GROUP PSYCHOTHERAPY

Journal of Sociopsychopathology and Sociatry

PSYCHODRAMA

SOCIOMETRIC METHODS
ACTION METHODS
THERAPEUTIC FILMS

RE-GROUPING
RE-TRAINING
SOCIAL CATHARSIS

SOCIODRAMA

Volume III MARCH, 1951 Number 4

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James M. Enneis, director of psychodrama, starts group discussion in post action phase of psychodrama session at the psychodrama theatre of Saint Elizabeths Hospital in Washington, D. C.

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CONTENTS

THE SITUATION OF GROUP PSYCHOTHERAPY, 1951

J. L. MORENO, M.D.

The situation has many favorable but also many unfavorable aspects. I have read, in the last few years, several hundred papers on group psychotherapy. They often read so much alike that one would think there is considerable agreement as to theory and practice among group psychotherapists. The tragi-comic thing however, is that practically everyone thinks he is original, presenting his own brand and so there is no agreement. It appears that we are just like our own patients—no insight.

Three ideas have been developed, first group psychotherapy, second sociometry to provide diagnostic foundations and third psychodrama to provide an actional focus for both. They are like three links of the same chain. The current crop of group psychotherapists is *second* generation (from 1935 to the present). Of the *first* generation (from 1910 to 1934) only two are still living, Joseph Pratt and myself, since Trigant Burrow and L. Cody Marsh have passed away.

I. We have to find agreement in regard to *terms, operations* and *facts.* This is the first step. We must agree first on the chief term, group psychotherapy and what it is, or at least, what it means to all of us. Even a preliminary definition which all can accept is better than none. The terms group therapy and group psychotherapy are now twenty years old. They were introduced by me and have since wandered throughout the entire literature on the subject. This term is one thing which we have in common. However, already here occurs a snag. There are some psychoanalysts who doubt that there is such a thing as group structure and group dynamics, that the psychodynamics which have been described in individual analysis are able to explain everything which takes place in the group and that the term group psychotherapy is a misnomer. It is too bad that these workers have used the term for so long and are still using it; it would be better for the movement if they would call what they do by a name which is appropriate and more accurate, expressing their view point, for instance, "psychoanalysis of groups" or "psychoanalysis within a group setting" and leave the term group psychotherapy to those who invented the term or whose conceptual framework is in accord with its meaning. Group psychotherapy is, of course, the first term to be agreed upon but there are other terms to which different meanings are given, like chief therapist, therapeutic

agent, spontaneity, group dynamics, transference, free association, reality testing, tele, sociodynamic effect, attraction-repulsion.

Next to the terms are the *operations* which take place in a group psychotherapy session. Which operations do all group psychotherapists have in common, consciously or unconsciously? Describe them first physically and visually, actionally and dynamically before you describe them theoretically and verbally. This should be easy, once we get together on the task of attempting visual definitions of our own operations.

The third are *facts* which are observed during sessions by every practitioner but often left out because they are so simple.

II. Only after agreement is reached in reference to terms, operations and facts can the next step be approached, that is, to find *agreement as to theories and interpretations*. At present this is practically impossible. Besides the still living original pioneers of group psychotherapy many representatives of the individual schools have entered the group field and they have naturally brought with them the theories and interpretations of their own school. They are the Freudians, the Adlerians, the Jungians, to mention three of the individual schools. Theories and interpretations are not given up overnight, they represent profound emotional, ideological and economic investments, not only of the individual representatives but also of the organizations to which they belong. It will take time and particularly a number of carefully carried out researches in group psychotherapy to bring the various points of view gradually to a better understanding.

III. Once such agreement has been reached or at least partially, the next possible stage can be tentatively approached, *the formulation of hypotheses to be tested by various group psychotherapists in different places.* A common body of theories will gradually emerge out of these validations of hypotheses. It will take hard work but this goal must be reached.

IV. The close dependence of group psychotherapy upon sociometry has to be stressed; it is the latter which has developed an objective diagnostic approach of groups. "Group psychodiagnostics" goes hand in hand with the development of group psychotherapy. Like in other fields of medicine *no therapy can be prescribed without diagnosis.*

V. The relationship of group psychotherapy to action methods like psychodrama is of similar importance. There is hardly a session without "psycho-

dramatic episodes" (there is no stage required for them) between patients, between patients and their relatives, between patients and therapists. If we call these interactions, which are often highly structured, "free associations" instead of psychodramatic episodes nothing is gained; these are new operations to which an old term is applied, expressing a different kind of process.

VI. The use of mass media, like television, motion pictures, or cartoons are in need of further investigation. They are significant because of the potentialities they offer for the development of mass psychiatry. An interesting technique has been suggested recently by the Commissioner of Mental Hygiene of the State of New York, Dr. Newton Bigelow, the use of the comic strip Blondie for arousing the responses of mental patients to standard life situations.

VII. Last but not least, at the present time the giving of status to group psychotherapists is the outstanding issue. Who is equipped with the knowledge and skill to practice group psychotherapy? One way to determine requirements and fitness is to establish "An American Board of Group Psychotherapy and Psychodrama" which should be qualified to give diplomas to practitioners after they pass a certain set of examinations. This Board would set the standards for applicants permitted to take these examinations and they should also be empowered to disqualify a practitioner or to cancel his diploma if he does not continue to live up to the minimum requirements. A first step towards such an objective has already been made by establishing preliminary sections on group psychotherapy and psychodrama within scientific societies which carry a high professional standard, the American Psychiatric Association, the American Psychological Association and the International Congress of Psychiatry.

Within twenty years group psychotherapy has become a world-wide "movement". Perhaps the next twenty years will integrate it into a "school" of thought.

The readers of the above points are requested to send their comments and suggestions to the Editorial Committee of this journal.

THE FUNCTION OF A *"DEPARTMENT OF HUMAN RELATIONS"* WITHIN THE STRUCTURE OF THE GOVERNMENT OF THE UNITED STATES*

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A dynamic nation follows three guiding principles, spontaneity, creativity and immortality—the spontaneity of the masses of its people; the creativity of the ideas to which it is dedicated; the immortality of the culture it is developing. Without spontaneity, the creativity of a nation would be perfectionism, lifeless; without creativity the spontaneity of a nation runs empty and ends abortive; without a goal, faith in the immortality—in the imperishable and ultimate value of its collective effort—there is no final gratification, there can be no all-pervasive faith.

The American's Creed** adopted by the United States House of Representatives in 1917 asserts proudly: "The United States of America is a government of the people, by the people, for the people." But a government aiming at such high aspirations would have to be based on *a science* "of the people, by the people and for the people."***

There is sufficient evidence available that a science of human relations—a sociometry—already exists and operates piecemeal, that it affects and shapes the policies of the U.S. government in numerous ways. The U.S. government makes conscious use in theory and practice of much of that source material gathered through a network of public welfare, church, health, educational, public opinion, labor, big business and political agencies. Now, an objective link ought to be established between the social trends emerging in the population itself and their translation into legislative, judiciary and executive decision. This translation and interpretation of social trends should not be left to arbitrary and casual expression coming from one branch of the government or the other like the departments of State, Treasury, National Defense, Interior, Labor, Commerce or Agriculture, it should be crystalized into a special department of government, a *"Department of Human Relations."*** Such a department should be designed to become a *nuclear structure* of the U.S. government, *that* unit towards which the wants, the feelings, the decisions of the people radiate

*From an address at the Moreno Institute, March 9, 1951.
**By William Tyler Page, Clerk of the U.S. House of Representatives.
***I presented this view in an address at the opening of the Sociometric Institute, April 25th, 1942. See, Sociometry, a Journal of Interpersonal Relations, Vol. V, 1942. A "science of human relations" was a semi-popular sociological fiction until a point of systematic crystalization was attained with the advent of sociometry twenty years ago and the appearance of my book "Who Shall Survive."
****Such a department is, of course, only a vehicle. There is no panacea to be expected from vehicles but they are the formal symbol for new, dynamic operations.

from every locality, county and state of the union. It should have its miniature sub-structures down the line in each of the forty-eight states, in every county of every state, and in every locality of each county. (See Table.) One objective of such a department would be a dynamic teaching of the science of democracy to all the people in all states of the Union and the social integration of every part of the nation with every other. Instead of leaving this most important task only to the press, radio, television and the various vehicles of propaganda, the new department should use *direct channels* of communication with the people, in cooperation with the latter.

One may object that the proposition of a new branch of government entails an enormous enterprise, a new bureaucracy, increasing further the already overtaxed governmental budget of expenditures. Only strong and desperate arguments could justify such action at a time as critical as this. But the reasons which have led the writer to repeat over the years such a drastic recommendation is the desperate and critical situation in which the United States of America finds itself in this hour of great decision. Herewith follows some of the reasons.

The Sociopathological (Sociatric) Situation of the U.S.A.

The republic of the United States of America is a novel experiment in societal development, about one hundred and sixty two years old. It is the youngest among the great nations, all others come from a long tradition of legal, social and political structure, some of which have been slowing down. One can take the position that the British Commonwealth and the French Republic have already had their "future." As a nation and culture the United States of America have hardly started. Now, what is America's future? What kind of human society is developing here? It is not built upon a single political ideology like the Soviet republics, or a single religion like Italy or Spain. It is more characterized by what it is not and by what it rejects than by what it is. The negative position has, from the point of view of spontaneity theory, powerful dynamic involvements of a positive character. The negative position does not mean a standstill, it means that it is fighting against the exclusive rule of any particular ideology, of any particular religion, nation or race, against the exclusive rule of any political system and that it protects its citizens by law and force against being ruled and subjected by them. The negative turns into positive because it emerges from an unconscious faith in the dynamic structure of society to take care of its needs and ills spontaneously, so to speak. But such a spontaneous drive towards an optimal level of its natural cohesion is not

without the profound anxiety of possible failure. This anxiety may explain the unlimited, almost hysterical faith in science "as a part of natural evolution," the drive of mobilizing science in all its forms as an ally in the fight for freedom and its gigantic development here being without parallel in the history of other nations.

The American nation suffers as a society from a social sickness which I have called "low cohesion."* If we could chart the nation's social structure, *a chart* of its human relations, positive and negative, of its sympathies and prejudices, we would probably see millions of small groups, each gravitating around its own center, the connections between them being in a majority of cases missing, weak or distorted. It would suggest the conclusion that a *binder* is needed to tie the parts together. This is what modern social inventions (as sociometry, group psychotherapy and psychodrama in the broadest sense of the word) promise and have in part started to do. They promise to transform areas of low cohesion into areas of high cohesion without sacrificing, however, the spontaneity and the freedom of the small groups. Cohesion of the group is measured by the degree of cooperativeness and collaborative interaction forthcoming from as many sub-groups and members as possible in behalf of the purpose for which the group is formed. There is great probability that in a spontaneously growing society the cohesion rises and declines in proportion to the number of small, independent groups within it and with the number of independent goals (criteria) around which they revolve. As a free, democratic society is more inclined to permit the production of a large number of independent small groups with a large number of different and independent goals, its cohesion will tend to be low. In contrast with this, the more authoritarian and unfree a society is, the less inclined it will be to permit the production of a large number of independent little groups. In consequence, its cohesion will be high. *The problem is, therefore, how to combine a society of high freedom with a society of high cohesion,* that is, if the deliberate objective of its government is to safeguard for all its citizens the highest possible individual and collective initiative. History has repeatedly proven that it is easier to produce a society of low freedom, a society of restraint which then goes hand in hand with a society of high cohesion and high stability, than to produce a society of high freedom which is easily fraught with low cohesion and low stability. Everyone for whom a society of high freedom is axiomatic should realize what sacrifice and risk this entails. Societies of this type have failed again and again

*"Note as to the possible meaning of Group Psychotherapy for the people of the U. S." See Group Psychotherapy, Vol. III, 2-3, 1950.

to survive in the past and because of low cohesion and low stability ended in social disintegration. Comprehensive analysis of social groups has disclosed that they need "checks and balances" of a new, unprecedented sort in order to have a better chance for perpetuation. The social health of a nation is dependent upon its cohesion. A society of freedom needs sociometry, group psychotherapy, sociodrama, mass psychiatry and many other methods designed to increase cohesion and prevent instability from rising. Societies of restraint and dictatorship like Soviet Russia do not need them as much, in fact, they do not allow them to grow. They have substitutes in their totalitarian ideologies by means of which they establish by decree and indoctrination a high cohesion on the surface and in the depth of their societal organization.

Let us imagine for a moment that a single individual grabs the authority for himself to make all the choices and decision for the members of the group. If he is a good and conscientious ruler he will reduce many potential tensions with one stroke and the people will get some of their satisfactions without having to exercise their spontaneity. But in the course of time their spontaneity will get stale and their sense of freedom will become dull and thus what is a temporary gain will become a permanent loss. It is not enough for a nation to have a ruler, a dictator who is spontaneous and creative in its behalf. But it is essential to have a government which is able to arouse the spontaneity and creativity of the masses of the people. A shortcut to high cohesion may turn out to be a dead end for liberty. Let us therefore start with liberty and let us see what happens to social structure if liberty is permitted to act unrestrained. Experiments with sociometry and sociatry have taught us that spontaneous interactions have a way of developing their own restraints, cleavages and barriers. An illustration is the function of certain deviate groups, for instance, its mental patients. Looking at the abnormals and deviates from a world scale they represent a small minority, they are comparatively harmless, they are rapidly segregated before they can exercise much harm, and last but not least, they are comparatively immune to many of the perceptions and prejudices of the normal networks of emotional communication. In the asylums they influence one another and form networks of their own which determine their standards. They do not imitate the normals whom they often fear and reject. The great manifestations of social insanity, the wars and revolutions are products of the normal, average, non-deviate minds. They influence each other through powerful social networks which they have unconsciously created and through which their feelings travel. The pathology and the therapy of the normal groups has been neglected but it is upon them that the social health of a nation depends.

The goal is unquestionably to combine a society of high freedom with a society of high cohesion. Two methods have been tested: to start with absolute restraint and dictatorship and interpolate more and more freedom, or to start with liberty and to interpolate more and more restraint. The question is which method works better. The answer is historically set. We started with freedom, we cannot betray our own past; we have to go on with techniques of freedom. We have to continue with our trust in science. We should not stop on the technical level but must go on towards the social. We must develop further, with all the violence of our ingenuity, a science of human relations, more precise knowledge and quicker ways of social communication. This is the only track we can travel and it must end logically in a Department of Human Relations which should bring the millions of little efforts into a single focus.

The Pathology of Economics in the U.S.A. and the U.S.S.R.

We cannot live from freedom alone, we need material foundations. Therefore, I would like to discuss at this occasion some of the underlying factors in general economics, the importance of the natural resources (n), the genesis of production and the finished product (p). A great deal of emphasis has been placed, especially since Marxism entered the arena of economics, upon the question: "To whom does the finished product belong?" The capitalist says: "It belongs to me, I bought the machines, I bought the materials and I have hired the men and paid them wages for their labor." The worker says: "It belongs to us, the profits you make belong to us, they are the fruits of our labor. The machines you bought have been built by the labor of our comrades nearby, they belong to them. No one had a right to sell them to you, it was outright robbery, the contract between one capitalist and another, it is null and void. The factory here has been built by other comrades, it belongs rightly to them and to us" and so, on goes the argument, endlessly. But no one stops and thinks and asks the more fundamental question: "What goes into the finished product *besides* labor?" In order to answer this question we have to analyze the situation before production begins, and define the locus and status nascendi preceding all production. What is it that is necessary to have on hand before production of goods is possible. First, there must be in existence the natural resources of the planet, the mountains and the rivers, the mines in the depth of the earth and the unleashed elements of the atmosphere. They are there before they are touched by any labor, before they are discovered by any man and they would be there even if mankind would not exist. Next to the natural resources are the generators of production, the creative ideas (c). They

are the fountainhead of all technical and social inventions, of the instruments and the blueprints; without them the processes of production could not be contemplated. Without creative ideas the most abundant natural resources of all the universe could go on for eternities unharnessed. Then there is another factor in the genesis which must exist before any production can start. It is spontaneity, that all-pervasive plastic element which begins to warm up our imagination as soon as the natural resources and the creative idea meet. These three phenomena, natural resources, creativity and spontaneity pre-exist and condition the labor process. They belong to the universe. They do not belong to the capitalist class, they do not belong to the labor class, they do not belong to any particular individual or any particular group. They are *universalia.* What the worker puts into the process is his labor and the time which is spent working. (n + c + s = u; l + g + t = h; u + h = p)*.

Marx, by reducing his analysis of merchandise and production to the part which labor puts into it, has left out, perhaps unconsciously, the deeper forces without which the labor process itself could not be realized. The capitalist as well as the Marxistic view of the labor process are both derivatives and functions of a more universal system of creative economics.

The Position of Sociometry in the Struggle for a New Social Order

The present crisis has arisen because of a war between two systems of social relations, the capitalistic and the communistic systems. The capitalistic system roots in the doctrine of the classical economics—that private enterprise should not be restricted, that the economic spontaneity of the individual should be permitted to let go without legislative interference, based on the implicit faith that nature will cure pathological excesses automatically. The communistic system is based upon the marxistic analysis of capital according to which pathological excesses, especially the "surplus value" of capitalism does not cure itself; it concludes therefore that direct action of the masses is urgent. Communism preaches a form of government which claims it can secure for the masses, for everyone, without exception, for all in accord with their needs, a higher standard of living than the capitalistic system is able to provide for them under similar circumstances. Therefore it preaches that the capitalistic system should be destroyed. The idea of communism must and can be halted. It can only be halted by an idea which is superior to it. It cannot be halted by physical weapons alone. Ideas have to be fought and conquered on the battle field of ideas. "Sociometric democracy" is the idea which is stronger than communism.

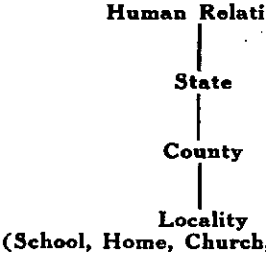
*n is natural resources; c is creativity; s is spontaneity; u is universe; l is labor; g is group; t is time; h is human; p is product.

The frequent question: "Which is superior, the capitalistic-democratic system or the Soviet system of dictatorship?" is a dialectic trap. The crucial question is: "Has human society a specific structure? Do we know anything about it? Do we know some of the rules and laws which govern it?" It is not until recently that we could answer in the affirmative: "Yes, we do." And it is precisely because of this that a new opportunity for the development of human society has begun. Both capitalism and Marxism grew as powerful social forces, only partly directed by reason, long before a metric of society, a sociometry, existed. It is hopeless, therefore, to compare them as we deal in both cases with crystalized social systems of behavior fighting for their survival. The strategic attitude, which also happens in this case to be the scientific one is to *refuse* to answer big questions in a futile way, but rather to study simple social systems first, undertaken in all humility, realizing that we know very little and that they may help little to solve the big problems, but hopeful that perhaps gradually they will open our understanding of what are the dynamic structures of groups. Maybe that after painstaking studies we will be able to make simple recommendations.

Sociometry was fortunate, perhaps because it asked only little questions, to discover a number of principles which appear to have universal application and, although not directly planned or perhaps because of this, was able to throw new light upon Marxistic theory of society, among other things. It has discovered, for instance, that the economic surplus value within the capitalistic system of production of which Marx complained so bitterly is not the result of an economic disease which is characteristic only for capitalistic societies. On the contrary, it was demonstrated that it is a symptom only, a "reflection" of a universal sociodynamic law which operates in *all* human societies, indeed also in sub-human societies, therefore must also operate in a society a la Marx, and especially in one governed by the dictatorship of the proletariat. We have discovered through simple sociometric experiments that the *cause* for the surplus value is rooted in the very foundation of human society and not in the capitalistic system. To start a world revolution in order to alleviate a symptom while leaving the causes untreated is as unscientific as it is barbarous and the masses of the people must be taught this truth. We should try to find remedies for the causes if there are any remedies for them. The few correctives which sociometry is able to make require, however, an attack upon the action matrix of society itself. A Department of Human Relations is a step in this direction—towards a gradually maturing human society.

UNITED STATES GOVERNMENT

Executive	Judiciary	Legislative
The President	The Supreme Court	The Senate and House of Representatives
	Administration Departments	
State		Interior
National Defense		Treasury
Labor		Agriculture
Commerce		



THE UNIQUE SOCIAL CLIMATE EXPERIENCED IN GROUP PSYCHOTHERAPY*

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The process of group-psychotherapy can be viewed from three aspects. Characteristic dynamics which operate in any form of group-psychotherapy and make it an effective tool for influencing individuals, can be observed on three levels: within the patient, between the members of the group and within the total group situation. There is a constant interaction between these three dynamic processes; yet they can be distinguished and separated in their significance. The analytic approach emphasizes the dynamics operating with the patient. Psychodrama and sociodrama are more concerned with the second aspect—the interaction between patients and sub-groups taking place in the total situation of the group in therapy. The third aspect, namely the characteristic and unique group formation, is often neglected. It is the purpose of this paper to draw the attention to the need for clarification, for exploration, analysis and proper evaluation of the total situation in which the group operates, which distinguishes it from other group situations.

Let us review briefly the dynamics which we recognize as therapeutic agents within the patient and between the members of the group. In group-psychotherapy the individual patient is observed in his attitude and behavior to others. Faulty attitudes are recognized and dealt with through the group procedure. Some assume that the group provides an outlet for aggression, permitting the abreaction of hostility, the formation of new identifications and ego satisfactions. Others see the therapeutic effect in new concepts which the patient develops about himself in regard to others, in his learning to cooperate, to become willing and able to accept the give and take necessary for social living, to reconsider his approaches which he had developed toward social interaction, the goals he had set for himself as an idea of security. Others again may see in the group the opportunity for the patient to develop his spontaneity, to free himself from the distance in which he had kept himself previously. This is not the place to analyze whether these various frames of reference describe the same process from various angles or whether they present a dis-

*Paper presented at the Ninth Annual Conference of the American Society of Group Psychotherapy and Psychodrama, New York, February 17, 1951.

tinctly different type of dynamics. They all have in common their concern with psychological processes occurring within the patient in group-psychotherapy.

Less variety of opinions exists in the second aspect of inter-group relationships. The psychoanalytic approach neglects this aspect almost deliberately, as all social relationships are considered the result and consequence of "intra"-personal dynamics. It is the contribution of Moreno to have pointed out the dynamics which operate between the various members of the group. Since then we have learned to deal in group-psychotherapy directly with the group medium, structuring inter-group relationships for the purpose of helping the individual patient. So far, there is relatively little difference of opinion about the significance, the procedure and the evaluation of inter-group dynamics, regardless of the theoretical frame of reference in which these processes are viewed. The recognition of the group structure and its deliberate manipulation permits each member to warm up, to come closer to the others, and to find his place in the group.

It is the totality of the group which we want to examine here, and which in our opinion deserves more attention on the part of group-psychotherapists. Each group has an organization. It is more than the sum-total of all its members and sub-groups. It has its own dynamics, as it is a unique configuration, a Gestalt. Any group is characterized by its specific social climate. This term is widely used to characterize various group settings, particularly in education. Most discussion on the social climate in classrooms is centered around the person of the leader, the teacher. Moreno* found characteristic differences in various group structures, be they authoritarian, democratic or of the laissez-faire type. They appear to depend on the attitude of the group leader. There can be no doubt that the group leader is responsible for the type of relationship which exists in the group. For this reason we will have to focus later upon the role of the therapist in establishing and maintaining the group atmosphere which we may recognize as being most desirable for effective group-psychotherapy. But first we must clarify some of the dynamics operating in a therapeutic group.

It seems that one does not do justice to the significane of any group, particularly a therapy group, unless one recognizes that each group is identified by the values which it represents and with which it affects each of its members. Our therapy groups are a natural testing ground for observation and ex-

*Sociometric Review, Hudson, 1936; see also Moreno's Sociometry, Experimental Method and the Science of Society, Beacon House, 1951 (see the Laissez Faire Test, The Autocracy Test and the Democracy Test p. 46-49.

perimentation with the phenomenon of group values. Relatively few people realize that by joining a group they are effected by values which the group establishes, unnoticed by most. We have to distinguish values from morals. Morals, expressing social conventions, do not vary to a large extent throughout our present American culture. But as most people belong to a variety of groups, their values are rather confused, because the various groups to which they belong do not engender the same value systems. The values characteristic for any family group differs not only from those in any other family, but also from those characteristic for each job situation. Again, different values characterize the church group to which the individual may belong, his political association or club activities. The same moral concepts permeate all of them. Decent behavior is considered the same way in all of them. But value is different from general conventional behavior. It sets a yardstick for superior-inferior orientation. The term value implies a quantitative and qualitative judgment; certain qualities provide higher or lower social status and desirability. The degree to which an individual possesses these qualities are measured quantitatively, while the evaluation of good and adverse qualities implies a qualitative judgment. The differences in group judgment give any individual with his personal qualities a different status in the various groups to which he belongs. The child is judged differently at home, in school, amongst his friends and again on the ball-team. The same quality which gives him a high status in one group may place him low in another.

If we regard the therapeutic group as a value promoting agent, we may come to a formulation of the values which are best suited for the therapeutic process. This would provide us with a yardstick to measure various therapy groups, and permit us to consider deliberate methods to obtain the desirable group atmosphere or social climate conducive for therapeutic values.

At the present time we find a great variety of methods and group structures in the reports of group-psychotherapists. It may be a lecture and classroom situation, an analytic group session, a discussion or a psychodramatic action-group. It is obvious that the social climate in these various therapy-groups is different. However, we witness a tendency away from an autocratic didactic group-therapy to a more permissive group organization, which today characterizes most forms of group-psychotherapy. It may be difficult, therefore, to recognize a common denominator, distinguishing all therapeutic groups from other forms of groups. Nevertheless, an analysis of the social climate found in most therapeutic groups may provide us with the recognition of such characteristic elements.

It is obvious that the permissive group atmosphere is the most distinctive group organization in the field. Nowhere else in our society can an individual fully behave as he wishes without losing status. For this reason our examination should start with this form of group-psychotherapy. Its characteristic significance will be interpreted differently by a therapist who is mostly concerned with the intra-personal dynamics of each member, differently by one who is considering the inter-personal group relationships, and again different by one who examines the total group climate with its characteristic values.

For an analyst the permissive group situation may provide an outlet for aggression without the threat of punishment, so that a new homeostasis may be established, more suitable for a stable emotional equilibrium. In this way the attitude of the individual to others and to social living may be improved, his castration fears diminished, his defensiveness and inner tensions eliminated. For the therapist concerned with group dynamics, the permissive group situation permits a closer integration of each individual, a better mutual understanding, greater friendliness and warmth and consequent increased cooperation. While the analyst tries to free the patient from his inner tensions, the socially oriented therapist tries to remove group tensions, affecting and improving thereby the attitudes and emotional reactions of each individual member.

Looking at the total group situation, other aspects become apparent as distinguishing the permissive therapy group from other groups. The most outstanding aspect seems to be the fact that in this group each member has his place regardless of his personal qualities, his deficiencies and assets. Nowhere else is this true in our society. In any other field of action, the individual is constantly judged according to his abilities and deficiencies, his accomplishments or mistakes. Not so here. One may say that the values which make a person higher or lower anywhere else in society, are discarded here. But no group can exist without definite values. For this reason, the therapy group cannot be identified by its lack of otherwise existing values, but only by the values which it tacitly implies itself. Such values may be recognized if we examine the factors which give each member status in the group. The first and most obvious is the "existence" of the member. Mere regular participation provides him with status. Only if he does not come regularly does he lose status. This is of extreme importance. It implies that full value is granted to each member by his mere existence, regardless of what he is or what he is doing, regardless of personal qualities, achievements or deficiencies. In this regard, the social climate of the group resembles a non-competitive, homogeneous primitive group,

where the full worth of each member is taken for granted, merely by his being a part of the group.

Another criterion of positive value is the ability of the member to reveal himself as he really is. Holding back his true emotions, covering up his intentions and hostilities, restraining himself and putting up a front are of low esteem in the therapy group, while they constitute highly valued qualities anywhere else. This stimulates each member to display himself just as a human being, without any pretense or shame.

That does not mean that such behavior is easy for anyone raised in our present cultural atmosphere. But these values for which the group stands present an intrinsic part of the therapeutic process, particularly if we recognize the patient's fears for his status, his inferiority feeling, his sense of inadequacy and failure, his over-concern with his faults and deficiencies as the causes for his tensions, anxieties and maladjustment. As he learns to accept the values operating in the therapy group, his concepts change, permitting a solution of his emotional problems. Psychotherapy in general leads in the direction of self-confidence, self-respect, certainty of one's social status and its concommitent emotional and action behavior. In individual therapy the therapeutic influence is limited to the relationship with one person, the therapist, and to the verbal expression of new and therapeutically effective values. In contrast group-psychotherapy provides a much more convincing and impressive experience. Here the patient "learns" by actual experience, not merely on the verbal level. For this reason group-psychotherapy is particularly effective for very disturbed patients who often cannot be reached at all through an individual approach. This is true, for example in cases of severe compulsion neurotics, psychotics and particularly for psychopathic personalities. The latter category is characterized by its defiance of the values accepted within society at large. It is almost impossible to reach such a person individually as the therapist and the patient talk a different language and have concepts and values which are incompatible. The value-producing group gives the patient an opportunity to be affected directly by new values, often without his own awareness that his mere association and existence subjects him to new values which he cannot escape. He discovers that he has value in the eyes of others just because he is a human being, while his previous social contacts made him believe that he never can belong in the adult society because of his deficiencies and faults. The psychotic can be drawn into a close human relationship which may affect and disrupt his isolation within his own "private logic" so that he again can share his thinking and his

concepts with others. As soon as he establishes that, the psychotic state is fundamentally dissolved.

This emphasis on a person's unquestionable status in the group, without regard to quality and achievement, seems to characterize all the different approaches and forms of group-psychotherapy. It is equally evident in a completely permissive activity group, in a non-directive activity group, in a psychodramatic action group, in a discussion or in an analytic group and even in some form of didactic groups, provided that the members of the group participate in the program and are not limited to passive listening. In each case an attitude of mutual understanding and respect develops, giving each member the realization of his status as an equal. In almost all cases the admission to the group already represents a fundamental deviation from any other social participation. Admission to a social group is usually based on some kind of accomplishment or asset. Most groups accept as a member only one who comes up to the standards they have set for themselves or who fulfills their value requirements. The child is accepted only in a class after he fulfills the age and scholastic requirements. He has a chance for participating in a social or athletic group only on the strength of his assets. This is equally true for adults. Only in therapeutic groups is the qualification for admission overtly based on some recognized and admitted deficiency. Alcoholics Annonymous, for example, will not accept anyone unless he admits to being an alcoholic. Then he can request understanding and help. One realizes immediately the profound change in the value system whereby a defect which normally provides extreme social degradation becomes a social asset. This is equally true for children who realize their social ostracism due to their unmanageable anti-social behavior and suddenly find themselves "privileged" to participate in a specially interesting group activity where they receive special attention and respect. Similarly, the adult patient who previously had been ashamed of his shortcomings and deficiencies, suddenly finds himself accepted by others on the strength of these traits which previously had been only a source of social embarrassment.

This unique social climate characteristic for group-psychotherapy does not only explain some of the therapeutically effective dynamics of this form of therapy; it also accounts for the tremendous fascination which it has provoked in our population. The practice of group-therapy not only enjoys an increasing interest and popularity amongst therapists; it also transcends the limitations of psychiatric practice and invades the community at large, leading to experiments in group-psychotherapy on levels heretofore not within the realm of either psychiatry or psychotherapy. Schools, community agencies and churches

have become interested and experiment with group-therapeutic procedures. All these tendencies can be well understood on the basis of the specific values provided by group therapy. Once it began within the field of psychiatry and psychotherapy a new social organization started within our culture, forming almost a foreign body in the value systems of our society. It must be said that religious experiences had provided similar group organizations which permitted each individual to have his full place as a "sinner," belonging to his congregation on the strength of his human frailty. But religion has lost for many its appeal, its efficiency of integrating the individual into the group. Fifty percent of all Americans do not belong to any church, and many who do, do it not for their religious faith, but for social and other reasons. It seems that many can no longer accept the authoritarian structure of a religious group and have not yet found a democratic and humanist religious organization which would fill the gap. Consequently, they live in emotional isolation, under constant tension of putting up a front so that nobody will know what they really are and how they feel. Otherwise, they would lose status, would endanger their prestige and might incur ridicule and contempt. Such a condition keeps everyone in fear and anxiety, in tension and uneasiness. People want to get out of this uncomfortable condition, but do not know how. The experiences of those who participated in group-therapy became an incentive for others who heard about it and sought it. This became a focal point for public demand. The rapid spread of group-psychotherapy is not only due to the increased recognition of this new medium by therapists and group leaders, but it also reflects public interest and request. The social values promulgated in group-therapy are in line with man's search for equality. At a time when society as a whole is rapidly moving toward democracy, the recognition of man's fundamental equality is of tantamount importance. In our competitive culture the full implication of human equality, irrespective of personal differences, qualities and achievements, is difficult to comprehend for most people. The spread of group-therapy implies more than assistance to individuals; it becomes a social factor in our culture which is a transition from an autoritarian to a democratic society. For this reason it is more than mere therapy, more than adult education. It is a living experience, a dynamic factor promoting a new social concept and fortifying cultural trends.

Group-psychotherapy has not only its effect on the patients participating in it, but also on the therapist and group leader himself. A social organization in which each member has the status of an equal is not only difficult to accept for patients who have been conditioned to other values; it presents also a tre-

mendous challenge to the leader, even more so as the individual therapist, both by tradition and by the requirements of his function, is inclined to take on an authoritarian position. It is difficult for him to function as an equal amongst equals, and great confusion is created amongst group-therapists as to the best approach to a truly democratic performance. All the complexities characteristic for an era which tries to establish democracy without sufficient precedent and clear techniques is evident here. Many therapists confuse democracy with anarchy, laissez-faire. They try to restrain themselves from directing, from answering questions, as this would imply the assumption of an autocratic role. Many pride themselves that they never answer questions which come up during the therapeutic session; they rather let the members find their own answers. They think that this is democratic. Little do they realize that such procedure not only sets them up as an autocratic ruler who decides not to divulge what he knows, despite the request of the group; it also indicates a lack of respect if one refuses to participate and holds back some knowledge which everybody in the group knows he possesses. Such behavior is artificial and contrary to the basic principle in group-therapy that each member, including the therapist, is himself without pretense and cover-up. It is not important what the leader does, but in which spirit he is doing it. He cannot deny that he is superior in knowledge. After all, he studied dynamics and knows more about them than the other members of the group. As long as he does not feel superior to them he can let them benefit from his information without setting himself up as an authority. The training of group-therapists would require the ability to function as an equal, to feel humble enough, to be just human without either feeling superior or inferior to anyone else in the group, irrespective of the individual differences which exist here as well as anywhere else in the world. Under these conditions the therapist can benefit from the group as much as any other member. Actually, every good group-therapist learns from this experience, which provides also for him a social climate which he cannot find anywhere else.

A DIAGNOSTIC NOTE ON THE CONSTRUCTION OF SOCIOGRAMS AND ACTION DIAGRAMS

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Ever since the publication of *Who Shall Survive** in 1934, the use of diagrams has become more and more popular in the analysis of group structure. It should be of value to anyone in pursuit of diagnosis, especially to group psychotherapists. The general procedure in the construction of such diagrams has been as follows:

1. The choice of a suitable criterion of relationship upon which to base the diagram.
2. The use of a brief questionnaire (or interview) to establish the choices and rejections of the members of the group.
3. The tabulation of the number of choices and rejections each member of the group makes and receives.
4. The placing of symbols (such as circles, triangles, squares) representing persons on a sheet of paper and drawing in the lines of relationship.

Such a standardized procedure may be adequate in many cases, but it cannot exploit the full value of using diagrams. Some of the pertinent problems are discussed here.

1. *Choice of an adequate criterion.* The choice of the adequate criterion depends on the appraisal of the investigator. It must be remembered that there exists motivation behind the analysis of the group. The group is analyzed for some specific purpose in a workshop, in a mental hospital, in a military squadron or in a classroom and not merely because "*it's an interesting thing to do.*" A teacher, for example, would be interested in knowing who the popular children are, and why they are popular. She wishes to know what cliques are present in her classroom, and also who the leaders are. It is of interest to know whether the child who performs well in his school work is desired as a working companion by his classmates. Is prowess in athletics the basis of leadership in another area? The information she seeks sets the criteria for the sociograms she will construct. The teacher who makes a sociogram on the basis of the overworked criterion, "With whom would you like to sit?" and feels that she has

*Moreno, J. L., Who Shall Survive, Beacon House, New York, 1934 and 1951.

fully explored the structure of her classroom group has commited the fallacy of accepting a well established procedure without exploring her own needs as well as those of her class. In order to avoid static results and interpretations, a little originality is required within the limitations of the method. It must be pointed out that direct and indirect criteria are possible, and the choice of an adequate criterion may tax the ingenuity of the concientious researcher and diagnostician.

2. *The choices of the members of the group.* Having established that she wants certain information concerning the structure of her group, the teacher also devises a questionnaire to give her class. She may not use a questionnaire, and instead, simply read the criterion to her class and ask the members to list names. In some cases, she may have the individual children come up, one by one, and name the persons they would choose according to the criterion. Any of these variations is good under different circumstances. Obvious limitations exist; questionnaires naturally could not be used with children who are too young. On the other hand, it should not be assumed that older children will give the same responses verbally to a teacher that they would give on an answer sheet or questionnaire. Among other things, in speaking to the teacher, the chlid may feel compelled to give names, whereas names might not be elicited in a questionnaire. In a mental hospital the tasks are similar; should they be unable to communicate their social feelings coherently their spontaneous attractions and rejections are watched carefully and plotted in diagram form ("observer" sociogram).

A problem which is frequently ignored by persons using the diagram techniques is that the directions given with the criterion may govern the types of results which are obtained on the questionnaires. Sociometrists have long since distinguished between the isolated person and the unchosen person. The unchosen person is one who chooses but is not chosen in return. The isolated person is one who does not choose and is not chosen.* If the teacher gives directions in the form, "List *three* persons . . . , " or "List in the order of preference three persons . . . , " the directions are so loaded as to obscure the isolates. Furthermore, the directions tend to restrict the choices in ways which may be undesirable. Not only do directions of this sort force responses where there would be none, force additional responses where there might be only two, but it also prohibits the individual from making as many choices as he might like. In certain instances, it would be just as important to know the person who makes many responses as it is to know the person who makes few or none.

*Personal communication (J. L. Moreno).

The possible restriction on the number of choices is not the only problem involved. It may be wise in some cases to group choices as "first choice," "second choice," etc. Generally speaking, however, the data gathered in this manner is not used in analysis. Heuristically, it would seem that grouping of choices into two or three categories is feasible, but grouping into more categories may be beyond any pragmatic value to the social investigator. If more than two categories of choices are made by the individual members of the group, the worker may tangle with the problem of deciding what meaning to give to the categories as defined by each person choosing. Indicating level of choice arises as a consideration when one is compiling tabulations or constructing diagrams. If colored lines are used in the diagrams to indicate level of choice, the use of more than three colors may well make the diagram unreadable.

The same problem discussed above has other facets. One might wish to indicate rejections as well as choices, and to incorporate this information in the same diagram. Frequently neglected by the social investigator, rejection is often the more important relationship. The teacher is not only interested in the fact that a child is isolated, unchosen, makes many choices, or is a star. She should also be interested in knowing how often a child is rejected, and which children tend to reject others.

3. *The tabulation of choices and the placing of group members.* A procedure which is very important in the construction of diagrams is the quantitative tabultaion of responses. This is usually done on a two-fold table, listing the names of the persons vertically and horizontally, and placing individual choices in boxes. In such a table, the number of choices made and the number received by each person can be easily summated. Mutual choices are easily identifiable. The limitation to such a table is that it is not possible to view clusters of relationships. Many individuals have indicated that they have found the tables more useful than the diagrams; upon analysis, this has always turned out to be a function of bad diagramming.

The usual procedure in diagramming is to place the star (persons who are most chosen are designated "stars") in the center of the page. Each person is represented by a circle, or if males and females are to be distinguished, the circle is reserved for females and triangles are used for males. Teachers of mixed classes find it especially useful to pay attention to sex classification since most diagrams tend to split according to sex lines. A group psychotherapist, on the other hand, may find that classification according to sex lines is irrelevant. The persons who are frequently chosen are placed around the star, and at the periphery are placed the isolates and the unchosen persons. At this point, the

lines of relationship are usually drawn and the diagram is pronounced complete. *It is far from complete, however, in most cases.* If the number of persons in the group is small, and the number of choices is small, then the diagram will probably be fairly easy to read. If such is not the case, then the diagram must be redrawn and revised in order to be meaningful as a tool for analysis. The obvious limitation of the aforementioned procedure is that it implies but one nucleus to the group under surveillance. It is assumed with this method that there are no sub-groups or that sub-groups are unimportant in the total consideration. It symbolically places the chosen persons in the center and the unchosen persons and isolates at the periphery, but diagramatically speaking, this is not indicated by the relative positions of persons or the flow of lines. The diagram may be a hodge-podge of lines which cross each other too many times; it is no wonder that some persons will state that the diagrams are not as usable as tables.

A readable diagram is a good diagram. To be readable, the number of lines crossing must be minimized. This may be taken as a primary principle in the construction of inter-action diagrams; the fewer the number of lines crossing, the better the diagram. The problem, then, is to find the procedure which best minimizes the number of lines that cross in a diagram. It is to be acknowledged that each group which is to be structured diagramatically according to a given criterion presents a specific problem. The following presentation gives some hints which have been found useful in making readable diagrams.

1. After having gathered and tabulated the choices, pick the two, three, or four persons who are most chosen. How many persons are chosen for this initial stage depends on the size of the group; in practice it is wise to begin with two or three persons in a group of from ten to twenty; three, four, or five persons in a larger group. If one knows beforehand that the group will probably split according to sex lines (as in grade school classes), it is advisable to begin with two or three persons from each sex and treat the sexes as *separate* groups initially. Use circles about one inch in diameter (or even larger if possible); place the persons in the natural geometric positions (three persons in a triangle, four in a square, etc.) well separated on the paper. A sheet of paper twelve by eighteen inches is sufficiently large for groups of up to twenty-five persons. Larger groups should have proportionately larger paper. The initial stage should look like the following samples:

Generally, it will not be necessary to replace the positions in the case of one, two, or three persons taken for the initial placement. With four or more persons, however, it may be found necessary to shift the initial positions to

facilitate diagramming.

2. The second step in making the diagram is to fill in the relationship existing between the initial members. With four or more persons, shift the symbols so that the number of diagonals is minimized. If two persons are mutual choices, draw in both lines so that the relationship will be emphasized in the diagram. The double lines will indicate early in the drawing the existence of sub-groups.

3. The third step is to place the remainder of the group members on the diagram. Begin with the persons who make the most choices. Since these persons are liable to choose widely, they are the most difficult to place once the diagram is started. Once these are placed, shift to the remaining persons who are frequently chosen. The last individuals to be placed are the unchosen persons who have made the fewest choices. The isolates may be placed at the bottom of the diagram, isolated in position as well as in fact. The prime point to keep in mind is that persons must be placed to minimize crossings.

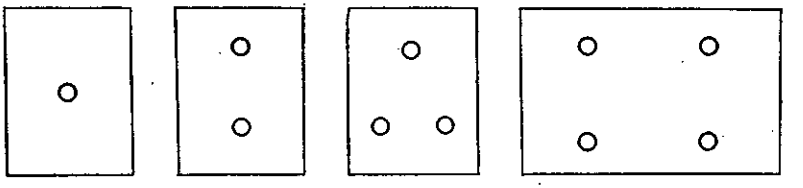
Even with the best of luck, the analyst will not get a diagram which has eliminated the greatest number of crossings at the first drawing. Patience, more than ingenuity, is the essential virtue to exercise here.

4. The fourth step is to analyze the sub-groups observable in the diagram. It may be that the initial placing of the most chosen persons was fallacious; the most chosen persons may not choose each other for a variety of reasons, but they might be chosen in common by a great number of other people. If this is the case, a large space separation may make the diagram itself awkward. This is not frequent. More frequent is the situation where sub-groups are evident, but may be so placed that one has difficulty identifying them as sub-groups from a cursory reading of the diagram. The sub-groups should be shifted so that they are readily identifiable, and so that it is possible to examine which persons serve as channels of communication with the larger group. As the sub-groups become apparent, it will be seen that lines which cross within the sub-group, and some that cross with the larger group should be shifted in some way to eliminate crossings. This can frequently be done by rotating the axis of the sub-group or reversing its symbolization to the mirror image. With experience other techniques will become evident.

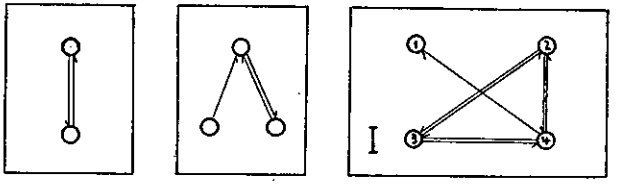
5. The fifth stage is the preparation of the finished diagram. To redraw the diagram, use symbols of a smaller size, usually half to three quarters the size originally used. In this way it is possible to make some of the sub-groups into "tighter" looking units. Furthermore, the reduction in size increases the distance between the symbols and lines which are in close proximity to them, which also affords a neater and more readable diagram.

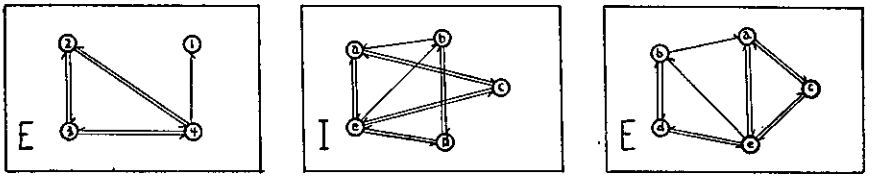
An example of the technique as applied to an actual situation is given in three plates. The diagram is an acquaintance diagram of session members at a special meeting of the sociometric institute. Analysis of these plates according to the techniques for diagramming indicated in this paper will serve as an illustration. It should be noted that even Stage One is easy to read. However, the final diagram concisely shows the greater group structure and the subgroups, and the lines between persons may aptly be called flow lines, whereas Stage One indicates congestion rather than flow.

For additional materials on diagramming see the following: "BUILDING DIAGRAMS OF THE GROUP AND THE INDIVIDUAL," edited by Zerka Toeman Moreno, **Sociatry**, December-March, 1948, and Moreno, J. L., **Who Shall Survive**, Beacon House Inc., New York, 1934; see also: "Sociogram and Sociomatrix" by J. L. Moreno, **Sociometry**, Vol. IX, No. 4, 1946, pp. 348-50.



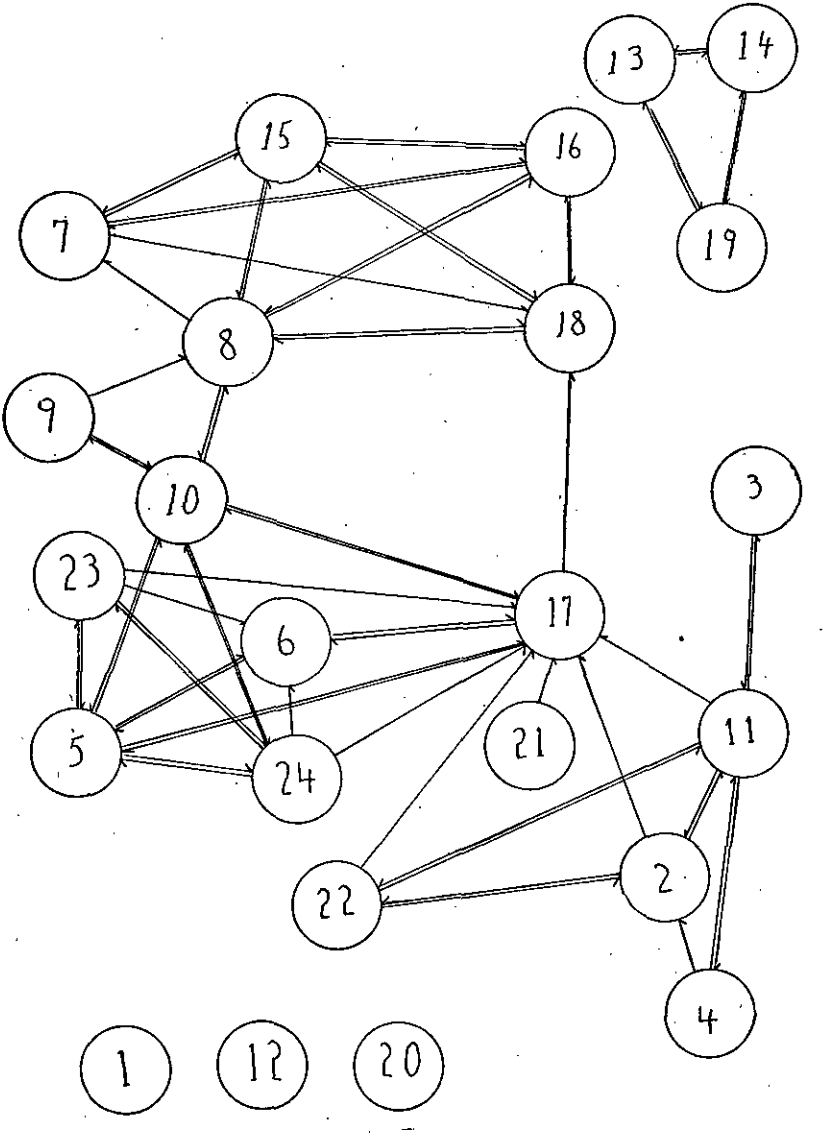
LOCATION OF MOST CHOSEN PERSONS



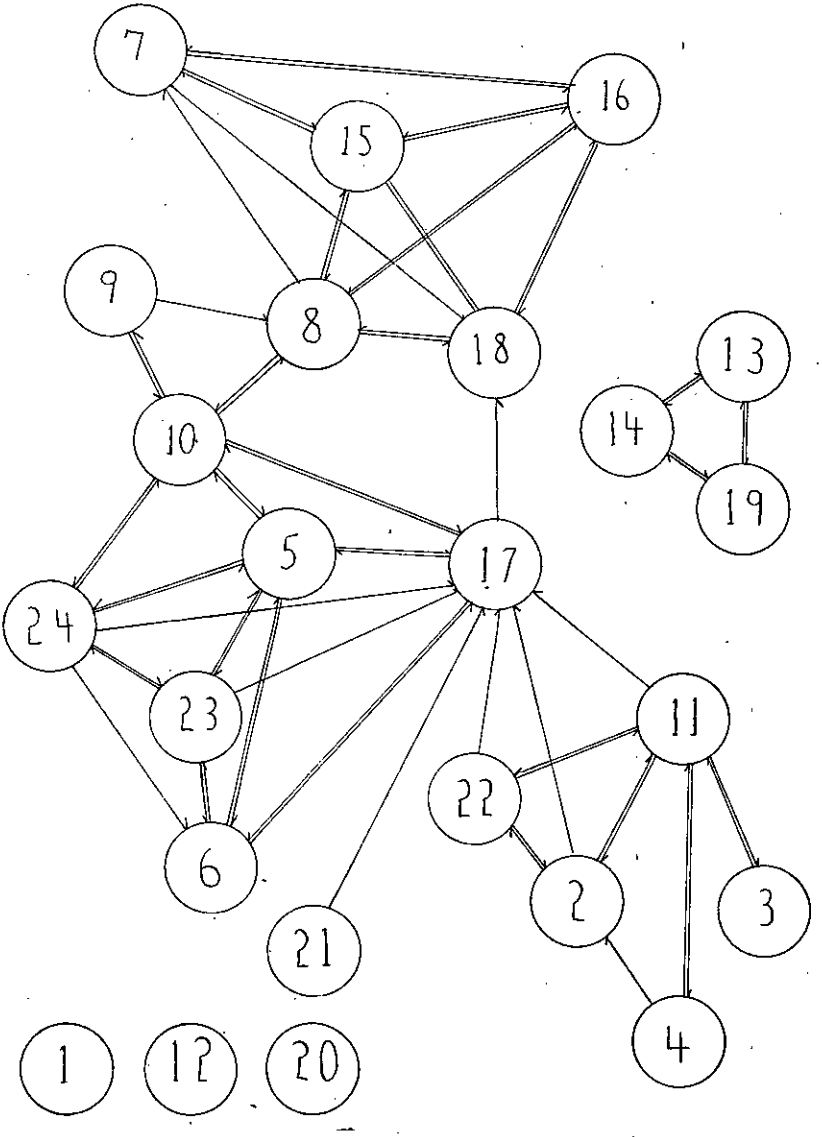


CHOICES OF MOST CHOSEN PERSONS

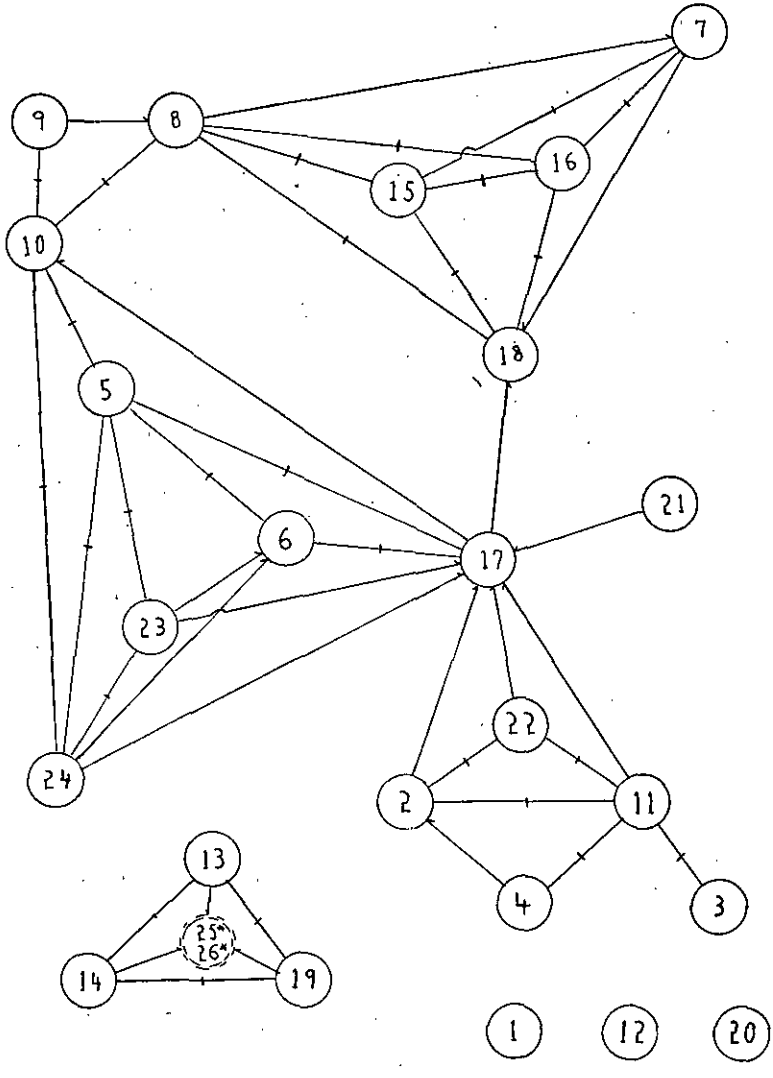
E = EFFICIENT PLACEMENT I = INEFFICIENT PLACEMENT



ACQUAINTANCE DIAGRAM—STAGE ONE



ACQUAINTANCE DIAGRAM—STAGE TWO



ACQUAINTANCE DIAGRAM—STAGE THREE

*Persons 25 and 26 did not participate in the acquaintance diagram or the sociograms

SPECIAL PROBLEMS IN THE SUPERVISION OF GROUP PSYCHOTHERAPY

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The established methods of supervision in psychoanalytic are of limited value when used without modification in the supervision of group therapy.

It is difficult for a therapist, to give an accurate description of an individual psychoanalysis. It becomes almost impossible for a group therapist to describe correctly the complex situation of group psychotherapy. When the therapist has mastered the task to unbiased reporting, he will not need supervision much longer.

The supervisor's knowledge of the therapist makes supervision easier. So to speak, supervisor and therapist talk the same language and know a multitude of implications though they remain unformulated. Such personal and sometimes intimate knowledge may also be used by the supervisor to diagnose difficulties in the therapist and his group work before the therapist becomes aware of them and consciously describes them.

It may happen, for instance, that the therapist may not recognize latent homosexual tendencies in his group because of his own resistance. Such a therapist may not be able to describe the group proceedings in a way which will help the supervisor to recognize mistakes. From his intimate knowledge of the therapist, the supervisor will be able to guess the defects in therapy, ommissions in the reports, and to proceed from there.

When the supervisor has made full use of his initial information about members of the group, when a good working relationship between supervisor and therapist have been established, and when the supervisor's knowledge of the therapist has been exhausted, the individual sessions with the therapist reporting to the supervisor should end temporarily. The supervisor should now enter the group and witness the therapist and his group at work.

SPECIAL ASPECTS OF SUPERVISION IN GROUP PSYCHOTHERAPY

It is important to know that the supervisor should *not* enter the group before the therapist feels confident about it. This does not imply that he is sure of "making a good impression" or of "recognition," praise or recommendation.

He should expect to receive help and understanding from supervision which will further his own development and his group's maturation. The suggestion to the group, that the supervisor attend will be accepted by the individual members of the group only when the therapist really wants it. Under these conditions the group will proceed with the necessary spontaneity.

The group can tolerate the presence of the supervisor without endangering the status of the therapist as the central figure, and will not lose its identity as a working group. This should be emphasized by the supervisor who should start his role as an interested and receptive onlooker.

In the first place, direct observations enable the supervisor to survey the situation. Such observations include, the set-up of the office, which often gives invaluable clues in supervised work, the seating arrangements of the group members, and the therapist's mannerisms and behavior. The supervisor can substantiate material which he gathered from the therapist's reports. In addition, he can make direct observations which as a rule defy description or which if described, take up more time than is available. The direct observation of such sub-liminal cues is difficult even for an intuitive supervisor who has trained himself to observe the therapist, the group, and his own place in the proceedings simultaneously.

In the second place, and most important, the supervisor has a chance to demonstrate his criticism, corrections and suggestions through action; and not only through words. Usually this shift of roles by the supervisor from the receptive observer to an active participant, takes place during the second half of the supervisor's visit. At the time when the supervisor becomes active in the conduct of the group meeting, the therapist then has his chance to observe the technique of the supervisor.

Again it must be emphasized that such activity by the supervisor in a group strange to him must be conducted with tact and mutual confidence, without which, team work is impossible. Anything, even slightly suggestive of "showing the therapist up," must be avoided.

In the third place, the experience of the teamwork can be used as a new stimulation and basis for further cooperation in the following hours of supervision between the supervisor and therapist. It may happen that the contrast between the supervisor's and the therapist's behavior, activates anxiety in the therapist. It seldom is used by the group as a form of resistance in hours to come. As a rule, the group also feels it to be a stimulating and helpful exper-

ience. Occasionally it happens that the group will "supervise" the therapist and continue where the supervisor left off.

A Clinical Illustration of Group Supervision*

The therapist who had asked for some group supervision was a physician trained in analytic therapy and experienced in group psychotherapy. His group consisted of six adults; they had met twice a week for two months with uninterrupted regularity. The therapist had reported almost weekly about the progress of the group, altogether six times. He was mainly interested in supervision in order to find out:

1. Whether he made proper use of his psychoanalytic knowledge in group psychotherapy.
2. Whether he could deepen his analytic technique in group psychotherapy.
3. Whether the supervisor could recognize mistakes which might have remained unnoticed by the therapist.

The therapist had been well known to me for more than four years. The group was composed of three men and three women, between thirty and forty. The diagnoses ranged from depressive episode, hypochondriasis and delinquent behavior to several more or less severe character neuroses expresesed in marriage difficulties and hysterical symptoms.

After the sixth supervised hour, I participated in a group meeting at the therapist's office. During the first half hour, I was observing and nobody took special notice of me. I was introduced as a friend of the therapist with special interest and experience in group psychotherapy. The group had discussed my being invited at a previous meeting and agreed to it with curious anticipation and without resistance. I was sitting a little separated from the group on the open side of the therapist's desk, which separated him from his group. I noticed this arrangement because it symbolized for me the detachment and reserve of the therapist. The desk served as a kind of barricade, protecting the therapist. I gained the impression during these thirty minutes, that the therapist was more passive, detached and reserved than I had realized in the hours of supervision. I realized that I was not going to learn much about the group, If I did not actively contact every individual. I was impressed that this group had learned to proceed independantly, the doctor almost limiting himself to keeping things moving. It seemed to me that he was neither the central figure, nor a real participant of the group. He behaved like a friendly shepherd.

*(I am indebted to Max Sherman, M.D., for having made the following observation possible.)

After the first half hour, I became more active. One of the patients gave me a chance to interpret a memory mistake which seemed to me significant. Almost immediately after this I had a chance to ask one of the women patients how she liked to be called a "Chatterbox." She had just been called by this name and tried to behave as if she accepted it gracefully. Actually she was quite bitter about it. As she began to feel her emotions, I noticed that the oldest male patient was drumming his fingers on the couch and I turned to him asking why he was so impatient. My immediate work on his resistance enabled him to formulate important but censored material.

To my surprise, I learned that he was not aware of his impatience. He stated reluctantly that he had something to say which he felt he should not say. He knew that one of the participants was going to be married soon and he thought this the most important issue to be discussed. I agreed with him and turned to the bride to be. I asked her, with my apologies and hesitantly, whether she was still a virgin, saying that it is better if people have some sexual experience before they marry. By then, everybody was up in arms. Later, the bride who intended to solve a therapeutic problem by acting out, felt relieved and encouraged.

I turned to one of the women remarking about her facial expression, which I described as the face of a child who assumes it is not loved and changes its attitude by saying silently to itself: "I know that you do not love me and I don't like you either, and I don't care anyhow." This turn illustrated to the therapist that it was time to change the topic. It also illustrated how to proceed from the surface of a person's expression to deeper and more meaningful levels.

Next, I turned to the youngest male patient in the group, who was perhaps the sickest one. He had participated very little, and I asked him something about his mother, guessing about her character and her behavior towards him. He slowly and hesitantly began to associate and mentioned the "soft job" he had had in the Army. I showed him that the soft job existed only in his imagination and that he was entitled to consider his Army experience as a trying and traumatic period. I had shown him with my questions that I "knew" him. He felt understood and could enjoy a token abreaction. By my active expression of understanding I had given him a carefully limited corrective emotional experience.

This illustrated to the therapist the kinds of activity which I consider indicated and possible. It also gave him some hints about technique, timing, and

dosage of therapeutic activity. In later supervised hours it could be demonstrated to him how many different therapeutic functions were exercised in a short interval of time.

I closed the group session which I had by then taken over, with an explanation and interpretation of my activity, pointing out that only a visiting therapist is allowed to be that active.

In a short interview with the therapist immediately afterwards, we agreed that the right technique probably lies, between the therapist's passivity and my activity. I felt keenly that this was a well trained group which could take care of itself. I could not have exposed the weaknesses and the soft spots of some group members with such toughness and activity if they were not willing to show it and to deal with the interpretations as given. I felt that I had worked like in psychoanalysis almost exclusively on the defenses and on the resistances.

The therapist was not defensive at all and summarized his opinions later:

"I felt that you agreed basically with my approach to group therapy, my attempt to apply analytic principles in groups comparable to individual psychotherapy.

"It was encouraging to note your response to my efforts to develop a therapeutically valid technique of group therapy, and to know that you felt such an approach is worth further exploration.

"In my preliminary discussions of the group with you, I wondered whether it was unreasonable to expect you to adequately grasp, through mere description, such a complex process. However, I found that in trying to convey to you this process, certain new questions and insights occurred to me. I became aware of anti-therapeutic counter-transference attitudes in myself, such as competitiveness, sibling rivalry, irritability, anxiety about therapeutic failure, which I could then better bring into self-analysis. These are not necessarily points which you actively demonstrated. Aside from your listening with encouraging genuine interest, you were also able to highlight certain transference phenomena and inter-group relationships, the significance of which had escaped me.

"The group readily accepted my suggestion that we invite a colleague, with whom I had discussed these sessions. They looked forward to his coming with interest.

"The presence of the observer, who, at first, was mainly passive but obviously interested, seemed to stimulate the group, and they participated more freely than usual, as if there were a temporary circumvention of transference

resistance. My underlying anxiety regarding possible loss of prestige, exposure of incompetence or inadequacy as a therapist, or competitiveness was ameliorated by the ready acceptance of the observer by the group, and the continuance of normal group activity. I felt pleased, then, that you had the opportunity to observe me functioning in a fairly representative manner, considering that this was my first experience also in this kind of supervised group work.

"Then, you turned the table, so to speak, by allowing me to observe you in the role of active therapist. Several things were soon apparent. You were much more a participant with the person in focus at the time than with the groups as a whole. You described it as greater activity which would not be advisable or even possible for the permanent group therapist, yet it made me aware of barriers within myself against recognizing and accepting and dealing with patients' feelings which to me had seemed subtle. In effect, by practical demonstration, I could see unconscious material in patients illuminated, which had escaped my attention, and which opened new areas that I could work on. It was also an opportunity for me to separate the wheat from the chaff. For example, that your flare for showmanship is not of the essence of therapy, and that while you may be able to use it as a vehicle to show genuine interest to a patient, it is not an essential for myself.

"The reaction of the group was an unanimous desire to repeat the experience. They found it stimulating and provocative. To some extent they reacted as if they had been through a magical performance. A number of interpretations and comments were valuable in reinforcing previous interpretations and stimulating the patient to work through problems with renewed impetus. The renewed interpretation by an impartial observer reinforces the reality testing of the patient, but in an instance where the observer made completely new interpretations or comments, the patient tended to ignore it.

"I believe a competent observer is therefore of actual help to the group itself, because even though some of his comments are out of touch with the working level of the patient, the patient makes allowance for the worker's lack of familiarity with the group, and accepts his comments that hit home, with the gratitude which comes from being understood."

SUMMARY

The therapists usual reports to the supervisor about the group was found to be limited. As a rule, it can be used mainly to inform the supervisor, but hardly for the benefit of the therapist in his continuing work. The suggestion

is made, that the supervisor should participate in the group sessions. The group can tolerate the presence of the supervisor without endangering the status of the therapist as the central figure, and without losing the identity of the working group. Observations by the supervisor of the therapist and his group in action allows him to diagnose mistakes and to demonstrate simultaneously his corrections. Later the experience of having participated at the group meetings can be used by the supervisor and therapist in private meetings. A relationship of trust and confidence between therapist and supervisor is a necessary condition for such team work. The reaction of the group to the visit of the supervisor can be utilized not only for the benefit of the therapist, but also for the therapeutic progress of the group. Contrasting the difference in technique, in inter-personal relationships, between the approach of the therapist and the supervisor may give valuable insight to the various members of the group.

An example of actual work in such a combination of supervision and active group psychotherapy was described in more detail.

THE EFFECTS OF PSYCHODRAMA GROUP THERAPY ON ROLE BEHAVIOR OF SCHIZOPHRENIC PATIENTS

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The purpose of this study was to measure the effects of a psychodramatic treatment method on the role-taking ability* of schizophrenic patients. Two related questions were investigated: (a) the effectiveness of a group action method (using role-taking techniques) in the treatment of schizophrenic patients, and (b) the influence of role-taking ability on total personality adjustment.

The study derives from a theoretical position in which it is postulated: 1) that the ability to take roles is essential for effective communication and the development of the "social self," which in turn, plays an important part in personality formation and adjustment; 2) that schizophrenia can be considered a developmental disorder in which individuals suffering from this illness have an inadequately developed "social self" and their maladjustment is reflected, among other characteristics, in their inability to take roles and share their thinking and feeling with other people; 3) that the schizophrenic's mode of communication tends to be simple, concrete and private. In view of these postulated factors, it was thought that a therapeutic technique, such as psychodrama, which permits communication through non-verbal, as well as verbal channels and which emphasizes role-taking in interaction, might be effective in increasing the schizophrenic's ability to communicate with other people and provide for social and emotional growth.

The *hypotheses* were that a limited number (twenty-five) psychodramatic treatment sessions will result in changes in role-taking ability as evidenced by performance on a Role test (Hypothesis 1) and the MAPS test (Hypothesis 2), but will not result in changes in basic personality variables (as measured by the Rorschach (Hypothesis 3).

*Role-taking ability is here defined as the subject's ability to put himself actually or imaginatively in the place of another person and to communicate with others on the basis of shared frames of reference.

Methods and Procedure

1. The study was carried out in a state mental hospital, from the population of which thirty male schizophrenic patients (all veterans of World War II) were selected as subjects. Selection criteria included the following: psychiatric diagnosis of schizophrenia with special characteristics of inadequate social development and communication; ages, twenty to thirty-five years; a maximum total hospitalization of three years; and no other treatment immediately before or during the experiment.

2. These subjects were divided into three "balanced" groups with ten subjects in each group; two psychodramatic treatment (experimental) groups, and one control group. Both treatment groups were conducted in the same manner by the same therapist (the experimenter), and each met twenty-five times over a period of two months. The control group did not receive any therapy outside the regular hospital routine. During the treatment period of approximately two months the original group of thirty patients was reduced to twenty because of administrative transfers, discharges, etc.

3. All subjects were given three tests: the Rorschach, the MAPS test, and a Role test. These were administered before onset and after the completion of the treatment sessions, in order to measure changes in areas of role behavior, judged significant, within the experimental group and between the experimental and control groups.

4. The quantitative data were derived from ratings by clinically qualified judges for each patient on scales based upon the testing instruments. On the Role test a scale was constructed, both as a method for recording the patient's role performance and for the purpose of rendering the data amenable to quantitative handling. The Role test was designed to get a direct measure of role-taking activity. On the other hand, from the MAPS test and the Rorschach, role-taking ability had to be inferred. On all scales the categories of role behavior measured, such as Realism and Interaction, were similarly defined and instructions for rating were given in terms of the test material. In order to determine the statistical confidence in rating the various scales interjudge reliability was obtained for each scale by Pearson r. On the Role scale average interjudge agreement was .90, on the Rorschach scale it was .77. After obtaining this measure of reliability the data was analyzed by t test comparisons between experimental and control groups.

Quantitative and Qualitative Findings

The *first hypothesis* was concerned with changes in role-taking activity, as measured directly by the patient's performance on a Role (action) test. Three judges rated role-taking performance on eight scales which comprised this Role test. Three of these scales related to areas which were felt to be most crucial (Realism, Interaction and Spontaneity) and were consequently given separate treatment. For each patient pre-test scores were subtracted from post-test scores, thus yielding difference scores. A *t* test comparison of these difference scores between experimental and control groups yielded results on the Realism scale at the 5% level of confidence and on the other scales showed trends in the expected direction.

The *second hypothesis* was concerned with changes in role-taking ability, as measured by inference on the MAPS test. Due to examiner differences a part of the test data did not lend itself to statistical analysis. The hypothesis was tested on a section of the MAPS test data which dealt with the patient's choice of story figures (on the basis of their outgoing and withdrawing characteristics); on this section no statistically significant examiner differences were found. It was felt that the outgoing-withdrawing quality, as evidenced by story figure choice, was involved in role-taking ability. In order to determine whether experimental and control group patients differed significantly in their choice of outgoing or withdrawing figures, three *t* tests were applied. All *t* tests resulted in differences at the 10% level of confidence and thus indicated that, at post-testing, experimental group patients chose more outgoing story figures, and fewer withdrawing story figures, than the control group patients. By inference, these findings show changes in role-taking ability and tend to confirm the second hypothesis.

In the *third hypothesis* it was postulated that no changes would occur in basic personality variables, as measured by the Rorschach. Again three judges rated the patient's test performance on Realism, Interaction and Spontaneity scales (based on evaluation of Rorschach records). A *t* test comparison of difference scores (pre-test score minus post-test score) between the experimental and control groups yielded results on the Realism scale at the 5% level of confidence and on the combined Realism, Interaction and Spontaneity scale between the 5% and 10% level of confidence. The *t* test comparison of Interaction and Spontaneity scales showed trends in the direction of "positive" changes. These findings were contrary to expectations and suggest that trends toward changes in role-taking ability are accompanied by similar trends toward changes in some basic personality variables.

While the quantitative results are inconclusive, the consistent tendency on all three tests in the direction of "positive" changes in the treatment groups, as compared to insignificant changes in the control group, lend some weight to these findings. Furthermore, qualitative evaluation and interpretation of changes confirm and strengthen the quantitative results.

Qualitatively, the specific aspects of role taking behavior which seemed to be most effected by psychodramatic treatment were found in:

1. *Four areas of interaction*: (a) social techniques; (b) ability to enter into relationships and develop them; (c) more mature choice of social relationships and (d) ability to share feelings.

2. *Changes in reality orientation*: that is, in the ability to perceive simultaneously more than one aspect of the same situation and to adapt the behavior accordingly, together with greater conformity of thinking, action, and self-perception with the real situation and the accepted norms of a "normal" environment.

3. *Increased emotional control*: that is, in the development of adaptive defense mechanisms which prevent explosive expression of impulses, such as hostility and aggression. For some patients, emotional control was accompanied by more free and spontaneous emotional expression, while for other patients this control was accompanied by rigidity and repression.

Conclusions of Implications

The results of the study lend themselves to the following conclusions and implications for further research:

1. A psychodramatic treatment approach appears to be effective in enhancing the role-taking ability of schizophrenic patients (whose history and pre-treatment condition indicate some deficiency and/or difficulty in social relationships), as evidenced by: (a) the patients' increased interest and more realistic perception of the outside world; and (b) the patients' greater ability in dealing with their personal and interpersonal problems.

2. The statistically significant Rorschach changes, together with qualitative observations of changes on all three tests, indicate that psychodramatic treatment may affect some fundamental personality processes as well as overt role-taking behavior. These findings tend to support the assumption that role-taking is not a mechanical skill superimposed upon personality, but an essential part of personality formation and adjustment.

3. The development of role-taking ability, especially for individuals in whom the skill was never adequately developed or has broken down, may be as important an aspect of treatment as the development of strictly emotional processes.

4. Quantitative and qualitative findings (particularly in the area of emotional control) imply that an "action" therapeutic technique does not merely stimulate expression of infantile needs and increases "acting-out" behavior, but leads to better personality integration and a gradual "working-through" of problems. In such a setting "acting out" is not the unproductive expression of resistance that it is in a non-action therapeutic situation, but rather the raw material of an action technique.

5. Psychodramatic group treatment appears to be particularly well suited for individuals with extreme difficulties in social communication and reality orientation. We do not have conclusive evidence concerning the effectiveness of this action method as compared to non-action methods, but research in this area might furnish needed information on the subject. Future research may also show whether the psychodramatic treatment technique can be used with equally beneficial results for more verbal, more socially skilled neurotic patients.

6. Finally, the study suggests that the development of role-taking ability involves a favorable emotional atmosphere, a "spontaneous" co-learning process and the actual activity of taking the role of another person. Past theories tended to overemphasize one or the other of these areas, while a "new" theory of role behavior and development would seem to require an integration of these points of view.

THE METHOD OF PSYCHODRAMA IN PRISON

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Crime is most economically explained as an individual reaction to social maladjustment. Everyone agrees that crime is *malum in se* and that it should be reduced in frequency and in severity. To this end two modern approaches have developed: individual therapeutic (rehabilitation-resocialization), and social amelioration. Let us bypass eugenic and socially restrictive measures. Large scale programs of social amelioration are the concern of all citizens as members of the body politic and are always the center of bitter debate, currently in this country as "fair deal" programs. But the individual approach is the other side of the coin and can be conducted independently of mass social action. As therapists, our concern is with the individual: he is the end product of a system of forces. So let us be concerned with the idiographic case. What do we find on studying men in prisons convicted of crimes?

By and large, the prisoner is a firm believer in free will. Like Henley, he is the captain of his soul, and although he may accept in theory that environment causes the crimes of others, he tends to accept the philosophy of personal responsibility. He firmly believes that he was the responsible person for his acts and that he has control over his failure.

THEORY AND TREATMENT

The therapist's theory of dynamic causation and of change, need not conform to his actual method of treatment. Therapists who do essentially the same type of therapy may have entirely different theoretical systems of behavior causation. From the point of view of the subject and from the point of view of reality, in these cases theoretical differences have no meaning and the method of treatment is what counts.

Therapeutic efforts in prisons, by and large, have been most disappointing. Two reasons can be given for this failure: first, the inability of therapists to do therapy in prison due to organizational blocks; and second, the inability of therapists to get deep participation of their subjects in the penal environment. As a consequence, in most penal institutions that which goes under the head of therapy often in no way resembles therapy as it is generally understood. It

would be more accurate to label these individual and group efforts as counselling and education because they are intellectual, not emotional; surface, not deep.

The writer speaks from experience in four penal systems in three states over a period of fifteen years, after observation of the efforts of some fifty group therapists. The writer has personally tried several "brands" of "methods" of group therapy, but has finally discovered that only one method, that of psychodrama, even approaches the effects of deep individual treatment. It is his purpose in this paper to give workers in the field of correctional therapy a short summary of a method for the establishment of Psychodrama in a penal situation and a method for the conduction of Psychodrama under the least optimal conditions.

Starting Psychodrama

Unless the therapist in a prison is able to understand the prisoner-mind, he cannot succeed in therapy. Prisoners as individuals are no different from anyone else, but in groups they are unique. We might explain this by saying that a mild type of institutional paranoia exists which results in extremely sensitive and suspicious individuals. The dynamics of prisons are such to create individuals who are hungry for the "main chance," opportunists who spend their whole working day in elaborate schemes to advance themselves within the social caste system that exists in any institution. The general attitude of prisoners toward officials, while it has been grossly exaggerated and distorted in the organs of information most accessible to the public, nevertheless is one of suspicion and fear. Understanding this group fiction requires that the initial establishment of successful Psychodrama be done in the following fashion which consists in a series of phases.

The first step is to form a firm transference, of a therapeutic type, with several natural leaders. These individuals should have superior intelligence and should be relatively high in the esteem of their fellows. They will generally be murderers and robbers. Burglars, sex criminals, homosexuals, and forgers generally should be avoided.

The next step is to bring these individuals together. From four to six is optimal, and in an informal type of office discussion, broach the issue of group therapy. By taking a completely democratic attitude and by stressing social values in several such sessions, the therapist can form a core of individuals who now have a common aim: to help themselves and others in group situations. The method of Psychodrama is discussed as one of the types of group therapy in order to acquaint the core group with the method.

The next step is to get these disciples to become apostles and to go out among the flock to get new converts. Some twelve to eighteen individuals is the best size group to begin with and is about the right size to maintain.

Official Steps

It goes without saying that official permission to establish Psychodrama should be obtained. I have found reactions varying from complete and enthusiastic cooperation through extreme reluctance on the part of penal executives in getting permission. When it is obtained, emphasis is placed on the following points: Psychodrama is a different kind of group treatment; it is deep, strong, and actually changes people. The method assists in the smooth running of an institution by offering a safety valve for the repressed emotions of prisoners. The method in its operation requires the confidence of the subjects, and for that reason, no information about individuals is to be released. Any member who should reveal information to official sources threatens the therapy and no such person should be planted in the group. Complete control of members retained is up to the therapist. The method, it is further explained, requires the adoption of a democratic attitude and is completely permissive. And finally, whatever benefits obtained are only within the group and the sessions. No official or unofficial attempts at intervention on behalf of any inmate will be done.

These points will also be stressed to the individual members. Only when there is absolute belief in the sincerity of the therapist in these matters can successful group therapy exist in a penal situation.

The Method

The three steps previously outlined: the formation of effective transference with natural leaders; the formation of a core; and the addition of new members by the core brings us to the first session. This session and several subsequent ones should be spent in general theoretical discussion, mutual introductions, role-playing and sociodrama, all for the purpose of enabling these diverse individuals to know one another better. Complete freedom to leave the group exists, and periodic weedings out, either by the group as a whole or by the therapist must be done to eliminate slackers, those who will not participate; incompetents, those who are so maladjusted to threaten the group; and all those who are completely unadaptable.

These preliminary sessions approach the open-confessional methods of the Oxford movement. Nothing is to be retained, all goes, each is to speak sincerely and frankly. Round-robin individual evaluations are done, with the

leader setting the tone of confessional and analysis. Role-playing, that is the enactment of artificial situations such as a foreman who wants to fire an employee and the employee who wants to ask this employer for a raise, are done to get subjects into the mood for Psychodrama, and Sociodramatic situations, re-enacting artificially real situations, such as appearances before disciplinary committees and job interviews are done as further ice breakers.

Along the line, perhaps after four or five such preliminary meetings, the leader announces that up to this point the individuals have been getting used to each other and to the therapist, and that now is the time to begin real therapy. I shall try to report in condensed first-person form the substance of this lecture.

"We are in deadly seriousness in this group. We are not here as a club or for entertainment. Our purpose is to make deep, lasting effects on our personalities. Anyone can leave our group at any time. The group can recommend the removal of any member. I can accept group opinion in this matter or use my own judgment.

"You are all criminals, convicted by the judgment of your peers. You are removed from your families and your homes. You are caged at night like wild beasts. The public regards you as such, and treats you as such. Prisoners when released are seven times more likely to return to prison. I view my efforts primarily for the purpose of helping society to keep you from committing new crimes. I also view my efforts as helping you from coming back to places like this once you are released. You are, remain, and always will be members of society and your values and your aims are no different from that of society. You belong in this group only if you actually committed a crime. Innocent people do not belong! You belong only if you are not a professional criminal. Those who intend to live a life of crime should go out. You belong only if, in your own opinion, there is something wrong with you—if you committed your crime due to some emotional condition.

"Now—let us see how we—this method—can help you. It can help only by your complete confidence in me—the method—and your fellows. By now this confidence should have been attained. If you still have any mental reservations in me—or in anyone in the group, we cannot help you. If you can never gain this confidence, you ought to go out.

"Now each of you has lived for thousands of days. You have been subjected to millions of experiences which helped to form you. How can we expect to make real changes in the matter of a few hours, and a few days, of

therapy? Yet this is exactly what we can do if you have faith and courage and hope. We have a powerful method of operation, known as Psychodrama, which can do the trick.

"Due to our situation, we cannot operate in the classical manner as used by Dr. Moreno, the founder of Psychodrama. We have to make compromise. Each of you is the subject for improvement, but each of you must also become a therapist. You must want to help yourself, but you must also desire to help your fellow men. In both ways you will be simultaneously helping yourself and others. If you expose yourself, then others can learn from you, and if you help someone else, you make yourself better. This may sound peculiar, but I want to insist that the most important commandment is to love your fellow man.

"Now this is the way we will operate. At the end of each session, we will ask for two or three volunteers for the following session. Whoever volunteers has a week of preparation during which time he thinks about himself and his past, his strength, and his weaknesses. The next session he comes up. All of us are now therapists and we want to help him. We do it by being honest, by being brave, by caring for him. The subject tells us about himself, trying to tell us things he is sensitive about, and things that really mean something to him. Then I shall take one or two situations, ask him to expand on them, and then ask him to pick people from the group to act the parts of the people involved.

"Then we re-enact the situation. Now—everything we have done succeeds or fails on this next point. Listen carefully. This goes for you as a subject and for you as an auxiliary ego.

"If you act your part, you fail. If you do what you think you ought to do, you fail. Everything we have done so far is a complete waste of time. You want to know what makes for success? The answer is reality. If you actually live, if you really and truly become involved, and if you feel, then only does therapy occur. You must throw yourself into the situation, say what first comes to your mind, over-act, let go, become spontaneous and free, give release to your feelings, use the worst language and the strongest expressions and develop the situation to its utmost. Don't hesitate to use physical force, strike or kick or threaten if you want to, just let yourself go completely. And when I stop the situation, which I will do by slapping my hands twice, thus; the actor immediately goes out of the room not to appear until the next session.

"The following session we will ask the subject to give us his feelings, and we shall analyze our subject.

"In summary, you are subjects, and you are therapists. You belong here if you have a sincere desire for real improvement and if you have a sincere desire to help others. In participating, you must not act. You must live your part—really become the person you are portraying. I assure you if you can do this, that you will receive tremendous benefits."

In the above section, I have outlined the modification of Psychodrama that can be used in a penal situation. The necessity of using other subjects as therapists may actually be a virtue, since the auxiliary ego role helps one to unlimber and to be more spontaneous when the subject himself comes up. By passive participation as spectators, some learning occurs and courage for one's own performance is increased.

Summary

In this condensed report based on a longer exposition I am writing, I have quickly gone over the nature of the institutional setting, the method of establishing Psychodrama and the method of operation in a prison community. For one, I am absolutely convinced that the method of action participation is far superior to any other method for group therapy, at least in prisons. I caution the necessity for a therapist to plan the strategy for Psychodrama in penal institutions in some fashion—perhaps as I have outlined it—so that the therapeutic spark can be struck.

GROUP PSYCHOTHERAPY; SOCIAL ACTIVITIES AS AN ADJUNCT TO TREATMENT

by

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It is well to reflect on the adequacy of academic psychotherapy to substitute for therapeutic life experiences. There are trends in therapeutic circles which come to preponderate and equate themselves with ultimate truth from which any deviations acquire an air of unorthodoxy. At the present time, psychoanalytic concepts hold sway, according to which practically the entire range of non-organic disorders are due to repression, and if the repressed energy be released, then by inference, it will more or less automatically flow into socially adaptive channels with resulting cure of the patient. But there may be some justice in an attempt to differentiate disorders of affective maldisposition from disorders of affective inanition. In the one instance, the requisites are there but poorly disposed; in the other instance, there would appear to be a deficiency in the quantity and *perhaps quality of the affective potential.* In the latter situation, any treatment designed to liberate energies would be a futile gesture; logically they should be designed to generate energy or amplify the energy which may still be utilizable.

Impartial observation of vast numbers of patients will disclose that the essential and major psychopathology is not due to any specific traumata, although the analyst will search diligently and may by a tour de force relate the psychopathology to some more or less important or trivial incident. A study of numbers of run of the mill patients, however, discloses that the major contribution to the disorders from which they suffer is the general conditioning to which their lives have subjected them, leading to misapprehensions and misconceptions of their roles in their respective milieux.

In these phases of personality malfunctioning a process of reconditioning or re-education is called for, and theoretical representation of this conditioning is very conveniently administered in the consultation room of the therapeutic session and the class room of group therapy. But like it or not, the psychiatrist needs some agency or apparatus to extend his ministrations and tuitions into the outer world, and to lend a hand to the patient's reacclimatization to society.

In any case, it is highly desirable, especially in the instance of convalescent schizophrenic patients.

For these purposes, an organization of patients serves as a kind of "air lock," acting as an intermediary before total immersion into society at large.

Many patients, whether they know it or not suffer considerably from what might be called "social hunger." This may be detected even in some badly regressed patients on the back wards of mental hospitals. Frequently when the doctor or other persons pass through the ward some very regressed patient, who will not have appeared to notice a thing about him, will stand up, reach over and touch the person of the visitor with a forefinger. This is probably the reaction to the feeling of freezing up internally, an effort of self-reassurance that one is still of the quick and to feel again the warmth and reassuring proximity of a fellow human being.

Psychotherapy unassisted by the social milieu of which the patient should normally be a part would, at times, almost appear to be futile. It does not seem logical that it could in all instances be capable of substituting for actual livinv, cumulative experiences. Toward such ends social club therapy is a useful instrument in the therapeutic armamentarium, and from indications it would seem to supply a means by which the influence of the therapist is extended out into a phase of everyday existence of the patient.

Group psychotherapy classes were begun at the Chicago Community Clinic on November 17th, 1948, and have been held continually since that date once a week. This institution is the out-patient supervising clinic for patients conditionally released from Illinois State Hospitals. Its principal case load is recruited from four state mental hospitals within the Chicago radius. The period of conditional release is usually of one year's duration with the possibility of renewal for a similar period of time. During the conditional discharge interim patients report at the clinic periodically in intervals of one week to three months for interviews with psychologist, social worker, or psychiatrist. Some patients apply to the clinic for treatment directly from the community and some are referred by other agencies.

Where indicated ambulatory electro-shock treatment is given. Intensive individual psychotherapy is administered in suitable patients and up to the limits of the clinic's facilities. In addition, group psychotherapy is given to a group of 15 to 20 patients. The criteria for selection are not based on the diagnostic categories, and most of the members of the class happen to have been

classified as schizophrenia. There are a few classified as psychoneurosis. The basis of selection is more the measure of latent reponsiveness in the patient rather than any diagnostic category.

It was noted early in the course of the group therapy that the members who attended regularly, as might be expected, began to form close personal friendships. By degrees the practice grew of holding an informal gathering after each class session. These patients would adjourn to the corner drug store and over coffee cups and sodas would further discuss the subject-matter of the class.

As given at the Chicago Community Clinic, group psychotherapy is of necessity administered in "open classess." That is, the patients are free to attend or not at will. New members may join at any time; the roll of members is never closed. It was early noted, therefore, that a large turnover of patients occurs in consequence, and one of the problems was to find ways and means of securing more regular attendance at class sessions. Any form of coercion could not be applied, of course. Therefore, a social club of the members, one promoting cohesion of the group was seen to be advisable.

With very few exceptions those patients who attend classes regularly over any extended period of time derive benefit. Objective appraisals by means of mass Rorschach tests and the P.M.S. (1) suggest some definite restructuring of the personality as a result of the group therapy. But there is a very noteworthy observation to be made in connection with class attendance. It was remarked early in the course of the group therapy that some patients will attend one time and then drop out of sight. Other patients will attend several times and will be lavish in their praise of what the group treatment is accomplishing for them, and with all the enthusiasm they are capable of, sincerely pledge themselves to the greatest constancy of attendance, but shortly thereafter will also drop out of sight, "spurlos versenkt." It is true that some will have secured jobs which interfere with class attendance, but in many such instances a careful scrutiny discloses that the main reason for the defection is the resistance to treatment. As soon as the material and context of the class work impinges on his secondary gain and threatens his defenses, his resistance comes to his rescue and he will drop out of class notwithstanding that it has considerable attraction for him. If asked, he may of course, advance a variety of rationalizations for his non-attendance. The writer has in his possession several letters from such a patient strikingly demonstrating this factor of psychic resistance. Thus one patient in an individual interview after his first attendance in class

in which he took a vigorous and active part, remarked something like this; "Why, I walked out of there wondering how it was I ever felt so bad. I was myself again. I felt whole and entirely recovered; nothing was the matter with me." But, he related, a couple of hours after that all his anxieties and phobias came trouping back like chickens coming home to roost. The therapist explained to him that the classwork had taken him by surprise at a moment when he was off his guard. The doctor assured him that if he would continue to attend we would again and again "take him by surprise," but nothing could induce him to come back to class.

A mild coercion which could be applied to the patients, compelling them to attend would be very helpful, since such coercion would appear unconsciously to patients not at all as coercion, but as interest and concern for them. Since coercion cannot be applied, recourse has to be had to all legitimate attractions possible.

One of the main incentives, therefore, for the therapist to organize the club was his desire to cut down on the rather large turnover of patients in the class. The organization, having been formed, there arose the additional objective of safeguarding the stability of the club and promoting its prosperity. For that reason a mimeographed monthly magazine has been published. The publication carries reports and the gist of class sessions, reports of business meetings, featured articles, editorials, aphorisms, jokes and cartoons.

All these activities appear now to dovetail into a unified whole, for the several aspects of the organization's activities will titillate the interests of some particular patients according to the personality make-up of the patients in question. Thus one young paranoid schizophrenic male, about 30 years of age, divorced, who had attended about four class sessions accompanied by his mother, and who subsequently dropped out, reappeared some time later at a business meeting. He had continued receiving the publication of the organization. When the mother had been in class, she had been stung into some protest over some subject-matter which seemed to challenge the divine right of parents. It is not impossible that the mother had discouraged the patient from further attendance at class. However, as long as he moves within the orbit of the organization's activities, there remains an opportunity for further therapeutic gains.

Likewise with C.B., a young spinster nearing 40, a college graduate. Classified schizophrenia. She had at first attended a number of class sessions and had taken an intelligent part in the discussions. Then she had dropped from sight,

but reappeared at club meetings, making herself useful there. Then in an individual interview, the reasons for the defection became evident, and even persistent but kindly invitations to rejoin class were steadfastly refused. However, during the interview she did allow herself a measure of catharsis, revealing that she lived with her widowed mother and sister. Mother, a misanthropic invalid, obviously of the psychosomatic kind, has been very demanding. The patient has been very much tied to her mother and sister. She relates that in one serious love affair years before, she had broken up with the young man largely at her mother's behest. So she has gone on from year to year, drifting along on the path of least immediate resistance. She recognized that her life has been dominated by her mother to her own detriment. Passively, she agrees to start on a life of her own, if necessary to move away from her mother and brave the lonliness. But, of course, this she does not do and continues drifting along the same channel.

It is obvious that her conflict had reached a quiescent state; she does not permit herself to think of her future, but is content to drift. But coming to class tends to reactivate the conflict and she therefore chooses to forego them.

However, as long as she continues to be interested in the organization's affairs there is a possibility of further therapeutic gains, and of titillating some aspect of the personality more responsive to psychotherapy.

The club has adopted a rather ambitious program. It was incorporated as a non-profit corporation under the laws of the State of Illinois on August 9, 1949. It's purposes as stated in its articles of incorporation are: "To promote the social rehabilitation of persons who have suffered from emotional and mental illnesses. To provide a forum for reality-testing. To provide a means for the emotionally and mentally convalescent to be gradually reinducted and absorbed into society. To counteract the evil effects of the stigma attaching unjustly to emotional and mental illness."

Pursuing its admittedly very ambitious program the club has decided to make minimal financial demands on its members. On the contrary, it is at present attempting to work up light industries to finance itself as well as furnishing gainful employment to its members. With its funds it proposes to run entertainments and educational projects for its members, perform sundry other services for them and carry out a public educational campaign. To date it has conducted one public lecture. It has managed a number of outings and small parties for its members.

The therapist attempts to be present at meetings frequently enough to act in the capacity of advisor and to keep in touch with its activities, and its publication.

The social club does in considerable measure carry out its original purpose. Just as patients will appear at business meetings after being absent from class over a considerable period of time, likewise are they apt to reappear in class. One patient reappeared in class after an absence of approximately six months.

In planning affairs and executing them, the patient's club does supply a forum for reality testing. It tends to provide realistic activities and is a good antidote to the usual regimen which obtains at home with regard to the recently released mental patients. The family is apt to believe that the patient is in no condition to engage in gainful employment or any other active affairs and should have a "rest." The "rest" frequently becomes an extended period of time to the detriment of the patient's mental status. In this the club can be very instrumental in supplying incentives, and creating a "forum for reality testing."

It is noteworthy how sensitive some of these class and club members become to the slightest nuances and changes in a fellow member's mental status. It may be a degree of diagnostic acumen which may take the novice psychiatrist several years to acquire. Thus one patient who had shown marked improvement in her mental condition and who had taken a job, and, hence, had not attended class for four months attends one of the business meetings. A day or two after the meeting, the president of the club asked therapist "What should we do about M.? Did you notice how she talked the other night." As a matter of fact the therapist had noted a slight increase in the stream of speech and in psychomotor activity. This increase was so slight that no one seeing the patient for the first time would have noticed anything out of the ordinary and even a therapist who might have treated her for any length of time would have to be carefully attuned to the patient's general mental condition to notice. Yet the president, herself a former patient, was very quick to detect this very slight variation.

A day or two later, a committee of members visited the patient and ascertained her mental status which seems to have improved in the meantime, and urged her to come back to class, as she had decided to quit her job anyway due to the household requirements. This help of one member to another becomes a conspicuous feature of the clubwork. A beauty operator gives other female

members beauty care, one member is instrumental in finding an apartment for another member etc., etc.

There is something noteworthy about the class work suggested by the president's own diagnostic acumen. Her own case is illustrative of the good results obtained from the therapy. She is a charter member of the class and at its inception was a helpless schizophrenic who in individual interviews sat with her head on her chest hardly uttering a sound, but occasionally moaning and crying over the previous therapist on whom she had developed a crush. In times past, she had gone limp and apparently swooned over him and had had to be carried out bodily. At present writing, she is nearing the close of an eleven month course in practical nursing, takes care of her 12-year old son, and is very active in club affairs.

To what extent the club does become a forum for reality testing, may be seen by a comparison with the usual conditions of average private psychiatric practice. The optimum conditions for treatment are perhaps exemplified by the requirements for psychoanalysis. We know that the prospective analysand is already self-selected. Even then the analyst exercises considerable selection on his prospects, excluding the so-called major psychoses, and those with more severe forms of psychoneuroses. In other words, the candidate for psychoanalysis must be of good intelligence and well motivated for the treatment, with psychopathology not too severe and still in status nascendi and with deeper insights more or less ready to erupt into consciousness.

What conditions are encountered in the average patient presenting himself in general private psychiatric therapy?

In one way or another, despite much initial resistance, he has finally mobilized enough courage to consult a psychiatrist. He sneaks into the doctor's office by the bi-ways and alleyways as if en route to a sorcerer's den. Finally, he finds himself closetted with a strange man who makes quite unusual requests of him. If the patient could concretize and verbalize his vague expectations, they probably would be: that the doctor would feel the bumps on his head; that he would administer a simple "twist of the wrist" to his spine or head; look deeply into his eyes and read his thoughts; or, at any rate, give him some strange nostrum or potion. When, instead of such procedures, the doctor tells him to go ahead and state what is in his thoughts, and so much of the burden of treatment is thrown back on his shoulders, many of the patients are actually insulted, at least rendered highly uncomfortable. It is, at any rate, all very weird to the patient.

But if the patient by some chance has mustered enough will to get well and gets over the initial hurdle, the doctor still finds himself between Scylla and Charybdis. Should the patient now be vocal enough to produce material, it will almost invariably take the form of enumerating complaints and symptoms. Interpretations designed to open up new channels often fall on sterile soil, and the patient seems obsessed with a need to enumerate symptoms. Attempts at launching the patient on another track, only results in the end in a reversion to the "organ recital," as if the individual were firmly rooted in the idea that the very accretion of signs and symptoms, this continual piling of Ossa on Pelion, will of itself effect a cure.

The therapist therefore is often forced to give the patient "his head" in the hope that in a relatively short time, the transference relationship, like ice forming on the surface of a pond, will soon be thick enough to bear the weight of a more direct frontal attack in the form of a weighty interpretation—that is, in the event that the meager productions contained in the "organ recital" afford an opportunity for such an operation. Even this "organ recital" cannot go on indefinitely without the patient's being aware of the lack of any progress in the treatment, and consequently bolting from further therapy. It is, therefore, incumbent upon the therapist to manage to open up some avenues of the unconscious and this must be done at the risk of its constituting a threat to the patient. The difficulties here do not all arise from the possible threat of some interpretation. In addition, there are often obstacles of (a) the lack of sheer intelligence to appreciate its meaning and application, (b) lack of ability or facility in abstract thinking, (c) lack of sufficient imagination, (d) such marked egocentricity as to preclude any approach to objectivity, (e) lastly, but very importantly, the monotonous "organ recitals" actually do not afford any opportunity for a good meaningful interpretation.

But, let us suppose all these more or less initial difficulties have been surmounted, and after a number of weeks or months, the patient is still coming for his treatment. The patient is now engaged in unraveling unconscious materials, but given in retrospect in the case of the average individual, interpretations given by therapist retain an academic character, are invested in an air of allegory. For it is only the more intelligent, sensate, individual in whom the representation of abstract quanta can rouse much anxiety. These factors, of course, account in large part for the lack of success with large numbers of average patients presenting themselves for psychotherapy.

That is not to say that, as far as is known, there exists any simple or absolute expedient to circumvent the aforementioned difficulties. However, any

means by which current experiences come under the therapist's scrutiny, under more or less controlled conditions, thus actually simulating an experimental set-up has the advantage (1) of more sharply delineating factors involved (2) relevancy and immediacy of given episodes for the patient, consequently (3) for the patient greater urgency for solution (4) potential opportunities for more clear-cut demonstration of consequences and trends involved.

Such conditions are to some extent realized in the patient's social club and this fact can best be demonstrated by the examples of incidents.

The president of the club already mentioned in the foregoing, it has been found many times in her treatment, has much marked repressed hostility which she has shown in a variety of ways. More or less as a consequence, she has been at the best very jealous of her rights and prerogatives as president of the club. The growing emotional maturity had been indicated in one episode which had occurred outside of club affairs in her school work at the hospital. On many occasions she had indicated a large admixture of paranoid trends when she used to complain to therapist that her classmates were treated with far greater consideration than she, and she was always being discriminated against as regards school grades and the character of cases and duties assigned to her. She ventured, then, on one occasion to voice her complaint to her supervisor (with whom incidentally therapist has kept in touch). The supervisor had countered with the statement that actually she, our patient, had been given more privileges than any other girl. This apparently was incontestably true, but quickly as a flash, the patient, venting unconscious hostility, had replied, "Well, I didn't ask for them." The supervisor had merely looked sharply at her and had refrained from further comment. Afterwards, relating this incident to therapist in an individual interview, she stated she had thought the incident over and recollected that she had actually asked for many of the privileges she claimed never to have sought.

But as regards the club activities, she had violently protested against any outsiders, other than mental patients, being permitted to join the club. She had made quite a scene over this matter.

Some time later, she called a Board of Directors meeting, and subsequently, since they expressed a desire to attend, therapist invited several other members notably, Mr. S. Mr. S. is the husband of a patient who has achieved a marked improvement. Out of sheer gratitude, Mr. S. has joined and has proved himself indispensable to the club. It may also be remarked here what a won-

derful impetus and encouragement it has been to Mrs. S., the patient, to find herself and husband joined in a common enterprise of this nature.

Now the president came in to the therapist's office and laid down the law. It was understood this was to be a Board of Directors' meeting and no one else must be present. She was president and would brook no interference from therapist, who was evidently attempting not only to undermine her authority, but breaking up the club. She grew so violent in her denunciations, that she could be heard all over the clinic. It was only by the most rigid self-restraint that therapist was able to keep his own temper under control, but he did manage to caution her that he, therapist, would not allow Mr. S. to be offered a single syllable of discouragement. Since Mr. S. wanted to attend this meeting, he would attend. He repeated that we would not discourage the slightest sign of interest in our organization.

She had thought it over and worked it through apparently, and the next time came to the office crying, "Why, oh why do I do such things?" There was genuine soul-searching and agony in her crying, and a marked accompanying depression. So much so that therapist found it necessary to attempt to mitigate it and point out that it wasn't so bad. "It isn't only you," she cried bitterly. "It happens so often with so many other people." Her depression was profound and well reflected in her very features. Here was the appearance of genuine and critical insight. Here was the occurrence of genuine change in personality, and the therapist sat fascinated by this veritable miracle of the transfiguration occurring before his eyes.

About a week or so later, by telephone, she recounted an incident which had occurred at the hospital. A splint which was at times removed from a child's arms had not been reapplied and she was asked why she had not put the splint back. She made some assertion about some of the girls doing it or not doing it; and received a reprimand. "I thanked her," she said, "and would you believe it doctor, for the first time in my life that I can remember, I felt no resentment at being bawled out."

Indeed her whole personality has undergone some change, and she is a more capable executive from what therapist can observe.

As a tangential observation, the above suggests that group psychotherapy could be an important step in the training of attendants and other personnel in charge of mental patients. It is true that many institutions do give indoctrination courses in certain essential principles of psychiatry. But this often

remains alien material, and largely "school learning." In actually being part of a group psychotherapy class, group identifications make such individuals an integral part of the therapeutic process, and in thus experiencing psychological truths from within, they are likely never again to feel themselves as of a race apart from that of the patient.

Conclusions

We have touched on and posed the possibility that therapy in the consultation room or the classroom may still have adhering to it some of the academic atmosphere. To the untutored and unsophisticated, which is of course to say the great mass of patients, the chasm between theory and practice is vast and well-nigh unbridgeable. From this aspect of the problem there would certainly arise a great need for some agency or apparatus that could and would extend the psychiatrist's influence into the practical affairs of everyday living, if for no other reason than to bolster efforts at reality testing. For the mentally convalescent and late convalescent, some kind of psychological "air-lock" is also a useful apparatus. The air-lock is provided by the social club, which does at the same time furnish more or less controlled near-experimental conditions in which the dynamics of psychotherapy are experienced in closer relation to real life situations, thus acquiring greater verisimilitude for the patient, at the same time permitting the therapist to deal with them *in situ*, as it were. In addition, the over-all picture that psychotherapy may present, as often practiced, may leave something to be desired. Psychoanalytically, the therapist is rather concerned about fixations on himself, and a possible so-called transference neurosis. He is therefore justified in maintaining a certain "therapeutic" distance between himself and the subject of his ministrations. The danger is probably a real one in individual psychotherapy. In institutions, again, much of that distance is maintained in official routine and regulation. Has this factor of distance been accurately assayed? Certain observations would lead to the belief that the patient is quite well aware of it, and will sometimes remark about the impossibility of the therapist really feeling for him personally; or doing certain things because he had a job and earns a living at it. To be sure, it is an evidence of immaturity on the patient's part, and not to be fostered, but is it certain that such frustrations of dependency needs, inevitable under the circumstances, do not militate against treatment? Is it certain that such a regimen, such "aseptic psychiatry" (e.g. "No human hands can touch you") is invariably conducive to the best therapeutic results? In any case, in social club therapy much of the foregoing objections can be eliminated with

relative immunity from the dangers of fostering infantile dependency or conducing to the formation of a so-called "transference neurosis."

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REPETITION-COMPULSION AND SPONTANEITY*

A comparison of psychoanalytic with psychodramatic concept

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One of the central ideas of psychoanalysis is that of repetition-compulsion, by which is understood the compulsion to re-enact in the present what the individual has found the best way in adapting to an early overwhelming situation. This compulsion to re-enact in fantasy and reality is more than a reflex; it has a definite purpose for the individual, e.g. it is dictated by an intensive hope for redress for past suffering (compulsion) and by the hope for eventual mastery and success (repetition). Because redress and mastery refer to past events and not to the current life situations the pattern is doomed to failure. From this, briefly, one of the basic rules of psychoanalytic practice can be stated, e.g. the neurotic's difficulty cannot be solved *by acting* upon his "transferred" modes of reaction but by making them "understandable" in the protective and private atmosphere of the analytic treatment relationship, where free association, dream analysis and interpretation open the way to the patient's unconscious for the purpose of enabling him to work through to greater emotional maturity with the help of the analyst.

One of the central ideas of group psychotherapy, as developed by Moreno,[1] is that of spontaneity, which has been defined as the voluntary enactment of an emotion which in everyday life situations may be enforced by determinants the person can not control. The concept of spontaneity places the emphasis entirely upon the person acting in the present situation together with others. The fact of compulsive transfer of earlier unsatisfactory modes of reacting is acknowledged, but instead of the psychoanalytic emphasis on verbalization in the form of monologue (and de-emphasis on "acting out") in the treatment situation, psychodrama emphasizes purposive acting out and intensive interaction between various members of the group; instead of the analyst's awareness that the patient deals with him now as father, or as mother or sibling at various stages of the patient's development, the group therapist using psychodramatic techniques places the patient into the active role of the actor, the

*"Sponsored by the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the author are the results of his own study and do not necessarily reflect the opinion or policy of the Veterans Administration."

1) J. L. Moreno in Psychiatric Dictionary, Hinsie & Shatzky, 1940.

passive role of the spectator, the roles of father, mother, etc., at various stages of the patient's past and present, and of his fantasies of the future.

The various psychoanalytic schools with their varying modifications of early analytic theory, as well as the varieties of group psychotherapy which are practiced today, can be understood by the position they hold between the polarities of the treatment situation, as indicated by the opposites of Freud and Moreno: free association versus spontaneous action; slowing down of the impulses to "act out" versus warming up to a spontaneity state; transfer of old reaction patterns upon the analyst versus direct acting out in the group setting, of experiences in which this reaction pattern becomes manifest; emphasis upon the patient's fantasy and intra-psychic process versus emphasis on his interpersonal relationships at the present moment of which the intra-psychic processes is only a part.

To illustrate some of these highly schematized notions, sketches of

a) A psycho-analytically oriented individual treatment session and of
b) A psycho-dramatic group session are presented.

1) *Individual Treatment Session**: The patient, a 25 year old highly educated woman, came to the session stating that she had felt fine and then discussed her feelings of passivity in treatment as well as in social situations. When asked why she feels that way she stated that she still has a difficult time coming here because she still looks at the therapist as a potential enemy, who might force her to give up some secret which was never to be released. Later on in the session, she reported a dream in which she stole some silver dollars in a department store and was found out by the store detective, who promised not to turn her in if she would turn over the money. This she did. In the following section of the dream she found herself assisting someone who murdered people, etc.

This material was evaluated by the therapist along three frames of reference:

1. It represents the patient's reaction to fantasy threats coming from treatment and the therapist, making more active participation in treatment as well as in social situations, a dangerous affair.
2. It represents her reaction to increased external pressures during the treatment interval during which she dropped all social engagements in favor of practicing for an imminent concert performance, etc.

*109th Treatment Session.

3. It represents the activation of earlier aggressive and sexual impulses as revealed in previous material.

Emphasis of interpretation was directed toward the relationships with the therapist and upon current external pressures rather than upon the early impulses which were reenacted in fantasy. This was done in accordance with current psychoanalytic schools of thought which emphasize the analysis of ego functions and defenses rather than the analysis of libidinal impulses of earlier psychoanalytic thinking. These ego functions and defenses, as yet inadequately understood by psychoanalysts, incorporate the social and cultural functions as embodied in social roles, with which group psychotherapy and especially psychodrama operate.

2) *Group Session*: A 29 year old veteran, who was a prisoner of war of the Japanese for 5 years and whose complaints are severe abdominal upsets, ticks, irritability, lack of interest, arguments at home and inability to stay on jobs, stated early in one of the group sessions* that his trouble started after Corregidor, although psychiatrists have told him it started much earlier, namely in childhood. During the ensuing discussion, the other group members argued this point drawing from their own experiences. When asked how J. felt at present, he stated that the day before he got very angry at his wife in the early morning hours when he heard from the bedroom how she got angry with their 8 months old son while feeding him in the kitchen. This scene was enacted for clearer visualization of what has happened, where other patients assisted J. by taking the roles of wife and baby. The enactment with various changes of roles where J. alternately represented himself, his wife and also the baby, lent itself to an instructive discussion of this scene by the group members and by the main actor. Enactment as well as discussion brought home clearly to J. and to the others that he, in his fantasy had identified with the baby that was forced to eat, but also in addition to this he feared himself of becoming like his father-in-law, who impressed him as a weak, ineffectual and henpecked man. The following conclusions were reached:

1. Each group member had reacted with similar feelings to comparable situations.
2. J. identified with weak and helpless figures in his environment.
3. The question was raised why J. does this. One explanation was that J.'s war experiences precipitated such identification.

*4th group session in which this patient participated.

J. was then induced to reconstruct one of the traumatic war scenes, where as a prisoner of war, he showed living conditions one evening after dark and how he was brutally punished because he was discovered overstepping the rule of not smoking after dark. Again discussion was focused on the feeling of enforced helplessness which induced severe but powerless rage. The discussion brought out the significant fact that this veteran elected at the spur of the moment one of the many similar scenes in which he himself had provoked discovery and punishment by putting fire to his sleeping sack.

The suggestion that helplessness, defenselessness and dependency is a normal phase in the childhood of every individual, brought out vivid memories of mistreatment by his father, who eventually abandoned the family when the patient was approximately four years old.

A review of this and previous group sessions in reference to this particular patient, brings out among other things:

1. He deals with himself in fantasy as if he were the helpless child who is forced to eat, the helpless and weak father-in-law who is dominated, the prisoner of war under brutal attack, as well as the child he was 25 years ago, who was mistreated and then abandoned by his father.
2. J. appears to reenact old patterns of behavior compulsively but unawares in life situations and in the group situation. He does so in the hope of overcoming the traumatic experience at last and of getting redress for the old injuries.

Similar to the individual psychoanalytically oriented treatment session, the material produced in the group session can be evaluated under the mentioned 3 frames of reference:

1. The subject's reaction to the therapist and to the treatment situation.
2. His reaction to recent events in his life's situation.
3. His reaction to early traumatic events and situations which in later life were traumatically reinforced, for instance, by his war experience.

In addition, a 4th frame of reference is given by the group situation. In this situation, the relationship to the therapist becomes altered by a shift in the direction and intensity of identifications and resistance, with the effect of an intensified reactivity to the immediate presence.

The question arises: Can a patient who deals with his current needs in relationship to others in an antiquated compulsive and repetitive pattern, over-

come this pattern by spontaneous reenactment in a specially designed group situation where he is assisted actively by the therapist and other group members who have gone through comparable early experiences? The emphasis appears to be taken away in the group situation from the singularity and uniqueness of the early traumatic situation as well as from the compulsion for reenactment. The subject does not have to feel so alone with his unhelpful method of dealing with himself in relationship to others; he does not have to carry the burden of his feelings of isolation, weakness and unacceptability which are concurrent with his inadequate lifelong method of dealing with himself.

This was recognized early by Freud, who postulated that the so called "narcissistic neuroses," cannot be dealt with by the early psychoanalytical treatment approach, a fact which in more recent years was more positively formulated in the recognition that "narcissistic neuroses" can be dealt with if given enough support. It appears that group psychotherapy and especially psychodrama are promising of methods of giving such support on an immediate reality level.

FRAGMENTS FROM THE PSYCHODRAMA OF A DREAM

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Introductory Note

This paper places its chief emphasis upon production techniques of dreams instead of upon their analysis and interpretation as is usually the case in current literature. Since the publication of Freud's *Interpretation of Dreams* (1898) innovations and modifications as introduced by Herbert Silberer, Wilhelm Stekel, Alfred Adler and Carl Jung referred to analysis and interpretation only. All these investigators, like Freud, deal with a verbal account of a dream given to them by the patient. In other words, the *operation* is in all schools of psychoanalysis the same, at least in principle. With the advent of psychodrama a *change in operation* itself has been introduced. In my paper "Inter-Personal Therapy and the Psychopathology of Inter-Personal Relations" (*Sociometry*, Vol. I, 1937, pp. 9-76) the simultaneous treatment of husband and wife and the psychodramatic technique of dreams is reported for the first time. The verbal account turns into an "actional" account. Free association is extended, it becomes production technique. Analysis of dream associations becomes production and action-analysis.

It is interesting to note that—if the concensus of numerous psychodramatists in the course of fifteen years of practice has any validity—what promises to become the most important contribution to dream work since Freud did not come from any of the psychoanalytic schools but from a school of thought which started from the diametrically opposite position, with action methods. Although the purpose of this paper is to demonstrate operations and production techniques the consequences for analysis should be equally revolutionary.

Procedure and Experimental Design

Thirty-six patients were selected for dream therapy; all were suffering from recurrent dreams, or at least, from dreams with recurrent dream characteristics. One third, twelve dreamers, (A Group), were treated with psychodrama, the second third (B Group) were treated with psychoanalysis, the last third (C Group) remained untreated and were used as controls; they were merely requested to record their dreams as soon as they awoke.

I asked myself several questions. 1) Does the character of a dream change or does the dream cease to recur after psychodramatic or psychoanalytic dream treatment? Which of the two methods is superior? Does the psychodramatic production of the dream teach the dreamer something which reaches the "action matrix" of the dream itself, so that when the dream recurs the "increased spontaneity" of the dreamer enables him to modify the dream? 2) Is the ability to recall facilitated by psychodramatic production methods and if so, how? 3) Does psychodrama bring the "action matrix" of the dream to direct view and does it expose it to a more complete analysis?

Case Illustration

The patient, Martin Stone, came to Beacon for treatment, at times together with his wife, once a week during the summer of 1941. In the course of treatment, two days after his second treatment session this dream took place. Its psychodramatic production was recorded by means of a Peirce wire recorder and an observer in the audience recorded the actions and interactions between the dream characters. Besides the couple, the psychodramatist and a staff of auxiliary egos, six other patients took part in this session from which the wife was absent. After Martin's dream was produced the patients were encouraged to relate themselves to the production and to communicate some of their own dreams.

(At the start of this session, Moreno and Martin are sitting on the center, or interview level of the psychodrama stage.)

Martin: Well, doctor, where shall we begin?

Moreno: Martin, thank you for the letter and for your notes which I read. I also received the dream, which I didn't want to read since I planned to work the dream out with you here today. We will have some control in comparing the data which you put down yourself with those which we will work out psychodramatically. When did the dream take place? What date?

Martin: This was Sunday night, just after I left here.

Moreno: That was . . . . .

Martin: July 6th.

Moreno: (Getting up, has Martin by the hand, takes him from interview position to top level of stage.) Let's see that. Was it during the night?

Martin: I'll have to take that back. It would be Saturday night or sometime between midnight Saturday and early Sunday morning.

Moreno: Do you sleep alone? (Drops Martin's hand, takes a step away from him.)

Martin: Well, in this case I slept alone.

Moreno: You slept alone. Well, suppose you fix your bed up the way it was. Is your wife sleeping in another room?

(The presentation turns now from the past into the *present* tense; this helps the warming up process.)

Martin: No, that's the particular circumstance of the dream. I am in my father in law's house. My wife is not here. (Walks to side, off stage, continues from there.)

Moreno: (Alone on stage.) You are in your father-in-law's house? Where is your wife?

Martin: She is in Worcester and this is in Boston. I went from here to New York on Saturday and then on up to Boston on Saturday night. Here I am, in Boston.

Moreno: And, of course, your in-laws . . . . (Moreno changes lights to soft midnight blue.)

Martin: They are in the back of the house and this room is more to the front.

Moreno: Is it a bedroom?

Martin: Yes.

Moreno: Have you ever slept in this house?

Martin: I slept in the house before but never in this particular room.

Moreno: Try to describe the room as best you can.

Martin: The room is ordinarily occupied by the grandmother in the family who happens to have gone away to visit another daughter. There's a table right by the bed and it is about 39 inches long.

Moreno: Why don't you put the bed up the best you can, just the way it is. (The scene is being set. Martin uses chairs to set up the bed, table and other simple furnishings to represent the room.) Why don't you move the bed further to the front?

Martin: (Indicating) This is the position the bed has in the room, next to the window.

Moreno: In what position do you sleep?

Martin: I sleep in all ways but usually toward my left side.

Moreno: Alright then, go to bed and sleep on your left side.

Martin: (Lies down on 3 or 4 chairs representing the bed and tries reconstructing the dream.)

Moreno: Have you a pillow?

Martin: Yes.

Moreno: How many pillows do you use? (Steps upon the stage again, stands behind Martin, puts his hands on his shoulder.)

Martin: Just one.

Moreno: And when you are in bed is that how your legs are placed?

Martin: I think so, about like that. They usually are crossed at the ankles, like this. (Crosses his legs.)

(The dream is presented *in situ,* in the locus nascendi of this particular dream; this helps the warming up process.)

Moreno: What are you doing with your hands?

Martin: The right is usually under me and the left is at my side.

Moreno: And you try now to fall asleep slowly. Are you comfortable? Try to make yourself as comfortable as possible under the circumstances. Try to concentrate on the dream. That is to say, try to have in your mind as clear a perception of the dream as you can. Are you concentrating now? (Closes Martin's eyes with his hands, gently strokes his hair.)

Martin: Yes.

Moreno: Do you see the dream?

Martin: Yes.

Moreno: The sequence of the dream? (Martin nods his head.)

Moreno: Try to concentrate now and try to visualize it the best you can, but don't tell us anything about it. Just concentrate on the dream. Do you have it now? Let it pass just like a sequence of scenes through your mind. Do you have it? (Moreno's voice is suggestive, gentle and softer than usual.)

Martin: Yes, I have it. (Is beginning to look more at ease.)

Moreno: Do you see the people in it? Do you see the media, the environment in which it takes place? (Continues to stroke Martin's head, his hair, forehead, helping him to relax.)

Martin: Yes, I see it now.

Moreno: Close your eyes. Try to fall asleep, deep asleep. Concentrate the best you can. As you are falling asleep all kinds of images go through your mind. Don't they? What goes through your mind as you are trying to fall asleep, Martin? Relate yourself to that dream which you are going to have . . . You know you are going to have that dream, right?

Martin: Yes (Looks quite relaxed, his body is at ease, warming himself up to an increased degree of consciousness, as if in a creative mood).

Moreno: In a few minutes you are beginning to have that dream so try now to visualize what kind of images go through your mind as you are going to have that dream? What is going through your mind?

Martin: Well, I seem to see an office of some kind.

Moreno: An office?

Martin: There is particularly someone at the desk, a doctor whom I know.

Moreno: A doctor whom you know. Do you see the doctor? Who is the doctor? You see him before you start the dream, of course, right? What kind of a doctor is it?

Martin: I think this is Dr. Miller, an eye doctor.

Moreno: Mmm. And what else goes through your mind now as you are trying to fall asleep? (Steps softly away from Martin.)

Martin: (After a short silence) I see my wife.

Moreno: What is she doing? Is she doing anything?

Martin: No, she is . . . (hesitates) she is sitting in the kitchen.

Moreno: Alright now Martin, close your eyes, breathe deep, breathe deeper and try to fall asleep. Concentrate on that dream. Very soon you are going to dream the same dream all over again which you had five days ago when you were sleeping in your father-in-law's house. Here you are, the dream is emerging now. Now the dream is emerging, what do you see *first* in the dream? *What happens first*?

Martin: Well, I see a group of women.

Moreno: A group of women! What are you doing there?

Martin: I don't know . . . I'm just watching them.

Moreno: Are you sitting or standing?

Martin: I am standing.

Moreno: Well, then get up and stand! Just as you stand in the dream.

Martin: (Gets up and stands.)

(The dreamer is here encouraged to portray every gestural and actional detail.)

Moreno: Where do you stand? Where are you? What kind of a scene is it?

Martin: We are in a room in my house.

Moreno: Which room is it?

Martin: It's the dining room.

Moreno: Which house is it?

Martin: It's the house I used to live in, in Boston.

Moreno: Where are you standing there?

Martin: I am standing near the kitchen door.

Moreno: Move towards the kitchen door! What else do you see?

Martin: There's a group of women. Quite a group of them.

Moreno: Where are they?

Martin: They're in front of me, in the dining room.

Moreno: They're in the dining room. Do you recognize any of them?

Martin: Yes.

Moreno: Who are they? (Motions to two female auxiliary egos to come up on the stage, they get up from the audience and come forward.)

Martin: My mother, there's a sister of mine.

Moreno: Your mother (motions to one auxiliary ego that she is to take the part of Martin's mother), a sister of yours (motions to the second to represent his sister), who else?

Martin: There's the wife of a professor friend of mine. Her name is Kay. My sister's sister-in-law is there, her name is Caroline. My mother is there. And my wife is there, too.

Moreno: (Motions to three more auxiliary egos to come upon the stage and they do so.) What are they doing?

Martin: They're discussing something.

Moreno: (Explaining to Martin, the auxiliary egos and all the audience present) You see, Martin, the characters in your dream are like wax figures on the stage; the auxiliary egos representing them move, act, speak or spring to life only as and when you, the dreamer, direct them. They have no life of their own, therefore, you tell them what to do. What are they discussing?

Martin: They're talking about the fact that my wife has to go to the doctor. (The auxiliary egos in their various roles immediately begin to act; they are talking about Martin's wife and the fact that she should go and see a doctor. They are standing around in a huddle and make a compact group.)

Moreno: What else do they say?

Martin: They're trying to decide to which doctor she should go.

Moreno: Alright.

(The women begin to question which doctor Jean should consult.)

Moreno: What else do they discuss?

Martin: They wonder what my attitude is going to be. They murmur.

(The women begin to murmur about how Martin will take Jean's visit to the doctor.)

(Spontaneously the whole audience begins to murmur.)

Moreno: What is your attitude?

Martin: (He is bending over, trying to listen to what they are saying, his eyes are half closed.) I am perturbed. I'm worried about it. I don't want her to go. I seem to feel she ought to go, but I don't want her to go. They're discussing the fact that I went with her to the doctor once and they don't think that this is the way to proceed.

(The discussion among the women is getting more intense.)

Martin: I listen and move closer to them, like this (steps closer to the bunch of women). They seem to think that I have no place being there, that it's not my place to be there.

Moreno: Who is talking? Who says that?

Martin: My sister says that. Mary says that.

Moreno (Prompting) Mary! Mary!

Mary: (Auxiliary ego) He has no business going to the doctor's with her!

(She talks to all the women and points her finger at Martin.)

That's no place for a husband to be!

Moreno: Is this your older sister?

Martin: Yes, all my sisters are older, but this is one of my sisters.

Moreno: To whom does she say that?

Martin: I think she says that to Kay, the professor's wife.

Mary: Kay, it's not right that he goes to the doctor's office! It's not right! He has no purpose there. What's the use of it?

Moreno: What does Kay say to that?

Martin: Kay doesn't say much of anything in response. The conversation is largely dominated by Mary.

Moreno: (Prompting again) Go on, Mary.

Mary: You know he gets so upset. Every woman has to go and see a doctor once in a while. Why Jean wouldn't go along if *he* had to see a doctor. It looks funny. It's silly!

Moreno: What is next?

Martin: They decide that the doctor she should consult is a doctor by the name of Stone, of a partnership. I think, at this point I see something, I see . . .

(Inaudible speech of the women in the background)

Moreno: What do you see?

Martin: I see a piece of paper. It's got the name Stone and something like . . . it begins with B. I'm not sure.

Moreno: Take the paper in your hand and read it!

Martin (Taking out a piece of paper) Like . . .

Moreno: What's the name? Look at it!

Martin: The paper is a doctor's bill. It says Stone & Bridge on it.

Moreno: Alright. What do they decide?

Martin: They decide that she is to go and ask for Doctor Stone. And then I become angry at their discussing all this and not taking me in. So I rush into the room . . .

Moreno: Then rush into the room!

(Martin runs toward the center of the stage.)

Martin: (Angrily) I don't like your talking about this . . . without my being here. It's *my* business not yours, mine and Jean's. What are you talking about anyway?

Moreno: What does your sister say?

Martin: She condemns me for doing something which I have no right to do.

Mary: You always get so upset. It's useless. Why do you have to go with her to the doctor?

Martin: It's *my* business if I get upset. I think I have a right to be there! I think I ought to know what's going on!

Mary: What *do* you think is going on?

Martin: Well, I don't know. That's just the trouble. I want to find out. No one ever tells me anything about this sort of business. I want to find out what's going on.

Mary: What do you suppose goes on in a doctor's office but examinations?

Martin: Well, that's what I mean. I don't know anything about this doctor. I'm taking him on . . . well, whose recommendation are we taking him on?

Mary: He's a perfectly well known doctor in this town.

Martin: I know there are lots of well known doctors. I don't like him. I don't know . . . I don't like him!

Mary: There you go, getting upset again.

Moreno: What is next in the dream?

Martin: Well, someone else is mentioned, another doctor, Doctor Magnus.

Mary: Well, Jean could go to Dr. Magnus.

Martin: I don't think he's a good man.

Mary: How do you know?

Martin: I don't know, I just think so.

Mary: Oh, you just think so! You always get full of ideas about what you think. You never even try to find out whether it's true what you think. You

just think so! She shouldn't go to a doctor just because you get upset when she goes to a doctor? Is that the idea?

Martin: Then all of a sudden they reject me. They push me out of the room.

Moreno: Push him out of the room!

(The five women push him out, off the stage. Martin resists.)

Martin: Then I go outside.

Moreno: Where do you go outside? Where are you now?

Martin: I don't know exactly. I can see a drugstore downtown in some kind of large city. I don't know where.

Moreno: What are you doing there?

Martin: I'm outside the drugstore. I'm just looking into the window.

Moreno: What do you see there?

Martin: (Moves towards the front of stage and points with his right arm at various objects which he sees.) I notice some razor blades, shaving brushes, various kinds of instruments.

Moreno: Instruments? What kind of instruments?

Martin: Oh, knives, scissors, and . . . they look as though they might be doctor's instruments. I'm not sure.

Moreno: Doctors' instruments. What else do you see in the window? Do you see anybody in the drugstore?

Martin: No.

Moreno: What else do you do before the drugstore?

Martin: Well, I'm trying to make up my mind whether to go back to the house or not. I don't know what to do. I want to go back and I don't want to go back. Finally I decide to find out what I'm doing so I go into the drugstore and I go into a phone booth that's in the drugstore. Here is a telephone booth (moves towards the left column on the stage) and I go into it. I call the number. (Dials a number.)

Moreno: What number?

Martin: It's 734128. And then I notice the number on the phone, I can't see it all the way, but it ends in 997.

Moreno: 997.

Martin: Jean answers the phone.

Jean: (Auxiliary ego) Hello. Who's this?

Martin: Hello, this is Martin. (Prompting "auxiliary" Jean.) You're surprised at my calling.

Jean: (In a surprised tone.) Hello Martin, where are you? I didn't expect you to phone me! I expected you to come home!

Martin: (Uncertain of himself.) Well, I'm downtown someplace. I didn't know whether to come home or not.

Jean: What do you mean, you didn't know whether to come home or not?

Martin: Oh, I don't know. What have you been doing right now? (Explains to auxiliary ego.) She tells me she's been taking a bath. She says . . . something about Scotch bathing. I don't understand it. She says she's been taking a bath, Scotch bathing.

Jean: I've been taking a bath, Scotch bathing.

Martin: Well, that sounds funny. I suppose that means you're going to the doctor. You always bathe before you go to the doctor.

Jean: I hope that's not the only time I bathe?

Martin: No. But I know that you always do before going to the doctor. That means, if you bathe at this time of the day it usually means that you're going out somewhere, if it's about one or two o'clock in the afternoon and you're taking a bath. Well, I guess I'd better come home. I don't know what to do!

Jean: OK, fine, you come home.

(Martin hangs up the receiver)

Moreno: Where are you now? From where do you phone?

Martin: I walk out of the telephone booth and somehow I'm not in the drugstore at all. (Walks across stage and looks searchingly around.) It's a grocery store. I keep seeing a grocery store. It's about two blocks from my house.

Moreno: What are you doing there? What do you see?

Martin: I see fruits, a stack of apples and grapefruits right here in this box. (Indicates where they are.) Frozen fruits over here. Then there are shelves down this way. (Indicates shelves behind him.)

Moreno: Who else is there beside you?

Martin: No one. I'm alone. That's all.

Moreno: Are you standing and looking at them?

Martin: Yes, just standing and looking at them.

Moreno: Do you buy anything?

Martin: No.

Moreno: Do you think that's a grocery store?

Martin: Yes.

Moreno: How do you feel as you are standing alone in this grocery store with so much merchandise around?

Martin: I feel as though I'm about to lose something. I mean, something is going on which I know nothing about and that represents a loss of some kind to me and I don't know what to do. It seems to be something which I must accept and I'm debating this question back and forth. I know Jean must go to the doctor and I don't want her to go but if she goes I feel that I ought to go with her. I feel very badly about it. I was still wondering while I was telephoning whether she was really going to go or not. I suppose I was hoping that she wasn't but when I called up and found out that she is taking a bath, then I knew for sure that she is going to the doctor. I feel very unhappy. I have the urge to do something. I raise my arm as if to hit someone. At this point the dream ends.

Moreno: (Walks up the stage to interview Martin.) Whenever she takes a bath she goes to the doctor?

Martin: Well, it seems to me that way whenever she takes a bath in the middle of the day. Otherwise she takes it in the early morning or late evening. But whenever she takes it in the middle of the day she goes to the doctor.

Moreno: While you are standing there you are fearful and displeased and anticipating a catastrophe or something extremely undesirable to happen to you. Now go back to bed in the same position in which you were before awaking, take the same position which you had, Martin. (Martin does this.) You are now closing your eyes. (Moreno stands behind Martin and strokes his head soothingly.) Close your eyes, try to fall asleep, deep asleep. And now concentrate on that *last moment* in the dream. You are standing there in the grocery store, you have a feeling of anxiety. You feel unhappy, anticipating something to happen. Concentrate on it! Do you see yourself?

Martin: Yes.

Moreno: And what happens now?

Martin: I . . .

Moreno: Does the dream come to an end and do you continue sleeping?

Martin: It comes to an end and I wake up.

Moreno: Then wake up! Wake up! Are you up now? You are sitting up in your bed?

Martin: (Sitting up) I wake up very slowly though. It's a very peculiar thing. As I'm more than half asleep I realize that I'm waking up and that I've been dreaming and that I ought to make some kind of record of it. I had this impulse to make a record of it. So while I'm still really half asleep I concen-

trate on the whole dream and try to bring it back into sequence and try to remember until I'm quite sure that I have it. And then I suddenly come wide awake and sit up. And I reach out to the table and snap on the light. Immediately I jump out of bed and I go and look at the clock and it's over on my dresser. (Does as described.)

Moreno: What time is it? (Takes off stage position again.)

Martin: It's five forty-five. I walk out the door and when I'm in the living room, I go toward the desk and get some note paper that is there and also a pencil. I come back and close the door and come over to the desk and sit down. Then as fast as I can I commence to write down what I remember about the dream. (Writes.)

Moreno: Did you have another dream since then or is this the only dream that you had that night?

Martin: I go back to sleep after I write this since it is so early in the morning. The sleep is quite dreamless and I sleep another six hours. (Sits on another chair near bed.)

Moreno: Then go back to bed, go back into the dream. (Resumes his position near Martin.)

Martin: (Protests) But that is all I dreamt.

Moreno: Just the same, go back into the position you last had when the dream ends.

Martin: (Lies down again and dreams, stretches out in bed, puts his right arm under, his left arm alongside of him.)

Moreno: (Again hands behind him, using gently relaxing touches.) Concentrate. Now, what do you see?

Martin: Now I see the attic in my house.

Moreno: Are you standing there?

Martin: Yes, there's a large box of some kind. I look at it and walk towards it.

Martin: (Gets up, walks across the stage, looks intensely at the floor and

Moreno: Alright then, get up and do that.

indicates the location of the box.) I bend down and try to lift it.

Moreno: Then bend down and try to lift it. (Moreno keeps fairly close, but off stage.)

Martin: (Trying to lift the box.) It's too heavy. I decide that I have to take something out.

Moreno: Go ahead then. What do you see in the box?

Martin: All kinds of things, books, articles of clothing, trousers, shoes . . . Someone is trying to help me.

Moreno: Who is it?

Martin: It's a woman, a stout woman, I think.

Moreno: (Motions to an auxiliary ego to come upon the stage. Auxiliary ego thus called upon comes on the stage and stands besides Martin, trying to help him lift the box.)

Martin: I start to take some things out (Goes through the motions of taking things out of the box and auxiliary ego helps him lift them). They are small articles, like rolls of paper. They're of no value and I'm going to force the box wider because we're going on a trip and we have to make it wider. I give the things to her. (Hands objects to auxiliary ego.) The woman throws them on the floor. (Auxiliary ego throws things on the floor.)

Moreno: Look at her! Who is she?

Martin: (Peers at auxiliary ego.) I guess . . . It's my mother-in-law! Yes, that's who it is. She's not terribly stout but she's not terribly slender, either.

Mother-in-Law: Let me help you, Martin.

Martin: Yes, mother. Finally when we've taken these articles out I see this rug. It's quite large. It's in several folds. It's about this thick.

Moreno: What kind of a rug?

Martin: It seems almost like canvas. It's a cotton rug of some kind.

Moreno: What are you doing with it?

Martin: My mother-in-law grabs it.

(Auxiliary ego grabs the rug.)

Martin: (Spreads rug over the stage together with auxiliary ego.)

Moreno: What are you doing?

Martin: We are spreading the rug.

Mother-in-Law: It's not in very good condition, is it?

Martin: No, it's badly stained.

Mother-in-Law: (Tries to rub the stains off.) I wonder if we can do something with it.

Martin: It doesn't seem worth while to take it along. Then suddenly my wife appears.

(Another auxiliary ego comes up, taking the part of the wife.)

Moreno: Whose rug is it?

Martin: It's our rug. It's very badly stained and it has a hole or two in it.

Moreno: A hole or two . . .

(The therapist repeats what the patient just said; it helps the warming up process.)

Martin: And then my wife comes in. I say to her "Let's throw it away!" (Prompting auxiliary ego.) You want to keep it, you're very anxious to keep it.

Jean (Horrified.) Oh no, no, no, no!

Martin: But it isn't any good. It's all stained. What can we do with it?

Jean: Oh, no, let's keep it.

Martin: (Becoming irritated with her.) It has to be fixed, it has to be redyed and the holes patched up.

Jean: I'm going to have it fixed. I'm going to have the holes patched up and I'm going to have it redyed. It's very important to me.

Martin: (Getting more upset.) But that will cost a great deal of money to have that rug repaired. I don't know how much.

Jean: How much do you think it will cost?

Martin (More agitatedly.) I don't know. Well, is this your own idea? (Suspiciously.) On whose advice do you think we ought to have this rug fixed up? (Turns to Moreno.) This is where Doctor Lowrey comes in.

Moreno: Where is Doctor Lowrey? Is he in the scene?

Martin: No, he's not in the scene. He flashes in and flashes out.

Moreno: You take the part of Dr. Lowrey, Martin.

Dr. Lowrey: I think you ought to take this rug along with you, to have the rug done over.

(Keeps popping in and out of the scene.)

Jean: Doctor Lowrey also seems to think it is worth fixing.

Dr. Lowrey: (Very businesslike.) After all, it's too valuable to be discarded. Of course, it will cost a great deal to have it fixed up but it will at least be worth it. You better have it fixed up and take it along with you, Martin, I can send you to someone who will renovate that rug for you alright.

Martin: (Taking his own role and also his own position in the group, pensively, his irritation gone.) It certainly seems odd to me to go fixing up an old rug like that, but if you say so it seems alright to me. But I personally think it will take a tremendous amount to have something like that done, something like a couple of thousand dollars. Maybe it would be better to discard it or get a new one, or something like that.

Doctor Lowrey: (Martin moves off stage again and takes Doctor Lowrey's position.) I know it will cost a great deal but it certainly will be worth it. Don't discard it.

Martin: (Moves across stage to his own position again, disconsolately hold-

ing the rug.) Alright, if you say so. If she wants the rug I guess we'll have to take it along. (Looks deflated.)

Moreno: And now, what happens, Martin? (Comes closer to Martin, takes his hand.)

Martin: I remember now. This dream which we just enacted, the one about the rug precedes and is immediately followed by the other dream, the first one we produced.

Moreno: The dream which starts with the women talking about you?

Martin: Yes, it jumped immediately to that one.

Moreno: It jumped immediately from one to the other. Now this took place in a different room?

Martin: Yes, this was up in the attic and the other was down on the second floor.

Moreno: Now, in the second dream, is your mother-in-law there or isn't she? I am referring to the one with all the women in it. (Drops Martin's hand, puts one hand on Martin's upper arm.)

Martin: (Thinks hard, tries to recall.) No.

Moreno: She's only in the first, but not the second.

Martin: (More certain now.) No, she isn't in the second.

Moreno: Now tell me, in that dream, did you awake from the first or did it all merge into one dream? (Drops his hand, continues to stand near Martin.)

Martin: (Doesn't respond, tries to remember.)

Moreno: When the dream ends, therefore, Martin, you have two feelings. One isn't a pleasant one, you didn't feel happy about it. On the other hand you have the urge to record the dream. You felt it might be useful. To whom?

Martin: To me, I mean, just to put it down, or maybe to you. I thought it was a good idea to get it down before it slipped away from me.

Moreno: You tried to put it down the best you could.

Martin: (Affirmatively) Hmmm.

Moreno: I want to ask you a few questions and you just muse about them the best way you can. The first one is: You think in your dream that your wife, Jean, before she has an intercourse with a man, takes a bath. Taking a bath and making yourself clean and neat, you make yourself attractive. In this case Jean makes herself attractive to the man with whom she is going to have intercourse. The second is: in the dream you resent very much that your wife should be examined by a doctor. Gynecological examination is something like a sort of sexual intercourse with the doctor. Going to a doctor to be examined is like having intercourse with a man. Is that what you think?

Martin: That is my reaction. I mean, I have the same kind of reaction as though it would be a real intercourse. If it were necessary to describe intercourse I have the feeling that that's what this is.

Moreno: You think that a woman who is preparing to go to a gynecologist has very many components which relate themselves easily to what a sexual act is —she takes a bath, she makes herself clean, she makes herself attractive. A woman, when she makes herself attractive to go to the doctor feels: "I want him to feel that I'm good looking, I want him to like me. I don't want him to feel that I'm neglecting myself and that I'm not clean and neat when I appear." In other words, it is for you, the husband of Jean, the same as if she would have an affair with a man. It is true that it is an affair that is highly dignified by custom and has a professional meaning. I know that you realize this, but, at the same time, you can't help having this compulsive thought that it has so many factors which are similar to the way in which a woman prepares herself for sexual intercourse. In fact, she takes more care of herself when she goese to the doctor than when she goes to bed with you. The doctor is a novelty, like a new and unknown lover whom she wants to conquer. She does not have to conquer you.

Martin: Yes, yes.

Moreno: She takes a longer bath, she cleans herself more when she goes to the doctor. She makes hereself as attractive as possible. She thinks of it as being a major adventure.

Martin: Come to think of it, she puts lipstick on when she goes out but I don't see her with too much lipstick on around the house. She does this only when she goes out. And when she goes to see doctors she appears to be most attractive.

Moreno: So, in your dream you can't stand the idea that she takes a bath because that means to you that she will have a sexual act, intercourse with the doctor. You resent very much that doctors have a privilege of doing that, just to examine and being paid for it in addition. Under the pretext that they are doctors they become very intimate with your wife. You don't want your wife to be available to every doctor's fancy. But the worst of it is: she seems to like to go. She doesn't put up any particular resistance. She takes every opportunity to go to the doctor to be examined. You feel that she should be stopped. What's the idea? She almost acts as if she and you were strangers. She doesn't want *you* to go along. That is exactly how a woman acts when she has a date with a stranger. Then she doesn't want another man to be around. She wants to be alone with him. Here she is alone with a man in a

room and he does the same thing to her that a lover would do. Now, you didn't marry her for that. There is no excuse for it! So you resent it violently and you are amazed that your own sister agrees to it. All the women seem to agree on this point. But you feel that it is the same thing as being intimate with another man. Who is Doctor Stone? Do you know who he is?

Martin: No, I was struck by the name. As I think of it, it's my own!

Moreno: It's your own name. To top off everything else she goes to another Stone. Who is the other one you mentioned, the one on the hill?

Martin: Bridge.

Moreno: Yes, Bridge.

Martin: I don't know how to make that out. She's never visited a Doctor Stone. There are a number of doctors, one by the name of Farrell, another by the name of Swanson, whom I mentioned to you before, one by the name of Brewster and another by the name of Hoffman. But no one by the name of Stone.

Moreno: Why does she go to so many doctors? Why doesn't she have only one. Why does she change from one to the other?

Martin: She changes because of my reactions. The first doctor I took any notice of was the obstetrician, Farrell. Swanson, before that, I took no notice of him. I transplanted the feeling to him after the experience with Doctor Farrell. I wanted to see him and because of my reaction I decided that I didn't like him and that she should look for someone else. So we went to Doctor Swanson. I met him and didn't like him. Then we went to a clinic and there we saw Doctor Hoffman and Brewster and I didn't like them. I saw three to five more. I got the same reaction. I just didn't like them at all. I had the same reaction with each one of them.

Moreno: You met them, saw them face to face?

Martin: Yes, I met all of them.

Moreno: You went to them to convince yourself that they are regular guys, that they are not in any way upset by it.

Martin: I went even further than that. I told one of them that the only trouble with me was that I didn't know what was going on and if I could find out, if I could actually be there I would lose this feeling of anxiety. So on two occasions when I went to this clinic, once with Dr. Hoffman and once with Doctor Brewster, on two occasions at least I went into the examining room. They made special arrangements. They fixed it up with the matron. I just said right out that we had come down together and if it was alright with them we would stay together.

Moreno: In other words, you stayed right in the examining room as she was being examined? You saw her being examined?

Martin: Yes.

Moreno: Martin, now let us return to bed and repeat the way your dream ended. (Moves back towards the bed. Martin follows.)

Martin: (Lies down in bed again, with his arms and legs in the position in which they were when he last enacted the end of the dream.) I feel badly. I raise my arm as if to hit someone. But here the dream ends.

Moreno: Are you satisfied with the end? (Stands near Martin.)

Martin: No. I have the urge to do something, to hit someone. I feel a grinding pain in my stomach. I can feel it all over again.

Moreno: Are you thinking of anyone in particular?

Martin: I'm thinking of myself . . . You know, I would like the dream so to continue that I'm the doctor.

Moreno: (Nods.) Let's see you as the doctor. (Moves off stage.)

Martin: I see myself coming to the examining room. I stand over there . . . (Points to right side of stage.)

Moreno: Then get up and stand over there.

Martin: (Gets up and steps eagerly across the stage.) My wife is over at the other side of the room. When I am the doctor I am between them.

Moreno: Your wife is over at the other side of the room. (Motions to same auxiliary ego who took Jean's role before; she comes up and goes to the side of the stage indicated by Martin.)

Martin: Then I suddenly turn into the doctor. (Moves towards the middle of the stage, walks slowly.)

Doctor: I want to make all the examinations myself. I see Jean before me, but she is not the patient, she is apparently the nurse. Suddenly she is gone. I'm talking to someone who is angry. I see his big eyes staring at me. I think it is Martin, I'm not sure, it may be the eyes of any man whose wife goes to a gynecologist. I say to him: "I see that you are suspicious of doctors. You think that I have performed a hymenectomy upon your wife, before she married you."

Martin (Soliloquizes.) Yes, that's it. (Explains: I'm continuously changing from the doctor's role to myself—when I do that I'll change my position on the stage; when I'm over here I'm the doctor, over here I'm myself—does as he describes.)

Doctor: (Shakes his head, acts embarrassed, his face is red.)

Martin: (Moves closer to where doctor stands; soliloquizes.) He wants to know why I believe this. (To the doctor.) Why? Because on the first night we were married our sexual intercourse was not as difficult as I imagined it would be.

Doctor: (Doesn't speak, acts guilty.)

Martin: (Soliloquizes.) I become excited. (To doctor.) My wife was a virgin and I expected difficulty, a rupturing of the hymen, a barrier to be broken through! I feel sure the hymen was missing.

Doctor: I didn't do it, didn't do it!

Martin: But my wife was a virgin, she had no previous sexual relations. There is no alternative. It must be. You did it!

Doctor: (Comes closer to where Martin stands, speaks gently.) Your wife was a virgin on the first night of your marriage. It was you who performed the operation, you, Dr. Martin Stone.

Martin: (Turns to Moreno.) At this point I'd like the dream to end. (Moreno comes upon the stage.)

(Moreno and Martin stand in the center of the stage, facing each other.)

Moreno: And where do I come in?

Martin: You mean, in the dream?—Of course, you too, are a doctor. (Walks a few steps away and returns.) But there is a difference. You are *my* doctor. I came to you just like Jean went to her doctors.

Moreno: Is that why you did not bring your wife along? (Affectionately puts his arm on Martin's shoulder.)

Martin: (Begins to smile.) Maybe the situation is now reversed. Now it is she who is anxious to come to my doctor. I'm trying to keep her away from you, just as she was trying to keep me away from her gynecologists. It's a sweet revenge. (Moreno and he both smile, shake hands. Moreno ends the session with a discussion of other patient's responses to the dream. These are omitted here.)

Discussion of Dream Production Techniques

Moreno: (Turns to Martin and asks him) Did your dream have all the actions which you produced here?

Martin: Yes, I tried to repeat all actions.

Moreno: Did it also contain all the words which you and the dream characters spoke here?

Martin: I don't know, but they came to my mind spontaneously, as I was trying to act it out. The acting and co-acting appeared to increase my ability to remember and to reproduce.

The objective of psychodramatic techniques is to stir up the dreamer to produce the dream instead of analyzing it for him. Even if one could be sure that the analysis is objective and reliable it is preferable if analysis is turned into production by the dreamer.

The *first* stage of the production was the dream which Martin actually had on the reality level on a specific date; then Martin was unconsciously his own producer. The stage of production was in the mind of the sleeper, the dreamer hallucinates all his auxiliary egos and auxiliary objects. There was no one to share the dream with him, he was the sole agent of his warming up process and the end which the dream had, pleasant or unpleasant, had only him as a witness and observer.

The *second* stage of production takes place in a Theatre of Psychodrama; it is here that therapy begins. As the dreamer begins to re-enact his own dream with the aid of a director and auxiliary egos, the manifest as well as the latent configurations of the dream come forth naturally. Whatever a verbal analysis could reveal to the dreamer is brought out in direct, actional terms. The dreamer does not have to "agree" with the analyst, his own actions tell him and the audience what processes take place in his mind. One might say that instead of being analyzed through analysis he is analyzed through production. Analysis becomes submerged into the production. It is of advantage that learning does not have the form of analysis but the form of living out in action, a form of self realization through the dream. Beyond this the dreamer brings forth experiences which are in analysis as well as in all verbal communication frequently guess work and as such often unreliable or at least limited.

The *third* phase of the dream production is stirring the patient up to extend the dream *beyond* the end which nature has set for the sleeper or at least the end which he remembers. He is encouraged to re-dream the dream, to continue the dream on the stage and to end it in a fashion which appears more adequate to him or which brings him to a better control of the latent dynamics upsetting him. Such a procedure becomes a veritable "dream test" and leads to an intensive form of catharsis which may be called "dream catharsis." This kind of "dream learning" leads up to the next stage.

The *fourth* stage finds the patient again back in his own bed, sleeping as he was in the first phase *in situ*, in reality. He is again his own director, hallucinating his own dream characters and objects. But what he has learned in the course of active dream production he is apt to apply now, to the same dream if it is a recurrent one, or to a similar dream emerging in him. One could speak

here of "post-psychodramatic suggestion" as one talks about post-hypnotic suggestion. In both cases an operation reaches into the patient's unconscious activities long after he has been exposed to it and it reaches him on a deep action level, for instance here during sleep; he becomes his own dream therapist.

Some Psychodramatic Hypotheses in Need of Testing

The testing of psychodramatic hypotheses within the framework of experimental design is the most urgent need in action research. Several noteworthy efforts have been made in this direction by Zerka Toeman in her *Role Analysis and Audience Structure,* (Psychodrama Monograph No. 12, 1944) in which she compares three audiences exposed to the same psychodramatic focus, coming to significant conclusions as to their structure. In another study "The Double Situation in Psychodrama," *Sociatry* (now Group Psychotherapy) Vol. I, No. 4, 1947, pp. 436-446, in which the verbal and action process taking place in psychodramatic situations are evaluated by means of controls. Other contributions were "Improvisations, an application of psychodrama to personality diagnosis," by Urie Bronfenbrenner and Theodore Newcomb, *Sociatry,* Vol. I, No. 4, 1947, pp. 361-382. A comparison of interview with role playing techniques has been demonstrated in "Experimental Sociodrama in an Industrial Setting," by J. L. Moreno and Edgar Borgatta to be contained in *Group Psychotherapy,* Volume 4, No. 1, 1951, and in "The Use of Psychodrama, Sociodrama and Related Techniques in Social Psychological Research" by Edgar Borgatta, *Sociometry,* Vol. 13, No. 3, 1950, p. 244-258 and Gertrude Harrow's article "The Effects of Psychodrama Group Therapy on Role Behavior of Schizophrenic Patients" in this issue pp. 316-20.

The following hypotheses have been extensively probed in clinical work and to an extent already checked by experimental design.

1. Probing the "depth" of production of subjects on a) the psychodramatic action level, b) the reality level and c) the verbal level; the probabilities are that the subjects will reach deepest, other circumstances being equal, on the psychodramatic action level, ranking second on the reality level, ranking third on the verbal level. Probing the "adequacy" of production and response to given situations the ranking may vary with the type of individual.

2. Recall and realization of determining factors operating in the past or in the present is facilitated by actions into which the patient moves himself spontaneously.

3. The deeper the action level reached by the patient the more explicit and extensive is the potentiality and range of recall.

4. A therapeutic change within the self and permanent removal of syndrome cannot take place except within the action matrix.

Instead of confronting symptomatic (or peripheral) therapy with causal therapy it is useful to consider them rather as ends of a scale with many degrees in between. In this sense suggestion therapies are more peripheral than interview therapies; psychoanalysis is the deepest among the interview therapies but it must be counted among the symptomatic therapies. Only action methods are causal and central, at least theoretically; only they are so constructed as to attack the action matrix of a person directly and, if possible, to change it.

5. Psychoanalysis differentiates between two categories, manifest and latent dream. A third category is here added, the "action matrix" of a dream.

6. The factor producing the dynamic exchange of interaction and "interfeeling" is not a one way approach like empathy, it is a two way approach, a "tele" phenomenon of which transference and empathy are significant parts.

7. The value of production and action techniques for the purposes of analysis is growingly appreciated by psychoanalytic therapists. Dr. Frieda Fromm-Reichmann in her book "Principles of Intensive Psychotherapy" reports the use of the "double" technique developed by psychodramatists. Although she does not call it by that name it is the same well known operation. The therapist, by imitating some puzzling gesture or muscular action of the patient may get clues to its significance by experiencing in his own mind what the action feels like.

ANNOUNCEMENTS

An International Congress for Psychotherapeutics

This meeting is to be held at Leiden-Oegstgeest, Holland, September 5-8, 1951. Among others, there will be a section on Group Psychotherapy. For further information contact Secretary of the Dutch Society for Psychotherapeutics, Psychiatric Clinic, State University of Leiden.

Group Psychotherapy at Brooklyn State Hospital

The group psychotherapy project which has been conducted for two years at this hospital under the direction of Dr. Nathaniel J. Breckir is being continued.

Current Trends in Group Psychotherapy

An address given by Dr. Louis Wender at the Association for the Advancement for Psychotherapy meeting, Friday, March 30th, at the Academy of Medicine. Discussants: A. Wolf, J. L. Moreno, S. R. Slavson.

Sixteenth Workshop on "Training in Human Relations"

Reservations are now being taken for the above mentioned workshops which are to be held at the Moreno Institute, Beacon, New York, on Decoration Week-end, May 26th through 30th respectively. Special rates given to large groups. These workshops deal intensively with group and action research and the application of psychodrama, hypnodrama, sociometry, sociodrama, group psychotherapy and therapeutic motion pictures to human relations problems. Room, Board and Tuition: $17.50 for 1 day or part of day; $25.00 for 2 days; $35.00 for 3 days; $42.50 for 4 days; $50.00 for 5 days. For further information and your reservation write to Moreno Institute, P.O. Box 311, Beacon, New York.

AMERICAN SOCIETY OF GROUP PSYCHOTHERAPY AND PSYCHODRAMA (ASGP)

Draft of Constitution

The ASGP is incorporated as a Membership Society in the State of New York. The draft of the new constitution will be presented to members for comment in the next Newsletter. It is the oldest society of group psychotherapy, having been founded in 1942, and had its first Annual Conference in 1943 (See Report in Sociometry, Vol. VI, 1943). Its first President was Dr. J. L. Moreno, its first Secretary the late Dr. Bruno Solby (1942-1943); he was succeeded by Dr. Frederick Feichtinger (1943-1944). The present Secretary is Dr. Leonard K. Supple, Beacon, New York.

A Section on Group Psychotherapy in the American Psychiatric Association

The Council decided, at its meeting on November 7th to postpone a permanent section but to establish one on a "trial" basis for several years. As a result of this decision a Symposium on Group Psychotherapy, Theory and Practice, has been organized for this year (Chairman, Dr. Winfred Overholser, Secretary, Dr. J. L. Moreno). The Symposium is scheduled for Friday, May 11, at 10:00 A.M. at the Netherland Plaza Hotel, Cincinnati, following the introduction of the incoming President-Elect. Additional papers will be presented in the afternoon of the same day.

Round Table Conference on Group Psychotherapy and Psychodrama

This Round Table marks the twentieth anniversary of the beginnings of this specialty within the American Psychiatric Association. There will be twelve speakers. A number of *special guests* will be present, pioneers and leaders of group psychotherapy and psychodrama. An effort is being made to have all those who have enriched or sponsored these new forms of therapy present in person or represented. Besides the listing of the Round Table Conference in the program of the American Psychiatric Association a special bulletin will be released featuring the occasion, listing all the special guests, speakers and some historical highlights. Enclosed is a reservation blank for the *Round Table Dinner*. Please make your reservation in the near future if you want to secure your participation.

Moderator: Dr. Alan Gregg; speakers: Drs. J. W. Klapman, R. Dreikurs, J. L. Moreno, A. Wolf, J. Bierer, Rosemary Lippitt, A. Bachrach, D. Shaskan, V. W. Bikales, D. Carmichael, J. D. Schultz. To be held during the meeting of the American Psychiatric Association, Thursday, May 10, Ballroom, Hotel Gibson, Cincinnati, 7:00 P.M.

Sections or Symposia on Group Psychotherapy in Other Organizations

The International Congress of Psychiatry held a symposium on Group Psychotherapy in Paris, France, on September 24, 1950. The Group for the Advancement of Psychiatry (GAP) has been contacted for the purpose of establishing a Committee on Group Psychotherapy within its framework.

Membership, Membership Dues in the ASGP and Subscriptions to the Journal Group Psychotherapy

In the last issue of the Journal *Group Psychotherapy*, Vol. 3, No. 2-3 we reported one hundred and twelve new members since July, 1950. Since then the new membership has doubled, about two hundred and fifty additional members having joined in six months. We are able, therefore, to continue the annual membership dues of $3.50, including subscription to the journal *Group Psychotherapy*. Foreign members pay $1.00 additional to cover postage and special handling. The increased subscription rate of this journal for non-members is $8.00 per annum in the U.S., foreign $1.00 additional. Membership application card is herewith enclosed.

Dr. J. L. Moreno, Candidate for the Presidency of the American Psychiatric Association

Having been petitioned by a large number of Fellows and Members of the American Psychiatric Association, J. L. Moreno's name will be on the ballot for the 1951 general elections.

Workshop in Group and Action Methods

This workshop is being sponsored for the second year by the Board of Education of the City of New York in cooperation with the Moreno Institute. The workshop is to be held at the Institute at 101 Park Avenue, New York City, and to be given to a selected group of teachers specializing in guidance and counseling who will get in-service-training-credit for salary increment. The new semester begins February 5, 1951.

Demonstrations of Group Psychotherapy and Psychodrama

Working as a team Dr. and Mrs. J. L. Moreno have been conducting clinical workshops at the following places in recent weeks: Phipps Psychiatric Clinic, Johns Hopkins Hospital, Baltimore, Maryland; Veterans Administration Mental Hygiene Clinic, Philadelphia, Pa.; State Hospital, Milledgeville, Georgia; Veterans Administration Hospital, Tuskegee, Alabama; Veterans Administration Hospital, Tuscaloosa, Alabama. The Moreno Institute, Beacon, New York will be glad to suggest to inquirers teams of Psychiatrists and Psychologists trained in group and action methods for seminars to be conducted in their own state and locale.

Group Psychotherapy and Psychodrama Projects

The following have been working on such projects recently: Drs. D. P. Morton and C. L. Morgan, Veterans Administration Mental Hygiene Clinic, Philadelphia, Pennsylvania; Dr. J. L. Combs, State Hospital, Milledgeville, Georgia (Superintendent Dr. Thomas G. Peacock); Allen's Invalid Home, Milledgeville, Georgia; Drs. P. P. Barker, James T. Morton, Veterans Administration Hospital, Tuskegee, Alabama; Drs. Louis Byers, T. J. Thomas, Martin J. Brennan, Veterans Administration Hospital, Tuscaloosa, Alabama.

The Journal Group Psychotherapy

Table of Contents of forthcoming issue, Volume IV, No. 1, April, 1951; Drs. Pierre Renouvier, "The Group Psychotherapy Movement, Its Pioneers and Founders;" J. L. Moreno, Edgar Borgatta and Theodore Jackson, "Group Psychotherapy and Sociodrama in Industry;" J. H. Pratt and Paul E. Johnson, "Group Psychotherapy at the Boston Dispensary;" H. Michael Rosow and Lillian P. Kaplan, "Individuo-Group Psychotherapy;" S. H. Foulkes, "Remarks on Group Analytic Psychotherapy;" H. R. Teirich, "Group Psychotherapy in Austria and Germany;" "Instructions on How to Form Therapy Groups;" "Inter-action Research," by J. L. Moreno; other papers by Dr. Abraham Schneidmuhl, Oscar Pelzman, Nathan W. Ackerman, and E. H. Crawfis.

Sociometry, A Journal of Inter-Personal Relations

Editors-in-Chief: Frederic M. Thrasher. New York University and Leona M. Kerstetter, Hunter College; Associate Editor: Edgar Borgatta, New York University; Managing Editor: Joan H. Criswell, Bureau of Naval Personnel.

Moreno Institute

The Moreno Institute, the successor of the Sociometric Institute Inc., has been incorporated by the Board of Regents of the State of New York and granted a *provisional charter.* The Institute will continue the program of the Sociometric Institute founded in 1942. The new catalogue announcing schedules of courses in group psychotherapy, psychodrama and sociometry at the New York and Beacon branches, staff of instructors and details as to fees and enrollments will gladly be sent upon request.

Fees are moderate, a few part-scholarships are available. Special rates are given to veterans.

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