Psychiatrists, Patients, and Sensitivity Groups

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All psychiatrists in the greater Cincinnati area were sent a series of three questionnaires concerning patients from nonstructured discussion or T-groups. Twenty-four respondents reported having seen patients who had become psychotic or acutely disorganized in association with such group activity. They received a fourth questionnaire asking for details about the 19 patients involved and about the groups in which they participated. These 19 cases came from an estimated population of sensitivity-group participants of 2,900 (0.66% casualties). Few (only five out of 1,750, or 0.28%) had been in structured "managerial grid" groups. Both positive and negative aspects of participation in sensitivity groups were elicited from the reported experience of these psychiatrists.

OVER THE last five years psychiatrists have been paying increasing attention to what goes on in sensitivity groups. Publications by psychiatrists have emphasized the need for pooling psychiatric and educational knowledge, toward reducing the risks and enhancing the benefits of small group discussions.[1-7] Psychiatrists have drawn attention to the *risks* of these groups in papers presenting clinical vignettes of transient adverse reactions[8,9] or case histories of patients presenting acute psychotic reactions precipitated by T-group experiences.[10] A psychiatric benefit which has been suggested by a nonpsychiatrist is that some individuals are motivated to enter psychotherapy in the course of sensitivity training.[11] Articles in lay journals and newspapers have often either overemphasized the possible benefits or dramatized the element of risk.[12] The Council on Mental Health of the AMA has made a policy statement emphasizing the need for physicians to be aware of the dangers or risks.[13]

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Methods

In order to collect some information on the experience of psychiatrists with patients who seemed to be harmed or benefited by sensitivity groups, we have made a survey of psychiatrists in one community by a series of four questionnaires. This survey was carried out in a community in which extensive training activities along these lines have developed in the last five years. The numbers of individuals participating were in the thousands, according to estimates by some of the organizers of these programs in the area.

We sent three questionnaires at monthly intervals to the 162 physicians in the greater Cincinnati area who were known to be seeing psychiatric patients: the entire membership of the Cincinnati Chapter of the Ohio Psychiatric Association plus all the psychiatric residents in training in the city. We sent a fourth questionnaire to 24 psychiatrists who had indicated, in their responses to the first questionnaire, that they had seen in diagnosis or in treatment, one or more patients whom they diagnosed as psychotic or acutely disorganized and for whom the reaction appeared to have been precipitated or aggravated by participation in organized, relatively nonstructured group discussions.

The first questionnaire was directed toward such adverse effects and the second questionnaire toward beneficial influences on the course of psychotherapy. (Two questions and an invitation to respond were on the first questionnaire. The second questionnaire gave the psychiatrists a summary of the returns to the first questionnaire and asked their cooperation in replies to three further questions.)

The third questionnaire asked for the psychiatrists' policies and practices in dealing with patients who were considering such a group experience. The questionnaire sent to only 24 psychiatrists asked many more questions to enable use to eliminate "overlapping cases" of patients who had been seen by more than one psychiatrist and to get some impressions as to the characteristics of the patients and the groups in which they had been participating.

Results

The results from the first three questionnaires are summarized in Tables 1 to 3.

A total 148 of the 162 psychiatrists in the community responded to the first questionnaire. This return rate, 91%, indicated a high interest on the part of the psychiatrists and suggested that few adverse reactions that had come to psychiatric attention in this community would have been missed in the survey. Of the 148 respondents, only 24, or 15%, reported having seen patients whose psychotic reactions or personality disorganizations, whether transient or long-lasting, seemed to be consequent to participation in such nonstructured groups. Various respondents reported having seen from one to six such patients, but when we had accounted for patients having seen more than one psychiatrist a total of 19 separate documented cases remained.

In order to get a general estimate of the size of the total population of sensitivity-group participants from which these 19 cases had come, we consulted the executives of all the organizations in the community known to be sponsoring such groups. We were given figures for numbers of separate persons participating in such groups over the preceding five years which totaled 2,900. This rough estimate was unbiased by our knowledge of the number of "casualties." Thus, the 19 who became acutely ill and were brought to psychiatric attention represent 0.66% of the population thought to be at risk. Of the 2,900 participants, 1,750 took part in more structured, task-oriented management groups. Five of the 19 re-

Table 1.—First Questionnaire, May 1, 1969

Questionnaire Circulation		
No. Receiving Questionnaire	No. Responding to Questionnaire	% Response
162	148	91%

Questionnaire Data			
Psychiatrists	None	One or More	% of Responders
Reporting cases of psychosis or acute disorganization	122	24	16%
Volunteering comments	102	20	14%

Table 2.—Second Questionnaire, June 5, 1969

Questionnaire Circulation		
No. Receiving Questionnaire	No. Responding to Questionnaire	% Response
162	127	78%

Questionnaire Data			
Psychiatrists	None	One or More	% of Responders
Reporting patients moving forward in psychotherapy	105	17	14%
Reporting patients entering psychotherapy as a result	110	13	10%

acting patients were from this segment of the population at risk, giving a percentage of 0.28% reactors from these more structured groups.

A total of 127 psychiatrists, or 78%, responded to the second questionnaire. Seventeen, or 14% of respondents, reported having seen patients who had seemed to move forward in psychotherapy consequent to participation in nonstructured groups. Thirteen psychiatrists (10% of respondents) reported patients who had been motivated to enter psychotherapy as a result of the beeficial effects of participation in such groups.

Ninety-six psychiatrists, or 59%, responded to the third questionnaire which dealt with psychiatrists' attitudes towards sensitivity training and similar groups. Forty-seven psychiatrists (49% of respondents) reported that one or more patients had announced to them their intent to seek such an experience. Fifty-four psychiatrists (56% of respondents) had been asked advice about such groups by their patients. The most common concern of patients asking advice seemed to be the effect participation in such groups would have on their personal lives, interpersonal relationships, and individual psychotherapy. Twenty-seven psychiatrists (28% of respondents) reported having recommended such experiences without having been asked by patients. Psychiatrists who recommended such experiences, whether on their own initiative or in response to requests for advice, did so mostly when they saw resocialization and the need for group interaction as major themes in individual psychotherapy. Twenty-eight respondents (29%) reported having observed progress, and sixteen (17%) had observed backward movement, in psychotherapy, which they attributed to the patients' having participated in such groups.

Nineteen Cases Found.—Of the 19 patients reported upon in detail (15 men and 4 women), nine manifested psychotic reactions and ten, reactions of major disorganization. Twelve of the 19 were seen only after participation in the group, six before going to the group as well, and one during group participation.

Reason for Entering Individual Treatment.—Eight patients entered treatment primarily because of their sensitivity-group experience, the remainder for additional reasons as well, such as job stress (seven patients), marital stress (three patients), loss in the family (two patients), and problems in therapy (two patients). Eight of the acute reactions began during the group meetings and five more within one week of the group experience such as "flying home from Bethel").

Description of Groups.—Nine of the groups were described as "T-groups," or sensitivity training groups, although there was also a "meditation group" and an "encounter group" which was hard to classify. Five patients were from "managerial grids." Most of the groups occurred one hour weekly, on a weekend, or during one week, and three marathon sessions were described. Seven of the groups involved physical contact, varying from hand-touching to "physical violence and sex."

Pressure to Attend.—Varying degrees of encouragement to attend the groups were noted, ranging from being assigned to being urged to attend; only one group involved screening. Seven involved some degree of specific pressure for attendance, such as in helping executive development. One third of the groups consisted of professional persons in the human relations field.

Diagnosis.—The predominant diagnosis was schizophrenic reaction (six patients). Depressive and anxiety reactions followed with three each, and the rest varied from transient situational reaction to a hypomaniac reaction.

Treatment.—Individual treatment consisted most frequently of relationship therapy plus phenothiazine drugs, but included a wide range of therapeutic approaches. One patient received electroshock therapy and one went back into psychoanalysis.

Prognosis.—The prognosis was quite good; though six patients had to be hospitalized, only one was still in the hospital four months after the group experience. Most of those hospitalized were discharged within one month to continue in outpatient therapy supplemented by drugs.

Reintegration.—Eight patients reconstituted at a level of adjustment similar to that before the group experience, three were more socially integrated, and four less socially integrated (in the remaining four this could not be determined).

Psychodynamic Formulation.—The most common psychodynamic formulation involved some variant of attack on the patient's habitual modes of coping. Two were specifically described as having their compulsive defenses attacked, and two specifically as having their self-esteem attacked by verbal diatribes from the group.

Three men experienced homosexual panic from the physical closeness involved in the group, and two women were heterosexually overstimulated by the group situation to the point that they used primitive mechanisms of denial and projection. One striking example of a psychotic solution involved one man's intense competitive feelings towards the other members of the group, coped with by insisting that they were all trainers and that he was the only trainee!

Table 3.—Third Questionnaire: Psychiatrists' Attitudes

Questionnaire Circulation		
No. Receiving Questionnaire	No. Responding to Questionnaire	% Response
162	96	59%
Questionnaire Data		
Patients	No. of Psychiatrists Reporting on Patients	% of Responders
Announcing intention of joining such groups	47	49%
Asking advice about joining such groups	54	56%
For whom respondents recommended such groups without being asked	27	28%
Seeming to progress in psychotherapy consequent to the group experience	28	29%
Seeming to fall backward in psychotherapy consequent to the group experience	16	17%

Comment

Jaffe and Scherl in their recent article[10] make five suggestions concerning T-groups including (1) that they be completely voluntary; (2) that they be based on informed consent as to what will happen; (3) that participants be screened by questionnaire or interview; (4) that participants be informed as to what types of behavior are permissible and that physical interaction, if allowed, should be limited to those interactions where the meaning is understood; and (5) that follow-up be available to all participants.

We concur with most of these recommendations, although screening is very difficult in practice. To the warning about physical interactions we would add even greater warning about attacks on individuals and their behavior. Such attacks often have little merit, and the individuals seem ill-prepared to cope with them. In this regard, the training of the group leader in some clinical setting becomes mandatory if he is to perceive subtle reactions of disorganization before they become full-blown. In addition, he should have sufficient clinical experience to be beyond the use of affective discharge and catharsis for its sake alone, as Gottschalk pointed out in his report of his experience at Bethel.[9] The leader must be alert to step in and protect members of the group from promiscuous attack.

The relationship between lack of structure and the likelihood of acute disorganization is indicated by our having found only five cases of adverse reactions among 1,750 participants in managerial grid groups. The percentage of reactors (0.28%) for these more structured, task-oriented groups is lower than the 0.66% overall figure, including miscellaneous T-groups and sensitivity groups.

Weakening of the ego via marathon sessions or breaching of the stimulus barrier by such an approach as touching in a nontouching culture such as ours, should be handled with great discretion. And, finally, the fact that psychosis can occur following the T-group suggests that participants should be made aware of post-meeting disorganizing reactions and avail themselves quickly of psychiatric care. We emphasize particularly psychiatric care because of the usefulness of drugs and hospitalization to facilitate resolution of these psychotic or disorganizing reactions.

Most recent publications[1,5,8-10,12,13] have emphasized the dangers of sensitivity training. Our study would indicate that the dangers are not alarmingly great and that advantages are also there to be capitalized upon. Certain safeguards, both in selection of group leaders and in the handling of the group members, could result in an even smaller number of casualties and amplify the usefulness of such groups in education, sociodynamics, and as a prelude to psychotherapy.

Major psychiatric reactions to participation in sensitivity groups are not frequent or long-lasting and, in the opinions of some psychiatrists whom we have surveyed, such adverse reactions are outweighed by beneficial influences such as enhancement of motivation for psychotherapy. More attention should, nevertheless, be paid to reducing traumatic factors such as pressure to participate in nonstructured discussions or encounter groups. Exercises involving body contact and direct attack on vulnerable individuals should be recognized by group leaders as potentially disruptive influences.

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