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EXPERIMENTAL TECHNIQUES IN GROUP PSYCHOTHERAPY WITH DELINQUENTS*

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Irrespective of the approach used, the treatment of delinquents is an extremely difficult—and often unsuccessful—venture. However, to the authors of this article, the technique of group psychotherapy, if properly employed, offers considerable promise in working with youngsters. Their paper first surveys the vexing problems which arise in dealing with delinquents and then describes a number of specific techniques and treatment adjuncts which the authors have found to be successful on an experimental basis.—EDITOR.

Treatment of delinquents, by whatever technique, is usually considerably more difficult than the treatment of other patients. Indeed, treatment of delinquents is, unhappily, characterized by more failure than success.¹ The problems presented by the delinquent, who is almost invariably resistant to treatment, are too often insuperable in terms of conventional approaches. The delinquent is practically anti-social by definition, and the treatment situation is hardly excepted from his typical reactions. This is in sharp contrast to the response from other patients, in that they usually seek treatment readily and expect to put up with certain inconveniences and imposed conditions in order to be treated.²

The therapist who treats delinquents must expect to encounter a variety of problems which shape in large part the philosophy, aims, and techniques of treatment and are derived from the nature of the delinquent as a patient, the thera-

pist's own background and experience in working with delinquents, and the setting in which treatment is offered.

In establishing a vehicle for psychotherapy with delinquents, the group approach appears to possess certain advantages over individual treatment. Inasmuch as many delinquents will not respond to the therapeutic ministrations of an adult therapist whose allegiance seems to belong to a world against which he is rebelling, the group situation may provide some security and protection against what is unfortunately the perceived enemy: the therapist. While it is true that group psychotherapy might be regarded as the method of choice with some delinquents because it is best suited to stimulate therapeutic interaction among them, it might also be regarded as the method of non-choice in that at times no other therapeutic vehicle can as effectively "reach the unreached."

Another advantage often claimed for group psychotherapy is that it may be used to reach a larger number of patients than possible in individual treatment. This argument may, in a sense, be illusory since the total volume of problems elicited from the larger group unit may be increased, thereby making more individual work

* This paper is based upon a presentation by the authors at a meeting of the Association for the Psychiatric Treatment of Offenders held in New York City.

¹ Chwast, Harari & Weisman, *Why We Fail*, 22 Fed. Prob. 36 (1958).

² Schmideberg, *Treating the Unwilling Patient*, 9 BRIT. J. DELINQ. 117 (1958).

subsequently necessary. In any event, this should be no deterrent, since developments would result in the provision ultimately of more services within an area of acute and unmet need.

This paper will discuss some of these problems and will focus, more specifically, upon some recent experimental group psychotherapeutic methods found useful with this population.

PROBLEMS IN THE TREATMENT OF DELINQUENTS

In its totality, delinquency emerges from an enormous conflict-producing matrix in which most causal factors remain essentially beyond the grasp of the individual therapist. Only occasionally can the therapist affect constructively a pathogenic family unit and even much less occasionally a pathogenic neighborhood. Nevertheless, he can and does affect the delinquent patient somewhat, provided that the latter remains operationally definable as a patient within the actual treatment relationship, and not as a construct in theoretical speculation. To achieve even this modest objective of establishing a treatment relationship is in itself quite a feat. Too often, however, therapists, under the pressure of their supervisors or the community or through the misapplication of treatment criteria which might be useful for middle-class neurotic patients, have striven for far more than could be obtained under the circumstances and, as a consequence, have suffered inevitable frustration and disappointment. This would seem to hold equally in group and individual forms of psychotherapy.

At the present time, we are in the midst of an amazing mushrooming of group psychotherapy programs in almost every conceivable treatment setting. This is as true among delinquents as it is with respect to other treatment populations. Unfortunately, though, while group psychotherapy for delinquents is being afforded primarily in institutional settings, only a trickle of work is being done outside such controlled environments. Thus aside from the social group-work focus of the various street club projects in New York, Philadelphia and elsewhere, very little work is being done with delinquents in non-institutional group psychotherapy projects.

Institutional versus Non-Institutional Treatment

Of course, there are similarities in the process of group psychotherapy no matter what the setting. Nevertheless, the problems, methods and results as between institutional and non-institutional

forms of group psychotherapy differ in many important respects. For one thing, while it is generally agreed that treatment outside an institution is more desirable if it can be obtained, treatment of such patient groups in institutions is, of course, made immeasurably easier in certain respects. Primarily, the patients are always on tap and hence there are no serious difficulties in getting them to the treatment office. Secondary advantages which also foster treatment attendance may be gained by the patient in an institution such as obtaining free time, a change of atmosphere, more attention, and possibly other privileges. On the other hand, these may concurrently prove handicaps to the treatment process, although it is undeniably true that a good number of such patients can get trapped into serious therapeutic involvement. Group psychotherapy with non-institutionalized delinquents not only overcomes the artificiality of the institutional setting, but also it may serve to prevent further delinquency by involving more directly in treatment efforts friends, family, and other significant persons.

In this paper we are primarily concerned with delinquents defined as such by legal authority and who come, in the main, from a lower socio-economic milieu. Their delinquency is expressed chiefly by some form of anti-social acting out. Of course, it is recognized that delinquents may be found at all social levels and also may be equally in need of treatment and equally difficult to treat.

Unlike other patients, the delinquent is ordinarily referred for and maintained in treatment coercively by an authoritarian agency in the community. This contrasts with the non-delinquent patient, as suggested above, who voluntarily goes to an agency because he has "troubles", i.e., some difficulty in adjusting to the requirements of his life situation. Since the delinquent's alternative to treatment may be confinement or some other penalty, he generally accepts treatment as the lesser of two evils.

The treatment of adolescent delinquents, as has already been indicated, is fraught with many difficulties. Such youngsters not only have a lack of trust in conspicuously middle-class adults, but also they are caught up in a whirl of life providing ready non-treatment sources of gratification. To become a patient, it is necessary sometimes for a person to arrive at some settlement with life whereby he acquires the recognition that he has problems for which help is needed. This point is,

of course, greatly facilitated by the visible reminders of the grim institutional setting for incarcerated patients, and for the non-institutionalized delinquent this can also occur as a crisis brought about by a killing, fight, or arrest, and consequent adult or even peer group pressure. In any event, the contact with the court, by itself, becomes a stern reality with which to contend. The delinquent might then enter into treatment in response to the demands of official authority and be kept in it subsequently.

Undertaking treatment of the delinquent implies a belief that there is some quality or group of qualities which is amenable to some form of psychotherapy. Too often the diagnosis of psychopathic personality, or its modern equivalent, the sociopathic personality, has been construed as implying unamenability. This may give us a clue to the reasons behind the frequent lack of success in treating delinquents, inasmuch as by definition many are viewed as untreatable. One cannot deny, however, that at best delinquents are extremely difficult to treat.

Of course, delinquency is not in itself a psychodiagnostic entity. Many types of individuals may be delinquents. Thus, the delinquent may be mentally retarded, organically impaired, psychotic or neurotic, and, in addition to his delinquent symptom, may manifest a variety of others, physical or psychological.

Resistance and Control

In treating delinquents one deals not only with unconscious resistance, but also directly with conscious resistance to involvement with the therapist. As already suggested, the problem of initially engaging the delinquent in treatment is unusually complex and crucial. The very fact of treatment in an authoritarian setting such as the court with the implicit threat that authoritarian powers may be invoked, although seemingly contradictory to the permissive spirit of psychotherapy, is probably essential to effective treatment of the delinquent. It is likely that control or support under these conditions may well provide something which the delinquent unconsciously senses that he needs. From the symptomatic viewpoint, treatment may be seen as helping the delinquent to achieve the control over his impulses which he had demonstrated he lacks.

Achieving control over anti-social impulses in effect signifies the discontinuance of delinquent

behavior--the abatement of the symptom. In general, therapies with non-delinquent patients would be regarded as superficial if they resulted primarily in eliminating a symptom or perhaps substituting of a new symptom for one discarded. It seems quite evident, however, in working with delinquents that the symptom of anti-social behavior must be given up or greatly reduced if the treatment relationship is to be continued.³ But this may mean that the delinquent's characteristic externalization of tension and anxiety by acting out may, if therapy is successful, lead to greater control. It can also produce an internalization of anxiety, perhaps manifested by neurotic symptoms. At this point, if contact with the delinquent is maintained, treatment may move ahead along more conventional lines in dealing with a neurotic type of problem. Whether we can move ahead or not, it is likely, regardless of how the delinquent progresses in treatment in clinical terms, that success will be measured by the degree to which he stops being a delinquent. A fundamental treatment problem then is that of drawing the delinquent into a therapeutic relationship, keeping him in it despite both expressed and unconscious resistance, and withstanding a variety of provocative maneuvers intended to interrupt treatment.

The Delinquent as a Patient

His delinquent behavior apart, the delinquent patient shares much with his lower socio-economic peers. Frequently, he has difficulty in learning at school (reading retardation of five years is often encountered).⁴ He usually demonstrates a poor capacity for understanding abstract concepts, low frustration tolerance, little capacity for delay, and tends to be concretely oriented. An emphasis on immediate gratification may reflect a realistic perception for the delinquent and his family of a bleak and unpredictable future. Delay can mean total loss. This is in sharp contrast to the typically nurtured frustration tolerance and long range perspective of the middle-class youngster.⁵ Despite somewhat different emphases, Davis,⁶ Cohen,⁷

³ Chwast, *Realistic Goal-Setting in Treating Delinquents*, 2 APTO J. 1 (1958); Chwast, Harari & Weisman *op. cit. supra* note 1.

⁴ Margolin, Roman & Harari, *Reading Disability in the Delinquent Child*, 25 AM. J. ORTHOPSYCHIATRY 25 (1955); ROMAN, *REACHING DELINQUENTS THROUGH READING* (1958).

⁵ Chwast, Harari & Weisman, *op. cit. supra* note 1.

⁶ DAVIS, *SOCIAL CLASS INFLUENCES UPON LEARNING* (1948).

⁷ COHEN, *DELINQUENT BOYS* (1955).

Kobrin,⁸ and Sykes and Matza⁹ have provided some excellent insight into the delinquent's subculture. Shulman,¹⁰ referring largely to institutionalized delinquents, Harrower,¹¹ and Peck and Bellsmith,¹² who worked in a court setting for children, have also described problems among delinquents which are similar to those considered in this paper. It is important for the therapist to find ways of adapting his own middle-class background and orientation, which relies largely on words and symbols, to the needs of a delinquent patient who is essentially non-verbal and concretely oriented.¹³

The delinquent in treatment, as in any of his relationships with authority figures, tends to be guarded, evasive, and suspicious. He fears that anything he says may be used against him. He views the therapist as a kind of policeman out of uniform. His perception of permissive acceptance on the part of some therapists is frequently one of greater suspicion, since he may fear that someone is trying to soften him up, trying to get him. Indeed, the plain truth probably is that therapists are doing just that—except in ways which are hopefully more constructive.

All of the delinquent's energies consequently converge on defeating this intrusion into his life. He may be provocative or threatening, and may try to persuade the therapist that he is so bad and tough that it would be futile to attempt to reach him. Furthermore, he may not feel that he has a "problem" in conventional terms; his problem, as he sees it, is that he got caught. This is in contrast to the typical neurotic patient who may present his problem on the basis of what makes him uncomfortable.

Because the therapist can directly represent an obstacle to freedom from control, all means are used to get around him: provocation, seduction, implicit threat, or other attempts to arouse anxiety in the therapist. This course of action can, however, prove very useful and become a vital beginning in treatment since the therapist becomes the pivot around whom a struggle between socially

adaptive and anti-social goals, values, and behavior takes place. In this struggle the therapist may have to outwit the delinquent at times.¹⁴ In a sense, treatment may become an engagement of maneuver and counter-maneuver. Sometimes, the touch of omnipotence with which the delinquent may endow the therapist can prove a major therapeutic aid. On the other hand, the therapist should anticipate attempts by the delinquent to deprecate and prove him soft and inadequate.

Therapist's Qualifications

The therapist should, of course, be well trained in his basic discipline. But what does it take to work effectively with delinquents? Why do some people enter an area of work which is so difficult and relatively unrewarding and where progress is often imperceptible with successes few and far between? Certain it is that whether on the basis of his own life experience or otherwise, the therapist must learn to understand, empathize, and identify with the delinquent. This is not to say that he condones anti-social behavior. Too great a distance between the therapist and delinquent may prevent meaningful contact, while too little distance may be damaging to the patient or possibly to the therapist. There is always the danger that the therapist may tighten up in repressing the impulses so freely acted out by the delinquent patient. On the other hand, the therapist may in some way provoke and vicariously exploit the delinquent in living out his fantasies in a manner characteristic of many parents of delinquents.

One therapist aware of the gap in his knowledge of delinquent backgrounds clipped a picture from a newspaper which showed a badly deteriorated kitchen in a slum tenement with broken walls, hanging pipes and cardboard covered windows. The caption indicated that a family of ten lived in this one room. The picture made vivid for the therapist what life was like in such circumstances and defined in concrete terms the low socio-economic delinquent population with whom he was working. This is perhaps a great need for many therapists—to experience in some way what it means to come from the delinquent's milieu.

Furthermore, the therapist must be perfectly clear about his own values, because in a multitude of subtle and overt ways these are constantly being probed and examined by the delinquent

⁸ Kobrin, *The Conflict in Values in Delinquency Areas*, 16 AM. SOC. REV. 653 (1951).

⁹ Sykes & Matza, *Techniques of Neutralization: A Theory of Delinquency* 22 AM. SOC. REV. (1957).

¹⁰ Shulman, *Delinquents*, in *THE FIELDS OF GROUP PSYCHOTHERAPY* c.11 (Slavson ed. 1956).

¹¹ Harrower, *Who Comes to Court?*, 25 AM. J. ORTHOPSYCHIATRY 15 (1955).

¹² PECK & BELLSMITH, *TREATMENT OF THE DELINQUENT ADOLESCENT* (1954).

¹³ Chwast, *Value Conflicts in Treating Delinquents*, 6 Children 95 (No. 3 1959).

¹⁴ REDL & WEINMAN, *CONTROLS FROM WITHIN* (1951); Schmeideberg, *op. cit. supra* note 2.

patient.¹⁵ The delinquent in fighting off treatment can do this more successfully if he can repudiate the values for which he expects the therapist, as an agent of the community, to stand. This objective is much easier to attain if he can find these values weak and inconsistent.

It goes without saying that to treat delinquents one has to believe that they are treatable; it is also essential to understand how delinquents are different from other patients. The therapist has to be prepared to drop many traditional and classical treatment techniques, particularly the emphasis on the verbalization of symbols, fantasies and dreams. This is not to negate the possibility that if the therapist can hold the delinquent patient with time—a long time, perhaps—these therapeutic elements may become accessible. The therapist must also be ready to leave the comfortable arm-chair and play his role whenever and wherever he may be needed. This may well require his presence in court or even in prison. Or it may necessitate active help in arranging for a job or school transfer. Undoubtedly, this calls for an extensive modification of the traditional self-concept of the therapist who may see himself as dealing primarily with the “sick” part of the patient, that is, his emotional life. Treatment of the delinquent, as often as not, may require planned intervention in his life.

The Setting

In the limited amount of time that the therapist usually spends in treating the delinquent, it is hardly likely that the impact of the more general setting on the delinquent can be overcome. Often the effect of the setting, whether in an institution or a clinic, is contrary to the goals and methods of treatment. It is easy to see how the delinquent's perception of the adult world of which the therapist is a representative can be strongly influenced adversely by such non-treatment persons in or about the treatment setting as a dour doorman, irate teacher, punitive house parent, or fussy counselor. Realistically, we must understand that those adults may often be far more significant figures in the delinquent's life than is the therapist. Their attitudes toward him many times reinforce the perception of a hostile adult society which the delinquent brings into the treatment situation. He may use this to support and augment his resistance to treatment.

Nowhere is the contradictory effect of the setting *vis-à-vis* therapy highlighted more than in an authoritarian agency. Obvious disadvantages arise from the delinquent's being compelled to enter therapy under threat of punishment from the court or another authoritarian agency. It must perforce be difficult for him to believe that the therapist can really be trusted. His perception of the therapist as a tool of the punishing agent is something that takes considerable effort to undo.

In an authoritarian setting, the pressures of the community upon the therapist are increased considerably. Thus when several boys in a therapy group leaned out of the windows to call and gesture obscenely to girls in a school across the street, immediate censure of the therapist was forthcoming from the probation officer and casework supervisor. Their demands for control of the group's behavior were strongly asserted regardless of the therapeutic indications.

On the other hand, there are important advantages in working with delinquents in an authoritarian setting. For one thing, because of his direct refusal to accept necessary treatment, the delinquent can be lawfully kept in treatment almost by force. Although some therapists may shudder at this, actually the threat of drastic punishment is one means whereby the therapist obtains at least one opportunity to sit opposite the delinquent patient and begin to talk.

More subtly perhaps and positively, the authoritarian setting gives ego-saving sanction to the underlying dependency that the delinquent brings to the therapeutic situation. Since the delinquent may perceive treatment as a confession of weakness and inadequacy, he can now consciously contend that he is in therapy not because he wishes it, but rather because of compulsion. This may thereby allow for a freer involvement in therapy than if he had to acknowledge openly that he, in fact, desired it. Oftentimes, as treatment proceeds, the protection afforded by this maneuver loses its earlier value so that the patient is more willing to concede his dependency. Thus, even when given an opportunity to leave therapy, several youngsters requested that they go on. In a recent case, a group of fifteen and sixteen year-old gang members had been apprehended for the possession of several zip guns. Given the alternatives of either clinic treatment when other community resources could not be obtained or probationary supervision, they chose the former. It

¹⁵ Chwast, *op. cit.* *supra* note 13.

seemed quite clear that even with their limited clinic contact during the group diagnostic process, they chose therapy even though probation would have necessitated less time and less emotional involvement.

Of course, the effect of the setting upon the therapist is most significant. Adolescent delinquents may act out in a variety of ways to the discomfort of the therapist and the agency. This is illustrated by the thirteen year old delinquent boy who stole a bottle of soda from the institution's canteen and brought it to his therapist. The therapist's dilemma hinged upon determining the significance of this act in the therapeutic process as well as in relation to the concern he felt about the reaction of the institutional authorities. Would they use the incident as a means of criticizing the therapist? Fortunately, the therapist was able to handle this dilemma constructively when he realized he was being immobilized by his own anxiety over agency reactions.

With delinquents, much is owed to the street corner approach.¹⁶ This has stressed the importance of reaching out to the delinquent in his natural habitat. As suggested above, therapeutic interaction can occur almost anywhere—in a candy store, park, or street corner. In the case of Joe, this even occurred in jail. Joe's therapist was able to conduct her therapeutic interviews during visits to him for over three months until a final court disposition was reached. Undoubtedly, the intense concern of the therapist for her patient so strengthened Joe that he not only continued treatment upon release but also did not get into further difficulty.

Despite the outer veneer of indifference to their surroundings, delinquents, as seen in the following example, are quite sensitive to nuances in their environment. A group of six boys involved in burglary, extortion, and mugging had for some time been meeting their therapist in a rather cheerful and airy room. Since the room was being repainted, they were moved temporarily to another which, despite the fancy paneling, was lark and dismal. Upon entering the new room for the first time, the boys appraised it casually and commented laconically, "We been demoted, huh?" In another case, when a court clinic refurbished a therapy room, most of the youngsters became

excited and openly expressed their pleasure at being considered important. They declared that they would like to live there, embroidering this assertion with elaborate fantasy.

SOME PROMISING TECHNIQUES AND TREATMENT ADJUNCTS

In the light of the preceding discussion of the philosophy and aims of treatment and the influence of the setting and therapist upon the delinquent patient, it is now appropriate to turn to a description of specific techniques and treatment adjuncts which have shown promise on an experimental basis. Hence, after taking a brief look at early treatment objectives with delinquents, we will comment upon a group intake procedure, tutorial group therapy, the use of a co-therapist, combined group and individual therapy, the natural group as a treatment population, therapist intervention, and the adjunctive use of food in treating delinquents.

Early Objectives

An examination of treatment methods with delinquents must first deal with the problem of making and maintaining therapeutic contact. The early encounters of the group with the therapist, being characterized by a touch-and-go quality, are of the greatest significance for therapeutic progress. During this time, the aim is simply one of keeping the delinquent within a therapeutic framework. If this is accomplished, it may be possible gradually to secure deeper therapeutic involvement. Essentially, primary objectives are to establish the understanding and motivation to continue in therapy. Their achievement may take considerable time.

Group Intake

Even before these early objectives can be aimed for, it becomes necessary to form appropriate groups which can benefit from group psychotherapy. In this connection, a rather interesting screening technique has been recently developed in a court setting. This is a group intake procedure which involves not only youngsters but also parents. One valuable outgrowth of this approach has been the development of a new diagnostic method referred to as "interactional testing." By this method, group responses are elicited to projective tests rather than the usual individual response, and from this a "group personality"

¹⁶ MCCARTHY & BARBARO, REDIRECTING TEEN-AGE GANGS—REACHING THE UNREACHED 98-126 (v. ed. 1957).

profile is constructed.¹⁷ More suitable groupings have become possible in that groups can be formed in terms of social peer responsiveness instead of an isolated case history or psychological test data alone.

Tutorial Group Therapy

Roman describes another experimental technique, "Tutorial Group Therapy," in which one group of delinquents received only remedial reading, a second received only group therapy, and a third received a combination of both.¹⁸ Interestingly, the third group improved not merely in reading but also in general emotional adjustment. It appeared that combined remedial reading and group psychotherapy lowered resistance to treatment because the delinquents shared a common problem: non-reading. The delinquents could understand in concrete terms the significance of this type of treatment. A curious twist in the anticipated treatment resistance phenomena also occurred in that the youngsters who did not wish to read could resist by talking; if they did not wish to talk, they could resist by reading. In any event, growth occurred simultaneously in both areas.

The Co-Therapist

The use of a co-therapist has also proven of value in treating delinquents. Often the co-therapist can serve as a foil in evoking reactions which vividly express the group's problems. This was seen in the group of pre-adolescent delinquents which had met for a few sessions with a single therapist, after which a co-therapist was introduced. The latter's presence was acknowledged by the group, although he was not directly addressed. The underlying reaction to him was revealed in a fight between the two dominant group members, who each insisted that the other had to leave. When it was interpreted that they were expressing the group's hostility toward the co-therapist, the fighting ceased. Upon this, the two adversaries united in attacking the original therapist.

The co-therapist can also serve as a target upon which a group may project malicious motivation. He may be seen as a "stoolie," a boss, or a punk. In addition, counter-transference phenomena are more sharply focused by co-therapists. Co-therapists may interpret their reactions to each

other in the group's presence. For delinquents the expression, acceptance, and resolution of differences by significant adult figures may be an unfamiliar but valuable experience. This would enable them to perceive the possibility that differences between adults need not imply destructive hostility, but rather can signify valid differences which are mutually respected. If co-therapists are of unlike sex, the group's reaction may become even more meaningful, particularly with younger children.

Combined Group and Individual Therapy

The combination of group and individual therapy is often quite effective with delinquents, irrespective of whether they are seen individually and in groups by the same therapist. This combination provides a considerably broader foundation for understanding and dealing with the youngster. It is striking how differently youngsters may appear in individual as opposed to group sessions. Frankie, a teen-age burglar, was sullen and detached in the one-to-one relationship, yet active and articulate in the group. Conversely, some youngsters, although frozen in the group, may thaw in individual sessions.

The manner in which a delinquent who cannot resolve a problem in one setting can in the other is illustrated by Jimmy. When Jimmy became angry at his individual therapist, he did not feel secure enough to take this up with him directly, but he freely vented his feelings before the group. The group pointed out how Jimmy's anger was directed against the individual therapist. With this support, he then became able to express his feelings to his individual therapist.

Natural Groups

Another approach which seems to be worth further development and experimentation, especially in getting to the resistant youngster, is the treatment of "natural" friendship groups. Such groups may differ considerably from groups which are ordinarily formed on the basis of pre-set criteria: age, sex, diagnosis, intelligence, etc. A "natural" group, as considered in this context, is a group of close compeers who enter therapy together, since they have been referred usually for anti-social acts committed together.

In this form of group treatment, feelings of estrangement are considerably mitigated and expression facilitated. The therapist may then

¹⁷ Roman and Bauman in HARROWER AND OTHERS, *CREATIVE VARIATIONS IN THE PROJECTIVE TECHNIQUES* c.3 (1960).

¹⁸ ROMAN, *op. cit.* *supra* note 4.

become more readily aware of significant changes within the individual and also in viable group relationships. Unlike the situation in individual treatment where the delinquent may become increasingly isolated from his peers, he is being socialized within a natural social framework. The natural group also affords inherent protections against estrangement by promoting simultaneously parallel therapeutic change within the individual youngster and his associates. It thereby eliminates an additional adjustmental hurdle within the community after treatment.

Treatment of natural groups also may make possible the reaching of a larger number of youngsters than could be seen either individually or in conventionally formed groups. For example, this was accomplished in conducting group therapy with the leaders of several gang segments. It was felt that positive changes in gang leaders resulted in some corresponding changes among gang members, even those not in therapy.

An arresting phenomenon with a natural group occurs when it may use an individual member to work out some of its central difficulties. Other types of psychotherapeutic groups, it is true, may also manifest similar reactions but usually do not appear to do so as quickly or as potently. A case in point is that of Billy who, although not an original member, was later brought into treatment by the group itself. The group had been experiencing considerable difficulty in discussing their feelings toward their parents. Billy, however, had no difficulty even though he was a newcomer. Stimulated by his open revelations, the group then gained the confidence to face more directly a focal problem they had been avoiding.

Natural groups, of course, possess fairly obvious disadvantages. For one thing, socializing by itself can betoken an increase in resistance. As a result, the therapist can often be effectively excluded. The problem of confidentiality also becomes more complex with natural groups, as illustrated by Max, who upon becoming increasingly aware of his homosexual trends, began to disclose more and more of this to the group. Since this was a natural group, the therapist tried to guard against the detrimental effects of exposing such ordinarily confidential and extremely sensitive information.

Another serious problem that may occur in natural groups is the struggle for ascendancy which can assume momentous significance to the patient who may serve as the group leader extramurally.

He often finds himself in conflict with the therapist and may feel threatened by the latter's control as he perceives it over the group. Reacting against this, the natural leader may seek to impose control and censorship over the group's behavior in treatment sessions; it is also possible that this may lead to retaliatory measures on the outside. Disclosures in therapy sessions may well expose a youngster to group punishment. The net effect, understandably, may be to prevent him from expressing his feelings in the session. In some instances, neighborhood gang leaders have actually appeared in therapy sessions in order to get a line on what was going on. One youngster who had been freely revealing hostile attitudes toward his gang leader was pulled into the bathroom and threatened with injury if he continued.

Finally, natural groups can also stimulate acting-out behavior so that expressed hostilities and antagonisms are more likely to be enacted either at the group meeting or elsewhere.

Therapist Intervention

Among the techniques in the therapeutic armamentarium which seem to warrant considerable investigation, experimentation, and evaluation, those concerned with the therapist's deliberate intervention deserve a high priority. Intervention can be so decisive a factor in treatment that it cannot any longer be dismissed blithely as primitive. The "helping process" may become a rather academic term if viewed only as helping the delinquent patient to help himself. With the delinquent the necessity is frequently for concrete and tangible help. This requirement would hold not only in individual treatment but equally in group psychotherapy and runs counter, as indicated, to the more usual non-involvement in the personal life of the patient.

Recently, Teddy, a fifteen year old, had been referred because of homosexuality with younger boys. Ted, who came from a home dominated by a tyrannical older brother and an ineffectual, alcoholic mother, was very depressed; life was bleak and hopeless, and there seemed no way out. Although he spoke of his desire to get a job, Ted repeatedly stressed the idea that "nothing good could happen to him." In view of the intense depression and pervasive feeling of hopelessness, the therapist felt that mere interpretation of the boy's feelings would not be helpful at this early stage; indeed it might threaten the continuance of treat-

ment itself. Since the only positive aspect of the situation was Ted's desire for a job, the therapist deliberately seized upon this to illustrate concretely his concern and capacity to help Ted with what he saw as important. The therapist thereupon set out systematically to help Ted obtain the summer camp job he wanted. Step by step, he helped with the application, interviews, medical examination and, finally, transportation. In this fashion, he distinctly demonstrated to the youngster that there was hope and good things could happen. During this time, the therapist utilized every opportunity to open up and explore various emotional areas of difficulty. This strategy enabled Ted to tie in relevant feelings and ideas with appropriate action.

Experience seems to show that a therapist working with delinquent groups should be prepared to expect many demands which are not made by other patient populations. Juan brought his mother to the clinic with a request that the therapist hospitalize her. She had become flagrantly paranoid, and he felt safe enough in bringing an immediate family problem to his therapist. This invitation to help, despite its connotation of dependency, presented the therapist with an opportunity to enlarge his understanding of Juan in the dynamic solution of a pressing reality problem. The gains for Juan in building self-understanding and integration far exceeded the crucial concrete help he received.

Adjunctive Use of Food

Unlike the previous instances of therapist intervention which were called forth by spontaneous developments in the treatment situation, the use of food constitutes a premeditated treatment tool. Thus in one agency treating delinquents, "cokes," cookies, and other refreshments are regularly provided—and indeed come to be expected. Actually with the delinquent—generally orally-deprived and concretely oriented—the giving of food becomes equated with an act of caring. Since delinquents can be so much more easily organized around the sharing of food than the sharing of feeling, the provision of the former facilitates the release of the latter, an essential treatment objective.

SOME CONCLUDING OBSERVATIONS

In this discussion of group treatment methods with delinquents, what emerges may constitute a

recital of problems encountered and suggestions for the future rather than a set of firm proposals and definitive answers. Despite the vast amount of research into delinquency and delinquents, one is impressed with the poverty of valid data about the delinquent in the treatment situation. This deficiency is undoubtedly ascribable in no small part to the delinquent's less than avid desire to participate in treatment. The delinquent, however, is not alone to blame since we have noted how the therapist and setting may contribute in muddying the therapeutic waters.

It seems quite certain that unless therapists gain a clearer insight into the actual nature of the delinquent's world, appreciate the invalidity of using techniques which may be appropriate to the middle-class patient, and develop a willingness to involve themselves more fully in resolving some of the delinquent's reality problems that not much progress ought to be expected.

The essential requirements for successful treatment of delinquents place burdens upon therapists which appear generally over and above the essentials of professional training and competency ordinarily accepted.

It is necessary to recognize that the delinquent comes principally from a particular low socioeconomic milieu and this vitally affects his attitudes, behavior, goals and motivations. A key problem for the therapist probably hinges upon a clear understanding of some real differences between himself and his delinquent patient. Not only does the delinquent share in common with all patients in therapy expressed and unconscious resistance to change and increased self-awareness, but also he usually specifically and overtly resists the very idea of being involved in a treatment relationship. Despite the usual minimization of the significance of symptoms by therapists, the delinquent's anti-social behavior as a symptom is profoundly consequential in contrast perhaps to its lesser significance for other types of patients. In a real sense, dealing with the delinquent's symptom is of the essence in treatment with him.

Recognition of the differences between the delinquent and other patient populations also suggests that therapists must become more fully aware of the need to depart from traditional treatment approaches. In this connection, group psychotherapy has much to offer in its advantages over other therapies in or out of institutions. For one thing, group psychotherapy fits in with the

adolescent's propensities for group adherence and participation. Furthermore, these tendencies are largely reinforced by the so frequently unsatisfying pattern of family living experienced by the delinquent. The therapist is also in a strategic position to help to fill this lacuna in nurturance experiences by concretely demonstrating his interest, involvement and capacity for providing tangible help non-exploitably and non-punitively. Indeed by this process, it may even become possible for the therapist to harness the delinquent's hostility and rebellion into activities for his own welfare by diverting these aggressive pressures into constructive pathways.

Further extension of group psychotherapy endeavors can also have important value both in reaching more otherwise unreached delinquents and in encouraging adaptations of such treatment techniques with other patient populations.

In terms of delinquency and group psychotherapy as well, psychological and psychiatric theory have tended to overgeneralize on the basis of inadequate sampling on most counts. One unhappy result for the delinquent has been that he has been considered untreatable in the main because he has been conceptualized within too limiting a frame of reference. This has largely been an outgrowth of orthodox psychoanalytic theory which first tended to equate the delinquent with the psychopath or sociopath and then in turn view him as untreatable. Paradoxically, the delinquent is probably untreatable if regarded in this light not only because he is so considered by definition but also because of the inapplicability of the treatment methods which would be applied consistent with the theoretical orientation. Actually, the orthodox psychoanalytic approach is probably inadequate for the treatment of the delinquent because it fails to encompass the many variables criss-crossing him, the therapist, and the treatment process.

Aside from this historic block to more effective treatment of the delinquent, other practitioners approach the methodology of group psychotherapy

rather rigidly and narrowly. Unquestionably, the need for broad empirical observation, experimentation, and systematic validation is of fundamental importance.

In general, while the results of group psychotherapy are mentioned here and there in the literature, it does not seem unfair to contend that the question of success and failure with delinquents is very complex. What is success in the treatment of delinquents? Are we successful when the acting out ceases? In realistic terms this might be all that we can expect to achieve.¹⁹ However, does this suffice from a mental health point of view? It may be true that the delinquent who no longer steals, shoots, or robs is less of an irritant to society, but may he not develop greater pathology because of the intensification of internalized pressure? To some, delinquency in itself is a cry for help. From this viewpoint, the delinquent act may be seen as an attempt to seek help in achieving a more effective integration. It is obviously important when evaluating success by the criterion of declining anti-sociality to guard against a possible specious implication that the drug addict, the depressive, or the neurotically withdrawn individual is healthier than the typically more active delinquent.

Moreover, effective treatment of delinquents seems possible without positing a gain in insight. It is not that the latter is not desirable if it should take place. In many youngsters, however, material personality and behavioral changes have occurred, although they have not demonstrated discernible insight into their own psychodynamic processes. Undoubtedly, the area of success and failure requires considerably more investigation. It would appear especially useful to delineate the various dimensions of success in both personal and social terms. Delinquency is an expression of the merged interplay of personal and social processes, and if treatment criteria take these into account, evaluation of success and failure based upon them will be more valid.

¹⁹ Chwast, *op. cit.* *supra* note 3.