GROUP PSYCHOTHERAPY

Journal of Sociopsychopathology and Sociatry

PSYCHODRAMA

SOCIOMETRIC METHODS
ACTION METHODS
THERAPEUTIC FILMS

RE-GROUPING
RE-TRAINING
SOCIAL CATHARSIS

SOCIODRAMA

Volume III APRIL, 1950 Number 1

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EDITORIAL ANNOUNCEMENT

The title of *Sociatry*, Journal of Group and Intergroup Therapy has been changed to *Group Psychotherapy*, journal of sociopsychopathology and sociatry. The undertitle is now the chief title in order to signalize to group psychotherapists of all versions the urgent need for a re-alignment of forces and the plan of this journal to become the official platform for all significant varieties of group psychotherapy. Its Board of Contributing Editors will be enlarged by the addition of new members to indicate the broadened outlook.

The original policy of the journal, to develop foundations of a mass psychopathology and mass psychiatry, a sociatry, is not altered, but the emphasis is now placed upon the more immediate objective, the theory and practice of group psychotherapy.

Executive Committee

Beacon, N. Y.

April, 1950

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HYPNODRAMA AND PSYCHODRAMA

J. L. Moreno

Psychodramatic Institute, Beacon, N. Y.

I divide psychiatry into three categories: Confessional psychiatry, Shakespearean psychiatry and Machiavellian psychiatry. An illustration of confessional psychiatry is psychoanalysis. An illustration of Shakespearean psychiatry is psychodrama; it heals and explores the truth by means of dramatic methods. I call it Shakespearean because Shakespeare, more than anyone else, has contributed, not to this form of therapy but to its content. Illustrations of Machiavellian psychiatry are electric shock therapy, insulin shock therapy and lobotomy. I call them after Machiavelli because he has advocated the cruellest methods in the government of human affairs, the means being justified by the end.

Psychodrama, among the three categories, is in a strategic position because it brings the three efforts into a synthesis. After the study of heredity, of anatomy, of physiology, of internal medicine, of histology, of neurology, after you have been psychoanalyzed and even after you have had your lobotomy you must enter the process of living itself, a world full of unknown opportunities and boundaries, or at least, full of uncertainties; a world ever changing, filled with unknown objects and people. After you have acquired all the knowledge your learnings need a finishing touch, you still have to learn how to live. This is what psychodrama and its allied methods and techniques propose to do for people: to provide them with the science and skills of living, a "life practice."

Historically the psychodrama grew out of the principle of play. Play has always been there; it is older than Man, it has accompanied the life of organisms as one of its excesses, anticipating growth and development. In our culture it was particularly Rousseau and Froebel who directed our attention towards the educational value of play. But a new vision of the principle of play was borne when in the years before the outbreak of the first World War I began to play with children in the gardens and streets of Vienna: play as a principle of cure, as a form of spontaneity, as a form of therapy and as a form of catharsis; play, not only as an epiphenomenon accompanying and supporting biological aims but as a phenomenon sui generis, *a positive factor linked with spontaneity and creativity.* Play has gradually been separated from its metaphysical, metabiological and metapsychological connections and shaped into a methodical and systematic principle. All this has brought the idea of play to a new universality, unknown heretofore; it has pushed and inspired the development of play techniques, play psychotherapy, theatre of spontaneity,

therapeutic theatre, culminating in the role playing, psychodrama, sociodrama of our time.

After the Viennese "garden revolution,"* the opening of the first therapeutic theatre—The Spontaneity Theatre—in Vienna (1921) was the greatest triumph of the play principle. Supplemented two years later by my book *Das Stegreiftheater* it signalized the surpassing of psychoanalysis by revolutionizing the *vehicle form* and *concept* of treatment. The psychoanalytic vehicle was the couch. The antiquated couch was transformed into a multidimensional stage, giving space and freedom for spontaneity, freedom for the body and for bodily contact, freedom of movement, action and interaction. Freud's free association was replaced by psychodramatic production and audience participation, by action dynamics and dynamics of the groups and masses. With these changes in the research and therapeutic operation the framework of psychoanalytic concepts, sexuality, unconscious, transference, resistance and sublimation was replaced by a new, psychodramatic and sociodynamic set of concepts, the spontaneity, the warming up process, the tele, the interaction dynamics and the creativity. These three transformations in vehicle, form and concept, however, transcended but did not eliminate the useful part of the psychoanalytic contribution. The couch is still in the stage—which is like a multiple of couches of many dimensions, vertical, horizontal and depth—sexuality is still in spontaneity, the unconscious is still in the warming up process, transference is still in the tele; there is one phenomenon, productivity-creativity for which psychoanalysis has given us no counterpart except a defective one, sublimation. Because of the extremely dialectic character of our century, being in a transition from one type of culture to another, this change in concepts and operations is hidden, insidious and Machiavellian in itself.

Some Comments on the Dynamics of Psychodrama Therapy

The question of dynamics in psychodrama is often the cause of misunderstandings. The logic of psychoanalysis is to take advantage of the transference of the patient, to work through the resistance he has against returning the repressed to consciousness. The logic of psychodrama is different and more complex because of the novel elements entering the situation. The transference to the therapist exists here, too—to begin with, but the relation is far more realistic, it often assumes the character of a real battle between therapist and patient. The patient feels far more threatened because the therapist wants so

*J. L. Moreno: Homo juvenis (in "Einladung zu einer Begegnung") Anzen gruber Verlag, Vienna, 1914, p. 12.

much more from him; not only does he want him to speak freely but to expose his whole inner drama in action and words and not only his own, but also that of people who are closest to him and whose secrets he fears to reveal. So he tries to put up a fight, as if against an attack. The therapist in turn is not the quiet, passive listener in psychoanalysis, he himself must put up a good battle in order to get the patient to produce. The transference, therefore, begins at times from *his* side and is overwhelming in character, like that of a man who is in love with a woman and takes the initiative. Therapist and patient warm up to each other, it is a battle of wits. The therapist wants something from the patient right away, but he refuses to give. This picture of an overwhelming resistance of the patient because of the therapist's need of an overwhelming transference should not mislead the reader. In most cases the resistance against being psychodramatized is small or nil. Once a patient understands the degree to which the production is of his own making he will cooperate. It is obvious that we are here using the concept of transference in a way which goes far beyond the ordinary definition and destroys its meaning. The fight between therapist and patient is in the psychodramatic situation extremely real; to an extent they have to assess each other like two battlers, facing each other in a situation of great stress and challenge. Each of them have to draw spontaneity and cunning from their resources so that whatever amount of projected transference operates from the patient towards the therapist is pushed into the background or reduced to a small element. Positive factors which are shaping the relationship and interaction in the reality of life itself take their place: spontaneity, productivity, the warming up process, tele and role processes.

But because of the dialectic character of the psychodramatic methods this first phase is rapidly eliminated and replaced by another. The therapist, after having made so much ado to get the patient started, recedes from the scene; frequently he does not take any part in it, at times he is not even present. From the patient's point of view his object of transference, the therapist, is pushed out of the situation. The retreat of the therapist gives the patient the feeling that he is the winner. Actually it is nothing but the preliminary warm up before the big bout. To the satisfaction of the patient other persons enter into the situation, persons who are nearer to him like his own mother and wife or individuations which are part and parcel of him like his delusions and hallucinations. He knows them so much better than this stranger, the therapist. The more they are in the picture the more he forgets him and the therapist wants to be forgotten, at least for the time being. The dynamics of this forgetting can be easily explained. Not only does the director-therapist leave the

scene of operation, the auxiliary ego therapists step in and it is between them that his share of *tele*, transference and empathy is divided. In the course of the production it becomes clear that *transference is nothing by itself, but the pathological portion of a universal factor, tele*, operating in the shaping and balancing of all interpersonal relations. As the patient takes part in the production and warms up to the figures and figureheads of his own private world he attains tremendous satisfactions which take him far beyond anything he has ever experienced; he has invested so much of his own limited energy in the images of his perceptions of father, mother, wife, children, as well as in certain images which live a foreign existence within him, delusions and hallucinations of all sort, that he has lost a great deal of spontaneity, productivity and power for himself. They have taken his riches away and he has become poor, weak and sick. And now the psychodrama, as if by the grace of God, gives back to him all the investments he had made in the extraneous adventures of his mind. He takes his father, mother, sweethearts, delusions and hallucinations back unto himself and the energies which he has invested in them, they return by actually living through the role of his father or his employer, his friend or his enemy; by reversing the roles with them he is already learning many things about them which life does not provide him. But when he himself can be the persons he hallucinates, not only do they lose their power and magic spell over him but he gains their power for himself. His own self has an opportunity to find and reorganize itself, to put the elements together which may have been kept apart by insidious forces, to integrate them and to attain a sense of power and of relief, a "catharsis of integration" (in difference from a catharsis of abreaction). It can well be said that the psychodrama provides the patient with a new and more extensive experience of reality, a *"surplus" reality*, a gain which at least in part justifies the sacrifice he made by working through a psychodramatic production.

But this second phase in psychodrama is gradually replaced by a third. Now the audience drama takes the place of the production. The therapist vanished from the scene at the end of the first phase; now the production itself vanishes and with it the auxiliary egos, the good helper and genii who have aided him so much in gaining a new sense of power and clarity. The patient is now divided in his reactions; on one hand he is sorry that it is all gone, on the other he feels cheated and mad for having made a sacrifice whose justification he does not see completely. The patient becomes dynamically aware of the presence of the audience. In the beginning of the session he was angrily or happily aware of it. In the warming up of the production he became oblivious of its exis-

tence, but now he sees it again, one by one, strangers and friends. His feelings of shame and guilt reach their climax. However, as he was warming up to the production the audience before him was warming up too. But when he came to an end they were just beginning. The *tele*-empathy-transference complex undergoes a third re-alignment of forces; it moves from the stage to the audience, initiating among the audio-egos intensive relations. As the strangers from the group begin to rise and relate their feelings as to what they have learned from the production, he gains a new sense of catharsis, a group catharsis; *he has given love and now they are giving love back to him.* Whatever his psyche is now, it was moulded originally by the group; by means of the psychodrama it returns to the group and now the members of the audience are sharing their plights with him as he has shared his with them.

The description would not be complete if we would not discuss briefly the role which the therapist and the therapeutic egos play in the warm up of the session. As this part has numerous versions I will limit myself here to their contribution to the treatment of mental disorders, especially in the psychoses. It is in the treatment of the psychotic personality that psychodrama has reached some of its most astonishing results.* The theoretical principle is that the therapist acts directly upon the level of the patient's spontaneity—obviously it makes little difference to the operation whether one calls the patient's spontaneity his "unconscious"—that the patient enters actually the areas of objects and persons, however confused and fragmented, to which his spontaneous energy is related. He is not satisfied, like the analyst, to observe the patient and to translate symbolic behavior into understandable, scientific language but he enters as a participant-actor, armed with as many hypothetic insights as possible, into the spontaneous activities of the patient, to talk to him in the spontaneous languages of signs and gestures, words and actions which the patient has developed. This is, of course, dangerous psychiatry. Psychodrama does not require a theatrical setting, a frequent misunderstanding; it is done in situ—that is, wherever the patient is found. According to psychodramatic theory a considerable part of the psyche is not language-ridden, it is not infiltrated by the ordinary, significant language symbols and it assumes that these silent parts of the psyche play a great role in the development of the psychoses. Therefore, bodily contact with such patients, if it can be established, touch, caress, embrace, hand shake, sharing in silent activities, eating, walking or confused

*See "Psychodrama and the Psychopathology of Inter-Personal Relations," **Sociometry**, Volume 1, 1937; "Psychodramatic Shock Therapy," **Sociometry**, Volume 2, 1939; "Psychodramatic Treatment of Psychoses," **Sociometry**, Volume 3, 1940; "A Case of Paranoia Treated Through Psychodrama," **Sociometry**, Volume 6, 1943.

activities, are an important preliminary to psychodramatic work itself. Bodily contact, body therapy and body training continue to operate in the psychodramatic situation. An elaborate system of production techniques has been developed by means of which the therapist and his auxiliary egos push themselves into the patient's world, populating it with figures extremely familiar to him, with the advantage, however, that they are not delusionary but half imaginary, half real. Like good and bad genii they shock and upset him at times, at other times they surprise and comfort him. He finds himself, as if trapped, in a near-real world. *He sees himself acting, he hears himself speaking, but his actions and thoughts, his feelings and perceptions do not come from him, they come, strangely enough, from another person, the therapist, and from other persons, the auxiliary egos, the doubles and mirrors of his mind.*

Introduction Into Hypnodrama

Hypnodrama is a synthesis of psychodrama and hypnosis. The idea of hypnodrama came to me through an accident. In the summer of 1939 the late Dr. Solby brought a young woman for treatment. She suffered from paranoid delusions accompanied by nightmares, every night the devil came to visit her. She was unable to get into a psychodramatic contact with the incident. After trying the self-directed technique and methods of mild prompting without results I became highly directive; this put the patient unexpectedly into a hypnotic trance. I decided to try a psychodrama under these novel circumstances. With the aid of two male auxiliary egos she was able to portray two meetings with the devil, one as it had happened the night before, one as she expected it to happen the following night. Apparently hypnosis operated as a "starter" and spurred her spontaneity.

I tried the technique several times since; it was particularly successful a few years later with Bill, a man who blamed his deep depressions and ideas of reference to a mysterious incident in a doctor's office. It was the beginning of his inability to produce, to love, to work and to enjoy things. He ran away, leading the life of a tramp until he was found and hospitalized. Like Marie, Bill had a vivid recollection of every detail of past and present experiences, but he could not evoke the spontaneity to speak about them or dramatize them. The inability to produce gradually spread over all his physical, mental and social functions, leading to a general loss of spontaneity to what I have called a "productivity neurosis."**

Here follows a description of the technique, some observations and recommendations. It is assumed that the hypnotic operation has a psychodramatic

**See "Creativity and Cultural Conserves," Sociometry, Vol. II, 1939.

nucleus which has to be mobilized and treated in order that it should attain real effect. The hypnotic operation itself is reconstructed from a psychodramatic point of view in all its aspects, a) in the role of the hypnotist himself; he becomes a psychodramatic director, assisted by a staff or auxiliary egos, b) in the acts of bringing about the hypnotic sleep; it helps the warm up if the patient improvises on the stage the genius loci—his bedroom—if he goes to bed and assumes the position of the sleeper; and c) during the hypnotic trance of the subject the verbal suggestion of the hypnotist is replaced by a psychodramatic production. The patient is treated during the trance like a subject in a psychodrama session, he is changed into a psychodramatic actor; he is the protagonist who, in cooperation with the hypnotist-director and auxiliary egos externalizes the internal structure of his mental world.

Although hypnosis is the starting point of a hypnodrama, the hypnotisand takes part in the production as the central character, he is exposed to a bombardment of psychodramatic stimuli and is suggested by the chief therapist to interact during the session with every auxiliary ego. The auxiliary egos materialize the persons, objects, images and scenes as they are projected by the patient. He often gives, upon instructions of the hypnodramatist, a soliloquized echo of every part played by an ego. Thus either he acts out or shapes the production step by step. The usual routine of hypnosis of giving simple, verbal orders to the subject is transformed in the hypnodramatic experiment into a complete psychodrama.

When Freud left Breuer he dropped a forceful element, the Mesmeric-hypnotic component which he did not know how to handle rationally. It was a logical move and consistent with psychoanalytic philosophy. The Mesmeric-hypnotic component is a dramatic, an action element which as an operation cannot be made part of psychoanalysis except post mortem, after the hypnosis is over. The two operations contradict one another, the hypnotist tries to make the patient unconscious of himself, the psychoanalyst tries to bring to consciousness unconscious experiences. The relation of hypnosis to psychoanalysis is somewhat similar to the relation of play to psychoanalysis. Play productivity and psychoanalysis do not fit together; they are opposite forms of warming up. With the advent of psychoanalysis Mesmeric hypnosis became antiquated, a form of magic, and rightly so. With the entrance of psychodrama into the arena of the medical therapies, however, a change has been taking place, as the literature of the last few years discloses. The conversion of hypnosis can proceed into two directions, a) submitting the patient to a material analysis *after* the hypnotic trance is over, which hypnotists or psychoanalysts trained

in hypnosis have frequently tried to do. But the hypnotic operation, turning the patient unconscious and the psychoanalytic operation, turning the patient conscious, contradict each other. The other conversion was to combine hypnosis with dramatic methods and use analysis supplementary to the process of psychodrama as it unfolds. These two directions, hypnosis plus psychoanalysis, and hypnosis plus psychodrama are actually in the process of developing, the one under the label of hypnoanalysis, the other as I have called it, hypnodrama. But if one watches some of the hypnoanalysts (as well as the hypnotists) of today as to what they actually practice, even if they camouflage it in writings, the more explicit it becomes that psychodramatic elements are becoming an intrinsic part of their operation and that they are becoming more and more conscious of these elements. When they interpret them they may or may not use psychoanalytic concepts but what they *do* has little similarity to free association; it does have great similarity to psychodrama. The same conclusion can be made as to the dynamic factor underlying the effect of sodium pentothal; it is the warming up of the patient by the therapist and the use of auxiliary ego techniques. The effect can be attained without sodium pentothal which is a handicap to full production.

In Mesmer's sessions the group was frequently a natural part of the procedure. But the psychoanalysts pushed the group out of therapeutic existence and turned psychotherapy extremely individualistic; this has had its salutary effect and may never be entirely abandoned. However, with the advent of psychodrama the group has come back into therapy and is again moving into a place of honor. By this I do not mean only the closed group method, but particularly the "open" group method (open to all comers) used in psychodramatic sessions. The group is coming back in full swing, in a controllable way, not in the uncontrolled way in which Charcot, Freud and others found it. In addition to the group factor, other elements will be added by future therapists which neither hypnotist nor analyst have ever considered in their schemes, the process of "training and retraining" in situ. The hypnotist and analyst delimit their therapy to the consultation room and left it unrelated to the actual living of the patient in the community. But it is on the action and reality level that the patients must find themselves, that is why these areas had to be integrated into the treatment situation. By means of role training, spontaneity training and so forth, this deficiency in medical psychotherapy has been overcome. The hypnotic operation is in itself of limited value, it can gain a new momentum as a psychological starter to psychodramatic production. It can serve a similar purpose as the psychochemical starters,

insulin, electric shock, alcohol, solium amytal, pentotal, etc., and replace them in many instances.

The usefulness of a starter for the patient can be noted in two areas: a) the area of communication, b) the area of productivity. There are, for instance, psychochemical starters which may make uncommunicative patients more communicative, for instance alcohol and insulin, but they may often lower the productivity of the patient, that is their "therapeutic" productivity. Many therapists who use psychodramatic methods superficially are identifying the phenomenon of abreactivity with therapeutic productivity. A distinction should be made for theoretical and clinical reasons between abreactive and integrative catharsis. Abreactions per se are often harmful, reinforcing rather than dissolving certain symptoms; this clinical experience is one of the reasons why Freud considered catharsis resulting from abreaction as unsteady and unsatisfactory, and why he replaced it by transference analysis. The abreactions, however, can be turned into reliable therapeutic contributions. Because of their dramatic character they can gain within the psychodramatic framework a new, appropriate, homeopathic character. Here they are not isolated, uncontrollable elements, previously at best food for analytic interpretation, but elements which are turned positive and integrative, as they can be structured into the psychodramatic production in process. Therefore as soon as the psychoanalyst tackles the abreactions and the unconscious *directly,* or if he tries to "provoke" abreactions, then he turns into a psychodramatist and stimulates the patient to react psychodramatically towards him. Whatever the role is which the doctor assumes, he operates then as an analytically oriented psychodramatist would. The modern Mesmerist is in a similar situation. He becomes unknowingly and gradually a hypnodramatist.

In Conclusion

It may be significant to quote here Ferenczi who is usually referred to as the author of active therapy in psychoanalysis and to place his statements side by side with quotations from my own writings. In order to indicate the contrast as clearly as possible I select some quotations from the most characteristic writings of the two authors which appeared at approximately the same time.

S. FERENCZI (1921):

"The fundamentals of psychoanalytic technique have undergone little essential alteration since the introduction of Freud's "fundamental rule" (free association) . . . For most patients the treatment can be carried out without any special "activity" on

J. L. MORENO (1919):

"If you . . . would produce your dramas on this stage they would exert upon you, the original and permanent hero, and everyone in the audience a comical, liberating and purging effect. In playing yourself you see yourself in your own mirror

the part of either doctor or patient, and even in those cases in which one has to proceed more actively the interference should be restricted as much as possible . . . Psychoanalysis as we employ it today is a procedure whose most prominent characteristic is **passivity.**" (See **Theory and Technique of Psychoanalysis,** p. 198 and 199.)

S. FERENCZI (1925):

" . . . One should not employ activity if we can assert with a good conscience that all available methods of the not-active (the more passive) technique have been brought into use . . . The analyst is therefore first and last inactive and independent and may only occasionally encourage the patient to do particular actions." (Op. Cit., 220 and 224.) The kind of activity Ferenczi refers to is for instance, a patient keeps her legs crossed during analysis on the couch and he, Ferenczi, forbids the patient to adopt this position because in so doing she is carrying out a larval form of onanism. (Op Cit., p. 191.)

on the stage, exposed as you are to the entire audience. It is this mirror of you which provokes the deepest laughter in others and in yourself, because you see your own world of past sufferings dissolved into imaginary events. To be is suddenly not painful and sharp, but comical and amusing. All your sorrows of the past and present, outbursts of anger, your desires, your joys, your ecstasies, your victories, your triumphs have become **emptied** of sorrow, anger, desire, joy, ecstasy, victory, triumph, that is, emptied of all **raison d'etre.**" (See "Die Gottheit Als Kommoediant," **Daimon,** April, 1919, Vienna. Transl. **Psychodrama,** Vol. I, p. 24.)

J. L. MORENO (1923):

"The persons play themselves— . . . they do not want to analyze reality, they bring it forth. They produce it, they are master; not as fictitious beings but their true existence . . . The whole of life is unfolded, with all its mutual complications . . . not one instance is extinguished from it, each moment of boredom is retained, every fit of anxiety, every moment of inner withdrawal comes back to life." Here total production of life is brought into view, not total analysis. (Das Stegreiftheater, p. 90-91.)

The ideal objective of psychoanalytic therapy is *total analysis.* It aims to give the patient more analytic insight than the routine of living activates in him spontaneously. The objective of psychodramatic therapy is the opposite; it is *total production* of life, it tries to provide the patient with more reality than the struggle with living permits him to achieve spontaneously, a *"surplus" reality.* The excess of life realization helps the patient to gain control and mastery of self and world through practice, not through analysis. Analysis occurs and is given to the patient whenever necessary but it is an adjunct to psychodrama and not the primary source of catharsis.

THE HYPNODRAMATIC TECHNIQUE

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While hypnosis as an adjunct to therapy has been in use for some time, hypnodrama serves as a vehicle for merging older uses of hypnotherapy with newer concepts of psychodrama. The term and concept of hypnodrama have been introduced by Moreno;* he was also the first to experiment with the technique. Although this technique has been found useful in certain types of cases, the full scope of its applicability has not yet been determined. It is hoped that this, the first in a series of papers on the subject, will stimulate interest in its application and result in research on a broad scale, thus enabling us to make a more accurate evaluation of the technique.

It is probable that workers in the field of hypnotherapy have been using dilute hypnodrama. In abreaction and other procedures which utilize the patient's ability to place himself in situations, the therapist often consciously or unconsciously takes the role of one or more of the people involved, thus becoming an auxiliary ego. In addition, through suggestion he causes the patient to create hallucinatory auxiliary egos. The patient reveals his relationship to these persons and to the situations through verbalization and modified motor activities. Since the patient is usually mildly restrained by the therapist, his actions are inhibited. This constitutes a major block to catharsis, since the organism is not free to express itself in action. The patient is limited in his expression mainly to those feelings and emotions which fall within his vocabulary range.

In hypnodrama the patient is free to *act*, and is given auxiliary egos to help portray his drama. Under these circumstances situations become more real and are more productive in the therapy of the patient.

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*J. L. Moreno, "A Case of Paranoia Treated Through Psychodrama," **Psychodrama Monographs**, No. 15, Beacon House, 1945, p. 16; see also Glossary of Terms, **Sociatry**, Vol. 2, No. 3 & 4, 1949, p. 435; and "Introduction to Hypnodrama," elsewhere in this issue.

Some Theoretical Considerations

The Warming-Up Process and Spontaneity States

In psychodrama the achievement of a state of spontaneous action is dependent upon stimulation of the patient by internal and external processes manipulated between the patient, director, and auxiliary egos. In hypnodrama, the hypnosis acts as a psychological starter for the warming-up process in that it frees the patient from many of his inhibitory barriers, and places him in a condition of readiness to rise to a state of greater spontaneity. It is made possible for the patient to warm up with a minimum of interference from the self.

There are two main types of spontaneity states*. One may be thought of as a comedy role. In this state the individual plays on many emotions without becoming deeply involved with any one emotional tone. He plays the role of the creator of the drama and at the same time is a critical observer of the action. In the other type of spontaneity state he takes one emotional tone and plays it though before going to another. In most psychodramas there are mixed types of spontaneity. The patient will play one or more single emotions through and then go into a short comedy role to regain perspective. This process appears to represent an attempt at maintaining a homeostatic condition regarding his inner needs and the demands of the situation.

Attempts to maintain dual roles in the state of spontaneity are weakened by the hypnosis as many inhibitions are removed, and the freeing of the creative ego is facilitated. There is an inhibition of the patient's acceptance of the roles of creator and observer, through which he may become critical of the performance. Responses to peripheral aspects of the situation, without integrating the deeper levels of the personality, are curbed. As the patient approaches a deeper and less critical state of spontaneity he tends to reject touching upon many emotions without deep involvement. He is more disposed to work out one emotional tone at a time. This results in greater catharsis, further delineation of role range, together with re-evaluation and reorganization of the concept of self. These processes of reorientation occur *in situ* and embody relationships to persons included in the situations portrayed and at crucial points in the situation. Thus they give the therapy more meaning in terms of life outside of the therapeutic setting.

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*J. L. Moreno, Theatre of Spontaneity, Pgs. 445.

While the more profound spontaneity states may be achieved without hypnosis, in many cases it requires long and arduous training. With hypnosis it is achieved more easily.

Pathological spontaneity states seem to occur more readily in hypnodrama than in psychodrama. Techniques for handling these states will be presented following the discussion of the protocol.

Hypnodrama has the advantage of showing the patient's deeper personality structure early in the course of therapy. He responds verbally and kinesthetically to a situation and carries through the action on his own terms, involving the major portions of the personality. There is a minimum of defensive and evasive behavior. This enables the therapist to make a good estimate of the situation in terms of the patient's present functioning, and to base his plan of therapy more directly on the patient's needs. As the patient is treated in inter-action with his social atom, the therapeutic results will be reflected in his extra-therapeutic life in a relatively short time.

Spontaneity training is aided by attaining the more difficult states early in the course of treatment. As therapy continues, the patient finds that lighter states of spontaneity, which mingle emotions, are made richer and become more in balance with his needs in the situation.

A deep catharsis may be obtained while therapy is in its beginning stages. Through hypnosis the gap between the stage *in statu nascendi* and the achievement of the more creative state is decreased. This hastens the development of the patient's ability to warm himself up and to use this ability to achieve states of spontaneity in terms of the moment**. He moves toward a condition wherein he is able to readjust continually as the demands of the situation change.

Action Catharsis

The greater catharsis achieved through action is undeniable. The patient is able to express kinesthetically many feelings for which he has no words. These feelings may be expressed through gestures, changes in posture, more active body movements, and inarticulate sounds. He develops emotional insight regarding himself and his relationships without its necessarily becoming verbalized. This insight is demonstrated through improvement in role function. Deviate behavior becomes more in tune with the situation. In many cases new and more adequate interaction with his social atom becomes evident, even though verbalizations of an insightful nature may be absent.

J. L. Moreno, **Psychodrama, Vol. I, Pgs. 104-105.

Extending situations and fulfilling act hungers which become apparent in the action allow the patient to show himself previously denied roles. His concept of self is thus improved. The lessening of inhibition in hypnodrama makes it possible to gain action catharsis on deep levels. The patient's ability to use symbolism in the expression of feelings may be utilized. Often he is able to verbalize the desire implicit in an act while he is still incapable of performance. In this case he may spontaneously symbolize the object of the incompleted act, then attempt to close the tension system through interaction with the symbol. At times it seems advisable for the director to initiate the process of symbolization so that the patient may gain release from specific tensions.

Hypnodrama forcefully brings out the necessity for considering the symbol as an expression vastly more primitive than words; as embodying several ideas at the same time, rather than being expressive of only one theme. Without knowledge of all the meanings which the symbol may have for the patient in a given situation, attempts at interpretation are at best incomplete. Their therapeutic value becomes doubtful, and clues to tense areas of the personality in its environment are passed without recognition by the therapist or the patient.

In hypnodrama the various meanings of a symbol may be brought to light in a comparatively short time. The techniques used to determine symbol interpretations allow the patient to ascribe the meanings, freeing the interpretations from the involvements of the therapist. At times the patient may not be able to verbalize meanings of the symbols but will gain catharsis and insight through his interaction with them. Work with symbols is possible in psychodrama but is made easier by the use of hypnodrama.

Production Techniques

Induction of Hypnosis

In hypnodrama, hypnosis is induced on the stage. Psychodramatic techniques are used to speed the process and to relate it to the patient's everyday experience. The patient is warmed up in a psychodramatic manner to being in his bedroom or some other situation which he associates with sleep. After the setting becomes real to him, the director continues with the usual suggestive technique for the induction of hypnosis. When the patient is hypnotized the situation for beginning action is brought out through a hypnodramatic interview. As action begins the situation may change; therefore, the entire procedure must be conceived as a flow of the warming-up process which is not rigid in its direction but changes with the demands of therapy.

In order to facilitate the introduction of auxiliary egos, it is advisable to warm up the hypnotized patient to the entire group present. This becomes unnecessary after the first few sessions. Auxiliaries are introduced in essentially the same manner as in psychodrama. The only important differences lies in the pre-action warming-up of auxiliaries. This takes place on the stage more often than is common in psychodrama. Hypnosis does not appear to limit the use of auxiliaries in any way, but allows a more rapid transfiguration of the auxiliary into the role.

Direction

In all action techniques the role taken by the director is defined by the situation of the moment. There are many circumstances which demand that the director become aggressive and structure the situation. Other conditions may require greater patient-direction with comparative passivity on the part of the director. He must assume his roles on a basis of the patient's needs. In making his assessment of these needs, the patient's internal tensions, as well as his position and interaction with his group must be considered. Knowledge of the group structure should be used to direct action toward a restructuring of inadequate relationships and the extension of productive ones.

When therapy is being done in a group situation, the inclusion of the group in the director's thinking is essential. This does not imply any restriction as to material dealt with. The arousal of negative feelings from the group toward the patient is rare. When this does occur it is due to inept therapy. The importance of the therapist's knowing the sociometric structure of his group cannot be over-emphasised, for without this knowledge, adequate group psychotherapy is impossible.

The closing of sessions on a high note is a cardinal principal of psychodrama. This applies in hypnodrama. When the patient has enacted frustrating roles, it becomes extremely important that he be warmed up to a pleasant situation which he can handle to his satisfaction before he is awakened. If this is not done, anxiety or depression may result. He must be given an opportunity to act a successful if not heroic role, thus allowing the warming-up process to become reoriented.

When the patient is out of the hypnosis, the director should interview him psychodramatically and analyze the session. The amount and nature of material retained from the hypnodrama will be brought out. Relationships between this and present or past experiences may be discussed.

In order that the process of hypnodrama be made clear, two sessions are presented below. The first protocol is that of an early session with a physically well developed, well nourished male of 24. He presented behavioral and psychosomatic problems in early childhood. Feelings of guilt, inadequacy, insecurity, and ideas of persecution began to crystalize when he was about sixteen. At this time he started making the rounds of social agencies and receiving therapy. This did not alleviate the situation. Within the home his relationship to his father, stepmother, and sisters was poor. His own mother left his father when the patient was an infant. He lived with his father and sisters until the father remarried when the patient was twelve. His sisters had made homes of their own about two years prior to this marriage. During that interval he had been going to school and keeping house for the father. When the stepmother was brought into the household, he resented her. Apparently she and the patient entered into a battle for the love and attention of the father. At nineteen he had his first brush with the law over stealing from the stepmother. This brought on interviews with psychiatrists, the diagnosis of paranoid schizophrenia with psychopathic trends, and further treatment. Still his adjustment became more inadequate and he was unable to hold a job.

He was brought to Beacon Hill Sanitarium. On arrival his behavior fluctuated between mild hostility and indifference. There was a tendency toward withdrawal and underactivity. He was generally apathetic. Intellectually, psychological tests showed him to be below normal. There was autistic thinking and difficulty with verbalization. Persecutory ideas and concern with his body odors were manifest.

In psychodrama, under comparatively passive direction, his performances were characterized by sluggish movements and difficulty with verbalization. When the director became aggressive he showed increased facility in speech and movement. This led to the decision to use hypnodrama since the director could become extremely aggressive in the induction process, and re-assess the relative aggressiveness of his role as the action began.

To understand the protocol it is necessary to state certain events which were taking place in the patient's life at the time of the session.

He had made friends with a female patient and had been escorting her to the movies with some degree of regularity. The friendship suffered a sudden breach about two days before this session. The girl claimed that he had tried to rape her, an act which he denied. In a later session it developed that in

helping her up some stairs he had put his hand on her shoulder, and noting the usual maze of straps, was prompted to say: "I don't see how you girls can stand wearing all that in this hot weather." Whereupon the girl ran into the house, firm in the conviction that she had been raped. The following session took place between this unhappy event and its clarification. The audience is composed of professional personnel and patients, including the "outraged" girl.

Unfortunately the recorder did not pick up the first step of the process. Actually the patient was seated in a lounge chair with his feet propped on a straight chair. The scene was warmed up to the setting of his resting on the bed in his room. When the scene had become real to him the hypnosis began.

HYPNODRAMA SESSION WITH JOHNNY

Jim Enneis: And now you are asleep—sound asleep. Deeper and deeper in sleep. Put your feet on the floor—put your feet on the floor. Now stand up. Stand up! (Johnny stands up)

Jim: Come over here. Turn around and face the audience. Stand right there. Now when you open your eyes Johnny, you will see a lot of people—you will see a lot of people in front of you—Open your eyes Johnny, and you will see them. (Johnny opens his eyes)

Jim: What are you thinking Johnny?

Johnny: That there is plenty of talk about me.

Jim: Plenty of talk about you—go ahead tell us what you think.

Johnny: They seem to a . . . About my personality.

Jim: What about your personality?

Johnny: The way I talk—the way I walk—my ah—stature. They seem to despise everything about me.

Jim: (whispering) Go ahead.

Johnny: That makes me mad.

Jim: Makes you mad?

Johnny: Yeah.

Jim: You're mad, huh?

Johnny: Yeah.

Jim: What are you going to do about it?

Johnny: Tell them to go to hell.

Jim: Well, why don't you tell them? Tell them off, go ahead!

Johnny: Go to hell, you God damn girls. I don't like girls anyway. They never did any good in this world except make people unhappy. That's all they ever do—just make people unhappy.

Jim: The girls are right here—tell them what you think.

Johnny: Yeah. Make people unhappy—that's all you ever do. I don't care if I ever get married now. I don't like girls anymore. They don't understand me.

Jim: They don't understand you?

Johnny: I try to make them understand but they don't seem to understand me. I try to be good and everything but they seem to—they don't like my—well they like me for a little while and then suddenly they don't like me anymore.

Jim: Why? Why do they suddenly not like you anymore?

Johnny: Maybe because they are traitors—that could be it.

Jim: Traitors?

Johnny: Yeah. Maybe they don't trust me?

Jim: They don't trust you?

Johnny: No.

Jim: (whispering) No!

Johnny: I don't know what to say.

Jim: What do they think you'll do?

Johnny: They think I'm too forward.

Jim: Too forward?

Johnny: And I don't think I'm any such thing as forward.

Jim: They think you're too forward . . .

Johnny: I like to go around with girls—I like a nice intelligent girl—intelligent and nice to be with—nice company but when this happens like this and they talk about me like that, it takes all the interest I had before—it takes it all out of me. I get to be a woman hater. I despise them. I see them on the street and I don't even look at them. I even despise my own sisters because they're girls. My stepmother is a woman—she—she practically ruined my life. My mother left me when I was small—she was a woman. What did I get from her? Nothing.

Jim: Go ahead Johnny.

Johnny: (Doesn't answer. Two female auxiliary egos are brought on stage and pantomime conversation begins.)

Jim: Who is that over there, Johnny?

Johnny: Elizabeth and Yvonne.

Jim: That's your stepmother over there. She's talking to her friend about you.

Johnny: Yeah, that's my stepmother.

Jim: That's your stepmother; she's talking about you. What's she saying, John?

Johnny: (Intently watching the stepmother and her friend.) That woman will never rest until she knows that my life is completely ruined. My stepmother—she's old and she's lived her life and she's got one more thing to fulfill before she dies and that's to ruin my life, and she's making a good job of it, with the help of others—spies she has—so called spies—that's what I call them. They're going around town trying to pick up every bit of information that they can so that they can talk about me.

Jim: What do they report to her?

Johnny: How I act—my speech—that I was seen out on the street at one o'clock in the morning talking to a fellow and that I can't be doing anything worthwhile at that hour. I should be in bed.

Jim: What else does she say?

Johnny: She says that she's going to hang me—someday she is going to bring me in jail—behind bars.

Jim: She's saying what?

Johnny: She's saying that she's going to see me behind bars someday.

Jim: That she's going to see you behind bars someday?

Johnny: In fact she said that that's where I'm going to end up.

Jim: That's where you're going to end up?

(Elizabeth and Yvonne acting as stepmother and friend talking about Johnny in Italian dialect about how he always wants to eat)

Johnny: She hides every bit of the food and keeps it under lock and key. If I want to eat, I have to ask her permission and when I ask her she says no.

Elizabeth: That's a lie. I've struggled all my life. I hate you. I've had such a hard life. I've suffered all my life.

Jim: What are you thinking Johnny? Say what you think, Johnny.

Johnny: She always kept saying that she didn't know how she was going to put up with that boy Johnny in the house.

Jim: What are you going to do about it?

Johnny: I want to get the hell out of that house. I can't stand on my own two feet in that house.

Elizabeth: (As stepmother—continuing to argue and talk about him, provoking Johnny as much as possible.) I will throw him out of the house, that's what I will do.

Jim: What are you thinking Johnny? What are you going to do about it?

Johnny: I can't do anything. It seems all the confidence I had in myself has been all drained out of me.

Jim: All drained out of you? And who drained it out of you?

Johnny: The continuous nagging—it's all been drained out of me. I just want to go in the kitchen and sit down and read a prayer.

Jim: You just want to go in the kitchen and read a prayer?

Johnny: Yeah.

Jim: All right, go into the kitchen.

Elizabeth: That's all he does. (Shouting) He sits and sits all day long.

Jim: You're sitting in the kitchen Johnny. What are you thinking Johnny?

Johnny: That's what got me, the continuous shouting. I wish the world would just crack open and everything would fall into it—like a—a universal earthquake. That's what I think.

Jim: Yes.

Johnny: I don't like anything. I despise myself—I hate myself—I hate—I hate my father—I hate my whole family. I don't want to be with anybody. I want to be by myself. I want to eat by myself. I want to be by myself. I have no interest—no love—no interest in meeting new people or nothing. (Johnny looks at the floor.)

Jim: What is that on the floor, Johnny?

Johnny: (Doesn't answer.)

Jim: Well?

Johnny: It seems like it's pulling my left leg—strong—I can't pull it back. (Johnny shows muscular strain in left leg.)

Jim: What is this force? Where is it coming from?

Johnny: It seems to be coming from that direction there but I don't see anything.

Jim: Look harder and you'll see where it is. See? See?

Johnny: It looks like some kind of a thing—what the devil is it? It looks like some kind of a lizard.

Jim: A kind of a lizard?

Johnny: It may be a snake or something. I never saw anything like that.

Jim: How does it look?

Johnny: It has a big long tail—it's got legs . . . . .

Jim: Well, look at the animal—how does it look?

Johnny: A head like a snake—it looks like a . . . . It's a lizard. Big feet with nails sticking out, three eyes and it looks like it can get a hold of me and eat me up.

Jim: What's it doing there?

Johnny: It's breathing hard and it's mouth is going up and down. He's looking at me—right in my eyes.

Jim: Keep looking at him, Johnny. Tell us what he does?

Johnny: He's making a noise and he has all scales all over his body. All kinds of scales. They seem to be very crusty and hard.

Jim: What sort of features does he have?

Johnny: A snake-like head.

Jim: Snake-like head?

Johnny: And a snake-like body but he has legs.

Jim: Look at his eyes, Johnny. Look at his face.

Johnny: I can't seem to move that leg now.

Jim: Can't move that leg?

Johnny: My left leg. (Makes unsuccessful attempts to move his left leg. His face expresses fear and is half turned away from the direction of the lizard. Both hands are clasped tensely around the calf of his leg. His body is half crouched and bent over.)

Jim: What is he doing to your body? Is he drawing you to him?

Johnny: I don't know. I can't seem to have any strength in my leg to move.

Jim: No!

Johnny: It just wants to stay there.

Jim: Wants to stay there?

Johnny: He seems to be more powerful than my own mind and makes me keep my leg there.

Jim: Yes. What's he going to do? What's he doing, Johnny, look at him!

Johnny: (Shuddering) It makes my blood run cold when I look at it. (Turns his face a little more, stares in horror at one spot on the floor. He is perspiring rather heavily.)

Jim: Why?

Johnny: Because—he must have tremendous strength in his jaws? If he ever grabbed my leg it would sure . . . .

Jim: Is he going to grab your leg?

Johnny: No, he seems to know that I won't move and he's taking advantage of it!

Jim: How is he taking advantage of what?

Johnny: He knows he's got me where he wants me and he wants to make me suffer a little, like a cat plays with a mouse before he kills it.

Jim: So, he's playing with you now?

Johnny: Yes. (Turns his head away again.)

Jim: Who is he, Johnny. Look at it! Who is it?

Johnny: That's my stepmother's nephew.

Jim: Your stepmother's nephew?

Johnny: That's right.

Jim: Yes sir, it is. It's your stepmother's nephew! What's he doing?

Johnny: He's looking at me yet.

Jim: What about your leg? Can you do anything about it?

Johnny: Now, I can move. I can move it up and down. (Does this once, then stops.) But I'm afraid to move it because he might make a lunge at me and snap my leg in his jaws.

Jim: Does he look as if he is going to do that?

Johnny: Yes. It seems that he moves his jaws if I move my leg a little and he's very fast and I'm afraid he might snap my leg in half.

Jim: Are you going to stay there all day?

Johnny: (Uncertainly) I don't know!

Jim: Forever? The rest of your life?

Johnny: I want to move but I'm scared. I'm just being cautious. I'm just staying here—I'm just hoping that someone will come in and kill it. Get behind it's back.

Jim: Why don't you kill it? You're the one that should kill it!

Johnny: I'm afraid to move. I wish I had a—a gun or something and then I would shoot it right between the eyes. There's nothing here in the kitchen to kill it with.

Jim: No gun in the kitchen?

Johnny: No.

What else is there in the kitchen that you might use?

Johnny: (With much feeling) There's nothing that will kill that—horrible looking—I don't know what to call it. It's got such thick scales all over its body.

Jim: What are you going to do about it?

Johnny: I yell for help.

Jim: Well, yell for help.

Johnny: It don't do any good.

Jim: Yell and see!

Johnny: I yell for my father. (He makes a feeble attempt.)

Jim: Well, yell for him! Holler for him!

Johnny: It doesn't do any good.

Jim: Try! You never know until you try. Try!

Johnny: He's working, my father.

Jim: He's not there?

Johnny: He's working—he's not in the house. I want to call anybody.

Jim: Well, call somebody.

Johnny: There doesn't seem to be anybody home. The people upstairs are out.

Jim: Well, what are you going to do? You can't just stay there.

Johnny: I'm afraid—I can feel a thud in my chest.

Jim: Watch it. Watch him, Johnny!

Johnny: He's starting to breathe deeper.

Jim: Breathing deeper? He's getting tense, Johnny!

(At this point it was decided to see the effect of a male and female directing together, so Zerka was sent up on the stage.)

Johnny: I know there's no use trying to fight that thing . . .

Jim: Watch his eyes, Johnny!

Zerka: Watch his eyes!

Johnny: His eyes seem to be getting bigger.

Jim: Yes and he's coming closer!

Zerka: Closer!

Jim: He's going to lunge.

Johnny: He's getting tired of playing and he's going to try something.

Jim: Yes, he's going to try something.

Zerka: What are you going to try?

Jim: Watch him, Johnny! Look at him!

Zerka: Look at his eyes!

Johnny: He's going to grab my leg—better to step away than lose my life. If he grabs my leg and breaks it off—I'll run—I'll go in the other room or someplace and close the door behind me.

Jim: Watch him Johnny. He's getting higher and higher. Look at him!

Zerka: Look at him. Watch him!

Johnny: I'll get something and put it between us.

Jim: Watch him. Look at his eyes!

Zerka: He's getting ready for something!

Johnny: He's got me licked. I can't do anything.

Jim: He's getting more and more tense.

Zerka: He's coming closer.

Jim: He's getting ready to spring. Look at his jaws!

Zerka: Look at them!

Jim: Look at those jaws.

Johnny: His mouth is open.

Jim: Yes!

Johnny! He's got a different shaped tooth. Now, he's got me scared, I can't move. I'm paralyzed.

Jim: He's beginning to breathe harder again!

Zerka: Can you see the scales?

Johnny: It's no use—I can't move. I just can't.

Jim: Well, try! He's tired—tired of waiting—tired of playing.

Zerka: He's mad too.

Johnny: I think he's trying to frighten me to death—that's what he is trying to do.

Jim: He's crouching again!

Zerka: He's going to get you!

Johnny: I can't seem to move—I have no will to move. I just want to sit here and be scared.

Jim: He's not going to let you stay there and be scared. He's going to lunge!

Zerka: He's not waiting!

Johnny: I know he'll bite.

Jim: He's going to bite.

Johnny: Even if he bites, I still don't want to move.

Jim: He's still going to bite. Watch him.

Zerka: He'll eat you. What are you going to do, Johnny?

Johnny: I feel like a . . . . I'm so disgusted that I don't care what the hell happens.

Jim: Watch him, Johnny! Watch those jaws! Look at him! Look at him! He's getting his mouth open bigger and bigger as if he's going to bite any minute. He's getting more and more tense. Watch him, Johnny! Watch him close!

Zerka: You just can't sit there! Watch him!

Jim: Watch him! He's looking at your leg, John. Look!

Johnny: He's looking at my feet. That's right.

Jim: Yes. He's looking at your feet.

Zerka: Are you going to let him get your foot?

Johnny: Now, he's making sounds with his throat.

Jim: Yes, hear them.

Johnny: Huh! I don't know whether to laugh or cry or what to do.

Zerka: What are you going to do with your foot? Are you going to keep it there?

Johnny: No, I'll move my foot.

Jim: He's going to get it, John. He's getting ready. See!!

Johnny: The only way I'll escape this thing—the table is in front of me. If I manage to move my other foot behind the table, to distract his attention and with a quick push, push the table in front of him and run away . . .

Jim: And run away? He'll follow you, Johnny.

Johnny: I can run faster than he can.

Zerka: Move your foot away, Johnny.

Johnny: I can move the table in front of him.

Jim: He's getting closer, Johnny.

Zerka: I can hear him now. He's moving.

Jim: Look at those teeth!

Zerka: His breath! His mouth!

Jim: He might bite!

Johnny: (Wincing) He's biting me now.

Jim: Yes, you can feel him on your foot. Feel those teeth sinking in!

Zerka: Deeper! Deeper!

Jim: They hurt, don't they?

Johnny: It's like something that's been after me for so many years and finally got me. He is all the people who have hurt me—my stepmother's nephew, my uncle, my father, my stepmother and all the others. His teeth are right in my leg.

Jim: Where are his teeth?

Johnny: Right here. (Pointing to leg)

Jim: How does it feel?

Johnny: Like a . . . Like a thousand needles in my leg.

Zerka: Can you pull it away?

Johnny: I can't. He bit me and he's got his jaws around my leg. My leg—the pain is terrible. I can't stand it.

Jim: Can you move the leg away?

Johnny: No, I can't move.

Jim: What are you going to do about it, John? Pull him off! Pull him off!

Johnny: I can't. He's too heavy.

Jim: Try! You must try!

Johnny: His teeth are sunk right in my leg.

Zerka: Can't you pull it away?

Johnny: I can't. He's too heavy. The more I try—I can't even move my own leg.

Zerka: Can't you do anything with your hands?

Johnny: It will be useless—His strength is too—He's got a thick coat of scales around him. He's protected in all ways.

Jim: Who is he, John?

Johnny: It's my stepmother's nephew.

Zerka: What's his name?

Johnny: Jerry.

Jim: Has he been turned against you, Johnny?

Johnny: His mind has been poisoned by my stepmother, by exaggerated lies. Other people that know me have told him how exaggerated they were.

Jim: How did he get those scales?

Johnny: I don't know. He's got them.

Zerka: Did he always have them?

Johnny: As soon as I saw that beast or whatever it is, I knew it was something that was out of this world. I don't think it can even be killed with a gun.

Zerka: Does she like him?

Johnny: She does like him. Yes!

Zerka: She likes him better than you?

Johnny: Oh—she even likes the dirt that she walks on, better than me.

Zerka: She loves a miserable animal like that and she doesn't love you.

Johnny: She despises the ground that I walk on—my stepmother does.

Zerka: She loves that beast there (With contempt).

Johnny: She's wanted me out of the way as long as I can remember. I couldn't even communicate with my father during the daytime; she'd be sneaking around listening. One time I was talking with my father and she didn't know I saw her, but she was sneaking there near the doorway listening to what my father and I were talking about.

Jim: The beast looks like her, doesn't it?

Johnny: Yes, it does.

Jim: What are you going to do about it, John? The teeth are sinking in further and further.

Zerka: You won't have any leg left, if this keeps up.

Johnny: I can't help it—I . . . .

Jim: Try to pull him off!

Johnny: I want to move away yet I can't . . .

Jim: Grab your leg and try to pull him off!

Johnny: (Makes a half-hearted attempt.) It's useless—it's useless.

Jim: It's not useless, John. Try!

Zerka: You want to have a leg, don't you? She won't give you a leg to stand on—you've got to keep your own leg.

Johnny: She wants me to be a cripple. She said so, "I wish you were a cripple."

Zerka: Well, don't give them a chance to do this to you, John. Get rid of it! Get rid of it!

Jim: Pull it!

Johnny: (Pulling at it)

Zerka: Harder! That's not the way.

Jim: Use your hands.

Zerka: Push it—push it away. Give it to him!

Johnny: I'm pounding his head and he's making a loud noise but it doesn't seem to hurt him. (Pushes with something in his hands.)

Jim: Try again, John! Harder!

Zerka: More!

Johnny: He's crouching and he's foaming at the mouth—all foam all over his mouth. I'm using the leg of the table to push him away.

Jim: Pull him off!

Johnny: He's getting mad.

Jim: Pull his head.

Johnny: I've tried but I can't.

Zerka: Keep at it—get rid of him.

Jim: Hit him with the table!

Zerka: Harder! Harder! Smash him!

Johnny: I'm hitting him with the leg of the table and it doesn't seem to be making even a dent.

Zerka: Smash It!

Johnny: He's making a sort of "ooooh" noise like that. He's very aggrevated now—very mad—

Zerka: Give it to him, John!

Johnny: All foam is coming out of his mouth. His mouth is so—like a . . . . . He seems to be worried now—he seems to know that I'm making an attempt to get away now.

Zerka: What about that leg, John? What about that leg?

Jim: Push him away again, with the table. Push hard, John! Push!

Zerka: Go ahead, Johnny.

Jim: You can beat him off!

Johnny: This thing is powerful.

Jim: Push harder, Johnny, you can get him off.

Johnny: I know I—he knows—he knows that I'm trying to get the courage to fight him back and he knows I'm doing a good job of it.

Jim: Sure you are, John!

Johnny: He's getting madder and madder.

Zerka: What are you going to do, John?

Johnny: I could . . . .

Jim: Push that head away—harder!

Zerka: What is he doing to your leg now?

Johnny: If I want to get away, I'll just get a club and throw it at his mouth. His mouth is burning now.

Jim: Push that thing harder and make him turn loose. Push that table at him and then you can get away. Push!

Zerka: Give him one good push! Go ahead give it to him!

Jim: Push it! Squeeze it!

Johnny: I'll try and crush that skull.

Jim: Well, go ahead and crush his skull!

Zerka: Kill it!

Johnny: I'm getting more power in my hands.

Zerka: More! More!

Johnny: I'll grit my teeth together. (Grits teeth.)

Jim: Go ahead and push harder.

Zerka: What about your leg, John?

Johnny: I think his grip is loosening.

Zerka: Good!

Johnny: But there's a deep gash in my leg.

Jim: You've got to kill him before you can do anything else. Get something to kill him with, Johnny.

Johnny: He's thumping his tail back and forth. If I can keep him there and get a heavy object—I'll concentrate on his head.

Jim: Go ahead and give it to him good, Johnny.

Johnny: His head isn't as good and as well protected as his body is. I'll concentrate on top of his head.

Zerka: Go ahead, John! Go ahead!

Jim: Get something to beat him with!

Zerka: Is there a knife in the kitchen?

Johnny: A knife wouldn't be any good. If I try to reach out, he might snap and grab my arm.

Jim: Get a club!

Johnny: It's going to be hard to kill this thing. I'll have to do it with the top of the table. (Pushes table in direction of the lizard.)

Zerka: That ought to do it. Give it to him.

Johnny: The leg of the table is about ¾ of an inch away from his head. Right now he seems to be going into a fit.

Jim: Give it to him, John.

Johnny: He's jumping all over the place. There seems to be a funny substance oozing out of his head—his brain—that might be his brain. Boy, how I hate this thing and my stepmother.

Jim: Did you step on his head? Is that your stepmother or your stepmother's nephew?

Johnny: That's my stepmother's nephew—that's my stepmother's nephew.

Zerka: Are you going to leave him right there?

Jim: Watch him, John. He might try to escape.

Johnny: I'm going to kill him and he won't escape.

Zerka: Give him a good heavy one.

Jim: Go ahead and give it to him good, Johnny.

Zerka: Go ahead and make it good and strong.

Johnny: I'm pushing this table further and further in his head. (Makes pushing motion again.)

Jim: Yes.

Johnny: I've got it about six inches in his head. (Pushing harder.)

Zerka: Ah, that did it.

Johnny: Oh—all white stuff is coming out of his brain—that's his brain. Oh—it makes me—I could almost throw up—that stuff keeps coming out of his head.

Zerka: Kill it! Kill it! Get rid of it! You have to finish it up.

Johnny: His mouth is all—keeps closing and opening.

Jim: Keep sticking it in him. Tell us what you think—tell us what is happening.

Johnny: I feel good—it gives me a good feeling now. (Keeps making pushing motion with table.)

Zerka: How is your leg, Johnny?

Johnny: My leg is—the pain in my leg—but I forget about that and concentrate on him.

Zerka: Is he still moving John?

Johnny: Not much but he's not dead yet—far from dead.

Zerka: John, what is he doing now?

Johnny: His mouth is opening and closing—he's going like this (Showing Zerka).

Jim: Look at the way he is moving around, Johnny.

Zerka: Look at him, the way he's thrashing. Hit him hard!

Johnny: I spit on him. (Spits)

Zerka: Kick him too—kick him hard!

Jim: Go ahead and spit on him some more.

Johnny: I want to kick him but I don't want to hurt my feet.

Jim: What does it look like, John?

Johnny: It's just like a cat . . . . that's been caught by a heavy truck.

Jim: Go ahead and look at him!

Johnny: It's just a bloody mess—his skin and scales all over the place—his head—there's just a white substance that's oozing out of his head.

Jim: Look at it.

Johnny: His eyes are—I can see his eyes—his eyes are open. (Looks with disgust turn his head away.)

Jim: Keep looking at it, what is it?

Zerka: What are you going to do with all that stuff, John?

Jim: Call the police department and tell them to send someone from the sanitation department to come and pick it up.

Johnny: No, I don't want to call them up.

Jim: Call them up and tell them to come.

Zerka: Come, let's call them up.

Johnny: You call them up.

Zerka: Okay, "Hello, please send over a truck with a hose, we have to clean a mess in the kitchen."

Jim: Well, John, that's all. (John walks away.) Where are you going?

Johnny: Ah—down to the corner.

Jim: Not yet, how do you feel?

Johnny: I feel just the way I felt when I was sleeping in the bed in the house—afraid, depressed, no confidence in myself, no interest in anything. Even after I destroyed that thing, I still have no feeling—isn't that funny?

Jim: What would have happened if you hadn't destroyed that thing?

Johnny: I still haven't destroyed the past, people when they see me, still remember the past—what they heard about me and they're still doubtful about what kind of a person I am. Even though I wiped it out completely, I'll never feel free—I'll still feel depressed and never relieved—I'll always be very dull, unhappy and sorrowful, doubtful. Everyone talks about me—that's what hurts, especially when they don't tell it to my face.

Zerka: What are they talking about?

Johnny: They're calling me names.

Zerka: What are they saying?

Johnny: That I'm—I'm no good. I know that, that's not true and I'm not exactly an angel but that's not true what they are saying.

Zerka: But they talk anway.

Johnny: They talk anyway. They use me for their gossip at all times.

Zerka: You can show them—you can show them that you are alright.

Johnny: I can show them but still I haven't got the will to do it—I want to do it and yet I can't.

Jim: What can't you do, Johnny?

Johnny: I can't go out and show them what kind of a person I really am.

Zerka: Why not?

Johnny: I know down deep in my heart that I can do it but I can't seem to do it. I feel like there's another million of those things I have to kill first. When I think of the job that I had to kill that thing—to make me discover that I could kill a million of them before I can wipe the past all out.

Jim: Is the pain still there?

Johnny: No, my leg feels swollen. (Presses his hands on his calf.)

Zerka: It's beginning to go away though—just take the poison out—make it bleed a little bit.

Johnny: No, I can't even feel the pressure I put on my leg with my hand—it's completely numb—from the knee down. It seems like it's way in to the bone and like I lost that part of my leg from the knee down. I got rid of that beast but that woman wants me out of the way.

Zerka: Maybe she's one herself.

Johnny: She is one. She's one that has all kinds of power—just like a devil. She seems to be helped by some strange kind of power—she's got a lot of power for a woman her age. She's strong—she's pretty well educated—she can read and write and she understands English and she can read a little English. She's got power, you know. She's very much against me, that woman.

Zerka: What kind of power does she have, John?

Johnny: You know the kind of people that can communicate with people.

Zerka: Yes.

Johnny: She can start a campaign of propaganda in that town and I had to leave Hackensack—Just one person to spread a rumor around and that rumor can ruin my life. That's what she's doing and it actually succeeded and she knows it.

Zerka: Why do you let her get away with it, John?

Johnny: There's nothing I can do about it.

Zerka: You can start a campaign of your own.

Johnny: I've tried that and I've tried everything. I've tried to consult with my father but he wouldn't understand. He opposed me—his mind had been poisoned. Everybody I know had heard this rumor about me. I walk down the street and people look like they are spying on me—watching every move I make.

Jim: Walk up the street, John, and let's see what happens. Walk down the street. Here is the street. (Takes Johnny by the hand. They walk around the stage together.)

Johnny: In fact I'm walking in a lonely part of the town, so I don't have to see any people. I'm afraid to meet people with those rumors floating around and when I see somebody, I cross the street. I walk on the other side.

Jim: Why do you cross to the other side?

(Zerka is called off the stage here and Jim continues directing alone.)

Johnny: Because I—I don't want to meet anybody. It gives me a lousy feeling—a feeling of guilt—I shouldn't have that feeling of guilt but yet I do have that feeling. She saw me cross the street and walk on the other side and I can imagine what she's thinking. She's probably thinking I've got a guilty conscience.

Jim: She's not here now and there is no one here that you are ashamed to meet. You're walking towards the white house. Walking towards the white house. (Drops Johnny's hand and Johnny walks slowly on, then stops.)

Johnny: I see a lot of people.

Jim: But there is no one here that you fear—you can go in the white house and go to bed. How is your leg now?

Johnny: It's better but it still feels numb.

Jim: Your leg is better and it will keep getting better. You will be able in a little while to use it completely. You will be able to use it fully. It feels good now doesn't it?

Johnny: Yes.

Jim: In a little while you will go upstairs and go to sleep. You feel very good and very relaxed. Very secure—very comfortable and very secure. You feel yourself sinking deeper and deeper into sleep. You're becoming more and more comfortable and more and more secure. It makes you feel very, very comfortable and very secure. You're going to sink even more deeply than you are now. You're beginning to feel very very good, very very comfortable. Very very good. You're going deeper and deeper. Deeper and deeper all the time. Now you are asleep. Now you are asleep. Sound asleep. Sound asleep.

Johnny: It's hot and stuffy.

Jim: You are in the woods. You see yourself in those woods. See the trees.

Johnny: I don't want to walk there.

Jim: You don't want to walk there? Where do you want to walk?

Johnny: I don't want to walk.

Jim: What do you want to do?

Johnny: I want to go and stay in my room.

Jim: You want to go and stay in your room.

Johnny: Yes, I want to stay in my room.

Jim: Yes.

Johnny: I don't want to go anyplace. That's all I want to do.

Jim: Why don't you want to do anything?

Johnny: That's where I would be now. (Walks to a chair and sits down.)

Jim: That's where you would be now—that's why you are in your room. Your windows are open. You hear the crickets outside. Now you are going to think about all the things you did yesterday. Remember yesterday afternoon. You were out on the lawn by the tennis court. You are thinking about these things and you are sitting on your bed in your room. Now take a deep breath

of that fresh air. As you are thinking of these things. You are going to sleep, deeper and deeper to sleep. You are thinking about yesterday, you were playing ball. You had a good time yesterday, playing ball. That's a good game isn't it?

Johnny: Yes. I hurt my finger.

Jim: You hurt your finger out there yesterday, playing kick the bat. Do you want to play kick the bat now? You would, wouldn't you?

Johnny: I'd like to break something.

Jim: What would you like to break?

Johnny: Anything.

Jim: Anything. What would you like to break?

Johnny: I'd just like to break things and play tricks on people. To hurt people as much as possible.

Jim: What people?

Johnny: All kinds of people.

Jim: All kinds of people?

Johnny: I want to throw things at them.

Jim: Alright.

Johnny: I want to hurt people because I've been hurt so much and I want to hurt them—I want to hurt people myself. I don't want to kill them, I just want to destroy them.

Jim: You want to destroy them?

Johnny: Yes.

Jim: What do you want to destroy?

Johnny: Everything.

Jim: Everything.

Johnny: Yes. Everything that people have built, I would like to break. Maybe that will hurt them.

Jim: Hmm. Why?

Johnny: It gives me a feeling . . . . ah—that I've hurt somebody. I want to hurt people myself.

Jim: What people?

Johnny: All people.

Jim: You mean the people here too?

Johnny: Everybody.

Jim: Everybody here has hurt you?

Johnny: Everybody—except—but they aren't here. Everybody.

Jim: Everybody here has hurt you. How has everybody hurt you?

Johnny: They haven't hurt me physically but with their talk, and with words.

Jim: What did they say?

Johnny: I don't want to talk about it. They've just hurt me, that's all.

Jim: They've just hurt you. Do you think they meant to?

Johnny: To my knowledge, yes. They might think before they speak. I feel worried and depressed.

Jim: Is that feeling past or is it still with you?

Johnny: Yes, I keep remembering.

Jim: Why? Are you punishing yourself?

Johnny: I am punishing myself.

Jim: Why?

Johnny: Because I keep thinking things over and over.

Jim: What things?

Johnny: I remember July 4th; we were eating outside in the afternoon and I remember seeing my father and my sister with me. Dr. Moreno was there and he spoke highly of me. He said something to my father and my sister. It affected me—I felt like—it made me lost all my trust, I felt all confused. He made me feel like a lazy good for nothing dog. He said there wasn't anything wrong with me. He said that to my sister. There must be something wrong.

Dr. Moreno: I'm sorry if you misunderstood me, John. It was because I wanted to express my opinion that you can get well. I meant that there is nothing organically wrong with you that you cannot make good. I believe that Johnny will get well completely. I want John to understand that as we are here in the treatment room and I believe he will get completely well..

Jim: Do you understand now?

Johnny: Yes, I understand .

Jim: You understand now and it makes you feel better, doesn't it?

Johnny: Yes, it does.

Dr. Moreno: I think Johnny has done wonderfully and that he will get entirely well. He will go home and go to work and show his stepmother and her friends that he is able to contribute something to the world. I believe that someday he will find a girl that will love him and whom he will love and will be able to spend the rest of his life with.

Jim: That sounds good, doesn't it, John?

Johnny: Yes, it does. It seems to put a sparkle of life in my system, just by saying that.

Jim: Of course it does, because you know it's true. Do you know it's true?

Dr. Moreno: We all like John and respect him.

Jim: Makes you feel good, doesn't it?

Johnny: Yes, but I . . . . I want to be fair to everybody but yet people get the wrong impression of me. I do my best for people—I try to be sensible —I try to be good to them and yet it always ends up that people get the wrong impression of me.

Jim: Did you get the right impression of what Dr. Moreno said, John?

Johnny: What do you mean?

Jim: About what he said during the 4th of July.

Johnny: Yes, I understand now.

Jim: Well, then you have to allow other people to make a few errors also. You didn't understand until he explained to you.

Johnny: I understand now that he has explained.

Jim: Well, will you allow other people a few errors then?

Johnny: Yes.

Jim: John, I'm going to wake you up now. (Puts his hand on his arm in a reassuring manner.) I'm going to wake you up. You're going to feel good. You're going to feel more comfortable, more relaxed and more rested. I'm going to count to six and when I finish you will be fully awake. One, two, three, four, five, and six. Get up. Wake up. Get up from there. Let me see. How do you feel?

Johnny: (Stands up) Alright.

Dr. Moreno: Now, perhaps a few words before we close. It explicitly shows that hypnosis working with psychodrama produces a lot of valuable material. Hypnosis, psychoanalysis and psychodrama are here combined. We have to maintain the unity in the warming-up process. A unity between the director and the actor, the director and the double. If this unity is working then hypnodrama is possible. (To Johnny) Do you remember anything you said during the test?

Johnny: I don't know.

Dr. Moreno: Do you remember with whom you spoke?

Johnny: I spoke to Mr. Enneis.

Dr.Moreno: With whom else?

Johnny: That's all.

Dr. Moreno: Were any other people on the stage besides Mr. Enneis at any time?

Johnny: Yes.

Dr. Moreno: Who?

Johnny: Three other people.

Dr. Moreno: Who were they?

Johnny: Elizabeth, Yvonne and Zerka.

Dr. Moreno: Did you speak with anybody else?

Johnny: No.

Dr. Moreno: Did anybody in the audience try to speak to you?

Johnny: No.

Dr. Moreno: Well, all the people who worked on the stage have a high regard for you. Recently I spoke to your father and sister. Do you remember that?

Johnny: No, I don't remember.

Dr. Moreno, Well, it was out on the lawn. Do you remember that?

Johnny: Yes, I remember that.

Dr. Moreno: Do you remember what happened then?

Johnny: Yes, I remember.

Dr. Moreno: What happened?

Johnny: We were eating our pie.

Dr. Moreno: Yes and they asked me about you. What did I say? Do you remember?

Johnny: You said that you thought highly of me and that there was nothing wrong with me.

Dr. Moreno: Yes, that's right. That's what I said. How did you feel when I said that?

Johnny: I felt this way . . . .

Dr. Moreno: Yes.

Johnny: That you are a doctor and you know your business and you can tell when there is something wrong with a person or not, so if there is nothing wrong with me, let's just say that I'm no good and lazy and that's what I thought.

Dr. Moreno: I didn't mean it that way. I didn't want your family to think that you are so sick that you will never get well. Do you know what I mean? I didn't want them to go home thinking that you are very sick and there isn't any possibility of your getting well. Do you understand now?

Johnny: Yes and I didn't think of it that way.

Dr. Moreno: I want you to understand Johnny that everyone here likes you and that we trust you implicitly. You have been very helpful. Thank you.

Discussion of Session

As the session opens, the patient is made conscious of the audience. He is then asked to give his thoughts *in situ*. The purpose is to try to get him to take the initiative in setting the scene for action. He does this. The effect of the tele between the patient and the audience is shown as he begins to warm himself up to the strained relationship with his one-time girl friend. As the warming-up continues, he moves toward a more basic pathology in his relationship with women through expressing the inadequacy of the roles played by his stepmother and mother in his life. This constitutes a major problem in his adjustment and it is deemed advisable to give catharsis in this area.

Two female auxiliaries are brought on stage and given the role of the stepmother and friend. They pantomime conversation, waiting for the patient to set the content and emotional tone for their action and audible dialogue. This is an example of the auxiliaries being warmed up on stage, and of the patient's beginning to direct them in their inter-action with him. In this session he uses the auxiliaries to mirror for us and for himself his concept of the stepmother's relationship to him.

As the action continues he verbalizes the effect which he feels the relationship has had upon him. He reacts by withdrawing into the kitchen where he begins to verbalize his own feelings of hostility and inadequacy. The warming-up continues in the direction of aggressive action taken toward him but now, in order to make the catharsis more complete, he spontaneously symbolizes the aggressors. During a soliloquy expressing the hopelessness of his existence he stares at the floor. First as a force and then as an animal he begins the process of symbolization. In past sessions he has spontaneously brought in snakes under similar circumstances. This is a new beast. The psychoanalytic interpretation of the animal is obvious and probably true, but not complete. His action and the actions which he ascribes to the animal show that it has multiple meaning. As the creature teases him he gives it the additional meaning of a specific person. His position becomes one of frightened passivity and hopelessness. He wishes to be rid of his tormentor but cannot take the action himself and rejects the possibility of help from others. He would be content to leave things as they are, but in order to force more aggressive behavior the director begins extending the scene, thus fulfilling the fears of the patient so that overt action will be taken.

As the animal attacks he recognizes it as representing all of the people who have hurt him and names several specifically. He attempts to play a defeated role but the director persists in forcing action on his part. As this continues he accepts the symbol, first as his stepmother's nephew and then as the stepmother, expressing his feelings about the relationship between these two, himself, and his father. At this point the director becomes more insistent in pushing the patient toward aggressive action rather than allowing him to accept what he considers to be the inevitable.

The degree of the patient's involvement after having killed the beast can be seen through his revulsion at the sight of the symbolic mess on the stage. Immediately after killing the animal he experiences a feeling of well-being for a short period of time. As the direction of the warming-up continues toward a job which he has considered completed, this feeling begins to dissipate. When it becomes necessary for him to have someone else's aid in cleaning up the mess, we observe the development of pathology in the warming-up. It would appear that a cooling-off process had already begun, reached a plateau and reversed itself to a warming-up in a new direction, that is, toward himself. He reverts once more to withdrawal and feelings of hopelessness. This brings him back to the situation with the girl.

Attempts at warming him up to further action in terms of the stepmother or the symbol are largely unsuccessful. As he shifts the scene of his action he begins to take over the direction more and more but his warming-up is more diffuse and he begins to warm up toward the symbol audience, past action and himself in a spotty manner. He resists suggestions of the hypnotist and tries to attain a state of immobility. Gradually he warms up to the group structure within the audience and brings out new material concerning his relationships within the institution. Here the action begins to take place between the patient on the stage and Dr. Moreno in the audience. As this new action progresses it begins to take on pleasant meaning for him, thus arriving at a point at which the session, under hypnosis, may be closed.

It seems advisable to use hypnodrama in conjunction with psychodrama so that we have a constant check on the patient's functioning level in the waking state.

Since this paper purports to describe a technique rather than a case history, no analysis of the psychopathology will be made. It may be of interest to the reader, however, to know that this patient has left the institution, obtained a job and has been getting along well for several months.

SECOND PROTOCOL
PSYCHODRAMA SESSION WITH SUSAN

(The subject, a young negro woman is hypnotized and the drama begins.)

Jim: What are you thinking Susan?

Susan: I am thinking of mother and me back when I was twenty-two.

Jim: Where are you?

Susan: At home with mother sitting on the porch.

Jim: Just you and your mother?

Susan: Yes. I was reading and talking.

Jim: Where is home?

Susan: Baltimore.

Jim: Address?

Susan: 501 East 105th Street.

Jim: Stand up Susan and set up the scene.

(Susan stands and moves to the lower level of the stage.)

Susan: This is the house here (points toward the rear of the stage, hesitates).

Jim: What kind of house is it? Wooden, brick?

Susan: Brick. This is the porch. (Moves on stage, begins to set up porch.) This is the swing and there is a chair here and another one over here. This is a pot of geranium. Mother is sitting in the swing. I am in the chair.

Jim: Is there anyone else with you?

Susan: No. Just the two of us.

Jim: Mother is in the swing and you are in the chair. Would you like to be your mother?

Susan: Miriam could be my mother.

(Miriam comes up.)

Jim: (To Susan) Look at Miriam. What is her name?

Susan: Mattie Frank.

Jim: How does she look?

Susan: Just like that. Mean and resentful.

Jim: How does she sit?

Susan: She sits like this. (Shows. Miriam sits in position illustrated by Susan.) I am sitting over here like this.

Jim: What are you doing?

Susan: Reading.

Jim: What is the name of the book?

Susan: *Gray's Anatomy.*
Jim: You are reading what?
Susan: The chapter on reproduction.
Jim: Look at the book! Look at the book! What chapter are you on?
Susan: Fifty-one.
Jim: You are twenty-two years old?
Susan: Yes.
Jim: Do you have a boy friend?
Susan: Yes. I go with a boy.
Jim: What is his name?
Susan: Bob Fulton.
Jim: How long ago did you meet him?
Susan: About three months ago.
Jim: What do you do? Do you work or go to school?
Susan: I work with my father. I help him in the shop.
Jim: Where did you get Gray's Anatomy?
Susan: In college.
Jim: In college. Do you go to college?
Susan: I did.
Jim: What happened?
Susan: The money ran out.
Jim: And you are reading Gray's Anatomy?
Susan: Yes.
Jim: What is your mother doing?
Susan: Sitting in the swing. She's sitting in the swing listening to me read.
Jim: Are you reading aloud to her?
Susan: Yes, and talking.
Jim: Go ahead.

(Long pause)

Susan: The woman's womb is a pear shaped organ which contains the embryo and when she gives birth it is an extremely painful procedure.
Jim: Does she answer you?
Susan: Yes.
Jim: What does she say?
Susan: She tells me about when she had her first child. She says . . . .

(Then Jim points to Mattie)

Miriam: I remember when my first child was born. I was so happy and didn't really mind the pain.

Susan: No! No! That isn't what she said at all. That isn't like her.

Jim: You take both roles. When you are here in the swing you are Mattie, when you are in the chair, you are Susan.

Susan: Oh honey, don't ever have any children. With that first child I thought I would die. It was just terrible. I thought I would be split wide open.

(Inaudible)

Susan goes back to her seat and soliloquizes her thoughts.

Susan: I was just fearful. I was fearful especially because it had said it was painful in the book.

Jim: Soliloquize what you think! Soliloquize what you think!

Susan: I was just fearful. I don't see how I could ever have a child. I had a figure like a pear. I don't see how I could ever come out. I'd like to talk to her about it but she thinks I am just dumb. I don't see how it could ever come out but it does.

Jim: I'm going to get you a double to help you soliloquize. Here is your double. You are Susan number one, you are Susan number two.

Double: A girl like me. How could I ever have a child.

Susan: I'm skinny. I'm not built like other girls. I begin to think I'm a boy. Just a boy who's lost his penis.

Double: I know there is something wrong with me.

Susan: The more I eat the skinnier I get. I look like a fly. I'm just so skinny I know that I would die, and I'm so shy that probably I would never have a chance.

Double: No one loves me. I just can't stand all that pain. Mother always loved Nattie my sister best. She thinks I am so weak. I was sixteen years old. I didn't even know what the world was about. I didn't know what had happened.

Jim: What did happen? Look at your mother sitting over here.

Susan: I didn't know what I was thinking. I didn't know what Kotex was and I didn't do it anyway. I came in at night and the toilet was stopped up and ran over. Daddy had been working all afternoon trying to get it fixed. It was stopped up with a Kotex. They said I had put it in there but I didn't do it. I didn't know what a Kotex was. I didn't do it. I didn't!

Inaudible

Susan: About that same time I went to see the doctor. I thought I had Tuberculosis. I was so skinny. My wrist bones just stuck out. It wasn't a real doctor; he was just an interne. When he looked at me he kinda laughed. I didn't have any clothes on. He called another interne. They were looking at my bejinie and they both laughed. They knew I was funny looking. I was built funny. I wasn't like other girls. I couldn't understand what they thought was so funny though. Then my sister wanted to take my boy friend. She wasn't skinny like me. Everybody loved her best. No one loved me. Mother always thought that I was doing all kinds of things. She accused me of everything. She accused me of trying to take her home away from her and her husband. My father worked like hell and lived in a living hell.

Jim: All right, Susan, I am going to change the roles. You are Mattie Brown. What is you husband's name? How old are you?

Mattie: Fifty-three.

Jim: What do you do?

Mattie: Nothing.

Jim: How many children do you have?

Mattie: Six.

Jim: Where is your husband?

Mattie: He is at work in the Tailor Shop.

Jim: What do you do all day?

Mattie: I clean the house and cook and look after my children.

Jim: Where is your daughter, Susan?

Mattie: She is in Washington.

Jim: You don't have to worry about her so much?

Mattie: No. I don't have to worry about her so much. She is doing all right there.

Jim: She is coming to see you. Mattie, Susan is coming to see you.

(An auxiliary comes in as Susan coming to visit Mattie)

Jim: Where does she find you, Mattie?

Mattie: In the living room.

Jim: All right Mattie, this is Susan. She's come all the way from Washington.

Susan: I would like to take both roles.

Jim: How do you feel Mattie?

Mattie: Oh, I feel about the same. I don't feel any too good.

Jim: You don't feel any too good. You want to see Susan?

Mattie: Yes. I want to see her.

Jim: How do you think she will greet you when she comes in?

Mattie: I think she will be happy to see me.

Jim: What do you want to talk to her about Mattie? Mattie, Susan's coming in.

Susan: Hello, Mother.

Mattie: How are you dear? Are you feeling better?

Susan: Oh yes. I'm feeling much better.

Jim: Louder. I can't hear you.

(Inaudible)

Mattie: Oh my God!

Jim: What is it Mattie? Why do you say Oh my God? (No answer). Alright.

Mattie: Hello Susan, honey. Let's start again.

(Auxiliary comes in as Susan.)

Susan: Mother, what's the matter? What's the matter Mother?

Mattie: Nothing. Nothing, child.

Susan: Tell me what's the matter Mother.

Mattie: You ought to know what's the matter.

Susan: Mother, tell me.

Mattie: Don't act to me like you're a damn little fool, Susan. You're no fool.

Susan: I want to know.

Mattie: You are no fool.

Susan: What is it? What have I done?

Mattie: You're just trying to act so damn innocent.

Susan: Why do you always talk to me like that?

Mattie: Don't just stand there. You know my feelings about your father.

Susan: Mother, it's not true!

Mattie: Get out of here! Get out of here! Do you expect me to believe you? You've broken up my home. You've taken my husband away.

Susan: It's not true! You've always believed that, but it's not true.

Mattie: I don't believe a word you say.

Susan: Mother, you're wrong.

Jim: Tell her what it is, Mattie.

Susan: What is it, Mother? Tell me, what have I done?

Mattie: You're not fooling me. Don't pretend that you don't know. Your father is never at home. He never comes home any more. I've stood for just about all I can stand. Your father talks like I'm going crazy. I'm not crazy! If I haven't gone crazy in all this time, I'll never go crazy!

Susan: You always blame me. You always blame me for everything. You always make me feel like I'm dirt.

Mattie: You don't love me. You never have loved me.

Susan: You blame me. You blame me for everything.

Mattie: I never make you feel like anything.

Susan: You're always blaming me.

Mattie: Go on. Go on upstairs. Get out of my sight!

(Susan goes upstairs with Mattie screaming, "Get out! Get out of my sight"!)

Jim: Here comes Dennis. He's coming in to see you, Mattie.

Dennis: Hi Mattie. What happened to Susan?

Mattie: Get out of here!

Dennis: What's the trouble, Mattie. What's biting you now? I want to see Susan. She's my gal. She's my girl.

Mattie: You go back to that woman next door. Get out!

Dennis: Now wait a minute, dear. I don't like to see you act like this. You act like a crazy woman half the time.

Mattie: No, I'm not half crazy. You've been telling me that all my life.

Dennis: I don't blame Susan for going half out of her head. You're enough to drive anyone crazy. Course I got a woman next door. Do you think I want to sleep with you? Do you think I want to sleep with something like you, nagging and fighting all the time?

Mattie: I've birthed seven kids for you.

Dennis: Seven kids to feed, huh! I'm not even sure they're mine. How can I ever be sure they're mine, the way you act.

Mattie: I've never had another man but you. You know that.

Dennis: Oh, I don't know how to talk to a woman like you. I'll have to go see the woman next door. I have to get out of this house. You always drive me out of this house. Where do you think I can go?

(Dennis walks off the stage)

Jim: Where is he going, Mattie? Where do you think he is going?

Mattie: To the shop.

Jim: To the shop. Does he have a woman next door?

Mattie: Yes.

Jim: Who is she?

Mattie: Bell Moody.

Jim: Are they in love?

Mattie: No.

Jim: What do they do together?

Mattie: They meet and I don't know what they do.

Jim: Mattie, Mattie, why does he have to go next door? Why does he have to go see Bell? Why isn't he happy with you? (Long pause) Why does he have to go there? (Pause continues) Do you know Bell well?

Mattie: Yes. She's my next door neighbor.

Jim: Mattie, come here. You take the part of Bell. How do you look and talk. Black hair, brown eyes. Are you married?

Bell: No. I'm divorced.

Jim: What's your last name?

Bell: Moody.

Jim: How many times have you been married?

Bell: Once.

Jim: What happened?

Bell: He died.

Jim: How did you get along with your husband?

Bell: We got along well. We had one boy.

Jim: Your boy is how old?

Bell: He's nineteen and he's in college.

Jim: You are Bell Moody?

Bell: Yes.

Jim: Tell me, Bell, do you have any boy friends now?

Bell: Yes, I have a boy friend.

Jim: Is he married?

Bell: Yes.

Jim: Does he have any children?

Bell: Yes. He has seven children.

Jim: What's his name?

Bell: Dennis Brown.

Jim: Where does he live?

Bell: Next door.

Jim: How old is he?

Bell: I don't know just how old he is.

Jim: How old are you? (pause)

Bell: I'm in my late forty's.

Jim: Bell Moody. That's a rather nice name. How did you manage that? Were you born with that name or did you marry that name?

Bell: I married that name.

Jim: Oh. It's rather a nice name, isn't it?

Bell: Oh, I don't know.

Jim: You sound sort of doubtful.

Bell: No, I just never thought of it.

Jim: Bell, you're having an affair with Dennis. Where does he meet you?

Bell: Oh, we don't meet any one place. We're too smart for that.

Jim: Oh. Well, suppose you walk around town and Dennis will meet you. You run into him. Go ahead. You'll meet Dennis somewhere along the way.

(Bell walks around the lower level of the stage. Dennis walks up.)

Dennis: Hi Bell, how are you? What's the matter Bell, don't you know Dennis? How are you, Bell?

Bell: Don't you know we can't be seen together? I just went by your house and saw Mattie sitting on the porch.

Dennis: Well you know, oh, I'll tell you. I'm having a hard time with her. Bell, I really don't know what I'm going to do. I'm living in hell.

Jim: Move to the front of the stage.

Dennis: Let's go sit down. Let's sit down over in the park.

Bell: All right.

Dennis: Here's a park bench. You know Bell, I'm very fond of you.

Bell: Yes, I'm very fond of you too, but it doesn't seem quite right somehow, all those children and you already married.

Dennis: Bell, you know what pure hell my life is there.

Bell: But isn't there something you can do about it?

Dennis: I don't like to run out on it but I just can't stand it. My poor Susan came to see me today. You know, I wish I could better understand what goes on between those two women, Susan and Mattie.

Jim: Dennis, get in the role. You are the lover of Bell. You love Bell. That's the important thing now.

Dennis: You know, Bell, I love you very much. You can give me things that Mattie has never given me. You know I haven't slept with her for over seven years. You seem to understand me and that's why I want to be with you.

Bell: I feel sorry for you but I can't have your wife coming over there annoying me and making a spectacle for the neighborhood.

Dennis: It doesn't somehow seem fair to you, Bell.

(Inaudible)

Jim: All right, Bell, come here. Susan, now you are Mattie again. What do you think about Bell?

Mattie: I know she has my husband. I know she's got him.

Jim: You know she's got him.

Mattie: Yes. She's got him.

Jim: She seems like trash to you?

Mattie: Yes, of course she does.

Jim: Just like trash to you.

(Mattie moves to the center of the stage in swing.)

Jim: You are sitting on your porch, Mattie?

Mattie: Yes, in the swing.

Jim: Look in the street. What do you see? Look at Bell. She's going to walk by. (Bell walks by humming in a seductive tune.) Soliloquize what you think, Mattie!

Mattie: She has no husband to keep a woman like that. She's taken my husband. A woman like that!

Jim: Look at her, Mattie. Look at Bell Moody. It looks as though she's coming on your porch.

Mattie: She'd better not come on my porch!

Jim: There she is.

Bell: Hello, Mattie. How are you?

Mattie: Get off my porch. She's got her nerve coming on my porch. A woman like that. Get off my porch! I'll get you off my porch.

Bell: What can you do about it?

Mattie: Get off my porch! I don't want to see you. You know you've got my husband. Get off my porch!

Bell: All right, all right. (Leaving) I'll take him away anyhow.

Mattie: It takes a woman like you to do it. Just one of your type.

Bell: I'll catch him. I'll see him tonight.

Jim: Soliloquize what you think, Mattie.

Mattie: She will. She will take him. She'll get him. There's nothing the matter with her. She's not a decent woman.

Jim: You are a decent woman, Mattie?

Mattie: I am. I've lived all my life being decent. I've birthed seven children.

Jim: What are you going to do about it, Mattie?

Mattie: There's nothing I can do about it.

Jim: Mattie, how old was your daughter Susan when she first began to wonder about sexual things?

Mattie: She was very little.

Jim: How old was she?

Mattie: About six years old.

Jim: About six years old.

Mattie: No, it was younger than that. Between three and four years old.

Jim: Between three and four years old she began to ask you about these things?

Mattie: No, I caught her.

Jim: You caught her? Doing what?

Mattie: I caught her playing in the woods.

Jim: With a boy or a girl?

Mattie: A boy. She was playing doctor.

Jim: She was playing doctor?

Mattie: Yes. She had his peter in her hand, and she was playing around. It was her little boy cousin.

Jim: Just where was this, Mattie?

Mattie: In back of the house.

Jim: Just she and her little boy cousin. Just how old was she.

Mattie: Between three and four.

Jim: Between three and four. How old was the boy cousin?

Mattie: About her age.

Jim: Were they sitting on a hill?

Mattie: He was lying on a hill.

Jim: Oh, he was lying on a hill. And where was Susan?

Mattie: She's standing up over him.

Jim: Standing up over him. How do you mean?

(Auxiliary comes in to play Susan.)

Jim: This is Susan. She's here as Susan should be. (Auxiliary playing the cousin lies on hill.) How does she stand?

Mattie: She doesn't stand exactly, she kneels and she's got that thing in her hand. She's got his peter in her hand and she's sticking a few little sticks over it.

Jim: And where are you, Mattie?

Mattie: I'm in the back yard and I'm running.

Jim: Run! Run, Mattie!

(Mattie runs over to Susan and begins to push her away. Susan begins to cry and Mattie to scream.)

Mattie: You'll ruin that boy! You'll ruin that boy!

Jim: What does she do, Mattie? What does Susan do?

Mattie: I don't remember what she does.

Jim: You do remember, Mattie. Mattie, what does Susan do? What does she do?

Mattie: I really don't know.

(Director reverses roles.)

Jim: You are Susan. This is Mattie. You are in the back yard on a hill. You are with your little cousin. What are you doing? How are you standing? Stand over him.

(Cousin lies on back. Susan sits on his thighs. Susan sobs, tries to open the fly of the auxiliary playing the little cousin. He gets panicky and gives her a thumb. She clutches and makes motions as if sticking twigs around. Auxiliary playing Mattie comes out screaming.)

Mattie: What are you doing? You'll ruin that child. Oh, you bad wicked child. You'll ruin that boy.

(Susan lies on the ground sobbing.)

Mattie: You get up from there, you bad child!

Jim: What does Mattie do next, Susan?

(Susan trembles and is broken out in perspiration. The role is reversed again. Susan is playing in Mattie's role in order that the action be continued.)

Jim: You, Mattie, this is Susan, go ahead. Action! Go ahead, Mattie. (Susan and Mattie both sobbing.) Mattie, Mattie, look at her. There is Susan, Mattie. What are you going to do, Mattie?

Mattie: I'm going to beat the hell out of her!

Jim: Here or somewhere else?

Mattie: Here. I'm going to wear her out good. There's a little tree over here.

(Mattie breaks switch and begins beating. Scene becomes very intense as Mattie beats Susan. Susan screaming, "Stop, stop Mother." Director decides to cut scene as he is afraid auxiliary will actually become hurt. Cut! Cut!)

Jim: Mattie, Mattie, Mattie, (In soothing tones to cool situation which has become overheated. Mattie begins sobbing more quietly.)

Mattie: I wore my hands out.

Jim: You wore your hands out? And what did that ungrateful girl do? (Pause) And what did that ungrateful girl do? (Repeated softly.)

Mattie: She is over there sitting in the corner.

Jim: Did you talk to her, Mattie?

Mattie: No, I didn't. I don't know how.

Jim: Would you like to talk to her now?

Mattie: Yes, I think I might, but I don't think it would do any good.

Jim: Why don't you talk to her Mattie? There she is. Talk to her, Mattie.

Susan: You hurt me, Mother. You hurt my feelings.

Mattie: A mother has to do that sort of thing. A mother has to have some way of teaching her daughter what is right and wrong.

Susan: I didn't mean to do anything wrong.

Mattie: But you did. You are a very wicked girl.

Susan: (Crying.) I want to be your baby.

Mattie: But you are not a baby.

Susan: But I want to be a baby.

Mattie: But you can't be a baby.

Susan: But I am a baby.

Mattie: I know you're not.

Susan: I didn't know I had done anything wrong.

Mattie: But you did. You are wicked now. I hope you understand that you mustn't do that sort of thing.

Jim: And so, Mattie, you might have talked to your daughter like that. Do you think that might have helped her, Mattie?

Mattie: No. I just didn't know how to talk to her, to any of the children. There's no way I could help them.

Jim: What were you afraid of when you saw Susan in the yard with the cousin?

Mattie: I don't know. I was just afraid it was the wrong thing.

Jim: Mattie, what are you afraid of? (Mattie holds stomach with an expression of pain.) Are you afraid you are going to become pregnant?

Mattie: I am just so ashamed. Somehow, I've never been able to do anything with my children. (Jim cuts session and awakens Susan. Susan, still in role of Mattie, begins a discussion with group.)

Discussion

The second session illustrates hypnodramatic action which deals directly with traumatic situations, whereas the first protocol is that of a highly symbolic production.

Hypnodrama has been found useful in cases where the patient is unable to express himself through other techniques sufficiently well to gain catharsis and therapeutic success. It has especial value in conversion hysteria and psychopathic states. It has been found to have some success with schizoid personalities. When used in conjunction with psychodrama, it speeds up the therapeutic process without loss of values attributed to therapy given on conscious levels.

Directorial Aids

The handling of pathological states of warming-up or spontaneity, such as the one illustrated in this record, may be facilitated by the following techniques:

1. A double may be sent in.
2. An aggressive auxiliary ego may be fitted into the action and change its direction.
3. The director may force the patient into a new channel.
4. It may be necessary to cut a scene and to set up a new one.

The following techniques are useful in determining symbol meanings:

1. Soliloquy *in situ*.
2. Detailed description of the symbol by the patient.
3. Observation of the action which the patient takes toward the symbol and of the action which he ascribes to the symbol.
4. Observation of inter-action of patient and symbol.
5. Extension of act hungers.

Dual Direction (See first protocol)

It was decided to investigate the effect of using a male and female director in this situation. In view of the patient's feeling toward women this attempt cannot be called wholly successful. In this session it was tried spontaneously and the two directors had not had an opportunity to warm up to each other in the situation. Therefore, the direction of the movement in the hypnodrama lacked unity. In later sessions dual direction was more successfully used, giving the opportunity to note the effect of mother and father figures directing the patient.

Memory and Hypnodrama

In other techniques of hypnotherapy many workers have found a lag between the patient's presentation of material under hypnosis and acceptance of it into consciousness. In general it has been felt that presentation under hypnosis speeded this acceptance and resulted in more rapid integration due to the partial catharsis which occurs under the hypnosis. Perhaps tension surrounding the event is released in sufficient quantities to make his conscious recall less painful. While work in hypnodrama is yet too meager to be conclusive, it appears that memory for action taking place under hypnosis is greater. This could be accounted for by the greater release of tension occurring in action. Memory for events occurring in hypnodrama seems to depend more upon the amount of tension surrounding the scene rather than the depth of the hypnosis.

Learning and Hypnodrama

Retraining which takes place in psychodrama has the advantages of adding the kinesthetic senses to those which are usually used for education. It becomes possible for the organism to learn as a whole and in situations which are not too different from those encountered outside of the therapeutic setting. Hypnodrama allows us to extend learning situations toward the upper limits of the patient's level of function. The ceiling of his upper limit is probably raised due to the lessening of inhibition and the achievement of deeper states of spontaneity. By forcing him to function closer to the upper limit, we bring out factors which have been inhibiting his production and enable him to approach this level in a waking state. Catharsis, spontaneity training, and improved warming-up processes allow him to realize new and more productive roles. These changed concepts readily transfer to the waking state.

Dreams

Dream work may be done with ease in hypnodrama as in psychodrama. It is interesting to note that the dream as told by the patient prior to his production on the stage is usually very incomplete. In hypnodrama the patient gains insight into the meaning of the dream without the therapist necessarily giving an interpretation. This insight may be considered an action insight and may or may not be verbalized by the patient. Hypnotic dreams may be produced in the patient and acted out on the stage. Such procedures afford cathartic value as well as allowing the patient to realize the roles which he has previously denied to himself.

SUMMARY

In this paper the technique of hypnodrama has been presented with some theoretical considerations. Technical information of use in direction is also given. Some of the uses of the technique have been pointed out. Two verbatim protocols of hypnodramatic sessions have been presented and discussed. Characteristics differentiating hypnodrama from the usual hypnotherapeutic techniques and psychodrama are pointed out.

Further work is needed before any definite conclusions concerning the full scope of the application of hypnodrama can be drawn.

REPORT ON PSYCHODRAMATIC THERAPY

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I. PSYCHODRAMA WITH PATIENTS AFTER SHOCK THERAPY

Psychodrama was considered an important adjunct to complement insulin and electric therapy.* The treatment was carried out in the form of group sessions participated in by all patients on the ward. Inasmuch as a majority of these patients expected to be discharged in the near future, most of the topics selected had to do with adjustment to the outside world. For example, interviews in an employment agency: a patient applied for a job after which other patients discussed the scene and suggested possible improvements, pointing out that applicant did not bring out with sufficient emphasis his job qualifications or that he had attempted to get a job for which he was not qualified. Patients would comment on his manners, bearing and appearance. A problem shared by all the patients was whether when applying for a position they should admit having been in a mental hospital or how they would account for the time spent.

An effort was made to remove the last vestiges of delusions and hallucinations. Some patients were encouraged to act these out, such as the feeling of being observed. Other patients discussed the scene or were placed in the role of a doctor who must decide whether the subject was ready to be discharged, thus gaining insight into whether they themselves had made sufficient progress to go home in the near future.

Patients with a number of psychosomatic complaints were placed in the role of doctor and others acted as the patient. The "doctor" was briefed to inform the "patient" that extensive laboratory studies had been made of his case, with negative results. Then the "doctor" had to give the "patient" an explanation of how it was possible to suffer from pain without physical illness. By this means he was forced to repeat in his own words the explanation which had been previously given to him by his own doctor. Then the two patients exchanged roles: the one who had acted as a doctor would take the role of patient and vice versa. Each patient served as a mirror-image to the other, helping him to see himself with his many unfounded complaints.

*See J. L. Moreno and Morris Schwartz: **"Psychodrama Combined with Insulin Shock Therapy,"** Psychiatric Quarterly, 1948.

II. Psycho-Therapy With Relatives

Again, psychodrama was found useful in bringing about understanding between patients and relatives. The treatment was carried out in the theater in which there was a regular stage. Visitors were invited to attend as part of the audience. The Social Service selected for this treatment cases which particularly needed adjustment between relatives and patients. The psychodramatic scenes selected were common to most of the patients, dealing with adjustment to the outside world. Many contingencies which the patients might face after release were acted out to see whether the patients were ready for discharge. Scenes were enacted to help relatives understand the mentally ill and how to handle them after their return home, and how to proceed in case of a relapse.

A number of cases of interpersonal difficulties between patients and relatives were selected for intensive treatment with the visitors being requested to return at regular intervals.

The following is given as an illustration: The patient, who appeared very immature, had corresponded with a woman whom he had not met for two years while he was in the service. Immediately after his discharge from the army he married her. The patient had many adolescent plans about the choice of an occupation, such as becoming a detective or a radio star. The wife interfered with the first because she thought it was dangerous and insisted that he quit radio school because he was squandering his time and money. The patient took the wife's dominance meekly, but finally felt that he could stand it no longer and after drinking to gain courage, smashed the furniture in their apartment in a drunken rage which led to his hospitalization. At the time of his admission he was determined to get a divorce. These events were enacted in short scenes, using auxiliary egos (nurses, O.T. workers, and female patients) to take the roles of the wife and friends. Finally the wife was induced to participate in these sessions and attended regularly twice a week. Both husband and wife learned to understand their deficiencies. The wife learned to tone down her dominance and the patient gained self-confidence and assertiveness. A practical solution was worked out so that the veteran would have a chance under the G. I. Bill, to pursue some of the studies to which he aspired and his wife was going to work. At the time of his discharge the patient and his wife appeared reconciled and happy.

Another patient had received a full series of electric shock treatments after a schizophrenic breakdown and seemed to have made a recovery. However, one week later he was brought back by his family, in a relapse. The difficulty appeared to be the over-anxious and over-solicitous attitude of his parents and his resentment towards them. Both parents were induced to attend regular sessions and their relationship to their son was worked out psychodramatically. They all learned to appreciate each other. The veteran now attends college, but lives away from his parents, visiting them twice a week.

It was found practicable to have joint sessions for male and female patients so that they could act as auxiliary egos for each other.

III. Lectures and Demonstrations for Attendants

Lectures and demonstrations on psychodrama were given to the hospital attendants in their advanced training program. Emphasis was placed on what the attendants can do to help the patients by becoming auxiliary egos to them. After each lecture, a demonstration was held in which a number of attendants were sent out of the room and then were called back one by one, each one acting the same test situation. The following situations were used:

1. An attendant is faced with the feeding problem, a catatonic negativistic patient. Some talked kindly to him, others were impatient and even closed the patient's nose to have him open his mouth. Then they pushed food into it. Others appeared completely helpless and said they would consult with the nurse.

2. Another scene was done to test the attendant's organizing abilities. They were given a group of men and told that they should arrange for the moving of furniture from one building to another. Some attendants appeared to be clever in distributing the work and explaining to each party their detail. Others were found to be unable to organize.

3. The third situation was used to see the spontaneous response of the attendants when faced with criticism. Again they were called in one by one and told that they were fired. In this test, the majority wanted to know what they had done that was wrong. Others said that they didn't care, that they would find another job easily and some even became insulting. Although these lectures were used primarily as a demonstration, it was frequently found that those attendants who did not make a good showing during this test, later on did not prove satisfactory on the wards.

IV. PSYCHODRAMA AND THE MAPS TEST. (Make a Picture Story Test.)

A research project was carried out in conjunction with the psychology department using psychodrama and the Maps test combined. The Maps test is a projective technique developed by Edwin S. Schneidmann, one of the psychologist at Brentwood Hospital. It is similar to the Murray Thematic Apperception test, but gives the subject more freedom. Twenty cards representing structured and unstructured backgrounds are used on which the patients place cut out figures, forming their own pictures. They were requested to tell a story about each picture and then encouraged to dramatize it. During this study, it was seen that some patients were better suited for the Maps test alone and others for psychodrama alone; and others seemed to derive benefit from using psychodrama and the Maps test combined. For example, a patient with obsessive compulsive ideas in the sexual sphere produced a wealth of material on the Maps test, but it was found difficult to dramatize these projections. The over-ideational schizophrenics did well both in the Maps test and in psychodrama. The coarcted schizophrenics on the other hand, clung tenaciously to each picture and were unable to free themselves from it in a dramatization. This was considered to be due to a deficiency in abstract concept formation.

THE SOCIAL MEANING OF CURRENT METHODS IN GROUP PSYCHOTHERAPY*

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INTRODUCTION

Group psychotherapy today is no longer considered an emergency measure dictated by lack of time, funds, and personnel. We approach group psychotherapy as a new and highly sensitive method in the treatment of emotional disorders, a method that is by no means easy to apply, nor is it inexpensive.

Scientific group psychotherapy is based on elements that as yet are not completely understood: inter- and intra-group relations and their effect upon the individual.

The practice of group psychotherapy was stimulated and propagated by the recent war and by the sudden great need for psychological treatment in settings lacking any previous contact with scientific psychotherapy. New demands had to be met by new methods. Many psychiatrists who work in this field today were encouraged to do so by their war experiences. No doubt the results obtained in the British and American armies were genuine and often remarkable.

While war-like emergencies still exist, there is also an increasingly felt need for more careful observation and scientific recording. We have come back from the war with feelings of frustration and with doubts. We were unequipped and unprepared to apply scientific checks to our methods of group treatment. Human nature tends to emphasize the positive sides of work and failures easily drop from our memories.

It is better to remain critical toward a method which one values highly, which we make use of, and which, no doubt, will develop into an outstanding instrument in the future treatment of mental disease.

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*This paper was read in part at the International Congress on Mental Health, Specialist Meeting, Institute of Social Psychiatry, London, August 19 1948.

I do not intend to involve the reader in the deeper dynamics of group psychotherapy. But I would like to mention briefly some of the known and used methods (and there is indeed a great variety of techniques in the field of group psychotherapy) which correspond with the needs and the functions of the most important social elements involved in group psychotherapy: the patient and the group.

The Patient

The emotionally disturbed patient nearly always experiences difficulties on the level of social relations. His maladjustment does not permit proper function in inter-relation with others and he therefore tries to withdraw. Yet, he cannot live without outside interference. The active and aggressive environment does not permit—not even temporarily—his withdrawal from social relations. His attempts result merely in acute conflict.

While individual psychotherapy applies mainly to the diseased aspects of personality, group psychotherapy appeals, from the very onset, to the positive social forces in the patient. It is surprising and reassuring to find, even in psychotic patients—that in the protected and guided milieu of a therapeutic group, the severely sick are able to function on a relatively high level, whereas, left alone, they withdraw immediately, using their remaining functions in a rather defensive way to shield their weak egos. In a well conducted group, outgoing forces are permitted to come to the surface again and anxiety and hostility are more easily controlled.

Good results, achieved under scientifically controlled conditions with proper evaluation of success and failure, have been obtained in work with children and adolescents. In the dynamic make-up of the younger groups there are several factors which make work with them more encouraging, especially when play, drama and other activities are used as means for group functioning. Children and adolescents regress often in group therapy—and regression, when handled adequately by the therapist, can be put to good use.

Interview group therapy with adults presents different challenges, especially in observation and control. The interchange within a group has to be emotionally highly charged if therapeutic results are to be expected. Success and failure of a therapeutic group depends largely on the selection of the patients. This does not suggest that patients should be selected rigidly according to their descriptive diagnosis. It is obvious that a group made up entirely of withdrawn schizophrenic patients would never work. It is equally dangerous to

select patients according to symptoms—the same symptoms might be manifestations of very different dynamics. While age, intelligence and education seem to be of importance in the selection of the group, the most outstanding factor is the capacity of the individual patients to deal with each other. As the therapeutic agent in the group consists largely of the actual relationship between patients, the dosage of this therapeutic agent—the maximum and the optimum of this "medicine"—must be handled while the group is in action. Only close observation will tell how much the individual patient needs and how much he can take. Intimate knowledge of the structure of the personality of that person who was selected for participation in the group is an important prerequisite. The technique of selection is still imperfect and "intuition" plays a larger part than is good for scientific procedure. We hope that the day will come when our knowledge and our methods in handling groups will be sufficiently developed to place any given patient in the therapeutic group milieu he requires. I am afraid that we are still far from this goal.

While group psychotherapy as the only therapeutic agent applied to certain types of patients is effective, group and individual psychotherapy should be combined whenever possible. Scientific rather than purely therapeutic reasons are in favor of a combination of both methods which provide us with insight into the deeper psychological reactions of the individual and his relations in and to the group. Free associations and dream material produced in individual sessions give us invaluable information about the influence that a dynamic therapeutic group exercises upon the unconscious of the participating members. We need this information in order to enlarge our knowledge of interpersonal relations between members of the group, of intra-group relations, of the relationship between the group therapist and the group, and between the therapist and the individual group members. Every one of these relations has its own dynamics and every one of them may, or may not be useful in the therapeutic process. A controlled therapeutic group whose members are also under deep individual psychotherapy is, at this time, the ideal setting for psychiatric research in group psychotherapy. From the foregoing it becomes clear that group psychotherapy can never use very rigid methods, since the combination of patients for a given group is a highly important determining factor for the development of the group atmosphere. It also means that the group is what its members—under the effective guidance of therapists—make of it. Group methods therefore have to be developed according to the type of patient we choose for treatment in a given group.

This is not adverse to the development of standard procedures. On the contrary, only the development of such standardized methods can enable modern group psychotherapy to function on a large scale. However, this necessitates the development of more than one standard procedure, in accordance with the varying needs of patients. Unfortunately, therapist's personal preferances have often been more influential in the choice of procedure than the scientifically established needs of the patients. Since, as yet, there is no generally accepted set of procedures in group psychotherapy, differences in the therapists' individual training and personality structure have been the determining factors for the use and development of the actual methods.

There is an unfortunate tendency to proclaim that a patient who does not profit from a certain method of group psychotherapy, cannot profit from group psychotherapy at all. I hope that in the course of progress this question will be solved by selecting the specific method from which a given patient can profit best.

I should like to illustrate this from personal experience. Analytically oriented groups that stimulate spontaneity to the largest possible degree in a permissive atmosphere, seem to be an established method for various types of psychoneurotic patients of high intelligence. The participation of patients with strong paranoid trends often disturbs the therapeutic progress in this type of group; the presence of mentally deficient patients slows down progress of the whole group. Neither the paranoid nor the mentally deficient patient improves in this type of group. But mentally deficient patients frequently do profit from participation in what is commonly called didactic groups. I have also observed that patients with paranoid tendencies are very comfortable and relaxed and become more manageable in orientation groups where, to a certain extent, discussion and procedure are controlled.

The method of choice depends, therefore, on the level on which treatment of a certain group of patients is planned—a similar procedure is frequently used in the referral of patients for individual psychotherapy. Many patients who cannot and do not need to be subjected to psychoanalysis, profit from superficial psychotherapeutic treatment. But the level of treatment must be decided upon from the very beginning, since the methods which reap good results in deep and long term procedure, are useless in short-time and superficial psychotherapy.

There is no panacea in medicine—that we have none in group psychotherapy should not discourage us. As we go on in research, accumulating more

knowledge through experience and observation, more and more patients will be helped through the various methods of group psychotherapy.

The Group

Since Gustave LeBon published his "Psychologie des Foules" 52 years ago, scientific research has been seriously concerned with the fact that the psychological reactions of groups and masses of people are by no means the sum of reactions of their individual members. Something new, something very complex (and to a certain extent, still mysterious) can be observed when we try to analyze the complicated psychological reactions in intra- and intergroup relations. 26 years after LeBon's publication, Sigmund Freud's contribution to mass-psychology "Massenpsychologie und Ich-Analyse" was published and was translated into English one year later. Since then, much has been added to our knowledge on the subject, especially through the efforts of Alfred Adler, J. L. Moreno, Kurt Lewin and their schools. In recent years also, two renowned scientific groups, the Tavistock Institute of Human Relations in London and The Research Center for Group Dynamics in America devote their efforts to the dynamics of group relations and the quarterlies "Human Relations" and "The Journal of Social Issues" occupy a prominent place in the contemporary literature in the field. The pioneering New York Sociometric Institute and the quarterlies "Sociometry" and "Sociatry" published by J. L. Moreno are devoted to "Interpersonal" and "Group and Intergroup Therapy"[1] and are concerned with healthy and pathological group relations.

Moreno has introduced the use of scientific methods in the exploration of intragroup relations. He has tested and charted the intricate forces that unite and divide human beings who live together in natural groupings, he was the first to use the term group psychotherapy and to apply the findings for therapeutic purposes. His early publication "Group Method and Group Psychotherapy"* (Beacon House, New York 1931) has opened new avenues for the understanding of healthy and pathological intra-group action and has made a basic contribution to the field of group psychotherapy as it stands today. The sociometric analysis of normal and pathological group dynamics has been established in America by Moreno's work—his book "Who Shall Survive?" "A New Approach to the Problem of Human Interrelations" was first published in 1934.

Recently, Dr. Oscar Sternbach, pupil of Sam Slavson, published a monograph on "The Dynamics of Psychotherapy in the Group" (No. 23 of the bro-

*Its original title: "Application of the Group Method to Classification."

chures published by the American Group Therapy Association), a topic that has been dealt with by Sam Slavson, the founder of the American Group Therapy Association, in a number of basic books and articles, especially "Introduction to Group Therapy." Foulkes in "Introduction Group-Analytic Psychotherapy" and Klapman in "Group Psychotherapy" also have made valuable contributions. The Institute of Social Psychiatry, under the leadership of Dr. Joshua Bierer, has started a new approach to the challenging question of therapy of groups. The handbook on "Therapeutic Social Clubs" which Dr. Bierer and his collaborators have published, is a stimulating contribution to the treatment of the mentally ill in and through the group. I have taken an easy road by enumerating the various writings on the subject of group dynamics. I admire the authors' efforts who try to elucidate what is going on in good and in poor group function, in social and in therapeutic settings, in good health and in individual and social pathology. It is not my intention to examine here the present state of our knowledge on group dynamics, nor even the forces mobilized in therapeutic group action. I will devote the following remarks to a few questions of therapeutic group procedure which may appear to be of purely technical nature but which, from my experience, are of primary importance for successful treatment in groups.

A Technical Bulletin of the U. S. Army, published in 1944, gave its definition of Group Psychotherapy as: "any procedure which tends to improve the mental health of more than one individual." This is a very broad statement which no longer corresponds to our concepts of scientific group therapy. According to the definition of the T.B., two patients could be used for the formation of a therapeutic group. Actually, this is not possible because experience shows that interaction in very small groups suffers from continuous friction and other difficulties which do not permit the development of a therapeutic atmosphere. Four or five members are necessary for a therapeutic group. If the group is analytically oriented and if work on a deeper psychological level is planned, six to eight patients are considered as the optimum. Beyond this, group interaction becomes so complex that proper direction and observation is not possible for a single group therapist. The introduction of co-leaders, especially of the opposite sex, might stimulate the creation of a milieu that repeats family and society. Several research projects have introduced more observers and have enlarged their groups to admit 10 or even 15 patients. I have doubts about the group function and its interpretation on a deeper level in so large a setting. The individual capacity of therapist is, of course, a variable factor, but all human beings are subject to limitations in the intensity of

psychological and emotional output and control. This intensity of therapeutic action within the group is of great importance and cannot be maintained over a longer period of time in an unduly large setting.

Didactic groups and orientation groups with their limited and frequently symptomatic goals can accommodate large numbers of patients. Even here, it becomes very difficult to observe definite responses of a therapeutic nature in groups of more than 15 or 20 patients. Club-like organizations have a wider range of action. Here, the therapist becomes either a leader or an observer, dependant on projected structuring of the group. A.A. Low's "Recovery" movement in Chicago has provided us with valuable material and I hope that Dr. Bierer and his co-workers will make an even more interesting study. All of us who work primarily with small groups on deeper levels are very much interested to learn more about the function of therapeutic action which tries to apply the exploration of deeper psychological areas and large numbers of people on a social level. The highly dynamic effect that psychodrama has on participants and spectators is a unique phenomenon which Moreno and his school have explored and described.

Here acting out and role playing replaces verbalization; the healing effect which is obtained through verbal interpretation in psycho-analytic and allied methods is achieved in psychodrama through reliving in action and counteraction with the auxiliary ego—the reality of the dramatic demonstration exerts a powerful influence on the unrealistic patterns of neurotic and psychotic patients.

There are a number of factors which all groups, large or small, have in common. One of these factors is the regularity and frequency of groups sessions. As in individual psychotherapy, the cancellation of sessions means disappointment, rejection, loss of love, and frustration to the patients and many of them will react accordingly—especially as long as their frustration tolerance is low. Sessions have to be kept and carried out according to schedule. Frequency depends on the degree and the seriousness of the patients' illness. Daily sessions are particularly desirable in the case of institutionalized patients. Ambulatory patients and convalescents need less frequent treatments, but therapeutic results cannot be expected if therapy is not applied at least once a week.

The duration of sessions is another important factor. Activity groups and club sessions with a variety of action and talk can be extended over several hours. Younger children in play therapy usually show fatigue and irritability if

sessions are longer than 90 minutes. 45 minutes is the minimum time for a group session and this is frequently insufficient in groups that need to use a phrase coined by Moreno, an extended "warming-up" period. An hour is frequently enough to achieve definite therapeutic results, but 90 minutes are preferable. Two hours is probably the maximum for interview groups on a deeper level.

The question of duration of treatment is completely open and depends to a large extent on the problem of open or fixed groups, i.e., on the change in membership and the regularity of participation. Frequent changes in a group, i.e., the dropping out of old, and admission of new participants, is always a strain on the group function and might cause disturbance and even disintegration. But it might also be stimulating and productive for a group in need of activation, if the change is well-timed. In groups that are planned over several months or even years, some changes of this kind are inevitable. Group psychotherapy with analytic orientation cannot have quick results and must be carried through systematically, but without rigidity. Never will all members be able to continue according to plan. And as the group is small from the very beginning, replacements will be necessary to prevent shrinking.

Large didactic and orientation groups are not as sensitive as smaller analytically oriented groups in respect to changes in membership. But even here a floating population has disruptive effects. A permanent nucleus of patients is needed in every group—and I suppose that this is true even for large therapeutic clubs. On the periphery of this central group, changes may occur without great disturbance. It is rarely possible to avoid the development of "peripheral" group membership. Changes in the central group are more serious and need very careful manipulation by the therapist. The central group does not only contribute more to group function, its members are also those who profit most from therapeutic interaction.

SUMMARY

I have discussed only a small, selected number of problems as they have to be faced and dealt with by the workers in the field of group psychotherapy. I have discussed the patient and the group but have especially omitted one problem that has enormous importance in the development of our new science: the position and the function of the therapist. Many valuable contributions to the question of group leadership have been published. The problem is far from being solved and further research about the position of the "group leader" in various kinds of structured groups is in progress. We feel that at the present

moment, international cooperation of all those who are interested in the advancement of group psychotherapy can and will greatly stimulate our common endeavor: to make group psychotherapy an effective tool in the treatment of emotional disturbances.

PASTORAL GROUP PSYCHOTHERAPY

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The growing interest in group psychotherapy in recent years has stimulated an exploration of the possibility for therapeutic work in voluntary groups already existing. Among such groups those organized within the church offer excellent opportunity for effective therapy. Just as group therapy developed in part as an effort at meeting the needs of vast numbers of individuals too numerous to be cared for in individual treatment, so it is becoming apparent that groups designed especially for therapy can reach only a small fraction of those that should have help. It is the purpose of this paper to consider how church groups can be used to supplement therapy groups and to help in preventing personality disorders.

The Christian Church has utilized group activity from its very beginning. Christianity has placed a major stress on interpersonal relations with the result that it has become, as Moreno points out . . . "the greatest and most ingenious psycho-therapeutic procedure man has ever invented,[1] . . . Jesus recognized full well the importance of group activity and made use of interpersonal relations in a discriminating way to accomplish his specific purpose. Moreno shows how he worked: "He treated Judas in arguing with Peter, Martha through Mary, the Pharisees through Magdalene."[2] From the creative interaction of the group of twelve disciples clustered around Jesus down to the present day the church has sponsored the kind of intimate fellowship units which have provided the type of group experience which is so essential for healthy personality development.

Church groups can help to meet the needs of disordered and maladjusted lives by providing a sort of laboratory in social living. Like the therapy group the church group can provide a mock society in which ideas and attitudes can not only be verbalized but can also actually be lived through. This living through of attitudes reaches its most complete form in psychodrama, but even within the more usual group setting it can be accomplished. Starting with the premise that each individual is a child of God and as such has limitless possibilities for making a unique contribution, the church group accepts each

one of its members with a sympathetic understanding and helps to provide opportunities for individual growth. When the group has a therapeutic orientation it can provide a suitable medium for the living through of feelings because from a psychological viewpoint the group repeats the family situation. For some persons it becomes a substitute family within which the ties of loyalty are strong enough to permit the release of rebellion, frustration, and pent up hostilities. Thus the group provides the atmosphere in which an effective emotional catharsis can take place. Feelings originally felt toward parents and siblings but repressed are given opportunity for release in the substitute group. The group leader becomes the substitute parent and the members become substitute siblings. The entire group helps in the resolving of conflicts as individual members testify to having similar hostilities and rebellions and anxieties about them. Guilt felt about such feelings of aggression is reduced as it becomes clear that such impulses are common to all and are not inconsistent with acceptable social conduct.

In addition to aiding the process of emotional release the church group functioning as a laboratory in social living tends to modify attitudes. The unfavorable response of the group to overt acts of non-social conduct serves effectively to change behavior. Through actual testing in the miniature society of the group the individual sees the result of his socially undesirable act and is given incentive for a re-direction of his emotions in order to be better accepted by his group. In actual experimentation he discovers the effectiveness of conduct that is fully acceptable; he finds that a defensive, hostile attitude is not necessary. Thus through the experiences in the group laboratory such a significant change of attitudes is accomplished that there is an entirely new alignment of emotional forces. The friendly and sympathetic understanding that the church group creates is somewhat akin to the permissiveness of the therapy group and serves in a similar way to make possible a personal discovery of the practicability of life lived according to socially acceptable standards.

There are few church groups existing today, however, which can serve in any therapeutic way as a laboratory for social living. Certain emphases need to be incorporated into existing church group activities if any degree of therapy is to be achieved. There must, first of all, be a recognition of the significance of the group, of the primacy of interpersonal relations. The person in trouble is an individual whose great need is for a supporting community, a group which gives him acceptance, support and unconditional love. Therapeutic groups are providing for such a need and are thereby showing the church the

need for a rediscovery of the possibilities in the interpersonal situation called religious fellowship. Therapists are insisting that identification with other persons and with groups is an integral part of the healing process for most patients.

The significance of the relation of one person to another in an actual social setting has received too little attention from the church. Groups for social intercourse have certainly existed, but when the church has sought to help its members to understand themselves and their world it has used the methods of intellectual indoctrination. The minister in the pulpit, the discussion leader in the young people's group, the Sunday School teacher in her class, the missionary chairman in the women's society have all attempted to guide behavior and mold interests and attitudes through imparting information. But far more successful than any intellectual process of handing down factual data is the method of living through an experience and thus gaining first hand understanding. Psychodrama has been instrumental in pointing out the value of action over verbalization. The most intensive group therapy yielding the most lasting results has been that in which the group was used as a laboratory for life. If it is true in group therapy, it is even more true for church work. A religious *weltanschauung* cannot be secured through indoctrination or through listening to sermons regardless of how effective they may be. The deeper meanings of religion "are achieved," as Carroll Wise points out, "only through experiences that involve the whole person in all his relationships . . . . Each person must work out the meaning of life in his own experience."[3] Religion has meant the most to those who have actively experienced it in intimate fellowship groups where study and worship and work have been combined.

The church seeks to aid in personal growth, but growth cannot be accomplished in a vacuum. It goes on in the interaction between persons, in the give and take of daily living. The child can hardly be expected to understand the concept of Christian brotherhood until he has learned something about cooperation and team-work in actual situations. It is through the child's social interactions that a growing Christian experience is possible. The Church School class is ideally a little society in which love can be practiced, tested and experienced. With adults, too, it is the concrete social experience that leads to the modification of attitudes. It is the group interaction rather than the intellectual content of subject-matter presented that fosters healthy personality growth. In the kindly, controlled environment of the church group the individual is given opportunity for testing out his attitudes, using the group as a

sounding board. Like a member of a therapy group he knows that he is not playing for keeps, that he will have another chance. His hesitant and only half formed ideas are gladly welcomed and thoughtfully considered. Through interaction with others his ideas are modified; with the help of others his growth is encouraged.

A second emphasis needed in church groups if therapy is to result lies in the atmosphere of the group. The group must be characterized by a democratic, permissive, voluntary atmosphere. Such a group is one in which leadership is by winsomeness rather than by autocratic control. It is the method that is fundamental to democracy, a method that gives so much respect to the individual human personality that domination by coercion is deliberately refused. It is the method which invites creativity and growth through the creation of a favorable environment.

The creation of such a democratic or voluntary atmosphere is one of the chief responsibilities of the religious leader. This atmosphere is one in which creative interaction can take place resulting in therapeutic growth. S. H. Foulkes shows how significant it is for the therapist to put aside the autocratic role with group members.

> If the psychotherapist resists the temptation to be made a leader, he will be rewarded by their growing independence, spontaneity, and responsibility and personal insight into their social attitudes. It happens in exact proportion to the psychiatrist's art of making himself superfluous[4].

This is not to say that the leader plays a passive role. The insistence is that emphasis be placed on the creative role that the group member plays. Therapy results in the group situation when the group itself is free to interact. Just as the effective sociodrama grows out of the experience of the group rather than of the leader, so the effective church group is one in which the group members play the leading role. The democratic, voluntary principle is deeply embedded in Christianity. The Christian faith is one of inner discipline based on voluntary choice. The life of the spirit grows not through compulsion but through creative effort, "first the blade, then the ear, then the full grain in the ear[5]."

A third emphasis needed in pastoral group work if therapy is to result is for organization of groups in terms of purpose. Therapy groups are not simply collections of individuals casually called together. Instead they are groups of carefully selected persons who are brought together because of some common

need or interest that makes for unity and coherence. There can be no truly therapeutic group unless there is some specific identity and if religious groups are to accomplish any therapy the same must hold true. Religious groups are well adapted for therapy in this connection since there is usually a well formulated goal. It is one of the distinctive marks of the church group that it has a purposive nature in seeking to discover what religion has to offer toward solving the problems of everyday life. It is only, however, when the church gives conscious recognition to its purpose that it becomes a therapeutic agent.

Such an identity of purpose develops, as in all therapy groups, with a recognition of individual needs. The group does not exist as an end in itself; it exists to serve as a medium through which individuals can grow. The purpose of the group is not to carry out some specified program. The purpose is much rather the meeting of the needs of the group members. The success of a program is a minor consideration except as it affects the individual. Church groups are often inclined to stress the program to the point where inappropriate members are eliminated thus tending to increase personal frustration and maladjustment already present. The therapy group, on the other hand, directs its attention toward helping the odd stick to fit in with the others. The program itself is designed to contribute to his specific needs by providing socializing opportunities. If the group activities in the church are centered around individuals, then it will be recognized that the mischievous boys or troublesome adults are the ones who need satisfying group experiences the most. Moreover, those who find it difficult to enter into group life or who are easily hurt in interpersonal situations will be recognized as the very ones who need to raise their frustration tolerance through interaction in group associations.

When a group in the church is organized with the purpose of meeting personal needs, then the program activities will center around the personal problems for which the group seeks help. Psychodrama and sociodrama could be used with particular relevance in such a situation. By providing concrete illustrations of typical problems these more-than-verbal methods could lead the group into a better understanding of their common difficulties and could lay the basis for fruitful discussion. Alternative solutions could be played out before the group with mutual benefit to all concerned. By moving away from theoretical discussion toward practical demonstration the psychodramatic technique gives an objectivity and a concreteness to the problems which are significant aids toward finding solutions. Group members find help in meeting their own needs as they strive to find the answers for others.

The therapy group has as its purpose not only the stimulation of interaction within the group as individual needs are dealt with but it also sets its sights on even broader interpersonal contacts. The experience in the group is understood as a proving ground for broader contacts in the future. The goal is the adjustment of the individual in a small segment of society so that he will then be able to take his place with greater ease and satisfaction in a larger society. If a group is to serve its best therapeutic purpose it must not be ingrown. The smugly self-contained clique, so easily developed in church groups, not only misses the opportunity for making a wholesome contribution to a growing experience of its members, but it even tends to check normal growth. Excessive loyalty to a group tends to restrict activity to levels of petty interests and tends to prevent criticism and evaluation. Group introversion can have the same effect as individual introversion. Like all therapy groups the church must make provision for graduating its members into other broader and more inclusive groups.

It is obvious, of course, that church groups can be developed with these major emphases only as groups are carefully selected and leaders are properly qualified. An understanding of the dynamics of both individual personality and group activity are essential for the well trained religious leader. The leader who is so trained understands quite well the possibilities in the intimate group relationship which the church refers to as religious fellowship. Therapists are insisting that identification with other persons and with other groups in an integral part of the healing process, and this is but a reiteration of the need felt by Christians throughout all ages of church history. By making use of the growing body of knowledge centering around group therapy the church stands ready to supplement the work of promoting healthy personality through pastoral group psychotherapy.

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THERAPEUTIC THEATRE OF ALASKA ESKIMOS

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The Eskimos at Cape Prince of Wales, most westerly tip of the American continent, conduct a primitive form of psychodrama theatre in their Kosgee, or community igloo.

During the long winter night of six months, they gather in this underground meeting place, with a stage at the back, and there portray in pantomime and chant the emotional experiences of their lives. An orchestra of drums, made like large tambourines with handles instead of the metal jingles, and a stick that beats the frame rather than the stretched hide, provides a background of invitation and stimulation to express the emotions and dramatize the experiences that have aroused and disturbed them.

The drums start their slow hypnotic beating, a group of men climb up on the stage and join in a ritualistic performance of their living, as handed down through generations. The audience settles down, children cease play, women's hands drop their sewing, the men leave their carving and sled making, a mood of self-expression and relaxation permeates the gathering.

Two or three men remain after the performers have jumped off the stage and quietly become spectators. The drum beat grows in volume, anah-ay-ay-ah-ay chant starts. They dramatize a long hunt, the storm that overtook them, their construction of an ice igloo for shelter, their discomfort and fear and finally their stalking of prey, the loading of meat and skins, the monotonous trip home and their pride in having food and furs for their family.

They drip perspiration at the finale. Every emotion has been put into the dance.

A lone man jumps up on the stage. He stamps and twists and turns his body to show his jealousy of another man, his chagrin at losing a woman in a love triangle, his rage, disappointment and sullen resignation.

Another follows with his cunning in a hunt, the pitch of tension at the crucial moment of the kill, followed by his scorn of the carcass lying at his feet.

A women's chorus of traditional chant and rhythmic movements portraying an old mating story of female and beast or bird—and expression of their fear of the fierce eagle, the surprise of a bear joining them in a hunt for berries, or being caught out alone with a pack of wolve delaying a return to the village. Their terrors are masked with the romance of being chosen as a bride in the animal kingdom.

Following the chorus, a couple of women jump on the stage to describe the wealth of the white man—his loaves of bread, his supply of canned goods, especially milk, his stores of coffee and tea. They may laugh at his long nose, his bulky physique, his helplessness on the trail, at the same time goading their husbands with the material things a white man possesses.

Then come the women with personal troubles to be dramatized and judged before the group. An illustration is that of a middle-aged widow who used her utmost technique in luring a proposal out of a man of her age, and her disgrace and anger when jilted for a younger woman.

No emotion has to be hidden, no mental turmoil left to rot the mind, no frustration untold. The Eskimos are a happy people, with a keen sense of humor. They laugh joyously at their own mistakes. They are dignified in a way that is often mistaken for pride. They look at things so objectively they have no false feelings of pity nor sentimentality. They have their own standards of morals, as high, or higher, than those of the white race.

It does seem strange that these primitive people, living in a stone age under conditions of ice and snow, where white man has not learned the art of survival, should have the wisdom of mental catharsis, developed in the last quarter of a century by Dr. J. L. Moreno in the Psychodramatic Institute of New York.

They have utilized the five instruments, stage, subject, director (in the person of the chief of the village who leads them in the age-old dramatizations), the therapeutic aides who inspire and release with their chanting and beating of drums, and the spectators.

On their stage of driftwood planks, in the light of flickering seal oil lamps they find freedom from mental stress, doubts, fears, jealousy and distorted habits of thought pattern. There is clarification of motives, realization of errors, and the joy of expressing experiences. Their delusions, comparisons, emotional conflicts, are translated by dramatic expression and placed in proper proportion to values in the revelation of acting them out from false conceptions to reality.

The ultimate in spontaneity and freedom is reached under the guidance of the director, a leader who has risen to this position through his wisdom and understanding. He guides and guards the timing with keen perception of the goal to be achieved.

Auxiliary egos aid, as they do on the psychodrama stage, in building up the characters of the patient-actor's world. Their presence verifies and brings into the open the core of the dramatist's mental condition.

Winning the audience to an understanding and projecting himself into their sympathy releases his tensions, encourages fullest expression, probing of depths, innermost searching to reveal facts and results.

The audience is helped by interpretation of many of their own situations, creating a duo-fold relief. They visualize the associations, the stimulus, as experienced by themselves, through the psyche on the stage, and benefit in translation of emotional experiences.

An advantage the Eskimo therapeutic theatre has is timelessness. There are no outside pressures, no hours measured by clock time during long winter months of darkness, no distractions to interrupt nor end fullest expression. Climax of performance comes when the chief calls the historian to repeat the past of their ancestors in wars, famine, invasions of outsiders, and results of activities that have made these people what they are today.

PSYCHODRAMA IN PRISON

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The modern trend in prison work toward replacing older practices of punishment and retaliation by re-educative procedures has led to the appointment of psychologists and psychiatrists in some institutions. These psychoclinicians are for the most part, expected to concern themselves with the "bad" cases. The responsible authorities further hope that their mere presence within the prison walls will pervade the institution with the spirit of mental hygiene and will make custodial personnel treatment-minded. These hopes have rarely been fulfilled. The "nut doctor" is looked upon with suspicion by both inmates and prison workers. Clinicians themselves cannot be completely exonerated from their contribution to this unfortunate situation. Unsophisticated workers have oftentimes transferred procedures from other situations to the prison (heavy reliance on psychometric tests, seclusive office interviews, lengthy reports in technical language, etc.) On the other hand, the prison administration frequently has a preconceived idea of somewhat limited functions of professional specialists, e.g. prescribing a fixed testing program for their psychologists or designating the psychiatrist as a specialist for the diagnosis and treatment of sex offenders.

Recently in a few encouraging reports, it was demonstrated that mental hygienists on a prison staff can do work of a more imaginative nature than has heretofore been expected of them. Giardini recorded in a survey (6) various functions practiced by "some psychologists in institutions at some time" which are beyond the stale assignment of testing for classification purposes. He very justly pointed out that the tasks any one psychologist performs in prison are determined by the exigencies of the institutional situation as well as the training and experience of the psychologist. With the present state of affairs, this is also true for psychiatrists. "Socio-analysis" of grievance situations and non-directive counseling of inmates has been reported by Greco (7, 8). Corsini (3) has used non-directive counseling to make the results of aptitude tests more meaningful to the prisoner-counselee.

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In their attempt to counteract the stunting or even regressive effect on the prisoner of a coercive environment and at the same time to elicit dynamic antecedents of an individual's criminal conduct, some workers have welcomed group methods. These have proven of value in military disciplinary units (1, 9). Moreno's psychodrama (13) essentially a form of diagnosis and treatment in a group, offers a unique opportunity for "action counseling."[1] Among many other applications it has been successfully utilized in a correctional school for delinquent girls (2). A modification of this, as proposed and previously described by Curran (4) was applied by this writer in a correctional school for boys of the minimum custody type (12). With an adolescent population, accustomed to regular shows in the school auditorium, playwriting and acting were found to be of value because of their projective possibilities. Their diagnostic-therapeutic function was easily masked by their entertainment aspect. With more sophisticated adult offenders however, this method is not applicable.

Upon his appointment to a diagnostic clinic for male felons, this writer as the only psychologist on the staff, encountered a program of compulsory classroom attendance for every new inmate. The classes consisted of free discussion on mental hygiene or related topics and were conducted under the leadership of "guidance counselors," persons with most diversified backgrounds, not especially trained for their tasks, and operating essentially on a trial and error basis. From these classes, a number of men were referred to this writer for further study, either because of their deviant conduct in the group or the peculiarity of their crime. Other inmates, presenting a variety of problems, spontaneously requested consideration. A maximum period of eight weeks was available for contact with any given man. Under these circumstances, psychodrama with certain modifications, offered itself as the method of choice.

The Population

In contrast with compulsory attendance at "Guidance Counselor Classes" participation in the writer's psychodrama was voluntary. Likewise, every member was permitted to drop out whenever he felt that he had nothing to gain from the procedure. Groups varied in size from four to ten. They were composed in a "stagger system." At any time, they consisted of newcomers who were permitted to join at will and "old timers," i.e. participants with up to eight weeks of experience. A natural termination of any "class member's" (this term persisted in the men's vocabulary) participation was set by his

[1] For a subtle analysis of the processes involved in this procedure see Moreno (14) and Haas (10).

transfer to one of the four state institutions, which always took place not later than ten weeks after his commitment to the Clinic. This transfer removed the prisoner from the jurisdiction of the Clinic personnel even if he remained confined in the adjacent prison. Considerations of a transference relationship therefore were a luxury which could not be afforded within custodial regimentation.

Within six months, thirty-five prisoners entered the psychodrama group. Out of these, fourteen asked to be dropped from the group before their transfer to a permanent institution. One of the most frequent reasons expressed for these requests was self-consciousness about attending a "nut class." Upon the termination of the writer's activities at the Clinic, twenty-nine former participants were confined in the adjacent prison and therefore could most quickly respond to a follow-up inquiry. These were contacted, irrespective of their adherence to or early abandonment of psychodrama. Returns from this inquiry will be discussed in a later section.

Participants ranged in age from 18 to 47. All were American born, all were white except for two negroes. Three had a bilingual English-Spanish background, while the native tongue of the rest was English. In intelligence quotients, they ranged from 80 to 135; in occupational level, from unskilled labor to accounting and chiropractic; in educational background, from the fifth grade to several years of college; in the severity of their crimes, from indecent exposure to murder. There were first offenders among them and "two-to-four-time losers." None of them showed symptoms of an acute psychosis. One had previously been hospitalized with a diagnosis of schizophrenia. Another one, (19 years old) appeared pre-psychotic and two had for several years been erroneously confined in institutions for mental defectives. No attempt was made to form homogeneous groups. Candidates were invited to join in the order of their referrals.

The Procedure

Sessions were held two to four times a week. No wire recorder was available, but stenographic notes were kept by an inmate assistant. In lieu of a professional "auxiliary ego" staff, those prisoners who had for some time participated in the group volunteered in this function. Besides, the writer's inmate clerk, a reformed alcoholic with artistic inclinations proved to be a most versatile and imaginative auxiliary ego and so did the inmate stenographer after having been under psychodramatic treatment himself. It will be shown later

that in his case this function served as an effective extension of treatment. In the absence of women, female roles and even children had to be impersonated by the men. Except for occasional chuckling, this surprisingly did not impair the effectiveness of the procedure once, through warming-up, the situational matrix had been provided.

While the notes taken were extensive enough to serve as a reminder for writer's individual case reports, they had too many flaws and ommissions to be utilized here as true samples of what went on during psychodrama sessions on either verbal or action levels. Therefore, in the following, an attempt will be made to illustrate the application of psychodrama in a diagnostic clinic for adult male prisoners by the presentation of ten typical case. In each case, a brief summary of the pre-commitment facts will be followed by the writer's contribution to the clinical case summary, based on psychodrama observation.

Sample Cases

Case 1 J. P. age 22, American born Mexican, marginal socio-economic background; former juvenile offender, originally sentenced for burglary under drunkenness, had been placed on probation, violated probation by being drunk and fighting and subsequently been placed in the county jail. Serving part of his sentence in road camp, escaped from there and was then sentenced to prison for this escape. In initial interview stated "I am just weak-minded—the temptation gets me." Felt unjustly treated, blamed his probation officer for his being in prison.

Report: J. P. re-enacted the events constituting this violation of probation. He also acted out situations which he anticipated might occur in his future parole, e.g., meeting a former fellow-inmate on the street, who suggests visiting a bar and "pulling another job"; being apprehended by the parole officer, etc. In the course of these dramatizations, J. P.'s tendency to lie and his suggestibility became apparent and were the focus of group discussions. He seemed to gain understanding of the value of alternative more desirable solutions if exposed to certain temptations. His happy-go-lucky disposition certainly was not altered within the short period available. However, when last seen, he was less glib about blaming everyone else except himself for his predicament.

Case 2. R. W. age 47, severe alcoholic, three-time loser, each time convicted of passing bogus checks, under the influence of alcohol. Married twice, the first time to a flighty woman, who was killed in an accident; the second

time with a more stable woman with whom he raised several children. A painter by trade, but more interested in the ministry, he had occasionally given a sermon in church on Sunday in his home town. In connection with his religious conversion, had had previous long periods of sobriety.

In interviews, in spite of high intelligence and an excellent command of English, was not able to go beyond a few common-place statements of his repentance.

Report: During psychodrama sessions, R. was extremely eager to delve into his past in a search for what caused him to drink. His lively re-enactments of certain events of his past life, interspersed by accounts of other periods, revealed a harsh childhood, followed by shiftless adolescence in the house of a domineering older brother, marriage to an irresponsible alcoholic (first wife), waste of obvious talent in running gambling concessions for easy money, several abortive attempts to reform himself after wife's accidental death. Religious conversion during second prison term; at that time, sincere eagerness to combat alcoholic tendency and to discontinue "fast life"; periodic recidivism, a strong desire for sympathy, as a "man in search of God," rigid ethical beliefs, in which even smoking is designated as an "immoral habit." Previous longest periods of sobriety obviously due to identification with prison chaplain and R.'s own ambition to be a preacher. Obtained partial insight into his difficulties stating in one of his sessions that most of his trouble stems from his inclination toward extremes . . . . His religious over-emphasis, being a rather shallow mechanism, was gently discouraged.

Case 3. B. R., age 25, dishonorably discharged veteran, convicted of grand theft; took fiancee's pay check from her on way to promised wedding and threw her out of the car. For years had adopted a rebellious attitude toward authority.

Report: In psychodrama sessions, B.'s rebellious attitude was traced back to his school years and in particular to his pre-adolescent period. His foster mother (a former school teacher) not only insisted upon his attending Catholic school with its higher academic standard (for which B. showed neither capacity nor interest) but also regularly and rigidly supervised his school work. She went over all his homework and allowed him no free time for play after school. B. who selected this last typical situation for psychodramatic re-enactment, convincingly portrayed the traumatic effect this coercion had had upon him. He seemed to derive some benefit from comparing these early

experiences with similar ones re-enacted by another group member from his life. It is recommended that in further therapy a de-emphasis of academic achievement as the foremost goal in life should be brought about.

Case 4. W. G., age 19, convicted of robbery, first degree; held up a college student from whom he obtained a ride on the highway. Effeminate, bashful youngster, brought up by foster parents. In interview, complained about having suffered ridicule from schoolmates, fellow workers and his buddies (for a short period in the army). As much as he desired it, he had never been able to be accepted by any group. In school he had bragged that he could kill a man. He is aware of the fact that his real mother had been deserted by his father and that she rejected him. In spite of good mental ability (A.G.C.T. score 114) former neighbors believed G. had "a mind behind his actual age." Described by foster mother as a "terribly confused boy." Made impression of pre-schizophrenic.

Report: In psychodrama it was revealed that W.'s rejection by his peers dates back to his grade school days. Foster parents' overindulgence prevented him from participation in active games. His compensatory conduct (making provocative remarks to boys and girls, tattling whenever possible) resulted in contempt by his schoolmates and fellow workers. In order to avoid teasing, he frequently withdrew to solitary life in the woods. At the age of 12, he made it his hobby to shoot and hunt, to protect himself from stronger aggressors. Whether he had had such experience or not, he was afraid of homosexual approaches. During appropriate dramatizations, he appeared sexually ambivalent, similar to boys at a pre-pubertal stage. During the sessions, he was able to win the friendly comradeship of two other group members and seemed to benefit from this experience. It is believed that psychiatric treatment, in particular group procedures, may prevent schizophrenic development.

Case 5. B. E., age 22, convicted of burglary, broken home background, parents separated, boy reared in foster homes and by relatives; later wandered from farm to farm for a living. Poor adjustment to Navy service, spent 18 months in disciplinary barracks for being A.W.O.L., drunken sprees with gambling, etc. Felt Navy authorities had been "mean" to him, never gave him a break. In "Guidance Counselor" classes, he remained aloof. Displayed behavior pattern which is commonly called psychopathic.

Report: E. was fully cooperative in psychodrama; he re-enacted his belligerent attitude at the Naval disciplinary unit and participated in group dis-

cussion on the futility of such conduct. On several occasions, when anticipated life experiences of other group members were dramatized, E. volunteered to play the roles of aggressive individuals. He established a sort of protective "big brother" relationship to W. G. (Case 4, see above) and took serious interest in solving the latter's problems, whom initially he had ridiculed. Dramatizations of escape plots, which are often made by inmates of a minimum security institution (E. was considered for such a transfer) were performed by him in a rather playful manner. It was felt that his comments on the futility and detriment of such enterprises were sincere, and that the very dramatizations afforded abreaction of any doubt which may have been on his mind.

Case 6. C. S., age 22, committed for issuing several checks with insufficient funds. Slender build, sensitive young man. Born in New York City, but reared in Puerto Rico in bilingual environment, like an only child, by great aunts and other relatives (Parents were separated). At age 4, he had suffered severe burns, use of right arm had been impaired since. After his return to Continental America, joined the Merchant Marine. Had served in Federal Penitentiary for impersonating naval officer. His only occupational experience beside merchant marine service, was that of a dancing instructor. Ambitious to be an interpreter. (A. had attended a private secondary school in Puerto Rico, without graduating, however) but obviously lacked sufficient educational background in both English and Spanish for this profession.

Report: A. was very apt to dramatize critical events of his past life: His attempt to become attached to his uncle's lady friend in his search for a mother-substitute; his desire to live up to his aunts' expectations which were always higher than he was able to fulfill; the financial ups and downs which he experienced after the death of his aunts, who had brought him up. Among his dramatizations, there was the scene in which he impersonated a naval officer merely because his former school mates, whom he came across in New York, expected him to be one. During the sessions, he became more and more aware of the strong influence other's expectations had had upon his actions. Through appropriate dramatizations and subsequent comments by the group he also began to realize the limitations of his linguistic knowledge in terms of an intended career as an interpreter. He not only gained considerable insight but also became eager to aid others in doing so. Thus, when one group member was hesitant to admit alleged homosexual experience, or even inclination, A. volunteered the information that he had had one experience of this sort at the age of twelve, but that this had been unsatisfactory and and therefore ceased

to be of interest to him. A's attendance at psychodrama sessions have contributed to his growing-up process. The status which he gained in the group and the assistance he rendered as an auxiliary ego solving other's problems, were helpful to him in his constant struggle against feelings of inferiority.

Case 7. G. H., age 40, convicted of lewd and lascivious conduct, involving little girls; denied charge emphatically. From well-to-do Southern provincial background, with some college education, Methodist church affiliation; women in family had been active in church activities. H. was three times divorced. Occupational level (railroad engineer) below family expectations. His first marriage, while he attended college, had been financed by his parents. Was defensive in regard to prejudice prevailing against his native state; also constantly defensive against political obstructionists, who in his opinion tried to block his political ambitions in union work. In spite of strong paranoid and hypomanic tendencies, there was no evidence of an overt psychosis.

Report: H. was in constant state of mental exhibitionism. He voluminously verbalized on the high social connections of his family, on his political and church affiliations, his personal achievements in the promotion of right and justice, his Christian beliefs, his religious tolerance, his competence as a railroad engineer, his interest in philosophy, etc. It was revealed that he had attached himself to, and identified himself with, both his mother and his aunt "who were saintly women and maintained high standards" unparalleled by any women of his acquaintance. There is obviously a close connection between H.'s mother fixation and his sexual maladjustment, as revealed in his three unsuccessful marriages. Throughout his life he has been striving for status, power and superiority, as was manifested in his purely egocentric verbalizations. Though he preferred to monologize in the group and to submit rather long written statements on his innocence, through group pressure he reluctantly agreed to re-enact scenes around his alleged crime. While offering a version of the events which agreed with his frequent pleas of innocence, he sweated profusely, squirmed, harped on insignificant details and repeatedly called the procedure a "foolish endeavor." As often as feasible, he fell out of his role, reverted to his preaching behavior, accusing his ex-wife, his neighbors and many others of plotting against him by accusing him of a "hideous crime." It is not believed that psychodrama has contributed to H.'s obtaining insight into his difficulties at this time, though there may be an after-effect some time later. However, diagnostically the sessions were by far more profitable than the preceding attempts to interview H.

Case 8. J. W., age 26, convicted of lewd and lascivious conduct under the influence of alcohol, involving a little girl. A high school graduate with poor occupational adjustment, chronic alcoholic for many years. Married the second time, after divorce of first wife. Mother and wife very concerned about his welfare and rehabilitation, in particular about his cure from alcoholic addiction. In court had made only partial confession of his crime, even when interviewed by court psychiatrist. In this case an unusual amount of dynamic material was revealed in psychodrama thus demonstrating the diagnostic value of the method. It should be kept in mind that W.'s intimate confessions were made in the presence of his fellow inmates, although sex offenders are usually fearful of the reactions of disgust they experience from other prisoners.

Report: During the first sessions, W. gradually revealed his guilt, fully confessing to the incident with the little girl as well as to another incident of indecent exposure which led to his arrest a few weeks earlier. In his eager search for the causes of his misconduct, W. re-enacted various crucial episodes of his previous life. It appeared that as the favorite son of his parents, he had been treated with over-indulgence by both of them. Back in his childhood, he was ambivalent in identifying himself with a domineering mother who maintained "high standards" and with a weak father, who surreptitiously circumvented the mother's prohibition of alcohol. His emotional growth was early stunted through his parents' ineffective handling of his first irresponsible acts. After the father's death, the mother possessively continued to keep J. W. in a state of dependence to the extent of excusing him and making up for damage caused by his criminal offenses. W. placidly took advantages of the ever available maternal protection. There is considerable evidence of sexual maladjustment dating back to his school days when sex instruction by his parents was totally lacking and when he felt guilt about excessive masturbation which brought him into conflict with the sex taboos of his milieu. This was followed by unsatisfactory contacts with amateur prostitutes and an unhappy marriage to a girl of a strict Catholic background. His wife's social ambitions with which he was unable to cope, for financial reasons, increased W.'s compulsive drinking habit, which had originated back in his school days, and his irresponsible handling of financial affairs. These two weaknessess have since characterized his adult life. W.'s statements between re-enactments reflected emerging insight into the cause of his difficulties. The opportunity to view objectively some of his previous pitfalls seemed to give him a new outlook on right and wrong. In acting out situations in which he had recklessly lied in order to gain immediate advantage, W. showed conspicuous tenseness with vasomotor reac-

tions and blocking, followed by immediate release when commenting to the group on the foolishness of such conduct. Upon terminating his participation in psychodrama which was necessitated by his transfer to prison, W. had gained a sounder outlook on life.

Case 9. D. F., age 28, convicted of assault with a deadly weapon; under influence of alcohol had threatened a filling station attendant with a gun, forcing the man to drive him to the Mexican border. He desired no financial gain from the victim. As a matter of fact, at the time of the crime, F. had a considerable sum of money in his pocket and more in his hotel room. The son of well-to-do parents in an Eastern city, F. had never taken over full responsibility for his own support and since adolescence had led a "fast" life, including heavy drinking. Had been seen by home town psychiatrist and by Yale Clinic, and also had previously joined Alcoholics Anonymous and the National Committee for Education for Alcoholism. Had done journalistic work for the latter organization which he found more satisfactory than partnership in his father's business. For one year had refrained from use of alcohol, but toward the end of this period, developed paralysis of one arm and sexual impotence. Marriage with a girl of different faith from his own, led to constant friction with in-laws. When the symptoms mentioned above made F. extremely tense, he decided to leave home, town and family, went on a drinking spree and drove to Florida to visit an old drinking partner; continued his pleasure trip to California, where he hoped to start a career as a movie script writer. Before he could make the contacts expected through a Hollywood friend, F. who was again drinking heavily, stole a gun, and soon after was arrested for the crime described above.

Report: S. entered into psychodrama with great eagerness. Significant dramatizations of domestic and business situations revealed the following: Alcoholism was tolerated since F.'s high school days by his utterly lenient and doting parents, who themselves were abstinent; parents had ignored F.'s vocational ambitions outside the sphere of business; having no affectionate ties to his parents, F. had recently tried to free himself from his dependence on them. Among others, F.'s visit to a psychiatrist before his episode, was the subject of dramatization. He vividly demonstrated his lack of sincerity in that situation, his intention to utilize the psychiatric interview for rationalizing his intended escapade. The basis of the neurotic conflict underlying various symptoms (alcoholism, functional paralysis, occasional sexual impotence) was not revealed during psychodrama sessions. However, it was observed that F.

obtained a better understanding of the social consequences of his irresponsible conduct and that he has become willing to consider himself a psychoneurotic, in need of treatment. Thus, for the first time in his life, he declared that he possessed an undesirable tendency to inflate his ego, of which he would like to rid himself. The psychodrama sessions elicited supplementary diagnostic material and laid the ground work for individual psychotherapy and participation in Alcoholics Anonymous.

Case 10. S. T., age 33 recidivist, convicted for fraud. Present crime is an exact repetition of his previous one. Single, physically unattractive, mentally alert, vocationally competent, of middle-class urban background; has failed to make adequate social and in particular psychosexual adjustment. For years has been a "lone wolf," has gotten into the habit of going out with Hollywood starlets who were taking advantage of his good nature and gullibility, carrying on platonic friendships with him. Both times his crime consisted of charging bills for luxurious feminine items given to his girl friends, to his uncle's account. This, of course, after he had exhausted his own means. He had attended Guidance Counselor classes at the beginning of both his prison terms. Here he had picked up a few psychological terms but had not gained insight.

Report: T. was one of the most eager members of the group. He entered it with his self-made diagnosis; namely that his problem was one of compensating for physical inferiority by mental and educational achievements as well as financial power. Dramatizations revealed a traumatic episode from his school life when he had been ridiculed by a classmate with a caricature and an insulting poem. His initial contact with his latest girl friend and some of his further experiences with her were also dramatized and formed the basis for fruitful group discussions. The problem of T.'s social insufficiency was found to date back to his boyhood which was spent in his grandmother's home. He had been reared by his (divorced) mother and grandmother (both illiterate) and had been early taught to hate his father, whom he hardly knew. In the same household were handsome young uncles and aunts, who had overshadowed him and who considered him too unattractive and clumsy to be presented when company called. It appeared that he had been able to compensate for his cinderella role by excelling in school but had become extremely shy with the opposite sex. In spite of frequent dating of girls, had no sexual experience at the age of thirty-three. Had never previously admitted this fact to either male or female companions, but seemed to gain relief from its discussion in a sym-

pathetic group. Had developed a strong need for emotional attachment to one woman, without having developed the skill to select a proper mate. At the start of the sessions, T. idealized and romanticized his last girl friend, for whom he had bought so many presents. From session to session, however, he came to see her somewhat dubious motives (and also those of his previous girl friend), until one day he frankly called himself a "sucker." Insight gained during session also included a more realistic view upon sexual matters. Thus, for instance he revised such adolescent notions as "the average woman has a higher moral standard than a man" and for that reason "she represses her desires." He became ready to admit to himself that he had tried to buy love, that his women and men companions had taken advantage of him and that his rehabilitation depended upon his acquiring more realistic notions about people. He recognized his need for joining groups with less dubious living habits than his previous associates.

The Result

Through a recent review of the literature on evaluating guidance precedures (5), the over-optimistic therapist is reminded of the inadequate criteria which are universally used. There is no single method among the seven enumerated in that review (2) which could be identified as the best. With a small group as the present one, evaluating a single technique within a total situation aiming at re-education, it seemed most feasible to resort to inquiring for clients' opinions a short time after the termination of the project. Therefore a letter was sent to the participants of psychodrama which read as follows:

"Dear Sir:

> As I am leaving here next week, I would like very much to know what you men who participated in psychodrama *really* thought about it. I am therefore asking each one of you to tell me honestly what your feelings are about the psychodrama sessions you attended. Did you personally get any help from them? That is, did you better understand your problem as the result? Which problem? Or, on the other hand, did you feel that they were of no help at all to you? Also, what effect do you think psychodrama had on the other men who attended? Please do not hesitate to offer any criticism you may have. To make it easy for you to answer honestly, use back of this sheet for your reply and *be sure not to sign your name or number.* Use the enclosed envelope, seal it and drop it in the mail box within 24 hours."
>
> Thank you. (Signed)

Nineteen of the twenty-nine thus contacted (see p. 3) or 60% replied. One possible explanation for the fact that only this percentage sent in returns is a dislike by some people of putting anything on paper. It may be argued that the returns, in spite of the request for anonymity, constitute a biased sample in favor of those having derived benefit from psychodrama, and that the ten men who did not reply were those unfavorably impressed. However, here is a survey of the replies obtained. Three of the nineteen disregarded the request for anonymity and signed their statements. Replies ranged in length from two brief sentences to a narrowly written two page essay. One prisoner with a poetic knack, added a poem which is appreciative of the writer's efforts but ends with a pessimistic clause saying that his efforts were "wasted on a stone."

Though the returns were not representative of the participating population, it seems worthwhile analyzing them, since a certain sincerity pervaded all of them. Omitting all phrases of personal appreciation for writer or belief in improvement due to writer's alleged skill, the statements made by the nineteen were classified into nine groups. The frequency distribution of these categories was as follows:

A. Self (or others) "started to think," "learned," "gained insight" (understanding)	13
B. Seeing oneself "as others see one," "facing reality"	5
C. Parallelism of own with others' problems	5
D. Beneficial effect of "advice," "suggestions," "constructive criticism by others"	6
E. Opportunity to talk freely about ones problems	2
F. Restoration of self-confidence and optimism	2
G. Other group members, not caring enough, could not be helped	4
H. "Should also deal in present problems, as well as in past experiences"	1
I. Should be applied to wider population and more frequently	8
	46

All response categories, except perhaps for the last three (G, H, I) represent positive evaluation of psychodrama, without reservation, from the standpoint of the participants. They include 33 out of 46 statements, or 72%. Response categories H and I (comments on the insufficient utilization of the method) though implying a favorable attitude toward it, may be termed "ambivalent." The only negative evaluations are represented in replies of the cate-

gory G (four in number, or 9% of all statements) referring to the ineffectiveness of psychodrama with certain members of the group.

Discussion

In a correctional institution psychodrama has wide applicability. In particular, at a diagnostic clinic of a prison system to which the inmate is committed in the beginning of his term, he is often willing to unfold his personality. Feelings of guilt, and fears in regard to the future make him receptive to psychotherapy. The permissive atmosphere of psychodrama, with its informality and its realities on an action level, is a useful adjunct to the diagnostic endeavors of the psychometrician, the sociologist and other specialists. It frequently reveals the core of a man's problem and starts him on a new way of thinking. While a complete reshaping of the inmate's personality cannot be expected in the course of a few sessions, it may safely be said that the most acute symptoms of personality maladjustment tend to disappear in the course of psychodrama sessions as described above, and that a sort of palliative cure has been achieved in most cases.

There are many occasions during a prisoner's term in which psychodrama could be utilized with similar effectiveness. Friction between inmates and custodial personnel, fights among inmates, breaks of discipline and the like could be dealt with faster and more effectively by psychodrama than by lengthy, stiff, disciplinary courts and their subsequent penalties. Likewise, less conspicuous difficulties in interpersonal relations, which some inmates demonstrate could be made subject of psychodrama and thus more quickly overcome. Another suitable stage for its use in prisons is the time the inmate is prepared for parole. His imminent return to a free society, from a heavily controlled environment, is accompanied by many fears, which are sometimes disguised by wild plans. Here psychodrama provides the opportunity for reality testing, similar to its use in the preparation of psychoneurotic patients for release from mental hospital (11). Also, parole officers, if available in a sufficient number and if properly trained, could hold regular group sessions with their clients and could utilize psychodrama as a medium for dealing with various difficulties of community adjustment. Finally, psychodrama should have a legitimate place in the in-service-training program of prison personnel, giving the custodial officers the opportunity to act in the role of their wards and thus to gain a better understanding of their feelings.

SUMMARY

In a diagnostic center for male felons, thirty-five men, all free of manifest mental illness or mental deficiency, voluntarily participated in psychodrama. The attitudes of most of them during the session indicated that they derived some benefit from the procedure. Asked for anonymous comments on their reactions, former participants commented favorably on the project. The largest single category of their comments deals with insight gained into *some* of their difficulties. To illustrate, ten typical cases have been selected with brief summaries of their pre-conviction story, and the reports on their participation in psychodrama have been given. The diagnostic aspect of psychodrama merges with its therapeutic role. For that reason, the method should be applied more widely and also be extended to other phases of the correctional system.

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THE "SILENT" AUXILIARY-EGO TECHNIQUE* IN REHABILITATING DETERIORATED MENTAL PATIENTS

By

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This report describes a continuing experiment in working therapeutically with 75 deteriorated women patients in a State Mental Hospital. The aim of the project is to readjust these patients by giving them an interest outside of themselves, thereby bringing them into a happier condition. Many of them are suffering from dementia praecox and exhibit the hebephrenic and catatonic features of that psychosis; emotional shallowness, negativism, and mutism are generally present in addition to regressed mentality. Rarely are they aggressive or greatly disturbed. During most of the day they sit on the benches or recline upon the floor apathetically oblivious of their environment. The attendants, usually two to each 8 hour shift, care for the ward and the patients. All day the rooms ring with noise, loud shouts, commands, and scoldings, for although kindly disposed, the attendants believe this is the best method to pursue.

Because retraining is largely a personal matter, the superintendent decided to open a daintily decorated room for the project and under the direction of the Occupational Therapy Department, placed an interested nurse in charge to study the patients' reaction to pleasant surroundings. The room came to be known as the "Habit Training Room."

SAMPLING PROCEDURE

Choice of patients for the habit training room was on the experimental level. Three of the women were assigned by supervisors owing to some specific difficulty; the others were added by the recommendation of their attendants who hoped they might profit by a change. However, the nurse was warned by the Occupational Therapy Department that she should return any patient to the ward who willfully disturbed the peace or happiness of others. Thus a few changes were necessary before the project could get under way. The Department also upheld the nurse's decision to permit no smoking in the room and posted a notice to that effect. This constituted the only rule. The unhygienic habit of spitting on the floor was "just not done" after the first offender was shown how to wash up the mess and then how to wax and polish the spot. Any mistake of untidiness was treated in the same way. Torn dresses were replaced by mended ones while the rip was fixed. No patient was ever reprimanded but was always encouraged to do better.

Cases 1, 2, 3 listed below are the ones referred to in the above paragraph:

**The auhor is a Charge Attendant Nurse at Boston State Hospital, Boston 24, Mass.

*Dr. J. L. Moreno suggested this approach in a personal conversation two years ago. "The silent auxiliary-ego uses gentle gesture in place of words, tries to motivate the patient to occupy herself constructively and surrounds her with an atmosphere of optimism."

CASE 1

Silent Treatment in a Case of Inertia

Miss D. W. showed little inclination to leave the ward. Upon being eventually persuaded to come into the room, she sat down, refusing to look at anything. Tea and cookies held no interest for her. So listless was she that a blanket was placed on the bench for her to recline upon. Sometimes from there she watched the activities, although refusing to join any except the walks. This "occupation" continued for six weeks until she was transferred to a medical ward on account of boils.

Back on the ward again she voluntarily joined the group going to the habit room. Here she seated herself at a table and took up a book of poems to read. Noticing that she was covertly watching a patient crocheting a hat, the "silent-ego" seated herself beside Miss D. and with yarn of the same color started crocheting a cap, then placed the work in her hands. She refused it, saying, "I don't want to do it. I just want to watch you."

After a few days she picked up a dress that had been placed beside her to be mended and sewed a seam quite poorly, but showed childish pleasure with her accomplishment and with the smiling approval she received for it. Her sewing improved and after a month she readily accepted the offer to work in the hospital's industrial sewing room. While walking over, she remarked, "It's lovely out this morning, so fresh."

During the four months' project, Miss D. W. went through a set-back of depression, when for two weeks she stayed on the ward spending much of her time on her knees in prayer, reverting to her resistant, negativistic ways. Upon coming out of this disturbed state, she resumed her previous pleasant manner.

CASE 2

Silent Method Used with a Destructive Patient

Mrs. G. D. willingly entered the habit training room. She walked around inspecting the equipment, then seated herself comfortably and asked what she should do. She accepted the proffered problem of fraying and knotting strands from a piece of burlap but her interest soon flagged. Suddenly she measured the piece of material and finding it would cover her, quickly tore a hole in the center large enough to accommodate her head, drew threads at the waist line through which she passed ravellings for a belt, frayed six inches for a fringed hem and delightedly donned this becoming dress.

Next day she found beside her seat a pin cushion, a needle and thread, some torn dresses and a few pieces of material. With a small cry of pleasure she started adding new cape collars to some, gathered skirts to others, or panels of a bright color. Always she modelled the finished dress, twisting and turning until she received the desired approval.

Games and dancing did not appeal to her. She preferred to continue the work occupying her attention at the moment. However, she much enjoyed music and the walks were a source of pleasure. She would pick flowers to bring in and reproduce artistically with paints or crayons. Her social manners were

charming. Most graciously she would wait upon guests and patients at tea; but she was jealous and if she felt another patient was receiving praise or turning on the phonograph, which she liked to do, she became disturbed and had to be led from the room because of her revolting language. This characteristic showed no improvement throughout the experiment. That she appreciated the Habit Training Room was evident from her refusal to attend the industrial sewing room. "Oh, no dear, thank you, I prefer this where I can crochet, draw, or sew just as I wish, but I would like to work here in the evenings and Saturdays and Sundays, too." she said.

During the experiment, Mrs. G. D. expressed no desire to rip. Possibly she had previously torn her dresses merely to change their pattern or perhaps to break the deadening monotony of idleness.

CASE 3

Helping an Uncooperative Patient

Mrs. B. S. presented a difficulty. On the ward she stood against the wall with her head lowered, mutely retired from the world. Her cafeteria actions were entirely different. Here she became active and dodging under the arms of patients carrying trays, she purloined food right and left, often tipping the whole tray up to her lips. The resultant mess on her face and dress did not concern her.

With the help of the Supervisor, she was persuaded and pushed into the room. She would not sit down and kept up a tripping movement back and forth within the space of a yard. She refused to look in the mirror, resisted having her face washed and would not accept a magazine. It was days before she would sit down and turn the pages of a magazine while keeping her head averted. When the nurse noticed her looking at a magazine she put a threaded needle into her hand and guided her fingers to sew on a button, hoping that since she has three growing children, the occupation might bring happy memories to Mrs. B. S. She dropped the needle many times and refused to pick it up. It came as a surprise, when one day, still pretending not to look at her work, she attached a button strongly in the correct place. She was now not quite as difficult to bring into the room and was tidy.

At this time electric shock treatments were given her by the doctors. Their effect was miraculous. She walked naturally, took pride in her personal appearance, discontinued her avid habits, took all responsibility for the tea parties and helped in countless ways. She is impulsive and presents the picture of an excitable high school girl rather than a mother. She was transferred to a more comfortable ward and is asking for dressmaking and cooking lessons.

CASE IV

Elimination of Activities

On the ward M. F. reduces clothes to something resembling a mouse nest. She fills her hands, her lap and often her mouth with these tiny fragments, then while seated she bends forward almost touching the floor with her head chat-

tering in a high pitched sing song. Otherwise she was mute. She always came willingly with a rather silly smile on her face. She was offered paper to tear and put the pieces into a prettily painted container. This failed to interest her. Material to rip met with no better result. Magazines, books, pencil and paper she refused still clutching the refuse she daily brought in. After ten days she ceased her chatter when dancing or swaying to music and began to sit upright. Then she accepted the project of threading wooden beads; however, the refuse which she would not discard prevented her from accomplishment. But when offered a needle and thread she dropped the refuse to take it as though she were pleased to be sewing as other patients were doing. She stuck the needle in and out as a very young child would do, so she was shown how to attach buttons to a piece of cloth. This occupied her for several days. When she was offered a broom she pushed it back and forth on the floor and picked up pieces by hand. She did not use the dust pan. A large cloth was tied over the broom and she happily polishes the floor, sometimes she picks up pieces but willingly puts them into the rubbish can. She has not since reverted to mouse nest making.

Technique

Dr. Moreno's silent-auxiliary-ego technique was chosen as likely to prove a satisfactory approach to these women who could close their minds to the spoken word. By gesture rather than speech the nurse might hope to break through their blockage and gradually, with patience and persistence, be enabled to meet their wishes and needs.

To further explain how the technique was used, the following typical cases are presented with these purposes in mind:

1. Bringing back mental vitality.
2. Presenting occupations likely to appeal.
3. Helping an uncooperative patient.
4. By elimination of activities finding projects that suited the patient's ability and whim.

The class was held five days a week and at first only six or seven women at a time were taken from the ward to the room and given freedom to occupy themselves with books, magazines, sewing, knitting, drawing and painting. Later, when a student nurse was assigned to help, a more varied program was instituted to include as well, habits of cleanliness and mid-day rest, music, dancing, games and walks on the campus, and 17 patients were enrolled. (See Table I.) After a few weeks, some patients, upon being handed a broom, accepted the responsibility of clearing up, while others folded the mended garments, put away materials, and cared for the phonograph. As they became more cooperative, less destruction and untidiness was recorded. (See Table II.) The three patients who did not improve evidently need further study in order to reach their deep seated disorders. Five of the 17 were acquisitive and showed

little change in their cafeteria avid actions, even after their manners had become socially correct at tea parties in the room.

Another method of measuring responses of the group was also undertaken. Daily notation was made of the number of acceptances or refusals to carry out suggestions. For example, a patient might be asked to sweep, to mend a dress, to play a game, or to partake of tea. That constitutes 4 activity situations. The number of acceptances might be 2 with one more that required urging and 1 refusal. This crude index did measure the patient's capacity to cooperate. There were no marked shifts that occurred in one month of use of this measure. Perhaps it might have indicated a trend to more acceptances if continued longer.

Patients who were decidedly better and seemed to need further advancement were given the opportunity of working in the industrial departments of the hospital. Four accepted the offer and are proving reliable helpers in cafeteria and sewing room.

The Habit Training Room was closed after four months and the work attempted right on the ward. Some success was achieved here with the method, the nurse carefully cooperating with any activity then in progress, appreciating the attendants' efforts while giving them no advice. Noticing the willingness with which the Habit Room patients swept and mopped floors before sitting down to mend torn dresses, they volunteered the thought that work does make a patient more content. Forthwith began vigorous training of others to sweep, clean, wax floors, fold clothing and help each other dress. The attendants have taken on an optimistic attitude, finding after their persistent efforts to train these dilapidated women, any success becomes a rich reward.

On the basis of the study, the following practical suggestions are made for continuing the test on a 24 hour basis for 75 deteriorated and untidy patients.

The ward would be divided into three groups designated Class 1, Class 2, and Class 3. Class 1 would contain the most deteriorated patients; Class 2, those who are beginning to work and dress themselves; Class 3, the ones who do not need so much supervision to keep them occupied.

To carry out the program, there would need to be:
7:00 A. M. to 3:30 P. M.—5 attendants (1 to not more than 15 patients.)

An occupational therapist, spending one hour daily on the ward assigning projects and recreation to patients and teaching the attendants how to carry work along.

3:30 P. M. to 11:00 P. M.—4 attendants.
11:00 P. M. to 7:00 A. M.—2 attendants.

Daily Program

5:45 A. M.—Class 3 is awakened and each given her bag containing clothes, shoes, comb, tooth brush, wash cloth, and soap. They are supervised in getting a shower, then dress themselves, put their night clothes into their bags, and hand them to the attendant, and help her with Class 1 and 2.

8:40 A. M.—In the cafeteria, 5 attendants will be responsible for the behavior of the same 15 patients daily.

9:00 A. M.—4 patients taken to the industrial department by attendant. Class 3 works on ward. Attendants teach classes 1 and 2 to sweep and clean. Attendants help patients play and dance. They take any to treatment room that need it.

12:45 P. M.—Dinner—as at breakfast.

1:30 P. M.—Occupational therapist on the ward for instruction.

2:30 P. M.—Attendant takes three patients to linen room and brings back sufficient clothing, then brings back patients from industrial work. Patients are helped to play games, sew, or read magazines, or exercise out of doors.

5:45 P. M.—Supper—as at breakfast.

7:00 P. M.—Class 3 helps the attendants getting Classes 1 and 2 to bed. Afterwards, each takes her own bag, takes out her night clothes, folds her day clothes, and puts them in it before handing it to the attendant, who supervises their preparations for bed and sings some hymns with them.

Before 11:00 P. M., she inspects each bag (about 12 or 14) to see it is filled adequately and ready for the morning.

To make a success of the test, all attendants should understand the project and be interested in it, should be pleased to become a part of it and promise to be on duty regularly unless sick, when they will notify the Nursing Office in time to be replaced by another.

Patients who have become tidy and are not destructive should be allowed soft mattresses with pillows and sheets, and be placed in the small rooms on the ward as a further incentive to recovery.

A further extension of the test is under consideration to embrace a one hour supervisory service five days per week from the personnel of the Occupational Therapy Department, additional attendants and student nurses, to carry through a twenty-four hour schedule.

SUMMARY

Seventeen deteriorated and untidy mental patients who had been in residence in a state hospital on an average of 16 years, were studied in a group habit training project. It was demonstrated that with the application of the "silent auxiliary-ego" technique, (activities suggested by gesture rather than speech) even very regressed and withdrawn patients could be reached and their cooperation gained. Only 2 of 17 remained untidy in toilet habits at the end of 4 months of treatment and 8 abandoned their destructiveness. Four patients were sufficiently improved to work in hospital industrial departments. Ward attendants' interest in helping patients improve was captured by the demonstration of a different method of approach to a most difficult problem.

NOTE 1: Miss Mary Sylvia, R.N., Superintendent of Nurses at Boston State Hospital made possible the carrying out of this experiment.

NOTE 2: Walter Barton, M.D., Superintendent of Boston State Hospital kindly organized this article from notes and jottings taken during the project.

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TABLE I

TABLE I — DESCRIPTION OF PATIENTS IN THE STUDY

		AGE	Years in Hosp.	Intel. On Adm.	*Diagnosis* On Admittance	Status at Start of Experiment
1	Mrs. H. B.	39	7	Normal	Dementia Praecox Paranoid	Destructive, continually winding strings around her extremities, pleasant, cooperative.
2	Mrs. E. B.	elderly	10	Normal	Manic Depressive (Stone deaf)	Restless, untidy, destructive, avid
3	Mrs. O. C.	48	20	Normal	Manic Depressive Stupor	Actively destructive, gentle, untidy, preferred a prone position.
4	Mrs. B. S. M.	47	9	Average	*Psychosis* Schizophrenic	Noisy, incoherent, destructive, untidy.
5	Mrs. G. D.	45	6	Normal	Involutional Psychosis	Destructive, aggressively noisy at times; otherwise charming.
6	Miss M. D.	49	29	Normal	Manic Depressive Psychosis	Destructive, untidy, noisy, avid
7	Miss M. F.	44	9	*Moron*	Dementia Praecox	Chattering in high pitched voice, bent over; destructive, untidy.
8	Mrs. J. L.	55	35	Normal	Dementia Praecox Catatonic	Destructive, aggressive, sitting mumbling incoherently.
9	Mrs. E. L.	59	14	Normal	Dementia Praecox Paranoid	Sitting in corner holding dress about her face.
10	Miss B. M.	38	23	Sub-Normal	Schizophrenic Psychosis	Mute, sometimes aggressive.
11	Mrs. M. C.	45	10	Normal	Dementia Praecox Paranoid	Untidy, destructive, sullen looking.
12	Miss M. M.	41	26	Normal	Dementia Praecox Paranoid	Untidy, destructive, uncooperative.
13	Miss E. S.	44	31	Normal	Dementia Praecox	Untidy, destructive, walked about smiling foolishly.
14	Miss E. M. S.	52	32	Normal	Manic Catatonic	Sitting in a corner, untidy, destructive.
15	Mrs. B. S.	36	3	Sub-Normal	Catatonic Manic Depressive Psychosis	Apathetic, untidy, uncooperative, avid.
16	Miss D. W.	24	8	Normal	Dementia Praecox Catatonic	Untidy, stubbornly uncooperative.
17	Mrs. D. Y.	38	1	Normal	Dementia Praecox Catatonic	Untidy, aggressive, mute.

TABLE II

PATIENTS' STATUS AT THE CLOSE OF THE FOUR MONTHS STUDY IN THE HABIT TRAINING ROOM

		Tidy	Destructive	Result
1	Mrs. H. B.	Yes	Yes	Winds her extremities with strings, cooperates in games and dancing, annoys other patients by rubbing them—No productive occupation.
2	Mrs. E. B.	Yes	Less	Stone deaf. Sews coarsely, mends diligently, cooperates in dancing by feeling the motion of her partner.
3	Mrs. O. C.	No	Yes	Tries to cooperate without result. Dislikes music.
4	Mrs. G. D.	Yes	No	Intensely interested while using her creative ability—sewing, chocheting, painting.
5	Miss M. D	No	Yes	No improvement. Uncooperative in games. Verbalizes continually.
6	Mrs. M. F.	Yes	No	Learned to sew on buttons, sweep and pick up pieces.
7	Mrs. J. L.	Yes	Less	Crocheted caps and wash cloths. She is sometimes aggressive.
8	Mrs. E. L.	Yes	No	Mended clothing and now attends sewing room. Answers questions.
9	Miss B. M.	Yes	No	Learned to knit wash cloths. Leads on walks and to cafeteria.
10	Miss B. S. M.	Yes	Less	Cooperative in games. Talks incoherently. Dries dishes.
11	Mrs. M. C.	Yes	Less	Learned to knot string, sews poorly. Aggressive and uncooperative on ward.
12	Miss M. M.	Yes	No	Aggressive unless gently treated. Works in cafeteria.
13	Miss E. S.	Yes	Less	Sews, mends and crochets. Quite emotional.
14	Miss E. M. S.	Yes	No	Can fold clothing, smiles at a joke. Refuses to play games or to join in dancing.
15	Mrs. B. S.	Yes	No	Highly emotional. Sews and knits after receiving electric shock treatment.
16	Miss D. W.	Yes	No	Cooperative, sews. Attends industrial sewing room.
17	Mrs. D. Y.	Yes	No	After doctors gave her electric shock she became friendly; liked to sew and crochet.

PSYCHIATRIC FRONTIERS

The opening of psychodrama at the Mansfield Theatre of New York City marks the lifting of new psychiatric frontiers. Dr. J. L. Moreno, the founder of group psychotherapy, has initiated a new movement toward mass psychiatry, using psychodrama and sociodrama as the medium of communication. Mass psychiatry seems more than a dream on some distant horizon.

As Dr. Moreno once said, "A true psychotherapeutic procedure cannot have less an objective than the whole of mankind."[1] The approach used at the Mansfield Theatre is illustrative of a therapeutic system which has this potential.

The opening of the Mansfield was marked by the greetings of the New York City Board of Education brought by Dr. J. Greenberg and by a few words from Dr. William H. Kilpatrick of Columbia University. Thus we see the philosophy of psychodrama and sociodrama exerting its influence in the most basic areas of psycho-social development.

The star of the second Mansfield production has described, in retrospect, some of his feelings while on stage and some of the effects which he feels his participation has had on his life. (See article by Stanley Moldowsky.)

The majority of the audience reacted to the production with enthusiasm and was extremely active in the discussion following the action part of the session. A negligible minority seemed to have come to the theatre expecting something quite different. It is felt that when the public begins to understand the nature of such productions and their goals, mass psychiatry will be realized.

JAMES ENNEIS

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1 Moreno, J. L., "Who Shall Survive?", Nervous and Mental Diseases Publishing Company, Washington, D. C., P. 3.

SOCIODRAMA SESSION AT THE MANSFIELD THEATRE

STAN MOLDOWSKY

Saint Elizabeths Hospital, Washington, D. C.

Date: November 27, 1949 *Director*: Dr. J. L. Moreno

Place: Mansfield Theatre, N.Y.C. *Protagonist*: Stan Moldowsky

Topic: Problems of inter-religious marriages

As the orchestra of the Mansfield Theatre began to fill up, I sat there reflecting on the events of the preceeding week-end. Eight members of the staff at St. Elizabeths Hospital, Washington, D. C. (including myself) had gone to Dr. Moreno's sanitarium in Beacon, N. Y. for the Thanksgiving Week-End Workshop. For some of us it was our first contact with the psychodrama stage. I was beginning to appreciate psychodrama as a therapeutic technique after having seen sessions with various patients at Beacon. However, I feel now that one can't get the *fullest* appreciation of psychodrama until one is on stage as a *primary* ego. Herein lies the essence of this report.

The lights dimmed, the curtain was drawn revealing a bare stage save for a few props, and out of the audience came Dr. Moreno, soliloquizing as he ascended the stage. He spoke about the sociometric structure of the present audience, about discovering the make-up of the group before beginning to work and about the dynamics of group psychotherapy. As he spoke he returned to the audience to interview briefly some of its members.

"Hello, what is your name?"

"I gave my name."

"Where are you from?"

"I'm from Washington, D. C. I'm a clinical psychologist at St. Elizabeths Hospital there. I'm interning for a year."

"Married or single?"

"Well, I'm single now but I'll be married in three weeks."

"What is your religion?"

"My parents are Jewish. I'm not religious."

"And your wife-to-be?"

"Her parents are Catholic."

"Any problems there?"

"Uh huh."

Dr. Moreno went on to talk to others in the group but in a short while I was on stage having a more intensive interview. As we reconstructed my social atom, members of the audience were called up to play auxiliaries to help me bring my problem to crystallization. My father, mother, fiancee, future father-in-law, and others helped me in the production.

We ran the gamut of psychodramatic techniques. I played my father, my mother, my fiancee, while auxiliaries played me (role reversals). I was involved in "double" scenes soliloquizing. The problem of the different religious backgrounds and the antagonism of both sets of parents was dealt with.

Pat (my fiancee) and I had been in love for a year and had planned to marry for the past three months. We had discussed the problem of our different parental religions many time before. Our own feelings were that since neither of us were interested in religion the religious problem was not a problem per se, for us, but rather the maintenance of good-will amongst the relatives.

In the scenes between my family and myself the question of how our future children would feel without a religion and also the feeling that Pat and I were hurting our respective parents became paramount. In playing the roles of my mother and father I began to feel some of the "hurt" they referred to. However, the various scenes seemed to indicate that the religious issue was really a pseudo issue and that more important were the feelings of "giving up the only son" on the part of my parents and a certain amount of "rebellion" on the part of myself. The parents seemed to harp on the religious differences as a way of thwarting the proposed marriage whereas actually this did not seem to be basic at all.

In playing the marriage scenes, it became apparent that Pat and myself were rather sentimental and the very business-like justice of the peace, and the religious marriage were both unappealing. A compromise informal wedding seemed desirable.

It is difficult at this time to recount the actual protocol simply because when one is deeply involved emotionally in the action on stage, only the feelings remain and the content becomes dim. It is interesting to note that Moreno describes this as the "spontaneity state." When one is in this spontaneity state and is involved emotionally, partly intellectually, and completely physically,

memory for the events occurring at the time are rather hazy i.e. you don't really know what actually happended. However, the feelings that have remained are worth elaboration since they have had an effect not only on my marriage but also on my decision to continue to work in psychodrama.

First, the audience was a very warm, receptive group and contributed very much in the discussion period following the session on stage. Many members of the audience had similar problems and discussed their solutions. It is reassuring to find that your own personal problem is not in the least unique but a very common social problem. Various audience participators told how their own inter-religious marriages have worked. A Unitarian minister mentioned how his own life somehow paralleled mine in that he left his father's church (Catholic) to become a Unitarian. A number of people mentioned that religion was no problem to them, but that the in-law problem still reared its head. "Start a life of your own, Stan, and stay away from the in-laws," seemed to be the predominating feeling expressed by the group. This advice to me has gone through a metamorphosis since the session because insights seem to develop in retrospect. I feel now that the in-law problem is a ticklish one but that I have made much progress in that respect. Playing the roles of my parents and Pat's parents helped me somehow to understand them a little better and through greater understanding the conflict diminished in proportion. Although physical limitations (distance) prevent much social intercourse with the in-laws, the few visits we have made have been very enjoyable ones. The fact that the rebelliousness in me has diminished, due to the greater understanding of them, has indirectly effected "the state of the union." Pat and I are very happy in our relationships with our parents and therefore the area is no longer so great a problem.

Another area which was only touched upon lightly, was my own feelings about beging Jewish, a member of a minority group. This, of course, is a deeper problem going back to the days when I first learned about discrimination via personal experiences. The catharsis obtained by working through a problem of this sort gave me a feeling of acceptance by the group. Likewise, since our parents were frowning on the marriage, parent substitutes (the audience) accepted it and reacted favorably. This gave me courage to complete our plans. The feeling of acceptance is not to be minimized. It is important to both Pat and myself and the audience's reaction had a lot to do with stabilizing us in community life.

Another effect of the sociodrama session was felt in relation to the other seven members of the hospital entourage who were present at the session. The effect of "baring oneself" on stage had a counter-effect on them. Many of them felt the need to give of themselves in conversations with me in the ensuing weeks. The session seemed to have lifted some barriers in our relationships which then allowed them to expand and grow. The opening up of new social experiences was a beneficial effect.

Finally, my own decision to continue in psychodrama and to be trained in directorial work was definitely formulated. I had been through an emotional experience which left me with a new understanding of the therapeutic possibilities of psychodrama. The sensitive director, seeing the star's problem areas unfolding leads the drama into situations so that the star can obtain insights and become more free. Becoming spontaneous in relationship to others where previously rigid behavior patterns were manifested is so much more possible through the action methods. Seeing some of this happen, especially in relation to myself, convinced me that it was an area I should like to develop in. Since that session I have had opportunities to direct patient groups in psychodrama as well as non-patients groups in sociodrama and I feel that these experiences are due, in large part, to myself having been a "protagonist."

PSYCHODRAMATIC, SOCIOMETRIC AND GROUP PSYCHOTHERAPY PROGRAM OF THE

MORENO INSTITUTE

Part Scholarships Available

Special Rates for Veterans

The Institutes of Beacon and New York have organized facilities for the enrollment of students for the course during the coming year. All students are to receive instruction and training in sociatry, socio- and psychodrama, sociometry and group psychotherapy, covering among others, the fields of: Nursery School, Child Guidance, Public School Education, Juvenile Delinquency, Speech Disorders, Intercultural Relations, Leadership Training, Family and Marriage Problems, Music Therapy, Therapeutic Films, Rehabilitation of the Returned Soldiers and their Families, Political and Labor Conflicts, Community and Religious Problems.

The objectives of the program are: (a) Training of directors of psychodrama, sociodrama and group psychotherapy in the conducting of sessions; (b) Training auxiliary egos (therapeutic and research actors), of group interviewers and group lecturers; (c) Training of social analysts in clinical and actual situations; (d) Seminars covering the fields of psychodrama, sociodrama, sociometry, group psychotherapy and therapeutic motion pictures; (e) Research and field projects in psychodrama and group psychotherapy, with study of methods and analyzing and classifying psychodrama, sociodrama and sociometric materials.

Teaching and training will be given jointly at the auditorium of the New York Institute and at the Therapeutic Theatre of the Moreno Institute.

Students fall under two categories. Category A: The Beacon Group. Enrollment in this group is limited to 30 students. Classes and sessions begin on July 1st and last for 4 months, until October 31st. Students of this group reveive their room, board and training at the Psychodramatic Institute at Beacon, New York. The fee for students of this group is $60.00 per week, $240.00 for a four weeks' stay. Directorial work is part of the training of this group. Application for enrollment in this group should be in our hands by May 30 with registration fee of $5.00. Members of the Beacon group may attend New York sessions at a small additional expense.

Category B: The New York Group. Students live in New York (those who have private residence) or commute from out of town and attend the classes at the New York Institute at 101 Park Avenue. These courses may be arranged throughout the year. For this group sessions and classes are given 3 times a week in the late afternoon and evening, so that they are able to pursue a professional occupation during the day, or other academic studies. The full enrollment capacity of this group is 80 students. The weekly tuition fee is $20.00, the fee for a 12 weeks' course is $240.00; with additional training in directorial capacity the fee runs to $360.00.

There are a number of half scholarships available. Students who qualify for and obtain such scholarships pay half the tuition for the 12 weeks' course, $120.00 and $180.00 respectively. New York students may attend week-end sessions at Beacon, N. Y., staying at the Beacon Institute for the week-end if room is available, for an additional fee. Such a week-end training is meant especially for students interested in directorial techniques and work with mental patients.

All students are required to pay a registration fee of $5.00 in advance.

J. L. Moreno, M. D., Director of the Psychodramatic Institute in Beacon and New York City, assisted by a staff of instructors, will conduct the seminars and sessions. Students will be permitted to use the library at the Psychodramatic Institute. Every student is expected to formulate and work out a research project related to his own field of application, under guidance. Upon completion of the course every student will obtain an official acknowledgment from the director as to the duration of the course and the accomplishments of the student.

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