SMALL GROUP TEACHING IN PSYCHIATRY FOR MEDICAL STUDENTS

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CONTENTS

I. INTRODUCTION ................................................................. 397
   A. The Medical School as a Teaching Setting .................. 398
   B. Functions of the Department of Psychiatry .............. 399

II. GENERAL ASPECTS OF GROUP TEACHING .............................. 401
    A. Presentation-Audience Groups ............................... 402
    B. Interactive-Inquiry Groups .................................. 402

III. SPECIAL ASPECTS OF SMALL GROUP TEACHING .................... 406
     A. Grouping of Students ....................................... 406
     B. Setting ................................................... 407
     C. Functions of the Leader .................................. 407
     D. Training and Selection of a Leader ...................... 410
     E. The Observer .............................................. 411
     F. The Problem of Excessive Tension ....................... 411

IV. USES OF SMALL GROUP TEACHING BY DEPARTMENTS OF PSYCHIATRY ......................................................... 417
    A. Small Group Teaching in the Different Years of Medical School ......................................................... 417
       1. The Pre-Clinical Years ................................ 417
       2. The Clinical Years ...................................... 420
    B. Didactic and "Therapeutic" Aspects of Small Group Teaching ............................................................. 422

V. CONCLUSION ................................................................. 427
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FOR MEDICAL STUDENTS

1. INTRODUCTION

Small group teaching in one form or another has been an established method of pedagogy since Socrates, and a method particularly favored in graduate colleges. Medical schools in the twentieth century have depended to a considerable extent on large group lectures and demonstrations, but such parts of the curriculum as laboratory experiments and ward rounds are still presented in the time-honored way. Traditional also is the spontaneous formation of small informal groups by medical students, presumably to meet their need for peer communication and support.

The Committee on Medical Education became interested in a re-evaluation and systematic study of small group methods, as they apply to the teaching of psychiatry, because of developments of the last ten years in the field of psychoanalytic group therapy and group dynamics. The effects of group forces, including facilitation of certain types of learning, have been studied; and the time seems ripe to consider implications of the newer understanding of group dynamics for psychiatric teaching.\

1. The Committee is indebted to Dr. Herbert Thelen for invaluable stimulation and help in the preparation of the entire report and to Dr. Ronald Lippitt and Dr. Samuel Bloom for help with various phases. Preparation of this report was begun under the chairmanship of Dr. Maurice Greenhill, and completed under the chairmanship of Dr. Jerome Frank.
2. See, for example, Berman, L., A group psychotherapeutic technique for training in clinical psychology, American Journal of Orthopsychiatry, 1957, 23, 322-327.
The report considers the uses of “small group” methods in medical teaching, especially by Departments of Psychiatry. Relevant overall attributes of the Medical School culture are first briefly considered in relation to the functions and problems of the Department of Psychiatry. The second section reviews some principles of group organization related to the education process. The third section discusses conditions for achieving educationally productive groups. The fourth section describes examples of small group teaching currently used by Departments of Psychiatry in the preclinical and clinical years, with special reference to the distinction between educational inquiry and group therapy. The concluding section presents ways of evaluating the effectiveness of small group teaching.

A. The Medical School as a Teaching Setting

The four years of medical school may be viewed as a maturational period for the medical student, in the course of which his self-image changes from that of a layman to that of a physician.

The medical school must train the student for a new social role requiring extensive changes in his attitudes and behavior. He must learn a host of diagnostic and therapeutic skills as well as the technique of entering into a special professional relationship with others. The imparting of information is only a small part of this process. The student must be trained to apply what he has learned in school to the situations he will meet afterwards. Since these situations are often emotionally trying, an important aim of all medical education is to help the student become master of the emotions evoked by his dealings with patients.

In general terms, the most effective way to bring about changes of this kind is to immerse the student in a new group whose standards represent the attitudes and behaviors he is to learn. It has been shown that the more one is attracted to a group, the more powerfully its standards will affect him. The medical school and teaching hospital form a “cultural island” where the student is a voluntary exile during most of his waking hours for at least five years and to which, typically, he is mightily drawn. The “island” often encompasses him so completely that he tends to shelve most of his outside interests and emotional ties. If he is married, his wife also is expected to submit to the standards of the medical school culture. It is little wonder that most physicians are profoundly and permanently influenced by their experiences during medical school and internship.

Ideally, teaching methods should be designed to take account of the differences in the student’s needs and in the tasks confronting him at different stages of his medical education. Our knowledge at present is insufficient to realize this ideal, but tentative comments will be offered to indicate possible lines of future development, with special reference to small group teaching in the Department of Psychiatry. In this connection a brief review of the functions of this department is in order.

B. Functions of the Department of Psychiatry

The general principles of teaching psychiatry to medical students have been explored by several competent groups. In their reports, curriculum time, course content, and organization of material have been emphasized. Questions of teaching-learning method have been left largely unanswered.

In considering how the objectives of the psychiatric curriculum relate to small group teaching the Committee outlined in concentric fashion the basic responsibilities of psychiatric teachers. The Department of Psychiatry has a core area of responsibility; unique, well-defined and non-controversial. This is the teaching of diagnosis and treatment of patients who are mentally ill or whose illnesses are closely associated with emotional factors. Since many of these patients are treated by non-psychiatric physicians, all students, whatever the specialized or general nature of their future medical careers, must be taught to handle problems presented by these patients in accordance with sound psychiatric principles. Thus the Department of Psychiatry must teach medical students the following content and related techniques: the diagnosis of psychiatric


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disorders; the proper disposition of psychiatric patients, including
referral; the nature and management of psychophysiological reac-
tions; and the rationale and technique of appropriate psychiatric
therapy.

Concentric to this core area are the contributions the Depart-
ment can make to the student's understanding of matters relevant
to all aspects of Medicine: the total or holistic functioning of the
"normal" organism; the emotional factors involved in all illness;
the psychosocial aspects of illness; and the contribution of the phy-
sician's own personality to the process of recovery in his patients.
Much of this material obviously could be presented by other de-
partments in the pre-clinical years and some should be inherent
in the teaching of all clinical departments. Among the responsibil-
ties the Department of Psychiatry should share with other depart-
ments are history-taking, interpretation of the doctor's role and the
concept of the doctor-patient relationship. The extent of its con-
tribution to these subjects should be determined by the medical
school's Curriculum Committee rather than exclusively by the psy-
chiatric teachers. In short, the Department of Psychiatry must train
students to handle clinical psychiatry in their clerkship, should
contribute its fair share to the orientation of all medical students,
and may extend its activities further as allowed by local circum-
stances.

It should be added that the primary aim is to teach medical
students about psychiatry, not to treat them. As the Committee
on Medical Education of the American Psychiatric Association has
stated: "... increasing empathy for patients, fostering emotional
maturation of students, promoting the student's awareness of his
own problems, etc., are not ends in themselves but a means of
opening the way for the acquisition of skills and knowledge. The
Committee believes that such matters are best approached through
concern with relatively normal ways of adjustment rather than
through entering upon therapy of the student. A teacher-student
relationship rather than a doctor-patient relationship should main-
tain in these subjects as in other areas of medical instruction."

II. GENERAL ASPECTS OF GROUP TEACHING

Basically, teaching problems of the Department of Psychiatry
are those of any other educational enterprise. The teacher is re-
quired to provide the students with factual information and to help
them assimilate it in a personally meaningful and useful way. How-
ever it is to be done, the medical student must get information,
learn practices and techniques, develop commitment to action, iden-
tify with the role of physician, and, finally, become launched on a
widening professional inquiry which will give point to his medical
career.

To guide the complex processes designed to achieve these ob-
jectives, the teacher needs basic organizing concepts of educational
method. The fundamental method of education is inquiry. A good
educative situation places the student in the role of inquirer, trying
to raise, consider and answer questions which are important.

Educators have pointed out that learning situations intended
to produce permanent changes in attitudes and behavior, to stimu-
late student inquiry, and to enhance the assimilation of substantive
knowledge should include, among others, the following five char-
acteristics:

1. Emotional support for the student as he goes through the
difficult processes of discarding old comfortable modes of thought
and behavior and trying to learn new unfamiliar ones;

2. Some means of fostering the student's involvement in the
learning task; that is, his conviction that something important to
the satisfaction of his own needs rests on his mastery of the job;

3. A chance to experiment with and practice new behaviors in
a permissive setting, i.e. where no serious penalty for failure
obtains;

4. "Feedback" to guide him by giving him information along
the way as to how well he is doing;

5. Lack of "closure," impelling the student to apply the new
methods he has learned to unsolved problems, rather than enabling
him to sit back complacently, feeling that all the questions have
been answered.

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Different ways of organizing the teaching-learning situation meet these conditions to varying degrees. Two contrasting patterns, which may be termed presentation-audience and interactive-inquiry, may serve as examples.

A. Presentation-Audience Groups

In this method the relationship is between the presentation and the audience. The “presentation” may be a lecture, a movie, a demonstration, or some such device. This type of organization most commonly characterizes large groups—often whole medical school classes—but may be used in groups consisting of only 10-15 members.

Certain gifted lecturers can provide inspiration and emotional support which may lead to profound changes in attitudes and which cannot be obtained from a textbook or from smaller groups. In addition, frequent meetings of the whole class probably help develop a feeling of class unity; and since the influence of a group on its members is a function of its cohesiveness, this possible value of lectures should not be overlooked.

Teachers familiar with special techniques to stimulate participation can elicit considerable involvement of students. Members of a group organized in this way, however, ordinarily have little opportunity for interaction. When discussions occur, they are usually monopolized by a few, for whom the rest may become a grudging audience. Experiment and feedback do not occur readily in this setting. Closure, on the other hand, is characteristically too easily achieved, thereby inhibiting inquiry.

B. Interactive-Inquiry Groups

Although these groups are usually termed “small groups” and are so designated in this report, it must be kept in mind that mere limitation of numbers does not automatically create an interactive-inquiry group. In medical school students form many other types of groups of limited size. Many are organized spontaneously and informally by the students and function without faculty leadership and usually extra-curricularly. Students may meet together to help each other study, to test their knowledge, or for mutual emotional support. Grouping may be based on various criteria such as a common task, for example dissecting the same cadaver, membership in the same fraternity or congeniality. Activities range from highly disciplined, task-oriented undertakings to relaxed “bull sessions.”

Other limited size groups are organized by the teaching staff. They may be formed of students engaged in a joint activity such as conducting a physiological experiment or attending ward rounds. Often they are essentially tutorial or preceptorial arrangements. For instance, during ward rounds the attending physician may listen to the student’s presentation of a patient and question him afterwards with three or four students as participant observers. At other times the instructor makes a didactic presentation to a small audience of four to twelve.

The distinguishing features of small groups organized and conducted by the staff are that all members can interact and are expected to do so, and all share responsibility for the group’s successful functioning. The success of these interactive-inquiry groups depends upon careful planning to achieve certain kinds of inter-relationships, and a clear understanding of what this particular type of group can accomplish.

Interactive-inquiry groups resemble spontaneously formed small groups in that their members can discuss not only the subject matter but also their attitudes toward the instructor and each other. To the extent that these groups give students a chance to express and resolve their feelings, they are a kind of institutionalized “bull session,” differing from these chiefly in that the group’s task more closely guides and disciplines the interactions of the members.

The five general characteristics of good learning situations outlined above afford a convenient framework for describing the essential features of interactive-inquiry groups. They offer emotional support to their members in various ways, two of which may be mentioned. First, the group encourages, at appropriate times, honest expression of emotions. Through this members discover shared experiences and reactions, leading to increased feelings of closeness from which they derive strength.

A second source of emotional support lies in the ground rules of these groups that all contributions warrant serious and respectful attention. Even rejection of a member’s idea, if based on adequate consideration, need not damage his self-esteem, and acceptance strengthens it by showing him that he can influence others.

While most medical students have a strong emotional commitment to the overall goal of becoming physicians, the degree of
involvement differs markedly among individuals, and for the same student with respect to different tasks. In various ways the small group fosters an amount of involvement in its members which is to some extent independent of its subject matter. Participation is fostered by recognition and encouragement of a wide range of contributions and ideas that the group needs for effective inquiry, and by the closeness of the teacher-student and especially student-student relationships. These relationships engender competitive, cooperative, and other attitudes in the participants, which involve them ever more deeply in the joint undertaking. As each strives to make his individual contribution, he develops a feeling of responsibility for the successful outcome of the endeavor which further increases his emotional commitment.

The small group is guided into developing standards which encourage each member to experiment with different ways of behaving or of thinking about a problem. Through such experimentation each learns how to contribute most effectively and develops his own potentialities. In some groups experimentation may be formalized through role playing, but more commonly it is spontaneous. For experimentation to be useful, the atmosphere of the group must be such that there is little penalty for failure, and must facilitate accurate feedback.

In small groups oriented to inquiry feedback is usually well tolerated for several reasons. It is seen as essential to realization of the group’s common purposes. Furthermore, a student offering a critique has been the recipient of similar comments previously and will be again. His awareness that roles may be reversed tends to keep his criticism objective. Finally, criticism from fellow students may be less threatening than from the instructor, and therefore more acceptable. Any critical comment he may make carries an implicit threat, and may arouse obstructive emotional reactions to authority in some students.

Feedback in small groups helps each student discover a variety of task-relevant strengths and weaknesses, to assess his own capabilities, and to become more aware of his own ways of thinking, feeling, and acting. If, as many psychiatrists believe, increase in the physician’s self-awareness facilitates better understanding of his patients, then the small group from this standpoint has special pertinence to psychiatric teaching.

Through its expectation of active inquiry, rather than of passive absorption of information, the small group, while it helps the student to integrate knowledge from different sources and levels, at the same time inhibits premature “closure.” It has been shown experimentally that effort coordinated toward group purposes enlarges the experience of each participant while at the same time increasing the objectivity of his evaluations. Eight persons usually generate more hypotheses to explain what has been observed than any one person. Each member becomes involved in the interplay of various viewpoints and, if the discussion is lively, comes upon many new questions and alternatives. Thus he receives excellent training in evaluating and integrating information and in developing methods of analysis which he can apply in future medical practice. This skill is especially important to a physician, who must evaluate each patient as a unique problem, not to be solved by rote memory of dosages or procedures.

Presentation-audience, preceptorial and interactive-inquiry groupings all have advantages, and all could be used in most courses, alone or in combination. The decision as to the most appropriate rests largely on administrative considerations. From this standpoint the great flexibility and adaptability of the interactive-inquiry group warrants its receiving a high priority.
III. SPECIAL ASPECTS OF SMALL GROUP TEACHING

A coverage of all aspects of small group teaching is manifestly impossible within the scope of this report. The following section considers a few points which seem especially pertinent. They are: grouping of students, setting, functions of the leader, selection and training of leaders, the observer, and the problem of excessive tension.

A. Grouping of Students

Experimental and empirical evidence suggests that a group's composition may play an important part in its success or failure. For example, a group with an overloading of inactive persons or aggressive individualists may be handicapped. This example implies that certain kinds of homogeneity in group composition may be inhibiting. Other examples might be cited which suggest that extreme dissimilarity in composition can be disruptive.

At the present stage of knowledge about group process no final statement as to the optimal way of composing groups is possible, but three methods currently in use may be mentioned. One is student self-selection. Teachers commonly express satisfaction with this method. Self-selection, however, is likely to restrict the variety of viewpoints to which each student is exposed. Also, such groups tend to develop an informal power structure in which a student may sometimes exert more influence than the faculty instructor.

Another method of group selection places responsibility in the hands of the faculty. For example, at one institution anatomy teams are selected on the basis of past academic records to insure heterogeneity of academic ability, on the assumption that an overloading of relatively poor students would be injurious to group performance.

Alphabetical placement is sometimes a deliberate method of insuring heterogeneity, sometimes an administrative expedient. In general, whatever system is used, it should provide for review and assessment of group functioning, and procedures for reassignment as experience indicates.

B. Setting

The meeting place should afford freedom from interruption and an atmosphere neither strictly professional nor completely informal. Details of physical arrangements are by no means immaterial to the functioning of a group. For example, the rate of interaction of group members is influenced by their mutual visibility—members sitting face-to-face tend to address each other more often than neighbors. This suggests an informal and flexible arrangement of furniture to assure maximal member-member visibility. Participants may or may not sit around a table. The teacher should not barricade himself behind a desk. Some feel it advisable for the teacher to shift his position at each meeting as a possible way of diminishing the group’s tendency to depend on him.

C. Functions of the Leader

Four functions of the leader in a small group may be distinguished although they are not mutually exclusive. These are to: (1) define the group task; (2) consolidate substantive knowledge obtained from different sources; (3) foster a group climate which stimulates inquiry; (4) encourage evaluation of group process.

1. Definition of the Task

In order to achieve optimal participation, the teacher should try to define the group goal or topic in such a way that everyone can contribute to it. He should be prepared to bring up alternative solutions to stimulate discussion. The participants must have a clear idea of the question they are trying to answer and feel that it is relevant to their experience. Thus, in case presentations the teacher should make sure that the presenter delineates the major problem or problems of the case.

The problem may have no one correct answer. Questions such as, “What do people think of doctors?” or “How would one handle a cancer patient?” help members to see that diverse opinions and attitudes are permissible, and so facilitate participation by all. Through them the student learns that he may properly speak his mind about matters concerning which everyone may legitimately

have an opinion. From this, he can move to speaking freely about more specialized or more personally felt issues. Sometimes it is useful to have the student who has had a direct experience with the discussion topic lead off—for example, one who has made a home visit, if the discussion is about a family care program. In more structured groups a helpful device is to have junior members speak first, since if the seniors or the teacher open the discussion the juniors are often inhibited from expressing different views.7

2. Consolidation of Substantive Knowledge Obtained from Different Sources

In conveying substantive knowledge, the instructor wishes each member to examine and react to it in the light of his own experience, rather than to accept it uncritically. To this end he may, for example, reveal the available data bit by bit, encouraging the group to try to solve the problem on the basis of what they know at a given point. Each successive bit of data narrows the possibilities but also raises questions which must be answered. This detective story approach, if skillfully handled, helps to sustain students' interest. It also serves both to elicit their creativity and to sharpen their critical thinking.

Whatever his technique, the leader seeks to arouse some effect in the students, and to control both the closeness to the student's self of the material, and the degree of intellectual penetration required, in the light of the readiness of the group. For example, a group was discussing a patient who exhibited signs of mourning. The leader asked for any personal examples which members felt they could recount. One student told about his dog's dying. With a good deal of feeling, he illustrated for the group the phenomenon of the "mourning work" in reporting how he and his father had lovingly reminisced over the clever and ingenious traits of their pet. This was an example which avoided the painful aspects of parental death. At the same time, in choosing it the student implied that he felt sufficient support from the group to enable him to share this experience with them, thus allowing all members to consolidate their knowledge regarding the mourning process.

3. Fostering Group Climate

The instructor seeks to foster the type of group climate which encourages optimal participation and personal commitment to the inquiry. This climate fosters serious consideration of every member's contribution, encourages expression of disagreement and inhibits premature closure.

A ground rule of agreeing to disagree is important, and to establish it the leader may sometimes have to protect a deviant who is being subjected to excessive group pressure. This protection should usually be subtle lest it damage his pride.

The ground rule that disagreements need not always be resolved raises the problem of "closure." Ideally, the leader should indicate that a solution to the problem is possible, otherwise participants may become anxious or discouraged, but he should not necessarily give the solution. He must leave questions open when appropriate. At the same time he should avoid giving the impression of deliberately withholding information which the group knows he has and they lack. This is seen by the group as teasing and creates resentment which blocks interaction and diminishes student interest in the discussion. In trying to walk this tightrope, the instructor should at least avoid "wrapping things up" out of his own need to achieve closure.

The leader must also establish the level of group introspection, that is whether the group process will remain implicit or be a subject for group discussion and evaluation. This point is considered more fully below.8

4. Encouragement of Evaluation of Group Progress

While, as indicated, the premature achievement of closure is usually undesirable, occasional summary and evaluation during or at the end of a group session, may be useful. Areas of consensus and disagreement should be delineated. Depending on the nature of the group's continuity, the group task for the next session may or may not be determined by the closing discussion. Post-meeting reaction forms may be used to supplement oral evaluation during the meeting itself. By permitting anonymous expressions of opinion, they can make available the reactions of students who are inarticulate in the group.


8. See Sections III F and IV B.
D. Training and Selection of a Leader

Small groups are informal, relatively personal situations, and their course is often unpredictable. Therefore, the leader of such a group must be more flexible, perceptive and emotionally secure than the leader of a more rigidly organized exercise and his proper selection is an important matter. Where possible, teachers should be assigned to lecturing, small group teaching, or tutorial work in accordance with their individual motivations and capabilities. Sometimes the teacher's own evaluation of his success in handling other small groups may help to determine his suitability and encourage him to volunteer for this type of teaching.

A department preparing to inaugurate small group teaching methods may find a consultant helpful, or may profitably send one or two faculty members to a training laboratory in group development. Faculty members who have conducted therapy groups often find it relatively easy to modify their approach to fit interactive-inquiry groups, although the two types differ in essential respects. Departments with an established program may train new leaders in small group methods by having them participate as members or observers in such groups. An inexperienced leader may profit from having a senior staff member observe him, either without concealment or from a viewing room. The senior person may even conduct part of a group session. In any case the two should discuss the meeting afterwards.

In one school where the group method is oriented toward the discussion of students' personal problems, the group leaders come from outside the institution and have nothing, even remotely, to do with the evaluation of the students' work, on the ground some students may be constrained by the knowledge that the group leaders' evaluation may affect their medical school careers. Small group teaching requires numerous instructors, who inevitably differ in personality, outlook, methods, and emotional reactions to their groups and to each other. If instructors come from several departments, as in some of the examples of coordinated teaching outlined in Section IV A below, they differ in familiarity with aspects of the course material. Programs of small group teaching should, therefore, include regular faculty meetings to discuss common problems, compare experiences, and coordinate their orientations and methods. Such group meetings, if properly conducted, can also help staff members to become more sensitive to group processes and to deal with their own reactions. These aims are facilitated if, so far as possible, the groups are fairly small and conducted along free discussion lines.

E. The Observer

Although an observer is not necessary, he can serve many useful functions, especially for groups whose task includes examination of their own processes. Choice of observer depends on availability of staff members. If none are at hand, the task can be assigned to group members in rotation; but the usefulness to the instructor of a student observer is obviously limited.

Leadership of a small group can be taxing. The teacher must be alert to the significance of individual members' behavior, as well as to group processes. In a spirited group, he can easily become emotionally involved, increasing the observational problem. An observer, therefore, can often perform useful functions. By discussing with the group what he has seen, he helps them to sharpen their understanding. In private discussion, he may help the leader to clarify his perception of his own behavior and its effect on the group, and to supplement or correct his observations of the events of a session. He can also give the leader a chance to express and resolve his own emotional responses to the group, including feelings of inadequacy. To be able to do this the observer should be personally congenial to the leader, and ordinarily not too far superior or inferior to him in academic rank. Otherwise, he may have a constraining effect.

F. The Problem of Excessive Tension

Once a small group is under way, many aspects of its functioning may facilitate or impede the learning process. Since all these cannot be covered in this report, the Committee decided to select an important one—emotional tension—for discussion, using it to
illustrate ways of thinking about the dynamics of small groups.\textsuperscript{13} A certain amount of emotional arousal facilitates learning but excessive tension impedes it; the ability to detect and control rising tension before it interferes with effective learning is an important attribute of a group leader.

In small interactive-inquiry groups, ambiguity is a major source of tension, exaggerated by the medical student’s unpreparedness to encounter it, since it is largely absent in other learning situations to which he is exposed. Tension is further aggravated by the relative difficulty of concealing one’s feelings in unchannelized group interactions; for although in most small groups the learning task may be defined, the means to solve it are not; its solution is expected to emerge from the members’ interaction.

The effort required to reach the most desirable solution of any learning task is strenuous. When the problem-solving steps are not clearly defined, the strain is increased. Therefore controlling the degree of ambiguity in content and structure is one way of controlling small group tension. The more factual and clearcut the topic of the group’s discussion and the more the interaction of the members is guided, the less tension is apt to develop. This way of diminishing tension, however, interferes with the very learning processes which the small group attempts to exploit, so its usefulness is limited. Another method of reducing tension, consistent with the aims and methods of small group teaching and an integral part of the learning experience, is to help the group examine the sources of strain and find better ways of dealing with them. To this end group members may usefully be trained to watch the subtle or non-verbal signs of tension such as restlessness, boredom, excessive laughter or silence, and to comment on them at the time. Such manifestations should be viewed as group phenomena rather than as identified with individual members.

\textsuperscript{13} For consideration of the other relevant components of small group process, see, for example, Bien, W., Experiences in groups I and Experiences in groups II, \textit{Human Relations}, 1948, 1, 314-320 and 487-496; Redl, F., Group emotion and leadership, \textit{Psychiatry}, 1942, 5, 573-596; Redl, F., Resistance in therapy groups, \textit{Human Relations}, 1948, 1, 307-313; Frank J. D., Some aspects of cohesiveness and conflict in psychiatric out-patient groups, \textit{Bulletin of the Johns Hopkins Hospital}, 1957, 101, 224-231.

In considering possible sources of tension, the leader should attend to the students’ relationships to him and to each other, arising from their joint efforts to define and solve the group’s task. Feeling dependent on their instructor’s good will, they try to please him, not only by working on the task, but by saying what they think he likes to hear, or by other forms of “apple polishing.” Concomitantly they dislike this feeling of dependence and rebel against it. This arouses conflict. The teacher should keep in mind that critical or rebellious behavior by group members may represent a healthy effort to counteract their feelings of dependence. Thus if one student seems successful in his efforts to please the instructor, he may anger others—not only because his success diminishes their prospects, but also because it implicitly threatens their own efforts to be more independent. Fellow group members are more likely to attack ingratiating students than critical ones, indicating that students can accept their counter-dependency more easily than dependency.

The leader must keep in mind that “transference” may affect members’ emotional reactions to him and must guard against taking transference-based reactions personally. He should not overlook the possibility, however, that members may be appropriately reacting to aspects of his behavior that he himself does not recognize. A group observer can help him considerably in clearing up such blind spots.

Students may be caught up in a conflict between competitiveness and cooperation. At first, united by a common feeling of insecurity, they tend to support each other. Later they become more openly critical and competitive. Though the leader should be alert to the presence of possible transference factors in their interactions, the extent to which he should direct the group’s attention to them calls for the exercise of careful judgment. Attempts to expose members’ hidden feelings toward each other, especially if unskillful, can create sufficiently intense embarrassment, constraint and resentment to impede the group’s activity. In special instances, however, identifying and discussing a transference reaction in a non-threatening way removes a serious obstacle to productive interaction.

It may sometimes be useful to view emotional interplay in a group in terms of a disturbing impulse and a defensive reaction.
The group's behavior is then seen as an attempt to find a solution satisfying both sides of the conflict. This is known as the group focal conflict. For example, a group may have the conflict: wish to please the leader versus fear of exposing their personal feelings. In this case, a group solution might be to discuss superficial matters very heatedly. By so doing they please the leader by the extent and quantity of their participation without really becoming personally involved. The leader might first inquire why there is so much fire and smoke about what seems a side issue. After some discussion of this, he might tentatively comment on the group phenomenon that members are afraid of exposing their attitudes to each other.

A common source of tension in small as in large groups is the student who monopolizes. Sometimes the teacher tacitly encourages his behavior because it relieves him of the responsibility for keeping the discussion going. A change in the teacher's attitude may be followed by cessation of this behavior. More often monopolizing is an expression of a personal need and this requires sensitive handling. Sometimes the teacher may rebuff the offender. He may have no other recourse. Even if tactfully done, however, this often tends to inhibit others from speaking lest the same thing happen to them.

A better alternative is to enlist the support of other members in checking the monopolist by helping them to see that the silent ones are equally responsible for the persistence of his behavior. That is, the instructor works toward establishing a group standard which inhibits monopolizing. In this way the situation can be used to increase the group's sense of responsibility for its successful functioning and the monopolist is less apt to feel personally attacked.

Too much tension may manifest itself as silence, flights into irrelevancies, excessive joking, and so on. Though silence need not be a sign of tension, at times it signifies dissatisfaction with the leader or meeting which no one dares express openly. Prolonged or repeated silences can lead to the development of a tacit group standard that the person who first talks is a weakling, so a vicious circle develops. At the other extreme, groups may develop a standard of intolerance of silence, which militates against members who cannot mobilize their thoughts rapidly. Such a standard also fosters aimless talk just to keep talking. Identifying and airing such standards or feelings may be the best means of dispelling them.

Subgroup formation may be simultaneously a source of tension, a manifestation of it, and an attempt to reduce it. Subgroups not infrequently appear transiently in a group meeting, as when two members conduct a side-conversation. Their emergence usually signifies that the needs of the members are not being met. The discussion may, for example, have lost its focus, or have become boring or upsetting to them. If the group meets over a lengthy period of time, the subgroups may develop into more or less permanent cliques which usually disturb the group's functioning although they may occasionally facilitate it. The likelihood of clique formation increases with the size of the group.

Members of cliques often act together in a preconcerted fashion to dominate the group, push through a particular viewpoint, or disrupt proceedings. A useful way for the leader to counteract the disruptive effect of a clique is to note that the discussion has taken an unproductive turn, and focus on what the group as a whole has done to permit this and how the problem could be remedied, rather than on the clique. Another maneuver with a hostile clique is to note and accept their antagonism and raise the question if they are speaking for others who have not been similarly courageous. If there is, in fact, a group consensus in their favor, then the clique aspect of the problem dissolves, and a group problem is defined. If the group proves to be not in sympathy with their viewpoint, the relationship between the group and the clique becomes the topic for consideration.

In summary, the small group leader should try to create and maintain a level of emotional tension which facilitates the learning process. His most effective means of heightening tension are to increase the ambiguity of the task and to stress freedom and directness of interaction among members. He can reduce tension by structuring the task and channelizing member interactions or by identifying group phenomena conducive to tension and bringing them to members' awareness. In doing this, however, he must

keep in mind the danger of increasing the group’s constraint instead of facilitating its progress. Phenomena related to tension which have been briefly considered are members’ expressions of feelings toward the leader and each other, monopolies, silences, and clique formations.

IV. USES OF SMALL GROUP TEACHING BY DEPARTMENTS OF PSYCHIATRY

Having reviewed some general principles and special aspects of small group teaching, it remains to consider some possible applications of this method by Departments of Psychiatry in fulfilling their teaching responsibilities. These applications will be viewed first from the perspective of the overall medical school curriculum, then as means of helping students to become more aware of the emotional responses of their patients and perhaps of themselves.

From the standpoint of the medical school curriculum, small groups should be used according to the needs and readiness of the students, as determined by their own development, the nature of the subject matter, and the general “atmosphere” of the different years.

A. Small Group Teaching in the Different Years of Medical School

1. The Pre-Clinical Years

At the start of his medical education, the student’s chief anxiety centers on how to know what he should learn out of a sea of facts which cannot be mastered in its entirety. At this stage he seeks definite task assignments and clear criteria of his success in mastering them. This is reflected in didactic, highly organized, content-oriented first year courses, with definite standards of achievement.

The first year course in psychiatry can advantageously use small groups in conjunction with lectures and other classroom exercises. Consistent with the type of material and the student’s level of maturity, such groups are often conducted in a fairly didactic manner. In one instance15 a seminar discussion forms the final hour of the three-hour didactic sequence as follows: (a) the didactic lecture; (b) other stimulus materials such as slides, films, labora-

15. Reported by Dr. Harvey H. Corman, Albert Einstein College of Medicine, New York.
tory demonstration; (e) small group discussion. The content of the presentation to the large group is used as a take-off point for the seminar discussion, but by no means to set limits to it. The goals are to provide information, to clarify such concepts as psychic determinism and the unconscious, and to emphasize attitudes of both doctor and patient as influences upon health and disease.

A variation of this method is to divide the students into groups of 5 to 12 and assign them topics to present to the whole class. Following the presentation, the class again divides into small groups to discuss the presentation. This leads the students to seek information for their presentations, on which they are graded, by resorting to resource personnel, social agencies, and the literature. The later small group discussion of this material and its amplification evolves from the personal experiences and attitudes of the group members. The goals of this course are to provide information about the individual and his environment, community resources, and social agencies; to stimulate an attitude of inquiry, and to increase self-understanding.

There is some evidence that these small group discussions are more valuable if held a day or two after the presentation to the class rather than immediately following it, since, in the latter case, students seem less able to shake off the passive set engendered by the presentation-audience arrangement.

In the first year course, presentations of mothers with their newborn infants, and later with older children, as well as fathers and siblings afford excellent teaching data. If the course includes a family medicine program, it is profitable to have in each small group at least one student who is himself a parent.

In the first year the student is beginning to grope toward a new self-image, and instructors represent models for him. The full effect of such models probably depends upon continuous contacts with a few instructors. Many pre-clinical teachers personify the highest professional ideals and so are admirable guides. The psychiatrist, as often the only clinician with whom students have regular contact in the first year, has a special opportunity to represent a humanizing viewpoint which counteracts the students' preoccupation with non-human materials. To this end he may use small groups with minimal formal structure, where students can begin to develop a broad view of health and disease, and simultaneously make their initial acquaintance with the psychiatric viewpoint.

In most medical schools, the second year curriculum still consists largely of courses packed with material to be learned. In addition, students are introduced to clinical work through courses in interviewing and physical diagnosis. Small group methods have a place in both types of course. In the first type, techniques are similar to those described for the first year, with emphasis on integrating material from the first year courses.

The Department of Psychiatry usually shares responsibility for the interviewing course. Integration of this course with Department of Medicine courses in history-taking and physical diagnosis is important. Otherwise interviewing techniques learned in the psychiatric course may not harmonize with those taught in physical diagnosis, to the student's confusion.

For practical reasons, most courses in interviewing are taught to numerically limited groups at the bedside, in small offices, or in one-way mirror observation rooms. Demonstrations by the instructor and, later, interviews by a student are often followed by group discussion. These courses vary widely in many respects. The instructors range from senior staff members to second year residents. The number of students varies from two to fourteen. The subjects of the interview are most often general medical patients, occasionally psychiatric patients and, rarely, volunteers who play the roles of patients, usually to bring out aspects of the doctor-patient relationship. The relative amount of interviewing by the instructors and by the students varies widely. Finally, there is considerable variation in the stress put on life history, the patients' behavior, and the process of interviewing. Through his identification with the instructor and his contact with patients, the student has his first opportunity to experience and cope with his emotional reaction to the doctor's role.

The second year curriculum begins the shift from the broad basic areas of knowledge characteristic of the first year to increased emphasis on skills such as history-taking and physical diagnosis which lend themselves naturally to teaching in groups small in number. The Committee believes that excellent opportunities are offered here to utilize sound small group teaching principles.
2. The Clinical Years

With the shift to clinical work, beginning usually in the middle of the second year, the task is to learn how to diagnose illness in the living patient, with some consideration of therapeutics. In the process, the student modifies his self-image to that of the practitioner. The student gains extensive contact with patients either vicariously by observing an interview, or by conducting diagnostic and therapeutic interviews himself under supervision. At this stage, the Department of Psychiatry, because of its focus on emotional aspects of human behavior, may play an especially useful role. In the clinical years, most of the teaching is in numerically small groups, traditionally organized on preceptorial or tutorial lines. As in the preclinical years, small group discussions interspersed with lectures can be reciprocally advantageous.

The Committee believes that small group methods are particularly useful in the clinical years, especially in psychiatric teaching. Psychiatric work-ups often are more time-consuming than comparable work-ups on other services. Therefore in a given period fewer patients can be seen. Moreover, therapeutic benefits often occur more slowly in psychiatry than in other specialties. It is obvious then that with the usual curricular limitations a student could observe very few patients if his instruction was limited to an individual tutorial arrangement. In small groups the experience of one student with his patient can be emotionally and intellectually shared by others through group interactions. The closeness of group members to the patient and their resulting emotional involvement with him provide a vital link between the theoretical material of preclinical years and its application in clinical practice.

In psychiatry, interviewing a patient, whether by psychiatrist or student, dramatically demonstrates the various behavior disorders, interviewing techniques and certain aspects of therapy. A skillful teacher can effectively interview a patient before a class, but the value of such an experience for the students is enhanced if they have an opportunity to discuss their observations and reactions in small groups. Ideally there should be a pre-interview group discussion to consider problems which may arise, and a group discussion following the interview to review what occurred.

This type of teaching can be conducted in both large public hospitals and university hospitals. For example, at one medical school students make several two-hour trips to a nearby state hospital. Each session is focussed on a particular diagnostic category. The instructor first reviews clinical aspects and personality characteristics of patients in the category for about fifteen minutes, then groups of two to three students interview patients for about forty-five minutes. Then they have twenty minutes to study the patient’s records, and finally the whole group reconvenes with the instructor to discuss their observations. The discussion is guided by the students’ questions. Each student is asked to hand in a brief report the following week on the patient he has interviewed, such as he might send to a colleague as a consultation report. The instructor goes over these while the students are interviewing the patients.

If the public hospital and the medical school are too far apart for brief trips to be practicable, small groups of students may be sent to it for three to four weeks of instruction.

In the university hospital, there is some variation as to whether in-patient work or out-patient work in psychiatry is given in the third or fourth year. In both settings patients are assigned to students who are supervised in groups of six to twelve. The goals are to foster the student’s understanding of therapy, help him learn the doctor’s role and increase his confidence in his relationship with sick people through a personal experience in diagnostic and follow-up interviewing.

In a typical arrangement for psychiatric outpatient teaching a small number of students work half a day a week for six to eight weeks in the outpatient department working up patients and discussing them with instructors.

A recent development is the assignment of a student to a single family, either in the clinical years only, or over the entire four years. This course is sometimes elective, sometimes required. It almost always incorporates small group teaching. In one such course, students discuss their problems in monthly group meetings of eight supervised by a psychiatrist, a social worker, and another physician who is frequently a psychiatrist. Thus each student learns from several families about emotional factors in family life, patterns of family interaction, and the impact of illness, including its

17. Personal communication from Dr. Barbara Botz, Johns Hopkins Medical School, Baltimore, Maryland.
social components. In the process he may become more aware of social and emotional factors in his own life.

At some schools a member of the Department of Psychiatry and an internist jointly conduct a group of six to eight students, during the students' clinical clerkship in medicine, in discussions of practical problems in medical practice.

Departments of Psychiatry may give students, during the clinical years, experience in psychotherapy at a level that they will find useful later as general practitioners or specialists in other fields. Typically at weekly intervals a student presents a resume of a therapeutic session, in a supervised small group. Each member has an opportunity to think about and express his ideas concerning the presentation. In addition, the small group method can utilize events occurring in the group to illustrate the interpersonal processes in the student (doctor)-patient relationship as discussed in the following section.

B. Didactic and "Therapeutic" Aspects of Small Group Teaching

Although the educational function of the Department of Psychiatry is teaching, not treatment, they cannot be sharply separated, since both aim to produce modifications in the student. This is particularly true of small group teaching which, as used by Departments of Psychiatry, is distributed on a spectrum with strictly didactic presentations at one end and group psychotherapy at the other.

Among the factors determining the position of any given group on the didactic-therapeutic spectrum are: the Department of Psychiatry's philosophy of education, the skill and training of the leader, the motivation and involvement of the students and the designated goal of the group, e.g. learning about paresis or learning about transference.

At one extreme the instructor may use a formal or informal didactic presentation to convey information, ignoring or minimizing possibilities for group interaction. He may, after the lecture, allow for only limited group participation in questions and answers. Adja-

effects, without an experience that will help them to know themselves better. 19

At the extreme “therapeutic” end of the spectrum is compulsory group psychotherapy for medical students, solely intended to change attitudes and promote maturity. A group therapy program was conducted for several years at Emory University Medical School including all students during their first two years. The justification for this program was stated as follows: “For a psychiatric teaching program to have real significance, it must alter the functioning of the student as a person in such a way that he is more adequate in all of his physician’s functions ... (he) needs an intensive training in the professional development of his subjective self.” 20 This program has since been abandoned and the Committee considers it to have been ill-advised.

Different leaders will handle the same occurrence in a group differently, depending on the position of the group in the teaching-therapy spectrum. For instance, when a student tends to monopolize discussion, one leader might choose to ignore it. Another might interrupt the offender, saying that other members also should be heard. A third might point out that this one student is monopolizing available time, ask the others how they feel about it, and suggest that they discuss it. A fourth might mention certain life experiences which might determine why one acts as this student does. He might indicate, for example, that some families encourage children to perform or show off for guests, or that a most favored or least favored child may continue to seek the center of attention in adulthood. Finally, a leader might inquire into this particular student’s early life for explanation of his behavior by asking him if he himself suspects the probable reasons, or by stating possibilities and asking him whether he thinks they might apply. Here the approach is presumably therapeutic but does not necessarily exclude teaching value for the group as well.

Although it is generally agreed that the competence of a small group teacher is related to his awareness of feeling currents (in-


all such leader interventions tend to make members anxious and self-conscious because they imply criticism, they should be resorted to sparingly and only when clearly in accord with the group’s ground rules. Finally, “psychotherapeutically-oriented” small group experiences, if offered, probably should be elective and should be prior to the fourth year, to afford the student ample time before graduation to digest the experience.

V. CONCLUSION

The ultimate criterion of success of any medical teaching method is the student’s later performance as a physician. Medical students are subjected to so many different influences in medical school and after it that evaluations by this criterion have not been satisfactory. An increasing variety of methods, however, are being developed to determine changes in students’ attitudes during or following a particular teaching experience, including small group instruction. Most so far reported have been attempts to assess the effects of teaching programs in family care\(^{21}\) or comprehensive medicine\(^{22,\,23}\). They include attitude questionnaires, projective tests, sentence completion tests, analyses of contents of recorded teaching sessions, tests students take after observing a filmed interview, and regular interviews with students. An example of the kind of result reported is that students trained in comprehensive medicine, as compared with a group not receiving this training, were more likely to view contact with a patient as presenting opportunities to be helpful, rather than exclusively as a means of learning medicine.\(^{24}\)

Another way of evaluating a teaching program is in terms of teachers’ and students’ satisfaction with it and the nature and amount of what the students learn. The teacher’s evaluation of his small group teaching, in addition to being a useful estimate of its value to the students, reflects his own feelings about this type of

\(^{21}\) McCandless, F. and Weinstein, M., Relation of students’ attitude changes to teaching techniques—a preliminary study, *Journal of Medical Education*, 1956, 31, 47-55.


close interaction with them. Thus it aids selection of teachers who would presumably lead small groups most successfully.

A student’s satisfaction with a group session, while not necessarily related to the amount he has learned, probably is not entirely irrelevant. For example, when a small group of students were involved in the discussion of a psychiatric out-patient they were more apt to concur in the instructor’s disposition of the case, than when the instructor gave his opinion after a brief lecture about the patient without permitting discussion. Although concurrence with the instructor’s opinion is not necessarily the desirable upshot of a small group discussion, it probably is an indirect measure of the students’ involvement in the proceedings and of their feeling of responsibility for the outcome. Thus it is suggestive evidence that the discussion was a better learning experience than the lecture.

Finally, changes in students’ actual management of patients following a particular training experience offer a method of evaluating it. For example, after a course in family-care organized around small group teaching, students handled psychiatric patients and their families better in the subsequent quarter than the controls who did not have the course. In a similar fashion, controlled evaluations by faculty members of students’ performance on wards might yield criteria clarifying the relative effects of different types of teaching. Such criteria have been successfully used in an assessment of a discussion group program for student nurses.

In summary, medical education attempts to teach students not only new knowledge, but a new role which requires extensive changes in their attitudes and feelings. Methods utilizing the principles of group dynamics developed in recent years facilitate attainment of these ends by fostering the students’ active participation in the learning process, and by giving them a feeling of shared responsibility for the outcome. In this report we have considered how, in furtherance of these aims, small interactive groups help the student develop an attitude of inquiry which is so essential to his work as a physician. They achieve this by 1) offering him emotional support, 2) involving him in the learning task, 3) giving him a chance to experiment without penalties for failure, 4) providing adequate feedback of information as to his progress, and 5) inhibiting premature closure.

These groups require specially trained leaders and attention to such matters as the most effective groupings of students. They also pose teaching problems, such as the management of emotional tension. Since medical school teaching already involves a high teacher-student ratio, especially in the clinical years, relatively little extra effort would be needed to exploit principles of small group teaching more effectively. On the basis of experience and information gathered in preparing this report, the Committee believes that more active experimentation with small group methods, with as careful evaluations as are feasible, is highly desirable. We are convinced that the educational potentialities of these methods are great.

25. Reported by Dr. Jerome D. Frank, Johns Hopkins Medical School, Baltimore, Maryland.
Group for the Advancement of Psychiatry

The Group for the Advancement of Psychiatry has a membership of approximately 185 psychiatrists, organized in the form of a number of working committees which direct their efforts toward the study of various aspects of psychiatry and toward the application of this knowledge to the fields of mental health and human relations. GAP is an independent group and its Reports represent the collective findings and opinions of its members as authorized by its many consultants. Collaboration with specialists in other disciplines has been and is one of GAP’s working principles. Since the formation of GAP in 1946 its members have worked closely with such other specialists as anthropologists, sociologists, econonists, statisticians, educators, lawyers, nurses, psychologists, actuaries, social workers, and experts in mass communication, philosophy, and semantics. GAP envisages a continuing program of work according to the following aims:

1. To collect and appraise significant data in the field of psychiatry, mental health and human relations;
2. To re-evaluate old concepts and to develop and test new ones;
3. To apply the knowledge thus obtained for the promotion of mental health and good human relations.

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