superficial knowledge of the complex
theory, ideology and therapy of Gestalt combined with purely
experiential indoctrination into its precepts. To address the
complex psychological and interactional difficulties posed in
a residential treatment centre for adolescents, requires con-
stant informational input, evaluation and analysis. These were
not integral facets of the Gestalt ethos.

Thus, it can be stated that the design and intent of
Gestalt Therapy relative to the training of its therapists was
not applicable as a training tool at Easton's treatment facility.

(II)   Staff Roles: Role Demands of Gestalt Therapist
                      vs. Role Demands of Easton Child
                      Care Worker.

As we have seen in Chapter IV, the Gestalt demands
for personal therapeutic development, awareness, emotional ven-
tilation, intuition, and creativity in therapeutic situations,
etc., clashed dramatically with institutional requirements for
staff control of adolescent behaviour in residences. Staff who
allowed themselves to gravitate toward a Gestalt framework of
behaviour, would allow themselves to break down emotionally
while working, or enter into extremely emotionally-charged re-
lationships with residents and other staff. They would give
the residents a high degree of freedom and responsibility, per-
missible in the Gestalt ethos, but would invariably come into
conflict with institutional rules. They were to find themselves
confronted by supervisors who were themselves sympathetic with

Gestalt, and were thus defensive about their authority role,
but were compelled to act upon <u>institutional</u> criteria for staff
behaviour.

This situation had three effects:

(i) It tended to frustrate the creative and competent
Gestalt-oriented staff members, and ultimately caused
them to leave because of the restrictiveness of the
environment; or

(ii) It tended to prevent the dismissal of incompetent
staff members whose inadequacies were covered as merely
a naive adherence to Gestalt principles; or

(iii) It tended to frustrate the energetic staff members
who were interested in a controlled and intellectually
stimulating unit where therapeutic competence was the
focus based upon an in-depth analysis of staff prac-
tices.

The excessively high staff turnover and generally low
staff morale are two indices of the tension created by the con-
tradiction between Gestalt ideology and institutional demands.
Staff interviews refer to the ideal counsellor as both a control-
ling person, competent and energetic, while at the same time,
spontaneous, intuitive, self-aware and free. This contradictory
picture bears witness to the fact that staff were largely unaware
of the behavioural contradiction between their ideology and its
institutional setting. The problem itself is manifest in mas-
sive staff turnover and constant low staff morale.

Thus, we can state that the design and intent of Gestalt Therapy relative to the role demands of a therapist were not applicable to staff role-demands as therapists at the Easton facility.

(III)   Patient Roles: Role Demand of a Gestalt
                         Seminarian vs. Role of an
                         Easton Resident.

As the staff interviews showed, the ideal-type adult staff behaviour was identified with successful therapeutic behaviour on the part of a resident. This included sensitivity, awareness, emotional ventilation, possessive individualism and personal responsibility for one's behaviour, behavioural flexibility and high self-esteem.

For the adult to break out of rigid, socially adaptive but self-defeating behavioural patterns, the above characteristics are very useful. For the adolescent, it can represent a regression into a more infantile form of behaviour. Emotional ventilationism and possessive individualism as behaviour and attitudes aimed at improving self-esteem, can indeed degenerate into explosive, infantile egocentrism or infantile grandiosity. From an institutional frame of reference, this is certainly not part of a therapeutic progression.

Further, the anti-intellectual vein in Gestalt can produce anti-educational proclivities in the residents and their adaptive needs for discharge preparation (work, school, family living) will not have been met. Again, the institutional demands for therapeutic progress toward discharge, contradict the treatment goals which apply for Gestalt theory.

Forty percent of the staff interviewed saw resident adaptation to social behaviour upon discharge as a major problem at Easton.

Gestalt Therapy demanded that the residents ventilate their anger, show their despair and despondency, change their physical environment to suit them, and show primary responsibility to themselves rather than to the needs of the group or institutional setting. External institutional representatives would often become aware of the consequences of such behaviour through the complaints of public works officials, governmental representatives, neighbours to the unit, or parents of the residents. Complaints to Easton's administration would filter down to staff supervisors and ultimately to Child Care staff. This would present residents and staff with a "double bind" situation. Either they acted as the unit ideology demanded or they acted as the institution required. In either case, they were due for significant criticism.

Hence, it can be stated that the design and intent of Gestalt Therapy relative to its behavioural expectations in a residential setting, were not applicable to the institutional rules of Easton as a Mental Health treatment facility.

(IV) Patient Roles: Gestalt Therapeutic Demands
                      Relative to Therapeutic Community
                      Long-term, Group-living Demands.

The ventilationist and possessive-individualistic demands of Gestalt Therapy pose specific problems in long-term residential living situations for adolescents, since Perls'

treatment units were short-term and did not attempt to comply
with the precepts of Therapeutic Community.

First, in terms of physical environment, we must
consider the social implications of noise and filth. As we
have seen in Chapter IV, the personal lack of cleanliness can
either mean the behavioural rejection of restricting social
rules, or it can be a statement of personal lack of a sense of
self-worth. It can also be a method of keeping people out of
one's group boundaries.

The "radical" and "critical" aspects of poor hygiene
or personal appearance tended to be stressed in the post-conven-
tional moral atmosphere of Gestalt Therapy, but with adolescents
in residence, communicable diseases are a definite risk and at
Easton there were high-risk periods on two occasions. Thorough
Nursing practices, not Gestalt individualism, are required at
such times.

Rules of residence cleanliness definitely clash with
Gestalt precepts which imply that if you don't wish to clean up
or straighten your room, or yourself, because you are not in
"the space" for it, then you must follow your own needs and de-
sires and suffer the consequences.

Washrooms can become public health hazards, unwashed
clothes can become repulsive, and messy surroundings can con-
front the sensitivities of other individuals. The necessary
rules for co-operative residence behaviour can be directly con-
fronted by the rules of Gestalt individualism. Open communica-

tion channels can act as a buffer against serious environmental deterioration, but in the case of an intransigent or very aggressive individual, this leads to confrontation and ventilation and creates another form of residential pollution: noise pollution.

In terms of noise the same problems apply. In a ventilationist ethos, the sounds of screaming and angry exchanges can be very anxiety-provoking to adolescents who have a very low tolerance for that type of anxiety. Screaming, loud record-players, unhygienic or messy public places, can all make life intolerable to the child of a more compulsive family background and can exacerbate an already intolerable emotional or mental state.

Conditions of noise or filth are in direct contradiction with the precepts of Therapeutic Community. As Edelson has shown, the goal of Therapeutic Community is to remove the patient from the terror and anxiety of a complex interactional situation and into one which, although more calm, does not deprive him or her of social contact. Social learning, co-operation, and group decision-making functions are the key therapeutic goals.

Predictability in environment, honesty, and provision of behavioural controls for those who lack them, are the primary concerns of Therapeutic Community.

Emotional contagion, withdrawal or regression, are to be thwarted by group-developed adaptive norms which focus on community co-operation and mutual self-respect. Responsibility

is not primarily to oneself but rather to the group of other patients in the mutual generation of a "ward culture". Gestalt possessive individualism and ventilationism are conducive to noise, filth, emotional contagion, and regression in both staff and residents and to a generally anxiety-provoking atmosphere, especially if it is within the confines of an institutional setting.

Furthermore, looking at the interactional consequences of an individualist ethic and ventilationist behaviour, one sees a distinct concentration of power in the hands of the larger, more verbal, and more assertive adolescents, and the Gestalt ethic gives it formal approval and reinforcement. It can generate aggressive behaviour in potentially inappropriate situations and facilitate hysterical behaviour in an adolescent group.

The dramatic difference between in-treatment behavioural demands and post-discharge behavioural demands has drawn attention to a very specific problem. Can the adolescent discriminate between social behavioural demands outside the unit and the individualistic, ventilationist demands inside the unit? Whether the answer is yes or no, it is a contradictory situation in which to place unstable, depressed, psychotic or inept adolescents.

The realistic demands of co-operative, therapeutic community living among adolescents, gave ample opportunity for a valuable group-living, group-problem-solving, mutual-respect and-honesty type of situation. This (in an informal sense) was

probably the primary curative factor in Easton's functioning,
but Gestalt Therapy and ideology did not tend to facilitate
such a process. Gestalt Therapy can tend to turn an educa-
tional experience into an experience in individual self-asser-
tion and manipulation, teaching the resident to navigate
through the informal rules of Gestalt, taking full advantages
of the contradiction between Gestalt ideology and institutional
rules. Those residents who could not discern and manipulate
this very delicate combination of individual assertiveness,
ventilation and compliance to formal rules, found it very dif-
ficult to avoid being scapegoated or ignored at Easton.

Given these contradictions, it can be stated that the
design and intent of Gestalt Therapy was not applicable to the
Easton facility as it relates to its function as a long-term,
twenty-four hour therapeutic community for adolescents.

In summary, we must attempt to draw conclusions as to
the applicability of Gestalt Therapy as a treatment method for
the Easton facility.

First, it has been shown that Gestalt Therapy was not
designed for the treatment of psychotic, delinquent, or severely
disorganized adolescent personalities who (in fact) constituted
a disproportionately large percentage of Easton's population,
despite intake criteria, which tended to favour Gestalt Therapy.

Secondly, it has been shown that Gestalt Therapy was
not designed for: (i) early adolescents (which as a treatment

population represent a specific set of therapeutic problems
and constitute 100% of Easton's population); (ii) lower
Socio-Economic Status groupings (which do not have the verbal
capacity or educational prerequisites for dealing with it); or
(iii) people of low verbal skill (who can neither understand
nor express their emotions in the complex language of Gestalt
terminology).

Thirdly, we have seen that Gestalt Therapy was neither
designed nor intended for use in: (a) an institutional phys-
ical setting, or (b) an institutional system of staff roles.

In terms of patient roles, Gestalt Therapy was in-
adequate as a set of behavioural demands relative to both long-
term group living and post-discharge behavioural expectations.

Given these findings as to the limits of the applic-
ability of Gestalt Therapy, it can be stated specifically that
the design and intent of Gestalt Therapy was not applicable to
the design and intent of the Easton treatment facility. This
suggests that Gestalt is not appropriate for the treatment of
young adolescents in a residential treatment centre describing
itself as a Therapeutic Community. However, what implications
can be drawn from this as to the general applicability of
Gestalt Therapy to the treatment of adolescents?

First, since the stress of Gestalt is on its use as
a "growth experience", we can speculate that, as with the adults
it treats, it may well be successful with highly intelligent but
withdrawn, overly-controlled, mildly neurotic adolescents who

are motivated to change their ways of contacting their environment and other people, in order to improve their happiness and potential in life.

Secondly, relative to its extreme abstractness, it could probably be stated that Gestalt Therapy might be successful with mature adolescents (eighteen to twenty-four years of age), who come from middle to upper-middle class Socio-Economic Status groups, and whose verbal skill and education are at better than average levels.

Thirdly, relative to its ideology of individualism, ventilationism, spontaneity and freedom, Gestalt Therapy might be applicable to the treatment of such adolescents in a remote, isolated and natural physical environment designed for emotional self-indulgence, where it was not meant to provide training for professionals treating anything but mildly-neurotic, mature adolescents or adults, outside an institutional setting.

Further, if the sessions were no longer than one week and did not require the forging of long-term co-operative living rules, Gestalt Therapy would probably work very well as a "growth experience". Extensive research is required if one is to make any firm statement as to the applicability of Gestalt.

Although towards the end of his life Perls appeared to be getting relatively grandiose in his assessment of the applicability of Gestalt Therapy, in his earlier days, he was well aware of its limits and stayed well within those parameters. The Easton experiment showed the efficacy of his earlier assessment and disproved the kind of universal applicability which

he assigned to it just before his death.

Perls was a medically educated, psychoanalytically trained Psychotherapist with lengthy experience in a wide range of therapeutic situations. In assessing any perceived success of Gestalt Therapy, one has to take his character and experience into account. His disciples, in their excitement at his success and influence, have often overextended the applicability of Perls' Gestalt Therapy. Easton has proven to be such a case.

With respect to issues of policy surrounding the applicability of specific treatment methods to specific treatment populations, it must be stated that thorough analysis on a theoretical level is necessary before conducting direct clinical experimentation. A theoretical analysis of Gestalt Therapy immediately brings into question its applicability in the treatment of severely disturbed adolescents.

In a facility such as Easton, theoretical analysis must be followed by on-going program evaluation and research to either verify or refute the clinical approach, and its method of delivery.

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APPENDIX "A"

STAFF INTERVIEW QUESTIONNAIRE

The Staff-Sample Interview was structured around this series of questions, which were ordered (in the Interview) as they are presented here.

Questions No. 12 and No. 13 have been omitted subsequent to the decision to make the unit, under study, anonymous.

QUESTIONNAIRE.

1. Do you have any apprehensions or presuppositions about the content of this interview?

2. Do you perceive my viewpoint of the unit as being one of: an insider, an outsider, both, or neither?

3. Do you perceive my stance with respect to unit program as being positve, negative, both or neither?

4. How long have you (or did you) work at the unit? At which of the various sub-units did you work?

5. What was your prior experience in the field of child care work?

6. What elements were involved in your decision to come and work at this unit?

7. In your estimation, does (or did) the unit operate on the basis of a specific theoretical orientation with respect to the cause and cure of emotional disorders?

8. Upon what bodies of theory (or upon what particular theorists) was the unit's orientation built?

9. In your estimation, does (or did) the unit operate on the basis of a specific therapeutic orientation, at the practical "therapy" level?

10. What therapeutic techniques have you applied (or seen applied) at the unit?

QUESTIONNAIRE (Cont'd.)

11. Would you say that the unit's treatment mode was a unique approach to the treatment of adolescent emotional disturbances?

12. Omitted.

13. Omitted.

14. In your estimation, is the unit's treatment practice appropriate to the treatment of the adolescents, in treatment? Explain:

15. In terms of your perception of individual resident's level of intelligence, social characteristics (class, ethnicity, race, demography), and type of emotional disorder, what adolescents were most helped here?

16. In terms of your perception of individual resident's level of intelligence, social characteristics (class, ethnicity, race, demography), and type of emotional disorder, what adolescents were least helped here?

17. In your estimation, is the unit's training program appropriate for training staff in the treatment of the emotionally disturbed adolescents with which they have to deal?

18. What are the strengths of the training program?

19. What are the weaknesses of the training program? What elements would you add to the training program as it stands? What elements would you omit?

20. What are the characteristics of the "ideal" unit counsellor: (a) as you perceive him or her, (b) as you feel the unit as a whole perceives him or her?

21. What are the characteristics of the "ideal" unit resident: (a) while progressing satisfactorily in a therapeutic sense, and (b) immediately prior to discharge?

22. Considering unit staff as a social group, what would you say the most important "in-group" behavioural expectations were?

23. What is your assessment of this interview? Did you feel cued or led toward specific answers?

24. Do you have any additional comments to make concerning the unit that may not have come up in the course of these questions?

QUESIONNAIRE (Cont'd.)

FOR STAFF NOT CURRENTLY EMPLOYED AT THE UNIT:

25. Why did you leave the unit?

26. Where did you go upon leaving?

27. Did you (ever) return to the Child Care Counselling field?

28. Would you ever return to the Child Care Counselling field?

29. Why or why not?

30. Did your experience at Easton affect this decision? How did it affect your decision?

APPENDIX "B"

A Compendium of Psychotherapeutic Slogans and Phrases Related
to Gestalt as Applied at Easton.

        This Compendium of slogans, phrases and definitions
has been compiled from Participant Observation material as
recorded on this researcher's Personal Journal, as well as from
the Recorded Staff Interviews and Unit Documentation. Defin-
itions of a general nature have been supplied for information
purposes, but they are subject to individual interpretations
because the slogans, phrases and terms were in fact, never
firmly defined or analyzed.

Slogan No. 1	". . . therapy, more than being something that you <u>do</u>, is some way that you <u>are</u>."(Easton Psychologist's Report. "A Brief Report on the Residential Treatment Unit for Emotionally Disturbed Adolescents", 1972, p. 1).
Meaning:	Therapy is not an act which can be done unto another person, but rather is a <u>message</u> or statement exuded by a therapist's total characterological presence.
Slogan No. 2	". . . a way of being. . .is more to be experienced than talked about."(<u>Ibid</u>., p. 1)
Meaning:	In Slogan No. 1, we saw that therapy was a "way of being"; here we learn that the "way of being" is to be experienced (i.e., lived) and cannot be verbally transmitted or analyzed. This makes the behavioural expectations for new staff, strategically obscure.
Slogan No. 3	". . . people (at Easton) take personal <u>risks</u> each time they make contact."(<u>Ibid</u>., p. 1)
Meaning:	To take a personal risk means to expose and reveal oneself personally in interaction; it means being "defenceless" against the hurtful behaviour of others. It is considered to be a positive and therapeutic "way of being".

Compendium (Cont'd.)

Slogan No. 4 The common problem with all Easton's adoles-
cents is that: "They all spend almost all
their energy in one form or other of resis-
tance; almost always they have not established
a sense of real self for themselves and they
all hurt."(Ibid., p. 1)

Meaning: Resistance: The disturbed adolescent is
assumed to be resistant to close interpersonal
contact with others, and resistant to exper-
iencing his own feelings of pain, joy, and
despair.

He cannot then (in Gestalt Terms), find a
"sense of real self".

Sense of Real Self: The ability to experience
one's own body as part of one's "self" and to
know the body's intuitive, automatic responses
to situations. This means general awareness
of the body and one's "real" emotions.

Hurt: To "hurt" is to be carrying (i.e., avoid-
ing the feeling of) past and present painful
experiences, and to act on the residual pain
rather than act on the full meaning of a "here-
and-now" situation or experience.

Slogan No. 5 We will only accept those children that will
". . . 'commit' themselves. . .a child that
shows potential to reach that point."(Ibid.,
p. 2)

Meaning: For a child to show commitment, he or she must
express motivation to change his or her current
behaviour; a sincere desire to enter the Easton
unit, and be able (in some way or other) to
verbalize his or her feelings of "hurt" and
frustration.

Slogan No. 6 "He (The Resident) is here to find himself."
(Ibid., p. 2)

Meaning: The resident is to find a real "centre", a
"core reality" within himself through exper-
iencing his or her own body and by being con-
fronted with his resistances and defences
against experiencing and acting upon his or her
own emotions.

Compendium (Cont'd.)

Slogan No. 7 ". . . he (The Resident) finds out they (the
staff) don't <u>expect</u> him to be productive or
good. Rather, they expect him to be honest
with himself and others, even if it means
facing and experiencing a lot of pain, fear,
frustration, and loneliness."(<u>Ibid</u>., p. 2)

Meaning: The resident is (ideally) not expected to
behave in <u>any</u> prescribed manner but is expected
to verbalize his feelings about himself and
others, and to experience the pain and misery
of his current situation and past life.
(i.e., by ventilating his emotions)

Slogan No. 8 ". . . we deal directly with the emotions that
this (Acting-Out) behaviour expresses or avoids."
(<u>Ibid</u>., p. 2)

Meaning: At the root of "Acting-Out" behaviour, are the
emotions of pain, fear, frustration, which are
avoided by "Acting-Out" behaviour. Once felt
as pain, fear, frustration, etc., (and ventil-
ated as such), the source of the behaviour is
(allegedly) removed.

Slogan No. 9 As a result of the above, ". . . the child
begins to develop a personal sense of self,
a sense of, 'I AM'. . . ."(<u>Ibid</u>., p. 2)

Meaning: Once the defences and resistances are removed
and the child can experience (rather than avoid)
his emotion, he experiences (allegedly) his
body and emotions as his own and can act as a
personally responsible individual. He therefore
has his own sense of "being" and can express
his "I AMness".

Slogan No. 10 (A Parable)-- "A new and confused young coun-
sellor (her initial phase) asked me once in
distress: 'What <u>is</u> the philosophy (treatment
theory) of (Easton)?' '<u>You</u> are the philosophy,'
I told her."(<u>Ibid</u>., p. 3)

Meaning: Essentially this Parable says that the thera-
peutic act is a mixture of the role-modelling
aspect of staff behaviour upon the residents,
so long as staff behaviour consists of a highly
individualistic, intuitive, responsive, sensi-
tive, personally responsible, and bodily-aware
and emotionally expressive system of behaviour.

Compendium (Cont'd.)

Slogan No. 11   ". . . get in touch with yourself and your feelings." (Ibid., p. 4)

Meaning: Know and express spontaneously, your bodily and emotional response to any situation. Spontaneous expression and ventilation is "being true" to the "self" which you ideally get "in touch with".

Slogan No. 12   "Stay with the feeling."(Ibid., p. 4)

Meaning: If you are experiencing a new emotion of pain, despair, joy or frustration, don't block it by doing something behaviourally or functioning intellectually; rather, "get into" the pain and "stay with it" through the full ventilation until the emotional involvement has exhausted itself, closure has been effected, and you are finished with it.

Slogan No. 13   "Achievement is not only not expected, it isn't even implied. We're not out to motivate or re-motivate him. In fact, we 'forget' the fact that he is a child and that children in our society are expected to be in school." (Easton Psychologist's Report. "Education as Part of a Residential Treatment Centre for Emotionally Disturbed Adolescents", 1972, p. 1).

Meaning: Self evident, except that therapeutic work on the resident's emotional development is top priority at Easton, and behavioural achievement or preparation is seen totally as a post-discharge problem.

Slogan No. 13a   ". . . the child is so involved in the process of therapy as to make cognitive achievement out of place."(Ibid., p. 2)

Meaning: Focused, achievement-oriented educational development cannot take place while Gestalt Therapy is taking place.

Slogan No. 13b   "Providing an extended educational program at Easton may solve. . .one problem, but at the expense of hindering the much more important task of therapy, a task that can have hope to succeed only in a completely non-demanding environment."(Ibid., p. 4)

Compendium (Cont'd.)

Meaning:	Going through the pain of self-exploration requires a completely non-demanding environment, at least in the sense of educational achievement or behavioural restrictions. The problem of course, is what are the inherent demands of the therapy (or implied demands), and how do they relate to the ever-present institutional demands?

Slogan No. 14   You've got to "work through" the emotional block. (Participant Observation)

Meaning:	This phrase assumes that a painful situation in the past, or a particular automatically-insensitive response to a range of current stimuli (i.e., sense of immobilization when in a crowded room), can be removed by letting oneself remember and experience the "true" source of the emotion, which should have been expressed at the time it originally happened.

Slogan No. 15   Staff Novitiate-- Question: "How will I know when I'm truly experiencing and 'going through' the past emotional block, as opposed to just remembering it?"
Answer: (From Senior Staff)-- "Let it happen, and you will know. It's got to be your own experience."
(Researcher's Personal Journal)

Meaning:	How you will experience your own pain cannot be explained to you. It must be your experience. We cannot tell you what we demand of you; it's got to come from you. There is a social process involved in this slogan. First, the non-verbal expectation is for ventilation of anger, despair or frustration, while the verbal expectation is non-specific. Therefore, the novitiate sees no overt demand on him to behave in any specific way (part of the freedom-and-responsibility ethic), yet the expectations are covertly expressed in the modelled ventilationist "honest and open" behaviour of the Senior Staff.

Slogan No. 16   "We try to give kids acceptance for what they are now."
(Director's Statement:(Easton)-- "The Residential Unit", Nov. 9, 1970, p. 1).

Compendium (Cont'd.)

Meaning: No matter what the behaviour, we have the res-
                    idents start by accepting it as a part of them-
                    selves. They must then explore its actual
                    consequences. The problem is that there is an
                    implicit judgment on that behaviour that brought
                    them to Easton in the first place, and an im-
                    plicit assumption that if they continue that
                    behaviour, they will not be allowed to stay at
                    Easton.

Slogan No. 17   We try to create a ". . . warm atmosphere where
                    relationships are offered without a demand that
                    they (The Residents) reciprocate."(Ibid., p. 1)

Meaning: Staff try to create an atmosphere of affection
                    and acceptance without asking residents to
                    reciprocate. However, as Monthly Reports on
                    the residents show, the criteria for their
                    therapeutic development included the ability to
                    relate to staff on a warm and personal level.

Slogan No. 18   (Definition): Open and Honest Communication.

Meaning: Communication which is self-revelatory and does
                    not hide any immediate, intuitive, or spontan-
                    eous responses to situations within the resi-
                    dence.

Slogan No. 19   "Physical contact is encouraged".(Ibid., p. 1)

Meaning: Hugging, touching, handholding, wrestling, and
                    "safe" physical fighting between staff, res-
                    idents, male and female, was encouraged at the
                    unit.

Slogan No. 20   "You're living 'in your head'; you're mind-
                    fucking and intellectualizing."
                                      (Participant Observation)

Meaning: This is a severe indictment within the Gestalt
                    Ethos. It derides the process of analyzing or
                    thinking-through a situation rather than just
                    passively experiencing it as emotion or bodily
                    sensation. It is a justifiable therapeutic
                    indictment, when an individual refuses to de-
                    velop the emotional part of himself and defends
                    himself with constant intellectualizations.
                    However, the abuse of this slogan comes into
                    play when it is used to prevent Gestalt-Group
                    self-critical evaluations from the viewpoint
                    of social processes.

Compendium (Cont'd.)

Slogan No. 21   "You're running from yourself."

Meaning: The implication is that you are being active
behaviourally, so as to avoid unpleasant
emotional motivations.

Slogan No. 22   "That's what you're thinking, but what's
really happening with you right now?"

Meaning: This is a "gate-keeping" phrase which usually
emerges when one criticizes (on analytic
grounds), the social processes operant in
Gestalt Groups. The phrase focuses on (and
tends to isolate) the critic and tries to get
him to respond in emotions (i.e., tears or
anger). Once group pressure pulls out the
effect, the substance of the criticism is lost
and criticism is effectively neutralized.

Slogan No. 23   The group-process is used to set limits on
aggression or acting-out behaviour in a com-
munity-decision-making fashion.(Ibid., p. 1)

Meaning: Group-process, in fact, refers to the methods
by which staff can secure rules for proper
community restraints on individuals, through
manipulating and re-educating the residents
into new, more adaptable patterns of community
living.

APPENDIX "C"

Characteristics of the Resident Sample

Resident	Age	Diagnosis	Education	Measuring Device	I.Q.
1.	14	Child. Schiz.	8	WISC	Below
2.	16	Adj. React.	10	MMPI	Average(+)
3.	17	Adj. + Speech	10	PSYCH	Average(-)
4.	18	Adj. + Grp.Del.	8	PSYI	V.(-) Av.
5.	17	Pers. Dis.	9	WISC	Above
6.	16	Beh. Dis.	9	PSYI	Av.
7.	16	Pers. Dis.	9	PSYI	Av.
8.	15	Pers. Dis.	7	PSYCH	Below
9.	15	Adj. React.	8	WISC	Av.(+)
10.	18	Beh. Dis.	9	PSYI	V.(+)Av.(+)
11.	16	Speech Dis.	9	PSYCH	Av.
12.	15	Beh. + Learn.	7	PSYCH	Below
13.	14	Beh. Dis.	7	PSYCH	Above
14.	13	Beh. Dis.	6	WISC	Av.
15.	16	Acute Schiz.	8	PSYI	Below
16.	16	Latent Schiz.	9	WISC	Av.
17.	14	Neurosis	7	WISC	Av.
18.	14	Border. Schiz.	6(-)	WISC	Av.
19.	16	Child. Schiz.	8(-)	WISC	Av.
20.	16	Adolesc. Schiz.	9	WISC	Below
21.	15	Latent Schiz.	9	PSYI	Av.
22.	14	Beh. Dis.	6(+)	PSYCH	Below
23.	16	Beh. Dis.	9	PSYI	Av.(+)
24.	15	Pers. Dis.	9	PSYI	Below
25.	15	Beh. Dis.	8	PSYCH	Av.
26.	15	Adj./Learn.Dis.	5	PSYCH	Below
27.	16	Adj. React.	8(-)	WISC	Av.
28.	17	Beh. Dis.	7	WISC	Below
29.	17	Beh. Dis.	11	PSYI	V.(+)Av.
30.	17	Adj. React.	10	PSYI	Above
31.	15	Beh. Dis.	9	PSYI	V.(+)Above
32.	13	Beh. Dis.	7(-)	PSYI	Av.
33.	18	OBS	11	WAIS	Av.
34.	16	Beh. Dis.	6	WISC	Av.(-)
35.	18	OBS + Pers.Dis.	11(-)	WISC	Below
36.	14	Beh. Dis.	9	PSYI	Above
37.	15	Child. Schiz.	7	PSYI	Av.
38.	18	Adolesc. Schiz.	9	----	-----
39.	15	Pers. Dis.	8	WISC	Av.(+)

LEGEND: Adj. React. - Adjustment Reaction of Adolescence
Beh. Dis. - Behavioural Disorder

Characteristics of the Resident Sample (Cont'd.)

LEGEND:
Border.	-	Borderline State
Child. Schiz.	-	Childhood Schizophrenia
Grp. Del.	-	Group Delinquent Reaction
Learn.	-	Learning Disability
OBS	-	Organic Brain Syndrome
Pers. Dis.	-	Personality Disorder
Schiz.	-	Schizophrenia
Speech	-	Speech Disorder or Impediment

MMPI - Minnesota Multiphasic Personality Inventory

PSYCH - Psychologist's Assessment

PSYI - Psychiatrist's Assessment

WAIS - Wechsler Adult Intelligence Scale

WISC - Wechsler Intelligence Scale for Children

V. - Verbal
(+) - Above Average
(-) - Below Average
Av. - Average
Above - Above Average
Below - Below Average