

PSYCHODRAMATIC SHOCK THERAPY A SOCIOMETRIC APPROACH TO THE PROBLEM OF MENTAL DISORDERS¹*

J. L. MORENO, M.D.

Moreno Institute, Beacon, N.Y., USA

SYNOPSIS

This paper presents a sociometric approach to the problem of mental disorders by means of the psychodrama. During lucid intervals of the psychotic attack or immediately after it the patient is stimulated by use of a warming-up process to throw himself back into the psychotic world. This upsetting experience is called "psychodramatic shock." The significance of the procedure is two-fold. It offers a research method for the study of the social atom in the psychoses, and thus offers a new frame of reference—the psychodrama, through which the deeper changes which take place in mental disorders can be understood. Secondly, it has a cathartic effect upon the patients. It enhances their spontaneity and creates barriers against recurrence. The treatment is illustrated by three cases—a schizophrenia, a manic-depressive psychosis, and a psychoneurosis.²

The outstanding problem in psychiatry is a therapeutic approach to the psychosis. This can not be attained with lasting effects unless it is based upon a thorough knowledge of the psychological and sociometric structure of the psychotic world. Pharmacodynamic studies and treatments have come to the front today and are holding the interest of the psychiatrist. They may be able to return the patient to lucidity for a certain length of time, but they cannot have a permanent result unless the personality of the patient has been so adjusted as to prevent a slipping back into the psychotic confusion. Therefore, a method based on a new frame of reference, the psychodrama, has been worked out and is presented in this paper.

When the psychotic attack itself is in progress the mind of the patient is absorbed by an experience which the attending psychiatrist is at a loss to co-experience with him. If he does not satisfy himself with a symbolical interpretation of the patient's conduct, the clinical description he can truthfully give is scant. The psychiatrist may even suspect that the experience the patient undergoes is extremely rich in detail, intense in feeling, a world of his own, but he does not have any tool with which to reach into that strange world in which the patient lives. An approach in this direction can be made

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by psychodramatic technique. The patient is asked to throw himself back into the hallucinatory experience when it is still most vivid in his mind. He is not asked to describe it; he must act. He puts his body into the position as it was then and acts as he acted then. He may select any members of the staff to recreate the hallucinatory situations. The patient usually shows a violent resistance against being thrown back into the painful experience from which he has just escaped. His natural bent is to forget—not to talk about it. He is full of fears that his new freedom may be shattered. The mere suggestion and still more the actual process, frightens him. The psychodramatist is encouraging the patient to act, to throw himself into the psychotic state, to lose himself entirely in it, however awful, ugly and unreal it may seem to him at the moment.

The first psychodramatic acts are usually of short duration. The patient is experimenting, tapping around, until he finally gets hold of a situation. He may then appear to the physician exactly as he was when in his acute state. All persons who have been in contact with the patient during the first psychotic attack must coact with the patient. They must stimulate his bodily and mental memories. Around the body behavior of the patient, numerous reminiscences flare up. A shakening and loosening of the patient takes place, and suddenly he is able to warm up to the mental states of which he was unaware before he began to act. The bodily states are the psychodramatic starters and guides of the patient, on the one hand, into the psychotic realm, and on the other hand, into a gradual integration and control of the roles he played during the psychotic attack. The patient is no longer a helpless victim as he was formerly.

The technique of embodiment, soliloquy and immediate analysis of each act as soon as it is portrayed enable us to reconstruct the psychotic situation. In the psychodrama of the dream the patient portrays a situation in which he was asleep. Certain odd phantasies which passed through his mind may be re-enacted. But in the psychosis, however dream-like his experience may have been, he was acting towards real things and real people. Indeed, there is even a possibility that we may understand dream constellations better when our knowledge of the actual events in the psychotic processes increases.

The *social atom* is that peculiar pattern of inter-personal relations which develops from the time of human birth. It first contains mother and child. As time goes on, it adds from the persons who come into the child's orbit such persons as are unpleasant or pleasant to him, and vice versa, those to whom he is unpleasant or pleasant. Persons who do not leave any impression, positive or negative, remain outside of the social atom as mere acquaintances. The feeling which correlates two or more individuals has been called tele. The social atom is therefore a compound of the tele relationships of an individual. As positively or negatively charged persons may leave the

individual's social atom and others may enter it, the social atom has a more or less ever-changing constellation.

In the original social-atom charts the ego of the patient was shown in relationship to his numerous partners. A more thorough consideration of the position of the individual within his social atom suggests considering him also in relationship to himself. As an infant grows he does not only experience other people but also experiences himself. As a result of this tele-relationship, he begins not only to feel himself, but also to see himself as one towards whom persons have acted in a certain way and as one who has acted towards them in a certain way. Gradually, he develops a picture of himself. This picture of himself may differ considerably from the picture others have of him, but it becomes considerably significant for him as life goes on. The gap between him as he is and acts and between the picture he has of himself is growing. Finally, it appears as if he had, besides his real ego, an outside ego which he gradually extrojects. Between the ego and his extrojection a peculiar feeling relationship develops which may be called "auto"-tele.³

The shape of the extrojection can be amorphous or clear-cut and sharp. It may have a close material resemblance to the real ego, or it may be a variation of it in some degree. It may be contrasting or even contrary. The relationship may be a feeling of acceptance and of accord, or it may be a feeling of rejection and discord. It may be a strong and powerful feeling, or it may be a weak feeling or even indifference. Therefore, the new social atom chart presents the center individual twice. The line between them portrays the "auto"-tele relationship.

In cases of complex personalities a patient may shape for himself more than one extrojection. A most fascinating illustration of this is the case of hallucinatory psychosis in which a break-up and distortion of the tele-relationship takes place, a breaking up of the auto-tele. And with all this, a chaotic condition within the social atom of the patient develops. Out of old tele particles and perhaps some new spontaneously created ones emerging during such an unprecedented psychological upheaval through which the patient passes, numerous embryonic extrojections are produced. Various roles crop up. Tele experiences from persons around the patient are synthetically combined with new particles which have for the observer an incomprehensible and confused appearance. But they are, as we know, not confused to the patient but extremely clear and real. Parallel to the breaking up of the auto-tele, all the tele between the patient and individuals and objects is breaking up; his social atom is in a state of revolution. It is not the sense of hearing, of sight, of touch, of smell and taste, not the alimentary and sexual urges which are disturbed as such. They are, in a sociometric sense, disturbed in specific relationships with definite persons and things and in different degrees of intensity with each of them. With the gradual loss of the tele realities, the sense of time and space may also become blurred. As the psychological

organization of time and space are disorganized the spontaneity states, instead of following one another in rapid frequency, producing the sense of time with the dimensions of a past and future, flow freely into space, since there is no barrier to prohibit this. Spontaneity turns, so to speak, into tele; and with it the projection, instead of into time, is diverted into space.

There is an old dogma in medicine that violent diseases demand strong remedies. There is nothing more violent and strange in the realm of human pathology than insanity in an acute phase. For the social atom, it is like a flood, uprising and submerging a town. The houses, the streets, may still exist somewhere underneath but the flood has risen so high that nothing can be seen or felt but water everywhere. During the sudden onset of an attack, the patient and the people around him alike are taken by surprise. It is an upsetting experience to the patient and to the members of his social atom, that is, it is a "shock." A procedure which throws a patient, barely escaped from a psychosis, into a second psychosis is a psychodramatic shock treatment. As a violent shock the acute phase of a psychosis is treated by another violent shock with material resemblance to it. Since a cathartic effect is expected from it, this recalls an old dogma in medicine: "similia similibus curantur."

Psychodramatic procedure tries to recreate the panorama of the psychosis. The break-up of the patient's social atom, his new experiences of his own self, the break-up of the auto-tele and its replacements, the replacement of the individuals and objects in the social atom by new constellations, come back into the bodily and mental experience of the patient. They also come back into the experiences of the physicians and nurses who are his partners in the act of reconstruction. Since they are able to enter, through the psychodramatic shock, the psychotic world of the patient, they are, on the one hand, able to investigate it guided by the patient; on the other hand they are able to guide the patient not to fear his own world but to understand it and to make it his own, if not a part of his manifest life, then a part of his psychodrama.

This is necessary because the process of returning to the common reality does not take place in the individual's organism proper. It takes place in the tele relationships within his social atom. From the point of view of a fully integrated personality, the tele formations existing during the psychotic attack have also to be brought back into the common reality. As long as unintegrated elements persist in some manner near the individual proper, or scattered within his social atom outside of his spontaneous controls, similar occurrences may again upset his balance. The personality of the patient has to be safeguarded against any emergency; otherwise, he cannot truthfully be labeled recovered from his mental disease.

There is no moment during the procedure in which the psychiatrist and the patient cannot say "stop." Immediately or a few seconds after the order is

given the patient may break up the procedure and act as if nothing had happened. These stop orders produce in the patient a significant co-experience. Acting on a psychotic level at a time when he is extremely sensitive, he learns to check himself. It is a training in mastery of psychotic invasions, not through intellectual means, but through a sort of spontaneity training.

In the history of the psychodrama, the Aristotelian concept of catharsis found its place in the spectator. The modern concept returns the place of catharsis to the spontaneous creator. The relationship between the creator and catharsis was not considered for a long time. The recipient of the tragic shock remained the person in the audience. The enormous possibilities of the psychodrama remained undeveloped. In the psychodrama, production is creation in the fullest sense. The subject has become creator of his own role, its author and actor at the same time. Consequently, he has become the recipient of the tragic shock.

Preliminary to the psychodramatic treatment itself, in the interview preparing the patient for the treatment, tracing with him the syndrome which may provide the material for the first shock situation, a form of catharsis takes place in the patient which operates largely on the intellectual level. It corresponds to forms of psychotherapy which try to cure through logical persuasion and suggestion (intellectual catharsis). Immediately after each act reflections take place to which there is a corresponding feature in the psychoanalytic approach. The relationship to the psychiatrist and to each auxiliary ego dominates (analytic catharsis). There are individuals who are as individuals well balanced; their difficulties center entirely in the sphere of their social atom. A Negro patient, for instance, felt well, but as soon as he entered a restaurant for white people, he suffered from great anxieties which disappeared as soon as he left the locality. At times the tele relations reach far into the psychological networks of the community. Then all the individuals involved have to be considered in the treatment (social and network catharsis). Creative catharsis, intellectual and analytic catharsis, and social and network catharsis may each play a role in the different stages of the psychodramatic shock procedure.

The difference between the psychodramatic shock and other forms of treatment which are accompanied by upsetting experiences, such as the treatment with hypnosis or the chemical shock therapy, is obvious. Hypnosis turns the patient into a state of sleep and insulin turns him into a state of coma; both procedures make the patient helpless and inarticulate. It is a shock—but in the dark. Psychodramatic procedure not only insists that the patient has to be awake and conscious but also insists that the patient has to reproduce with his own body and with the bodies of as many auxiliary egos as he needs that phantastic world into which he has been drifting. At times the reconstruction may have to be as confused as it was in the original psychosis. The psycho-

dramatic shock is the only method which shakes the patient so deeply that the lost psychotic world is reborn before our eyes. The patient acting on the stage shocks himself, his "auto"-tele, and his social atom until it gives way to the pathological constellations of his psychotic state.

In the course of every psychotic attack there are many moments of relative lucidity. During any of these lucid moments an application of the psychodramatic shock may be considered. The ideal time for its application, however, seems to be after the attack has burned itself out immediately after its natural course has terminated. The outbreak and course of a psychotic attack are so far removed from any rapport that no other approach is able to give us direct information about the actual structure of these psychotic worlds.

For the demonstration of this new approach three cases have been selected, each representing a different category of mental disorder according to current classification—a schizophrenia, a manic depressive psychosis and a psychoneurosis.

CASE 1

M. F., an Italian woman of thirty years, had a sudden outbreak of her present mental illness a few months after her marriage. The patient had never been mentally ill before, but two members of her mother's family have been mentally ill. There have been several factors in the social setting of the patient which must be considered contributory factors. Her father, to whom she was deeply attached, died recently after a short illness. She and her father had always disagreed with her mother. She directed, single-handed, the father's business after his death. The cleavage in her own family group was accentuated by a cleavage in her sexual feelings. She was at once attracted to men and to women. When she fell in love with a Protestant boy, her mother, a Catholic, protested violently. This conflict led to a hostile division of opinions in the networks of the small community in which they lived. Shortly after the wedding, the patient says, a man stood, early one morning, in the window of her bedroom. "The man in the window" was probably her first hallucinatory experience. Within forty-eight hours she developed an acute psychosis which required her immediate hospitalization.

FIRST PHASE

The first acquaintance with the patient was made in an automobile which brought her to our hospital. The situation in the car was selected as the first situation to be recreated by the patient through psychodramatic procedure. On the left side of the page is presented the conduct of the patient during the automobile trip as recorded by a physician. On the right side of the page a reconstruction of the same situation is given by the patient on the stage of the therapeutic theater.

The patient sits erect in her seat. Staring ahead. Everybody in the car feels apprehension. Nobody speaks.

She looks at the doctor. Stares at him frightfully for a long time.

The car passes red traffic lights. The patient evidently becomes more excited.

The car passes a policeman. The driver asks him for directions.

They drive on for awhile. The patient jumps up—is forced back.

Suddenly throws her arms around her mother's neck. Speaks for the first time, saying: "Let us pray."

The patient sits erect in a chair on the stage of the therapeutic theater. She soliloquizes:

"It is dark as hell. Everybody looks so sinister. The devil is driving the car. Something terrible will happen."

She looks at the doctor, soliloquizing: "Who is this man? He looks like my father. But he does not move. He must be dead."

"I see so many red lights. What do they mean? Why do they put their heads together? They bring me to a house of prostitution."

The car stops. "They talk to a man. He is dressed like a policeman. But he looks like 'the man in the window.' He comes to kidnap me."

"The car is doped. Dope comes from every corner of the seats." Jumps up. "Why do they put needles into my leg?" Is forced back. "Why do they kick me? It hurts." Suddenly throws her hands around her mother's neck. "They want to crucify me. Let us pray."

ANALYSIS

The patient is agitated in the car. The clinical picture is full of gestures and actions but poor in verbal content. In contrast, the psychodramatic shock reveals an invisible world rich in delusions and hallucinations. The patient acted in the car with few exceptions as if she were alone, shut in, as if the world around her were not existent. In the reconstruction we see a highly moving interpersonal drama in which every person in the car participates and in which many imagined persons and objects appear. Many incidents which the patient did not mention in the preliminary interview were discovered during the shock through "psychodramatic recall." It appears that in the process of action, of throwing her body and mind into a state of frenzy, avenues of recall were reactivated which could not be reached through a verbal interview. The starters for these recalls are often bodily starters. As the patient explained during the analysis: "When I jumped up during the act on

the stage, for an instant I really felt the needles in my legs. That made me immediately shout in pain. When I was forced back on the stage by the nurse, I also felt suddenly a real kicking. And again I shouted in pain. After the act was over it went like lightning through my head that that is what had happened in the real situation in the car." The string of associations was apparently this: the jumping was associated with the feeling of the needles. And with this were associated the words "Why do they put needles into my leg?" The being-forced-back was associated with the feeling that she was kicked and with this the words: "Why do they kick me. It hurts."

The patient had been in the car about two hours without speaking. But according to her psychodrama she was actually living through many intense scenes in which many persons were involved, some actual and some imaginary, and in which her life was threatened. She spoke almost incessantly. She saw and heard, did and felt innumerable details.

We are here at a dilemma; an event cries for an explanation. We had observed some actions which she denied having made. On the other hand, she reported some actions which we are certain were never performed by her. As we have no reason to doubt the patient's sincerity we can assume that, due to the break-up of her acts, parts of them reached us at different moments without giving the impression of coherence. But she may have experienced them at one moment as parts of the same act. The break-up of her acts and the break-up of her social atom occur hand-in-hand. In fact they are different parts of the same process.

The mannerisms, stereotypes, speech imitations and other automatisms which appeared during this psychodramatic shock were recorded. These actions were found similar to the actions of the patient during her acute schizophrenia. The patient perspired profusely during the session. Every one present was apprehensive and feared that she may become insane again. For several hours afterwards she was withdrawn from reality. She was unable to report how long the shock lasted, what movements she had made, in what direction, what her gestures had been, and what she had said. She appeared as if she were only half conscious during the act. This corresponds to the deep alterations in time and space which took place in the patient's mind between the real attack and its reproduction.

SECOND PHASE

In the first shock the patient reconstructed an initial phase of her psychotic attack. In the second shock the patient reconstructs a later phase when the psychosis is in full development. Rapport with the patient was not possible. In the automobile she was full of fear. Now she is full of aggression. It was difficult for us to suggest a definite situation which she might construct because wide discrepancy was evident between what we remembered clinically

and between what she produced psychodramatically. Whenever we told her what she had said or done she replied: "I did not say this. I did not do that. I do not remember." Thus we could not guide her into the shock. She had to guide herself. Instead of suggesting therefore a specific situation we tried to pin her memory upon a locality, the "middle room," in which she had been for about twelve hours.

Middle room:

Actual duration of this period, twelve hours.

The patient is stretched out on a mattress. The patient holds the nurse's hand tightly.

Two physicians enter the room. She smiles at Doctor A.

Frowns at Dr. B.

She snatches with her fingers at Dr. B. and points down to the ground.

She breaks herself loose and begins to bang with her hand on the wall.

The patient shivers. She dips with her fingers into space.

Psychodramatic duration, as experienced by the patient, several years. "When I came to this room, I was a young woman. When I left it I felt like an old woman."

Patient lies down on the floor. The same nurse takes part in the psychodramatic procedure. She holds the patient's hand. "She holds my hand. The hand is her hand, but the head is the head of my dead father."

Two physicians step on the stage. She smiles at Doctor A. "He is like a little boy, two years old, small in size. His voice is sweet."

She frowns at Dr. B. "He is dark, so big in size. How could he get through the door?"

She snatches with her fingers at Dr. B. and points down to the ground. "This is your end. Dead."

She breaks herself loose and begins to bang with her hands on the wall. "It is an earthquake. It sounds terrific. I am a great magician. Houses are breaking down. People are dying on the street. This is the end of the world."

The patient shivers. "It is so cold here. There are many holes in the wall. The wind is blowing through them. It is a flood. Water must be everywhere. She dips with her fingers into space. Tries to touch the water: "I see the water and I touch it."

She tears her sheet and pillow cases to pieces.

The patient is put into restraint. Her arms are stretched out. Her legs are crossed.

She indicates the tearing of her sheet and pillow cases. "This is my wedding dress. I have torn it to pieces now."

The patient lies down on the floor with outstretched arms and crossed legs. "I am crucified. I am Christ on the cross. My hands are bleeding. I see blood on the joints of my elbows, blood on my knees and blood on my feet."

ANALYSIS

The analytic outcome of the first shock was that the situations, actions and words recorded during the psychotic attack could not be used as starters by the patient for the shock procedure. The patient showed an almost total amnesia for many occurrences, which was extremely striking to the participant observers, physicians and nurses. She must use starters of her own, buried and meaningful in her psychodrama. She must play after her own key. An explanation of the causes producing this mechanism becomes possible through the analysis of this shock. The clinical observer has an amnesia for certain things which may remain a total non-experience. The patient has an amnesia for a different set of things. The second shock shows clearly the break-up of the patient's social-atom-constellation and with it a break-up of the "auto"-tele. It is this break-up which may guide us to an explanation of the amnesia cleavage. The result of this break-up is:

The size of things and persons has changed. A knock on the wall sounds to the patient like thunder. Six feet look like two feet.

The shapes are changed. Some persons look swollen and curved. Some look faint, like a shadow.

The time pattern is changed. The dead father is alive and the living doctor is dead.

Duration has changed. Twenty-four hours becomes many years.

The ego has changed. It is replaced by such roles as magician and Christ.

A "persona" is composed of parts which belonged originally to different individuals and topics. For instance, the hands of one individual are connected with the head of another individual. The outcome of the psychotic attack is like debris after an earthquake. Isolated elements whose original place is hard to detect and new combinations appear. The patient's social atom is smashed.

THIRD PHASE

The patient was removed shortly before the attack from the "middle

room" to a room next door to it. Since we could not construct any psychodramatic situation with which the patient would agree for reasons already explained, we left it to the patient to recreate herself in the mood she was in when she found herself in this new setting.

The patient is stretched out on a mattress. The nurse sits by her side. A glass of water is given to the patient. She grasps it so tightly that it breaks. The water falls on the mattress.

She closes her eyes.

She cries like a baby.

She looks through a window. First, an expression of astonishment, then of bliss.

Calls her nurse incessantly with a plaintive voice: "Stay with me."

The patient lies down on the floor. The nurse sits by her side. A glass of water is given to the patient. She holds it tightly. "I am here on a ship. I am the captain. I hold it tightly. The boat begins to sink. Cold water is all around me. We sink to the bottom of the sea."

She closes her eyes. "Now I am in a box. I am dead and safe on the bottom of the sea. It is so pleasant here. Wonderful and quiet. All the water is above me."

"O, the box begins to rise. I rise with it higher. The box opens. I am reborn. I am an infant." Cries like a baby.

Looks through a window. "What a strange place in which I am. There is an open window. A beautiful tree full of leaves. The sun is so warm."

Pleads with gestures not to leave her alone. With a plaintive voice: "A wonderful face is on my bedside. It is the face of a woman looking at me. She feeds me. She takes care of me. She is so strong and big. I am so weak and helpless. Stay with me."

ANALYSIS

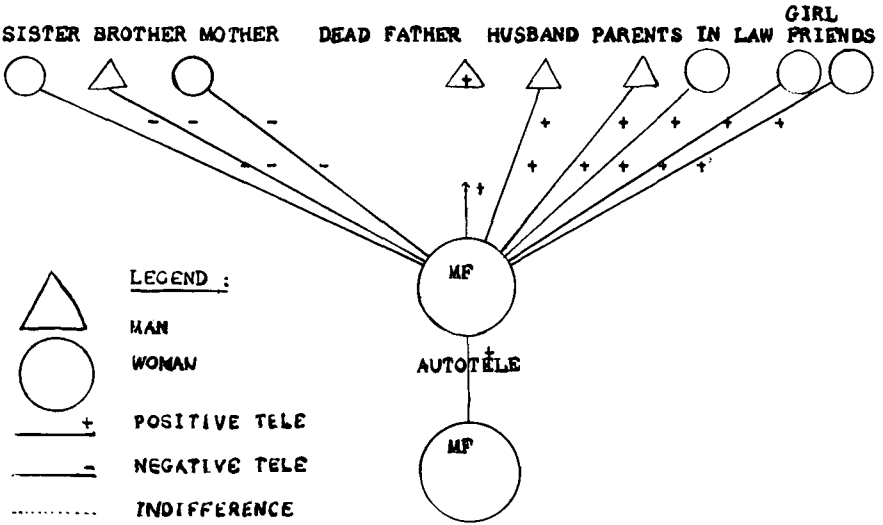
In the third shock, the patient portrays the act of her rebirth. She discovers the world again. It is an unbelievable world. Everything is so strong in it; the colors are deeper; the sounds are louder; the time is longer; space is broader; people are bigger and more important. It is this moment when the patient comes out of the acute state that has enormous possibilities for increasing our knowledge of the psychoses and for their catharsis. If the attack has come to an end the patient herself gives a signal that the bedlam is over. She feels "like new." She has a thrill which she never forgets. She looks

at the world as if for the first time. Everything she sees and touches is more beautiful, more real, more exciting than ever. She herself becomes poetic, religious, exuberant with vigor. It is the normal response of an individual from whom a heavy burden has been removed. This moment is the crucial time to apply the psychodramatic shock. The more days and weeks go by the more the psychological navel-string, which binds her present situation to the psychotic world from which she comes, fades and finally breaks. But if the shock treatment has begun at the crucial time before it is too late the psychosis is kept alive in the patient. She develops a double relationship towards two different worlds. For many months the treatment can go on. Shocks are timed daily or as often as the treatment required. The shocks, one succeeding the other, hinder the patient from freeing herself prematurely from her illness. We prolong her illness artificially. We keep the psychosis alive in her. Being normal and "as if" psychotic, at the same time, she develops spontaneous controls. The outside event has become a part of herself. It has found a tie to her own existence.

The third shock also portrays a period of infancy. The patient is in a state of great inferiority. She is threatened by everything from which she was safe during the psychotic attack. She feels dependent upon every person who protects her, preserves her life, feeds and loves her. The two persons, nurse and physician, who have taken care of her in this period of awakening, attain for her great authority and meaning. Later they became the natural agents to prepare and guide her into the difficult adventure of psychodramatic shock treatment. She follows them blindly into the psychosis just as she followed them blindly into the real world.

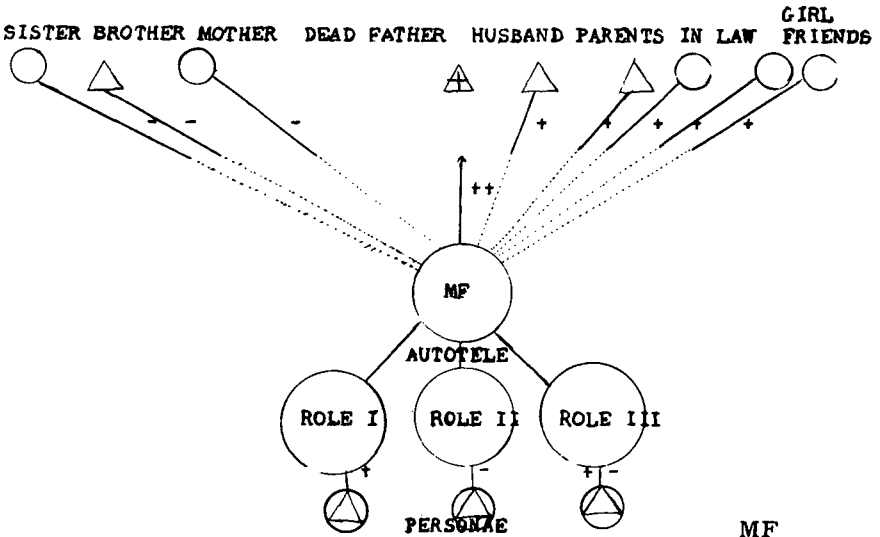
Sociogram I portrays the normal configuration of her social atom. Negative tele goes to all members of her family, positive tele to all members of her husband's family who are positively attached to her. Such a distribution of tele produces a cleavage between the two family groups. There is a positive tele for her dead father. It is charted because of his dominant role in the development of her psychosis. A positive sexual tele for two girl friends is indicated. The tele towards herself, the "auto"-tele, has the following characteristics: it is of clear-cut shape, positive in valence, strong in intensity and unbroken.

Sociogram II indicates that with the beginning of the acute phase of the psychosis all the interpersonal relations preceding it were, at least to all appearance, washed away. The patient does not ask for her husband, her mother, her siblings, her other relatives and friends. She does not show any interest in them when their names are mentioned. If these persons, who have been so close to her life are in her presence, she hardly notices their existence. It is as if she had lost her social atom. A new configuration has developed instead and is revealed through the psychodrama. The only figure of the old social atom which persists is the symbol of her dead father. The intensity of



Sociogram I

MF
1



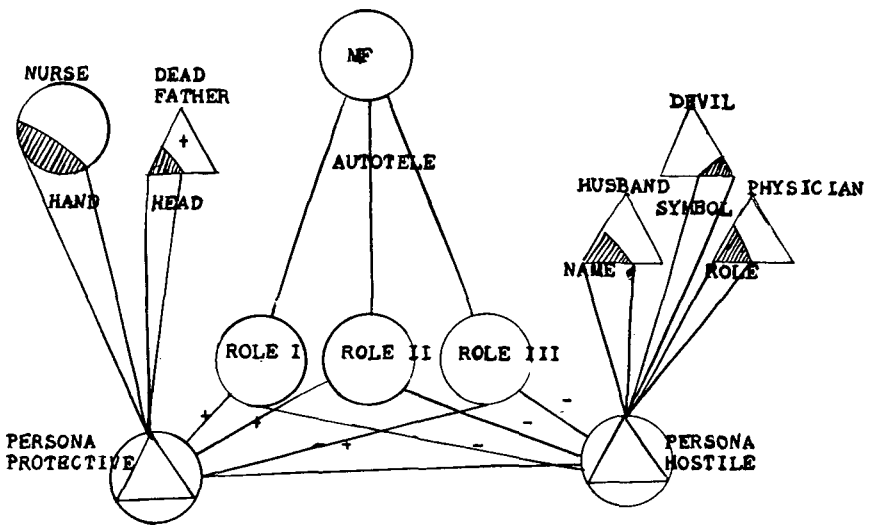
Sociogram II

MF
2

The author is indebted to Dr. Bruno Solby, Senior Psychiatrist, Beacon Hill, Beacon, N.Y., for his aid in collecting material for the Sociograms of M.F.

relation is enormously increased. The most important individual in a social atom is the patient herself. In the case here illustrated the patient's role in her social atom is replaced in successive phases by at least three new roles—the role of the magician, the role of Christ and the role of the newborn infant. As a magician she can produce an earthquake merely by banging on the walls, or kill a man instantly by merely snapping her fingers. By breaking a cup and letting the water drop out she starts a great flood which submerges the whole world and drowns everything. In the restraint, she becomes Christ, bleeding with his wounds, and out of the general destruction she arises newborn, an infant. The sociogram indicates, furthermore, numerous relationships which the patient has in these new roles towards half actual and half imagined beings—the “personae.”

A persona, illustrated in sociogram III, is emerging when the hands of a certain nurse are the hands of this nurse, but the head is the head of the patient's father. Another persona is a physician to whom she gives the symbol of the devil, her husband's family name and the title of a doctor. Numerous other personae develop, but they are not portrayed in this sociogram. One of them is the man whom she calls by his right name but whom she sees having a peculiarly curved swollen shape. Another persona is a man, who is about six feet tall but has for her the size of a two-year-old baby. Instead of his manly



MF
3

Sociogram III

voice she hears a voice which is weak and pleading. Another persona is a physician whom she sees twice his actual size and who impresses her as dark and sinister.

As she develops a new role and with every new role correspondingly new personae, she also develops towards them certain tele relations. Towards the baby-shaped man, for instance, the tele is positive; towards the oversized sinister man the tele is negative.

As we have indicated, in the normal social atom an individual has, besides the tele relationships to other persons, a tele relationship towards himself. Since, in the psychotic sociogram, the individual is replaced by numerous roles, the relationship of the individual to himself is replaced by a relationship of every *role* to itself. The original "auto"-tele is thus broken up into several units. Consequently, the relationship between the individual and his social atom is replaced by a relationship between his roles and the personae.

M. F. had more than fifty sessions, each session lasting from half an hour to an hour. The sessions were sometimes one day apart, sometimes a week or more. The proper timing was carefully considered, since we tried to avoid any risk harmful to the patient. Certain symptoms continued to affect the patient's mind long after the violent period was over. The most dominant symptom was a fear of recurrence. The patient felt that it had come unexpectedly; it might come unexpectedly again. But she understood that the psychodramatic shock treatment was applied to prevent the recurrence of an attack. The patient recovered; her insight is complete. She is back in business, effective and successful. She has resumed all her old friendships and social functions. She is fully reinstated in her social atom.

CASE 2

N. W., a Canadian woman of 47, suffered from mild depressions during her pregnancy about 20 years ago. A continuous conflict with her husband and mother-in-law produced an unhappy married life. The family problem and her change of life have been contributory factors in the precipitation of her present psychosis.

When the patient arrived, her whole disease was reduced to a single symptom—the wish to die. This symptom can be interpreted as the role a person plays who feels dead in his social atom and who therefore is in search for means of self-destruction. N. W., in accordance with this role, liked to stay in bed, the bed being as close as possible to a coffin. She refused food, using starvation as the most inaggressive way of working towards the goal of death. Her position in bed was that of an ego in complete dejection and deflation. It was definitely the attitude of a body which is unable to move, of a person who is unable to act. Her bed technique, her technique of self-denying and self-destruction had one thing in common—the effort to warm up to an act.

Her ego was bent toward an act of self-destruction, but that ego was at the same time determined to forbid herself any action—all in all, an impossible and desperate situation. The patient was therefore wavering between two extremes which can never meet—the desire to die immediately and the inability to do anything toward that end. Therefore the main expression reflected in her conduct was despair. The patient herself was aware of the absurdity of her situation. When a person is unable to act, unable to warm up towards a single purpose in life, prayer is a probable reaction. N. W. persistently repeated: "Please let me die." A prayer is characterized by its form of perpetual reiteration. The same words are repeated in the same rhythm with the intensity of the whole person. The person believes that if something is said again and again, it will finally happen. The prayer is spoken in the belief that the weak ego will find an ally in another great person, an auxiliary ego, a god.

The most outstanding symptom of N. W.'s mental disease was a general weakening of her spontaneity as it expressed itself in regard to every physical and mental function, the spontaneous ability to warm up. By spontaneity we mean here the emergence of a feeling or thought related to a momentary situation and experienced by the individual as something novel and not as a repetition of previous moments. An ordinary person, for instance, when drinking his orange juice for breakfast, has during the act, at least subjectively, the experience of uniqueness, although it is an act which he repeats every morning. For the observer there may be nothing new in the act; for the subject, however, the total experience may be spontaneous and unique. Our patient, having lost the ability to reach out in the present, finds that she has to live without living in the present moment. One momentary situation after another marches by. But she can not bind herself to the moments. The binder is missing. One person after another comes into her orbit. But she also cannot bind herself to persons. Apparently, the same binder which links her to an act links her also to a person. The process of warming up is reduced to a minimum. The reduction of the warming-up process to a minimum has numerous manifestations—loss of interest in mother and father, husband and child, sister and brother, and finally, all people and things. It may be summarily expressed as a loss of tele. At the same time the warming-up process is retarded or negated in regard to functions like eating or drinking, waking up or falling asleep, walking, sexual interest, speaking and even thinking. All momentary reality is apparently erased, the whole mind being focused on one point in the past. This process may be summarily expressed as a loss of spontaneity (spons). For the patient, at least, the loss of tele and the loss of spons are parallel.

FIRST PHASE

One of the patient's disappointments had been an inability to impress her

will upon others and to be aggressive towards them. But when she tried to turn her will against herself she was equally unsuccessful. A procedure which would give her the feeling that she could make an end to her life might give her renewed self-reliance, although in a negative way. A psychodrama of death might reinforce her hold upon life. Just as her wish to die was inarticulate so also her scheme of what she might do to commit suicide was weak and inconsistent. Since her husband was a druggist she thought of drugs, some injection which would terminate her life rapidly. Although she herself never made but a futile attempt, a shock situation was constructed which would suddenly place her before adequate means for committing suicide and before the alternative of life and death. The patient was taken into an examination room. She was instructed that immediately her wish would be gratified. After a discussion of the various drugs which could be used and their possible effect, a syringe was made ready for an injection. All was done in such a manner that the seriousness of the procedure could not be doubted. Then her arm was prepared. The patient, who up to this point had been extremely attentive and cooperative, suddenly became excited. "I am afraid to die suddenly. If I could die more slowly, just as it is with a natural disease, in a week or so." We agreed to give her the lethal drug in small doses every day. From then on the patient was taken every day to the examination room and the procedure repeated in such a way as to appear to comply with her wish.

Consequently, the patient concentrated her attention upon the psychodramatic operations which were daily performed and which would bring her slowly and painlessly to the point of death. All her dreams, phantasies, and discussions centered around the daily act. She began to eat better, thinking it might be her last meal. She began to dress and clean herself. Her appetite increased. Gradually her desire to die faded away and instead of her prayer, "how may I die?" a new prayer was on her lips: "If I could only be as I was two years ago!" Although her mind was still turned away from the present and towards a remote situation, it indicated an interest in living and not in dying.

SECOND PHASE

The desire of the patient to return to the condition she was in two years ago can be explained. She was once a beautiful woman, much admired and proud of her looks. During the last two years, age had begun definitely to turn her hair gray, wrinkles began to appear, her teeth began to decay; admirers became rare. This analysis led us to consider a new psychodramatic situation for the patient. If she could really live through the inner situation of two years ago, such a warming up process should operate like a shock. Two years ago she was still beautiful and well, but on the brink of slipping into the psychosis. She was unable to warm up "backward" and to reactivate that

situation through her own effort. She needed an auxiliary ego to stir her up to that mood. A number of situations were constructed in which an auxiliary ego acted as one of her admirers. Another situation was created in which she and her daughter introduced themselves as sisters, and another situation in which she dressed up to go with her husband to a party. The effort to warm her up was difficult. She had to be coaxed again and again. Several persons were tried as her partners until one succeeded.

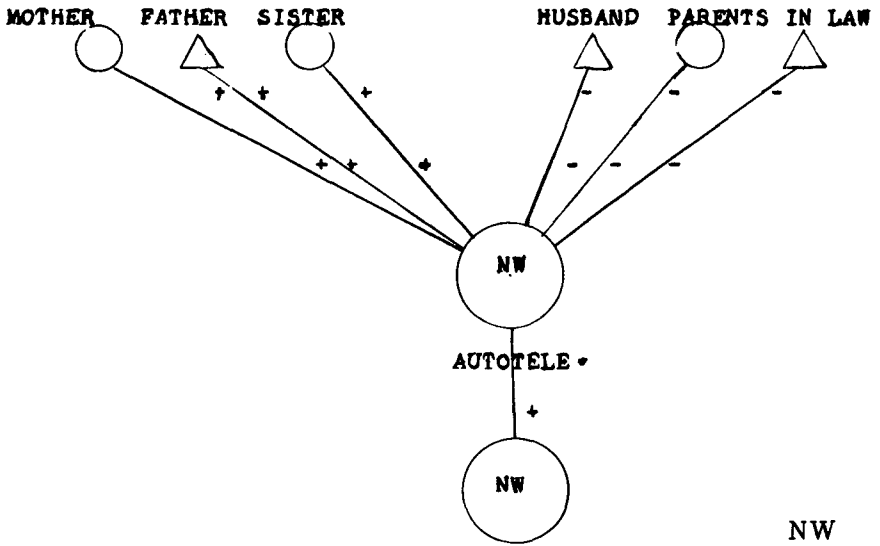
It appears fruitful to see the process of symptom formation as a gradual disintegration of momentary processes, instead of through the psychoanalytic concept of a trauma in early childhood which continues to live throughout decades in the mind of the patient and reaches into his momentary context of living. Here the warming-up backward is an active reaching out into the past. It is an active warming up towards a past moment and not, as the psychoanalyst visualizes it, the warming up of a past moment into the present.

THIRD PHASE

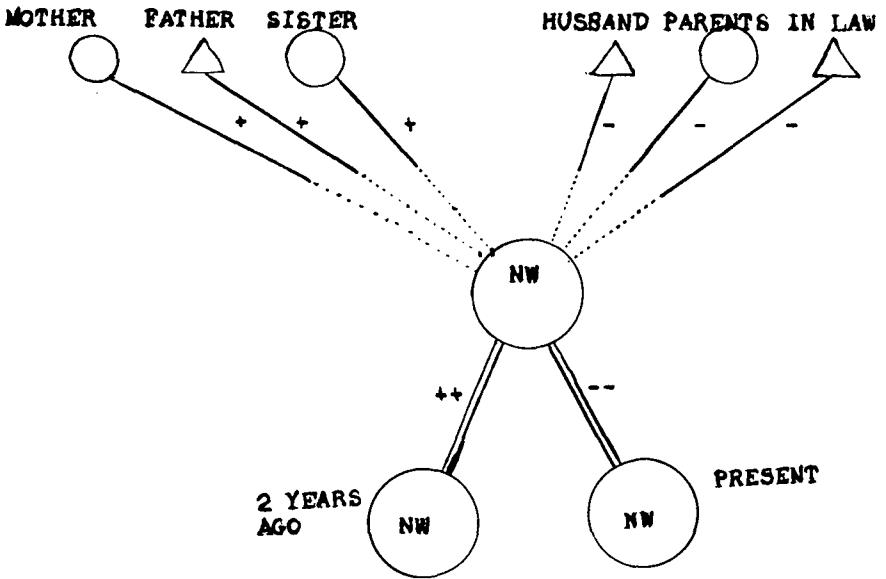
After several sessions N. W.'s backward time complex began to fade out. Her reiteration of "two years ago" now alternated more often with a new prayer, "If I could be at least as I was *one year ago*. Then I began to neglect myself." Now she used to approach doctors, nurses and even strangers with the repetition, "What have I done to myself?" This remark seemed mysterious and puzzling. We had to find the key to it. However, all questions to explain the meaning of these words she evaded or refused to answer. One day she confessed to a nurse that during the last year she had acquired a peculiar habit in connection with her constipation. The anxiety connected with this habit caused her to delay eating in an attempt to solve her problem. Every meal became a torture to her. An analytic treatment on the interview level, however much analysis might have reached pertinent emotional complexes, would have given a symbolical and sketchy catharsis. Fortunately, N. W. had shown an excellent emotional contact with one of the nurses who became her auxiliary ego in overcoming her difficulty.

Sociograms 1 and 2 portray the configuration of the social atom of the patient N. W., before and during her psychosis. They indicate the characteristic structural changes which have taken place. Before the outbreak during her normal life her affinities are either extremely positive or negative towards the crucial persons of her social atom. This produces on the one hand a cleavage between her parents and her sister, to whom she is violently attracted, and her husband and his relatives, on the other hand, whom she violently fears and dislikes. The characteristics of her "auto"-tele are of clear-cut shape, of positive valence, of weak intensity and unbroken.

During her psychosis, the social atom pattern remains unchanged in emotional distribution and in its proportions. The cleavage persists; she loves



Sociogram 1



Sociogram 2

and fears the same people as before. But the intensity of her emotions have totally changed. The hate and disgust directed towards herself dominate the picture; that is, a negative "auto"-tele absorbs most of her emotional energy. In consequence all her tele relations to other persons, although changed in quality, have become extremely weak. One can speak of a shadowing of the tele pattern. Her auto-tele shows a peculiar break. It is positive towards her body as it was two years ago; it is negative towards her present shape of body. Her response to the shock demonstrates that if she could have committed suicide she would have destroyed her body in its present shape, but would have preserved the shape of her former self of which she was so proud. Since this was impossible she was in a dilemma.

N. W. underwent about ten sessions, each about two to three weeks apart. Since it was difficult to warm the patient up for any action, the preparatory phase consumed three quarters of every session. Each session lasted about one hour. The effect was striking. The patient who until then rarely left her bed began to lead a more normal life. She got up in the morning, dressed herself, came into the dining room for her meals, stopped with her suicidal prayers, calmed down generally, began to read and to occupy herself with handwork. The patient is now in a process of rehabilitation. The treatment is continuing.

CASE 3

H. B., a Jewish woman of 50, is a victim of political changes in Berlin. She was leader of a large business, a widow who lived alone, a master of her own life. She had two children, a son and a daughter, living in America to whom she had become rather indifferent. When the new regime came it swept her off her feet. It took everything she had, her prestige, her money, her business, and finally she was put in jail. She emigrated to the U.S. As soon as she was safely on land, her present psychosis began.

In the two cases previously mentioned the social atom and tele structure are illustrated as they develop in the course of a psychosis. Case H. B. shows how the social atom and networks break from the normal to the pathological level, their changes in psychological organization in the critical moment, how they are uprooted within a few days and how a sensitive person, the patient, is uprooted with them. The initial phase, the early evolution of the psychosis, becomes visible.

This is the impression the patient made at the first examination: She could not sit. She could not stand still. She paced in her room in motor restlessness "like a tiger in her cage" as she described it. She grew warmer as she proceeded, perspiring from every pore, gesticulating violently and begging for something with which to end her life. When this was refused, she became violent to the point of hitting the nurse and breaking things. The attack usually lasted a few hours and was followed by a pause in which she was

calmer but fearful of the next attack. Chemical means could not prevent them or diminish their intensity. The pauses between attacks became shorter and shorter and finally she was submerged in a frenzy in which she became abusive and destructive, childish and confused. In her lucid moments she repeatedly said: "Do not ask me questions about what happened to me in the old country. The Nazis and the jail have nothing to do with my present condition. I do not care that I lost my money, my business, my independence." She became indignant when the subject was mentioned. A few weeks later, after a remarkable recovery, this point was discussed again. She began to admit "That the situation in Germany may have had something to do with my illness but I do not know in what way."

In the preliminary interviews, it was difficult to determine which of the events was more or less crucial for the development of her illness. Therefore we suggested to her that she might reconstruct on the stage all situations she could remember in sequence beginning with the moment when the fear became general. She should not leave out any situation however insignificant it might seem to her. She should describe all the persons who took part in these situations and select members of our staff to portray the different people with whom she had come into contact. Her performance on the stage was a form of psychiatric revue, short compact scenes, each lasting about two to three minutes. Some of the situations re-enacted were: A Nazi commissar takes away the keys to her store. Police make a search in her home. She calls up her son in America. She asks the American consul to help her. A state revisor controls her books and finds some irregularities. She is taken to a prison cell. She is released from prison. She leaves by train. She takes the boat to New York. For the purpose of this paper two situations are described. They give us the crucial clues.

It is the patient's apartment. The patient enters through the door. She has just given over her store. She paces up and down. She calls up her lawyer. The maid answers. "Mr. S. is" "What happened to him?" no answer. "I understand, may I speak with Mrs. S.?" The maid answers, crying "She took her life with him." "When, how, what. . . ?" No answer. "Terrible, within three days my physician took poison, my bookkeeper took gas, my banker shot himself. One friend after another is leaving this way. What shall I do?"

The patient reconstructs a situation in prison.

It is night. She paces restlessly up and down in her cell. She talks to another inmate who is resting.

She perspires. Throws her arms around a prison matron.

"Why don't they come? A week ago they said tomorrow. Yesterday they said tomorrow. There is no end. I was a coward. So many have done it. I should have done it too."

"This waiting. This waiting. There is no end."

Bangs her head against the wall.
Shouts.

"Is nobody here who can help me?
There is nobody. My son, my daughter,
nobody calls. Have they all forgotten
me?"

Sniffs.

"The air is so sticky. It smells
here."

As she shouts other inmates who
try to sleep and are awakened protest:
"Silence, be quiet." The
patient:

"I cannot help myself."

ANALYSIS

The patient warms up easily. She acts so rapidly; her ideas prompt her so quickly that her partner finds it difficult to follow. At the end she is exhausted and cries. The crucial problem of the patient is the role of death in her social atom and its relationship to her personal death. Death becomes a more frequent guest in the social atom of an older person. It calls away more and more of the intimate members of his social atom—parents, a brother, a close friend, etc. As life unfolds, the arrival of death has an accelerated but natural rhythm. The effect upon a person concerned is a cumulative shock. A man dies a bit with every death within his social atom before he dies himself.

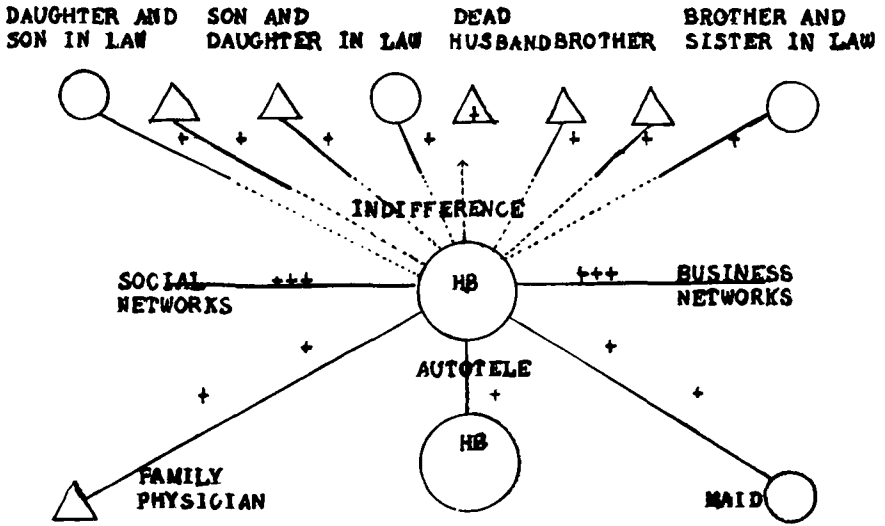
The psychological organization of the social atom is a determining factor in producing this effect. Its structure is more rigid in older persons. If a loss of important members occurs in advanced age, replacements are hard to make. Gradually the social atom shrinks. The situation up to this point is normal but something extraordinary has taken place in the life of our patient. Due to a regime of violence in the community in which she lives death moves in such a swift pace into her social atom that it crumbles before her own eyes. It may be soon exterminated. Its extermination is something near death. Death of the social atom resembles organic death. It is hard to start a new social atom at old age. The patient has become estranged from such members of her social atom to which a woman and mother clings when she becomes old. After her husband's death she had decided to lead her own life and to end it a lone wolf. It is hard to turn the clock back. Her situation is colored by the fact that it is not natural death from which her friends die. It is voluntary, self-made death—suicide. Suicide has become a normal reaction, a standard, the proper thing to do. It has become abnormal to go on living when the intimate associates of one's social atom have one common answer to life—suicide. She paces up and down on the stage in a gesture of despair. All her friends were able to make this decision. She cannot. In the prison cell the sudden break of her social atom is symbolized by her imprisonment and isolation. The social atom has been her identity, the carrier of her honor and

self-respect, of her achievement, of her loves and hates. She cannot return to it. In the prison cell she is thrown at her naked self. But the self is not fully alone. That nucleus of feelings which every individual develops from early infancy on in regard to himself and which produces a mirroring reflection of her position in the community, was with her. This shadow of herself, the product of the auto-tele, has definite shape. It changes as a person grows older and probably reaches its climax of clarity and intensity in the years after adolescence. Its intensity diminishes with the advance of age, but may gain in clarity and precision. Its shape may become confused and blurred if the social atom becomes disorganized and is in distress. The strongest image which recurred was the image of her dead body. That meant final rest. To be the executioner of her own death appealed to her as much as to have been the director of her own life. The frequency of associations which brought her nearer to the act of suicide was immensely increased. With every pace in her cell she demonstrated that she could do it. With every protest and shouting she rebelled against a life which was lost.

When she arrived in the United States, her fear that she could not start anew as a business woman, mother, or mother-in-law, became rapidly justified. She hated and she was hated. She wished she could go back to the jail to fight it out to the end. Through the performance of insanity she could return to herself and become the center of events. The frustrated psychodrama in jail, and frustrated suicide plan at her home could be worked out. Her psychosis was an exaggerated replica of her psychodrama of suicide. She tried to swallow drugs and buttons and as a result projected pain into every part of her body. She feels that every one in the hospital wants to do her harm and, just as she wanted to escape from the Nazis in death, she wants to escape from us by doing harm to herself. The desire to get out of jail and the waiting from day to day had a perfect counterpart in her desire to get out of the hospital.

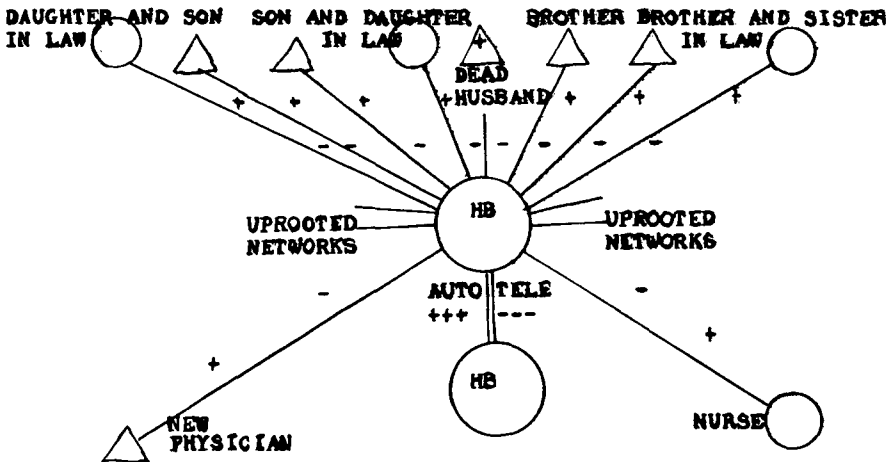
Sociogram I indicates a cleavage between her relatives in distant countries towards whom she has become indifferent and herself, her business, and her business associates who form a positive nucleus of emotions around her—the boss. She has a large number of acquaintances among whom she has the prestige of being a remarkable business woman. The only person to whom she is strongly attached are her family physician and her maid.

Sociogram II portrays her social atom during her stay in the hospital. It indicates that her auto-tele has increased in intensity. The indifference towards her relatives who brought her over to America has turned from indifference to a negative tele. She can not accept her in-laws and not even her son and daughter who have outgrown her as an adequate replacement of her intimate friends in the old country. She can not accept the physician and nurse as replacement of her good old doctor and maid who took care of her. Nothing is acceptable to her. Foreign land, foreign language, foreign people, her



HB
1

Sociogram I



HB
2

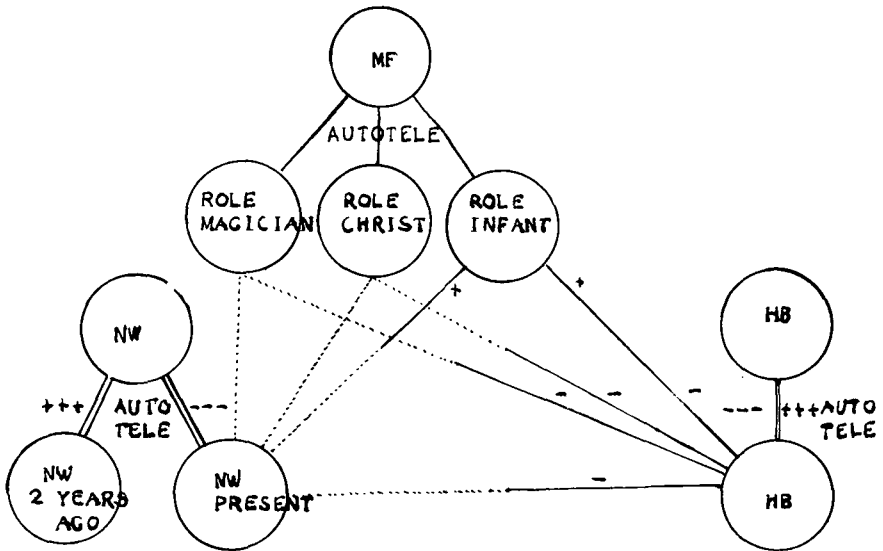
Sociogram II

business and social networks are uprooted, she can never be at home. Her social atom is reduced to her auto-tele. The movement of feeling between her ego and her counter-ego is at times extremely positive, at other times, extremely negative. It is always of a maximum intensity and makes her psychodrama a struggle between two roles—life and death.

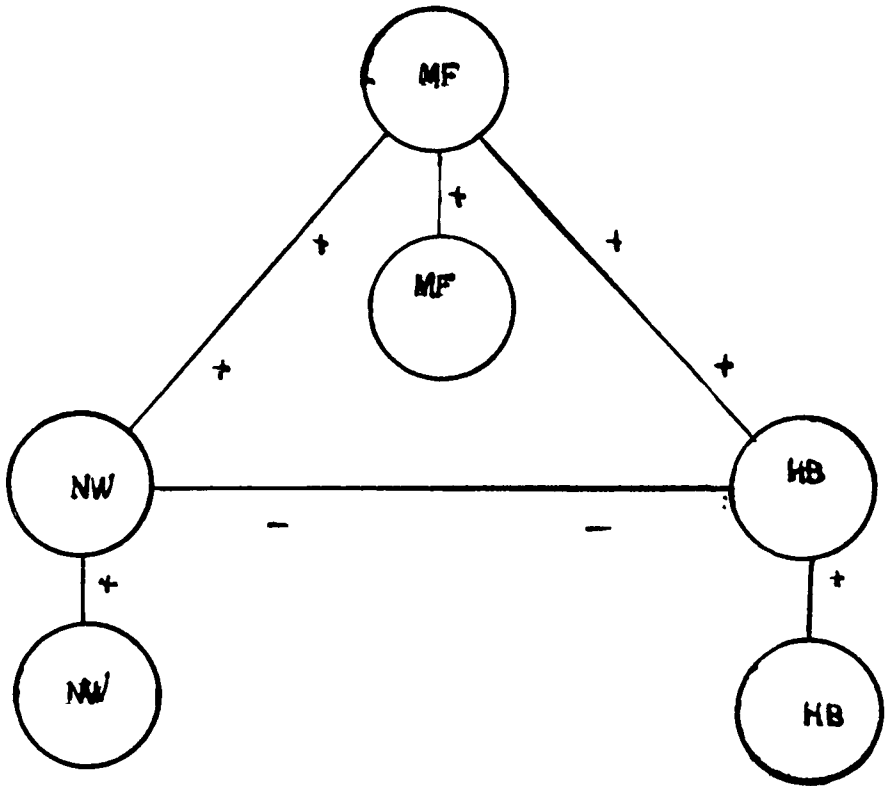
M. Z. had only a few sessions. But they were more helpful for the understanding and reconstruction of the case than the daily interview and observation during a period of four months.

Sociogram III portrays the relationship between the three patients M. F., N. W. and H. B. during the active phases of their psychoses. M. F. is supplanted by three new identities. In the roles of magician and Christ no tele was directed towards H. B. or N. W. In the role of the infant positive tele goes to both. In this role H. B. appears to her as an important personality, the owner of the hospital and N. W. appears to her as a beautiful distinguished lady. H. B. has a negative tele towards M. F. in all her three roles and towards N. W. in that role in which she is visible.

Sociogram IV indicates the situation after the treatment. A positive relationship developed rapidly between M. F. and N. W. and between M. F. and H. B. but a mutually negative tele between N. W. and H. B.



Sociogram III



Sociogram IV

SUMMARY

The chief difference between the psychodramatic shocks in the three cases is that in the first and in the third, however surprising and upsetting the procedure may be, the patients are at all times fully aware that they are partners in a therapeutic procedure. The shocks in the second case are applied in true life situations and in such a fashion that the patient has all reasons to believe that the effects of the procedure are real. Only when the patients were induced to assume roles of a past time, then at least a partial awareness of the fictitious character of the situation was present. It appears that the degree of the cathartic effect produced by a shock depends upon the degree of active spontaneity to which the patient can warm up. The process of warming up produces during the shock a higher frequency and a wider range of

associations than during the course of the disease. It enables the patient to put himself into action and activate bodily and mentally his crucial conflicts so that he feels more clearly all the possibilities of a solution and eventually will turn his will towards a new path, away from his impotent and perverse efforts.

NEW FRAMES OF REFERENCE

The social atom appears as a fundamental pattern which reflects the essential situation of the individual in society. Each individual has his own pattern of social atom which like his handwriting can be distinguished from that of other individuals and which maintains its individuality. The social atom patterns of normal persons of different ages have been studied and found to portray typical variation with development of age. Thus a frame of reference is given with which we can compare the changes within the social atom of individuals afflicted with mental disorders. A person with an abnormal social atom development may go through life without clinical manifestation of a mental disturbance but these can be rapidly activated as soon as a precipitating cause appears. The precipitating cause may be at one time a physical condition, for instance, arteriosclerosis of the brain; at other times, a psychological condition, for instance, a feeling of inferiority; at other times, a social condition, for instance, death of a parent; at other times, an economic condition, for instance, loss of a job.

The three patients, M. F., N. W., and H. B., appeared sociometrically abnormal long before they appeared clinically abnormal. The actual life within a social atom however is far more complex and richer in texture than sociometric tests alone are able to reveal. A procedure had to be devised to bring into the view of the investigator the social atom in its living reality and the persons participating in their visible and invisible roles. The psychodrama comes closer to giving a totalistic picture of human relations than any other form of expression, better than handwriting, dreams or free association. In the arts the drama has been considered superior to all forms of expression because it contains them all and is a synthesis of them all. Just as it embraces the lyric and the epic element and brings them to a new synthesis, the psychodrama embraces the mind and body of many individuals united in action and brings them also to a new synthesis. Thus it portrays the dynamics of a miniature society and provides an experimental situation for the study of the simplest and most complex patterns of interpersonal relations.

NOTES

1. The author is greatly indebted to Ernst Fantl, M.D., resident physician, Beacon Hill, Beacon, N.Y., for reading and assisting in the editing of this paper.
2. Some terms used in this paper are defined as following:

Tele

A feeling process projected into space and time in which one, two, or more persons may participate. It is an experience of some real factor in the other person and not a subjective fiction. It grows out of person-to-person and person-to-object contacts from the birth level on and gradually develops the sense for inter-personal relationships. The tele process is the chief factor in determining the position of an individual in the group.

Auxiliary ego

A person whose function is to live through the subjectivity of the patient and identify himself with all the patient's expressions as far as organic limitations allow.

Networks

An inter-personal structure in which individuals comprising certain links are unacquainted with those in more distant links but can exert an influence by indirection.

Social atom

The tele range of an individual. The smallest constellation of psychological relations which can be said to make up the individual cells in the social universe. It consists of the psychological relations of one individual to those other individuals to whom he is attracted or repelled and their relation to him.

Warming-up process

A technical term derived from spontaneity work. The spontaneity state is brought into existence by various starters. The subject puts body and mind into motion, using body attitudes and mental images which lead to the attainment of the state.

Psychodrama

A therapeutic situation similar to the social situation of a patient. The patient is asked to relive a former experience by expression through gestures, words, and movements, and if necessary, to act with a group of auxiliary egos who represent to the patient certain roles played by members of his social atom.

3. Dr. Ernst Fantl suggested the term "auto-tele" as expressing the broad implications of the problem.

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