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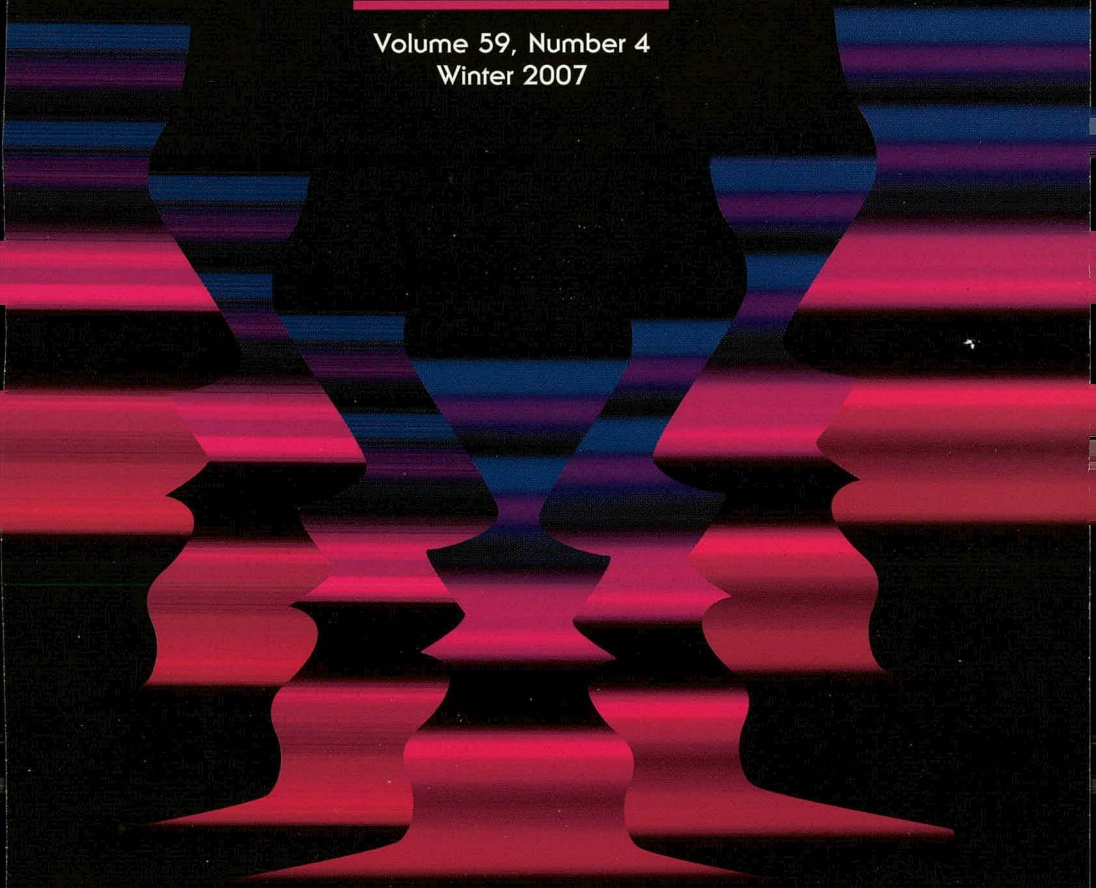

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Founded by J. L. Moreno

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Modeling Conflict Resolution in Group Psychotherapy

MARILYN LEWIS LANZA

ABSTRACT. In a time-limited therapy group for aggressive men, an episode of conflict between coleaders and its resolution evoked a wealth of useful material for advancing the anger management skills of the group members. The author discusses how the conflict arose from the senior leader's lack of appreciation of the shared leadership, and how the resolution of the conflict resulted in her growing acceptance of the junior leader and, eventually, in their mutual trust and respect. The dual leadership allowed for a shared ability to step back and reflect while the other leader took over and became more active. The coleaders' hard work came to fruition at the group's end. The patients discussed how it was novel to see coleaders being angry with one another and to observe the anger being expressed and resolved in the group directly. The anger between the coleaders added to the patient experience as well as to the group experience, because the leaders in fact emulated what they discussed. Expressing anger in a direct manner can have a positive effect, and will not necessarily lead to disruption of the leader or group relationship.

Keywords: aggression, coleadership, communications, conflict resolution, differences, psychotherapy

PSYCHOTHERAPEUTIC TREATMENT OF VIOLENCE is a particularly challenging task. It is definitely not a quick fix approach and does not allow the clinician to make one assessment that yields the hoped-for outcome of avoiding disaster. The therapist feels clever and omnipotent, yet all these countertransference feelings, pleasurable as they may be, still need to be processed. For example, it feels wonderful to be "so gifted" in working with highly assaultive patients, but this feeling is short-lived. The psychotherapeutic process involves an ongoing reassessment of the individuals as new strengths, as well as evidence of comorbid weakness, become evident. Psychotherapy with violent people puts one in touch with one's own vulnerability. The fear is always present that one might make a mistake in judging how safe

a patient—or a therapist—is at a particular point in time or during a specific therapeutic intervention. Psychotherapy with violent patients entails getting to know the patients well, putting oneself in their shoes, and giving up the attitude of us versus them. Once one understands the patients' feelings more fully, one begins to see their view of the conflict. For example, when I led a group for men who had been convicted of assault in which the group format included both staff and student observers, the observers found that, over time, they began to really like the patients and developed the ability to consider the patients' situations with a different reality focus. Working with violent clients also involves disquieting experiences for therapists, including getting in touch with their own rage, their murderous fantasies, and their vulnerabilities, and coming to terms with their beginning to like the aggressor.

Group therapy is a viable therapeutic approach only for certain clients. Some patients may be too assaultive or unstable to participate in group therapy, for example, whereas others may not be willing to accept the pressure to conform that invariably exists in groups. However, for many patients the group is a safe place. First and foremost, group members realize that their issues are not unique—they are not alone. Many group members grew up in dysfunctional environments, and the group becomes an oasis where the patient is encouraged to work through issues caused by such upbringing. The group becomes the family from which the patient can get support, encouragement, reassurance, and insight. Through feed-back, the group members help one another learn important social and interpersonal skills and they learn how to express both positive, and more important negative, feelings in a constructive manner (Berg, 1987).

Group leaders working with groups of violent patients must cope with intense intrapsychic pressures. The therapists as well as the patients have a tremendous fear of being exposed, although this fear is largely unconscious. The therapists are expected to keep their composure, feel the angst of their patients, and not act prematurely on one hand but, on the other hand, not ignore real risks such as, for example, keeping a man who makes disguised threats to other group members in the group. These requirements are a tall order and one that leaves the therapists, at least during the group sessions, on their own.

Shame

Through working with aggressive and violent patients, experienced therapists begin to discern an underlying theme of shame (Lewis, 1987). A patient who gets angry in group and acts out that anger by punching another person will often, after calming down and discussing the incident, feel sorry for the victim. This feeling of sympathy is often accompanied by a feeling of shame

for having lost control and having resorted to violence. Another example of such shame is the child rapist who initially is excited and enjoys the sexual experience. In his mind, the child "wants" sex and "asks for it." However, after having considered his actions and his inability to control himself, this patient also feels shame (Lewis).

Dual Leadership

Threats of violence are an aspect of therapy with assaultive individuals that group leaders may find difficult to cope with and might prefer to ignore (Steinberg & Duggal, 2004). However, having a coleader is an advantage when conducting psychodynamic group therapy for aggressive or assaultive men because it diminishes the feeling of the therapists' aloneness. Although in dual leadership, one therapist will often have more experience or authority than the other (Rutan & Stone, 2001), the coleaders equally share the responsibilities for directing the group and attending to group boundaries (Williams, 1976). Dual leadership allows for a fuller and more complete view of the group and protects against blind spots in either therapist (Msyzka & Joseflak, 1973). Dual leadership also allows each therapist the opportunity to move in and out of active and passive (or observational) modes (Gans, 1962). Although such leadership offers excellent training for the junior leader, it has certain disadvantages, such as the junior leader's constantly being evaluated by the senior leader. This may be distracting and uncomfortable for the junior leader and the discomfort may be exacerbated if group members voice their evaluation of the leadership skills of the two therapists.

It is vital that the two leaders have a fundamental respect for one another, even when their skill level and group experience differ significantly. It is also of utmost importance that the leaders allow for thorough exploration of the group process, the group relationships, including transferences between the members, and especially of the relationship between the two leaders. The difference between having dual leadership instead of solo leadership is that new subgroups often arise and the members will respond accordingly, including by developing different fantasies about the leaders, either as individuals or as a pair (Rutan & Stone, 2001).

Although dual leadership and the consequent particular dynamics are hardly a new topic (Anderson, Pine, & Mee-Lee, 1972; Benjamin, 1972; Friedman, 2002; Gans, Rutan, & Lupe, 2002; Hellwig & Memmott, 1978; McMahon & Links, 1984; Mehlman, Baucom, & Anderson, 1983; Paulson, Burroughs, & Gelb, 1976; Segalla, 2001), we encountered some unique situations in conducting the group for assaultive men, which I discuss in this article. The coleaders' shared dynamics may be illustrated by a situation involving aggression between a patient and a therapist, such as when a patient

gets angry at one of the therapists. The other leader can serve by calling the attention of the group to the wider issue being discussed—in this case, to the patient's intense anger at the therapist and to what lies beneath it—and a general discussion of how the issue relates to the rest of the group should follow. The shared dynamics, thus, allow each therapist to assume the dominant role. If the usually dominant therapist is made anxious by a particularly angry patient, the junior leader takes over, allowing the other leader to refocus. In an incident like this, the solo therapist would not have been able to explore the aggression to the same extent as that which shared dynamic group leadership allows (Rutan & Stone, 2001).

There are many different kinds of group therapy, including rational client-centered therapy, gestalt therapy, and rational emotional–emotive therapy. In rational client-centered therapy, the group leader is considered the facilitator who helps clients reach their full potential to solve their own problems and make better choices. Gestalt therapy focuses on the here and now; the present becomes the foundation for change, and the leader's role is to teach the patients to take responsibility for their feelings and behaviors. In rational–emotive therapy, the group leader uses the patients' belief in irrational ideas about the self as the foundation for internalization of a more rational life perspective that can be used for behavior change (Rice & Rutan, 1987). However, most group leaders use an eclectic rather than a pure theoretical approach (Rice & Rutan).

In our therapy group, which we called *Coping with Aggression*, we used the psychodynamic approach, which focuses on conscious and unconscious mechanisms that are present intrapsychically, interpersonally, and within the group as a whole (Rutan & Stone, 2001). Members talk about conscious and unconscious conflicts within the self, between two or more people, and within the entire group.

Coping With Aggression in the Group Environment

The Coping with Aggression group was conducted by two coleaders (both nurses) at a Veterans Administration Hospital and consisted of 8 male patients, each of whom had committed an assaultive act in the past year, either in the hospital or in the community. For our purposes at the Veterans Administration hospital, violence is seen in terms of assault. Assault occurs when a patient tries to hurt or does hurt another person with his or her body (e.g., hitting, kicking) or with an obstacle (e.g., using a knife; Lanza, Keefe, & Henderson, 1998).

The group met once a week for twelve 1-hr sessions. Members could enter the group through the fourth session and could be self-referred or referred by a staff member. The mean age was 52. Participation was voluntary. Although

many had been members of general psychotherapeutic groups prior to attending this group, members had usually only experienced a cognitive–behavioral approach to dealing with their aggression.

A group contract served as guidelines rather than strict rules to be followed. For example, the contract called for the members to be on time for the group but at times, something interfered and made a member late. Tardiness would not prevent the patient from participating in that particular group, but the incident would be discussed by the group—with or without the patient present—even if the patient was only a few minutes late. The group contract applied to all members, including the leaders. Confidentiality was a vital aspect of the contract, and information discussed in the group remained within the group, unless a member was likely to commit an act of physical harm to himself or another person or was unable to care for himself. However, the group leaders would communicate the general themes of the group to the unit staff and the patients' records.

A coleader and myself led the group. In addition to training in group psychotherapy, I, the leader, had extensive experience in conducting this kind of group. My main area of expertise is treating assaultive patients. However, I had suffered a serious stroke 4 years before starting this group and was continuing to recover. Initially, I had right-sided paralysis and occasional dysphasia—I would forget names, especially if I was a little anxious. I explained the condition to the patients so they would know that they were important to me even though I might forget their names. The doctors had said that I would not improve much after 1 year but I have made significant progress; I now walk without assistance and am continuing to improve cognitively. The coleader had several years of experience in conducting support groups but was new to a group focused on patients with aggression and, in general, had very little experience working with aggressive and assaultive individuals. Both leaders attended group supervision with a highly respected psychologist who was employed elsewhere. He had been advising me continuously for 15 years on my leadership of psychodynamic groups but was new to the coleader.

My coleader and I were fortunate to have a strictly professional relationship, with no fraternizing outside of work. This is similar to the ideal of not having group members interact with each other outside of the group in the most rigorous type of formal psychodynamic setting. A social relationship complicates matters because of the politeness factor. If cotherapists are also friends, they may not be as honest in a group setting as they would be if they were exclusively colleagues. This reasoning parallels why it is preferable that a patient and therapist do not know each other socially.

The group allowed staff to observe the meeting for training purposes. The staff sat in a larger circle around the patient group and, after the session, the staff would meet with the leaders to discuss what they had witnessed. I, the

senior leader, would instruct the staff on parallel issues between the Coping with Aggression group and the group of observers and would discuss my methods of processing material.

The purpose of the group was to help the patients identify, understand, and deal with the underlying problems of their aggressive behavior, to improve their interpersonal skills, and to help them find more appropriate ways of expressing their anger. Therefore, we coleaders made clear to the group members that we would tolerate no physical violence in the group. If, for example, a group member were to hit another, we would ask the assailant to leave the room until he had gained sufficient self-control. The nonviolence policy included aggression against objects. If a patient hit a chair with his fist, we would ask him to express his anger more appropriately (i.e., with words). Then we would give the group the opportunity to discuss the outburst and explore the cause of the patient's anger.

In this particular group, the members did not show any assaultive behavior. However, 3 members got into heated arguments with others outside of the group over who would get a particular parking space. We coleaders were active in promoting verbal expression of anger rather than allowing group members to express anger through behavior. Members often became extremely angry but generally expressed it appropriately. Two examples of indirect anger were a patient opening and closing his fist, and a patient pounding his knuckles. We made both members aware of their behavior and instructed them to talk about their anger, not act it out. In both cases, the behavior ceased immediately. Very rich group discussion defining the nature of indirect anger followed these incidents.

Challenge for the Senior Group Leader

One of the biggest challenges for me in conducting Coping with Aggression was having a coleader. Because this was the first time since my stroke that I was to lead a group for assaultive patients, a highly respected colleague suggested that I have a coleader in part, at least, for safety. I resisted the concept of having a coleader. The prospect of having one both annoyed and demeaned me. I had conducted several groups for assaultive patients alone in the past, and not only did I consider myself capable of continuing as a solo leader, I did not believe that dual leadership would make me safer. Actually, I felt that having a coleader, an extra person to worry about, would only add to the stress that I felt in conducting my first group since my illness. Furthermore, I liked being the star of the group because I would not have to discuss and compromise my thoughts. Reflecting on the situation now, I realize that having to share the spotlight made me feel as if I had lost a part of the group work that I liked. However, I buried my feelings initially. The group began,

and the coleader was very much in the background: Group members saw me as conducting the group and saw the coleader as the assistant.

Everything went smoothly, according to me, for the first few sessions. Then, during one meeting, the coleader had a parallel conversation with a group member while the rest of the group proceeded with the issue at hand. I interrupted the coleader's conversation and asked if she and the patient had something helpful to add to the discussion. I was angry and added very sharply that she "had broken the rule of not conducting a separate conversation with a group member." The coleader was very embarrassed but I still reasserted that there should be only one conversation at a time. I was surprised at the force with which I expressed myself; what I did not realize at the time was my wish to deny the need for dependency.

In the next session with our supervisor, I revealed to him and my coleader that my anger toward the coleader was caused by my resentment at having her present. It was never my intent to colead the group and, until that point, I may have kept silent about my feelings because I felt insecure about whether my illness would affect my leadership skills. Again, this was the first time since the stroke that I was leading this type of group. The coleader felt embarrassed about the incident in the group and perceived that I was right in my rebuke of her (Segalla, 2001) but, at the same time, she now felt that we had dealt with the issue satisfactorily. However, I kept feeling chagrined by the intensity of my anger because I had always thought of myself as firm but kind.

In the next group session, I explored with the group how the members experienced my expression of anger at my coleader. Several of the members initially agreed with the coleader—"it was no big deal." I explained that I had in fact lost my temper; "I can become angry during group, but in this incident, my anger was out of control for me, causing me to be negatively critical of my coleader." My coleader was so intimidated by my admission that she kept insisting to the group that I was right; even though she had just wanted to wake up a patient who was sleeping and she had spoken very softly, the problem was that there was already one conversation taking place. I reasserted that there needed to be one conversation at a time, but I also acknowledged there were ways of saying that without becoming so angry. The group further explored what it was like for me to lose my temper and how this related to the patients' own lives—to when they lost their own tempers. A surprise to the group, though, was that two individuals could still work together despite angry feelings (Gans et al., 2002); the patients experienced firsthand how to discuss anger within safe limits without acting on it.

As a consequence of this incident, I felt calmer and allowed the coleader to become more involved. We began alternating who was in charge of the group: I usually set the stage but if I became too anxious for some reason, my coleader would take over the group.

Despite years of training on the benefits of cotherapy, when it came to actual practice, I was not very good at sharing leadership. I would accept reactions by patients but it was very difficult for me to entertain feedback from my coleader. However, I was beginning to actually learn the value of examining situations from multiple perspectives, a process that first and foremost benefits the patients. The critical lesson for everyone, including the leaders, was that not only can disagreement occur in a group between coleaders but also, instead of being concealed, such conflict could—and should—be explored openly by all parties.

Changing Roles

Looking back, I now realize that my resentment of my coleader also reflected my displaced feelings of unexpressed anger toward a particular patient who, 10 years earlier, had been especially aggressive toward me in a group—a connection I was not consciously aware of at the time of the incident with my coleader. In addition, I was frustrated with my body's failure and was questioning whether I was more compromised than I had recognized. All of these thoughts represented my unconscious fear of dependency.

One of the advantages of the new experience of having a coleader was that it allowed me to take more chances with angry interchanges (Friedman, 2002): Someone else would be there to step in and manage the group, if necessary. Another function of cotherapy is that of modeling (Gans et al., 2002). A healthy cotherapy relationship can comfortably include discussion of disagreements without concomitant loss of face, thus modeling effective and satisfying interpersonal relations (Hellwig & Memmott, 1978).

A coleader also adds a different point of view, which encourages group members to consider various perspectives and thus enlarges their range of coping techniques (Hellwig & Memmott, 1978). In addition, when subgrouping took place within our group, the coleader would present another target and give me a chance to step back and reflect on what was happening. Stepping back and looking at the role relationship from a wider perspective illustrates how the mutual support of cotherapists can catalyze the therapist–patient relationship. When therapists feel that a cotherapist supports them as well as the patients, the therapists are less likely to back off when the patient thrusts up defenses (Hellwig & Memmott). When two therapists have resolved the dependency–independency issue and, thus, participate in the group process as peers, the leadership will move back and forth between them (Gans et al., 2002). This circumstance enhances the group experience in two ways: First, it allows group members to observe healthy interactions between two untainted adults, and second, it allows one therapist to assist or take over when he or she sees that the colleague has come to an impasse (Hellwig & Memmott).

An Example of the "Tables Turning"

The last three sessions of the group were particularly notable. One day, on my way to group, I fell as I was ascending the stairs. Four group members, who were close by, helped me get to my feet and picked up my books and papers. I was embarrassed by my body's betrayal and decided to explore my dependency in the group. That part proceeded well.

After the group, in the meeting with the observers, an observer noted that a patient, when helping me, had touched my arm. There was a contract item of no touching in the group and I adamantly denied that I had broken the rules. I had a coat over my shoulders and, since I had not felt being touched, I was sure that the observers had not been able to see my arm clearly. However, other observers confirmed the touch. There had been contact between the member and myself. I felt devastated—I had violated the contract. This was my most intense example of shame.

In the next session, the coleader discussed what happened. I felt an enormous weight off my shoulders by having someone else bring the issue out into the open. This was a time when my coleader and I had clearly switched roles. The patients had noticed the touching, but had "not made a big thing" out of it because they felt that worrying about feelings was a woman's issue. We took advantage of this incident to extrapolate this "woman's issue" to how the patients ignored feelings when aggressive. This discussion allowed me to regain my composure and colead the group in a comfortable manner. The split between the coleader and myself had lessened, and I was grateful to my coleader for taking control of the group when I felt so vulnerable. It was as if she allowed me to retreat and just observe what was taking place. The resolution of our crisis had been essential to the maturation of our cotherapy relationship. An increasing mutual respect was developing between she and I, and with this respect came bonding. On the verbal and nonverbal levels, we had sorted out many of our similarities and differences. This, again, is a decided advantage of having a coleader: to trust each other enough to argue and have different ways of completing tasks in the group (Paulson et al., 1976). Dual leadership represents an opportunity for the cotherapists to test their competence as a pair within the group. Ultimately the pairing of group participants parallels the pairing of the cotherapists.

However, we did not process the patient's attempt to comfort me through touching. It would have been very helpful to discuss the incident in the group, but this was an awareness we did not have until after the group terminated. The unresolved feelings about this omission, such as anger towards the therapists, may have played a part in why the group member who had helped me when I fell left the group prematurely. This particular patient had made significant improvements in handling his aggression. However, he decided to end the group

by avoiding the last meeting. He may have experienced a temporary return to receiving negative recognition, and by avoiding the group, he would not receive any positive feedback—a temporary reliving of his initial problem.

Discussion

The advantage of writing this article was that it forced me to put my experience into a larger context. For example, my not feeling the patient touch my arm seemed horrible and incomprehensible. However, reading about a developmental crisis in cotherapy relationships, which in fact purported that a crisis is essential for cotherapy maturation (Segalla, 2001; Weiss et al., 2002), gave me a new perspective. I could view the incident as one that group members and therapists could discuss in the group to the patients' advantage and this perspective lessened my feeling of shame. Such discussion would make group members better able to tolerate their own shame. For example, it would cause the group members to feel badly for their victims rather than just ridiculing them with "how victims cause themselves to be hurt."

The final phase of the group had a profound impact on the coleaders as well as on the patients. At the last meeting, the patients talked about loss and how they would proceed when the group ended. Some patients had acquired better ways of discussing anger and noted how their responses to anger had changed. Some patients were even able to admit to being afraid when they used to get into fights and all patients agreed that the coleaders' disagreements and arguments served as a real-life model of how to handle disagreement and anger without blowing up (Segalla, 2001). Although the competition between the coleaders continued throughout the full course of the group sessions, we continued to work hard at our relationship and even though we had planned a fixed number of sessions, we did not want the group to end. We felt that the group had gone well, in spite of some rough times. We benefited from exploring the coleadership issues but the degree of insight was unexpected (Weiss et al., 2002). Thus, both coleaders and patients, through parallel process, demonstrated ambivalence regarding the group sessions coming to an end.

In summary, having a coleader not only provides the opportunity for one leader to step back and observe the coleader and the group, it also allows the leaders more time for reflection. When a leader is active, it is beneficial to have a coleader who can share what he or she sees and perhaps offer a different point of view. Also, when the group experiences anger or has other intense feelings, it feels safer to have two therapists confronting such anger. In addition, having a coleader enables a leader to make an intervention that one would not make if one were the only leader. When a leader is alone, it may be too unsettling to confront a very angry patient with how his rage affects the group, and how hard it is for the rest of the group to give him feedback. Dual

leadership makes such directness possible, and patients experience first-hand how healthy relationships and interactions are possible.

Recommendations to Other Therapists

In reviewing this article, I would like to make several recommendations to other therapists:

1. Gain experience as both a solo leader and a coleader early in your career. Take advantage of the opportunities that having a coleader provides to move in and out of the role of the active leader and to explore more difficult situations than would be possible as a solo leader.

2. Learn to be extremely open to all your feelings and how to express them. This openness includes becoming aware of what you need to share with the group and what you need to process by yourself. This might be called *therapeutic use of yourself.*

3. Ensure that you and your coleader have excellent supervision.

4. Learn to model for your patients what you are trying to teach them.

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Morenean Approaches: Recognizing Psychodrama's Many Facets

ADAM BLATNER

ABSTRACT. Psychodrama is only one of many approaches developed by J. L. Moreno in his lifetime. Rather than being thought of as a single method, his work would be best served if recognized and utilized as potentially separate components. Although the effectiveness of these individual components might be increased by using them in concert, there are many situations in which they can be applied in their own right.

Keywords: improvisational drama, psychodrama, role playing, role theory, sociodrama, sociometry

THE TERM PSYCHODRAMA has come to be used in two senses. The first meaning refers to the therapeutic role-playing method usually conducted in groups. This approach was developed by J. L. Moreno, MD (1889–1974) in the mid-1930s, and it is sometimes referred to as *classical psychodrama.* A more general meaning has come to refer to the entire complex of Moreno's ideas and methods developed from 1908 onward, including:

1. A revisioned "religion of encounter" and a sense that the Divine can "speak" through the creative process in any individual, around 1908 (Moreno, 1989, p. 29–34).

2. The use of improvisation to enliven the dramatic play of children in the parks of Vienna, also around 1908 (Moreno, 1989).

3. The use of self-help, egalitarian group work (rather than having the group leader as authority) with prostitutes in Vienna, around 1912 (Moreno, 1989).

4. The idea of allowing people the freedom to express their preferences and having those preferences respected, so that people can affiliate with whom they

chose rather than be assigned arbitrarily to subgroups (i.e., the roots of sociometry, in the refugee camp of Mittendorf, near Vienna, around 1917; Moreno, 1989).

5. The creation of what was possibly the first improvisational drama troupe, "Das Stegreiftheater (i.e., "Theater of Spontaneity," in 1921–1923, in Vienna, and later, other experiments with impromptu theatre in New York City, around 1930–1931 (Moreno, 1989, p. 73).

6. The application of the aforementioned egalitarian spirit and recognition of the therapeutic benefit of group therapy at Sing Sing prison, which was presented to the American Psychiatric Association in 1931 (Moreno, 1989).

7. The development of sociometry in assigning and working with residents at the Hudson School for Girls around 1933–1936 (Marineau, 1989).

8. The extension of work with groups, impromptu theatre, and sociometry, leading to the development of classical psychodrama, around 1936–1937 (Marineau, 1989).

9. The development of theories about roles, social networks, interpersonal relations, and the like as written about in early journals produced by Moreno, around 1937 and beyond (with this in turn becoming one of the foundations of role theory in sociology and social psychology).

10. Promoting the integration of spontaneity and imagination into other creative arts therapies and the general exercise of the arts in culture, in contrast to an earlier over-emphasis on learning the "right" methods and structures, or following the compositions of the masters.

11. Development of ideas about spontaneity and creativity, which though noticeable in earlier writings, become more elaborated in his published journals.

In this article, I emphasize that Moreno's work is more encompassing than psychodrama, which was just one application of his varied interests. Nor do his many contributions constitute an inseparable package. The reason for this over-focus on Moreno's work as applied to psychotherapy is that Moreno, having trained as a physician, found he could make a living doing therapy, and this application became the most prominent aspect of Moreno's work. Yet he always held a vision of a goal that was far broader. (In this, he was similar to Freud, who did not want psychoanalysis to be used only by physicians in treating mental illness—the challenge of helping people become more aware of their own unconscious forces applied to many other fields, from anthropology to literature.)

In the 1940s and early 1950s, Moreno wrote as actively about sociometry as he did about psychodrama. Even after giving his journal *Sociometry* to the American Sociological Association in 1956, he continued to make efforts to emphasize his interest in this broader vision.

During the 1950s and 1960s, psychotherapy was a growing element in psychiatric treatment, and the writing in Moreno's journals focused more on these concerns. Also, because Moreno's home base was his sanitarium at Beacon, in upstate New York, students came to learn about psychodrama as a type of therapy. Finally, those studying with Moreno were most impressed by the personal experiences they had as protagonists and the power of his method for helping to resolve the psychosocial issues in their own lives.

This focus on the psychotherapeutic applications of Moreno's work was reemphasized in the decision in the later 1970s by the newly formed American Board of Examiners in Psychodrama, Group Psychotherapy, and Sociometry to make the attainment of a degree in one of the mental health professions a prerequisite for certification. Then, in the examination process for certification, students of psychodrama were also expected to be knowledgeable about sociometry and Moreno's philosophy. Nevertheless, a general impression has emerged, I think, that psychodrama as therapy is the key, and that the complex of Morenean approaches constitutes an inseparable package. However, in this article, I challenge that assumption.

The Scope of Morenean Work

It is important to remember, then, that psychodrama as therapy was only one of Moreno's valuable contributions. Different people might find any of his other general ideas equally compelling: (a) a philosophy and psychology of creativity and spontaneity; (b) a metaphysical or spiritual philosophy or theology emphasizing creativity and also immanence—that is, the power of divine energy as channeled through the creativity and consciousness of every sentient being; (c) role theory as a powerful, user-friendly language and theory of individual, family, and social psychology; (d) sociometry as a useful method for clarifying interpersonal and group dynamics; (e) improvisational theatre as a potentially useful vehicle for *sociatry*, an extension of psychiatry into the general community and culture, for mental hygiene and intergroup healing; (f) sociodrama as an activity that applies psychodramatic methods to address cultural issues; (g) psychodramatic methods and action techniques, using the various specific techniques alone or a few at a time in a wide range of other therapies, education, and other contexts; (h) applying group interactive methods to foster experiential learning for education, business, rehabilitation, recreation, community building, religion, political action, and so forth.

Each of these ideas has its own value, and can be applied creatively on its own. Using them in combination often is even more effective. However, although synergy is generally a useful principle, it is not required in every case. Indeed, this often implicit requirement may stifle the ultimate optimal spread of these very valuable individual components and subcomponents.

Problems With Terminology

The term *psychodrama* has connotations that are different from its formal definition. That is, the prefix *psycho* and the suffix *drama* are semantically loaded, evoking unintended subtle emotional associations.

First, the prefix *psycho* has been contaminated. Although it refers to the mind, psycho recalls the slang word for psychotic, as in the suspense-filled 1950s Alfred Hitchcock movie *Psycho*. Also, for much of the mid-20th century, the field of psychology was most popularly associated with mental illness. Another problem with the prefix *psycho* is its association with psychoanalysis, which in turn is associated with Freud, sex, hidden motives, and the vague threat of having one's deepest secrets exposed. The cartoon theme of an odd patient on the couch in a bearded psychiatrist's office has become ubiquitous. As the legendary Hollywood producer Sam Goldwyn (of MGM) once said, "Anyone who sees a psychiatrist should have his head examined!" The major and minor psychiatric disorders were conflated, and seeking help for any of them was socially stigmatized. To this day, many people still are prejudiced against anything with *psycho* in the name.

As for the suffix *drama*, this term has become associated with the cultural tradition of scripted and rehearsed theatre, something phony. Drama is also often associated with overacting, hystrionics, overreacting, being self-indulgent, exhibitionistic (showing-off), and almost by definition, with being narcissistic and egocentric. It is the opposite of the virtues associated with being cool, understated, or the strong, silent type, or with being modest and simple. To dramatize is to self-indulgently exaggerate, and one who does this is labeled a "drama queen."

The term *drama* also suggests a situation that has been artificially exaggerated, with its more emotional elements heightened. Also, a drama may suggest complex subplots and a hint of mystery or tricky obscurity. Unexpected plot twists are almost expected. For these reasons, the suffix *drama* often turns people off and makes them wary about becoming involved with anything related to drama.

The related idea of *play,* as in role-playing, gets confused with the idea of pretending, pretense, and, by extension, inauthenticity. Saying that someone is "just playing a role" can be a kind of accusation of deceptiveness (Blatner & Blatner, 1997, p. 113).

The prejudices against psychology and playfulness are changing gradually, to be sure. Society is moving into a time in which knowing practical psychology is becoming recognized as being as relevant and necessary as a knowledge of science. Even more than therapists, leaders in the world of business and organization are discovering this fact. On the whole, unfortunately, most people still seem to be fairly wary of anything involving psychology. As a

result, people who want to sell their skills regarding any parts of the wonderfully rich complex of Moreno's ideas and methods often select less semantically loaded terms to describe what they do. Often they use alternative terms to describe the process, combining words such as *experiential*, *action*, *role*, *simulation*, or *sociodramatic* with other terms such as *methods*, *techniques*, or *approaches*, among others. Advertisers take into consideration such problems of naming when deciding how to market products, and psychodramatists who would market their services to businesses, organizations, schools and other contexts might do well to follow suit.

Can Sociometry Be Applied Separately?

It is possible to do psychodrama without sociometry or sociometry without psychodrama. Sociometry, like psychodrama, may be understood as a broader category including an awareness of group dynamics as well as the narrower category of a formal method for assessing interpersonal preferences. In this larger sense, it is good for a psychodrama director to "think sociometrically," even if no specific sociometric techniques are applied in the group itself. However, I focus here on the point that one can systematically employ sociometric methods without doing classical psychodrama and vice versa.

Many professionals use mixtures of sociometry, with or without variations of role theory, to facilitate social dynamics in schools and businesses. This may be done with no recourse to any actual role-playing or enactment. For example, Diana Jones (2001) consults with businesses in New Zealand and uses sociometric techniques to clarify and improve interpersonal and organizational dynamics.

The problem with the word *sociometry* is that, like psychodrama, it also can be used in a more nonspecific, general fashion, or in reference to the methods themselves that assess group dynamics. This more restricted meaning also can refer to two types of methods: The more classical approach in sociometry assesses reports in groups of the group members' preferences regarding some specific criterion. Other methods, sometimes called *near-sociometric techniques*, elicit feedback from the group about their feelings about various issues. Techniques such as the spectrogram, circle sociometry, and the locogram, among others, could all be classified as near-sociometric methods. Although these techniques are generally associated with sociometry, it would be better to recognize them as simply action techniques that facilitate group dynamics. All types of sociometry may or may not be combined with role-playing, sociodrama, or psychodrama, but this synergy is not required in all cases.

Moreno considered sociometry to be one of his primary contributions to what he envisioned as a yet-to-be-developed field of applied sociology. He considered his book *Who Shall Survive? Foundations of Sociometry, Group*

Psychotherapy, and Sociodrama to be his magnum opus, his most significant work. Psychodrama was hardly mentioned in the first edition, though it was more prominently included in his 1953 second edition. Moreno tried to reassert his broader vision, which went beyond the formal sociometric method, and included the more general goal of promoting spontaneity in social networks, not just in individuals. In that broader vision, Moreno hoped for a society in which everyone would have greater freedom of expression and input, and people would be helped to be more open to feedback and to integrate it in constructive ways.

Role Theory

Like sociometry, role theory can be applied in innumerable settings without the requirement that any role-playing or enactment be used. People are wary of performing, and of the increased and uncontrollable self-disclosure that comes with enactment. They tend to feel more vulnerable, and they and the group may need a great deal of warming up before feeling comfortable. In some groups with multiple agenda, it is questionable whether the group trust can be raised to the degree needed for actual enactment.

One modification that addressed this wariness about performance was offered by the fields of drama therapy: Have people play roles that are more distanced, in which the person is not playing him- or herself, but rather some fictional character. One may feel less revealed that way, and many people with less psychological mindedness, less maturity, or a great deal of defensive structure require such protections. One major leader in drama therapy, Renee Emunah (1994), views psychodrama as a kind of culmination of the drama therapy process, but notes that people require more or less time in getting ready for that phase of the process.

I envision role theory as a relatively natural language for teaching basic principles of psychology, so the general public can participate more readily in mastering the concepts, and also more as equals in exploring the situations. The reduction of the mystification of the expert fits with many contemporary theories of adult education (Knowles, 1984).

Psychodramatic Techniques

I envision psychodramatists appealing to various local departments of psychology, counseling, clinical social work, pastoral counseling, teacher training, and so forth, and offering a wealth of techniques and concepts that can be integrated with the other approaches to therapy being taught. Psychodrama need not be presented as a separate approach, to be compared as a whole with Jungian, Adlerian, Rogerian, and other schools of thought. Of course it can be

so presented, but I think psychodramatists will be more effective if they can influence people to adapt and include these ideas and methods in whatever way they are willing and able to do so.

It may be enough to begin with teaching one session or occasional sessions within a whole course or to teach one course as part of a curriculum. A separate class might be given to sociometry, for example, because it is rich enough to be used in other contexts. Creative adaptation of the teaching material will be necessary.

Psychotherapy and counseling are becoming increasingly eclectic, and this opens even more possibilities for practitioners utilizing the many benefits of Morenean methods. Role reversal, simple action sociograms (family or social network sculptures), empty chair technique, and others may be used during the session, and such techniques require neither the presence of a group nor auxiliary egos. Many of these techniques are used already by therapists who claim to be adherents to other approaches, such as family therapy or Gestalt therapy, often without acknowledging their source. Describing the many possible applications of psychodramatic methods in therapy would quickly go beyond the scope of this article.

I have emphasized psychodramatic *methods* in the titles of some of my books and chapters precisely because I felt that the methods themselves may have far wider acceptance, utilization, and impact than would the whole classical method. I also have likened classical psychodrama to major surgery, but there is another far broader category in medicine known as minor surgery. Minor surgery is done not by surgeons, but by general physicians, physicians' assistants, and nurses and includes such procedures as sewing up lacerations, taking small skin biopsies, or draining abscesses. Minor surgery uses some of the same principles of major surgery, such as tying off blood vessels, suturing, sterilizing, and anesthetizing, but in a more modest fashion. Also, there are many more occasions for minor surgery in an office than major surgery, which requires a team of nurses and others, a special operating room, and more. Similarly, I envision a far more widespread use of psychodramatic methods integrated with other kinds of therapy compared to classical psychodrama. This is not a matter of ideal or theoretical value, but of practical realities.

Moreno's Concepts

Many of Moreno's other basic principles can be similarly usefully integrated into other therapies (Blatner, 2005). His ideas about the valuing of creativity, the cultivation of spontaneity, and the connections between these qualities and their spiritual source can also be framed as an extension of the metarole of the *choosing self* and its relationship to its own guidance and leadership (Blatner, 2007). The goal is to help clients shift their identity

away from the roles they play and more toward the metarole that acts more like a psychodrama director, an inner self-manager. With this metarole, one can reflect on, explore, and decide which roles will be played when and how they will be performed. Indeed, the implicit development of the skills of the metarole might be the main common denominator among many if not most of the different approaches to psychotherapy. With the help of role theory and through a slight modification in the way role-playing or psychodrama therapy is conducted, this shift can be made quite explicit. As a result, the client becomes a more active collaborator in the healing process.

Beyond therapy, focus on the development of metarole identity and skillfulness can also be used in personal development—helping the normal or healthy to become even healthier—in coaching, spiritual direction, or leadership training.

Applying Drama Beyond the Clinical Context

Fifteen years before developing psychodrama as a type of therapy, Moreno developed a type of socially activist improvisational drama in Vienna, his "Theater of Spontaneity." His goals included a revitalization of theatre itself as well as making the process of participating in theatre as either actor or audience member more interactive, involving, and authentic. Other innovators in the theatre arts, such as Konstantin Stanislavski, Anton Artaud, or Jerzy Grotowsky have had similar inspirations, though they well may never have heard of Moreno. As a result, there has been an increasing convergence as theatre artists have been applying drama in the fields of education, community building, personal development, business, religion, and other nonclinical areas.

In a larger sense, this serves Moreno's ideal of *sociatry*—taking the principles of psychiatry or clinical psychology beyond the context of treating those identified (by self or society) as sick, and addressing the cultural contexts that need healing and development (Moreno, 1946). In the past 15 years, the convergence of different types of what has come to be called *applied theatre* marks an increasing cross-fertilization among professionals who are using drama in these nonclinical settings.

A notable example of this is the way Jonathan Fox and Jo Salas' method of *Playback Theatre* has been significantly expanding. This approach, though influenced by psychodrama, is really a creative synthesis of other nonscripted theatre approaches. Another growing subfield has been the *Theatre of the Oppressed*, developed by Augusto Boal in Brazil in the 1960s. These and other approaches are described more fully in a recently published anthology about applied theatre (Blatner, 2007).

As these forms evolve, there is room for cross-fertilization with other, more directly Morenian methods. Sociodrama and role-playing in education were

promoted by Moreno and his followers in the 1940s, and have continued to be used and incorporated into related approaches. I encourage practitioners to recognize these extraclinical related fields, join with them, and cross-fertilize with them. The goal is not just to get recognition for Moreno and psychodrama, but to suggest that his complex of tools and ideas is so deep and rich that people should return and find still other resources, possible applications, and new adaptations and variations.

Related Arts Fields

Psychodrama has held itself a bit apart from other creative arts therapies, and that is understandable, considering its historic roots as primarily a type of therapy that uses drama, rather than being an art form that subsequently is found to have therapeutic applications. However, Moreno not only promoted the integration of improvisation into the creative arts therapies, but also encouraged pioneers in this endeavor to publish in his early journals.

This angle again extends beyond the clinical context, as there are efforts in personal growth and development programs and continuing education programs to add more improvisation to the learning and exercise of the arts.

Group Work

Moreno supported group work of all kinds—especially emphasizing those approaches that put less emphasis on the teacher or analyst as the focus and that fostered interactivity. These groups did not need to be psychodramatic to gain his support. He was the impetus and primary founder of the International Association of Group Psychotherapy, which has recently expanded its mission to include more than clinical types of group leadership. Group work in many fields is becoming recognized, in part in recognition of the need for teamwork for optimal creativity.

Mid-career, Moreno (1956) wrote about the third psychiatric revolution, which for him was the emergence of group approaches in therapy. (His view of the history of psychiatry was was based on mid-20th century knowledge.) The first revolution was the humane treatment of the mentally ill, beginning around 1790; the second revolution was the introduction of psychodynamic psychology and psychotherapy, beginning with Freud. Group therapy was becoming popular following the Second World War, and Moreno was thrilled with its potential. He did not anticipate what would actually become the third psychiatric revolution—the introduction of psychotropic medicines and the decline of the large numbers of chronically hospitalized patients. (His vision still may be somewhat valid as a fourth psychiatric revolution, as group approaches become more integrated in the preventive formats of education, self-help programs, personal development workshops, and the like.)

In the late 1960s, a hint of Moreno's vision was reignited with the growth of community mental health, but that, too, has just struggled along, underfunded, in a late 20th century political turn toward the ideals of self-reliance and the neglect of the disadvantaged. I think Moreno may have been not just 50 but perhaps 100 years before his time in this vision, but I think he was on to something: The power of self-help groups, learning groups, and healing groups of all sorts is increasingly being recognized, and the general theme of empowerment is becoming more widespread.

The Need for a Revisioning of the Field

Psychodrama as a method of psychotherapy is becoming increasingly marginalized because of a number of factors, including (a) the relative lack of published papers with hard evidence of efficacy; (b) the relative paucity of academically associated teachers who especially value the method (compared to the numbers who identify more with other approaches); (c) a continuing proliferation of other methods, many of which integrate certain elements that were first developed in psychodrama, though often with no acknowledgment of this Morenean source; (d) the difficulty in finding clients and contexts that can support the more extended (more than an hour) group sessions—which includes the difficulty in lining up groups in general, and the economic pressures that cut into the income of the director if a codirector or several trained auxiliaries are included; and (e) people who have had negative experiences with role-playing or psychodrama, perhaps from leaders who were overly confrontational, too focused on evoking emotion, or who did not generate sufficient warm-up (Blatner, 2000).

Perhaps one way to counter this marginalization is to reframe the mission. Rather than focusing the primary identity on being purveyors of classical psychodrama, psychodramatists could instead promote themselves as being able to introduce a generous variety of approaches that may be useful in a wide range of contexts. I have likened Moreno's methods to carpenter's electric tools: They can be useful whether one is building a chair, a house, or a finely crafted jewel case.

Classical psychodrama still offers great value, and should be retained as a more intensive type of treatment, often effective when mere talk therapies cannot reach the deeper complexes of bodily feelings and images that are more associated with the right hemisphere of the brain and limbic systems. Yet Moreno's insights should be recognized as transcending this application and as extending into many arenas.

More recently, for example, the International Association of Group Psychotherapy (IAGP) expanded its own name, becoming the International Association of Group Psychotherapy and Group Processes, and recognized that this

added dimension includes not only therapy, but also aspects of education, organizational development, and even social change. Moreno is honored as the founder of this IAGP organization (in 1973) because of his persistent efforts at promoting preliminary conferences in Europe and South America in the 20 years before his death. The recognition of the applications of group approaches beyond the clinical context is in line with the expanded frontier and identity of psychodrama I propose in this article.

Summary

Moreno developed many ideas about the values of spontaneity and methods for promoting this source of creativity, not only in individuals or in one-to-one therapy, but also in families, groups, larger organizations and institutions, and even in cultural activities and international relations. His work included forms of improvisational drama that have influenced the formation of a variety of increasingly popular offshoots or parallel developments (e.g., Theatre of the Oppressed, Theatre in Education, competitive improvisation as a recreational sport, Playback Theatre, bibliodrama), as well as innovative approaches to business consultation (e.g., applied sociometry; Blatner, 2007). Among other uses, components of his psychodramatic methods are used by lawyers in preparing for trials and by teachers of medical students, to promote empathy.

Psychodramatists would do well to recognize as their mission not just the promotion of psychodrama, but also the dissemination of concepts and methods developed by Moreno. This broadening of identity would help Moreno's contributions be appreciated and utilized in other approaches to therapy as well as in other nontherapy fields, such as education or organizational development. This broader vision also would allow for a more open adaptation of influences from other fields, including insights and developments by innovators other than Moreno so that the processes of cross-fertilization and ongoing creative development can continue.

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Practitioner's Perspective: Introduction

This new section is devoted mainly to hands-on techniques, such as warm-ups and structured exercises. We invite readers to send us, for example, material that outlines a technique that worked for them in therapeutic, educational, or organizational settings. All techniques have theoretical underpinnings, and we want to see how theory applies to the method. This section will allow contributors to share tools and techniques that have worked well for them and challenge theorists with fresh and compelling observations. We hope that this practical application section will ignite interest in (a) how the integration of theory and practice strengthens one's ability to be an effective practitioner, and (b) how new theory develops through the successful application and practice of knowledge.

The idea for this section is based on a *Psychodrama Network News* column that appeared for about a year in the mid-1990s. As we wait for manuscripts from readers, we will reprint select columns as they appeared in the newsletter to serve as a model of the structure readers should use to report their creative expansions and new ideas. We request that each article be organized in five sections: (a) *rationale for the technique,* a short literature review of where the idea came from and description of the theory underpinning the technique, (b) *description of the technique*, (c) *contraindications of use*, (d) *director's instructions*, and (e) a *case example* that illustrates its use and implications. This may include a discussion of how well the intervention solved a problem, met a goal, or served a purpose. Case examples must maintain the confidentiality of all participants and usually require consent from everyone involved.

LINNEA CARLSON-SABELLI
TIAN DAYTON
PAMELA REMER
THOMAS TREADWELL
Executive Editors

PRACTITIONER'S PERSPECTIVE

A Sociodynamic Technique: Heart Mates

LINNEA CARLSON-SABELLI

Rationale for the Technique

Heart Mates focuses on the physiological rhythm of the heart and its influence on interpersonal "dances" we create with others. We use it to illustrate in action, the process theory (Sabelli, 1989, 2005) principle that change and creativity emerge through the interaction of coexisting opposites. The exercise provides an opportunity for participants to explore their own process of cocreation and to examine the extent to which their actions influence and are influenced by internal physiological rhythms as well as the actions of others. It also introduces a new sociodynamic tool (Carlson-Sabelli, Sabelli, & Hale, 1994), the diamond of opposites (Carlson-Sabelli, Sabelli, Patel, & Holm, 1992) to enrich the report of experiences that involve conflict, ambivalence, opposition and contradiction. Heart Mates provides a relatively nonthreatening way to examine aspects of one's own interpersonal style and to quantify and examine the impact of heart rhythm on interpersonal actions (see Figure 1). It brings up for discussion sociodynamic issues of connecting, separating, belonging and not fitting in, opposing and cooperating, sabotaging, and collaborating. As our case example illustrates, it may also serve as a warm-up for personal psychodrama.

Description of the Technique

The Director facilitates the participants to focus on the rhythm of their heart, develop an individual dance, and engage others as described in the sec-

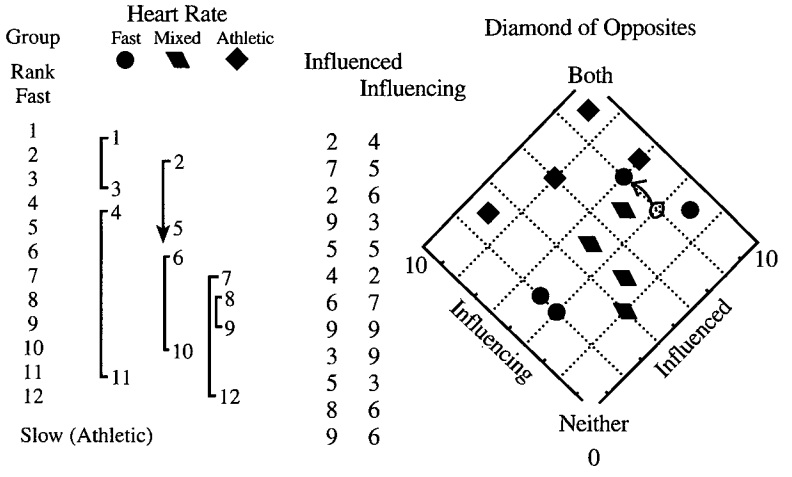

FIGURE 1. The configuration of information generated by twelve members of an ongoing training group participating in the exercise Heart Mates. Each member is identified by a number, 1 to 12, and arranged in a continuum, where 1 represents the person with the fastest pulse rate, and 12 represents the person with the slowest. Everyone found a partner (indicated by connecting brackets and each set of partners found another set, making 3 groups of 4). The intensity scores each person gave for the two forces, "Influencing"—exerting influence on others, and "influenced"—being influenced by others, are detailed in table graphed on the diamond of opposites (a coordinate plane rotated 45 degrees to the left), and coded with a different shape for each group.

tion "Director's Instructions." To conduct the sociodynamic exploration of the exercise, follow these steps.

Step 1: Instruct each group of heart mates to show their dance to the rest of the group one at a time.

Step 2: Ask each person to reflect on the experience, and to decide on a number between 0 and 10 that reflects the extent to which they feel they exerted influence on the others in the collective movement, and to identify a second number between 1 and 10 reflecting the extent to which others influenced them.

Step 3: Create a coordinate plane, drawing it on an easel, blackboard, or with masking tape on the floor. Explain that one axis represents exerting influence and the other, being influenced by the other.

Step 4: Instruct each person to mark the spot indicating the intensity of both opposites—exerting influence and being influenced, stating the reasons for the rating.

Step 5: Have each individual find his or her own heart rate (number of beats in one minute) and form an action continuum that is ordered by pulse rate. The person having the fastest pulse is at the top, while the person having the slowest pulse is at the bottom.

Step 6: Add another dimension to the action continuum by separating the participants into their respective small groups. One group remains where they are, the members of another group make one large step to the left, the third group moves two steps to the left, etc., until there are as many vertical lines of participants as there were groups. In this way, each participant can see how pairing related to individual heart rates.

Step 7: Facilitate a discussion of the experience. What was it like for you? What did you learn about your contribution in the cocreation? Were there any surprises for you? How did your experience reflect patterns in your life? What needs to be done next?

Contraindications of Use

This exercise is physically rigorous. Before starting this exercise, instruct participants to take responsibility not to overexert themselves physically. Watch closely, and give permission to stop and sit this one out, or modify the pace for the whole group, as you see the need. Focusing on something as basic as one's heartbeat also brings up life and death issues for individuals with cardiac problems. Be prepared to shift focus to deal with these issues, should they emerge. An alternative is to instruct individuals to focus on breathing, a biological rhythm that is slower, and perhaps less likely to evoke emotional issues related to health.

Director's Instructions

Ask the group to clear the room, providing as much space as possible for unrestricted physical movement, find a place to stand where they have some space to move, and wait for further instructions:

Instruction 1: Find your pulse any way that works best for you. You might place your fingers on the side of your neck, or on the inner side of your wrist; using your thumb instead of your fingers might enhance its intensity. (Wait until everyone has found their pulse before continuing.)

Instruction 2: Close your eyes. Focus on the rhythm of your heart. (Wait about half a minute.)

Instruction 3: Now put the rhythm into a movement. Experiment with several movements until you have found one that suits you. Now exaggerate

the force of the movement. Now diminish it. Now let the movement return to its natural form.

Instruction 4: Add a sound to the movement. This is your "heart step." Again, experiment until you have found the sound and movement that depicts your heart rhythm just now. Exaggerate both the movement and sound. Diminish it. Now let it settle in where it feels best. Practice your heart step until you know it very well. (Wait until everyone seems ready to proceed.)

Instruction 5: Now, continuing your sound and movement, open your eyes. Focus on others in the room. Look at each other person, noticing the heart steps of others. Mentally note what it might feel like to be partners of each one.

Instruction 6: Begin moving, trying, as you move, to maintain your own sound and movement. As you approach someone or they approach you, take time to focus on the movement of the other. Focus again on yourself. What is happening with your own sound and movement when you are with this person? Keep moving and exploring. Now find a partner whose sound and movement seems to fit in nicely with your own, someone to pair with, to stay with for a few minutes. If you are without a partner (which happens in an uneven group), see if it feels better to join a pair in progress or to stay alone. Exaggerate your movements and sounds. Diminish them. Let them return to where they began, or to something new. Notice what emerges with your heart mate.

Instruction 7: When you are ready, taking your partner with you, find another pair to join. If you have been alone or are the extra pair, join any group that will let you in. (There should be mostly groups of four.)

Instruction 8: Close your eyes, and focus on only yourself. Return to your original sound and movement if you can. Exaggerate it. Diminish it. Let it settle back to where it was before any pairing. Open your eyes. Attempt to maintain your original sound and movement as long as you can. Now, still moving and making sound, turn your focus outward on the other members of the group. Keep dancing. See what emerges together. Dance as a team of heart mates. Practice until your dance is sealed in your mind.

Instruction 9: Take a beverage break and return ready to process the experience. (The group will be thirsty and physically tired.)

Case Example

Figure 1 indicates the data emerging in the action processing of this exercise with a group of 12 psychodrama students.

Individuals in the group familiar with the diamond of opposites reported

their scores first, modeling this method of report for newer members. The ranking by heart rate was done after the group members reported influenced/ influencing scores. The arrangement by group on the diamond of opposites was plotted after the exercise and discussion, although it could have been pointed out to the group at the time.

Participant 11 originally reported his influencing score as 4, but changed it to 6 when he saw the low influencing scores reported by his partner, participant 4, and the two members (participants 1 and 3) they joined with. Participant 4 reported it was difficult to keep up with participant 11. In reality, participant 4 exerted the most influence both in the initial pairing and in the group; participant 4's initial perception was shifted in action as the reports of the others were made known. Note also, that he had a low heart rate, whereas his partner and the other pair they joined had fast rates. The first group, indicated by a circle, is named the fast group, because collectively they had the faster heart rate. Their heart dance was a big sweeping movement where pair participants 1 and 3 moved in one direction, and pair participants 4 and 11 in the other. It was spontaneously declared the most pleasing, and required the most energy. On the opposite end of the continuum, the members with the slowest heartbeats formed a movement that was solid and strong, but had less range. Low heart rate is associated with an athletic, robust, efficient heart. It is striking to note that the individual members of the group with the lowest heart rates reported the highest scores on both influenced and influencing. In this case, biological power is expressed in the arena of interpersonal influence. Participant 5 stated it was hard to keep one's own rhythm and although the group created its own heart dance, it was unclear where the influence came from. Participant 5's group was the most mixed (and perhaps balanced). This group formed a movement which its members characterized as a womb-like rocking. Commenting on the exercise, students noted: Most dyads had dissimilar heart rates. The position of participant 9 on the diamond (apart from the others in the left high influencing corner) was spatially similar to this participant's position in the group in the previous week's sociodramatic exercise. As partners were formed, some group members began to feel closer, especially as they created together. Participants 12 and 7 reported canceling each other out. Participant 2 reported losing the sense of personal identity as groups were formed. At the end of the discussion, the participants were asked to put their hand on the shoulder of the person they would most like to see as protagonist. There were two selections with 6 choices, and each of the chosen initially chose the other. One of the chosen declined the offer of a psychodrama, and the other accepted, stating that the warm-up not only brought up the issue, the need to find a sense of autonomy in group situations, but gave enough of a feeling of belonging to enable the decision to be a protagonist for the first time.

NOTE

The idea for this exercise is based on a warm-up introduced at a workshop by Ulf Klein (1994) of Germany. Klein cited Dalmiro M. Bustos, Argentina, as the originator of the idea to use physiological rhythms to illustrate the relation between chaos theory and creativity. This article is an updated version of an article that was originally published in the January 1995 issue of *Psychodrama Network News*, an ASGPP publication.

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Book Review

Interactive and Improvisational Drama, edited by Adam Blatner with Daniel J. Wiener. 2007. Lincoln, NE: iUniverse. 410 pp. ISBN: 0595417507.

Interactive and Improvisational Drama, edited by Adam Blatner and Daniel Wiener, is an anthology of short chapters on different forms of interactive and improvisational theater and an eye opener for those who have long worked in the somewhat insular world of psychodrama. Gone are the days when Morenians saw the Morenos' training center at Beacon, NY, as an isolated outpost from which flowed all wisdom related to spontaneous, unscripted drama, or thought that psychodramatists were a tiny minority with an idiosyncratic point of view. Now thousands upon thousands of people regularly practice some form of unscripted drama. Many trace their origins explicitly to Moreno, psychodrama, or sociometry. Others seem unaware that if there had been no Moreno, they would not be doing anything like what they are doing.

Blatner has classified the different applications into five sections: "Applied Theatre for Community Building," "Applications in Education," "Applications in Psychotherapy," "Applications for Empowerment," and "Applications for Life Expansion & Entertainment." There are short chapters on playback theater, bibliodrama, and improvisational drama in schools and its uses in businesses, churches, and even museums. There are many uses with special populations such as actors, women, the physically handicapped, prisoners, and parents who are divorcing. Other approaches are adapted for use with specific age groups ranging from children to the elderly. There is a section of applications for pure pleasure that is even a pleasure to read. It includes medieval reenactments and mystery theater groups. There are 33 chapters all together, 5 of which Blatner wrote himself. One of these, in the psychotherapy section, is called, "Psychodrama, Sociometry, Role Playing, and Action Methods," and in it, Blatner covers all these topics for the naive reader. This particular chapter may be less useful to readers of this journal, because not even Blatner can include much that psychodramatists do not already know in 10 pages with large print and wide margins. Still, it often helps to be reminded of basics and there are the 32 other chapters full of surprises. The chapters also

contain references to books, articles, and especially, relevant Web sites from which to gain additional information. (More authors and editors of books of this type would do well to follow Blatner's example of including Web sites in their references. To reach out and click might be a more tempting invitation than to make a special trip to the local library.)

Another of Blatner's own chapters in the education section (chapter 8) covers the use of creative drama and role playing in the public schools. Here, the reader learns about a program for children and teenagers called *Enact*. In this program, improvisation is used with children considered difficult to reach by traditional methods and other children from underserved neighborhoods in New York City. The program uses professional actors trained to conduct improvisational groups. Dropout rates have declined in places where *Enact* was used, so the program has proven its effectiveness. It has already served some 100,000 students.

Also from the education section is a chapter by Daniel Kelin (chapter 11) who taught English to a group of students aged 9 years and older, from several different Pacific islands. The students did not even know each others' languages. Instead of teaching grammar and vocabulary, Kelin began telling them a very simple story. Having modeled this role, he got each student to tell a story from their own culture (perhaps partly in English which had to be used as a *lingua franca* if the students wanted to be understood). Kelin proposed that they write a play together. To do this, they agreed on a story and broke it into very small parts to be expressed as a series of tableaux. This required the children to move around continually to get into the proper positions. Thus, action was employed before words, and it provided a good warm-up with little language needed. Throughout all this activity, the children were not concentrating on learning English, only on creating their play. This method placed learning the language out of the focus of the children's attention so it did not generate resistance from them. Next, the many tableaux were put together to form the play itself. In the next stage, the children improvised speech for their characters to say at various crucial moments. Kelin says that the final performance of the play was only the "icing on the cake" (p. 116). It was the making of the play that helped the children to interact, improvise, and learn English at the same time.

In chapter 20, part of the section titled "Applications in Psychotherapy," Clark Baim explains how he used improvisation in the rehabilitation of inmates in prison. One method was to have the inmates use masks to represent the face that they show to the world, but when they were communicating to a trusted accomplice, for example, they could peek out from behind the mask for a moment. This method helped the inmates distinguish the two contradictory elements always present in a criminal mind and the criminal's burden of maintaining a perpetual double identity. The importance of having the oppor-

tunity to tell the truth was emphasized. Baim also describes how inmates improvised fictional crimes. In the improvisation, the criminal protagonists were encouraged to describe all their feelings and motives. After that, they were put in the role of the police officer, the spouse of the crime victim, the crime victim, the reporter at the scene, and anyone else who was involved. This improvisation made it very difficult for the inmates to avoid having an expanded empathy. Baim notes though, that the clinicians most avoided any direct attempts at moralizing. Under these conditions, it appeared that even hardened criminals had some superego.

The chapters in the section on life expansion and entertainment ranged from the sublime to the ridiculous. In the former category was Bernie DeKoven's "The Theatre of Games" (chapter 32). He developed a drama curriculum for elementary school teachers. For this he worked with a group of 5- to 11-year-olds that were sent to him as "somebody else's behavior problem" (p. 332). He decided to use improvisational drama in the form of games and tried to involve the children in various warm-ups and skits. His test of the efficacy of his effort was to leave the room for 2 min and see if the children were still playing the game when he returned. In his presence, the children politely went along with his instructions but when he left the room, they always stopped playing. Finally he turned to Viola Spolin's famous improvisational theater games and guess what? They also failed that test. Having exhausted his options, he asked the children what game would be fun for them. The replies were the very games adults remember from their childhoods: various kinds of Tag, Hide and Seek, May I, etc. For 2 years, DeKoven studied the extensive literature on childrens' games and tried to classify and analyze them to find what kept them alive in childrens' culture for hundreds of years without adult reinforcement. He even played the games with the children when they allowed him, so he could sense what made the games fun. He found that, "As a theatre piece, tag is as profound as it is entertaining...[Older children are] more interested in games where the role of authority is reversible...If *It* tags you...you're *It*. There's an instant reversal of roles" (p. 334).

In chapter 30, Doyle Ott describes interactive clown practices. Clowns are interactive and improvisational when they mix with the audience and induce audience members to join them in their antics. To engage different audience members, clowns must make up what they do or say. Noting that clowning can be approached from many perspectives, Ott quoted Schaffer and Sewall (1984) as saying "The very act of becoming a clown is a symbol of a person's decision to accept Christ."

Can one improvise too much? There was one such example of excessive improvisation in a chapter by Tom Stallone on medieval reenactments (chapter 29). Many people participate in weekend reenactments of certain historical periods or events, including reenactments of Revolutionary or Civil

War battles and also medieval reenactments. Some people who engage in this hobby are very serious indeed—they choose their roles (e.g., a lady-in-waiting to a princess or a knight returned from the third Crusade), dress the part, and remain in character all weekend. They wear appropriate armor and engage in jousting contests. They fence using blunted swords and develop real skill. They do serious research to be ever more authentic. The excess comes from this: Some reenacters become so invested in these self-selected roles that they spend increasing time, energy, and money on them until the reenactments become more important to them than their real lives. They lose motivation to learn about anything else, to advance in a career, or to enjoy family life. They know that the reenactments are only reenactments, but the gratifications of Camelot are greater than those of daily life.

How Blatner found all these improvisers, I will never know, but by all means, get the book. It provides a synopsis of the world of many of psychodrama's close relatives, written by people eager to get the essence of their approach across succinctly, and Blatner has done his usual masterful job of tying these disparate systems together with summary remarks that introduce each section and a useful glossary.

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ASGPP NEWS AND VIEWS

Letter From the President of the ASGPP

Greetings to you all,

Exciting times are upon the American Society of Group Psychotherapy and Psychodrama (ASGPP). As J. L. Moreno wrote and taught, those that shall survive will have adequate spontaneity and creativity. These elements are evident as changes within the society and its social atom are observed. The ASGPP Web site, www.asgpp.org, recently updated, includes many dynamics created during the past year. Through the Web site, the society has an opportunity to reach out and be reached in ways that continue to build on J. L. and Zerka Moreno's vision for sociometry.

Heldref Publications, in collaboration with the Executive Editors of the *Journal of Group Psychotherapy, Psychodrama, & Sociometry* (JGPPS) and the ASGPP leadership, is making changes to this journal to help broaden the impact of this vital instrument of the society. I would like to thank Heldref and the Executive Editors for including the leadership of the ASGPP in policy making and in print.

The 2007 annual conference continued the tradition of providing attendees the opportunity to meet, greet, and renew connections as well as experience the many workshops offered. The theme, "Giving Peace A Chance," affirmed by the moving keynote address of Amy Goodman, will reverberate as we witness the coming of age of psychodrama and sociometry in the 21st century. I am excited as we plan the 2008 annual conference of the ASGPP in San Antonio, Texas. The theme of this upcoming conference, "Blazing New Trails Into Creative Consciousness," brings anticipation of another successful conference. More information may be found on the Web site. The Executive Council is playing more of an active role in the cocreation of this conference.

This change is a result of the concerns of many that the conference needs to be more efficient in its operation, thus making the conference more inclusive, accessible, affordable, and professional.

I will be appointing many new committees charged with evaluating current conserves within the organization and making recommendations to the Executive Council as to what might strengthen the ASGPP. I invite the members to visit the Membership Forum "What's New in the ASGPP" section and peruse the various ways a member can be of service to the society.

In closing, I would like to reiterate that the membership's request to be heard by the leadership remains first and foremost in my mind. I heard this same request at this year's annual business meeting in New York. Zerka's letter to the leadership, read during the meeting, admonished the officers of the Society to be active and diligent in creating democracy, inclusiveness, and efficiency in the organization. These might well be three cornerstones for continued growth for the ASGPP. The membership, at this writing, is now 531, and growth will be ensured if we all give thought and effort toward these three dynamics. Let us remember Zerka's closing remark: "Let's not forget what gives the spark to our organization. If we are not spontaneous and creative, how can we account for ourselves?" Is it here that the fourth cornerstone may be found?

JOHN RASBERRY, MEd, LMFT, TEP

ASGPP Events and Notices

1. ASGPP is calling for nominations for the 2008 Awards. Go to www.asgpp.org for more information on the awards process, past recipients, award categories, and criteria. The deadline for submissions is August 31, 2007.

2. Elections! Nominations are now being accepted for Vice President, Treasurer, Secretary, four openings on the Executive Council, three openings on the Nominations Committee, and one opening on the Professional Standards Committee.

3. The 2008 Annual Conference, "Blazing New Trails Into Creative Consciousness" will be held April 10–14, 2008, at the Sheraton Gunter Hotel in San Antonio, Texas. Register online at www.asgpp.org.

A Tribute to Helen Kress

Helen Kress retired from her role as managing editor of the *Journal of Group Psychotherapy, Psychodrama, & Sociometry* (JGPPS) in July 2006 after working in this role at the Helen Dwight Reid Foundation (Heldref) for about 25 years. Her devotion to the journal was greatly appreciated by all involved, and she will be missed.

Helen was more than a first-rate professional managing editor. She brought a great deal of experience to Heldref and JGPPS and was always eager to learn more about the content published in the journal. She shared the growing pains of the journal and she made sure that we, the editors, were on the same page. She dispelled conflicts and pushed hard when the journal experienced hard times. Her steady presence in keeping the journal going, through a name change and change back, many different editors, and changes in formatting, all contributed to the stability of our field. She did a great deal for the integrity of the journal and we are thankful for the hard work she put forth.

David Kipper, a former executive editor, reflects, "Now that you enter a different stage in your life, this song is for you, Helen:

> It's a long way to Tipperary, it a long way to go,
> It's a long way to Tipperary, to the Helen Kress I know.
> Goodbye little funny e-mail notes, farewell Leicester Square,
> It's a long, long way to Tipperary, but my heart's right there.

Best wishes to you Helen, and I'll miss you."

Helen has 10 grandchildren living within a 4-mile radius on the outskirts of Washington, DC, and she is busy keeping up with their activities. She also teaches English as a second language to new immigrants and supports preparations for citizenship examinations. Helen likes cooking and baking and is enjoying her retirement.

LINNEA CARLSON-SABELLI
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Executive Editors

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INFORMATION FOR AUTHORS

The *Journal of Group Psychotherapy, Psychodrama, & Sociometry* contains manuscripts on the theory and application of action methods in the fields of psychotherapy, counseling, social and personal skill development, education, management, and organizational development. The journal welcomes manuscripts bridging research and practice appropriate to educational and clinical simulations, behavior rehearsal, skill training, and role playing within group settings. The focus is on action interventions, psychodrama, and sociometry. The journal publishes theme issues, main articles, and brief reports on small research studies, case studies, and empirically tested new action techniques.

Manuscripts should be submitted to the Managing Editor, *Journal of Group Psychotherapy, Psychodrama, & Sociometry,* Heldref Publications, 1319 Eighteenth Street, NW, Washington, DC 20036-1802.

All manuscripts should be prepared in conformity with the style and format described in the *Publication Manual of the American Psychological Association,* 5th edition (2001). Manuscripts must include an abstract of no more than 120 words, be double-spaced throughout, and ordinarily not exceed 25 pages. Special attention should be directed to *references.* Only articles and books cited in the text of the manuscript are to be listed in the references. Authors should avoid using abbreviations, symbols, and footnotes. It is the responsibility of the author to ascertain that the activities described in the manuscripts are consistent with the generally accepted standards of ethical practice. Manuscripts that do not conform to the *Publication Manual*'s standard (margin, sexist language, references, format, etc.) will be returned unreviewed to authors.

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Accepted articles must be submitted electronically as double-spaced Word files with minimal formatting in Times or Times New Roman. Authors should not use word-processing styles, forced section or page breaks, or automatic footnotes. Tables must be e-mailed in one separate file and figures in another separate file. A hard-copy version of text, tables, and figures will be needed as backup.

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