S. H. FOULKES (1946) "ON GROUP ANALYSIS"

Originally published in the *International Journal of Psychoanalysis,* 27:46-51, 1946. Later in a shortened version in *Selected Papers: Psychoanalysis and Group Analysis*, pp. 137-144, eds. M. Pines y E. Foulkes, Karnac Books, Londres: 1990.

Contextualisation:

The ideas about group analysis described here were developed by Foulkes during the Second World War, first in private praxis and then in a military hospital. The wider context of this development was the experience of fascism during this period of history. This leads Foulkes to think that group analysis, in the narrower sense, is an adequate way of understanding and living interpersonal relations in a democratic society; also to avoid falling into the trap of an authoritarian leadership and giving in to the primary need of people to find and follow a leader.

INTRODUCTION

The interest of a Psycho-Analyst in any form of collective treatment is likely to be only an indirect one. Of all forms of Psychotherapy, Psycho-Analysis calls least for supplementation. If carried our simultaneously, it might almost be considered as one of the contra-indications for Group treatment. Otherwise, Analysis would have to reconsider its own approach to the problem of Psychoneuroses. Valuable clues towards an answer to this particular problem might result if one were to subject a number of patients, by way of experiment, to full psycho-analytic treatment and Group Analysis at the same time. On the other hand, to be a Psycho-Analyst does not, in itself, qualify anyone to conduct groups. Indeed, it can be expected that Psycho-Analysts have as many resistances to a group approach as any psychotherapist or psychiatrist. I will, therefore, on the present occasion not say much on procedure or technique. Nor will I speak on results and the reasons for them, which belong to the theory Group Therapy. I must refer in this respect to previous publications (Foulkes and Lewis (1944, and Foulkes (1946). It would also be premature at this stage to try to give such an account. What one can say at the present is that everyone experienced in group methods, no matter how widely they differ from one another, is agreed on their therapeutic value and on the fact that the theory is in its infancy.

It has been rightly said that group therapy has a very long past and a very short history. To compare and contrast different methods might prove confusing. Until fairly recently, I only knew by hearsay of the work done by others, and my knowledge of it is patchy at present. I may, therefore, take it that you are interested in having some information on the development of group treatment as I know it from my own experience. I want, however, to make it clear that in confining myself to my own work, I am doing so from lack of adequate knowledge and not from any disregard or disrespect for the work done by others.

GROUP DEFINITION

Talking about a group, I ought to give you a definition first. The word is used for a wide range of human aggregations. We cannot embark upon the task of disentangling the way in which these various collections differ and wherein they essentially agree. As it seemed impracticable to avoid the term altogether, I will at least say what is meant by a group for our present purpose.

Imagine that a number of people, say not fewer than five and not more than ten, preferably seven or eight, are called together in an informal way. They may be sitting in a circle, or around a table or a fireplace, and they make themselves at home. The person who has called them together we shall call the conductor or director. In our present case these people are patients under treatment for neurotic trouble, and the conductor is their therapist. They come together as part of their treatment, and it is intended that they use language as a means of communication in attempting to deal with their difficulties. In the case of a military hospital they would be soldiers and would probably already have formed all sorts of links between themselves. Their therapist would be an officer as well as a doctor; civilians, if out-patients, would meet only for the particular hour or two once or twice a week. Even so, special and dynamic relationships soon begin to form between the individuals and the conductor and between themselves, as well as between the assembly as a whole and any of its members. Two or more factions might develop, in manifold ways. All this may be more fluctuating, or more firm and permanent. Group members will show increasing interest in each other and consider themselves concerned, as a whole, with what happens to any one member. They will consider opinions, attitudes or actions, pass judgment, show tolerance or intolerance, present characteristic features, moods and reactions.

They will begin to live, feel, think, act and talk more in terms of 'we' then in terms of 'I', 'you', and he'. At the same time, and I want to stress this point, the individuals do not become submerged but, on the contrary, show up their personal characteristics more and more distinctly within the dynamic interplay of an ever-changing and often highly dramatic scene. «As soon as this little sample community shows signs of organization and structure in the way described, we will call it a group».

DEFINITION OF GROUP ANALYSIS AND PRINCIPLES

The type of group treatment in which we are interested has been called group analysis. It could be mistakenly understood that this claims to be an equivalent of or substitute for a psychoanalysis. If you take a very broad view, you could say that it uses psychoanalytic principles. As a matter of fact it is far less but also far more than a psychoanalysis in groups.

For the purpose of understanding, I shall have to say something about my own orientation. In my approach the qualifying word 'analysis' does not refer to psychoanalysis alone, but reflects at least three different influences, all of which operate actively.

1) The principles evolved by Kurt Goldstein and Adhemar Gelb in their epoch-making work on patients with brain injuries, in which I was privileged to take a modest part as a young man. They termed it 'psychological analysis'. This was the neurobiological equivalent of the Gestalt and allied schools, as, for instance, Kurt Lewin's field theory and others, all of which came to the fore in the

1920s.[1] These schools were to a greater or lesser degree opposed to psychoanalysis. Being convinced of the truths embodied in these new teachings, as well as that of psychoanalysis, it took me much hard thinking to find a synthesis [cf. chapter four, this volume]. Goldstein's approach is radically 'holistic'. It considers that the whole is more elemental than its parts and cannot be explained by the summary interaction, however subtle, of these parts as they appear in isolation. The parts can only be understood in the context of the whole. Regarding method, it is stressed that all observable data are of equal significance. If a theory is adequate, it must include all these data, the theory coming last. Too often we are prejudiced by introducing a preconceived theory into the observation of facts without being aware that we do so. We must be in spontaneous contact with a life situation. The observer is aware of forming an integral part of the situation. He introduces dynamic forces into the field and is permeated by forces emanating from it. If this basic insight is wanting, a group cannot be handled or even observed correctly.

2) The second influence is psychoanalysis itself. Being a psychoanalyst is, of course, reflected in one's orientation. What this implies must not be elaborated here. Everything that we know from our analytic work is of the greatest value; nothing is invalidated simply because people meet together in a circle. This refers particularly to the appreciation of unconscious meaning and the dynamics of the unconscious mind. The method of free association is used with such modifications as the group situation demands. In his attitude towards transference phenomena, resistances and other defence mechanisms the group analyst is governed by the same considerations as the analyst with an individual patient. <u>This refers to all aspects of the situation in essence. In detail, however, everything is different</u>.

Group analysis must be distinguished from other forms of group therapy in the same way as is psychoanalysis from other forms of psychotherapy, and for the same reasons. The group is not used as a vehicle for the direct treatment of symptoms, for suggestion, persuasion, hypnosis, or the like. The aim is to approach the basic emotional conflicts, to achieve insight, to subject behaviour, symptoms, transference, resistance and the like to further analysis and not accept them at face value. In this way it is hoped to achieve a genuine and more lasting change in the patients "mental economy" than do other forms of group therapy, potent as they are. It is astonishing enough if we achieve this, even to a modest degree, considering the time factor alone. *The time spent in actual session per patient is somewhere in the proportion of 1:50; if we count group sessions alone, 1:250*[2]*.* Yet we have every reason to think that this aim can be achieved. These results are in my opinion predominantly due to forces which are peculiar to the social setting and which cannot take effect outside it. In this respect group treatment is far superior to any individual treatment. *In reference to our example, which is based in a rough but fair estimate, two corrections must be made: 1) The time in terms of calendar months would be in proportion of 1 : 8. 2) Group treatment, should not be compared at all to psychoanalysis, but if anything to shorter forms of psychotherapy.*

[1] These schools were to a greater or lesser degree opposed to psycho-analysis. Being convinced of this truth, at the same time convinced of the truths embodied in these new teachings, it took much hard work and thinking to find a synthesis. However, truth, like peace, is invisible. In retrospect I have written an article which tries to clarify the problems and to help towards their solution (Fuchs, 1936).

[2] Counting 3 months = 12 weeks at 1 !/2 hours for sessions/ patients and 2 years psychoanalysis at 250 hours a year as average. If we add to this 6 hours of individual treatment, supplementing groups, we allow for the whole time spent.

It must be stressed that economy in time, important as it is, does not in itself justify the value of group treatment. It is neither a substitute nor a short-cut: it demands to be appreciated as an essentially new orientation in psychotherapy and socio-therapy.

3) The third contributory to the meaning of the term group analysis is what might be called sociological analysis, or socio-analysis. The group situation offers a first-rate opportunity for the investigation and treatment of all the currents permeating the community as much as the particular group on hand, for instance a group of repatriated prisoners of war. In this respect the standards of what is considered normal and acceptable are under revision and are re-established by the consent and verdict of the group itself. Individual ego boundaries and superego standards become fluid and are recast. Karl Mannheim, in this book Diagnosis of Our Time (1943), has used the term 'group analysis', independently, from a sociological point of view. He has written a whole chapter on it, which has only recently come to my notice. He rightly stresses the importance of this method of imparting, as well as gathering, information, for observation and education. A group approach has, of course, many aspects which have been well known to educationalists for longer than to psychiatrists. In this context, group analysis should be looked upon merely as a tool; it becomes particularly clear that it is not an end in itself. My own interest in this form of treatment arose from the appreciation of the basic importance of the social nature of human behaviour and conflict. Nothing carries greater conviction of this than observing human beings in the social setting of a group situation.

This, then, is the three-fold sense which the name of "Group analysis" is meant to convey:

1) Akin to Psychological Analysis.

2) Akin to Psycho-Analysis.

3) Akin to Socio-Analysis.

Now we shall try, in seven league boots, to follow a development that has taken five years of much work and thinking. For convenience's sake I shall describe it in five stages, each of which can roughly be said to have taken a year. In reality, these five stages overlap and merge into one another, and the later ones were already implicit in the first. It is an organic development, like a tree growing from a seed, a shift of emphasis rather than a series of distinctly new steps, and the tree is still very young indeed.

Stage 1. This was the stage of the first approach. Treatment in the group was conceived as supplementary to individual treatment. Both were analytically oriented. The group was relatively individual centred and relatively centred round the therapist. Communication was verbal, based on free association. Pooling was encouraged, the spontaneous trend of the group observed and left as free a range as seemed feasible. Attention remained chiefly attached to the content. The therapist's function was predominantly that of interpreter and catalyst. It was observed that the group session engaged the patient's interest at the expense of his individual session. This was then treated as resistance, though material from the individual interview was also referred to the group, and difficulties and objections to bringing it to the group session were analysed. Group method and individual method were fully complementary to the benefit of both.

The principle of leaving the lead to the group was understood in the same sense as the psychoanalyst leaves the lead to the patient. This tendency to put the group into the centre was used in a more determined form in the out-patient group clinic started soon afterwards at a child guidance clinic. This leads to the next stage.

Stage 2. Here the group session was almost the only form of treatment available. It was not a case of group versus individual treatment, but since time would not allow for both, it was decided to see whether group treatment by itself was workable and what it would achieve. Refuge into private session was justified only on special occasions. This was now treated as a resistance, as it was from the point of view of the group session, and if ever possible, the material was referred back to the group. In spite of growing mutual participation and the emergence of the group as a new entity, this approach was directed still mainly on the interaction between individuals and on the reaction of these towards the material brought forth.

In both of these stages the therapist could be said to treat individuals **in** a group setting. Group patients in both these stages had no contact with each other outside the session. They varied in number, and the group changed in composition. This was later called the **«open group system»**.

Stage 3. This corresponds to a new start under military conditions. The patients were soldiers, inmates of a military neurosis centre, whose period of stay was as a rule limited to a maximum of three months. The patients shared not only the ward under the same psychiatrist but also all other features of hospital and army life. Under these conditions the «closed group» was used more often. Individual interviews were again combined with the group method, but for rather a different purpose since many practical points, such as the question of disposal, had to be discussed individually. There was, therefore, more of a division of labour between what was dealt with in group sessions and in private. Under these conditions free association became modified to what might be called a «free-floating discussion. »

Hospital affairs, Army problems, any matters affecting the group as a whole, became more prominent. As the question of the character of the man, his morals, his co-operation, his attitude to further service, etc., became of paramount importance, the emphasis of observation shifted from content to behaviour and attitude in the group and towards the group. Thus the group meeting became much more group centered, ***treatment more of a group than in a group****. This phase coincided with a hospital atmosphere which was not always helpful for psychotherapy. The conductor found himself sometimes, siding with the patients in respect of some of the criticisms. This did not do the slightest harm provided he himself was honest and his attitude fundamentally positive. Naturally, with lessening conflict in his own adaptation to army life, such criticisms appeared to arise less frequently and could be dealt with even more easily.*

At that stage the ***Training Wing****, although belonging to the hospital, was sharply divided from it, even by its* ***khaki*** *as opposed to the* ***blue*** *of the* ***Hospital Wing****. It was* ***equally divided in spirit and orientation****, while its living conditions, representing "the Army", also provided a marked contrast. The move from Hospital to Training Wing, symbolizing a return to army life and soon to Duty, was therefore a rather sudden jump, the more so as it happened to most patients within two or three weeks' of admission. This could only be exploited therapeutically by accepting the situation as a reality to be faced and the reality of Army life in particular. The soldier who had been sent to the*

hospital just because he could not adapt himself to this Army life, found himself confronted with an addition of it, which had some of the unfavourable and few of the good features of the life in a Unit. Nevertheless, in the net result, Group treatment had a particularly marked effect on the improvement of morale, towards the group itself, towards the ward, the hospital and the army. All this is mentioned here because it forms a striking contrast to a phase to be described presently, when the whole hospital became a most helpful therapeutic milieu. Before this happened, all that was possible for the therapist was to create a good atmosphere within his own sphere of influence, on the ward. Few realized its importance. This fitted with a competitive spirit between individual psychiatrists as to their therapeutic results and the standard of morale of their patients. Group treatment and an equivalent approach to individual treatment, weighted on the side of positive cooperation and community sense, won this competition hands down on all counts, even statistically. The main new features characterizing this stage were:

Treatment group centred, conductor following the lead of the group rather than leading it, object of treatment more the group as a whole. Emphasis shifted to present problems affecting the group as a whole. While the common background of personal difficulties came more to the fore, individual differences appeared as variations of the same themes. The total personality and behaviour in and towards the group claimed more attention than individual symptoms and their meaning. The group's therapeutic function towards its members became more manifest.

A significant experience was that this shift of emphasis, at the expense of 'depth' in the usual sense, did not affect therapeutic results adversely, and the group seemed to have found the therapeutic optimum under existing circumstances

Stage 4. This coincided with the beginnings of an interest in group treatment on the part of some of the other psychiatrists. Hitherto tolerated, this method was now encouraged, and the first steps were taken to synchronize the hospital's therapeutic aims, as well as to coordinate the work of the psychiatrists with hospital policy. This had to be in a constant state of flux in accordance with ever-changing circumstances and claims. It was therefore necessary, for practical and didactic purposes, to formulate simple and clear general directions for group treatment.[3] These had to allow for the fact that not all therapists were very experienced in psychotherapy, still less in psychoanalysis. Guiding principles had to be sufficiently general to allow for the widest range of individual differences which would, in any case, determine each psychiatrist's approach to the group. The first step was to help the psychiatrists to overcome their own difficulties and encourage them to face groups. Once exposed to the dynamic forces within the group, the doctors became increasingly aware that they were facing the same problems as the group and that they were in fact a part of the group. The emphasis was increasingly focused on the group as a whole, with the aim of dissuading the conductors from interfering with the spontaneous expression and activity of the group. They had to learn to tolerate anxieties and tensions within themselves, to resist the temptation to play the role of the authoritative leader but rather to face problems fairly and squarely with the group. The more a conductor succeeded in this, the greater was the reward— growing emotional maturity of his patients, their increasing capacity to tackle problems and conflicts by their own efforts, their growing sense of self-reliance, confidence, responsibility and independence. The psychiatrist in his turn learned that the best leader is one who is sparing with interference, keeping in the background, and

[3] Manual de Terapia de Grupo en las Fuerzas Armadas, de Foulkes

who can most easily be missed. The effect of all this on the psychiatrists would make a fascinating chapter. Light was thrown on their own emotional contribution in maintaining an unsound, infantile, neurotic doctor patient relationship. Group treatment in this form put this basic problem into the centre of therapy, much to the benefit of patient and psychiatrist.

The outstanding feature of this stage, therefore, was that treatment was not merely in a group or of a group but by the group and, of course, for the group.

Stage 5. Meanwhile a large-scale transformation of the hospital was taking place. Higher authority had decided to use experiences gained elsewhere, in particular of **War Office Selection Boards'** experiences in which the ideas and work of **Bion** and **Rickman** (Bion, 1946) had played a prominent and fruitful part and had borne fruit. The living exponent of these ideas, the bearer of this mission, was Major (later Lieutenant Colonel) **Bridger** and his staff. Bridger (1946) proceeded forthwith to coordinate the hospital as a whole, with the idea of letting it grow into a self-responsible, self-governing community [described in Foulkes, 1948, pp.112-113].

No effort was spared to sense the patients' needs, to unearth their spontaneously felt desires and urges, to create opportunities for all conceivable activities, whether for work, artistic interest, sports or entertainments, in and outside the confines of the hospital. While the patients were given every encouragement to express their wishes and helped to articulate them, coercion was neither used nor needed. Group approach was the natural corollary of all this. But the initiative had always to come from the patients and the onus of responsibility in the execution of all matters, large or small rested in them. The importance of all this from the therapeutic point of view was that the patient was at every step brought face to face with a social situation to which he had to give his characteristic response. The degree of his adaptation could thus be observed and influenced. Co-operation between us was perfect and there was not a single question of principle or detail in which we did not see eye to eye. Thus the relationship of the therapeutic group in the narrower sense towards the hospital changed, the smaller unit becoming more definitely oriented towards the larger community of the hospital. Neither of them is workable, or even thinkable, without the other. It never occurred to us to ask how much one or the other of them contributed to the therapeutic result, so fully did we look upon it as an integrated whole. Apart from this. the psychiatrist was (or should have been) operative in all the different groups in which his patients were engaged. To look upon this experiment otherwise is to misunderstand its basic idea as well as that of the psychotherapeutic group itself. The exact way in which the group changed and re-oriented itself towards the new conditions in the hospital was one of the most interesting points to observe. It furnished experimental proof of the truth that the individual group's and the individual person's mind is conditioned by the community in which it exists. Under these conditions, group approach could be developed in variety of new forms and new dimensions could be added to it. While this is of far reaching importance and will be described elsewhere, no more can be done here than just to mention a few of the varieties of group formation which were observed.

There were spontaneous group formation Patients could be seen in the social setting of the selected activities. This might be a fluid and loosely knit' casual community resulting from doing the same type of work or being in the same hut together, or it might be a more organized body working together as a team at the same project. Such a team could be drawn from the patients of different psychiatrists, or it could be formed deliberately from one's own patients. In turn such team might or might not

meet in the same composition in therapeutic session. Very interesting promising features developed in such groups as were deliberately chosen to go through the whole of their time in hospital together as a closed group. They had their beds together in the ward, shared group sessions and worked together on the same project, preferably one related to the Hospital itself. For instance, one group did all the work for the stage, from cleaning to designing and making the properties. They did all the technical work in connection with the performances,: including lighting arrangements, etc. Others would constitute the hospital band, or produce the hospital newspaper, from collecting the material, reporting hospital events, writing articles a editing, to printing and selling it and so on. A group was formed to receive new patients and introduce them to the hospital, conducting them round and giving them all help and information they wanted. Others ran the club or had special functions in their own ward. There were a great variety of therapeutic groups of all descriptions, selected according to a variety of points of view, as well as quite unselected ones. There were also a number of experiments with spontaneous acting, individually and in groups. Groups were confronted with each other. For instance, the newspaper group at one time would act their own daily office meeting for a special purpose, but also all sorts of impromptu themes which they liked. While solving their own problems in connection with the newspaper itself, they often discussed one difficulty or another which they found with ' the patients ', their readers. It was proposed to them that they should invite one of my groups to watch their performance, so that they could approach them directly. This was done and led to a most lively discussion between the two groups with far reaching effects on both of them as well as the relationship between the paper and the hospital. Often patients were seen from the very first in groups of about eight together, individual contact arising out of this and individual treatment being used only to settle special problems, a method which I personally used by preference and found very expedient. Whether one liked it or not, it became obvious that many patients improved so much under this management that not only individual treatment but even psychotherapeutic group sessions tended to dry up or became subsidiary to the work project, ward activities or the social activities of the hospital. The effect of all this on the psychiatrists' group was very interesting too.

Many interesting observations could be made on the importance of assignment and selection of groups, but in this respect we never reached a stage which would enable us to make systematic use of them. After all, we were not an experimental station or a research unit, but a military hospital working under high pressure where the practical needs of the day had to be met. The stage of the war made certain interesting selections for us. For instance, **at the time of the invasion of Normandy** [1944], the hospital received **acute battle casualties**. Group observation easily sorted them into two main categories: those who were to return to fighting duties within a week or two, and those whose condition ruled this out. The latter needed longer treatment and had to be considered for modified employment or discharge.

Later, there were groups of **returning prisoners of war**, who were studied both 'in pure culture' and mixed with non-ex-prisoners of war. In my opinion the latter was on the whole preferable. In this type of task the group approach showed its amazing superiority, allowing finer diagnostic and prognostic assessment and bringing out the salient problems shared by the group, apart from its therapeutic effect.

At a yet later stage, equally interesting observations of disintegration could be observed. The war was now over, Bridger had left, the staff was depleted by demobilization. The hospital policy had changed semi-officially to one of rehabilitation to civil life. Everything was affected. The old division

between khaki and blue hospital uniforms changed its meaning completely. A certain note of apathy had descended upon both staff and patients. Hospital life had become stale and incoherent, the activity side somewhat departmental and institutional.

What was to be done? I had the good luck, at my own request, to be transferred to the activity department. It became quite clear that levers had to be used to bring about an effect on the hospital spirit as a whole. The situation suggested the remedy. Groups had to be formed whose task was directly related to the hospital itself and who, by their function, found themselves forced into contact and cooperation with others. I was reminded of Freud's quotation from the Aeneid, as a motto to The Interpretation of Dreams: 'Flectere si nequeo superos, Acheronta movebo' [which Foulkes translates as: 'If I cannot impose my will upon the gods, I shall let hell loose'].

In principle, as well as in detail, this new approach opened fascinating vistas. One had to find one's way into the hearts of groups —or remnants of them— and bring them to life again. One had to be very active before one could be spared and the groups would once more live, grow and move under their own steam. I needed help. I founded one group called the coordination group who with new-found enthusiasm soon became a most active factor in the life of the hospital. Their influence was felt within a week or two throughout the hospital, from the commanding officer to the last patient, orderly or office girl. New life blossomed from the ruins, brains trusts and quizzes between psychiatrists and patients and similar events resulted, producing once more healthy and positive contact and cooperation. These experiences were among the most interesting I had yet had.

Returning to our theme, the psychotherapeutic group in the narrower sense, it too had found a new meaning again. It became the best occasion for working out all these experiences and for reflecting upon them. Quite informally, I termed it the 'reflective 'group, as distinct from the ' functional' or activity group. Once more, but on a higher plane, it had found its particular place: that of imparting insight, intellectual and emotional, into the more profound and individual, personal and at the same time more general and universal significance of all this turmoil of life around and inside itself.

It will be seen that from the development described, the following shifts of emphasis emerged:

- *From individual centred to leaving the lead to the group.*
- *From leader centred to group centred.*
- *From talking to acting and doing.*
- *From the still artificial setting of a group session to selected activities and to groups in life function.*
- *From content centred to behaviour in action.*
- *From the controlled and directed to the spontaneous.*
- *From the past to the present situation.*

In order to avoid misconceptions as to the role of the conductor, I am bound to say that, in spite of all the emphasis on his receding into the background, he is in fact a most active agent and his influence remains the decisive factor in a therapeutic group. ***While it is easy to become a leader —in the popular misconception of the term—it is much more difficult to wean the group from having to be led, thus paving the way for their own independence. With both methods one can have success and it is in the last resort a political decision or a question of ' Weltanschauung ' which one prefers. One***

way lies Fascism, the other a true democracy. Moreover, in the latter form, the truly democratic one, the group method pays in fact the highest tribute to the individual.

Group treatment can thus be looked upon in a number of different categories*.*

The narrowest point of view will see in it merely a time saver perhaps, or a kind of substitute for other more individual forms of psychotherapy. Possibly it will concede that it might have special advantages, have its own indications, say, for instance, for the treatment of social difficulties. A wider view will see in it a new method of therapy, investigation, information and education. The widest view will look upon group therapy as an expression of a new attitude towards the study and improvement of human inter-relations in our time. It may see in it an instrument, perhaps the first adequate one, for a practicable approach to the key problem of our time: the strained relationship between the individual and the community. In this way its range is as far and as wide as these relationships go. Treatment of psychoneuroses, psychoses, crime, etc., rehabilitation problems, industrial management, education, in short, every aspect of life in communities, large and small. Perhaps someone taking this broad view will see in it the answer in the spirit of a democratic community to the mass and group handling of Totalitarian regimes.

REFERENCES

FUCHS, S. H. (1936). ' Zum Stand der heutigen Biologie ', Imago.

FOULKES, S. H. and LEWIS, E. (1944). Brit. J. Med. Psychol., 19, 20, 175, (1946). Lancet, 1, No. IX, 303.