PSYCHODANCE, AN EXPERIMENT IN PSYCHOTHERAPY AND TRAINING*

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I. INTRODUCTION

This paper describes an experiment with Psychodance at the St. Louis State Hospital Training Institute for Psychodrama and Group Psychotherapy. Three interests motivated the program:

(1) We wanted to retest the hypothesis that a non-semantic approach is often initially more efficacious than a verbal approach in reaching and helping the severely ill, hospitalized, mental patient. For some patients a verbal revelation of their complex pathology is extremely threatening and anxiety producing. With other patients idiosyncratic use of language protectively blocks communication of their thoughts and feelings to others. Some patients seem to have regressed to the point of pre-verbal childhood levels and function wordlessly. For severely regressed patients of this type, verbal therapies are most often inadequate.

Psychodance techniques utilize natural responses to music and rhythm, and are designed to operate without the demand for language responses by the patient. It was felt that Psychodance might provide the most effective way of initially reaching these "Non-Verbal" patients. It was also assumed that the patient who is approachable by verbal means could also profit from and utilize a non-verbal approach which would provide him with opportunity for expressive movement, and action catharsis; and, which would guide him toward reaffiliation with interpersonal pursuits through a non-verbal role training emphasizing social interaction.

Once contact and rapport have been established the techniques of Psychodrama, such as doubling, mirroring, and role reversal can be utilized in non-verbal dance modes, as well as in the more conventional verbal-action manners. The techniques of Psychodance can be enhanced through adaptation and usage of Psychodrama techniques. Reestablishment of verbal communication through Psychodance techniques can be followed up in

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situ by a shift to verbal Psychodrama. In effect, by blending elements of Psychodrama with Psychodance we attempted to provide a therapeutic effort that maximized spontaneity and reintegration throughout the entire continuum of human communication. A primary interest in this program was the development of an integrated action therapy method which blends Psychodance and Psychodrama techniques. The programs to be described are lineal descendants of Psychodance and Psychodrama as practiced by J. L. Moreno, M.D., at Beacon, New York (11); by Eya Rudhyar-Branham in California (16, 17) and by Marian Chace at St. Elizabeths Hospital, Washington, D.C. (1-6, 11).

(2) Our second purpose in instituting this program centered about training needs. Awareness of the non-verbal aspects of behavior is extremely important in understanding and treating mental illness. We felt that no amount of didactic instruction could equal the learning that the trainee accumulates through a number of non-verbal experiences in an ongoing group. By being immersed in the non-verbal communications processes involved in a Psychodance group the trainee is powerfully forced to become sensitized to this crucial dimension of behavior. He also is sensitized to the therapeutic implications of non-verbal interventions.

(3) A third reason for this program was to implement our growing interest in social milieu therapy (12) in which there is an effort not only to reach the patient, but to influence the staff treating the patient as well. We stress the idea that a better working staff group—a group that feels ready to accept each other—will provide better patient services. We predicted that involvement of staff, especially nurses and aides, in ongoing therapeutic groups of a non-verbal nature could lead to better working relationships among the staff; toward better acceptance of the staff by the patients; and to better understanding of the patients by the staff. When ward staff are included in verbal therapy groups they often become defensive and hostile as they worry if their working competence is being checked upon. We anticipated that the indirect approach to the problem of better communication and better working relations through involvement in the Psychodance Program would arouse less defensiveness in the participating staff.

II. Theoretical Background for the Program

A. *Implications of Non-Verbal Behavior*

Physical movement is a fundamental medium for communication, but as the complexities of language develop, movement is relegated as a less and

less important function. Primitive peoples accept actional modes of communications and emotings to a far greater degree than language oriented cultures. To illustrate: Primitive peoples dance at highly significant life moments. Dance ushers in war, the hunt, marriage, birth and death. Dancing together, and moving together, they share feelings and thoughts. They employ physical movement to express their most poignant experiences. The dancing savage readies himself for war; then moves to the encounter. He has built a readiness for action through a generative complex of physical movement, and communicates this readiness through the dance. The dance of the primitive serves the function of meeting individual and group needs for encouragement, affection, communication, and catharsis.

While action language remains more covert in modern civilization, motor activity is effective as conscious and unconscious manners of expressiveness. Facial expression and body postures reflect for most people their reaction to ongoing situations. The body slump and slack facial expression of depression, and the erect carriage and beaming countenance of elation are extreme examples of the physical manifestations of our feelings. Sometimes these non-verbal actions are meant to communicate but more often they are unconscious reflections of inner thoughts and feelings.

Music and rhythm drives modern man as well as primitive man. Motion pictures employ "mood" music to help set and recall emotional tones for the audience. Often one has an impulsive urge to move his body to music and senses a growing awareness of feelings which are related to associations and reactions to the music. The feelings precede the words that describe them. In our civilized culture we learn to repress and inhibit action expression. Psychodance taps natural resources which we have forced underground.

For the infant and through early childhood the main means of communication is non-verbal or pre-verbal. The baby's face brightens when he sees his milk coming. He moves his hands and feet and tries to reach the bottle or breast. The small child jumps up and down when he gets his new toy, and he rocks when he is sad and lonely. As we mature, the social pressures of cultural sophistication demand the use of finer verbal tools of expression. Inevitably the individual is forced to minimize his use of non-verbal body expressions as they are said to be immature, unsophisticated, and perhaps too communicative. As verbal responses are rewarded, non-verbal reactivity becomes more and more subdued and covert. The child is weaned and fitted to his culture's use of language.

When social pressure and individual need conflict strongly, the in-

dividual may develop personalized meaning for words. This is particularly true with the psychotic who often acquires an autistic usage of language. Meaning of words become idiosyncratic and the individual is handicapped in relating satisfactorily to others through verbal communication. Reusch and Kees (13, pg. 166) say: "The appearance of primitive or uncoordinated movements in individuals suffering from severe psychosis may be viewed as attempts to reestablish infantile system of communication through action. These patients are trying to relive, in later life, the patterns of communication that were frustrating in early childhood, with the hope that this time there will be another person who would understandably reply in non-verbal terms." Reusch emphasizes that the jerky movements of many schizophrenics are due to the unsatisfying experiences that they have received at pre-verbal levels in their early lives. Double-Bind Theory (8) suggests that for the schizophrenic patient there existed an inconsistency between the verbal messages and the non-verbal messages he received from his parent. The child had met the words "Come here. I love my sweet child," coupled with physical actions related to disgust and rejection as he was pushed away. Now, in later life he has a continued insecurity and unsureness as to the trustworthiness of verbal messages he receives.

The significance of the non-verbal message is emphasized in the treatment of psychosis by such people as J. L. Moreno (11) and Whitaker and Malone (18). They stress both the importance of pre-verbal communication in the developmental stages of the individual, and the importance of the non-verbal element in establishing clear and congruent communications in Psychotherapy. L. J. Fine (7) stresses the need for awareness on the part of the therapist as to the non-verbal dimensions of Psychodrama. Recognition of these dimensions by the therapist allows for systematic investigation and use of this medium of expression and communication in therapy and research.

Marian Chace says, "In a psychotic, language loses much of its effectiveness as a means of relating to others, serving as a defensive barrier rather than as a means of direct communications" (5; page 219). When one stresses the non-verbal aspects of personality and psychotherapy, he is speculating that the primary functions of psychotherapy are: To clarify for the individual the nature of the congruency between verbal and non-verbal communications; to increase the individual's spontaneity of reaction when movement and action behavior have been severely inhibited; and to satisfy or alter primitive non-verbal cravings so that the individual may be freed to move toward maturity. Focusing upon non-verbal aspects of psychotherapy, we take advantage of natural and trained reactions to rhythm and music as basic modes of establishing rapport and influencing changes of behavior.

B. *Basic Assumptions*

The psychotic has basic emotional problems which inevitably block him from reaching reality in a satisfying way and which lead him to withdrawal and isolation from the environment. The psychotic patient constricts his level of responsibility to establish measures which protect him from anxiety. We assume, if we utilize more archaic types of communications similar to those once used in early childhood, that we will be able to make initial contact with the regressed patient more directly and with less danger of misunderstanding. We assume also that for the less regressed patient an encouragement of awareness and sensitivity to his own non-verbalized feelings, and to those of others, will lead to the growth and freedom that Moreno calls spontaneity.

The general therapeutic frame of reference from which we operated was provided by the following conceptualizations about therapeutic process:

1. *Basic Need Gratification*

We conceptualized the Psychodance session as a primary vehicle for basic need gratification. According to Maslow (10, page 107), the basic psychological needs are love, esteem, and self-actualization. Love is provided by allowing the patient to participate at the level at which he is able. He is accepted as he is. If at first the patient sought to watch from a distance, the therapist accepted his need to become involved gradually. When the patient indicated through physical movement that he was ready to draw closer, the therapist would reach out and gently draw the patient into the group. Love and acceptance were communicated to the patient through group approval of self-actuated physical activity, no matter how minute or simple. If a patient was capable only of moving one finger in time to the music, this was accepted and rewarded through group imitation and praise from the therapist. In essence, the patient was accepted at the level of behavior of which he was capable.

Acceptance and love were also expressed in group movements such as joining hands, or putting one's arms around one another and rocking, or swaying in time to the music with hands placed on the shoulder of another. There were many opportunities for a more active patient to aid a more regressed patient. In activities such as putting one's arms around another and rocking, or joining hands and dancing together, or placing one's hands on the shoulder of another, the more active patient received the opportunity to express love and the desire to help by initiating the activity, and the regressed patient had the opportunity to comfortably receive interest and

attention from another person. In addition, since the rhythmic physical movements towards others contained the symbolic elements of giving and taking, they tended to increase self-esteem, and self-acceptance. Indeed, as the patients became aware that the director was utilizing their spontaneous movements to build the Psychodance, the feelings of belonging, esteem, and acceptance were greatly enhanced.

It must be pointed out that the director's acceptance and encouragement of movement extended not only to non-verbal behaviors that were at the moment in vogue in the group, but also extended to the acceptance and encouragement of idiosyncratic movement that clashed with the immediate movement-mood of the group. The individual displaying this behavior was invited to continue and expand his movement sometimes in the center of the group. Thus these movements of independence were accepted. This acceptance, in turn, allowed the individual to reciprocate by accepting the movements of others in the group. In effect, being accepted by others made him able to accept them. Thus the individual was encouraged to develop movements that deviated from the immediate group movement-mood, and realized the self-esteem and self-acceptance that came with having this behavior accepted or imitated. In turn, he learns to accept social interaction and cultural norms through imitating and accepting the movements of others.

2. *Emotional Release*

We further conceptualized the Psychodance session as method of stimulating psychological growth through cathartic release. The Psychodance session encourages both conscious and indirect and symbolic release of emotions. Emotions which are socially inhibited, such as anger, hostility, and aggression, as well as all the warm emotions, such as the expression of love or acceptance, are expressed through symbolic movements. Music plays an effective role as a stimulant in encouraging the patient to release socially inhibited feelings. Movements such as jumping, vigorously punching the air, stamping on the floor, pushing a partner, and kicking out are designed to relieve emotional tension at an actional level. The movements may be made in isolation and associated to only by the individual; may be made with verbalizations by the therapist at symbolic or actional levels; or may occur with verbal associations and declarations by the patient.

As an example, the patients are asked to visualize that they have chains on their feet. These chains hold them down and restrict their movement. They symbolically walk about the room dragging these heavy chains of responsibility with them. They begin to shake the chains off as they dance.

Then they begin to move their feet and kick them loose. They vigorously kick and shuffle and move and begin to move faster and freer. Personal associations may follow but are not necessarily sought by the therapist. Another example is when we invite the patient to imagine or visualize an individual who restricts him and then to imagine pushing this individual who restricts. In the dance, really rhythmic movement to music, the patient is encouraged to push the interference aside and to make for himself the freedom to move. At first, all may be at a fantasy level, but later pairs of patients may team together to enact and interchange both roles. In essence, aggressive movement toward individuality is encouraged.

Another example paints a movement picture of swimming to the music. The therapist richly verbalizes the warmth of the water and encourages a smooth, vigorous, steady swimming stroke. As they "swim," they see in a distance, as a goal, a nice island where they will be safe and rested. They begin to swim harder and more vigorously; kicking, and stroking, and moving toward the goal. The therapist is symbolically fostering and allowing movement toward satisfaction and self-enrichment.

There is a developmental pattern to these rhythmic movements. Short, negative, unsociable, and unfavorable movements are at first encouraged. The therapist shows he permits negative expression. Then gradually the patient is guided toward more positive, more self-rewarding actions. Punching the air movement becomes stretching and giving; stamping on the floor ultimately becomes a smooth outgoing waltzing step toward others. The patient learns that he can be aggressive, and that acting out the aggressive movement can lead to more socially acceptable and rewarding activities. The patient is accepted for his negative activity; his vigor is encouraged; and he is led toward the positive, rewarding results of his animation. Carl Rogers (14) says acceptance of both mature and immature impulses in an individual is critical to accepting the patient as he is. Often the catatonic patient is reluctant to make any kind of aggressive movement. Through the medium of Psychodance, movements are initially made without apparent association. The movements are initially made as part of the dance or "exercise" activity. Bit by bit the patient becomes able to make movements through space. As he does so, he begins to associate and may verbalize. The movement may then be associated to real life problems, but this is not critical. If change of behavior occurs through an unconscious reintegration, then we do not care whether the patient is able to verbalize the "insights" leading to the change. Reintegration and new behaviors which are self-enhancing are the goals. If the patient does associate to the generalized dance, the therapist can then

encourage him to dance out his verbalization or can move him into a verbal psychodramatic psychotherapy session. In the latter instance, the dance has served as a warmup to a Psychodrama.

3. *Learning of New Behavior*

A final conceptualization about the therapeutic process involved in Psychodance centers around the use of Psychodance as helping patients to acquire new modes of relating to others and new perceptions of human relationships. The patient's re-learning is effected through new, action responses towards others in response to music and suggestion. The basic psychotic pattern of turning inwards into one's self is broken as the director suggests dance patterns which encourage moving out into space (or life) towards others. Interacting in the protected and encouraging environment of the therapy session, the patients test out now modes of response to others. Nurses' reports of improved ward behavior indicate that these new modes of positive interacting are generalized. The patient begins to open up in his ward behavior after he has moved outwardly in the Psychodance. For example, one member of the group was a catatonic woman who at first refused to enter into activity and watched from the side. Nursing reports noted that she never talked in the hall. After weeks of watching and responding by foot tapping or swaying, she at last entered the group activity. As she related by dance and movement, she began to speak again. Her speaking to others generalized outside of the therapy hour. As she began to relate, she became more amenable to individual sessions with her psychiatrist and to other milieu programs. At no time did the patient verbalize about her psychodynamics in the Psychodance session. Initial entry into therapy was established at a "distance" via non-verbal action modes associated with rhythmic movement to music—Psychodance.

C. *Dimensions of Psychodance*

Psychodance (as we use it) is a form of psychotherapy used with a group. It depends upon psychodynamically timed psychotherapeutic interventions which utilize physical-rhythmic, symbolic movements through space. These movements emphasize both self-expressive and interpersonal contact operations. Music, usually supplied by phonograph, is essentially a stimulating and unifying force which carries the educative and cathartic experiences which occur. Music and movement to the music provides an easily accepted and powerful method of promoting an individual's involvement in the group at a non-threatening, distance level. Psychodance provides protection and

distance and does not require a direct, conscious insightful working through of problems but rather permits symbolic and indirect working through which leads to unconscious reintegration. Psychodance is ideal for patients who are unable to communicate verbally about their problems and for patients for whom uncovering therapy is inappropriate.

Through non-verbal means Psychodance attempts to reestablish two-way communication. The autistic patient utilizing words in a defensive manner loses the ability to communicate with others; and, is therefore reinforced into an isolated life and further autism. Language that does not communicate forms a powerful barrier to appropriate relationships. Psychodance provides the opportunity for a direct mode of reestablishing contact with others. Learning to physically move through space towards another in the Psychodance is the beginning of a generalized response of moving through the life space to others in the world of reality. The process of re-socialization and rehabilitation is stimulated and rewarded through the successful communication which occurs without the confusion or threat of formal language.

Psychodance may be extended and used in conjunction with psychodrama or other verbal therapies. With the less regressed patient, Psychodance may be used as a warm-up to a psychodrama session. The associations to the dance or the interpersonal experience become the themes for verbal or actional exploration. Psychodance may also be used within a regular psychodrama session and provides additional flexibility of action. When words hamper, movement may substitute, emphasize or clarify. Psychodance may also be designed to cool off an intense psychodrama session. Psychodance and Psychodrama augment one another.

A difficulty with formal forms of music is that they are identified with cultural conserves. The individual in growing in his culture has associated certain feelings with certain themes and rhythms. His association may be culturally determined but may also have idiosyncratic meaning. The music may suggest a mood, or a memory, or a learned dance pattern. In Psychodance, music must be gauged for its general association value and used judiciously. For example, Rosen (15) feels that Viennese music has a flexibility for us in that it does not force a fit into certain rigid forms of movement that current, popular, dance music may suggest. The vital point here is that music is not supplied so that individuals may adhere to certain fixed patterns of movement such as the fox trot, twist, or waltz steps, but rather that the music supply the driving force for *new, spontaneous* modes of relating. The Psychodance therapist avoids the use of such cultural move-

ments as stereotyped dances. The use of phonograph music unassociated with formal dances (such as symphonic themes or folk music) is one way of countering the expectancies of the individual to adhere to learned dance patterns. The therapist must also protect the patient from the hesitancy and embarrassment that inhibits involvement when the individual feels that he cannot do the dance patterns that are expected. Social dancing may be an effective means of rehabilitation but Psychodance is not social dancing and must not become dependent upon stereotyped movements.

Psychodance is symbolic, spontaneous, creative reaction to music. The therapist may seek to discover the associations that an individual patient has for a given set of music. These associations (verbal and non-verbal) will be utilized in designing therapeutic interventions. The senior author's patients relate that Hawaiian music is "soothing"; that waltz music "cheers us up"; and, that marching music "makes one feel like walking proudly." The senior author therefore uses Strauss waltz music for warming the group up; Hawaiian music for relaxation; and, Russian folk or marching music for vigorous or aggressive movement. She plays soft and slow music at the end of the session for calming down the group. Marian Chace has written extensively as to the selection of musical themes in her articles "Dance as an Adjunctive Therapy with Hospitalized Mental Patients"; (5) and "Dance Therapy at St Elizabeths Hospital" (3).

A final dimension of Psychodance concerns the particular therapeutic function of the director. The Psychodance Director is concerned with understanding the ongoing group process as well as individual dynamics in utilizing here-and-now happenings for therapeutic effect. The Director observes the group and the individuals in the group, and derives and develops specific dance forms from the non-verbal suggestions of the patients. The spontaneous movement of an individual is picked up, expanded, and perhaps interpreted by non-verbal means. For example, a hesitant forward movement by a patient is picked up and practiced by the group. It is then bridged into a free and expanded forward movement. The hesitant assertive action has been accepted and encouraged by the therapist, and group support has led to a more intense outgoing action. The Director sets the pace with movements that have been derived from patient movement. He interprets and/or extends the movement for the group, and at times uses suggestive techniques to encourage involvement. Accompanying verbalizations by director or patients vary according to therapeutic goal and style.

III. Examples of Psychodance Technique

The methods and techniques described in the following section were derived primarily from the experimental dance program conducted by the senior author. The ward selected was a "push" hall, where patients were provided with maximum environmental stimulation to prevent their withdrawal and inactivity. The Psychodance program was one of many activities run on this female ward. The ward was composed of eighty patients ranging in age from seventeen to seventy-one; most had a diagnosis of chronic undifferentiated schizophrenia.

The Psychodance was held as an open group program, that is, everyone on the ward was encouraged to participate including the staff and nursing students. Attendance was self-determined, and patients could come and go from the group as they wished. The group was regularly directored by the senior author who had occasional staff visitors and three volunteers from the community who acted as auxiliary-egos, (or assistants) and occasionally directed under her supervision. One-hour meetings were held once per week. An after-session discussion for the staff helped to clarify therapeutic aims and to train the staff. As previously stated, the aims of this experimental program were: (1) To provide a therapeutic experience for the patients; (2) To establish better communication between patients; between patients and staff; and amongst the staff itself; (3) To experiment with combined forms of Psychodance and Psychodrama; and (4) To develop techniques for training staff in the non-verbal aspects of Psychotherapy. Sessions in the early stages of the program were quite different in nature than sessions in the latter phase. In the beginning we used a straight Psychodance approach. Later Psychodance and Psychodrama were mixed.

A typical session early in the program began with the therapist inviting the group to sit in a circle and to listen to phonograph music. The therapist generally chose some mildly stimulating music such as a Chopin waltz. During this warm-up period the patient was allowed to become involved at her own pace. No set physical activity was used to force warm-up. When the patients began to show readiness through spontaneous movements, the Director picked up these movements and imitated them. Ordinarily many of the patients, without being told to, would then imitate the Director. The Director or her assistants might verbally encourage the more reluctant but would not force involvement. Early in the warm-up the spontaneous movements of several of the patients would be picked up, amplified by the Director, and imitated by the group for very short periods of time. Time

segments are kept to short duration, especially for groups whose attention spans are small. The Director would then lead the group in simple movements such as walking, stretching, foot or hand shaking, etc. These simple movements were gauged to be of a level that all were capable of doing so that success experiences might be assured. The Director (or prime therapist) would lead by verbal invitation and directions; by suggestive-symbolic word pictures; and, by non-verbal movement which the group could imitate. This gradual involvement, paced to the patients, provided the patients with feelings of security and confidence and stimulated their interest in what was to come. In essence, the acceptance and reward of success in simple movements; the moving together as a group; and, the stimulating effects of the music provided an easy, non-threatening entree into the social and symbolic activity which followed and prepared for deeper levels of involvement.

As the warm-up (both within a session and over a series of sessions) progressed, group members became more physically and emotionally involved and their movements became more individualistic and symbolic. If a patient wished, she might dance alone, or the Director would help her to lead the group in the movements she had created. From time to time the Director would introduce simple social movements which would build one upon the other. The Director would ask the patients to imagine and then to practice walking alone; then walking toward another person; then walking hand in hand; and, finally moving or dancing together. A more psychodynamically oriented set of movements centered around rocking. The patient would rock herself to the strains of soothing music; then rock an imaginary baby; and, then she was asked to rock another patient; and then to be rocked herself. In all of these movements the therapist had to attend to individual tolerance and readiness. Patients were not urged beyond the level of activity at which they felt comfortable, but rather were rewarded for what they could do. Typically movements and sequential patterns would start with an individual focus but would build toward interpersonal contact.

A rest period was periodically provided in which the patients sat on the floor holding hands with closed eyes. In this period they were addressed in a soothing voice by the therapist and told they could sleep and dream a little if they liked as they listened to the music. Fantasy material produced during this period might then be danced by the patients when general group movement was again started. The session typically ended in some outgoing, friendly movement such as shaking hands, or linking arms and moving in tandem to the center.

It was our belief that Psychodance could be made more effective through

the adaptation and usage of psychodrama techniques. In the latter phases of the group, after Psychodance had been established, we began to experiment with the extension of Psychodance by introducing psychodramatic techniques. Once again our efforts were guided by the desire to maximize spontaneity and communication. Following is an exposition of some of the techniques used in our combined Psychodance-Psychodrama approach:

Non-verbal Doubling. Some patients are unable or unwilling to perform certain movements. An individual might "freeze" when attempting to execute a movement which to her possessed threatening psychodynamic significance. For example, one patient could not move forward and touch another person's hands. This patient remained rooted to one spot awkwardly moving her hands and feet while the rest of the group members were shaking hands. It was evident from the quality and direction of her movement that she desired to move forward and shake hands but was afraid to do so. A double assigned to this patient imitated the posture and movement of the patient. When the patient swayed forward and reached out slightly, the double did likewise. When the patient moved back, the non-verbal double mirrored her expression of fear. The auxiliary-ego tested moving forward again. Gradually the patient began to accent the reaching out movement and to minimize the inhibiting or retreating movements. When the double took a step forward, the patient was able to follow. At this point the remainder of the group members who were caught up in the protagonist's struggles, began to give her support. One patient cried "You can move your body!"; another said, "Come to me—Come to me!"; a third spontaneously took a double position and said "Just move your feet like this." The protagonist responded to the doubling and support and eventually shook hands with another patient. As she smiled tremulously over her achievement, her double amplified her pleasure with broad smiles and an open armed gesture. In response to this, the protagonist laughed openly and said, "I was afraid, but now I'm happy I did it." Engaging in this simple, everyday activity was a major step, full of effort and threat for this patient. The success experience in moving out toward others encouraged her to try even "more dangerous" activities as therapy progressed.

James Mann, M.D. (9) says that the essential aim of psychotherapy for the "very sick" patient is to establish contact with him. He notes that it is typical of the "very sick" psychotic patient to have a profound fear of having a relationship with anyone else. "His fear of closeness is a fear of getting killed . . . either he will be killed or someone else will." In the incident described above the auxiliary-ego met the patient in her world and guided

her toward a relationship with others in the group, as well as toward a relationship with the therapist. The contact and guidance initially occurred without language on an actional basis; later language acts reinforced and extended the encounter.

Verbal doubling. At times the use of simple verbal messages are extremely effective in provoking the maximum in spontaneity and release. For example, many patients found release for feelings of anger in vigorous air punching and in stamping dances stimulated by war chants and drum music. However, some patients were extremely inhibited and weak in these movements and could do no more than shuffle, or loosely shake their hands. One patient, Fran, could only stand and tremble with her arms rigid at her side. An auxiliary assigned to double for Fran voiced an hypothesis of Fran's fears. The auxiliary-ego verbalized that she might become too vigorous and then she might hurt someone if she joined in the group expression. In reaction to this, Fran began making rather sweeping gestures with her arms. After several tries the auxiliary made the correct verbal double, "Give me room—get back." The therapist accordingly moved the group back giving Fran a comfortable distance between herself and the group. With the encouragement of the group, Fran began wildly gyrating, flailing her arms, and stamping in time to the music. After several minutes, Fran's movements began to quiet, then abruptly changed to a self-protective covering of her face and head with her arms. At this the auxiliary doubled, "Don't punish me, I'm afraid." Several of the patients were moved to answer "Don't be afraid, Fran," and "That was a good dance," and one patient was able to embrace Fran and rock her. At this point the therapist changed the music to suit the group mood and movements or rocking, swaying, began to predominate.

Here we have Moreno's tenet: "Each patient the therapeutic agent of the other" being exercised as the other patients have become aware of Fran's inner fears and feelings. In this instance the verbal double was instrumental in stimulating Fran's catharsis, and helped to make Fran's behavior understandable and acceptable to the group. The verbal communication, while extremely minimal, was a necessary element in the therapeutic action. The non-verbal expression and communication were basic and preliminary to the process. However, the process would have lost much of its effectiveness without the key, verbal, interpretive doubling and which led to the support and encouragement by the group.

Use of dance surrogates for family figures. The Psychodance session provides movement towards other *real* people, but also provides the oppor-

tunity to work with *transference* phantoms. Feelings of affection or hostility towards key persons in the patient's life are worked with by identifying the therapist, or auxiliaries, or patient members of the group, as significant personages in her social atom. The patient had the opportunity in the dance to move towards or away from these persons and to communicate affection or resentment. She has opportunity to work through her feelings to the real, but absent elements of her world. This progress may take place without any overt verbal identification of the figure to whom the patient reacts. For example, one patient would never dance next to, or anywhere in the vicinity of one of the volunteers. This volunteer was a particularly distinguished looking, white-haired lady whom many patients chose to rock them in the dance. During one of the sessions in which the volunteer was rocking another patient to lullaby music, the patient, Susan, ran from the group and turned off the record player. When asked if she would rather dance to some other type of music, Susan responded by choosing the Hawaiian War Chant. With the encouragement of the therapist and the group, Susan began to stamp and pummel the air with her arms. After Susan was warmed up and well involved in this movement, the therapist placed a large rag doll on the floor and said, "This is Tess (the volunteer), dance with her in any way you want." Susan then picked up the doll, dashed it to the floor, and kicked it. She repeated this action several times during an extremely vigorous and extended dance.

In the case cited above, there was no explicit identification of the volunteer or the doll as the mother surrogate. The interaction and the resultant catharsis took place at a sub-verbal level. In other instances, however, the use of dance surrogates for important people in the patient's life involves a more explicit and conscious process. As an example, the Director might ask the patients to pick a partner and to rock this person. (This, of course, was preceded by the usual group warm-up, and accompanied by restful music.) When the movement was well established, the Director asked, "Imagine who you are rocking." While some patients respond with the real name of the patient they are rocking, others would name some individual in their family. A patient, Beth, is receiving a great deal of pleasure from rocking her partner. When asked who she is rocking she responds, "My sister." The Director then encourages her to express her feelings about her sister either in words or dance or both. Beth closes her eyes and says, "I like this very much. I could never hug my sister at home. I always was fighting with her. I was always afraid of her. It's different here."

A final example of the use of family figures in the Psychodance is one which could utilize an even more structured and directed approach. Follow-

ing the warm-up, a patient who has evolved as protagonist might be asked to dance like "a mother," or "a father." The protagonist would be allowed to select the type of music she wanted, and encouraged to dance in any way she wanted. As the protagonist warmed up, the instructions would be changed to "Dance like *your* mother." Here we have role reversal in a dance form. The mother would then be danced by an auxiliary and the patient could reverse and dance her reactions to the mother's dance. The aid of a non-verbal double, and support from the Director and group could be provided. Teams within the group could become "mothers" and "daughters" and could dance their relationships. Materials arising from the projective dances would provide for direction of the rest of the session. This is Psychodrama in dance form.

Role training. As we have stated, many psychotic patients are afraid of, do not trust, and do not attempt interpersonal communication. Frequent failures in communicating with others, and failures in establishing relationships with others leads to isolation and fear. A goal of therapy is to help the psychotic patient use the protected atmosphere of therapy to re-learn to communicate, and to lose his mistrust of interpersonal activity. To help effect this it is necessary to create a generally safe and rewarding group environment, and to engage in role training of the most basic communication skills. We have described how an individual's spontaneous, idiosyncratic movements may be picked up and worked with, but the Director may also select a general problem typical to the patient group to serve as a guide for therapeutic activity and intervention. An example of this may be seen in the movement in which everyone moves to the center of the circle with hands held out to each other. This movement culminates in hand shaking or touching and is accompanied by a simple verbal expression such as "Hi!", or "How are you?" This example demonstrates a core process in which patients, as a group, re-establish communication with one another. There is a clear cut, non-verbal movement that is congruent with the verbal expression which accompanies it; there is a safe environment in which to practice; there is strong support and aid from the group; and a successful result of an outgoing action is almost guaranteed through proper timing by the therapist and by individual aid to the particular patient in need by an auxiliary therapist.

Role training of social roles of a more complex nature involves the use of doubles, suggestion, and group encouragement in the assumption and development of the physical postures, movements and actions that are integral to the role. Practicing the acts integral to a role are particularly useful for the patient who has a limited role repertoire as a result of early constric-

tion of behavior. Practice of acts in the protected environment of therapy may also serve to open roles which in the past required defensive suppression. Role training is a very direct approach as it asks the patient to try out and practice behaviors which are new to him or which have been threatening to him. Role training seeks direct behavioral change, not insight into current behavior.

The senior author reports:

> "I had a very stimulating experience in one of the sessions. I suggested to the group that they make faces. I said 'Let's look like you usually do. Let's make our usual face.' They made faces of their 'usual look.' Some looked sad; some looked silly; some looked angry. Then I said 'Let's look sad.' In one way or another they looked sad. Then we tried a 'proud look,' an 'angry look,' a 'smiling look,' etc. I, then, realized that some of the patients looked the same all the time. When they were supposed to look angry, they did not look a bit different than when they were supposed to look happy. I noticed one girl who looked as though she was almost crying when she was supposed to smile. I decided to go around the circle asking each one of the patients to smile. When this girl's turn came, I said 'Frieda, let's see your smiling face.' She said 'Okay' and 'smiled' but her face looked like a crying face. I asked the group 'How does she look to you?' Immediately somebody asked 'Are you smiling, Frieda?' Frieda angrily said '*I am* smiling.' I asked another patient in the group how Frieda looked to her. She said Frieda looked as though she were crying. Frieda insisted that she was 'smiling.' I said that I agreed with the group. One of the patients said 'That's the way Frieda looks always.' Then Frieda replied with a really crying face, 'Yes, I always feel like smiling. I am always happy.' I asked the group if there was anybody who could imitate Frieda's "smiling" face (non-verbal mirroring). Upon seeing her own expression, imitated by another person, Frieda admitted that it looked like crying but still insisted that it was not her look because 'I look this way when I smile'—then she made that crying look. I said 'Frieda, you may think you are smiling, but you don't look like it. Maybe you are not using your facial muscles in the right way.' Then I said to the group 'Let's show Frieda how we smile.' Then we made big smiling faces, with wide open mouths. One of the patients volunteered to teach Frieda to smile. She instructed 'Put your lips wide.' Another said 'You have to show your teeth.' Being helped and supported by the group, Frieda finally smiled. The group, pleased with the result, agreed that Frieda looked 'much better.' Frieda herself was surprised how she had been smiling differently before than now and admitted that she had always thought she was smiling but 'maybe crying inside.' Frieda still looks as though she is crying sometimes, and whenever

I catch this expression on her face, I ask her, 'Are you smiling or crying?' Then she smiles."

Short verbal psychodrama within the psychodance session. In the later stages of the program we sometimes used a short psychodrama as part of the session. At times a patient, following the stimulation and freedom provided by the Psychodance, demonstrated a readiness to work at a verbal level. It must be made clear that at no time did we impress verbal methods, or attempt to make them the rule. Role playing and verbalization was used very sparingly, and then only when the patient seemed ready. The scenes were always a natural evolvement of the non-verbal processes and were entered gradually to provide natural transition from non-verbal to verbal approaches.

To illustrate: In one of the later sessions a young patient, Clara, did not enter into the warm-up or early developments, but remained aloof. She stood angrily with folded arms at the side of the group. In one of the dance warm-up processes the Director noted that whenever Elaine moved into the vicinity of Clara, Clara would stiffen visibly. A non-verbal double was assigned to Clara and expanded her movements to include a shaking of the fist at Elaine. In response to this, Clara cried out "Why do you always grab the sugar bowl before me? . . . You are supposed to be my friend." At this point comments both verbal and non-verbal came from the group. One patient said "Yes, she is selfish." Others nodded their heads in assent. As the group was involved and ready, the Director set up a short scene in which Clara and other patients, who empathized with her, sat at the dinner table while Elaine hogged the sugar. With the aid of doubling the patients verbally expressed anger with Elaine and Elaine responded (with the aid of her auxiliary-ego) that she was always afraid that she would not get *any* sugar. At this development the patients who had been criticizing Elaine changed in their demeanor and began to sympathize slightly with her. Clara commented, "You don't have to be afraid, I'll leave you some." At this juncture the therapist returned the group to dance forms. In this sequence, the development was from non-verbal to verbal, and when the usefulness of, and tolerance for the verbal was exhausted, back to non-verbal. It was generally found that these patients could not long tolerate verbal communication, and became restless and frightened if it were prolonged. However, it was clear, that meaningful verbal communication could be re-established through the primary action communications practiced and rewarded in the Psychodance. For some patients the move toward relating to others, once given impetus, gains in momentum and leads to rehabilitation

within the community. For other patients the gains from Psychodance leads to involvement in more intensive individual or group therapies.

Training functions of the psychodance group. The bulk of this paper has considered the theory and technique of the psychotherapeutic aspects of the Psychodance program. In the introduction we indicated that the program serves three other purposes: (1) to provide training for staff and students as to the role of non-verbal behavior in communication and in therapy; (2) to provide a means of influencing staff attitudes toward therapeutic rather than custodial patient care; and (3) to help the ward staff to establish better relationships between themselves and the patients.

In our program students learned by being included in the on-going Psychodance program with patients as well as by participating in after-sessions where the occurrences in the group were discussed. As words had relatively little importance and use, the student was forced to focus upon the non-verbal ramification of the behaviors in the group. Attending to non-verbal behaviors led to speculation about their meanings, and, in turn, to increased awareness of their own non-verbal behavior. Marian Chace at St. Elizabeths Hospital conducts Psychodance programs for student groups in which they are their own subjects, and in which they examine their own behavior. She encourages students to examine such simple movements as a person walking across the room. Does the person move from one step to the next with hesitation, or is there an aggressive rush through the space? The student is led to speculate about the meaning of personal style in walking, moving, posturing, and gesturing. In our program the approach to the student was more indirect as the student focused upon patient behavior rather than upon his own behavior. Non-verbal dimensions may be taught through study of the literature, by lecture, and through evaluation of therapy sessions. It seems to us that much more vivid and effective learning is provided when the student experiences both self involvement and patient involvement.

The combination done by Miss Chace at St. Elizabeths of examining patient behavior and examining self behavior is probably the most effective method of helping the student to focus on the non-verbal dimensions of personality assessment and therapeutic intervention. Including the ward staff in the project almost necessarily leads to change in the relationship between the Project Director and the staff and the patients. The ward staff feels that they are a part of things. They feel that they are no longer merely custodians but that they are an active part of the treatment program. They are given opportunity to more fully understand patient behavior through observation of this behavior in the group as well as through discussion in

the after-sessions. Too often the aides and attendants are surprised to find that there is meaning in the peculiar behavior of some patients. They learn that sick behavior also conveys messages, and that when these messages are understood the patient may react in new ways. In this project we were limited to participation by student nurses and some ward staff and so the purpose of changing the milieu of the ward was not as effectively approached as might be. In our other studies such as Ossorio and Fine (12) and an unpublished doctoral dissertation by Dr. Daly entitled, "Psychodrama as a Core Technique in Milieu Therapy," we found that including physicians, nurses, residents, aides and attendants in on-going group projects could considerably influence their relationships to one another and, in turn, could considerably influence the climate of the ward. Open group therapies held on a ward lead to changes even in those who do not directly participate. Active members of the group influence other members on the hall. Having such a project as Psychodance on the ward, and permitting and encouraging ward staff to participate, leads to attitude change which generalize and which effect a good deal more than the one or two hours of assigned therapy.

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